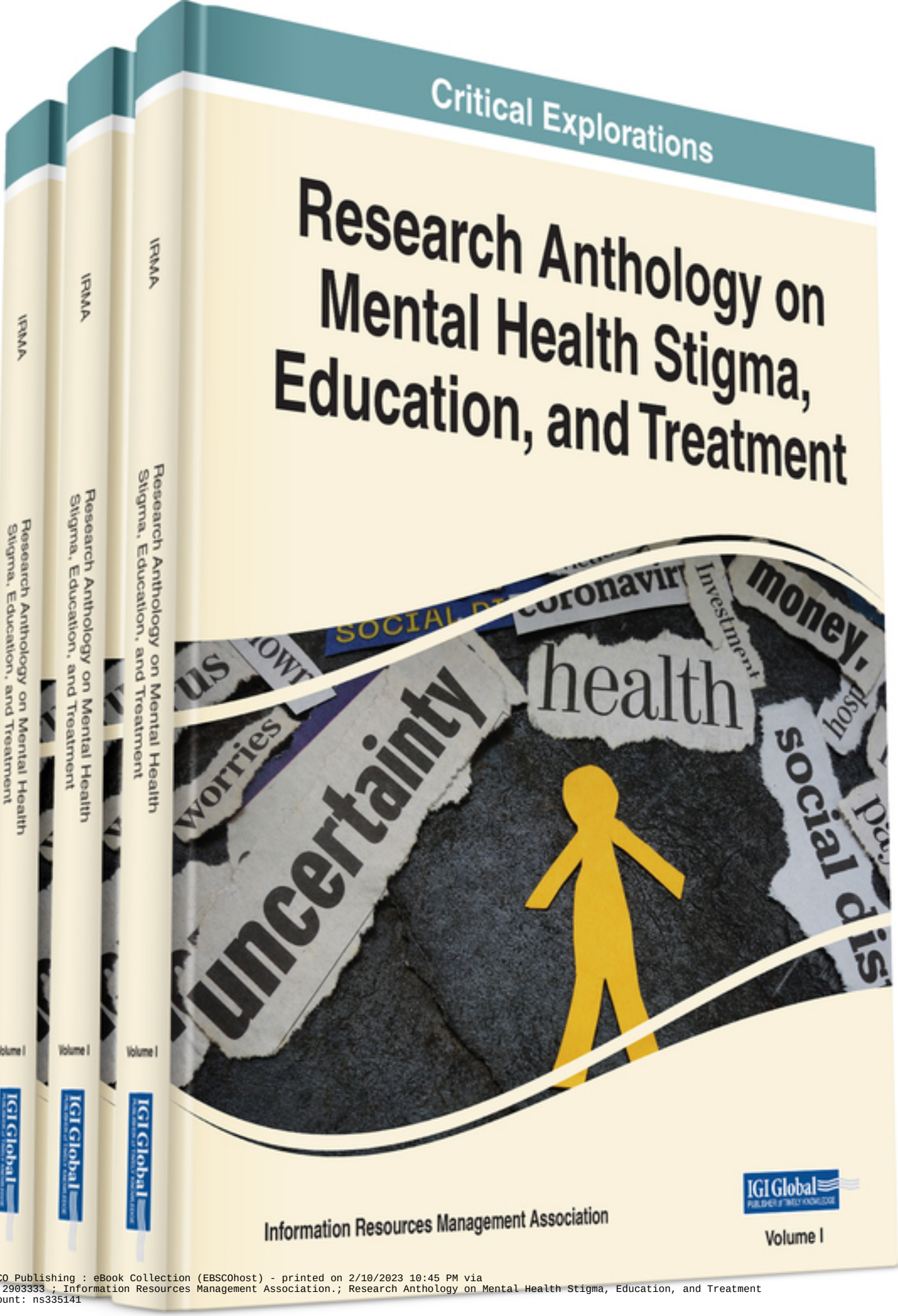


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Preface

Mental health has always been a critical issue in society, yet it has not always gotten the proper attention and recognition it deserves. Recent efforts have been employed to reduce negative mental health stigma and better provide education on the different mental illnesses. By better informing society, including those in the medical field and working in mental health, better treatment options and new explorative methods and advancements have been discovered and can continue to improve in the future. Opening the dialogue on mental health, reducing negative stigmas, providing more accurate education, and advanced solutions and treatments will create not only an informed and engaged public but a better quality of life for those living with mental health issues. Examining current research, case studies, and applications can lead to a greater understanding of not only the mental illnesses themselves and the people living with them, but how society and the medical field can better treat and handle mental health for a better future.

Staying informed of the most up-to-date research trends and findings is of the utmost importance. That is why IGI Global is pleased to offer this three-volume reference collection of reprinted IGI Global book chapters and journal articles that have been handpicked by senior editorial staff. This collection will shed light on critical issues related to the trends, techniques, and uses of various applications by providing both broad and detailed perspectives on cutting-edge theories and developments. This collection is designed to act as a single reference source on conceptual, methodological, technical, and managerial issues, as well as provide insight into emerging trends and future opportunities within the field.

The *Research Anthology on Mental Health Stigma, Education, and Treatment* is organized into six distinct sections that provide comprehensive coverage of important topics. The sections are:

1. Fundamental Concepts and Theories;
2. Development and Design Methodologies;
3. Tools and Technologies;
4. Utilization and Applications;
5. Organizational and Social Implications;
6. Critical Issues and Challenges.

The following paragraphs provide a summary of what to expect from this invaluable reference tool.

Section 1, "Fundamental Concepts and Theories," serves as a foundation for this extensive reference tool by addressing crucial theories essential to the understanding of mental health both in a historical context and modern times. This reference book opens with the chapter "The History of Unreason: Social Construction of Mental Illness" by Profs. Samuel Teague and Peter Robinson of Swinburne University, Australia. It outlines how health and illness can be understood as socially constructed by illustrating how

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mental health has been constructed uniquely across cultures and over time. This first section concludes with "Mental Health: A Global Issue Affecting the Pattern of Life in Kashmir" by Prof. Asma Ali, an Independent Researcher, India; Profs. Shazia Ali and Hussain Bhat of Sheri-Kashmir Institute of Medical Sciences, India; Prof. Amat Us Samie of Superspeciality Hospital Shireen Bagh, India; Prof. Aashiq Tariq Mir of Government Medical College, Srinagar, India; and Prof. Barre V. Prasad of All India Institute of Medical Science, India, which explores the patterns of resilience in people surviving war and conflict in Kashmir over the last 60 years with a focus on the young population.

Section 2, "Development and Design Methodologies," presents in-depth coverage of how counseling systems and mental health programs are designed and developed. This section starts with "Paradigm Shifts in the Theory and Praxis of Mental Health Counseling" by Prof. Moly Kuruvilla of the University of Calicut, India. The chapter focuses on the role of gender in clinical psychology, specifically feminist psychology, and how these views have changed over time. This section ends with "Attitude Training for Police Cadets: Addressing the Problem of Arresting Suspects With a Mental Illness" by Prof. Bruce L. Mann of Memorial University, Canada, which describes an approach for attitude-training programs with police cadets to better prepare them for dealing with people with mental illness.

Section 3, "Tools and Technologies," explores the various tools and technologies used to provide mental health services and make them more accessible and acceptable to society. Beginning this section is the chapter "Real-Time Mental Health Monitoring: The Indian Scenario" by Profs. Vishal Jain and Ritika Wason of Bharati Vidyapeeth's Institute of Computer Applications and Management, India and Prof. Prashant of Thapar Institute of Engineering and Technology, India, which analyzes how real-time mental health monitoring has helped improve productivity among the global workforce as well as prevented deterioration of individual mental health across the globe. This section ends with "Narrative Therapy to Address Trauma for Emergency Medical Services and Firefighters" by Profs. Amanda C. DeDiego and Andrea M. McGrath of the University of Wyoming, USA and Prof. Isabel C. Farrell of Wake Forest University, USA, which explores narrative therapy as an ideal option for mental health treatment of first responder trauma, providing a collaborative approach to therapy using the natural coping strategy of storytelling.

Section 4, "Utilization and Applications," describes how programs and services are being developed and offered for mental health along with the trends in how mental health issues are addressed and portrayed. Opening this section is "Individual Funding for People With Mental Health Issues: Opportunities, Tensions, and Outcomes" by Profs. Christina David, Carmel Laragy, and Elizabeth Hudson of RMIT University, Australia, which outlines the key features of individual funding programs and examines their suitability for people with mental illness. The chapter "Media, Social Media, and the Securitization of Mental Health Problems in Nepal: Yama Buddha's Case Study" by Profs. Sudeep Uprety and Rajesh Ghimire of Tribhuvan University, Nepal concludes this section by unfolding the trend and nature of mainstream and social media coverage on mental health issues and providing recommendations for the future.

Section 5, "Organizational and Social Implications," includes chapters discussing the impacts of living as an individual with mental health and the social and organizational impacts of mental illnesses. This section begins with "Barriers to Practitioners' Endorsement of a Recovery Perspective: Considering Attitudes Through a Schema Lens" by Prof. Debra Kram-Fernandez of Empire State College (SUNY), USA, which is concerned with the impact of practitioner biases on the experience of a meaningful life for individuals who live with serious mental illness (SMI). It ends with "Occupational Risk Factors and the Mental Health of Women Firefighters" by Prof. Brittany Sara Hollerbach of the National Develop-

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ment and Research Institutes, Inc., USA, which examines relevant literature pertaining to firefighters and mental health with a specific focus on behavioral health aspects that may impact the mental health of women firefighters.

Section 6, "Critical Issues and Challenges," presents coverage of academic and research perspectives on the challenges and issues within mental health and the strategies to mitigate negative impacts and provide affective solutions and therapies for individuals with mental illness. This final section opens with "Adolescent and Adult Mass Shooters: Trauma, Mental Health Problems, and Early Prevention" by Prof. Christopher A. Mallett of Cleveland State University, USA, which takes a broader approach to understanding why mass shootings may have happened by reviewing the empirical literature to identify possible correlations from childhood and adolescent trauma experiences (and subsequent mental health problems) to later adult violence. Concluding this reference work is "Deliberate Self-Harm and Suicide Ideology in Medical Students" by Profs. Vinod Gopalan, Erick Chan, and Debbie Thao Thanh Ho of Griffith University, Australia, which explores assessment, preventative, and management strategies to improve education, awareness, and ultimately reduce the rates of deliberate self-harm (DSH) and suicide risk.

Although the primary organization of the contents in this multi-volume work is based on its six sections, offering a progression of coverage of the important concepts, methodologies, technologies, applications, social issues, and emerging trends, the reader can also identify specific contents by utilizing the extensive indexing system listed at the end of each volume. As a comprehensive collection of research on the latest findings related to mental health, the *Research Anthology on Mental Health Stigma, Education, and Treatment* provides researchers, administrators, psychologists, psychiatrists, therapists, school counselors, trauma specialists, teachers, mental health professionals, academicians, students, and academicians with a complete understanding of the role mental health has in society along with the new methods for treatment, education, and the reduction of negative stigmas. Given the vast number of individuals living with mental illnesses and the many ways in which mental health impacts society, the *Research Anthology on Mental Health Stigma, Education, and Treatment* encompasses the most pertinent research in the technologies, theories, and methods being employed to better understand mental health and provide effective treatments and services for the impacted individuals.

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Section 1

Fundamental Concepts and Theories

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Chapter 1
The History of Unreason:
Social Construction of Mental Illness

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ABSTRACT

This chapter reflects on the importance of the historical narrative of mental illness, arguing that Western countries have sought new ways to confine the mentally ill in the post-asylum era, namely through the effects of stigma and medicalization. The walls are invisible, when once they were physical. The chapter outlines how health and illness can be understood as socially constructed illustrating how mental health has been constructed uniquely across cultures and over time. To understand this process more fully, it is necessary to consider the history of madness, a story of numerous social flashpoints. The trajectories of two primary mental health narratives are charted in this chapter. The authors argue that these narratives have played, and continue to play, an important role in the social construction of mental illness. These narratives are "confinement" and "individual responsibility." Drawing on the work of Michel Foucault and Roy Porter, the authors describe how Western culture has come to consider the mentally ill as a distinct, abnormal other.

INTRODUCTION

In the years preceding the seventeenth century, the mentally ill were placed on boats, taken to foreign locations, and dumped there, and for European populations, this was the primary method for dealing with a portion of society considered abnormal (Foucault, 1967). Michel Foucault (1967) described this *Ship of Fools* as a vessel for those who had no real connection to time or place, for "as the madman sets sail for the other world, it is from the other world that he comes when he disembarks" (p. 8). This image of the mad as incongruous and lost on the high seas resonates in the imagination of the twenty-first

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century sociologist, because while the *Ship of Fools* no longer exists, the authors suspect that society's perception of the mentally ill as both deviant and abnormal endures.

Even throughout the twentieth century, western civilization continued to perceive and construct mental illness as an abnormality. In the original 1952 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1952), patients could be diagnosed under one or more of 106 conditions. In 1994, the DSM-IV contained nearly 300 disorders, an increase of close to 300% in just five decades (American Psychiatric Association, 1994). Peter Conrad (2007) included these statistics in his thesis on the problems inherent in modern medicalization, and used them to outline the modern trend within which human beings are increasingly defined as sick rather than healthy, and as abnormal rather than sane. Certainly, the introduction of Prozac in 1987 as a drug for the treatment of depression has signaled the dawn of a new era where antidepressant medication is used to treat "life problems" as well as serious illness (Conrad, 2007, p. 61). In this chapter, we show that from the *Ship of Fools* to the introduction of Prozac, western civilization has sought to understand and develop ways of controlling those being treated for mental illness.

This chapter details the history of mental illness, as portrayed by Roy Porter (1987; 2002), Michel Foucault (1967), Andrew Scull (2015), Erving Goffman (1959; 1963), and Peter Conrad (2007). The authors trace the trajectory of the principal narratives that have characterised this history, and outline how they persist and operate today. Scholars who have sought to interpret present media portrayals of the mentally ill have neglected an appreciation of the history of mental illness. An account of the history of mental illness is critical in interpreting the present socio-cultural media landscape. In constructing this detailed historical account, the chapter is divided into four parts.

The first introduces the notion that the lived experience of mental illness can be understood as socially constructed. Attention is given to the debate between essentialist and constructionist perspectives, and the authors outline how the two can be considered in unison. The section summarizes the biomedical approach to health for the purpose of detailing how social understandings of health and illness are constructed uniquely across cultures. The second section of this chapter describes the history of madness, and drawing predominantly on the work of Michel Foucault, the authors chart the trajectory of two primary mental health narratives which have played, and continue to play, an important role in the social construction of mental illness. These narratives are "confinement" and "individual responsibility". In part three, this historical account continues, addressing the legacy of Sigmund Freud, the closing of asylums in the 1980s, and an account of the breadth and scope of modern medicalization. The chapter concludes with a focus on Australia's mental health history from 1870 to the present.

BACKGROUND

Mental Illness as Socially Constructed

The experience of mental illness can be understood as socially constructed. By considering mental health from this standpoint, emphasis is placed on the importance of historical accounts, the mental health narratives that underpin these, and print media's role in shaping public attitudes towards the mentally ill. It is the social constructionist standpoint that forms the foundation for this chapter. Questions around how mental illness can be understood have long been characterised by the philosophical debate between "constructionists" and "essentialists". Greider and Garkovich (1994) argue that even the physical en-

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vironment – a wheat field or savannah plain – can be understood as a socially constructed "symbolic landscape" (p. 1). They propose that a real estate developer, a farmer, and a hunter each perceive the environment in distinct ways, making a concrete physical reality a myriad of potentials "grounded in the cultural definitions of those who encounter that place" (p. 2). For these scholars, a rock is not merely a rock, but a sacred stone, a cutting tool, or a wishing pebble, as the world is infinitely constructed and reconstructed.

Latour and Woolgar (1979) expand on this argument, arguing that the scientific study of external phenomena is mostly political and "entirely fabricated out of circumstance" (p. 239). Observing scientists at work in a laboratory, these theorists found that the objective of positivist study was to extend and speed up the credibility cycle for scientists through the creation of work that would grant them a status of higher esteem. In other words, scientists are social creatures first and foremost. Latour and Woolgar (1979) found that the scientists at the center of their research were writers and readers in the business of being convinced and of convincing others, operating within a laboratory that engaged in an organised system of "persuasion through literary inscription" (p. 88). Neurosurgeon and writer Paul Kalanithi (2017) wrote just twelve months before his death in March 2015:

Scientific methodology is the product of human hands and thus cannot reach some permanent truth. We build scientific theories to organise and manipulate the world, to reduce phenomena into manageable units. Science is based on reproducibility and manufactured objectivity (p. 169).

This particular example illustrates the breadth and scope of the constructionist perspective, which suggests that if scientific facts can be understood as socially constructed, then so too can mental illness.

Bury (1986) presents an alternate perspective, arguing that in giving little attention to the existence of a concrete physical reality, constructionists undersell the important role it plays in shaping our understanding of the world. Bury argues that physical reality and human knowledge partake in a fluid relationship, whereby knowledge engages and operates with physical reality, while that physical reality simultaneously imposes itself on human knowledge. He believes that too much emphasis is placed on the human appreciation of a landscape or phenomenon, when the relationship between the two is an interwoven tapestry, and he takes issue with Steven Shapin's (1982) argument that scientific knowledge is routinely constructed to serve the interests of its users. In other words, facts about the origins of a particular disease are "discovered" in the laboratory so as to aid doctors in the treatment of their patients, and Bury argues in response to this that by representing medical knowledge as constructed in the interests of powerful institutions and groups, the sincerity and compassion at the basis of the medical profession is undermined. If facts about illness are constructed, then doctors become mere actors in the constructed play of life.

A balanced view can be a panacea to a philosophical divide. A concrete physical reality can exist, but the construction of attitudes, perceptions, and beliefs around the phenomenon are fluid, malleable, and worthy of study. Barnes (1977) argues that a concrete physical reality and our ideas about it can exist together.

Knowledge is related to activity which consists precisely in men attempting to manipulate, predict and control the real world in which they exist. Hence knowledge is found useful precisely because the world is as it is; and it is to that extent a function of what is real, and not the pure product of thought and imagination. Knowledge rises out of our encounters with reality (p. 110).

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This perspective emphasizes the power of social institutions and the human beings who operate within them to construct external phenomena. As a result, social constructions can be liberating because they remove expectations and allow for reconstructions.

A significant amount of social research supports this argument, that an external social world can be constructed around a distinct organic entity. Julie Hepworth's (1999) account of the social construction of anorexia nervosa suggests that the reality of this illness, for many centuries, has involved three common elements: the starving of oneself, weight loss, and the exhibiting of a common mental dullness. In the twelfth and thirteenth centuries, anorexia nervosa was associated with holiness, as those who chose to subsist on minimal nutritional quantities were considered divine, and subsequently revered (Hepworth, 1999, p. 13). Today, the same individuals are defined as unwell, mentally ill. While the three common elements of the illness have not changed significantly, society's understanding of the phenomenon has, and in a cyclical fashion. This shift in understanding and attitude has transformed the lived experience of anorexia nervosa, which we argue is evidence of the power of human beings to construct and re-shape reality.

Michel Foucault (1967) and Roy Porter (2002) base their respective historical accounts on the assumption that the lived experience of mental illness can be understood as dependent on social forces. Foucault's thesis concerns the power and influence of social institutions.

Whether madness is described as a religious or philosophical phenomenon … or as an objective medical essence … these conceptions are not discoveries but historical constructions of meaning (p. xiv).

While Porter questions some aspects of Foucault's argument, he supports the claim that the history of madness is an account "not of disease and its treatment but of questions of freedom and control, knowledge and power" (Porter, 2002, p. 3). Neither Foucault nor Porter claim that psychological anguish is fictitious, but that the social world around the individual being treated for mental illness is a construction.

Thomas Szasz was a significant figure in the anti-psychiatry movement, which was most prominent in the second half of the twentieth century, and he states in his thesis on "the myth of mental illness" that madness is manufactured to serve the interests of psychiatrists with a view to professional advancement, "endorsed by society because it sanctions easy solutions for problem people" (Porter, 2002, p. 2). Szasz contends that the majority of human suffering originates from life circumstances and stress and that the psychiatric profession routinely medicalises these experiences. This chapter acknowledges this claim, but draws more on the accounts of Foucault and Porter because of the attention they give to the significance of historical narratives.

Biomedical Approach

Western culture's construction of health and illness is apparent in the dominance of the biomedical approach. Biomedicine explains illness as a malfunction of the body's biological mechanisms, and it generally ignores the social origins of health and illness (Engel, 1977). It is a model that places medical professionals such as doctors in positions of power based on their status as experts in the field (Wreford, 2005). Like health and illness more broadly, medical practice has been constructed uniquely across cultures and over time. Engel was one of the first scholars to outline biomedicine's fallibility in its failure to account for the psychological, social, and environmental aspects that are so important in understanding health and illness. Engel's (1977) utopia is one where diabetes and schizophrenia are human experiences

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as well as disease, and he presents the biopsychosocial model as an alternative to biomedicine. Cooper, Stevenson, and Hale (1996) offer support for this approach.

With the biomedical approach, healthy people become manifestations of healthy, cellular activity; ill people become manifestations of dysfunctional cellular activity. The patient becomes a 'problem' to be solved, and the solution to that problem lies in adopting a scientific, mechanistic approach that precludes any consideration of social, psychological, or behavioural influences.

Cooper, Stevenson, and Hale (1996) draw attention to a subtle irony that underpins western medicine in that while biomedicine is itself a cultural construction, illness is considered almost entirely through the framework of biological function or malfunction.

That biomedicine is a social construct is supported by the differences in treatment and medical beliefs that exist cross-culturally. In African cultures, traditional healers are important in providing spiritual assistance to the sick and dying (Wreford, 2005). South American shamans see illness as a force beyond the confines of physical degradation, instead addressing sickness as "inherently socio-political and cosmological" (Greene, 1998, p. 641). In the remote ethnic communities of Peru, physical affliction is considered the product of spirits, natural forces, and even deceased ancestors. This approach is not considered guesswork in this culture, but a legitimate medical practice broadly termed "shamanism" (Bastien, 1992; Mehl; 1988). A comparison of biomedicine and shamanism emphasizes that where the custodians of legitimate medical knowledge differ, human beings forge unique and contrasting models of health and illness.

Even one's definition of mental illness can be problematic. A sociological definition of mental illness must acknowledge health and wellbeing as constructed distinctly across cultures, environments, and historical epochs, while simultaneously accepting the dominance in Western culture of biomedicine, a medical model which assumes mental illness is a disease. The argument underpinning this chapter, that mental illness can be understood as socially constructed, is derived from the work of both historians and sociologists. Thomas Szasz (2007, p. 3) described mental illness as a "metaphorical disease", invented by psychiatrists to legitimate their authority, while Roy Porter (2002) and Michel Foucault (1967) illustrated the construction of madness across specific socio-historical contexts.

Aneshensel, Phelan, and Bierman (2013) describe mental illness as a concept requiring the insights of several disciplines, and in reviewing the literature from the standpoints of psychiatry, psychology, anthropology and sociology, divided opinion prevails in the search for a universal definition of mental illness. Aneshensel and colleagues (2013) argue that mental illness consists of a vast range of behavioural, cognitive and emotional phenomena, including:

Speaking to a companion whom no one else can see; sitting silently in a room, alone, eating little and sleeping less, contemplating death; becoming suddenly overwhelmed with intense anxiety for no apparent reason; consumption of alcohol to such a degree that it becomes difficult to hold a job or maintain friendships; frequent sickness with no identifiable physiological disease; and feeling no remorse when others are injured by one's actions.

The behavioural, cognitive and emotional phenomena included in this description can form part of the lived experience of mental illness. Feelings of intense and overwhelming anxiety are often characteristic of deeper mental health issues, while the use of alcohol and illicit drugs as a form of self-medication

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to mask underlying mental health concerns is common and can lead to significant upheaval in an individual's life circumstances (Harris & Edlund, 2005).

As a definition, however, the description is inadequate because one could reasonably assume some of these behaviours and emotions are characteristic of the lived experience of the mentally well person. A readiness to associate problematic behaviour with mental illness is at the core of negligent media reporting on mental health topics. And the rush to explain violence through the lens of mental illness offers an explanatory device for every perpetrator of domestic violence.

THE HISTORY OF MENTAL ILLNESS

The history of mental illness is a story of control; a tale of both subtle and transparent confinement. It begins in the early thirteenth century, when according to Michel Foucault (1967), King Louis VIII set in motion the opening of "lazar houses", secure places for the containment of those individuals with leprosy. Such was their effectiveness that by the middle of the thirteenth century, two thousand of these institutions were in operation across France (Foucault, 1967, p. 3). While the mentally ill would not pose a problem requiring state-sanctioned control for at least another three centuries, Foucault argues that the leprosaria are an important institution in the history of madness because they signaled the creation of a specific "fearsome figure" who could be carefully excluded from society "after a sacred circle had been drawn around him" (Foucault, 1967, p. 5). Put simply, madness was leprosy's heir to the throne of otherness.

The lazar houses closed at varying rates across Europe between the fourteenth and eighteenth centuries. In 1348, the leper house at Saint-Alban in France was home to just three inhabitants, and in 1627, the leper house of Saint Bartholomew was closed also. Throughout the decades in which the lazar houses were abandoned, and before the institution of the asylum appeared across Europe, the mentally ill were placed on boats, taken to foreign locations and dumped there (Porter, 2002). This practice was the dominant means for ridding cities of the presence of an undesirable group, and it is in this practice that we find the legacy of the leprosaria. Important are its implications for European attitudes towards abnormality and deviance in the seventeenth and eighteenth centuries. Long after leprosy had vanished along with the fear of its burden, the physical structures, social attitudes, values and images that had been attached to the leper and associated with a fearsome "other", would be attributed to the mad.

In a number of European states, the seventeenth century saw the emergence of a more organised form of social control, what Foucault (1967) calls "The Great Confinement". The year 1656 marks the date, founding in Paris, the first Hôpital-Général. These institutions were not houses created solely for the insane, but for those members of the population that posed a threat to normality and progress. The idle were locked away with the mad; the venereal with the gypsies. Within three years, the Hôpital-Général in Paris became home to more than 6000 people – approximately one per cent of the French population – and just twenty years later, a royal edict decreed that an institution of the sort established in Paris should be built in every city of the Kingdom (Foucault, 1967, p. 54). The rate at which the mad were confined within these institutions differed across most European nations. Britain appears to have followed the trend in Paris. In 1651, the Navigation Act was passed in Britain signaling the formal beginning of a movement which would utilize every member of the 'abnormal' population as part of the broader workforce (Foucault, 1967, p. 67). The structures that formerly housed the lepers became sites for the confinement of vagrants, homeless, gypsies, prostitutes, and the mentally ill.

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The process of placing the "abnormal" within structures that had previously been utilized for the leper marks the emergence of two primary mental health narratives, which have contributed to the social construction of mental illness and characterized its history. These narratives are "confinement" and "individual responsibility". Foucault (1967, p. 118) described the practice of confinement as having two important consequences. First, by locking away the debauched, the venereal, the alchemists, the libertines, witches, vagrants, the homeless, the idle, prostitutes, and the insane, the outcome was that all came to be considered as one "undifferentiated mass". Particularly for the mad, European society began to distinguish the mentally ill less clearly, with the "slightly deranged" and the "crazed lunatic" sharing the same label, and subsequently, the same stigma. This is not unlike twenty-first century western countries treating someone diagnosed with paranoid schizophrenia the same as someone diagnosed with an anxiety disorder. The second consequence was that in the depths of these European asylums, madness found its place in opposition to reason and progress. Foucault (1967, p. 28) describes the relationship that developed.

Madness becomes a form related to reason, or more precisely madness and reason enter into a perpetually reversible relationship which implies that all madness has its own reason by which it is judged and mastered, and all reason has its madness in which it finds its own derisory truth. Each is a measure of the other, and in this movement of reciprocal reference, each rejects the other but is logically dependent upon it.

Within the four walls of these institutions, society's so called abnormal became one undifferentiated mass, and this mass was portrayed as opposing reason and progress. Outside lay progress and inside, its threat. As late as 1815, Bethlem Hospital in London showed its insane every Sunday for one penny, with the institution accruing an annual revenue of almost 400 pounds from 96,000 visitors who came to see the mad each year (Foucault, 1967, p. 143). This figure is the equivalent today of a little more than US$44,000. The portrayal of madness as a social spectacle and public scandal emphasizes the place of the mad in the consciousness of European populations. They were the abnormal other, not unlike the lepers centuries before, and it is important to consider this history when evaluating present day attitudes towards the mentally ill.

The second narrative – individual responsibility – is one with firm historical roots cultivated and fostered throughout the seventeenth and eighteenth centuries. The earliest depictions of mental illness, dating back to 650BC, locate madness in the context of an inner devil (Porter, 2002). The seeds of modern Western medicine saw mental illness as originating from an imbalance in the body's basic fluids and juices; or "humours" as they were called (Porter, 2002, p. 37). For a long time, at least until the beginning of the seventeenth century, many behaviours considered mad "remained fixed within the tradition of these four humours", or more pointedly, within the individual (Foucault, 1967, p. 113). Early Greek attitudes towards madness found their place within the tragedy of literary figure *Oedipus*, while Shakespeare transposed his understanding into *King Lear*. In each of these works, madness is depicted as a self-created affliction, which, through introspection of the self, forms a potential road to self-discovery. In both cases, the disease is described as a problem for the individual. Society is an audience.

While the Christian view held reason and sanity were found walking in harmony with God, most early analyses of the origination of madness came from the Socratic belief that self-control held the key to one's living conditions. If one could summon free will and base one's actions on it, then madness could be abated. Western culture, according to Foucault (1967, p. 54), saw madness as "the weakening

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of discipline and the relaxation of morals", an overflowing measure of uncontrolled passion within the individual. Foucault (1967, p. 228) contends that this belief was pervasive among European populations during the seventeenth century.

The possibility of madness is offered in the very fact of passion. It is true that since long before the classical age, and for a series of centuries that has probably not yet come to an end, passion and madness have been kept in close proximity.

The belief that individuals were responsible for their own mental health continued throughout the nineteenth century. Edgar Sheppard (1872) was the Professor of Psychological Medicine at Kings College in London, and in 1872 he wrote that the majority of those he would describe as insane "have made themselves what they are by their own vice and wickedness". We can assume that the views of professionals during and before this time were reflected in the attitudes and perceptions of society as a whole. As Erica Bates (1977) explains, knowledge on the issue of mental health is a two-way process whereby "popular beliefs influence professional thinking, and professional thinking modifies popular beliefs". It is worth considering the extent to which these two narratives persist in the twenty-first century.

Critiques of Foucault's *History of Madness*

Five decades following the publication of Foucault's (1967) *History of Madness*, the French historian's central thesis regarding the confinement of the mentally ill is still subject to critique, revision, and interpretation. As this chapter draws heavily on Foucault's narrative history, it is important to offer a short analysis of his critics' primary appraisals.

The most common critique of Foucault's history is that it is too simplistic and that his account of the confinement of the mentally ill is grossly over-generalized. Yannick Ripa (1990) agrees that madness is a social construction, one that can be interpreted as a product of changing social norms, but believes that his history neglected a "more intimate and fastidious examination of particular [social] groups" that were confined, in particular, to women. According to Ripa (1990), institutionalisation was the ultimate form of feminine repression at a time when women were being held to an absurd expectation of morality, one to which men were immune. Indeed, in his summary of the confinement of the idle, the vagrants, the homeless, and the mentally ill, Foucault (1967) makes little mention of the female asylum experience. There is very little debate on whether the movement to confine the "abnormal" took place, with Lawrence Stone (1982) describing it as "undeniable". But Midelfort (1992) and Porter (2002) both contend that Foucault misread the motivation behind society's institutionalisation of the mad. Porter (2002, p. 95) argues that the rise of the asylum was not an act of state, but a "side effect of commercial and professional society". As the affluent accrued more medical services that had previously been offered in the home, madhouse keepers were in the business of persuading the public that services in the asylum were therapeutic. By 1800, the confined mad in England were largely housed in private asylums. Midelfort (1992, p. 36) extends this argument, stating that the great confinement was aimed "not at madness or even deviance, but at poverty", and instead of a deliberate attempt to segregate the mad, the poor of every kind were locked away.

These critiques suggest that Foucault generalized French confinement and overlooked the unique characteristics of the movement in France's neighbouring countries, yet Foucault's legacy is in his depiction of confinement as a retrogressive step by which the mentally ill became one solid mass, within

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which variation would go undetected. Andrew Scull's (2015) account of the segregation of the mad offers support for that presented by Michel Foucault in his own description of the history of madness. Scull's (2015, p. 190) account reinforces the importance of the asylum in the history of mental illness, stating that the "presumed need to segregate the mad … remained so notable a feature of the Western response to mental disorder until the last decades of the twentieth century". Scull described this movement to confine and segregate the mad as "a new geography of suffering", and the asylum became the "chosen solution" to the broad set of problems posed by this deviant group (p. 190). As was documented by Michel Foucault (1967), Roy Porter (2002), and Elaine Showalter (1985), conditions in these institutions were as horrendous as those experienced by animals housed in factory farms in the twenty-first century. The following account from French physician Jean-Etienne Dominique Esquirol, who lived from 1772 until 1840, documents the conditions "inmates" encountered inside these institutions.

I have seen them [the mad] naked, clad in rags, having but straw to shield them from the cold humidity of the pavement where they lie. I have seen them coarsely fed, lacking air to breathe, water to quench their thirst, wanting the basic necessities of life. I have seen them at the mercy of veritable jailers, victims of their brutal supervision. I have seen them in narrow, dirty, infested dungeons without air or light, chained in caverns, where one would fear to lock up the wild beasts that luxury-loving governments keep at great expense in their capitals.

Scull (2015) argues that across England, Europe, and North America, it was not uncommon to find in those institutions that specialised in the confinement of the mad, infestations of fleas and rats. Beating and whipping were commonly employed as means for enabling greater control of "inmates", and Scull notes that "female patients were frequently raped" (Scull, 2015, p. 191). The presence of naked women "chained haphazardly to the walls" in these institutions was common, and this treatment was the same for men. At the York Asylum in England, Scull (2015) reports that conditions were the very worst, as filth and neglect were combined with the frequent rape and murder of patients.

By 1860, the asylum revolution was essentially complete. Countries sought to replicate the Western institutional model which began in France, where in 1838 the National Assembly "passed a law directing every department in the country to build an asylum at public expense to house the insane" (Scull, 2015, p. 192). The same took place in England in 1845, while Tsarist Russia embraced the asylum once the Crimean War ended in 1856. Scull (2015) notes that Britain's settler colonies, notably Australia, built their own institutions rapidly and modeled them on those established in Britain. Australia's "inmates", by contrast with those in Europe and England, were mostly men, and many were violent. Even China and Japan would adopt the Western asylum model roughly one century after Europe and North America. An American missionary named John Kerr opened China's first asylum in 1898, in what is now known as Guangzhou. Japan passed the Mental Hospitals Act in 1919. Argentina eventually yielded to the status quo, as supporters of the asylum regime argued that these institutions were the mark of a "civilized society" (Scull, 2015, p. 200). It appears that when confronted with the problem of mental disorder, and the mad, countries looked instinctively to the asylum instead of old modes of family care, and it was a collective movement that fueled the "Great Confinement" Foucault described.

The institutions described by both Foucault (1967) and Scull (2015) developed from madhouses into asylums, where care and proper treatment became paramount. Scull (2015, p. 206) noted that "just as reformed asylums run on moral treatment principles were nothing like the madhouses … so too the new generation of superintendents were necessarily quite unlike their predecessors". He explains that at the

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York Retreat, established by William Tuke in 1792, all forms of physical violence and coercion were forbidden, and chains were dispensed with. This new approach, replicated in all asylums scattered across Western nations, transformed the asylum system into a "moral machine", that Scull and Foucault both argue was no less confining and no more liberating than the conditions characteristic of the madhouse.

Whether or not the motivation of confinement was to round up the mad or the poor is largely irrelevant because too much evidence exists to support the locking away of the mad as part of a broader group that threatened progress and reason. Inheriting the stigma and abnormality that had long been associated with the lepers, even the slightly deranged became synonymous with the dangerous lunatic. The mad were considered as one. Foucault might not have, as Lawrence Stone (1982, p. 26) puts it, "got his history right" in accordance with a strict adherence to facts and moments, but his depiction of the movement of confinement and its transition in varying forms into the twentieth century has been replicated by others of that time and has been undeniably powerful.

What is certainly clear is that Foucault did fail to account for the large number of asylum "inmates" who were women. Elaine Showalter (1985) explains that while Foucault's description of the repressive ideologies of confinement was "brilliantly exposed", he did not explore the possibility that the irrationality and abnormality that the asylum sought to confine was also the feminine (p. 6). It is worth noting that this critique mirrors the views of Midelfort (1992) and Porter (2002). Where these scholars argued that Foucault misread the motivation behind the "great confinement", pinning it on madness instead of poverty, Showalter argues for a similar misinterpretation. Showalter's work, entitled *The Female Malady*, demonstrated how cultural ideas about "proper" feminine behaviour have shaped the definition of female insanity for nearly two centuries, giving mental disorder in women a gender-specific connotation, one which eludes the sick man. Women's madness has historically been tied to the female body, with sickness derived from any one of an unfettered female sexuality that disturbs and threatens the intelligent man (Ussher, 1991); the reproductive functions of menstruation, pregnancy, and menopause; or even a simple tendency towards strong emotion (Russell, 1995). This is significant because if women's madness comes to be associated with the female body, and this is replicated historically, this link presents female suffering as inevitable. On this topic, Showalter (1985) states: "[women] are typically situated on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind".

As a consequence of this linking of insanity with femininity, society came to seek the same symptoms in the male (Showalter, 1985; Wright & Owen, 2001). Since the beginning of the twentieth century, scholars have sought to revise this association, citing male representations of madness through literature and art which are equally powerful in comparison with the feminine images of suicidal Ophelia, crazy Jane and violent Lucia. Elaine Showalter describes in *The Female Malady* the three major Romantic images of female insanity – suicidal Ophelia, crazy Jane, and violent Lucia. She argues that all three were constructed to establish female sexuality as the primary source of madness. Wright and Owen (2001) state that "images such as the mad genius and the criminal lunatic portray men's madness as a 'malfunction' of masculine rather than feminine traits", suggesting that there has been movement beyond madness as being linked entirely with the female body (p. 145).

That Foucault overlooked the oppression of women within the asylum regime is certainly a shortcoming of his narrative history. But the purpose of his work and its resulting legacy still has important implications. Whether or not the movement to confine those perceived as threatening European reason and progress was aimed at the poor, the feminine, the mad, or all three, is largely irrelevant. The legacy of Foucault's work is in confinement as a deliberate system of control, and that the mentally ill were one

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part of a large, undifferentiated mass that fell under this oppressive system. This was not a new form of control, as even the institutions used to confine this mass had once been saved for the lepers. And similarly, even after these asylums and the institutions known as madhouses had closed, our modern world has sought new ways to control and confine those who appear as abnormal, undesirable, or threatening. Sometimes this confinement is physical, sometimes more subtle, as is the case through the use of language.

Mad, Bad or Sick

Early asylums across Europe, Great Britain, and North America came in "all shapes and sizes", and according to Porter (2002), many were atrociously run given medical supervision was not a legal requirement until well into the nineteenth century (p. 97). Treatments were basic and mostly ineffective, as was the case with either hot drinks or ice-cold baths that Foucault (1967) describes were a means to return the human flesh to its "natural suppleness" (p. 316).

In the cold shower proper, "the lunatic was tied to a chair and placed under a reservoir filled with cold water, which poured down directly onto his head through a wide pipe". The variant was the surprise bath where "the patient was … tipped backwards into the water". This violence promised the rebirth of a baptism (Foucault, 1967, p. 317).

In the years preceding the seventeenth century, the mad who were placed on foreign-bound boats searched for their reason out on the high seas. Even throughout the eighteenth century, Foucault's quote illustrates how this image persisted, as water remained the dominant purifying method for the treatment of madness. Yet among this prolonged ill-treatment were periods of progress where compassionate ideals were adopted. These began most clearly in 1794 when Philippe Pinel liberated the mad in chains at Bicêtre, an asylum in the south of Paris. It was Pinel who would pioneer moral therapy in revolutionary France, promoting more compassionate ideals that were to be mirrored by physician William Tuke in England (Porter, 2002, p. 106).

Despite the rapid increase in the number and scale of mental hospitals throughout Europe in the nineteenth century, reforms were introduced that minimized restraint and delivered some freedom back to the insane. Roy Porter describes the rate at which non-restraint methods were adopted at the Lincoln Asylum in London. Between the years 1829 and 1838, the total number of patients restrained went from 39 to 0; the total number of instances of restraint went from 1727 to 0; and the total number of hours passed under restraint declined from 29424 to 0 (Porter, 2002, p. 115). This example serves to illustrate the power of human beings to construct the lived experience of mental illness. In the short span of nine years, the asylum experience had changed dramatically, transforming from a life characterised by restraint to one with the possibility of autonomy and freedom. Discarding methods of restraint, the mad were treated with greater levels of compassion throughout the nineteenth century, contributing to a process whereby madness would transition from "badness" to "sickness".

For present day understandings of attitudes towards mental illness, the asylums of Europe, Great Britain and North America would develop into locations and structures for the delivery of psychological treatments, largely on the back of the pioneering work of William Tuke and Philippe Pinel. It was these individuals who devised the first true methods of psychological treatment, ones that would form a platform for the work of Sigmund Freud. It is at this point in the history of unreason that the story of confinement takes a subtle turn. The following section depicts the psychiatric relationship as a modern means of confining the mad.

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The Legacy of Sigmund Freud

The practice of confining the mad within asylums has formed one part of a broader narrative that has defined, and continues to define, the history of mental illness. As has been established in this chapter, western civilization has used this method for over three centuries, and has done so in both subtle and overt ways. In simplistic terms, the sixteenth century saw the mentally ill placed on boats, taken to foreign locations and dumped there. In the seventeenth and eighteenth centuries, western nations found convenience in segregating the mentally ill within workhouses, a system of confinement that would continue in varying forms until asylums were closed in the 1980s (Barham, 1992). In the nineteenth and twentieth centuries, following the pioneering treatments of William Tuke and Philippe Pinel, the expression and treatment of mental illness were confined within the institution of the psychiatric relationship. In proceeding with this chapter's account of the history of unreason, I argue that Sigmund Freud played a central role in connecting the physical confinement of the seventeenth century with the more subtle segregation of the twenty-first. In this section, I detail the legacy of Freud and place particular emphasis on his role in the birth of modern medicalization.

Born in 1856, Sigmund Freud came to prominence at a time when the legacy and effects of confinement had become two-fold. First, madness had become entwined with unreason. Both metaphorically and physically, the mad posed a threat to enlightened thought and progress, and so justified 'normal' society's sequestering of this group within asylums (Foucault, 1967). Second, within confinement the mad became one undifferentiated mass, with individual insanity distinguished less clearly. It is only with the value of hindsight that one is able to assess the relevance of these consequences for the development of Freud's work. Yet it is clear that these two effects formed a platform from which he could develop his psychoanalytic approach. The mad were guilty of unreason, and so required a treatment that could deliver them back to normality. And with the mad as one unbroken mass, theories and hypotheses could be freely developed for a group that was, during the eighteenth and nineteenth centuries, relatively static. If the mad were not this solid body of despair, threatening civilized society, they would have been too fragmented and fluid for the development of a large-scale therapeutic technique. Ironically, Sigmund Freud could thank confinement for ensuring the inception and ongoing relevance of his talking cure throughout the twentieth century.

Following the publication of his first major thesis, *The Interpretation of Dreams*, Freud began to develop and outline the fundamental tenets of his psychoanalytic approach, a set of theories that would become the dominant therapeutic method of the first half of the twentieth century (Porter, 2002). His work on the unconscious, the symbolic meaning of dreams, hysterical symptoms and infantile sexuality laid the foundations for the work of other prominent European psychologists, notably, Eugen Bleuler (1857-1939), Carl Jung (1875-1961), Pierre Janet (1859-1947), and Alfred Adler (1870-1937). Roy Porter argues that each would extend and reshape Freud's theories.

While asylums were still prominent well into the twentieth century, Freud's work allowed for the flourishing of a more subtle method of control, namely, "the doctor-patient relationship". As Michel Foucault explains, Freud's most powerful legacy was in opening up the possibility of a dialogue between madness and medical thought, and so bringing mental illness back in tandem with unreason (Foucault, 1967, p. 339). He argues that Darwinian-based positivism had reduced the experience of madness to silence because it locked it away inside the walls of the asylum and within the confines of incurability. The development of a therapeutic technique prefaced on conversation reopened the gateway between

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reason and madness, with the consequence that it concentrated the treatment of mental illness within the doctor-patient relationship, laying the foundations for twenty-first century medicalization.

This transformation was mostly subtle. Freud did not change the nature of the structures put in place by his predecessors, he simply moved them from the madhouses into the psychoanalytic situation. He did not change the nature of madness, but altered its location and so forced others to see it in a new light.

Freud made sure all the structures integrated by Pinel and Tuke into confinement were appropriated by the doctor. He freed the patient from that asylum experience … but he failed to spare him the essential components of that existence. He concentrated its powers … and placed them in the hands of the doctor. He created the psychoanalytic situation, where … alienation became disalienating because, in the doctor, it became a subject (Foucault, 1967, p. 511).

The doctor came to be seen as the sole means by which a patient could be delivered from their suffering, as madness was now a subject for the doctor to decipher. This is a transition of power that remains to this day. Considering the development of this doctor-patient relationship with the growth of medicalization following the second World War (Conrad, 2007), and one would suggest that confinement did not end with the liberation of the mad in chains at Bicêtre, or the birth of psychoanalysis. Rather, the walls remained, but they became invisible.

Medicalization

Medicalization is the process of taking non-medical problems and reframing them as issues that require medical attention (Conrad & Schneider, 1992). It is not the direct work of Sigmund Freud, but there is little doubt that medicalization has benefited greatly from the platform of the doctor-patient relationship, without which its ability to expand in both breadth and scope would be greatly diminished. Medicalization is an important figure in the history of madness for two reasons. First, it represents a continuation of the confinement narrative, albeit in a more subtle form. Second, it is a social process that supports the constructionist view of health and illness, explored in the early stages of this chapter. Peter Conrad (2007) offers a suggestion for how mental health can be understood as socially constructed through a description of medicalization's bidirectional nature.

Medicalization is bidirectional, in the sense that there can be both medicalization and demedicalization … For demedicalization to occur, the problem must no longer be defined in medical terms, and medical treatments can no longer be deemed appropriate interventions. A classic example is masturbation, which in the nineteenth century was considered a disease and worthy of medical intervention (Conrad, 2007, p. 7).

Conrad's thesis on the medicalization of society focuses on balding, erectile dysfunction and adult ADHD as more recent examples of non-medical problems that have been defined and treated under the umbrella of the medical model. This medical imperialism has been aided by major pharmaceutical companies and their development of medication designed to treat what Conrad (2007) argues are not illnesses, but "life problems" (p. 61). These developments became most evident in the second half of the twentieth century.

The introduction of penicillin in the 1940s and chlorpromazine in 1954 became precursors to the pharmacological revolution (Barham, 1992). Chlorpromazine was the first antipsychotic drug designed

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for the treatment of mental illness, and significantly changed the way the insane were treated in asylums during the twentieth century (Barham, 1992, p. 6). Elizabeth Bott (1976) explains that medication was useful in British institutions because it solidified the distance thought necessary between the insane and their carers. She states that "talking to patients is dangerous because it threatens to puncture the barrier that keeps sanity and madness in their proper places" (Bott, 1976, p. 133). The use of medication to confine and control, evident in Bott's description, represents an overlap in the confinement narrative. While the confinement of the psychiatric institution faced imminent closure towards the end of the twentieth century, the confining effects of medication and its inherent linking with the doctor-patient relationship were rapidly developing in its stead. Barham (1992) argues therefore that the legacy of the asylum is the "abolition of the *person* who suffers from mental illness", replaced by the mental patient, identity permanently spoiled, exiled on the margins of society (p. xi).

In 1987, Prozac was first introduced as a new type of medication to treat depression. Conrad and Schneider (1992) argue that the introduction of Prozac was important because while the 1980s saw the widespread closing of asylums and the end of physical confinement for those defined as needing treatment for mental illness across western countries, the mentally ill would find a new segregation within the doctor-patient relationship, the site at which they remain dependent for their antidepressant and antipsychotic medication. The uptake of prescription medication has been rapid and unrelenting. Between 1990 and 2007, there has been a 2.5-fold increase in the number of visits to a doctor in the United States that resulted in a prescription for a psychotropic medicine, suggesting that "problems that a decade or two ago would not have been deemed appropriate for medication are now managed with psychotropics" (Conrad, 2007, p. 129). Between 2011 and 2012, there were over 23 million prescriptions written for mental health medication alone (DoHA, 2012). According to Conrad, medicalization holds biological factors accountable, and it is here that prescription medication and the physician who prescribes them, present themselves as necessary for complete recovery. In describing the patterns of use for mental health medications in Australia, the Australian Bureau of Statistics (1995) reports:

Almost everyone who used … anti-depressants did so on the advice of a health professional, mostly a General Practitioner or medical specialist … Nearly all people who used medications in these groups obtained them either by prescription of from a doctor or a hospital. Patterns of use differed by the types of medications used … of people who used antidepressants, 94% used them regularly and 91% used them daily. Of people who used antipsychotics, 90% used them regularly and 87% used them daily (ABS, 1995).

Peter Barham argues that this dependency on medication has been one of the major consequences of the closing of asylums in the 1980s. He also believes that it propelled the process of deinstitutionalization forward, arguing that multiple factors originating from the middle of the twentieth century combined to reinforce a focus on deinstitutionalization, namely, "the literature of protest against the indignities of the mental hospital regimes on the one hand, and the new-found psychiatric optimism about the major tranquilizers on the other" (Barham, 1992, p. 12). With inadequate community-based support set up to meet treatment and care needs, the mentally ill were discharged and expected to re-join the broader community outside the mental hospital seamlessly. Evidence suggests that doctors were the most vocal enthusiasts for community-care policies, based on their belief in the effectiveness of new drug treatments. Community care facilities were envisaged as a stepping-stone between a brief stay in a mental hospital and complete reintegration back into society (Barham, 1992, p. 12), and so it appears there was a discrepancy between the commitment to scale down mental institutions and the establishment of

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alternative forms of service. As a consequence, a vast majority of the mentally ill found new forms of confinement within prisons, on the streets as the homeless, and finally, through the confinement of the doctor-patient relationship, an institution that began with the work of Sigmund Freud at the beginning of the twentieth century. In the final section of this chapter, I shift the focus more locally, outlining how twenty-first century confinement is taking place in Australia.

AUSTRALIA

Australia's mental health history mirrors that which has been described throughout this chapter for seventeenth-century Europe, blended with some characteristics unique to Australia's rich Indigenous culture (Martyr, 2010). Brenda Happell (2007) reflects that in the 1800s, Australia's approach followed the British model, tending to "reflect the views of medical superintendents who migrated to the colonies to oversee the asylums" (p. 1440). By the year 1811, at the Castle Hill Lunatic Asylum in New South Wales, mental illness was still referred to as "madness", and its origins remained the product of "bad blood" or character flaws, as opposed to illness (Happell, 2007). This suggests that the "individual responsibility" narrative introduced in part two of this chapter was transposed from the British context into Australia. The mad were managed through methods of physical restraint and isolation, and there appears no evidence of mental treatment, with a far greater emphasis placed on the custodial role (Keane, 1987). The treatment of supposed mentally ill Indigenous Australians between 1870 and 1914 has emerged as a unique characteristic of Australia's mental health history also. Philippa Martyr found that between 1870 and 1914, a total of 30 Indigenous Australians, mostly from Western Australia, were charged and/or diagnosed with lunacy. The incarceration that followed forms part of White Australia's mistreatment of Aboriginal Australians following colonisation. Yet as the moral therapy pioneered by Tuke and Pinel signaled the transformation of European attitudes towards mental ill-health, Australia's approach began to consider mental illness less as a moral failing and more as an issue requiring behavioural treatment and change (Happell, 2007).

In line with broader changes occurring in most western countries at the time, mental illness was shifting from "badness" to "sickness". In 1867, an Act of Parliament ensured that the mentally ill were sent to asylums rather than prisons, and by the middle of the nineteenth century, mental patients were being transferred from jails to newly opened asylums in all major Australian cities (Happell, 2007). Responsibility for mental illness was becoming less individual and more societal. In 1955, the Stoller Report became the first document to outline the consequences of social indifference towards public mental health services, and the effect this lack of attention could have on the mentally ill (Bates, 1977). Erica Bates (1977) described the report as "the first public recognition that the problem of mental illness is a general problem, and not one to be blamed on the individual" (p. 20). The Stoller Report proved prophetic. Following deinstitutionalization, Australia's mental health approach accelerated towards community-based care, ensuring the responsibility for mental illness came to rest on society more broadly. How effective this process has been for the treatment of the mentally ill is debatable, yet community mental health organisations naturally increased in prominence as a result of this trend, with *Reach Out* founded in 1996, *beyondblue* in October 2000, and *Black Dog* in 2002.

Despite this increase in community-based care practices, western medicalization continues its rapid expansion, of what has been described in this chapter as a modern form of mental health confinement. This control, enabled through psychiatric diagnosis and psychotropic medication, has been no less

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pronounced in Australia. Following the publication of the DSM-V in 2013, the Australian Broadcasting Commission (2014) reported that current definitions of mental illness were so broad that "50% of western populations can be diagnosed with a mental disorder". To an extent, this is exactly what is taking place. The prevalence of mental illness in countries like Australia has become a problem taking on epidemic proportions. According to the World Health Organisation (2013), major depression is the most prevalent psychological disorder in the west, affecting approximately 350 million people, and surpassing heart disease as the world's leading cause of disability. This growth is symptomatic of a society seeking to solidify the boundaries between normality and abnormality, reason and unreason. In clarifying this divide, western civilizations have re-enacted an historically effective method of controlling the mentally ill. This method is confinement.

The process of identifying more and more behaviours as symptomatic of mental illness segregates the mentally ill because it concentrates the site at which mental health issues are treated: within the doctor-patient relationship. It also focuses the problem within the individual at the expense of a thorough exploration of broader social causes. From the leprosaria to *The Ship of Fools*, and from the madhouse to the therapeutic relationship, society has developed the "deep disposition to see madness as essentially Other" (Porter, 1987, p. 35). As a consequence, modern society seeks to segregate and control this deviance, and since the closing of asylums in the 1980s, medicalization has been an effective means of enabling this control. Peter Barham suggests that to some extent, the asylum provided a more certain system of care than the one offered today.

It is clear that people with long-term mental illness in the community may find themselves as structurally isolated as ever they were in the asylums, and in addition their health needs may now be ignored (Barham, 1992, p. 32).

Within the asylum, the mentally ill were neglected as patients. Released into the community, they are now neglected as both patients and citizens, in equal measure. In this way, Western society has developed a subtle continuation of seventeenth century European confinement, representative of a powerful arm in the social construction of mental illness.

CONCLUSION

This chapter charted the history of mental illness as a means for illustrating how it can be understood as socially constructed. Drawing on the work of Roy Porter (2002) and Michel Foucault (1967), we have shown that social norms, attitudes, beliefs, and institutions within which treatments are delivered define the lived experience of mental illness. These phenomena, particularly social institutions, are all dependent on social forces. The individual confined in a Parisian Hôpital-Général in 1656 experienced their illness differently from an American teenager diagnosed with depression in 2018. Their social worlds were different and so also were the understandings of mental illness – madness in the case of the Frenchman – and the treatments they received. The mark of stigma affects the way an individual understands their illness, and we have shown in this chapter that this stigma has distinct historical origins.

Roy Porter's (2002) description of the rate at which non-restraint methods were adopted at the Lincoln Asylum in London between 1829 and 1838 illustrates how quickly human beings can reshape and reconstruct the lived experience of mental illness. The central argument of this chapter is that while methods,

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treatments, and institutions have changed over time, the purpose of these changes has almost exclusively been to exercise a tighter form of social control. Institutions like the Lincoln Asylum eventually discarded their shackles in the mid-late nineteenth century, but Porter (2002) and Foucault (1967) argue that the institution then became a site for moral segregation, moving mental illness from "badness" to "sickness".

The dominant mental health narratives that characterised this history have been "confinement" and "individual responsibility". While the *Ship of Fools* no longer exists, nor the madhouses that were borne out of what Foucault called "The Great Confinement", we argue that this narrative persists in more subtle forms, namely, through the invisible walls of stigma and medicalization, which continue to frame the mentally ill as a distinct, abnormal "other". An appreciation of this history allows for an acknowledgment of our ability to construct and reconstruct the mental health lived experience.

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Chapter 2
Mental Health and Well-Being: Societal Influences

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ABSTRACT

In this chapter, the authors provide a brief overview of the distinction between flourishing and non-flourishing mental health and well-being for people not diagnosed with a clinical mental disorder. While recognizing that genetics and personality impact the well-being of people, research supports the profound impact of societal constructs in American life. As part of a team of faculty who work with undergraduate students in Teacher Education, the authors feel this distinction is essential to understand as medical issues require diagnostics by people trained in that area. The book's focus is to examine what the college community can do to promote flourishing mental health in its social construction in classrooms, on campus and beyond. Dominant influences for non-flourishing mental health and well-being for college students rest in ideologies, happiness seeking and digitalization within American life, membership in groups that are underrepresented and well-intentioned but enabling parenting that ill prepares children for adult responses in life.

INTRODUCTION

In this chapter, the authors provide a brief overview of the distinction between flourishing and non-flourishing mental health and well-being for people not diagnosed with a clinical mental disorder. While recognizing that genetics and personality impact the well-being of people, research supports the profound impact of societal constructs.

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The chapter then focuses on the non-flourishing mental health of undergraduate students in college and the social constructs that have impacted the development of these anxieties. These include the influence of living in American society with its polarizing politics and obsession with the pursuit of happiness and media views of what this looks like, the influence of being a part of groups that are underrepresented in America, such as race and culture, religious beliefs, classism, sexual orientations, gender, and the influence of over-productive parenting and early educational experiences.

NON-FLOURISHING MENTAL HEALTH AND WELL-BEING

No one is raised in a vacuum and this is true of college students. Genetics and environment influence all, and people seeking higher education are no exception. While this life transition can trigger intense feelings of joy, it can also activate feelings of anxiety and depression. For purposes of this book we are not focusing on those with clinical mental illness but rather as Corie Keyes, full professor of Sociology at Emory University and UVM's Keynote for the 2nd Annual Conference "Mental Health Matters: Building a Resilient Campus" (Oct. 28, 2016), identifies those who are struggling emotionally, but who are not classified as mentally ill. He counters the often-held belief that if one does not carry a mental illness then one is mentally healthy, but this denies a category of people who are neither mentally ill nor mentally thriving or flourishing. According to Keyes, this middle category of "not flourishing" can include over 40% of the population.

This chapter will primarily focus on social constructs that can influence mental health and well-being: 1. membership in America's citizenry that promotes the "pursuit of happiness" and the often superficial representation on social media, along with America's current Nationalistic polarization, 2. membership in American's subcommunities that are underrepresented within the larger whole, and 3. membership in families and educational settings that may over-protect and over-control with good intentions, keeping young adults overly dependent on others and insecure in their own abilities and decision making skills. Later in the book there will be information regarding the role the campus community can play in easing some of these social constructs and in building a more supportive, proactive and safe collegiate society.

Using Keyes' Mental Health Continuum, John Fink (2014) identified and analyzed predictors from students about their college experiences that impacted their mental health favorably as college faculty and staff found entering freshmen to have "all-times highs of emotional disengagement" (Fink, 2011, p. 380). The World Health Organization published a report on Promoting Mental Health (2005) that shored the research that mental wellness is more a societal issue that is less about individual interventions and more about "social structures and processes" (p. 29). British author Ruth Whippman in her 2016 book, *America the Anxious: How our pursuit of happiness is creating a nation of nervous wrecks* analyzes America's obsession with happiness and the resulting failure of our intense multiple pursuits of it. She notes that the American Psychological Association (2012), forewarned that the US was on the precipice of "stress-induced public health crisis" (p. 10).

Many would say that it is the larger college community itself, beyond individuals, that creates the climate of stress. A recent study concludes its research with imagining a "different kind of academy, exploring the practices that produce it can be differently enacted…" (Peake, L., & Mullings, B., 2015, p.253). One of the hopes of Peake's and Mullings' study is to begin to create a space for mental wellness that de-stigmatizes people with mental and emotional stress so that care of self is more emphasized and that the corporate mindset of universities is minimized. (273). Whippman recognizes the impact that

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social media bring to these stresses in chapter 7 entitled, "I'm not a happy person; I just play one on Facebook". The intense need for a positive public persona on social media can result in the creation of a disingenuous self with exaggerated superlative displays of happiness that can play into readers' insecurities as well. This manic polarizing drive to pursue perfect happiness can also result in disconnections from real life and real people.

Informally and in support of the above, we in Teacher Education have observed more students who self-describe themselves as anxious, depressed and overwhelmed in this program so these findings don't surprise us. However, it does challenge us to better understand so we can provide more effective assistance in a systemic and empowering manner, as we acknowledge student responses to frustration, social status and anxiety often run counter to their paths for college success.

THE AMERICAN WAY OF LIFE, PARENTING, AND BRIBERY

The review of literature indicates many influences for non-flourishing mental health on campuses, reflective of the social constructs of communities in which students' live. Beginning in homes with overprotective parenting and/or from parenting immersed in economic survival to students' reactions to the new institutional community they've joined may or may not scaffold this new acclimation. Living in a culture that advocates for 24/7 perfect (and unattainable) happiness presets disappointment for many. People who are from underrepresented groups and who are away from their first home bases may come to realize unique isolation and stressors that might or might not be present for those in the dominant groups. Parenting contributes to mental health status, ironically and particularly from homes that believe they are protecting their children from the world that they believe is difficult to navigate safely (Lythcott-Haims, J., 2015). It's theorized current college students are struggling to find their place in a world with an expansive generation gap, ranging from digital nativism, economic disparities, interpersonal challenges and isolation in spite of life in the world-wide web and a sense of entitlement (Levine, A. & Dean, D., 2012).

At issue for many young college students can be found in Lythcott-Haims' book *How to raise an adult.* She presents a compelling argument that much parenting, while good intentioned, has handicapped young adults who learned to overly rely on protective adults for any decision making, inadvertently undermining their confidence and willingness to take risks, and creating a false expectation that perfection can someway be attained with interventions by authority figures. She argues that current parenting and formal early schooling do a good job of caring for children but a bad job of preparing them to be adults who are independent thinkers and contributors in their adult communities as most of their youths they've been kept safe and involved in adult-decided and supervised recreation and activities. While there are sane reasons for this parenting approach, given milk cartons with many different pictures of children who've been abducted and Halloween candy penetrated with sharp instruments, she thinks this approach went too far and hovering parenting has become the norm. Children have absorbed their parents' fears and tread lightly into the larger world of unknowns. These children have not had enough experiences making their own decisions, such as setting and applying agreed upon rules for pick-up games, where fairness was negotiated among the players. Children have not often had opportunities to recover from incidents dealing with hurt feelings or conflict resolution among themselves. Too often parents become involved to "save" their child from any hurt be it in schools, with peers, with coaches, the list goes on.

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How do children know they can recover when things don't go the way they'd like? How do they learn to problem solve when there are no problems for them to solve on their own?

Lythcott-Haims says children learn two things from over parenting: they learn they are inept and the world is not safe. This results in passivity, inertia and apprehension. The parent's fears, of which the parent may say is responsibility-taking, turnkeys into insecurity and inaction in the child. An independent, decision making adult has been submerged into a timid, insecure, anxious adult. With good intentions or not.

Jessica Lahey in her book: *The gift of failure: How the best parents learn to let go so their children can succeed* offers a similar sentiment for parents and teachers. She, too, says that over-parenting, of which she concedes complicity from her own parenting, has the potential to undermine children's confidence and undermine their education. Children need many opportunities to have success from their own making or they learn they can't create their successes. Failure is not failure as reputed but rather it is necessary for success to occur. Ms. Lahey learned for herself and now tells others that it is important to embrace children's failures as this is where they learn about life and learn what they can handle on their own.

In this same vein of overprotective parenting, Lukianoff and Hadt perceive colleges campuses and classrooms as over protecting students "from words and ideas students don't like, seeking punishment of those who give even accidental offense" (2015, 42). They build a case showing that guiding students to question their unexamined thinking is challenged with a "new protectiveness" that may encourage pathological thinking and compromised mental health. Reflective of the current culture of polarized politics and hostility and the "self-righteousness fueled by strong partisan emotions" (45), students may feel the pressure to join a side and be true to the "team". The social media used by these true "social-media natives" has shifted the faculty/student balance, putting faculty in fear to offend. Thinking is dominated with strong emotion and defensiveness by both Millennials and Gen Zers, who've received the message from their homes that adults should protect them from the dangers of life, including each other. They further reason, citing psychological theory that people with anxieties need help in facing their fears, not be protected from them.

Many students enter college with the expectations that rewards are attached to everything they do and this could be result of their experiences in K-12 schools and elsewhere. Alfie Kohn espoused the problems with our externally motivated tactics in school operations in his 1993 book, *Punished by rewards: The trouble with gold stars, incentive plans, $, A's, praise and other bribes.* Kohn argues that these "incentives" undermine self-confidence and create a sense that learning is contingent only for the bribe, giving the sense that the learning is secondary. Creative thinking is minimized as getting the bribe becomes the focus and accountability for one's work is greatly diminished as the goal becomes to get through or survive some project, activity, or routine to get to the reward. College students have been well immersed in this world of extrinsic motivation and not enough has been done to develop more fully internal motivation to creatively problem solve and be thoughtfully engaged with the needs of the community in which they live. Rewards become punishments when not received and anxieties can result when the external bribes are not present per expectations.

Daniel Pink in his 2009 book *Drive: The surprising truth about what motivates us* develops this thinking more thoroughly arguing that institutions operate in ways that run counter to science research about what motivates people to engage with full energy in tasks to think deeply and to creatively problem solve. He says the extreme emphasis on rewards and punishment to get work done actually runs counter to learning and problem solving and to the quality of the work. Current young adults have been programmed to do what's minimally expected to get by for a reward or not, but generally not for the joy of the work and/or learning.

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Today's college students are living in a world that is very different than their parents, according to Arthur Levine and Diane Dean in *Generation on a tightrope: A portrait of today's college students.* A chart in this book (p. 17, 2012) analyzes four critical areas of difference for today's college students and their parents: technology, globe, economy and demographics. Parents grew up in era where the cold war and two super powered countries thrived. Russia was already dissolved before students were born, and students were babies when the twin towers were attacked by al-Qaeda. They grew up in a world of escalated terrorism and a less powerful nation than the one their parents lived in. Their parents' world was pre-digital (analog) while digital technology is all current students have known. The dominant white middle-aged baby boomer time period in the Northeast and Midwest that parents of current students know has been replaced by many more people from countries other than European heritage, and there's been a shift of living in the NE to the West and South, along with a now aging baby boomer population. Parents' lives began with an economy that was industrial while their children primarily have only known one that is based on information and one that has been in recovery from recession. These social contrasts for students born in the 21st century have been dramatic and realized in a relatively short time period and "give insight into the generational experiences we are experiencing today" (p. 17). In addition, this diverse and different world students inherited "may be far more profound, affecting career choices, economic opportunity and attainment, and the future of the American Dream" (p. 35).

DIVERSITY AND IDENTITY FORMATION

Citing the 1998 study *When Hope and Fear Collide,* Levine and Dean note that the "multicultural divide is less deep; the gap between diverse groups is less wide" (p. 97) and that higher education campuses are not the same as yesteryear. However, they also note that racial, religious and sexual identities are still problematic. And as this digital generation is not strong in interpersonal skills, there is an undercurrent barring good communication and understanding, as does a sense of being political correct. "Diversity problems are one of the topics most frequently left for parents to raise with the dean" (p. 99). Self-segregation by race and lesser by religion is still present on campuses with many students of underrepresented racial and ethnic groups socializing primarily with those in their same groupings. As a result of this inclination there has been a rise in student affinity groups where clubs and organizations are focused on specific populations, such as religious organizations, racial/ethnic and sexual orientation groupings. While these grouping provide assistance to students who are underrepresented in their identity formation, they also can be barrier like to the larger community.

Economic status is a powerful variable in the development of a flourishing mindset. In a December 2015 report from the Pew Research Center entitled. "Parenting in America" it was concluded that there is a notable divide in parenting that is more related to economic circumstances and less for the parenting analysis between the overprotective parenting and the more laid back parental approach for children's life success. Lower income parents have more challenges than higher income families and this shows itself in children's less participation in extracurricular activities, like sports or scouts or the arts and in getting affordable after school care. Social issues like teen pregnancy and legal troubles are higher for those in low SES, and worries about their children being victims of violence are increased too. The heightened propensity for single parenting in the lower SES groups impacts this divide as well. Survivors of those who have lived with poverty have a steeper uphill journey to thrive in colleges.

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College students who come from groups that are underrepresented, including students in the LGBTQ community (Sabato, 2016), students who are female (Liss & Erchull, 2015) (Merianos et al., 2013) or students from races that are neither White nor English speaking have different experiences and challenges in college than those in the dominant groups. This "outside looking in" also extends to those students who are from indigenous communities (Scholl, 2006) (Dellinger et al., 2016), to students with different learning abilities (Carroll, Muller & Pattison, 2016) to students who belong to religions other than Christianity (Abdel-Khalek & Lester, 2017). Extra challenges exist for those who are first generation college attenders (Wheeler, 2016), for those in a lower socio-economic status carry (Brown et al., 2015) and/or for those with different abilities (Piers & Duquette, 2016). The campus climate itself may contribute to mental wellness in terms of available supports and sensitivity to the emerging adults' developmental, physical, social, emotional and learning needs.

Identity formation is an integral component of undergraduates' development and a strong indicator of their well-being. Family background, race, ethnicity, religion, sexual orientation, gender and ability can be components of identity as can genetic inclinations and environment that begins with family of birth. It's been found that people with moral and emotional maturity along with identity integration possess more positive mental health and thus engage in fewer risky behaviors (Hardy, 2013). Erik Erikson theorized that there are life stages of psychosocial development, focusing on the crisis for each human in each stage that can conflict with societal expectations. Adolescents search for personal identity in the midst of efforts to clarify their roles in the world to about 18 years of age, the entry age to college. These emerging young adults throughout their undergraduate years in college then search for intimacy as they balance their own sense of isolation. This is where the pursuit of close relationships outside of family develops (McLeod, 2013), and as in all of Erikson's theoretical stages, it is essential for the person to successfully maneuver the elements of "crisis" within each stage and to integrate the skill sets that are necessary for a healthy personality development for life.

This personal life developmental trajectory provides enough hurdles for those born with privileges of belonging to groups in areas such as class, gender, heterosexuality, race, physical, emotional and learning abilities, and language. Even if students' families are familiar with college rigor, demands and expectations, students still need to navigate the new collegiate territory, and this is much more challenging for those without the membership in dominant groups.

For first-generation college students (FGCSs) there may be a lack of grounding in understanding higher education and its operations. In addition, many FGCSs carry the hopes of their families for success and the responsibility to bring them honor and respect. In addition, there may be some intensity around finding careers to support family and this often requires college degrees (Wheeler, 2016). This extra burden can be substantial enough, but if completion of plans or program shifts and the expected success in the career path is at risk, mental wellness may swing toward non-flourishing and as research shows currently, retention of FGCSs is very low compared to other college peers in the first year of college (p. 112). Guilt, a sense of failure and of disappointing family, a belief that the sacrifices of the family make this "failure" difficult to discuss with them in the midst of confusion for next steps can compromise students' mental strength to stay in college and/or approach another career path (p. 114). Compared to their peers, many FGCSs carry a stronger sense of belonging to their families and culture, but when they feel they've broken their commitment to bring honor and improved economic status for their families, this belonging sense can be broken, making them more vulnerable to poorer mental health (p. 115). It's recommended that career counselors understand the uniqueness surrounding the FGCSs' experience in college, so extra steps can be taken to guide and work with them (p. 114).

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For students in underrepresented groups of race, culture and/or gender, obstacles for college success and flourishing mental health are present. In a study designed to analyze students from these groups in terms of health wellness compared to White peers, it was found that poorer mental health has a propensity to rest in those from the minority communities, regardless that they may attend colleges where their minority grouping was the majority (Smith, Chesim & Jeglic, 2014). While students who are White may experience social issues around money, academics and entrance into new sub-communities, students who are in the minority also experienced these and additional stressors, such as racism, depression, feelings of isolation, suicidal ideation and self-harm (p. 85). Female students in this study of 461 students ranked at risk for depression, isolation and suicidal ideation as well and if the females were also from the minority racial/ethnic community, there was a higher probability for mental health to not flourish more significantly (85). This study shared a limitation that they didn't distinguish between minorities born in the US and those born elsewhere, so Blacks and Hispanics were situated as one group. It was recommended that this distinction be recognized for a future study (p. 87). There have been many studies from which this study built and it is clear that being from an underrepresented race or culture can impact the well-being of mental health.

Class influences perceptions about higher education. One study used the metaphor of a funnel to better explain "there are "cumulative disadvantage results when first-generation and low-income college students are disproportionately filtered out at each stage of the postsecondary education process: (Aronson, 2007, p. 1). If parents don't possess a college degree, there is a higher likelihood that encouragement for their children to attend college is lessened as ambivalence about dropping out is heightened, as that may reflect their family norm. Financial aid is complex and many students begin in community colleges and try to transfer to 4 year institutions, often with a loss of credits at a financial cost. Academic performance is poorer compared to their more advantaged peers who benefited from a stronger K-12 program.

There is much disparity in readiness for college in terms of what is taught in high schools and college expectations as well as great differences between students living in poverty and those living with economic advantages, parental support and expectations to continue with higher education (Venezia & Jaeger, 2013). Discrepancies are found in schools well-funded from higher SES locations as opposed to those centered in inner cities and rural areas reflecting a lower SES. All public schools are not equal per economic structures that fund public education's resources and programming among low SES public schools, either in urban or rural areas, and this disadvantages students preparing for higher education (Klugman, 2012). The growing stratification within higher education precludes most who are not in the higher SES from attending many selective institutions (p. 803).

As a result, too many students are entering colleges ill prepared for the academic rigor. There's a need for reforms that "take a systemic, comprehensive approach to provide students with both academic (like the CCSS) and nonacademic resources and opportunities" (p. 122) to more comprehensively support students' college readiness needs. Students who are from low SES and those who are first generation to attend college may need to compensate for learning advantages denied them. The additional struggles that students from low SES and those who are first generation impact success at colleges of choice as it influences their mental well-being in juggling feelings of inferiority and feelings of frustration and anxiety in trying to keep up with the college work and often with employment to augment college costs.

Keyes, et al (2010) concluded that genetics play a role in influencing social and emotional health, as does environment. Burris, et al analyzed several factors that contributed to students' psychological distress and well-being. Among them they found that the best predictor of positive mental health was a positive disposition (2009). Students who can see the glass half full rather than half empty demonstrate

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perseverance in their studies and work. This study also found that students who see their health as important (HAV-Health as value) also have better mental health. Exercise, good nutrition and minimizing alcohol intake show a positive indicator for better mental health. More study is needed to connect religiousness, spirituality and sexual behaviors but there are indicators these, too, could be predictors.

Supporting Keyes' research, Fink explored elements that could predict student mental health in college life (2014). Keyes had developed a mental health continuum, describing positive social functioning and the implicit optimism in working with and expectations of individuals and groups to be indicators of mental health from languishing to flourishing. Fink added Astin's I-E-O conceptual framework that identifies input, environment and outcome to project how precollege characteristics along with the college's environments could reflect scores that indicate flourishing mental health. While this study highlighted several predictors of flourishing mental health for college students, such as supportive social arenas, ease into college routine, sense of belonging and self-confidence, this study didn't show relationship with students' college environs and positive mental health.

Levine and Dean have also found that there are differences in thinking and attitude in this generation of Blacks, Whites, Hispanics, Asian Americans, Females and Males in being less polarized with race and gender and having more satisfaction with college. They've expressed a community feeling, having professors who are accessible, experiencing good teaching quality and having comfort with expressing unpopular or controversial positions. There is more positivity regarding race and discrimination and opportunities for women than in their parents' generation. "There is more homogeneity between groups and greater heterogeneity within diverse groups than in the past as well" (p. 107).

However, as social constructs are considered in analyzing non-flourishing mental health for college students, there needs to be mention of the dramatic shift in US leadership this year of 2017. "A culture of war buttressed by the forces of white supremacy and militarization has been unleashed in a series of policies designed to return the United States to a history in which the public sphere was largely white and Christian, and the economy was and the state were governed by a ruling corporate elite" (Giroux 2017, p. 1). We are experiencing a pugilistic attitude at home with Muslims, women and their reproductive rights, immigrants and the poor, along with the sense that war abroad could happen at a tweet's moment. Giroux argues that those with social liberal perspectives need to pay attention to the politics and the causations for this shift in leader shift, this polarization of citizens who are passionate about being ignored, losing good jobs and benefits and who are looking to a hero to save them. Emotions are high and fear is widespread from both polarized positions of those believing the current POTUS can right the ship to those fearful of his capricious, erratic functioning.

Just prior to his election in fall 2016, some of these fears were articulated in a journal that re-constructed his Nationalistic slogan, "Make America great again" to "Make America hate again". Rage was and is widespread in reaction to a slowed economy, terrorism, social and demographic transitions, mass shootings, crime and gun control, in addition to leadership that well knows how to manipulate these emotions for personal benefits. Sasha Abramsky describes hateful behaviors toward Islam, Muslims, immigrants and those not white. She says this "rejection of democratic norms" will be felt for years to come not only in the US but around the world (Abramsky 2016, p. 29). As a land of immigrants and people of diversity in religion, culture, race, language and sexual orientations, those in these groups, at college or not, may have a higher propensity toward non-flourishing mental health and those of us in public and private institutions need to shore each other with support and strategies for coping with this public state of affairs. Polarization in thinking has threatened engaging conversations to understand and compromise with the other.

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One study about traits of college students identified several factors that contribute to what the researcher called "the mental health crisis in North America". Based in Canada but inclusive of the United States' populations, Kruisselbrink Flatt (2013) cites a study that determined that depression in Canadian and US institutions found first year students met the criteria for depression with 7% being male and 14% being female. She notes that nearly 100% of campus psychological counseling centers have reported a rise of cases with students seeking mental health interventions. In this paper, she notes several factors that contribute to this "crisis", with academic pressure being first with the high-grade expectations, the reality check for this and millennials difficulty in dealing with failure. The competitive economic environment also creates strain for employment probabilities, along with student loan debt increasing the more years in higher education to prepare for life after. Kruisselbrink found in her research that it wasn't the amount of the debt that was the stressor but rather it was the students' worry about the debt that impacted their academic performance in a negative manner. Another factor cited was the accessibility of higher education for those from lower SES brackets who previously wouldn't have had this option to further their education, speculating that the competitive college environment may trigger for some college students from disadvantaged backgrounds mental health stressors as survivors of less than desirable home environments.

In a March 2014 study, the Pew Research Center focused on "Millennials in Adulthood" and found that "they are relatively unattached to organized politics and religion, linked by social media, burdened by debt, distrustful of people, in no rush to marry and optimistic about the future" (p. 1). They also describe them as "America's most racially diverse generation" (p. 2). In spite of their optimism, they also carry more debt than the previous generations of Gen Xers and Boomers as a result of the convergence of The Great Recession, globalization and rapid technological change on the American workforce. Millennials that are only equipped with a high school degree particularly feel this divide with higher unemployment and lower wages than those in previous generations. It is not a stretch to understand Millennials lack of trust of institutions and their critiquing of those in charge, such as politicians, priests/ministers/rabbis etc. teachers/professors, management personnel and decision makers. According to this report, that while Millennials vote Democratic, more than half choose "not to identify with either political party" (p. 8).

Levine and Dean find that Millennials are very conflicted. They are passionate about desiring social change as Obama promised but find themselves disillusioned with social institutions and they have disengaged from social activism with outspoken liberal leaning but conservative beliefs and the conservative identification but liberal positions. It's as if they refuse to fit in any mold (p. 131). The environment and globe tend to bring them together as a group. They overwhelmingly say they want to make a difference in the world, and it appears global environmental issues and local issues tend to be more on their radars. However, "Their commitment is not large-a median and mode of eleven to twenty hours a year" (p. 146).

Levine and Dean discuss the irony of technology usage for Millennials and Gen Zers that brings social life into the classroom while replacing the need for social life on campus. They discuss the "new tribalism" in which social media contacts can expand to present and past friends, family and any number of people 24/7 in class and out, creating their virtual communities and a lack of need for face to face relationships. The existence of diaphobe which is "the fear of being without a digital device" (p. 75), creates an inherent intense focus on the device in which some would say much time is wasted. With this comes the expectation that everyone else is reading texts and email as soon as they are sent and that the expectation for an instant response creates impatience and a sense that Millennials and Gen Zers are the "I want it now generation" (p. 75). We know fellow college instructors who share both frustration and

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feelings of anxiety around the emails late at night to answer questions re: coursework. Synchronous time overlaps with students with asynchronous time. Many faculty want to help students as much as possible, but maybe not at midnight. Many students expect answers when they ask the questions. And many students obfuscate social media "friends' with genuine ones. The social navigation remains complicated in spite of technological advances.

An Undergraduate Survey 2009 shows that more than a third of undergraduates do not participate in the general social activities on campus like: the gym or fitness center, academic or professional clubs, lectures, debates, or other academic events. The library is one exception. Part of this finding is that more students need to "work longer hours, attend college part time, and extend undergraduate education beyond age twenty-four" (p.57) in at least State schools and community colleges. However, this is not the only causation for less involvement in campus activities. In three studies in response to the question about what they like to do for fun, drinking and partying were number one response. This isn't a new phenomenon but how and what they drink may be. They are not drinking beer in the same way but rather they drink hard alcohol with flavored vodka as a new favorite. They also drink more intensely, not just five or six but often twelve or more (p. 60). And as a result, as always when alcohol is in the mix, good decision making is compromised. Sexual encounters, harassment, stalking, violence, drug use other than alcohol can be advanced and the next day's regret can contribute to non-flourishing mental health.

Boundaries have been blurred for Millennials and Gen Zers as a result of public posting and the needed self-restraint to think before response posting. As a result, stalking has escalated and this is not easy to differentiate from checking out others' posts which might be called voyeuristic but not with carried intent to invade another's space for harm. From the 2009 Undergraduate Survey quoted by Levine and Dean, nearly half of the undergraduates "believe they can trust the people they meet through Facebook" (p. 76). Strong emotions result when they find this isn't always true.

While today's college students are not the people of yesteryear, this has been said of young people by older people for decades, if not centuries. We do, however, have a better profile of who we are teaching when we consider the research. We know we have many more people in our classrooms that come from underrepresented groups; we have people who have always lived with full immersion into technological access; we have people who may need to shore their interpersonal skills, who are more comfortable online communicating than they are in person; we have people who have lived in economic times that are less secure financially than their parents were with less hope to improve their quality of living as had been the expectation of earlier generations; simultaneously, we have people who are more impulsive consumers who want what they want when they want it; we have people who have been over protected and not given enough opportunities to think and act on their own accord and as a result expect life to go their way with minimal effort, on their part.

We also have college students who are more comfortable with diversity than previous generations. They are experienced technologically savvy, networking as they think globally rather than "in a flattened world" (p. 163). They have potential to become genuine multiculturally competent humans with needed digital expertise in this global society.

Our future work on campus centers around the question: How do we help undergraduates manage their anxieties for more flourishing mental health and well-being, so they can access their talents for their own personal developments and that of the communities in which they live? Much of their non-flourishing selves finds causation within the communities in which they have lived. We as faculty are building our own mindfulness as we move forward to address strategies to help our students manage

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their lives for their own well-being. The following chapters will speak to character trait development, emotional intelligence awareness and campus-wide initiatives, in addition to our thinking about "next steps". We know there is no perfect as we also believe we can do better tomorrow.

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Chapter 3
Neurobiology of Well-Being

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ABSTRACT

This chapter is designed to review much of the research on the neurobiology of well-being. A distinction between hedonic well-being and eudaimonic well-being is made. The brain reward center was discussed in relation to well-being, which was followed by an in-depth discussion related to drugs, neurotransmitters, and well-being. Neurochemicals related to hedonia and eudaimonia were then discussed, followed by another discussion on gene expression. Finally, brain structures involved in well-being were the discussed followed by concluding thoughts.

INTRODUCTION

Well-Being: Hedonic and Eudaimonic

There is a plethora of concepts directly related to the psychology of well-being, including but not limited to life satisfaction, domain satisfaction, positive and negative affect, emotional well-being, hedonic well-being, perceived quality of life (QOL), happiness, psychological well-being, eudaimonia, authentic happiness, flourishing, positive mental health, psychological happiness, prudential happiness, perfectionist happiness, the good life, etc. Philosophers and psychologists of well-being have much to say about these concepts and their meaning (Sirgy, 2012).

In a review of the literature on subjective well-being, Diener, Suh, Lucas, and Smith (1999) defined subjective well-being as a broad category of phenomena that includes people's emotional responses, domain satisfaction (satisfaction in important life domains such as satisfaction with family life, health life, work life, leisure life, social life, etc.), and global judgments of life satisfaction. Diener and his col-

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leagues added that each of these concepts should be studied separately, although the constructs often correlate substantially with each other.

Sirgy and Wu (2009) assert that true happiness occurs when an individual experiences satisfaction in terms of their basic needs (based on Maslow's hierarchy of needs), but also in terms of their growth needs (i.e., social, esteem, self-actualization, knowledge, and aesthetic needs). This type of satisfaction is referred to as eudaimonic or psychological well-being. Ryff refers to eudaimonic well-being as human flourishing. Ryff's construct involves six dimensions: self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy (e.g., Ryff, 1989, 2017; Ryff & Singer, 2008; Ryff et al., 2016). Whereas the hedonic approach to well-being focuses on pleasure attainment and pain avoidance (Kahneman, 1999), the eudaimonic approach focuses on meaning, self-realization, and purposefulness. Throughout this chapter hedonic well-being and eudaimonic well-being will be referred to as two major components that define overall well-being.

In sum, well-being is an umbrella concept that captures hedonic well-being and eudaimonic well-being. Hedonic well-being is the affective dimension that reflects preponderance of positive affect over negative affect. Eudaimonic well-being focuses on experiences related to personal growth and character development.

The Reward Center and Well-Being

What is the mechanism of action that produces pleasant emotions that result in hedonic well-being? The mechanism involves brain centers that reflect what neuroscientists refer to as "the reward system" (Wise, 1996). The seminal study demonstrating the presence of the reward circuit involved rats that pressed a bar to administer a brief burst of electrical stimulation to specific sites in their brains (Olds & Milner, 1954). Said behavior had no value to their survival (i.e., food) or to that of the species (i.e., sex), but resulted in compulsive repetition of bar pressing. This phenomenon has been referred to as "intracranial self-stimulation" or "brain-stimulation reward" (Wise, 1996).

Research investigating intracranial self-stimulation has identified several brain sites that are involved in the reward system. Some regions stand out more than others (e.g., the ventral tegmental area (VTA) and the medial forebrain bundle). Stimulation of these regions activates fibers that form the ascending pathways from dopamine-producing cells of the VTA that project to the nucleus accumbens (NAc), the amygdala, the hippocampus, and the prefrontal cortex (Advokat, Comaty, & Julien, 2014; Kolb & Whishaw, 2014; Rickard & Vella-Brodick, 2014). This system, referred to as the mesolimbic dopamine pathway, plays a crucial role in reward. Drugs of abuse activate this reward system either directly (e.g., cocaine) or indirectly (e.g., opium). Much evidence shows that increases in dopamine (a neurotransmitter) in this pathway are directly involved with positive affect (i.e., feelings of pleasure and even euphoria).

The mesolimbic system shows a marked increase of dopamine when animals are engaged in intracranial self-stimulation (Olds & Milner, 1954). The same system shows a marked increase of dopamine when animals engage in rewarding behaviors (e.g., feeding and copulation). The reward system also shows a marked increase in dopamine with all drugs taken for pleasure, such as amphetamines, opiates, barbiturates, alcohol, THC, PCP, MDMA, nicotine, and even caffeine (Kolb & Wishaw, 2014, p. 438). Other addictions, such as compulsive gambling, pathological overeating, and sexual addiction, have also been strongly correlated with changes in the VTA-NAc dopamine system (Nestler, 2005). Chronic dopamine activation diminishes endogenous dopamine release and causes down-regulation of dopamine receptors which is a major aspect of drug tolerance (Volkow et al., 2005). Fewer dopamine receptors creates a

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"reward deficiency syndrome" that accounts for addicts' lowered responsiveness to natural rewards and predisposes addicts to seek out drugs to experience even normal levels of pleasure.

Other neurons interact with the dopamine-producing neurons in the VTA, and other neurotransmitters are involved in the increase of dopamine in the system as well. The endogenous opioid system (EOS) is one of the principal modulators of the mesolimbic dopaminergic reward circuitry (Mathew & Paulose, 2011). The use of acupuncture has been linked to the enhancement of endogenous opiates, resulting in pain relief from multiple disorders, surgeries, and diseases (Patil et al., 2016). The "runner's high" is an example of intense pleasure following the release of endogenous opiates (endorphins) during prolonged vigorous exercise (Gianoulakis, 2001). When observing individuals with borderline personality disorder (BPD), it is believed these individuals will go to any means to experience pleasure, regardless of the harmful effects that may accompany it, such as using whips to cause heavy bleeding to reach a heightened state of ecstasy (Gratz & Gunderson, 2006). This suggests a dysregulation in the EOS of individuals with BPD.

Heller et al. (2013) examined neural responses to positive stimuli and found links between sustained activity in the reward center (ventral striatum and dorsolateral prefrontal cortex) and higher eudaimonic well-being. In other words, participants with higher levels of eudaimonic well-being experienced sustained activation of the reward center in response to positive stimuli and lower levels of cortisol. Panksepp (2005) has argued that the brain reward center is the motivating force underlying growth needs or higher-order needs *a la* Maslow (cf. Silton et al., 2011). Specific areas of the limbic system (i.e., the reward center) may help actualize a diversity of internal wants and desires, thus motivating the individual to satisfy growth needs that lead to positive affect. On the other hand, the person that seeks to increase hedonic well-being by using drugs regularly will experience lower life satisfaction because of the tolerance that develops. The reasons are threefold and due largely to the changes in the reward center: 1) the reduction in dopamine and dopamine receptors in the VTA means that the person will feel less pleasure in general when the drug is not on board, and 2) they will need greater amounts of the drug to experience the original level of euphoria the drug produced, and 3) to satisfy the craving that results and the need for the euphoric effect, the person will spend greater time and resources engaging in drug seeking behavior, time and resources needed to maintain life quality in various life domains.

In sum, the brain center responsible for hedonic well-being reflects what neuroscientists refer to as "the reward system." The reward system involves several regions in the brain. Stimulation of these regions activates pathways from the VTA that project to the NAc, the amygdala, the hippocampus, and the prefrontal cortex (i.e., the mesolimbic dopamine pathway). Increases in dopamine in this circuit produce feelings of pleasure or positive affect. Sustained activity in the reward center is associated with higher levels of eudaimonic well-being and lower levels of cortisol. The brain reward center seems to be the motivating force underlying growth needs related to eudaimonia. The mesolimbic system is characterized by marked increases in dopamine with all drugs taken for pleasure, such as amphetamines, opiates, barbiturates, alcohol, THC, PCP, MDMA, nicotine, caffeine, and even compulsive gambling, pathological overeating, and sexual addiction. Other systems interact with the mesolimbic system such as the endogenous opioid system. Individuals seeking to increase hedonic well-being through drug use are likely to experience lower levels of life satisfaction because of the adverse effects of drug tolerance.

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Drugs, Neurotransmitters, and Well-Being

Throughout the history of humanity, people have used drugs of all types to make them feel happy and numb the pain of life's adversities. Probably the most common drug is alcohol. Other drugs include opium (derivatives of opium include morphine and heroin), cocaine, amphetamines, benzodiazepines, and cannabis (THC). These, and many other drugs, stimulate the reward system and produce euphoria in the user, which makes these drugs key candidates for abuse.

Cocaine (a potent psychostimulant) can dramatically induce the release of dopamine (as well as norepinephrine, epinephrine, and serotonin). The net effect is heightened alertness, euphoria, lowered fatigue, decreased boredom, depressed appetite, and insomnia (Advokat, Comaty, & Julien, 2014). In 1884, Freud recommended using cocaine to alleviate depression and chronic fatigue. However, the rebound symptoms (once the drug leaves the system) are fatigue and depression (McKim & Hancock, 2013) making the therapeutic use of cocaine for depression ill advised.

Looby and Earleywine (2007) compared a large sample of people that had never used methamphetamine to a group that had used it at least once in the past year. They found that methamphetamine use decreased subjective well-being. It was also predictive of feeling more depressed and apathetic, less happy and having lower levels of satisfaction with life. This could mean that unhappy people seek out psychostimulants to self-medicate, or it could indicate that using methamphetamine produces depression, symptoms of which have been shown to be increased in methamphetamine users in other studies (e.g., Dyer & Cruickshank, 2005). While acute use may produce hedonia, it has long-term detrimental effects on well-being.

Opiates (morphine, codeine, and heroin) have euphoric effects. In small doses opiates decrease anxiety and reduce pain; higher doses can produce euphoria. The brain and body make their own opiate-like chemicals, commonly referred to as "endorphins" (endogenous morphine-like peptides). Endorphins control pain by stopping the flow of pain signals to the brain. Engaging in physical activities such as distance running could produce an "endorphin high."

Clearly, drugs that act on the reward system in the brain influence hedonic well-being (i.e., short-term positive and negative affect). However, do drugs affect other forms of hedonic well-being or eudaimonia? The answer is yes, drugs affect life satisfaction in a negative manner. Consider additional evidence:

- Focusing on substance abuse, a longitudinal study conducted by Bogart et al. (2007) clearly showed that the use of cigarettes and hard drugs at age 18 was associated with lower life satisfaction at age 29. In contrast, marijuana use and alcohol consumption at age 18 was not related to life satisfaction at age 29. Low income, poor health, and cigarette consumption in adulthood were determined to be mediators of the link between cigarette smoking and earlier hard drug use and lower satisfaction at age 29 (Bogart et al., 2007).
- A recent study (Khan & Shah, 2014) compared the subjective well-being of two groups of addicts, those who received drug-de-addiction treatment and those who did not. The study found that those who received treatment scored better on certain dimensions of subjective well-being (i.e., confidence in coping and perceived ill health). However, the two groups did not differ significantly on other dimensions such as general well-being, positive affect, expectation achievement congruence, transcendence, family group support, social support, primary group concern, inadequate mental mastery, deficiency in social contact, and negative affect (Khan & Shah, 2014).

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- Quite a bit of evidence suggests that those with substance use disorder (SUD) and those seeking psychiatric treatment do not score as well on quality-of-life (QOL) measures as participants without a SUD or with no psychiatric condition (e.g., Donovan et al., 2005; Rudolf & Watts, 2002; Smith & Larson, 2003). Laudet, Becker, and White (2009) confirmed the finding but also found that QOL played a critical role in longitudinal remission. Higher QOL correlated with sustained remission. However, if QOL decreased during the measurement period it predicted increased vulnerability to substance use and relapse.
- Zullig et al. (2001) conducted a large study of public high school students and found that several drugs of abuse were correlated with a reduction in global life satisfaction (cigarettes and chewing tobacco, marijuana, cocaine, alcohol use, and steroids). In addition, the earlier the age at which they first used marijuana, alcohol, cocaine, or cigarettes, the stronger the association with reduced life satisfaction.

Research has also shown drugs such as opiates may activate both dopaminergic and nondopaminergic systems (e.g., Spanagel & Weiss, 1999). Such findings led to the development of the incentive-sensitization theory of addiction (Robinson & Berridge, 1993, 2003). This theory asserts that rewards involve two separate dimensions: "wanting" (which may be viewed as an incentive) and "liking" (which can be viewed as evaluation of the pleasant sensation). For example, a person may feel the desire to eat chocolate ("wanting"), and he may experience a pleasant sensation having eaten the chocolate ("liking"). The dopamine system seems to be related to both the "wanting" and "liking" components, whereas the "liking" component may also involve opioid and GABA (an inhibitory neurotransmitter) systems.

Another theory explained the role of dopamine in learning. More specifically, the dopamine system responds to the "unpredictability of rewards" (Berns et al., 2001) or errors in prediction (Schultz, 2002). That is, learning occurs when the reward is better or worse than expected. Learning does not occur when the reward matches expectations. Dopamine release is concomitant with learning. This learning is evidenced in brain plasticity involving significant neuronal changes—increased dendritic length and complexity in the nucleus accumbens and prefrontal cortex, as well as activity increases in areas involved in learning such as the hippocampus (e.g., Robinson & Berridge, 2001). Given the dopamine release in situations when expectations are negatively disconfirmed (worse than expectations), dissatisfaction may follow, and of course dissatisfaction is reflective of negative affect. Negative affect cannot be construed as "reward." Hence, neuroscientists now feel more comfortable using the term "reinforcer" rather than "reward." In other words, dopamine plays a crucial role in the "reinforcement" system (i.e., learning), as well as in the "reward" system.[1] In addition, large and fast increases in dopamine, such as those triggered by drugs, are associated with phasic dopamine firing in the brain, which conveys information about saliency as well as reward (Schultz, 2010). Therefore, when a person expects a certain euphoric high from taking a drug but the euphoria is lower because tolerance has developed, they will experience negative affect. This may contribute to the decreases in life satisfaction observed in those with substance-use disorder.

Based on the research related to drug dependence (e.g., Kalivas & Volkow, 2005; Kalivas et al., 2006; Volkow et al., 2005), the following theoretical notions concerning well-being can be extrapolated:

1. Humans possess a reward circuit that is activated by both drug and non-drug rewards. The most well-known reward circuit involves stimulation of neurons in the ventral tegmental area which project to and cause release of dopamine in the nucleus accumbens, amygdala, and prefrontal cortex. This produces subjective feelings of pleasure.

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2. Thus, dopamine underlies the reward experience and promotes learning through brain plasticity. The projections, over time, facilitate brain changes (at the neuronal level) promoting learned associations with those behaviors perceived to have led to positive affect or the reduction of negative affect, as well as progressive tolerance to the substance, ultimately resulting in less pleasure. With repeated exposure to the drug, there is a transition such that activation begins to occur more in the dorsal striatum (the caudate nucleus) as opposed to the nucleus accumbens. This is thought to underlie habit learning, in which drug taking switches from a reward-motivated behavior to a behavior that is automatic, habitual, and even compulsive. This results in negative emotionality, but also higher drug craving (see Volkow et al., 2014 on marijuana abusers).
3. Although dopamine release in the nucleus accumbens is important for the association between the behavior and the reward to be established, repeated behaviors (i.e., habits) cause recruitment of the frontal cortex and involves glutaminergic efferents to the nucleus accumbens, amygdala, and hippocampus. Kasanetz et al. (2010) found that rats developing an addiction to cocaine via self-administration showed permanent impairments in long-term-depression in the nucleus accumbens, whereas those rats exhibiting controlled drug intake were able to recover this form of neural plasticity.
4. Habits then persist as a result of enduring cellular changes in glutamate neurons in the frontal cortex. These glutaminergic projections from the frontal cortex to the nucleus accumbens are involved in motivating the individual to maintain his/her habits. Interference with the glutamate pathway impairs the ability of the prefrontal cortex to mediate response inhibition and impulse control (one consequence of chronic drug use). There are increases in prefrontal cortex activity in response to the drug itself or to cues associated with drug use (e.g., Wang et al., 1999). Volkow et al. (2005) showed an increase in metabolic activity in the orbitofrontal cortex, anterior cingulate cortex, and the dorsal striatum with drug craving as well. As a result, the drug-addicted person cannot control the craving, the impulse to take the drug, or even to avoid seeking out the drug.
5. As such, the drug-addicted person cannot control the impulse to take the drug or even to avoid seeking out the drug. Drug-addicted individuals show an enhanced motivation to procure drugs; they will go to extremes to obtain drugs despite the adverse consequences. The drug seeking and drug taking motivational drives consume much time, energy, and resources undermining both hedonic and eudaimonic well-being.

In sum, drugs of abuse provide us with a window to identify neurotransmitters and brain systems involved in hedonic well-being. These drugs stimulate the reward system and produce short-lived positive affect (as well as reduce negative affect). In the long-term, these same drugs undermine feelings of well-being via multiple mechanisms. The neurotransmitters involved with these drugs include dopamine, norepinephrine, epinephrine, serotonin, glutamate, and endorphins, which are discussed next. Furthermore, the research shows that dopamine and glutamate play important roles in the experience of well-being, learning, habit formation, and drug seeking behavior.

Neurochemicals Related to Well-Being

With or without drugs, the preponderance of the evidence from neuroscience shows the major neurotransmitters implicated in positive affect include dopamine, norepinephrine, serotonin, and oxytocin,

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with cortisol being implicated in negative affect (Advokat, Comaty, & Julien, 2014). Discussion of these neurotransmitters in relation to well-being follows.

With respect to dopamine, much evidence from psychopharmacology suggests dopamine has a direct role in the experience of positive affect because it is the primary neurotransmitter for the reward system in the brain. The vast majority of activities people engage in for pleasure (e.g., eating, drinking, having sex, listening to music) influences dopamine neurons, specifically the release of dopamine in the NAc, which then projects up to the frontal lobes (Advokat, Comaty, & Julien, 2014). The net effect is not only feelings of euphoria but also arousal and quick thinking. Wenk (2009) uses the analogy of the gas pedal and race car to explain the adaptive function of dopamine. The brain is like the race car and dopamine is like the gas pedal. The brain feels euphoria when the gas pedal is pushed, one result of which is quick thinking. The forces of evolution have shaped the brain to enjoy working fast; the faster the better. Creatures that work faster and better are likely to survive and pass this trait to the next generation.

Studies focusing on dopamine have shown maternal separation leads to a lower density of neurotransmitter sites for dopamine (e.g., Brake et al., 2004). In actuality, dopamine and norepinephrine work together to allow the individual to experience positive affect. An insufficient amount of norepinephrine will lead to poor concentration, restlessness, and irritability (Mathew & Paulose, 2011). On the other hand, Davis et al. (2015) found an association between low eudaimonic well-being and higher levels of tumor norepinephrine in female patients with ovarian cancer. The authors also found an indirect relationship between eudaimonic well-being and psychological resilience, such that increased eudaimonic well-being appeared to improve physiological as well as psychological resilience in these patients.

Neurons that produce and release serotonin are located in the brainstem but project throughout the brain (Kolb & Whishaw, 2014). Serotonin is involved in wakefulness and modulates many psychological processes including sexual activity, aggression, sleep and body temperature. Serotonin is also implicated in the regulation of mood, anxiety, hostility, and depression. Low levels of serotonin may be the underlying cause of depression and aggressive actions (Coccaro & Kavoussi, 1997). Peirson and Heuchert (2000) found that higher levels of platelet 5-HT_2 receptors, corresponding to lower levels of serotonin (5-HT), were significantly correlated with depressed mood in college students. Although Peirson and Heuchert's participants were not diagnosed as depressed, the authors noted that clinically depressed patients also showed this effect in several other studies. One study (Flory et al., 2004) found that central serotonergic function measured by the peak prolactin response to fenfluramine was significantly related to positive mood averaged across seven days, but was not correlated with negative mood in a nonpatient sample of adults. The authors suggested that reduced serotonin may result in the absence of positive mood. Williams et al. (2006) found that whole-blood levels of serotonin were positively correlated with positive affect using the PANAS scale, but not with negative affect. A two-way interaction between serotonin synthesis and mood is also a possibility. Meaning that while mood may be influenced by serotonin level, it may also be true that the opposite occurs–serotonin level may be influenced by mood (Mathew & Paulose, 2011).

Turning to oxytocin, research has shown this hormone to be associated with childbirth and lactation, mother-infant bonding (Kendrick, 2004), stress, and the regulation of social behavior (i.e., Elkins, 2016). Early life experiences, such as child abuse or any childhood trauma, was negatively correlated with oxytocin levels, suggesting those early experiences can cause social deficits in the future. One study confirmed the use of oxytocin as a buffer against stress in pregnant women and showed it protected women who were of high stress from developing depressive symptoms, which, in turn, may have increased sensitive maternal behavior (Zelkowitz et al., 2014). Oxytocin has also been found to reduce symptoms related to alcohol withdrawal (Pedersen et al., 2013) and cannabis craving. The use of cannabis has been linked

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to stress, and a study involving marijuana-dependent individuals supported this idea. McRae-Clark et al. (2013) assessed a baseline using the Marijuana Craving Questionnaire (MCQ). The individuals were then administered oxytocin or a placebo prior to a psychosocial stress task. Intensity of craving was assessed immediately after the task and also 5-, 35-, and 60-minutes post task. The overall results showed a significant reduction in craving of marijuana in response to the stressor in the group that was administered oxytocin. Another observation from the study was a lower anxiety response in the oxytocin group versus the placebo group (McRae-Clark et al., 2013). Oxytocin is also released during sexual orgasm (Huppert, 2009) and while experiencing feelings of trust (Kosfeld et al., 2005).

With respect to cortisol, studies have shown that exposure to stressors activates the hypothalamic-pituitary adrenal (HPA) axis and results in increased secretion of the stress hormone cortisol. Individual differences in emotional style (positivity versus negativity) modulate stress-induced elevations in cortisol (e.g., Jacobs et al., 2007; Polk et al., 2005; Pruessner, Hellhammer, & Krischbaum, 1999; Smyth et al., 1998). However, it is not only the absence of cortisol that is important, research has shown that it is the pattern of cortisol release and the recovery to baseline following stressors that correlates best with well-being (e.g., Steptoe, Gibson, Hamer, & Wardle, 2007; Ryff et al., 2006). Consider the Ryff, Keyes, and Hughes (2003) study as an example of how cortisol is implicated in eudaimonic well-being. The study compared US Blacks with Whites. Blacks were found to score higher on inventories of purpose in life and personal growth than Whites. Correspondingly, Blacks registered healthier profiles of diurnal cortisol (steeper diurnal decline) compared to their White counterparts.

Pressman and Cohen (2005) conducted a meta-analytic study establishing an association between trait positive affect and reduced release of stress hormones (e.g., cortisol, epinephrine and norepinephrine). In aversive situations, the amygdala sends signals to the HPA axis causing cortisol to be released from the adrenal glands. As such, people with a positive affective disposition tend to have lower basal cortisol levels compared to those with a negative affective disposition.

Several studies have shown that a pattern of cortisol secretion that involves a post-awakening peak and a 20-fold decrease later in the day is associated with high scores on measures of well-being (e.g., positive affect, optimism), but not with scores on measures of ill-being (e.g., negative affect, pessimism, anxiety, fear) (Lai et al., 2005; Ryff et al., 2006; Steptoe et al., 2007; Steptoe & Wardle, 2005). Individuals with a lower score on eudaimonic well-being experience increased activity in the HPA axis, which resulted in greater cortisol release (Heller et al., 2013; Lindfors & Lundberg, 2002). Thus, both positive and negative affect seems to be associated with the cortisol response, but they seem to be independent of each other. Excessive stress may result in wear and tear on the body and brain. This excessive stress can cause the HPA axis to remain activated because it is less able to shut itself off, which leads to an impairment in the immune system. This impairment may decrease well-being by making the individual more susceptible to illnesses, as well as depression and anxiety disorders (McEwen, 1998b; Walker & McGlone, 2013).

Having a social support system can serve as a buffer for this stress reactivity, which can aid in increasing well-being, therefore, decreasing the probability of illness. Studies confirming this theory demonstrated the decrease of cortisol responses when a significant other was giving social support in comparison to when a stranger was providing it (DeVries et al., 2003; Walker & McGlone, 2013).

Another method that may aid in reducing stress, which also inhibits excessive cortisol secretion, is prefrontal transcranial Direct Current Stimulation (tDCS). It involves the placement of two macro-electrodes on the skull in certain brain regions and sending a weak current between them. Austin et al. (2016) used the F3 and F4 brain regions, and applied it to healthy, early adult females to observe if

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there was a difference in psychological distress after tDCS. Typically, the F3 and F4 regions are used in the treatment of depression. The results yielded significantly less psychological distress from daily stressors in the participants and a decrease in negative mood states (Austin et al., 2016; Siever, 2015). The Petrocchi et al. (2017) study involved only anodal stimulation, which is related to an increase in neuronal excitability and is followed by a decrease in GABA. They sought to find a correlation between heart rate variability and positive emotion in healthy individuals. This study placed an electrode on the left temporal lobe only. Researchers found one session of tDCS increased heart rate variability, and in return, this stimulation triggered soothing positive affect, which was associated with peacefulness, contentment, and well-being. Their study provided support for the effectiveness of tDCS on depression and other psychopathological conditions (Petrocchi et al., 2017; Stagg et al., 2009).

In sum, much of the evidence shows that the major neurotransmitters implicated in positive affect include dopamine, norepinephrine, serotonin, and oxytocin. Cortisol, on the other hand, is implicated in negative affect.

Gene Expression and Well-Being

Chronic stress or a major acute stressor (e.g., divorce) is highly correlated with clinical depression, especially for those genetically susceptible (Kanarik et al., 2011; van Praag, 2004). Kanarik et al. found that the Gsk3b gene (glycogen synthase kinase-3) was significantly down-regulated in the frontal cortex following chronic social stress in rats. This gene, Gsk3b, is inhibited by lithium, a mood stabilizing drug (Gould et al., 2007), as well as other antidepressants and atypical antipsychotics (Beaulieu, 2007). Kanarik et al. concluded that down-regulation of the Gsk3b gene is an adaptive response to severe stress. Kanarik and colleagues also found down-regulation of the Map1b gene in the frontal cortex and the hippocampus due to chronic social stress. The Map1b gene has also been implicated in neural plasticity (e.g., Nozumi et al., 2009; Kuo et al., 2009) and regulation of serotonin and glutamate receptors (e.g., Moritz et al., 2009; Sun et al., 2008).

Genetic susceptibility to stress can be inherited directly or promoted via epigenetics, an interaction between the environment and the genetic makeup. For example, Francis, Diorio, Liu, and Meaney (1999) found that rat litters receiving low maternal attention (specifically lower levels of licking and grooming the pups) were more fearful and showed a higher hypothalamic pituitary adrenal response to stress as adults than those that received high levels of maternal attention. The differences in maternal care caused glucocorticoid receptor (GR) gene expression changes in the hippocampus, which resulted in differences in hippocampal GR levels and glucocorticoid negative feedback sensitivity (Liu et al., 1997). Additionally, Weaver et al. (2004) found that the maternal behavior produced alterations of DNA methylation and chromatin structure. Relatedly, van Hasselt et al. (2012) examined the effect of maternal attention at the level of individual pups using a complicated cross-fostering system to ensure that the experience was translated through an epigenetic mechanism of inheritance. Specifically, the frequency of licking and grooming during the first postnatal week correlated with mRNA expression of the hippocampal GR gene and with the ability to induce long-term-potentiation in the dentate gyrus (associated with cognitive ability). These findings point to the possibility that the glucocorticoid receptor gene NR3C1 may be a key candidate in epigenetic investigations of stress and depression (e.g., Labonte et al., 2012; Perroud et al., 2011).

Research has also documented the effects of hedonic versus eudaimonic well-being in gene expression, specifically the conserved transcriptional response to adversity (CTRA). CTRA is characterized

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by expression of pro-inflammatory genes and antibody synthesis genes. For example, Fredrickson et al. (2013, 2015) found that hedonic well-being was associated with CTRA up-regulation (i.e., increased expression of pro-inflammatory genes and decreased expression of antibody synthesis genes). In contrast, eudaimonic well-being was associated with CTRA down-regulation (i.e., decreased expression of pro-inflammatory genes and increased expression of antibody synthesis genes). The authors suggested that the immune system of the participants was more sensitive to the source of their happiness than their own conscious experiences. As such, eudaimonic well-being seems to be associated with health benefits related to gene expression not evident for hedonic well-being (cf. Cole et al., 2015). A similar study by Cole et al. (2015) found the same effect when they controlled for loneliness as a factor. However, when eudaimonia was controlled for in the data analysis, CTRA was less correlated with loneliness. Cole and colleagues concluded that social well-being could be compensated for by treatment aimed at increasing a person's sense of purpose in life.

In sum, gene expression seems to also play a role in both hedonic and eudaimonic well-being. Several gene alterations have been found to be correlated with depression and high levels of stress. Hedonic well-being seems to be involved in CTRA up-regulation, whereas eudaimonic well-being was associated with CTRA down-regulation. Mechanisms that may explain some aspect of the role of well-being in immune function.

Brain Structures and Well-Being

Huppert (2009) suggested that the individual differences seen in baseline activation in the prefrontal cortex corresponding to emotional style also correlates with adaptive cognitive and emotional responses in relation to psychological well-being. Several studies by Davidson and his colleagues (Davidson, 2004; Tomarken, Davidson, Wheeler, & Doss, 1992; Urry et al., 2004) have shown that activation in the prefrontal cortex (PFC) is asymmetrical and that higher baseline activation occurs in the left PFC in those with a positive, more resilient, affective style, whereas those with a negative affective style show higher baseline activation in the right PFC. Davidson (2004) states the mood of patients following damage to the left side of the PFC results in a greater incidence of depressive symptoms compared to damage to the right side. Consistent with these findings, Grajny et al. (2016) found that stroke damage in the left dorsolateral prefrontal cortex was associated with greater symptoms of depression. In addition, Turner, Cipolotti, Yousry, and Shallice (2007) found that in human lesion patients, damage to the left lateral PFC was associated with deficits in organization and strategy, whereas damage in the right lateral group caused failure of error detection and the checking system. Taken together this data suggests that the PFC is very much involved in both the emotional and cognitive aspects of well-being.

Stroke patients with damage to the left side PFC tend to experience more anxiety and depression than comparable right lesion patients (e.g., Robinson & Sztela, 1981; Starkstein et al., 1987). Similarly, patients with right PFC lesions tend to experience flat affect, implying that the right hemisphere based PFC is implicated for negative affect. Furthermore, much research using electroencephalographic methods supports the association between frontal asymmetry and positive affect and well-being (see Rickard & Vella-Brodick's literature review, 2014, pp. 443-445). The implication from these findings is the left PFC may be involved in approach-related, goal directed planning of actions, as well as positive affect; and conversely, the right PFC may be related to threat-related vigilance (see meta-analytic studies by Murphy et al., 2003; Wager et al., 2003). Additionally, interventions (such as mindfulness meditation)

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aimed at increasing well-being appear to increase left-sided frontal asymmetry, possibly by promoting emotion regulation (Brefczynski-Lewis et al., 2008; Davidson et al., 2003).

With respect to eudaimonic well-being, Urry et al. (2004) found that those with high eudaimonic well-being show greater left than right superior frontal activation in response to emotional stimuli after adjusting for reported levels of hedonic well-being. Van Reekum et al. (2007) examined amygdala activation in response to negative stimuli. The study showed that those who were faster to evaluate negative information also showed increased amygdala activation. However, the pattern of amygdala activation varied between high and low eudaimonic subjects. High eudaimonics were slower to evaluate negative information (showing reduced amygdala activation) as well as increased ventral anterior cingulate cortex activity—possibly evolved to deal with aversive stimuli (cf. Schaefer et al., 2013). Lewis et al. (2014) found an association between eudaimonia and insular cortex volume—those with higher well-being had greater volume of the right insular cortex gray matter. These data suggest that regulation of emotion via PFC inhibition of the amygdala may correlate with higher eudaimonic function.

Furthermore, research (Boyle et al., 2010, 2012) has shown that eudaimonic well-being is negatively associated with Alzheimer's disease and mild cognitive impairment. Specifically, purpose in life was found to significantly mitigate the effects of Alzheimer's disease pathology (evidenced by a global pathologic score and a measure of neurofibrillary tangles) on cognitive impairment. Additionally, Yu et al. (2015) have shown that greater purpose in life was associated with significant reduction of risk of cerebral infarcts (macroscopic infarcts caused by lacunar infarcts).

In sum, research indicates that expressions of well-being are associated with prefrontal cortex activity. Specifically, activation in the left PFC is associated with positive hedonic well-being, whereas activation in the right PFC is associated with negative hedonic well-being. The pattern is somewhat different in relation to eudaimonic well-being. Although individuals high in eudaimonia experience a similar pattern of activation in the left PFC, they are better in controlling their negative affect via PFC inhibition of amygdala response. Furthermore, high eudaimonic individuals are also less susceptible to cognitive impairment than their low eudaimonic counterparts.

CONCLUSION

Hedonic well-being was defined as an affective dimension that reflects a preponderance of positive affect over negative affect. In contrast, eudaimonic well-being refers to experiences related to personal growth and character development.

Much of the research shows that the brain centers responsible for hedonic well-being involve the VTA and the medial forebrain bundle. Stimulation of these regions activates pathways from the VTA that project to the NAc, the amygdala, the hippocampus, and the prefrontal cortex (i.e., the mesolimbic dopamine pathway) generating a surge of dopamine, which in turn induces positive hedonic well-being. Drugs of abuse and addictive behaviors produce their euphoric effects via the mesolimbic dopamine system. Endogenous and exogenous endorphins (opioids) modulate the reward system. Chronic excitation of the reward system (e.g., by a drug) generally results in a reduction in hedonic well-being, and at the same time, an increase in wanting the drug (resulting in compulsive drug-seeking behaviors). Furthermore, the research indicates that the reward system (the system that produces hedonia) is also involved in eudaimonic well-being, possibly as a motivating force underlying personal growth.

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Stress hormones, such as cortisol, are heavily implicated in negative hedonic well-being. Not only does positive affect, and a more positive disposition, correlate with increased well-being, but also with decreased cortisol release. Reduced cortisol release is associated with higher levels of eudaimonic well-being as well. Hedonic well-being has been found to be correlated with a poorer immune system response as measured by CTRA, whereas increased immune function is associated with higher scores on eudaimonia. Healthier profiles of diurnal cortisol are correlated with inventories measuring personal growth and purpose in life.

Hedonic and eudaimonic well-being appear to differ in their neural substrates. Hedonic well-being is more closely associated with the mesolimbic dopamine pathway, whereas eudaimonic well-being is more closely regulated by the prefrontal cortex; although both brain regions are clearly involved in both types of well-being. Individuals high on eudaimonia not only experience a higher pattern of activation in the left PFC but also are better in controlling their negative affect via PFC inhibition of amygdala response. Evidence suggests that the left PFC may be involved in approach-related, goal directed planning of actions, as well as positive affect, whereas the right PFC may be more involved in threat-related vigilance and negative affect. Individuals with high eudaimonia are also less susceptible to cognitive impairment than their low eudaimonic counterparts. Individuals who have a purpose in life, a major characteristic of eudaimonia, have an advantage in this regard as well. Importantly, a person's sense of purpose in life seems to increase resilience, buffer against mild cognitive impairments, and protect against relapse to substance use.

Much progress has been made in neuroscience research related to well-being, and much remains to be done. The hope is that this chapter will provide scholars interested in the neuroscience of well-being with a brief synopsis of this research and possibly inspire and motivate future research on this very important topic.

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ENDNOTE

[1] It should be noted that the current level of subjective well-being experienced by an individual is likely to moderate the effects of euphoric drugs, such as pain killers or psychostimulants, as well. This phenomenon is commonly known as the "Law of Initial Value" (Wilder, 1958). Wilder's law states that a change, such as that produced by a drug, cannot affect the person's mood or cognitive state beyond their capability for change. In addition, the effect of the drug depends on the user's initial state. If the person is close to their maximum state for the effect in question, then little change will occur; however, if they are quite distant then the greater the potential effect. For example, a person who is currently in a negative mood state (i.e., experiencing anxiety, pain, or melancholy) may experience euphoria when given small doses of morphine. In contrast, a similar dose of morphine given to a happy person may have little effect or even induce anxiety and fear (Wenk, 2009, p. 20).

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Chapter 4
Posttraumatic Stress Disorder:
Children and Psychological Trauma

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ABSTRACT

We all know that the baby's world is a 10-20 square foot field, which grows steadily over the years. The small world plays a leading role in shaping the child's mind at a rate inversely proportional to its size. In fact, not only stressful pieces of life but all kinds of experience takes part in the psychosocial development of the child, good or bad. Herewith, the conditions that cause chronic stress such as neglect, abuse, poverty, domestic or societal violence, war, and dislocation leave unfavorable traces that are difficult to change in the human mind. Today, while we, the mental health workers, are more focused on the apparent wounds that such adverse experiences have left in our souls, the unseen wounds continue to shape the child, society, and us all.

INTRODUCTION

"Everything is related to how the world is presented to the child," says Donald Winnicott, to state the importance of the environment on the mental development of the child. We all know that the baby's world is a 10-20 square foot field, which grows steadily over the years. The small world plays a leading role in shaping the child's mind at a rate inversely proportional to its size.

The infant mind, which does not host almost any content, in the beginning, gets a position that affects every area of his later life by being shaped with the effect of its close environment. A position where he can see the world as it passes through its lenses.

In fact, not only stressful piece of life but all kinds of experiences take part in the psychosocial development of the child, good or bad. Herewith, the conditions that cause chronic stress such as neglect, abuse, poverty, domestic or societal violence, war and dislocation leave unfavourable traces that are difficult to change in the hu-man mind. Today, while we, the mental health workers, are more focused on the apparent wounds that such adverse experiences have left in our souls, the unseen wounds continue to shape the child, society and the universe (Terr,1990).

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Although the neuroimaging technologies in the years that Winnicott pointed out the importance of the environment were far from showing the effects of such experiences on brain development, today, there is growing evidence that shows the structure of the brain is shaped by one's experiences(Teicher,2016). Today, it is also well known that traumatic experiences such as accidents, sexual or physical abuse, surviving war or maltreatment can lead to structural or functional changes in various brain areas, and may cause suicidal behaviours and PTSD or other psychiatric disorders(Dyregrov,2006).

It is becoming clearer every day that chronic stress which arises from traumatic exposure lead to changes in the brain circuits related to working memory, attention, emotion regulation, cognition and threat detection systems(Teicher,2016) which cause significant deterioration in the detection, integration and representation of internal and external stimulus (Van der Kolk,1996). Although traumatic stress may have negative consequences for everyone, the impact of such incidents in early years which is the most critical time for the brain development is more devastating because of the destructive consequence of the chronic fear response on the development of the central nervous system(Kaufman,2001).

Since the effect of chronic stress on the function and volume of related structures of the brain is addressed in the relevant parts of this book, it will be discussed the impact of traumatic stress on the development of a unique psychiatric disorder, PTSD, in the light of literature findings in the present chapter. The epidemiology and the effect of PTSD on the psychosocial wellbeing and functionality of the child will also be addressed.

DEFINITIONS

Although it was not believed that the diagnosis of PTSD is relevant for children and adolescents, studies by Leonore Terr, David Kinzie, William Sack, William Yule, Van Der Kolk and many others who researched whether mental wellbeing of children is adversely affected by traumatic events proved otherwise. Thanks to the authors, today it is, undisputedly accepted that PTSD could develop in children following life-threatening traumatic incidents(Dyregrov,2006).

The traumatic experience is defined as exposing to an incident that threat person's bodily integrity or his life (Karakaya,2007) Many people are exposed to traumatic incidents such as injuries, violence, natural disasters, fire, traffic accidents or sexual and physical assault during childhood. Besides, witnessing the injuring or killing of someone, and learning death or serious injuring of a close relative or parents after a traumatic event could also be traumatic(Ozgen,1999;DSM 5,2013). Besides, some medical interventions, such as various medical procedures and surgery, are similarly traumatic for children (Ari AB et al,2017).

Psychiatric disorders arise as a result of the complex interaction between social, psychological and biological factors (Cuhadaroglu,2008). An accumulation of ad-verse experiences and risk factors cause greater harm to mental health(Sack,1999). Both the type of event and duration of exposure may increase risk by intensifying personal threat (Hodes,2008). It has been showed that the number of exposures to traumatic incidents is associated with increased PTSD probability (Laufer,2009; Thabet,2000).

It must be known that PTSD mean neither ''as a normal response to stressful situations or events'' nor the person with PTSD is ''emotionally weak'' or "mentally ill''. But it could be conceptualized as an "information-processing disorder that interferes with the processing and integration of current life experience"(Vander Kolk,1996).

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CHILDHOOD TRAUMATIC EXPERIENCES

Epidemiologic studies have revealed that two-thirds of US population survive at least one traumatic severe incident at one point of their life. However, when it is taken in to account that the most of the community in many countries live in areas under conflict and expose to violence, it is estimated that the global prevalence of experiencing traumatic incidents worldwide might be higher than in the US(Galea,2005)

Many people are exposed to traumatic incidents in their childhood. In a national study conducted in the UK, the prevalence of exposure to a traumatic event was found to be around 8.7% in children 5-10 years of age, and about 12.6% in children aged 10-15 years. (Ford,2003). It is estimated that children in underdeveloped countries are exposed to more traumatic experiences. Given that a considerable part of the world's children's population is gathered in developing or underdeveloped countries, it is estimated that traumatic experiences are more than an exception for children.

Unintentional injuries which increase gradually after the age of five are the leading cause of traumatic experiences and one of the main causes of mortality and morbidity during childhood and adolescence(Minino,Peden 2008). Just traffic accidents, each year, lead death of over a million, and injuring of nearly 50 million people worldwide (WHO,2015), while, every day, 2000 children lose their lives as a result of unintentional injuries (Branche,2008).

The data show that millions of children are treated in emergency services every year due to various accidents. For example in 1997, in England, more than 72 thousand children were treated in emergency services because of a traffic accident, and 16 per cent of these children had fatal injuries. Beyond causing death, injuries are also the leading reason for permanent disabilities in children and adolescents (Peden,2008). Literature shows that the number of children who die from accidents and injuries is higher than the total number of children who die from various infectious diseases (Molnar,2001).

Sexual and physical abuse are also common during childhood. Epidemiological studies indicate that child sexual abuse (CSA) is far from being an exception (Molnar,2001). A review of community–based studies that investigate CSA from various countries reported a range of 7% to 36% for females and 3% to 29% for males (Finkelhor,1994). Another review revealed that 12% to 35% of girls and 4% to 9% of boys were forced to have sexual involvement before age 18 years(Putnam,2003). Nevertheless, the fact that child sexual abuse is largely hidden and never disclosed suggests that childhood sexual abuse might be at the epidemic level. Over 2 million cases of child physical abuse reported in the US in 2008, which estimated to represent only a small part of the actual incident rates(Nooner,2012).

Violence is also one of the significant traumatic experiences of childhood. War by its nature is one of the prominent reason for chronic stress for people who survive it. It has been estimated that more than 160 wars which caused the death of 24 million people have taken place since 1945 (Pedersen,2002). Although fatalities are the worst toll of the wars, the adverse impacts of conflicts are not limited to deaths and physical destruction. It also leads to the displacement of many people and devastated and everlasting psychological wounds. As a consequence of war, conflicts and violence, every minute, 24 people were forced to flee their homes in 2015. Accordingly, the number of displaced people has risen from 37 million to 65 million in the past two decades (UNHCR,2015).

Today, 352 million children are trying to grow up in areas under conflict which are mostly underdeveloped countries. Living in the conflict zone does not just mean exposing violence. It brings with it many negative experiences such as the violation of human rights, maltreatment, the attainment of basic physiological needs, uncertainty, inability to reach educational opportunities. However, children

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in underdeveloped countries expose to many other traumatic incidents. For example, it is also reported that accidents and unintentional injuries are more common among children living in these countries

Refugee and asylum-seeking children also constitute another group of children ex-posed to intense traumatic experiences. Today, children account for more than half of the refugee population, which has reached the highest number of all time, rising to 65 million. Findings of investigations with refugee children indicate that these children have been exposed to a large number of traumatic experiences which are not limited to the pre-migration period and continue after the resettlement. It has been showed that various traumatic and adverse life experiences such as violence, loss, physical, emotional or sexual assaults, uncertainty, poverty, overcrowded and unsafe housing, domestic violence, impaired parenting, limited access to education and health services, discrimination, stigma or social exclusion by new culture are all very common among refugee children (Fazel,2005; Heptinstal,2004; Ibrahim,2017; Ahmad,2008; Kinzie,1986)

As mentioned above, children worldwide expose to various traumatic events which is at the epidemic level. Although the adverse effects of traumatic events on children's mental and psychosocial well-being are better understood day by day, we must accept that we have failed to protect children from such traumatic experiences.

Post-Traumatic Stress Reactions in Children

Following traumatic events, various stress symptoms such as excessive fear, shock, crying, intrusive thoughts, hyperarousal, unable to calm, sleeping problems, impatience, nervousness, abdominal or muscle pain, stomach cramps, irritability, fatigue, dizziness, unwillingness to go out, school refusal, loneliness, social isolation, enuresis, sudden change in preferred games and activities may develop in children and adolescents. Additionally, memory and concentration difficulties and attention problems are also observed frequently. Suicidal thoughts and sense of worthlessness are other significant symptoms that can develop in children and adolescents after traumatic events.

Symptom cluster may vary with age and by gender. And it may manifest with classic attention deficit hyperactivity disorder (ADHD) symptoms such as hyperactivity, restlessness, impulsivity, irritability or distractibility in younger children (De Bellis,2013;De Bellis,1999), and "unless a careful history of traumatic exposure is taken in relation to the timing of the onset or worsening of symptoms, these conditions may be difficult to distinguish"(Cohen,2010).

Although externalizing problems, repetitive plays (and drawing) or behavioral re-enactments could be seen in all ages; younger children more commonly exhibit such behaviors(Dyregrov,2006). Irritability and feeding problems might be seen during infancy. Problems in emotional regulation, irritability, intense fear, regression, sleep and eating problems and are common in the early childhood period. Pre-school children may manifest the overwhelming stress by repeated games, aggression, difficulties in impulse control, separation anxiety, enuresis or encopresis and night fears. Attention and concentration problems, peer problems, separation anxiety, somatic symptom, drop in school achievement, isolation and various fears could be observed in school-age children. Despite the fact that, most of these symptoms disappear within 2-4 weeks, these symptoms may increase rather than diminish, and they can reach dimensions that threaten the child's functioning over time. Although such symptoms could be alarming for children, it could be tough for parents to be aware of these symptoms because of children's unwillingness to talk about these symptoms to not upset their parents.

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Physiological and Biochemical Measures

It is suggested that "fight and flight" response to traumatic incidents are less compatible with younger children(Perry,1995). When exposed to a traumatic event, children tend to respond with irritability at the beginning, which is to attract the attention of adults. But if traumatic exposure or threats persist without help, the response might switch immobilizing or freezing and then dissociation or surrendering(Tebbit,1997).

Traumatic exposure triggers physiological and biological changes in traumatized children. These changes can forward to mobilize the child to escape from the traumatic exposure. However, these changes may normalize if the traumatic exposure persists for a period or the child start to dissociate. (McFarlane et al., 1987; Shaw et al., 1995),

Post-Traumatic Stress Disorder

Although the negative outcome of traumatic experiences on mental well-being has been recognized for a long time, systematic research has carried out for the last 50 years. In 1952, post-traumatic reactions conceptualized as the "Great Stress Reaction" in the Diagnostic and Statistical Manual of Mental Disorders (DSM) –I.. It took place in DSM-III, with the name of "Post-traumatic Stress Disorder", especially after the monitoring of soldiers injured in the Vietnam war. The PTSD diagnosis has come up with some minor changes but has remained in all subsequent DSM updates including DSM-V.

In DSM V, post-traumatic stress disorder is defined as a psychological disorder characterized with intrusive (repetitive, involuntary images, memory and emotions associated with the event etc), avoidance (situations associated with the trauma or emotional numbness etc.) and hyperarousal (irritability, anger, sleep and concentration problems etc) and negative alteration in mood and cognitions that occur after encountering one or more traumatic events and persist for at least one month. The diagnostic criteria were separated for children under the age of 6 and people older than six years in DSM-V as shown below:

DSM-V posttraumatic stress disorder diagnostic criteria for people older than 6 years:

1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    a. Directly experiencing the traumatic event(s).
    b. Witnessing, in person, the event(s) as it occurred to others.
    c. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    d. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

2. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

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a. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
b. Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
c. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

3. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   a. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   b. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
4. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   a. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
   b. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," 'The world is completely dangerous," "My whole nervous system is permanently ruined").
   c. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   d. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   e. Markedly diminished interest or participation in significant activities.
   f. Feelings of detachment or estrangement from others.
   g. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
5. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   a. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
   b. Reckless or self-destructive behavior.
   c. Hypervigilance.
   d. Exaggerated startle response.
   e. Problems with concentration.

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   f. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
6. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
7. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
8. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

DSM-V posttraumatic stress disorder diagnostic criteria for children younger than 6 years:

1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   a. Directly experiencing the traumatic event(s).
   b. Witnessing, in person, the event(s) as it occurred to others, especially primary care givers.
   c. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

2. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   a. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   b. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   c. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.
   d. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   e. Marked physiological reactions to reminders of the traumatic event(s).

Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.

3. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):
   a. Persistent Avoidance of Stimuli
   b. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
   c. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).
   d. Negative Alterations in Cognitions

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   e. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
   f. Markedly diminished interest or participation in significant activities, including constriction of play.
   g. Socially withdrawn behavior.
   h. Persistent reduction in expression of positive emotions.
4. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   a. Irritable behavior and angry outbursts (with little or no provocation) typically ex pressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
   b. Hypervigilance.
   c. Exaggerated startle response.
   d. Problems with concentration.
   e. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
5. The duration of the disturbance is more than 1 month.
6. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
7. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

The lifetime prevalence of PTSD was estimated in The National Comorbidity Survey (NCS) as 7.8% (Kesssler,1995). However, prevalence rates vary from study to study widely related to, sample selection, the type of trauma and methodology of the survey. For example, it has been reported that higher rates of PTSD are observed following man-made traumatic incidents and sexual abuse, than exposure to natural disasters (Donnelly 2002).

Clinical presentation of post-traumatic stress varies widely. For example, hyper-arousal can be manifest as, concentration problems, irritability, anger outbursts or problems in emotion regulation. Difficulties in sustaining attention may also observe as a consequence of reexperiencing the traumatic event. Thus, children may look like having hyperactivity(Donelly,2002)

Although many children who experienced a traumatic event will develop PTSD, this rate varies considerably from study to study. It has been suggested that the differences between the results may be related to the traumatized person and the nature of the traumatic event (De Bellis,1999). Thus, the nature of the traumatic event, individual's physical or emotional proximity to the incident, person's age, psychological development and previous experiences family characteristics and cultural factors can influence the development of PTSD (Langeland,2008;Kilptrik,2003; Olofsson,2009;Pfefferbaum,1997). The physical proximity is described as physical distance from the traumatic event, while emotional proximity is characterized as emotional involvement with the survivors of the incident(Pynoos,1987).

PTSD has been criticized for being a culturally constructed disorder which does not have validity in other nations (Summerfield,2000). However, high rates of PTSD has been shown in many non-western countries (Fazel,2005;Heptinstal,2004; Ibrahim,2017;Ahmad,2008; Kinzie,1986) which showed that PTSD is not limited to any culture, and it is universal among all cultures which were exposed to traumatic events (Mollica,2001;Yule,2015).

Although PTSD has been reported to have severe negative impacts on self-control, concentration, attention, cognition, emotion regulation, memory and learning that may threat children's school attendance

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and academic achievement, the impact of PTSD on academic functionality has not been adequately studied (Heringa,2017). However, studies which investigated the impact of traumatic experiences on school drop out or academic problems among children have shown the negative outcome of such experiences on the academic life of survivors (Broberg,2005;De Prince,2009).

Complex PTSD

The psychiatry field had ignored the effects of psychological trauma on mental health for long years. However, it was eventually wiped out with the involvement of PTSD in DSM-III. Discussions are not finished after accepting the PTSD diagnosis in the DSM-III. Some authors argue that PTSD symptoms are normal reactions against an abnormal situation, while others say that DSM criteria are from covering the effect of psychological trauma in depth. In addition, studies have shown that there is a significant difference between stress reactions that develop following a single traumatic event and reactions which develop after exposing repetitive and prolonged traumas. However, the trauma literature suffices to focus on PTSD that develops after a single trauma for many years. However, studies in recent years have revealed that the traumatic events are not causing just classical PTSD. In light of these new findings, a new diagnosis, Complex PTSD, has been suggested. Although there have been many studies on the validity of Complex PTSD and serious studies have been undertaken to include it in DSM 5 as a different diagnosis from PTSD, this diagnosis has not been included in DSM 5. However, the diagnosis of Complex PTSD has taken part as a different disorder than TSSB in ICD-11.

Complex post-traumatic stress disorder (Complex PTSD) is conceptualized as a “disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).” And it is characterized by “1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, ac-companied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others” in addition to all diagnostic requirements for PTSD.

EPIDEMIOLOGY

Almost all children exposed to traumatic events develop some of the post-traumatic reactions mentioned above, most of these symptoms disappear in a couple of weeks. However, a considerable proportion of these children develop PTSD which characterized by re-experiencing, avoidance, hyperarousal and negative alterations in cognition and mood (DSM-5,2013).

PTSD is not a rare or occasional disorder. However, the prevalence of PTSD in the community sample varies considerably from country to country ranging from 7 to 12%(Breslau,2012). The differences in study findings are acknowledged with methodological or sample differences, the nature of the traumatic incident, assessment tool, cultural differences, time of assessment, and demographical characteristics of the investigated population (age, economical or educational situation etc.) (Dyregrov,2006).

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Prevalence of PTSD in Community

In a study of 490 adolescents aged 16-22 years evaluated with a semi-structured interview tool, 3% of girls and 1% of boys were found to have PTSD (Olofsson,2009). The results of a study of 287 children in Afghanistan showed that more than one in four men (26%) had PTSD. In the same study, it was found that 14% of the girls had PTSD(Catani,2009). The lifetime prevalence of PTSD which is reported to be as high as 8.7%, is estimated to be higher in the USA than in Europe (dsm-5,2013). It is concluded that 61% of children will experience a potentially traumatic event and PTSD will develop in 4.7% of them by the age of 18(Mc Laughlin,2013).

Although it is reported that PTSD is less prevalent in children and adolescents than adults. This might be because of previous criteria did not fully account for develop-mental differences (DSM-5,2013). In a child and adolescent psychiatric epidemiology study in the UK that assessed 10,438 children aged 5 to 15 years, PTSD was found to be around 0.14% of this age interval (Ford,2003).

It has been reported that adolescents might be at higher risk of experiencing trauma than either adults or children (Nooner,2012). In a study of adolescents aged 12-17 in the United States, the 12-month prevalence of PTSD was determined to be 6.3% in girls and 3.7% in males, and the co-morbidity of depression and substance use with PTSD was also high, Thus, it is noted that PTSD may also be a risk factor for substance use in children and adolescents (Kilpatrick,2003). Nooner et al., by evaluating studies from 2000 to 2011, reported that the prevalence of PTSD among adolescents is 3–57% (Nooner,2012).

The results of a study with 8th Grade students in Denmark show that the lifetime prevalence of PTSD of these kids is around 9%. And, another community study in the United States reported that one out of every ten children had PTSD (Kessler,1995). The results of a comprehensive meta-analytic study examining the development of PTSD in children and assessing a total of more than 2500 children revealed that more than a third of children (36%) developed PTSD after exposure to a traumatic event (Fletcher,1996).

"Traumatization within attachment relationships has profoundly different impacts on affect regulation, self-concept, and management of interpersonal relationships than do disasters and motor vehicle accidents"(Van der Kolk,1996). The incidence of PTSD after different traumatic events vary enormously which explained with differing methodologies, different types of traumatic events or cultures (Dyregrov,2006).

Traffic Accidents

It is known that traffic accidents are the main factors causing PTSD development in adults (Blanchard,1997). In a follow-up study in which adults were evaluated, the incidence of PTSD was 32% one year after the traffic accidents, and the stress symptoms of the person following the accident were more correlated with the development of later PTSD than the severity of the injury by accident (Koren,1999). However, it is not known exactly how much such traumatic experiences lead to the development of PTSD in children (Keppel-Berison,2002). The results of studies conducted with children who were evaluated following traffic accidents indicate that a quarter to one-third of these children suffers from PTSD (Langeland,2008).

The results of a study with children showed that 24% of children who were assessed after 9 months of traffic accident had stress symptoms and 14% had PTSD (Keppel-Benson,2002). An-other important finding in the same study is that the supportive approach of the police or health team after the incident has been effective in preventing the development of PTSD symptomatology in children. This result

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shows the importance of the supportive attitude of the team that interferes with accidents or injuries when it comes to children.

In another study, 35% of the children reported having PTSD (Stallard,1998), while another study findings revealed that PTSD developed in 50% of the children (Milgram,1988). In a follow-up study in which the children were evaluated immediately after the accident and at 1, 6 and 18 months, symptoms of PTSD in children were observed in 69%, 57%, 59% and 38%, respectively (Schreirer,2005). In a review included twelve studies, it was reported that PTSD was observed around 30% of children over the period of 1-2 months after the event (Qouta,2003).

War and Violence

Another group of children with a very high prevalence of PTSD is the children who live in areas under conflict. The studies which carried out with children exposed to violence, war or terrorism have revealed a high prevalence rate of PTSD among child survivors (Thabet,2008).

In one of the first study which carried out with children from areas under conflict Kinzie et al. revealed that one out of two Cambodian refugee children residing in the US has PTSD (32). The findings of a study of 121 children living near a bombardment area in Palestine revealed severe PTSD symptoms in 51% of the child (Qouta,2003). PTSD was found in 87% of children in a study conducted 5 years later with children in the Halabja region of Kurdistan where the Iraqi Ba'as regime carried out genocide with chemical weapons (Ahmat,2000). Seventy per cent of Kuwaiti children evaluated after the Gulf War was also observed to have significant PTSD symptoms (Nader,1993). The results of a comprehensive community sampling study which carried out in Algeria, Cambodia, Ethiopia and Gaza with people older than16 years revealed that the proportions of PTSD in these places were 37.4%, 28.4%, 15.8% and 17.8%, respectively(De Jong,2001). The results of a study with child survivors of the Bosnian war suggest that 28% of children have PTSD (Papageorgieu,2000). In a research that evaluates children aged 1.5-5 years, there was PTSD in more than one third (37.8%) of children living near a conflict area (Feldman,2011). The results of a study which carried out with 99 Cambodian children aged 18-25 showed that 86% of these children had PTSD or PTSD-NOS (Savin,1996). Another study with Cambodian children also reported high rates of PTSD (%37) among child survivors (Realmuto,1992). Results of Kızılhan et al.'s fascinating investigation with child warriors showed that 48.3% of these children had PTSD. They also revealed that PTSD rates in child soldiers were higher than other child survivors of the war (Kizilian,2018). Ceri et al. also reported high rates of PTSD and Acute Stress Disorders among Yazidi child survivors (Ceri,2016). The finding of a systematic review reported PTSD ranging from 4.5 to 89.3%, with an overall pooled estimate of 47% among children exposed to war (Attanayake,2009).

Displaced Children

Study results with refugee children indicate increased PTSD rates in these children (Bronstein,2011). This increase is reported to be ten times higher than non-refugee children. Studies from various countries such as Uganda (Betancourt,2009), Somalia (Betancourt,2009), Darfur (Morgos,2008), Cambodia(Kinzie,1986), Bosnia(Goldin,2008), Syria (Kandemir,2018) and Iraq (Ahmad,2008) have shown high rates of PTSD among displaced children.

In a review that evaluate 260 refugee children, Fazel and his friends reported the TSSB rate as 11%. Dyregrov and Yule (2006) report that 25% to 70% of refugee children have PTSD in conclusion of their

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review on PTSD in children (Dyregrov,2006). Another comprehensive review which included 22 studies concerning refugee children from over 40 different countries reported that 19 to 54% of refugee children residing in Western countries had PTSD (Bronstein,2011).

The results of a series of studies with refugee children in Turkey have shown that, even after years of resettlement, PTSD was observed in 9% to 43% of these children (Ceri,2016; Yalin,2017; Nasiroglu,2016). Çeri et al. in their study which carried out with Yazidi children immediately after their arrival to Turkey revealed that 18% of these children had acute stress symptoms, and, PTSD was diagnosed in 10% the children (Ceri,2016). In another study, Nasıroğlu and Çeri reported that 36% of refugee children have PTSD (Nasiroglu,2018). Another study found that more than half (55%) of refugee children had PTSD (Hodes,2008). The results of a study with Bosnian children showed that 65% of these children had PTSD even after one year of their journey to the US (Weine,1995). The result of a follow-up study in Netherland indicated that the psychological distress of refugee children are severe and It has a chronic nature (Bean,2007).

Child Abuse

High rates of PTSD have been reported among victim of CSA (Rowan,1993). A national cohort study revealed increased lifetime PTSD diagnosis for females (39%) and males (29%) who sexually abused during childhood. The lifetime PTSD diagnosis was 5.7% and 3.8% among for females and males who have not childhood sexual abuse (Molnar,2001). Finding of a meta analysis which included thirty-seven studies involving 25,367 people indicated that "there is a 143% increase in the risk of developing PTSD symptoms following CSA among the general population"(Paolucci,2001). Another study which carried out with child survivors of sexual abuse reported one out of two (48%) children suffer from PTSD (McLEER,1988).

Natural Disasters

Post-traumatic stress reactions which develop following disasters is a serious public health problem as millions of children are affected each year (Nooner,2012). In a review which investigates the epidemiology of PTSD after disasters Galea et al. (2005) revealed that PTSD rates are ranging from five to sixty per cent among child survivors(Galea,2005).

A study which carried out with children who survived a hurricane reported that 56% of children have PTSD 3 months after the incident. The PTSD prevalence was found as high as 34% 10 months after the hurricane (LAGRECA,1996). Another study revealed that 20 per cent of children who survive an earthquake have PTSD (Hsu,2002). A meta-analysis which consists of forty-six articles involving 76,101 earthquake survivors indicated a 23.6% prevalence rates for PTSD (Dai,2016). Another study which investigates psychological problems among children after hurricane Katrina reported a 32% of PTS symptoms (Lai,2015). Seventy per cent of the children who live in an area impacted by a tsunami in India also reported suffering posttraumatic stress symptoms two months after the disaster (John,2007).

Various Traumatic Incidents

A study which carried with children who affected by the 11/09 terrorist attacks revealed that 84% of children had experienced moderate or severe posttraumatic stress reactions (Fairbrother,2003). 37% of

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children aged 2 to 15 years who survived the demolition of a dam, were found to have PTSD symptoms two years after the incident (Green,1991). Another study which carried out with children who survive a sniper attack in school revealed that 38% of the children had a significant level of PTSD symptoms (Hinton,2009). Reports have shown that one out of two children exposed to physical abuse also has PTSD (Dubner,1999). Domestic violence is another common kind of traumatic experience for exposed children that associated with high PTSD rates of about 36% (De Bellis,2009).

PTSD AND FUNCTIONALITY

Childhood PTSD does not only lead to psychological difficulties in the child but affects the child's academic life and is associated with increased depression, sub-stance use and suicidal behaviors. (Warshaw,1993) PTSD, which develops after a traumatic experience, can seriously disrupt the developmental process of the child and can negatively affect the social and academic life of the child by causing considerable loss in functionality (Karakaya,2007). It has been reported that survivors were more easily annoyed, had more difficulty controlling their emotions, and were more aggressive towards family members after a traumatic experience (Hinton,2009; Abe,1994). It was found that when people with PTSD are nervous, their heart rate increases more (Beckham,2002). Several studies have also shown that PTSD has a detrimental effect on cognitive functions (Gil,1990;Kocak,2017). It is therefore understood that PTSD has a serious negative impact on children's social and academic functioning (Ainmani,2017). It is stated that early treatment may prevent the later negative out-comes by preventing further functionality loss (Olofsson,2009). However, it is stated that PTSD in children is not well recognized in the society and treatment can be delayed (Ceri,2018; Ceri,2017).

Children's immediate attention may switch on physical safety or survival after ex-posing a life-threatening event and may not turn to the normal function for a while (Pfefferbaum,2016). Even though a traumatic event will not lead the development of PTSD among all of the exposed children, partial symptomatology could be debilitating and should be the target for treatment even in the absence of full syndrome criteria(Pfefferbaum,2016). Several studies have investigated whether traumatic events have an adverse effect on concentration or attention of child survivors. A study which Sprung carried out with children exposed to a hurricane reported lower concentration levels among child survivors (Sprung,2010). Another study also reported attention problems among children who indirectly exposed to 11/09 attacks (Hock,2004). Problems in attention, memory, learning and concentration were reported in several other studies that carried out with children exposed to traumatic incidents (Scrimmin,2009; Vasterling,2009; Chemtob,2008). Another study findings revealed significant deterioration in verbal intelligence scores of children who survive an earthquake (Chetomb,2008). Other studies also reported a decline in school achievement in children exposed to various disasters (Pérez-Pereira,2012; Ward,2008). It is also reported that adolescents with PTSD are under risk to failed a grade or suspended from school (Nooner,2012). Another study revealed a drop in attention and executive functions of children with PTSD (Beers,2002).

A study which conducted with children witnessed domestic violence revealed that those children had diminished executive functioning. Their attention and IQ also tended to be lower (Samuelson,2010). Another study which carried out with the child survivor of sexual abuse showed reduced ability to inhibit automatic responses in the Stroop test (Barrera, 2013). Findings of another study reported diminished cognitive skills or neuropsychological deficits among children with PTSD (De Bellis,2013). A study which assessed executive functions such as automatic response inhibition, self-regulation, monitoring,

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and cognitive flexibility, indicated significant difficulties in women who had a history of CSA (Navalta,2006). Worsened performance in the visuospatial domain task also revealed among children with PTSD (De Bellis,1999)

PTSD, Brain Development and Neural Circuitry

The development of the brain and central nervous system which is associated with the progression of cortical myelinization continue during childhood and adolescence (Sowell,2001). Pediatric PTSD causes structural and functional abnormalities in neural circuits that regulate distress and emotion. It is also stated that abnormalities are observed in the development of frontolimbic circuits in these children and that abnormalities in these pathways make emotional control difficult and lead to increased perception. It is also reported that children and adolescents with PTSD have a decreased hippocampal volume and an increase in amygdala reactivity (Herringa,2017).

Neuroimaging studies have revealed an association between PTSD and emotion regulation, dopamine, and norepinephrine activation (Nooner,2012). Reduced grey matter volume in the anterior cingulate cortex, ventromedial prefrontal cortex, and hippocampus have also been showed (O'Doherty,2015). Functional brain imaging studies have revealed hyper-activation in the amygdala, insula and mid Anterior cingulate cortex, whereas hypo-activation is indicated in the medial prefrontal areas and Dorsal Anterior Cingulate Cortex (Hayes,2012). The effect of traumatic exposure on brain might vary according to the age of survivor. In a study conducted with victims of sexual abuse, it was reported that abuse before age 14 effect hippocampus volume, while abuse that exposed between 10-11 years of age is associated with amygdala volume and aged 14-16 years with prefrontal cortex volume (Teicher,2016).

Risk Factors

An accumulation of adverse experiences and risk factors cause elevated harm to mental health (Sack,1999). Both the duration of exposure and proximity to the event may increase risk by intensifying the threat on the survivor (Hodes,2008). The number of exposures to traumatic incidents is reported to be associated with PTSD (Laufer,2009; Thabet,2000),

In a meta-analysis, Cox and colleagues reported that eight factors are associated with higher PTSD rates among traumatised children after traffic accidents such as threat to life, previous psychopathology, younger age, female gender, previous traumatic exposure, severity of injury, involvement of a family member or a close friend in the accident (Cox,2008). Another meta-analysis which involved 32,238 children aged 6-18 years and investigated twenty five possible risk factors for PTSD revealed race, younger age, female gender, low intelligence scores, low SES, pre and post-traumatic adverse events, low social support, peritrauma fear, perceived life threat, social withdrawal, comorbid psychological problem, poor family functioning, distraction, previous psychological problems in the individual or parent, low self-esteem before trauma, post-traumatic parental psychological problems, bereavement, time, trauma severity and exposure to the event by media as risk factors for PTSD (Trickey,2012).

Another research that aims to investigate risk factors for the development of PTSD pointed out the nature and impact of the traumatic event, physical proximity, expo-sure time, children's and parents previous experiences as important factors in the development of PTSD in children and adolescents (Pfefferbaum,1997). Nooner et al. in their review revealed that 4 out of 5 adolescents had been exposed to a serious traumatic event, while PTSD developed in 3 to 57% of them. Gender, type and number of traumatic

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exposure and age were associated with increased rates of PTSD (Nonner,2012). Gekker et al. suggested that child abuse is leading to more severe PTSD which is associated with more comorbid disorders and resistant to treatment (Gekker,2018). Level of exposure (Pine,2002), age, ethnicity(Meiser,2002), lack of social support, problems in family cohesion, female gen-der, prior exposure to trauma, prior psychiatric problems, and strong peritraumatic reactions (Pine,2002) have also reported to have an association with development of PTSD after various traumatic events in children. Although risk factors vary across studies, previous psychopathology and personal threat to life were found to be significant in all studies (Trickey,2012). The miscognitions or misinterpretation of the event, extreme worry about the safety of family, disruption in parental relationship, relocation, neglect, and avoidance-focused coping methods are also stated as risk factors for the development of PTSD in children following a traumatic event.

Course

It is stated that negative childhood experiences are the main cause of preventable mental disorders and substance use (Teicher,201).

Exposure to traumatic events in early childhood is particularly toxic due to its devastating effects on healthy development. The traumatic experiences in early childhood may prepare the ground for the development of other debilitating conditions. Toxic stress might lead to severe biological changes that cause problems in cognition, emotion and behavioral regulation which are associated with impaired social skills, aggression, violence and impulsivity (Donelly,2002).

It has been showed that childhood onset PTSD could persist for as long as 33 years (Morgan,2003). A follow-up study which carried out with adolescent survivors of a ship sinking revealed that 34% of survivors have PTSD years after the event (Yule,2000). Another study which assessed child survivors of a landslide disaster, 33 years after the incident, found that 29% of children still have PTSD (Morgan,2003). Sack et al. in their follow up study which carried out with refugee children of Cambodia reported that the onset of PTSD was quite variable, with 18% of subjects developing PTSD at least five years after cessation of the traumatic exposure (Sack,1999). They also reported that PTSD persists in one out of every three children even a decade later (Sack,1999). A study which carried out 20 years after an earthquake showed that 30% of children have full PTSD, the prevalence of partial PTSD symptoms were as high as 56% among the survivors (Najarian,2017).

New findings point out that the effects of toxic stress may extend its influence be-yond the survivor into next generations by leading behavioural changes in the ex-posed person or epigenetic changes that transmit directly to the offspring of the survivor (Neigh,2009). Furthermore, when left untreated PTSD may lead the development of affective or anxiety disorders, and substance use and impair their psychosocial and academical functioning in the later time course (Bolton,2000). Psychiatric comorbidity is as common as a norm rather than an exception in people with PTSD (Creamer et al., 2001). Even adult-onset PTSD patients who have a history of child abuse may represent a subgroup with a more severe form of the disorder that is associated with a higher comorbid depression, psychotic symptoms and phobic disorder, severe clinical course, treatment resistance and poorer outcome (Gekker,2018). Findings of National Comorbidity Survey showed that lifelong PTSD is associated with increased mood, anxiety disorders and substance abuse (Kessler et al., 1995, (Jeon et al., 2007). Comorbid psychiatric conditions lead to more functional impairment and treatment resistance and worse quality of life in PTSD patients (Post et al., 2011; Araujo et al., 2014; Pagotto et al., 2015; Gekket 2018).

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It has been shown that lifetime traumatic event exposure increases suicidal thoughts, substance abuse and binge drinking in adults (Forman-Hoffman,2012). It was reported that the history of having traumatic exposure or PTSD might lead a three times increase in suicide attempts in adolescents (Nonner,2012).

Individuals with a history of child abuse, as compared to their counterparts without such history, showed a more severe comorbidity profile in general, characterized by a higher mean number of lifetime and current comorbid disorders and a greater life-time and current prevalence of panic disorder (Gekker,2018).

TREATMENT

Early Interventions

Although prevention is better than treatment, it is a hard task to achieve in most of the disorders which arise as a result of complex interaction of social, psychological and biological factors (Cuhadaroglu,2008). However, the preventing of PTSD may be achieved very easily by ending the happening of traumatic incidents or the exposure of children to such events. Thus making policies and arrangements to decrease accidents, child abuse or maltreatment and exposing violence may have a significant effect on reducing rates of children who suffer from PTSD

In case of exposure to traumatic events, early interventions will also be very useful if its effect on preventing the development of PTSD could be shown. Like the ABC of first aid in medical support, the psychological first aid starts with ensuring that the child feels secure and safe and to make certain that the child knows what is happening around him and provides information and explanation about the status of family members and his/her friends(3). Despite strong evidence have shown that traumatic events increase psychiatric morbidity and the initial distress might be far greater than PTSD, there is no effective way to protect children from developing PTSD after traumatic exposure (Rose,2002).

Various preventing or supportive interventions have been developed to support children to cope with post-traumatic stress (Rose,2002). A program which teaches cognitive behavioral coping strategies to prevent the development of psychopathology following stressful events results indicated a significant decline in depressive and externalising symptoms (Jaycox,1994). Crisis Intervention Program for Children and Adolescents (CIPCA) has been recently developed by Abdulbaghi Ahmad to prevent post-traumatic psychopathology among displaced children and adolescents (Ahmad,2014). The findings of a recent study pointed out that a single session of CIPCA might be effective in preventing and/ or relieving the symptoms of PTSD in displaced kids (Ceri,2108). Debriefing is also a psychological intervention that aims to reduce the psychological morbidity after traumatic exposure (Hodgkinson,1991). It consists of encouraging of the survivor to express his emotion, support to process the traumatic event and increase social connectedness (Rose,2002). However, meta-analysis fails to show the effectiveness of such preventive interventions, and it is recommended to carry out further investigation to evaluate whether preventive intervention programs are efficient (Rose,2002; March,1998). Although the efficacy of these interventions has not been showed systemically, it is important to be aware of that reduction of even one symptom of PTSD might have notable favourable effect on the functionality of children (Donelly,2002).

Partial symptomatology is widespread in kids exposed to traumatic events and may impair the functioning of the individual even if the exact criteria are not met (Giaconia et al., 1995). Thus, it is crucial to recognise all symptoms and to think about treatment even when the full PTSD symptoms have not

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developed. This is especially critical for children whom PTSD might undermine their development (Tebutt,1997).

Study findings have revealed that psychological interventions might be useful in relieving posttraumatic stress symptoms. Results of a recent meta-analysis have indicated a significant weighted mean effect size in PTSD improvement as a result of psychosocial treatment, which pointed out a 74% reduction in PTSD. Furthermore, kids getting any psychological intervention improved considerably better than those children not get an intervention (Newman,2014).

Treatment of PTSD

Because even partial PTSD symptoms may lead significant impairment in the child's social, emotional or academic functionality, "treatment decisions should take into account functional impairment and symptom severity regardless of whether or not they have an actual PTSD diagnosis" (Cohen,2010).

Treatment of PTSD start with education of parents and the child about PTSD. School teachers also should be involved. PTSD treatment requires trauma-focused approaches such as trauma-focused cognitive-behavioral (CBT), psychodynamic, or family therapy (Cohen,2010).

Trauma-focused CBT which has a sizeable supporting data about its effectiveness in school-age and older children is recommended as the first choice in PTSD (March,1998). Pharmacological interventions are not suggested as an initial treatment option. How-ever, using pharmacological agents as an adjunct (Cohen,2010). Deblinger, Stauffer and Steer (2001) revealed better outcomes among children enrolled in group CBT than children enrolled in a support group (Deblinger,2001). Another study also showed the effectiveness of CBT in PTSD among sexually abused children (King,2000). A study which carried out with 229 children with PTSD reported better outcomes for PTSD and depression symptoms in children assigned to Trauma-Focused CBT, compared to those as-signed to child centered therapy (March,1998). Findings of a (Cohen,2004) meta-analysis revealed that CBT, EMDR, Exposure, and Eclectic with CBT interventions are all effective for children and adolescents (Newman,2104). Another meta-analysis also give some evidence for the effectiveness of psychological therapies in both prevention PTSD and treatment of PTSD in children and adolescents (Deblinger,2010)

Cohen et al stated that a trauma-focused psychotherapy should directly address children's traumatic experiences, include parents in treatment, not focus only relieving PTSD symptoms but also enhancing the child's functionality and resilience capacity, and supporting his/her developmental trajectory(Cohen,2010).

Neither therapies nor medications expected to be useful in settings where traumatic exposure is ongoing in the life of a child (Gillies,2016). The pharmacological interventions should be considered in the early phases of the treatment when severe and debilitating symptoms such as hyperarousal or avoidance are limiting the child's functionality or interfering with therapy (Donelly,2002).In a review that aimed to assess the effectiveness of pharmacotherapy in the treatment of PTSD in 1999, Donelly et al. concluded that there were not enough studies in the Pediatric PTSD literature to confirm treatment recommendations(Donelly,1999). Although there have been two decades passed, we still don't have adequate evidence for pharmacological interventions in PTSD treatment in children and adolescents.

In conclusion of a meta analysis concerning treatment of PTSD in adults Trauma Focused Psychotherapies (TFP) were recommended as first-line interventions. Stress inoculation training and potentially sertraline or venlafaxine, rather than entire classes of selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs) were suggested as a second-line treatment option (Lee,2016). A meta-analysis on pharmacotherapy of PTSD in adults also reported favourable

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results with selective serotonin reuptake inhibitors compared to placebo in reduction of PTSD symptoms (Hoskins,2015). Another review which aims to assess medication options for treatment of PTSD in adults concluded that medical treatments could be useful for the treatment of PTSD and to reduce its core symptoms and functionality loss (Stein,2000).

Adrenergic agents such as clonidine and guanfacine and the β-adrenoceptor antagonist propranolol could be useful in the treatment of hyperarousal and impulsivity in PTSD by reducing sympathetic arousal (De Bellis,1994). However, there are not adequate data to recommend such agents in children with PTSD. Similarly there is no evidence about dopamine blocking agents in the treatment of pediatric PTSD. However, these agents could be used for patients with PTSD who exhibit paranoid behaviors, para-hallucinatory phenomena or intense flashbacks, anger, self-destructive behavior, or psychotic symptoms (Donelly,1999).

Psychotherapy and pharmacotherapy is represented as the twin cornerstones of intervention for PTSD (Stein,2009). And, it is stated that "regardless of what type of treatment intervention is preferred for treatment of PTSD, the ultimate goal of the intervention should be symptom reduction, and ideally, resolution, as well as a full return of optimal psychosocial functioning (Stein,2009)

Donelly et al. recommended a stepwise work in selecting pharmacological agents for treatment of PTSD in children and adolescents which start with accurate diagnosis and recognizing even partial PTSD symptoms that lead significant functionality loss in the child's social, emotional or academic life. The second step is focusing comorbid conditions which are very common with PTSD such as depression, anxiety disorders and ADHD etc. Thirdly, target symptoms and reasonable treatment goals must be identified (e.g. reduction in sleep latency, frequency of nightmares, or avoidance behavior). The fourth and final step is selection of therapeutics. However, it must not be forget that psychosocial support, psychoeducation and CBT is the first choice and such interventions must always be in mind before consideration is given to pharmacotherapy (Donelly,2002).

A gradual approach should be followed in pharmacological treatment of PTSD in children which begins with the treatment of the most disabling symptoms first. It also must be taken into account that reduction of even a single symptom, might lead considerable relief and improvement in overall functioning of the child (Donelly,2002).

Summary

Growing amount of evidence showing that traumatic experiences have a devastating impact on the child, by deteriorating their physical, cognitive, emotional, and social development. Beside causing psychiatric disorders such adverse experiences shaping the whole community by leading disruption in traumatized children's way of life, sense of self, other and community. However, the findings of research on effect of traumatic stress on the child could be summarized in five measurable areas stated below

- Leading severe mental, interpersonal and behavioral problems such as PTSD, depression, suicidal ideation, affect regulation, poor judgement, peer and relationship problems and substance use
- Academic and occupational problems, deterioration in language use, literacy and math skills
- Changes in brain structure and neuronal circuits, volume and functional changes in distinct brain structures such as hippocampus, amygdala, dorsal prefrontal cortex and anterior cingulate cortex
- Increased risk for physical health and lowered life expectancy due to various medical conditions

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Chapter 5
Technological Issues in Emotional and Mental Health

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ABSTRACT

In the 21st century, people are connecting with technology, and most of the people are spending time in social networks for sharing information. For the most part, spending time on social media is linked with an increased risk of loneliness and depression. Negative effects of social media and social network are affecting the person's mental, emotional, and physical health. The World Health Organization (WHO) reported that 8,000,000 people are dying due to suicide every year, and especially, every 40 seconds teenagers are dying. Generally, most of the teenagers are emotionally imbalanced; most of the suicide is committed on high depression. Depression is the foremost cause of emotional and mental illness. Emotional health is a state of emotional wellbeing, and it's a hidden and invisible factor as well as a factor for good mental health; mental health is a deep-seated problem for most humans. With this background, this chapter discusses the emotional and mental health with respect to technological issues.

INTRODUCTION

Emotional health is so important of every human's life because no humans can live without emotions such as smile, enjoy, angry and so on. Emotions are innate characteristics, and exposing and realizing of emotions are depends on individuality. Emotions play a crucial role in human life for their happiness and mutual understanding with the society. Emotionally healthy persons can control their emotions, feel-

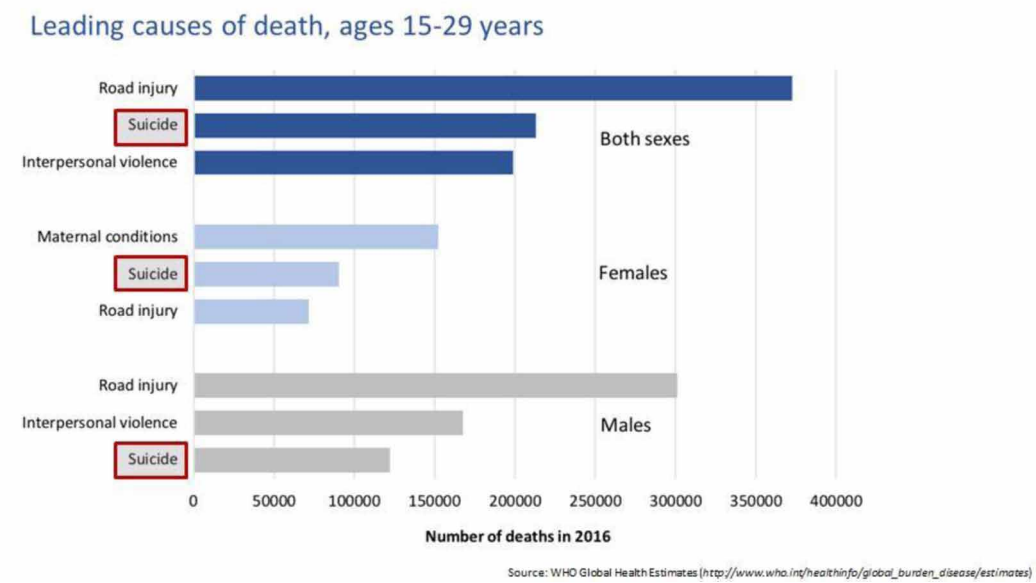
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ings, thoughts, overall behaviour and realize the potential of them. Generally, emotional outburst created by destructive emotions suffers other seriously. An emotionally unstapled administrator always getting angry easily and scolds his/her subordinate is an example for emotional outburst. Emotions cannot be controllable but manageable. Some peoples are not compromise with their negative/destructive emotions that directly suffers others and themselves also. Suicidal activities are the result of uncontrollable destructive emotions. Everyone take care about

Figure 1. 15-29 years ages causes of suicides (WHO, 2017)



World Health Organization (WHO) reported that 8, 00,000 people are dying due to suicide every year and every 40 seconds 15-29 years old people are dying is deployable news. Roving the blue whale game also is one of the best examples of illness of emotional health problems. American Association of Suicidology (AAS), 'Blue Whale Challenge' is a social media game and the teenage people addicted to this game. It purposefully encourages the activity of hold in self-harm and suicidal behaviour to the young people. AAS also insisted that the teenage people directed by the game to do suicidal activities and ending their lives. Because of teenage people are not known to how rightly deal with their own emotions.

Emotionally Healthy person is an individual who knows how can aware of negative emotions, how to manage their negative feelings and they can handle the emotional problems. Maintaining emotional health is one of the skills to improve our lifestyles and travel our life path in positive manner. Emotional healthy persons always manage the destructive emotions and he/she follow some management strategies. They always prefer constructive emotions for maintaining the mental and emotional health. Emotional health is linked with one's mental health and physical health and so on.

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Meaning of Mental Health

WHO (2004), Mental Health is a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Medical dictionary (2012), mental health is "emotional, behavioural, and social maturity or normality; the absence of a mental or behavioural disorder; a state of psychological well-being in which one has achieved a satisfactory integration of one's instinctual drives acceptable to both oneself and one's social milieu; an appropriate balance of love, work, and leisure pursuits"

Public Health Agency of Canada (PHAC, 2006) states that ——mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.

With the help of above definitions, some of the common things are listed below and they are representing the mentally healthy person.

- One can easily solve the emotional problem and manages the challenges of their stresses.
- Mental health persons comprise the psychological well-being such as oneself and surrounding of others also accepting social integration behaviour.
- Mentally Healthy person having a positive sense of emotions and give respect to the values and the honesty of the rules.
- Mental Health persons also be emotionally healthy, psychologically healthy and socially well-beings.

Factors Affecting Mental Health

Mental health disturbed with internal or external. Internal factors like emotions, feeling and external factors like fevers, different type of aches and diseases may decide the status of one's mental health. Every individual should care with these factors to maintain their mental health and they are briefly explained below,

- *Internal factors:* The factors that relevant to the individual that are also called as psychological factors. The internal factors like self-esteem, emotions, feelings, stress and depression are involving the increase or decrease the level of mental health.
- *External factors:* Other than the internal factors which are not relevant to the psychological factors of an individual and they are indicates the outside of the individual. Physical conditions, different aches, diseases, fever, abuse, ill-health, family breakup, loneliness, bereavement, homelessness and environment are the external factors.

On the other side, mental health may be affected by the environment in which the persons belong. Generally, the learners' mental health affects in two environments, they are briefly explained below,

- *Home environment:* Home is an innate environment to the learners, because the learners were born in a home where they remain in the company their mothers in the formative years of infancy. The

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home is the first community and school to the learners and it is a first place to engage the character and personality development. The parents of the learners always care about their future. Of course, the parents control the learner over to childhood for discipline. The first important requisite condition for learners is affection should feel secure and loved in their home. But, Parents meet the legitimate needs of their child. This legitimate atmosphere cannot be accepted by the learners. The learners always want to be free. But, the home atmosphere made these opportunities ever. Thus, the home environment turned to make metal illness of learners and it affects mental health. The ideal home atmosphere provides proper and conductive environment up to early childhood. Pleasant and satisfaction giving experiences should be provided for harmonious development of the personality of the child. The parents should keep the following things into consideration.

- Provide proper affection and love to the child.
- Provide conductive environment in home.
- Do not criticize the child.
- Do not compare the child with other children.
- Don't ask irritable questions to the child
- Be a friend in time
- Don't use harsh words to the child while they did wrong
- Do not reject or overprotect the child.
- Do not quarrel in present of the child.
- Do not be over anxious about the future of the child.
- Try to be democratic in your dealings.
- Meet legitimate needs of your child.
- Provide guidance where necessary and build self-confidence in the child.

These points will assist the parents to create mental healthy individuals. Otherwise the learners become mental illness which affects the academic performance and other outcomes on the child.

- *School environment:* Schools are the second community or social place. In India, most of the parents are illiterate and ill informed who cannot be charged with the responsibility of providing proper guidance for mental health. The school has the great responsibility in harmonious development of personality of the learners. Normally, the learners spend six to seven hours in schools. Schools are in position to help in the development of children potentialities by catering their needs. In schools, the teacher should maintain the students' mental health when they are learning. The atmosphere of the schools is in the hands of the teachers. The teacher is a second parent of the students. It is one of the responsibility of the teacher who providing proper guidance for developing mental health. Because of the school are in a position to help in the developing of children's potentialities. The following school factors may affects the students' mental health.
  - Bad environment of school leads to make fear tension and frustration of the students.
  - The teacher autocratic style leads the authoritative environment in schools.
  - The undesirable participation of teacher to forget makes the positive attitude.
  - Some time the school rejects proper human relations.
  - Less facility of schools.
  - Irrespective activities of teachers and the head.

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Qualities of a Mentally Healthy Person

Like a proverb 'Face is the index of the mind', the face is also the index of the mentally healthy persons. Emotionally disturbed persons never behave with the qualities of a normal person and their qualities are generally different from a normal person. The following qualities are identified and it's mostly fit for the mentally healthy persons. Jha and Bhatt (2010) quoted the following qualities are possessed by the mentally health persons and they are;

- *Adaptability and resilient mind:* The individual, who is adaptable to the changing conditions of his environment receptive and not rigid in his behaviour, can be said mentally healthy.
- *Social adaptable:* A mentally healthy person is socially awakened. He participates in social activities and his personality functions properly under strain ad stress of emotional disturbances.
- *Emotionally satisfied:* The emotions of mentally healthy persons are well trained and controlled. He is free from persistent emotional tensions in his life.
- *Desires are in harmony with socially approved goals:* The mentally healthy person does not indulge in anti social activities. The goals of the person of life are in accordance with social norms. The person's objectives are harmony with other people.
- *Insight into his own conduct:* The mentally healthy person has insight into his own conduct He self evaluates his behaviour. He improves his behaviour on the basic of his self-examination.
- *Enthusiastic and reasonable:* He has enthusiasm in life. He works with curiosity and is devoted to his profession. He is responsible in his actions. He accepts criticism sportingly.
- *Good Habits:* The healthy person has good habits. He is balanced and is not easily annoyed.
- *Philosophy of Life:* The healthy person has his own philosophy of life. He develops definite attributes towards values of life.
- *Provision for sex and moral education:* Most of the problems of adolescents are concerned with sex and moral conflicts which cause mental disturbances. It will be great use if sex and moral education are made an integral part of regular curriculum.
- *Art and craft:* Writing for understanding and release of emotional tensions can also be used in mental hygiene programme.
- *Guidance:* School students should be given guidance through guidance services for their benefit. This is of three types: personal, educational and vocational.

Meaning of Emotional Health

Mental health and emotional health are interrelated but both are slightly different. Ones lack mental health; those persons can be affected mental illness such as depression/ mood disorder, anxiety, personality disorder. National Alliance on Mental Illness quoted in their report that one in five adults in the United State suffers mental illness each year.

According to Peterson (2015), Emotional health is a psychological functioning and it's based on a positive manner. Emotional health is the extension of mental health and its function the inner and outer worlds of human to build one's thoughts, feelings and behaviours.

According to mental health foundation, "Emotional health is a positive sense of well being enables an individual to be able to function in society and meet the demands of everyday life."

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From the above definitions, Emotional Health comes from several common points that common points are,

- To build up the thoughts, feelings, and behaviour from the ones psychological functioning.
- Emotional health is fully depending on the positive manner and engages with society in optimistically.

Factors Affecting Emotional Health

There are many factors contribute increase or decrease the level of emotional health and it is a key factor in promoting or de-promoting the mental health. So, the before said factors in the topic 'factors affecting mental health' also affects the emotional health. In addition to that the following factor also affects the emotional health and they are;

- *Level of anxiety:* It is a basic emotion that assists an individual from the dangers. Fluctuation in anxiety causes emotional imbalance and it directs less emotional health. Anxiety is a manageable emotion by the interventions and strategies like relaxation and mindfulness.
- *Level of self-confidence:* It is a belief of one's to reach the goal or the task assigned to the individual. Self-confidence makes the person to face the challenging, difficult and complex situations. The poor self-confident individual easily getting fear and anxiety which pushes the imbalance in emotions.
- *Physical illness:* It is also changes the level of emotions. Diabetic persons always feel about the activity of injecting artificial insulin in their body and kept medicine with themselves as well as their eating styles. This may repress the emotions in negative directions. On the other side, fever, diseases may make emotional instability.
- *Undesired events:* Pleasant events makes the desired emotions and opposite are vise versa. An individual getting happy for pleasant events and upsets if the person facing an unpleasant event.
- *Capacity to manage emotions:* Escaping from the emotional issues, the person may have managing capacity or coping capability (Emotional Intelligence) in outburst of destructive emotions. Some persons having balanced emotions that are they maintain the emotions in average level. These types of persons not excited too for pleasant events and vice versa.

Qualities of Emotional Healthy Person

An emotionally healthy person is having high tolerance because those people are easily adopted in a new situation. They are always feeling free with others. The television Programme titled 'Big Boss" has been organized by Star Vijay Television is showing the emotions of the participants. This programme is normally telecasting for 100 days and the participants are insisted to stay with a group in a closed home. There is no mobile phone, entertainment for the participants and they are requested to cook the food themselves with the limitation of vegetables. Their activities are watching through a camera and high emotional participants are

Emotionally healthy people,

- Try to grow up their self-awareness and self-esteem,

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- Known their boundaries of characteristics,
- End a bad relationship for good things,
- Easily adopt any emotional situation,
- Chooses the best approach to others and them following their passion

Barriers of Mental Health Services

Raguram, Weiss, Channabasavanna and Devins (1996) stated that the most important barriers in looking for mental health is unavailability of professional services, low literacy, socio-cultural barriers, traditional and religious beliefs, and shame. According to WHO (2017), the median number of mental health beds per 100 000 population ranges below 7 in low and lower-middle-income countries to over 50 in high-income countries; from 100,000 people just 0.4 psychiatrists and 0.02 psychologists. Mental disorders are disgustingly underestimated by the community and health system in India and across the world. In the year 2000 estimation of the mental disorder, 12.3% of disability-adjusted life years and 31% of years lived with disability. Projection proposes that the health trouble owed to mental disorders will increase to 15% of disability-adjusted life years by 2020 (Murray and Lopez, 1996).

According to the National Commission on Macroeconomics and Health (2005) shows that at least 6.5% of the Indian population has some form of serious mental disorders. Mental health workforce breakdown per 100,000 populations by WHO region such as noted in the table given below.

Table 1. Mental Health Atlas. (WHO, 2018)

	Psychiatrists	Psychiatric Nurses	Psychologists	Social Workers
2001	0.4	0.04	0.02	0.02
2005	0.2	0.05	0.03	0.03
2017	1.3	3.5	0.9	0.3

Technological Issues and Remedies for Mental and Emotional Health Problems

In the older time, people often used typewriters, cycling, dancing, did puzzle, played board games and played in the ground for entertainment. Nowadays the boom of technology, computers, tablets, and mobile phones has replaced all those things and become very popular. Gaming technology in mobile phones, laptops, tablets and video games like a PUBG and Blue whale, have been as entertainment and hobby of the young students. Many years ago there were not very many forms of technology that stay alive. If an individual is not using technology for some form of entertainment, they are most likely using it for something along the lines of school or work. Technology has gone from being a suitable tool for being a bad impact on society. Not only is it slighting the brainpower and mental health of many people, but it is also taking away from one's social behaviour.

During the past years, the rapid development of technology in human mental health is based on social media such as facebook, twitter, Skype, whatsapp and my space was used to interact and communicate to others.

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American Association of Suicidology stated that social media is a significant impact on mental health towards young people. An exception of vague booking, social media usage may be misplaced (Berryman, Ferguson & Negy). Sometimes technology can also offer new ways to treat mental health disorders. More than mental health apps also available for alternative treatments the apps also available in Smartphone such as,

- What's up: Cognitive Behavioural Therapy (CBT) and Acceptance Commitment Therapy (ACT) Method
- Mood kit: Cognitive Behavioural Therapy and Mood improvement activity
- Twenty-Four Hours a Day: Meditation book for people in recovery from addiction. Companion and Focus on moderation of addiction behaviour
- Quit that: strike their habits or addiction, perfect recovery tool and monitoring the progress.
- Mind shift: It is an anxiety app, this app trying to avoid anxious feelings and changing the negative thing about anxiety
- Self-help for anxiety management: Social Cloud" feature to confidentially connect with other users in an online community for additional support
- Bipolar Disorder Connect: Identify the struggles of people and monitor the people moods
- IMoodJournal: Analyze the daily feelings through the summary charts such as noted the stress level based on rising and falling.
- Talk space Online Therapy: This app is used to support one's through the ones own depression
- Happify: This app is fast-track to a good mood. Try various gratitude prompts, activity suggestions, engaging games and more to train your brain as if it were a muscle, to overcome negative thoughts.
- Recovery Record: Recovering from an eating disorder and inadequate to build up a more optimistic body image and used to stick the meal plan.
- nOCD: nOCD giving mainly two treatments such as mindfulness and Exposure Response Prevention Treatment.
- PTSD Coach: to find and giving an opportunity for Post-Traumatic Stress Disorder from a self-assessment
- UCSF PRIME: This app is used for schizophrenia groups. It also lets people track "challenge goals," belongings they'd like to accomplish or improve about them.
- Headspace: This app is used to make meditation in a simple way, that meditation on the lot from stress and anxiety to sleep and focus.
- Calm: Calm provides people experiencing anxiety and stress with guided meditations, breathing programs, sleep stories and relaxing music.
- MY 3: This app is suicidal prevention app and used to recognize ones warning signs through one's safety plan and listed warning plans.

The above apps are using the people to develop mental health in positive manner, technology impact the humans in both way. Technology can impact society in positive and negative. So human only choose the correct way and tools to grow up the living style, personality and so on.

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CONCLUSION

In this chapter, the authors discussed various opportunities for all people for maintaining mental health and emotional development. Our focus is that the individuals growing up with good emotional and mental health. For that, the authors briefly discussed technological issues regards to mental and emotional health. Everyone knows that emotions are innate, cannot be controlled but manageable and it is a hidden factor for developing good mental health. Generally, destructive emotions affect an individual's mental health and high on that emotions may throw the individual as a murderer or committing suicide. Constructive emotions ensure stress-free and peace of living, which develops good mental and emotional health. So, emotions play a vital role in maintaining emotional health which is a factor for developing mental health. Notwithstanding this, some technologies also fluctuate emotions and direct emotional and mental health issues. Hence this chapter discussed with technological issues regards to mental and emotional health and providing remedies for emotionally and mentally healthy life.

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Chapter 6
Romantic Relationships, Online Dating, and Mental Health Issues

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ABSTRACT

This chapter attempts to present the overview of mental health issues associated with online dating and online romantic relationships with relevant research background. It briefly cautions about the possible risks involved in the world of online dating platforms and later delves into mental health concerns that can emerge out of experiences while selecting a potential partner online, developing a romantic relationship, and being involved in a romantic relationship online. It also discusses safety measures that need to be taken before and while being active on such online dating sites. The chapter draws attention to the specific role of mental health professionals that is needed while dealing with victims of online scams and abuse.

INTRODUCTION

Love and affection are very basic human needs. Romantic relationships are significant part of our lives and contribute in our physical, social and emotional well-being. A good relationship enhances our overall health. (Cohen, Frank, Doyle, Skoner, Rabin, & Gwaltney, 1998), and even help in speedy recovery from various disorders (Kiecolt-Glaser, Loving, Stowell, Malarkey, Lemeshow, Dickinson, & Glaser, 2005). Most of the people find their partners through their social or professional sphere. However, these circles are limited in number and thus the choices can become narrowing. Consequently due to the advent of new technology, people want to widen the scope of finding a more suitable partner and they find the solution in online dating sites.

Using the internet has not just remained a convenience but has become a necessity. With the advancements in technology, today we have plethora of very diverse social networking platforms which are unique in their own way connecting people together online. Social media has revolutionized and

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digitized human interactions and relationships. Rosenfeld and Thomas (2012) found that the Internet has allowed users to find partners more easily, especially homosexuals and middle-aged people who operate in a "thin market.

With the popularity of online dating sites, the stigma of online dating has diminished considerably in the last decade. According to the survey conducted by Smith and Anderson, (2015), overwhelming majority of Americans suggest that online dating is a good way to meet people. Interestingly, more than 15% of adults say that they have used either mobile dating apps or an online dating site at least once in the past. Online dating services are now the second most popular way to meet a partner.

WHAT PERSONALITY CHARACTERISTICS ARE ASSOCIATED WITH THOSE WHO PREFER ONLINE DATING?

1. In a research finding it was concluded that loneliness was found to be one of the major factor that encouraged people to go for online dating. (Lawson & Lake, 2006). The participants reported that they felt less lonely after being a part of the online dating websites.
2. It was observed that individuals scoring higher on the romantic beliefs and especially idealisation of the romantic partner were more vulnerable to being deceived on the online dating sites. These individuals also tended to be more agreeable and more likely to opt for online dating. (Whitty & Buchanan, 2012)

WHAT IS WRONG WITH ONLINE DATING?

In a popular blog post by Ryan Anderson, several warning signals regarding online dating have been put up and they seem to be resonating with reports of Indian newspapers on the same topic (Psychology Today, 2016).

1. People tend to lie about themselves on online dating sites. Out of over 1000 online daters in the USA and UK, 53% confessed that they have lied in their online dating profile; mostly about look, height, financial status. This was an attempt to project an ideal self to attract more partners.
2. It's basically virtual! Smith and Anderson (2015) found out that more than one third of their research participant (online daters) never actually went on a date and those who went found it difficult to connect to the person they had met online.
3. It makes people judgemental. Various online daters confess that they judge the person based on the looks. The apps and websites offer an interface where only the physical aspects of the individual are highlighted so as to make the website more appealing. Naturally the users dismiss the not-so beautiful candidate in just a swipe or a click.

EMERGING MENTAL HEALTH ISSUES RELATED TO ONLINE DATING

However there are some shortcomings of this epidemic of developing romantic relationships. Right from becoming a victim to identity or financial frauds to brief, deceitful and virtual nature of relationships,

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online dating poses a serious danger to the person's sense of self and his or her relationships with others which in turn lead to many mental health-associated issues.

1. Short and unsuccessful relationships. The very virtual nature of the online dating scene itself suggests that it promises a 'fling'; meaning a very casual, non-committal relationship or so the stigma associated with online dating suggests to people. People are attracted to online dating when they feel lonely or are disappointed by the conventional dating experience or "let some steam off". Thus it becomes apparent that these relationships are not looked upon to be serious and following study attest to that.

A recent study by Paul (2014) showed that couples who met on dating sites are less likely to get married and even further he also pointed through surveys that breakups were more common in couples who met online versus those who met in more traditional set ups. This study asserts that this result is consistent with both married and unmarried couples.

We know that short term and less meaningful relationships that lead to breakups do not contribute to our well-being. Frequent or even one incident of breakup leads to bereavement symptoms including intrusive thoughts and attempts to suppress them and insomnia as well as morbidity factors including broken heart syndrome and immune dysfunction (Field, 2011). In this way online dating can really pose a threat to one's well-being.

2. Online dating scams. As discussed above online dating sites are not safe as in the candidates can put up false information about their looks, financial status, marital status and you have no means to crosscheck this information. A huge number of scams including financial frauds, sexual abuse, internet bullying and blackmailing have mushroomed with the increasing use of online dating websites and apps.

Professor Whitty and Professor Buchanan from the University of Leicester and Westminster have conducted comprehensive studies of the victims of online dating scams. They appraised from a nationally representative sample survey that almost 230,000 people may have been tricked by romance fraudsters in UK only. They assessed the 2 sets of such victims i.e.: 1) those who lost money due to frauds done by online romantic partners, and; 2) non-financial victims.

The victims who had lost money reported significantly higher emotional distress than those who did not lose money. Many non-financial victims too reported high levels of emotional effects. Both set of participants reported experiences of depression, guilt, shame, embarrassment, fear, feeling suicidal, extreme emotional distress, emotionally violated, loss of trust in others, feeling stupid, denial, problems in appetite, sleep and sexual functions.

3. Body Image and Self-Esteem. As discussed above the dating apps and websites bank on the good looks of the candidate and hence the individual with more appealing physical appearance are desired by the opposite gender and they get the most right swipes/likes/interest requests. This creates a problem in how one looks at one's own body and how much importance is attached to looking beautiful.

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In a study presented at the annual convention of the American psychological association, researchers explored the psychological effects of a certain popular dating application on a group of 1300 college students. These participants were asked questions based on their appraisal of their own body image and how they compare their looks with others. At the end of this questionnaire they were asked if they used that certain application.

The results showed that individuals using that application had lower levels of self-worth than those who did not use the app. They also reported being less satisfied with their facial features and they were ashamed of their bodies. They also constantly compared themselves with the appearance of others and were self-conscious. Surprisingly, this research even showed that all the findings were true for men and women both, because women tend to judge their own looks negatively (Strubel & Petrie, 2016).

Body dissatisfaction appears to be associated with greater impairment in self-esteem and other aspects of psycho-social functioning in males (Furnham, Badmin, & Sneade, 2002; Wardle & Cooke, 2005).

A longitudinal study examined the relationship between low self-esteem and depression and found that low self-esteem is a causal risk factor for the development of depression. (Robins, Widaman, & Conger, 2014)

4. Too much attention is not good for you! In the world of online dating, the *super like, like, comment, right sweep* is like a tiny dose of positive reinforcement and it is highly pleasurable to the receiving candidate. The rampant world of social media has wired our sense of identity to how we look on our social or dating profile online. People either tend to get more arrogant when they are desired by many people or lose their self-worth because they are rejected or ignored.

An online app user confessed to Times of India how using this app first gave her too many feel good emotions and how she became significantly arrogant and narcissistic. However, when her profile was rejected by a good-looking individual and he said that she was too pretentious she fell in the spiral of self-doubt, low confidence and despair. This shattered her self-worth and she spent hours in the late night to see if anybody has liked her profile or not. The rejection stung her too much and she began crash dieting and her work-life and mental health deteriorated (Times News Network, 2017).

5. Online sexual abuse. Women on various dating websites report the experience of receiving rude, disgusting messages, sexual propositions/requests which if entertained go on to develop sexual abuse. As announced by the UK's national crime agency, online dating related rape has increased by more than 450 percent in last 5 years (2016). The report elaborated that online relationships generally progress at higher rate as compared to offline relationships because in the virtual world people tend to feel free and express their emptions readily. This increased trust leads to individuals taking more risks in the relationship and be willing to participate in vulnerable situations. In these cases previous online flirting, messages with sexual content increase the intimacy between the partners and thus they have higher expectations about sexual activity when they meet for the first time. The offenders use the strategies of persuasion, perseverance and coercion to get the victims agree on the early first date.

This can result into serious mental health problems leading to development of disorders like depression, suicide attempts, Post traumatic stress disorder etc. Research consistently identifies the negative consequences of being a victim of cyber abuse. Victims experience loneliness and social isolation. The

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person's consequent social withdrawal is likely to lead to low self-esteem and depression. Those who abuse others too are at risk too. They are more likely than non-abusers to engage in a range of maladaptive and antisocial behaviours and at risk of alcohol and drugs dependence, depression and suicidal ideation (Cowie, 2013).

PROTECTING ONE'S WELL-BEING WHILE DATING ONLINE

Now when we are familiar with what dangers online dating poses to our emotional and physical well-being, it becomes mandatory to go through some safety measures candidates need to take before embarking on the journey of online dating. These tips are compiled from various dating websites and cyber security professionals (eharmony.com, Tinder™, OKcupid.com, National Cyber Security Alliance).

Though these measures cannot make the person absolutely immune to the horrors of online dating scams and abuse they can definitely prevent many unwanted situations. It is ultra-important to stay safe online.

1. Use a trusted online dating site or app which has strong customer support, better privacy and those who approve the candidate profile only after checking the claimed information with valid documents or proofs.
2. Check the privacy policy, required details and permissions by the website so as to safeguard your sensitive information and how they handle cases of abuse or scams, features like blocking a profile or disabling instant messaging/ location tracking or the option of reporting a profile are very much necessary.
3. Do not provide sensitive information about yourself and financial details, do not divulge in sharing private and personal details. Do not respond when request of financial details or sexual content are made, block that person and immediately report his profile to concerned authority. Do not exchange private and personal information.
4. Be careful to not disclose your personal mobile numbers immediately. Do not trust blindly.
5. Use a disposable email id for dating sites.
6. Create an honest profile and be specific in your expectations from prospective partners. Do not upload inappropriate pictures or those containing information about your car number, house location etc.
7. Check the person's identity through Google, Facebook or other platforms. Make sure that the name, face and other details are correct.
8. Do not develop too much intimacy online. First meet the person as soon as possible and when your fact check is complete you can slowly develop the relationship.
9. While going on first dates learn to say a firm "No" to any sexual requests, always confide the location details of your date with a known person (family or friend). Meet in public places and avoid long drivways or lonely places. Do not drink too much on the date and be vigilant to any cues of dangers. Confront and ask question when something looks fishy even online and in person.
10. Confide in your near and dear ones about your dating experience online. Do not choose online dating just because you are too lonely, depressed or recently broke up with someone. Make an informed choice.

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ROLE OF MENTAL HEALTH PROFESSIONALS

The increasing number of cases of cyber abuse and scams are leaving the victims stranded in the miserable state of anger and disappointment and in many cases their reaction is that of experiencing a trauma. Mental health professionals need to be aware of unique challenges these victims face and they need to prepare themselves to tailor their interventions in such a way that they meet the needs of victims of such abuse.

The study done by Whitty and Buchanan (2012) proposed the shortcomings of the help given by counsellors to such victims. The professionals were inept to understand the nature of the trauma and were quick to judge the victims for being conned financially and emotionally.

The counsellors also did not understand that the victims could not turn to their family and friend for social support and they felt withdrawn and isolated from others.

Hence the mental health professionals need to take care of following aspects as a reflection of Whitty and Buchanman's study;

1. Increasing awareness about such abuse and scams in their working field and spread word of caution. They also need to be approachable to such victims and come out of traditional therapy/counselling set up to meet these victims.
2. Law enforcement agencies need to have strong tie-ups with mental health professionals to facilitate timely referrals and crisis intervention in earlier stage when the victims are vulnerable to suicidal ideation, substance abuse and other such situations.
3. It is necessary to understand that this trauma reaction is similar to the stages of grieving as explained by Kubler-Ross's (1969): denial, bargaining, anger, depression, and acceptance.

The denial stage when unresolved can lead to re-victimization which is much more dangerous. Appropriate interventions need to be employed to fully resolve the grieving response.

4. The increased mistrust towards other people the victims have developed after the trauma can lead to transference issues.
5. Ways of coping with the distress need to be realistic rather than dreamy and farfetched; the professionals need to understand that empowering the victims for a long term is essential rather than for a temporary basis.
6. The professional need to understand the '*double hit'* victim has suffered- the financial loss as well as the loss of a perceived significant relationship.
7. It is necessary to protect the victim from the second wave of being conned.
8. The victims who go through such trauma are often seen to have history of previous sexual abuse and other mental health problems. These vulnerabilities need to be sensitively handled.
9. The victims need to know that professional help is available and professionals need to standards of uphold highest ethical and moral conduct to safeguard the confidentiality and well-being of the victims.

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THE POSITIVES OF ONLINE DATING

It goes without saying that even after enlisting many drawbacks of the world of online dating it also has some uses and that is why it is so popular. Finkel and colleagues (2012) discuss the plus points of online dating:

1. **Access:** Online dating equips the individuals with access to many more potential partners than they could often find in their daily lives. This is especially true for individuals interested in partners of a particular type, orientation, lifestyle, or in isolated areas.
2. **Matching:** Many online dating sites offer various types of personality testing and matching. Such matching can help guide individuals toward dating partners who may be more compatible.
3. **Communication:** Online dating offers a number of ways to get to know a possible date before meeting in person. Such computer-mediated communication allows for safe and convenient interaction, without much risk or time commitment. For the busy professional, or the safety-conscious, such communication is an excellent way to "check" potential partners.
4. **Individuals With Social Stigma Attached to Their Particular Condition or Way of Life:** It is difficult for individuals who have social stigma associated with them like homosexuals, people with disability or people having mental illness to find a romantic partner through conventional methods of dating. But these individuals have found it useful to search for a suitable partner through online dating and they are finding meaningful romantic relationships online.

CONCLUSION

In conclusion, it is necessary to understand that both the traditional and online methods have their own advantages and disadvantages but the key to cultivate online romantic relationship is to be cautious while wading through the virtual world. Online dating is a start but meeting the person as soon as possible leads to trust building and rule out dangers of being conned. Considering internet as way to engagement with real human beings and not mistaking it with actual relationship is of utmost importance to protect own mental health and overall well-being.

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Chapter 7
Special Issue:
Sexually Transmitted Infections – Diagnoses, Stigma, and Mental Health

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ABSTRACT

Misconceptions regarding the cause(s) of sexually transmitted infections (STIs) has led to a number of prejudices against those with such diagnoses. A fear of being the object of prejudicial attitudes and behaviors leaves many individuals concerned about the social stigma of a STI diagnosis. This, in turn, may leave people unwilling to get tested or hesitant to disclose their diagnosis to others, which may fuel the spread of such infections. In addition to the numerous medical concerns associated with STIs, the psychological consequences of STIs are notable as well. Understanding the stigma related to STIs is an important step towards improving the mental health of people with such diagnoses. This chapter provides the reader with an overview of STI diagnoses, and an explanation of their physical and mental health consequences. The chapter continues by examining the three types of stigma as well as their components. Finally, the chapter offers a number of suggestions regarding how to combat STI stigma, which may be extrapolated to combat other forms of stigma affecting mental health.

INTRODUCTION

According to the Center for Disease Control (CDC) (2016), there were 1,526,658 cases of chlamydia, 395,216 cases of gonorrhea, 23,872 cases of primary and secondary syphilis, and 487 cases of congenital syphilis reported in United States in 2015. These figures, which only include a small fraction of potential sexually transmitted infections (STIs), represent a substantial increase in reported diagnoses from the previous reporting period (2014), suggesting that the transmission of sexually transmitted infections (STIs) is on the rise. What is interesting about these figures is that they paint only a part of the picture. The CDC

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relies on the reports of local health authorities and other public reports to gather its data. As such, these figures are estimates, at best, and likely greatly underrepresent the STI epidemic plaguing the country. The fact is that many cases of chlamydia, gonorrhea, and syphilis go undiagnosed and/or unreported. Further, data on other STIs, such as herpes simplex virus, trichomoniasis, and human papillomavirus, are not routinely reported at the national level. As such, information regarding the pervasiveness of the current STI epidemic is based on estimates. In 2016, the CDC estimated that approximately 20 million new cases of sexually transmitted infections occur every year within the United States (CDC, 2016).

While the exact prevalence of STIs are unknown, their impact is evident. Research indicates that STI diagnoses influence people's short-term and long-term physical health and often impacts their mental health statuses as well. Additionally, STIs also contribute to a number of burdens that broadly impact society as a whole, including compromised productivity as well as economic outcomes (CDC, 2016). In 2016, the CDC estimated that the country spends over $16 billion in health care costs related to STIs (CDC). Despite these known effects, trends in the data suggest that many people remain resistant to pursuing adequate testing and/or treatment for possible STIs due to their concerns regarding the stigma of having such diagnoses (Foster & Byers, 2008). This resistance may not only compromise the health of the individual with the STI, but also has the potential to negatively impact his or her current and future sexual partners.

There remain a number of misnomers regarding STIs, including information regarding the manner in which they are contracted as well as their treatability. This misinformation may lead individuals with potential or confirmed STI diagnoses undue stress, which may compromise their overall mental health functioning. It likely also aids in the further perpetuation of inaccurate myths and subsequent stigma regarding sexuality and reproductive health.

The goals of this chapter are to:

1. Introduce the reader to the effects of a STI diagnosis and the consequences of non-disclosure,
2. Explain the types of stigma typically associated with STI diagnoses as well as their components,
3. Explore how STI stigma compares to other forms of stigma affecting wellness, and
4. Review strategies to reduce stigma

By the end of this chapter, readers will better understand the impact of stigma as it relates to sexually transmitted infection diagnoses and associated mental health functioning. Understanding the nature of STI stigma will provide insight into the nature of stigma, as a whole, thus allowing the reader to further deconstruct the stigma of mental health specifically. The ability to more fully understand the nature of stigma will allow advocates an increased capacity to combat it effectively.

BACKGROUND

Physical and Psychological Effects of an STI Diagnosis

There are over 20 different types of viruses known to be transmitted via sexual contact (NICHD, 2017). Of these, the most common include: chlamydia, gonorrhea, syphilis, herpes, HIV/AIDs, human papillomavirus (HPV), bacterial vaginosis, and viral hepatitis. While each variable in the display of its specific symptoms, STIs may have a profound impact on a person's physical health. For example, chlamydia, an

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infection that may spread via oral, anal, or vaginal sex, may lead to a variety of symptoms. Some with the infection will experience no symptoms while others will experience high fevers, abdominal pain, and unusual genital discharge. Chlamydia may also cause a woman to develop pelvic inflammatory disease (PID), which, if it develops, can lead permanent damage to her reproductive organs and lead to infertility. Further, there is an increased risk to the health of the fetus of women pregnant whom have this infection (NICHD).

Gonorrhea symptoms most typically include genital discharge and/or painful urination. Like chlamydia, this infection is spread via genital, anal, and oral contact and may also result in PID and its associated consequences. Research indicates that gonorrhea can spread to multiple parts of the body and eventually become a life-threatening illness. This diagnosis may also place an individual at an increased risk of contracting other STIs, such as HIV (NICHD, 2017).

Syphilis is also spread via oral, anal, or vaginal sex. Its most recognizable symptom includes painless genital sores. If left untreated, this infection may involve other organs of the body, including skin, blood vessels, the liver, and bones. Over a period of years, the infection may further spread to involve the nerves, eyes, and brain, often leading to death. Mothers carrying the infection may spread it to their fetuses, which could result in miscarriage, stillbirths, or a number of other birth deformities. Additionally, research indicates that those with syphilis are two to five times more likely to contract the HIV virus (NICHD, 2017).

There are two types of herpes, which is caused by the herpes simplex virus (HSV). This virus is typically spread via genital, anal, or oral contact. Herpes leads to the development of painful blisters, which typically appear around the genitals or anus. Fever blisters or cold sores may also develop on the lips as well. While some people with this infection may remain asymptomatic, the virus is incredibly easy to spread. Like many other STIs, herpes poses great risk to the unborn fetuses of women whom are infected (NICHD, 2017).

The human immunodeficiency virus (HIV) may lead to the development of acquired immunodeficiency syndrome) (AIDS). HIV attacks a person's immune system by killing the blood cells that fight infection, leaving those infected with the virus particularly susceptible to further illness. A few decades ago, the presence of the HIV virus would typically mean almost uncertain death, however recent research has led to a number of functional cures for the virus. Further, increased sexual education has helped curb the spread of this virus (NICHD, 2017).

The most common STI at this time is human papillomavirus (HPV). Thus far, research indicates that there are over 40 variations of this virus, which commonly lead to infections throughout the body, the development of genital warts, and the growth of certain cancers. As with HIV, scientists have developed some medical interventions aimed at minimizing the prevention of HPV, including effective screening procedures to identify the presence of the virus as well as an immunization against it (NICHD, 2017).

Women are susceptible to bacterial vaginosis, a vaginal infection that is thought to be sexually transmitted. While the symptoms associated with this particular infection tend to be minimal, its presence is of concern as it puts women at increased risk of contracting other STIs, PID, and suffering from compromised reproductive health (NICHD, 2017).

Viral hepatitis results from one of several viruses that are typically transmitted through sexual contact, exposure to infected needles, exposure during birth, or exposure to infected blood. This infection results in a serious liver disease. There are several forms of the infection. Hepatitis A typically results in a serious, but short-term liver infection. Another form of the virus, Hepatitis B, is a serious liver disease that can result in urgent illness as well as well chronic infection, which can lead to death. Like Hepatitis

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B, Hepatitis C can result in an immediate illness or a more chronic infection of the liver, which can contribute to one's death. Vaccination is said to help prevent the spread of Hepatitis A and B, but there is no cure or prevention for Hepatitis C (NICHD, 2017).

MAIN FOCUS OF THE CHAPTER

Issues, Controversies, Problems

Collectively, the research pertaining to these STIs indicates that they can lead to acute infection (NICHD, 2017), chronic pain (CDC, 2016), severe reproductive health obstacles, including infertility and pregnancy complications (CDC), or even death (NICHD, 2017). As such the prevalence of and efforts to prevent these infections should not be taken lightly. Luckily, as medical science has expanded so too has our understanding regarding the very nature of these infections. Medical interventions, including a number of immunizations and antibiotics, are now available to help prevent and/or combat the symptoms of these illnesses.

The impacts of STIs are not limited to physical health, however. STI diagnoses may also have a notable impact on one's mental health presentation as well. Past research confirms that those diagnosed with one or more STI diagnoses are likely to experience embarrassment, anxiety, shame, and fear both sexual and social rejection (Darroch, Myers, & Cassell, 2003; Duncan, Hart, Scoular, & Birgrigg, 2001; Osborn, King, & Weir, 2002). STI diagnoses are also correlated with depressive symptoms (Chen, Wu, Yi, Huang, & Wong, 2008; Khan et al., 2009) as well as symptoms of anxiety (Arkell, Osborn, Ivens, & King, 2006) and increased suicidal gestures (Badiee, Moore, Atkinson, Vaida, Gerard, & Duarte, 2012).

Disclosure and Non-Disclosure

There are a number of reasons a person may choose not to disclose his or her STI diagnosis to others. More often than not, the primary reason is to avoid stigma (Lichenstein, Neal, & Brodsky, 2008). Past research confirms that internalized stigma and the potential for treatment stigma often lead people to avoid seeking help for their STI-related symptoms. More specifically, people endorse concern regarding the confidentiality of their diagnosis status as a main treatment-seeking barrier (Clement, Shauman, Graham & Maggioni, 2015). Concerns regarding others' external stigma, which is often rooted in religious and cultural expectations, leads many people to avoid disclosure primarily due to the fear of social judgement, and, in some cases, fear for personal safety (Kingori, Ice, Hassan, Elmi, & Perko, 2016). Non-disclosure has several potential effects. First, it may exacerbate the cognitive and emotional toll of the diagnosis itself, causing increased stress, shame, and discomfort to the individual. Further, the failure to disclose one's symptoms to parents, medical providers, and others affecting one's healthcare may prevent access to effective treatment, which could actually help minimize symptoms and/or prevent the infection from further developing.

The impact of an STI is not limited to the person diagnosed. In addition to the many social consequences of such infections, including high medical costs, compromised productivity in the workplace, and similar circumstances, one's sexual health also affects his or her current or future sexual partners. Individuals who learn of their partners' STI diagnosis may need to reconsider sexual practices, including what activities to engage in and to what extent as to reduce their own chances of infection. Additionally,

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increased protection, such as the use of condoms, may be warranted. Of course, learning of a partner's STI status after exposure may also have psychological consequences as well. Bender and Hill (2017) conducted a phenomenological study, which reveals that partners often wonder about their partners' level of sexual responsibility, commitment to their relationship, and monogamy practices secondary to learning of their partners' STI diagnoses. This, in turn, often creates situations in which the partner of the person infected experiences heightened levels of psychological distress, including anxiety, anger, and depression. Given the potential for conflict with one's partner and/or the prospect of being denied sexual intimacy, it may be tempting for some people to not disclose their STI diagnoses with their partners. Failure to disclose such diagnoses leaves the partner at an increased vulnerability to future infections and associated medical complications.

Defining Stigma

The definition of stigma is inconsistent within the literature. Most explanations of the concept refer back, in some form, to the word's Greek origin of 'a sign or a branding mark' (Sharfestin, 2012). In his seminal book on the topic, sociologist Erving Goffman (1963) defined stigma as an 'attribute that is deeply discrediting" ultimately reducing an individual "from a whole and usual person to a tainted, discounted one" (p.3). Within his explanation, Goffman (1963) highlighted three categories of stigma: tribal identities, body abominations, and blemishes of individual characters. Tribal identity (also referred to as 'group identity') refer to a person's group membership as determined by religion, nationality, sex, race, and similar characteristics. Body abominations refer to physical deformities. Finally, blemishes of individual characters refer to circumstances such as the presence of a mental health diagnosis, unemployment, addiction, etc. Each of the categories, according to Goffman, renders those with them as distinct from those whom do not have them, thus paving the way for prejudicial attitudes and subsequent discriminatory practices to occur. Goffman explained, "By definition, we believe the person with a stigma is not quite human" (p. 5). Within this framework, stigma devalues the individual and excludes him or her from societal acceptance (Goffman).

Jones and colleagues (1984) suggested that there are six stigmatizing dimensions that fuel the separation between a 'usual person' and a 'discounted one' (Goffman, 1963, p. 3). These dimensions include: Whether the stigma is visible vs. concealable, the perceived origin of the condition, the aesthetics of the condition, whether or not the condition is viewed as perilous or not, whether or not the condition is likely to be disruptive to ongoing social interaction, and the projected course of the condition over time.

Explaining Stigma

Social scientists have not only struggled to define stigma, but also to explain it. There are a number of psychological and sociological theories that help describe this phenomenon. Corrigan (2004) suggest that three paradigms exist, which help explain stigma. First, the social cultural perspective suggests that stigmas form to substantiate prevailing social injustices. The paradigm of motivational biases suggest that stigmas develop secondary to meeting basic psychological needs. Finally, social cognitive theories suggest that stigmas result as the consequence of human information processing. Of these three paradigms, the social cognitive theories are most widely accepted. They are said to be the most theoretically rich and best supported empirically out of the three.

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Social cognitive theories recognize that people engage in a number of heuristics, which allow them to quickly categorize individuals into groups (Dovidio et al, 2011; Kahneman, 2011). While a normative process, this categorization likely organically leads to prejudice and discrimination. Gordon Allport (1954) suggested that this tendency to categorize others an essential element of social life. Assigning those we encounter into categories allows us to process large volumes of information about those we encounter by filtering that data into specific classifications. Categorization also allows us to cluster that information efficiently by relying on previous assessments regarding individuals and situations that we recognize as similar. This, in turn, may also allow us increased access to emotions more easily, as we tend to develop distinct like or dislike for those things we have categorized. Finally, categorizing people also allows us to identify them with speed and efficiency. Prejudice, it is suggested, is an organic consequence of this categorization. Prejudicial beliefs, often lead to discriminatory behaviors associated with stigma.

Stigma Impact

Link and Phelan (2001) suggested that most common definitions of stigma are too simplistic due to the perspectives traditionally held by stigma researchers, which are rooted and limited by their participants' experiences, as well as the individualistic focus of the research dedicated to understanding the phenomenon. They argue that a larger cultural focus must also be considered when operationalizing stigma. Link and Pehan expand the term stigma to refer to "when the elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation…" (p. 367). They assert that stigma likely serves as a "key determinant of many of the life chances…from psychological well-being to employment, housing and life itself" (382).

There are four commonly accepted manifestations of stigma, including: 1.) public stigma, which refers to people's social and psychological reactions to someone with a perceived stigma, 2.) self-stigma, which refers to how an individual reacts to the possession of a stigma, 3) stigma-by-association, or courtesy stigma, refers to the social and psychological reactions to people associated with a stigmatized person or how people react to their own associations with a stigmatized person, and 4.) institutional stigma, which essentially is the legitimatization and perpetuation of a stigmatized status by society's ideological systems and institutional practices. Each of these manifestations is likely to impact a person's wellness and functioning. Public stigma and stigma-by-association, lead to biases, negative stereotyping, and negative judgment (Kendra et al., 2014). Similarly, institutional stigmatization may lead to increased difficulties securing employment, social status, or housing (Sickel, Seacat, & Nabors, 2014). These factors may serve as barriers to treatment, contribute to increased isolation, and facilitate a variety of negative psychological effects. Further, self-stigma may impact an individual's self-esteem and opportunities (Watson, Corrigan, Larson, & Sells, 2007). All forms of felt and enacted stigma are likely to negatively affect a person's quality of life (Gerrida-Hernansaiz, Helyen, Bharat, Ramakrishna, & Ekstrand, 2016).

STI and Mental Health Stigma

STI-related stigma refers to an individual's awareness that a STI diagnosis is accompanied by a negative social judgement (Foster & Byers, 2008). Historically, the acquisition of an STI has been misattributed to deviant behavior and immorality rather than a consequence of normal sexual activity. Misperceptions regarding the cause(s) of STIs has led to a number of prejudicial attitudes and beliefs against those with such diagnoses. A fear of being the object of prejudicial attitudes and corresponding behaviors leaves

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many individuals concerned about the social implications and general stigma of such diagnoses. This fear of social stigma secondary to a STI diagnosis leads a high proportion of people unwilling to get tested for STIs and/or to disclose their confirmed diagnoses. This, of course, not only compromises their own health, but also increases the likely transmission of STIs to others, further fueling the STI epidemic.

There are three components of STI stigma, including: shame, sexual anxiety and social desirability. STI-related shame is a "negative affect that an individual experiences as a result of internalizing stigma" (Foster & Byers, 2008, 194). This relates to feelings of immorality and often leads people to think of themselves and themselves as "dirty". Secondary to this label of being 'dirty' due to their diagnosis, those suffering experiencing shame related to the STIs assume that they will be viewed negatively by others (Foster & Byers). Foster and Byers (2008) found that those who reported higher levels of shame were less likely to get tested for STIs and less likely to disclose their diagnosis; again, risking their future health and that of those with whom they are sexually intimate.

While the shame associated with having a STI may affect anyone at any time, research suggests that it is especially prevalent among women. East and colleagues (2011) report that women typically attribute other women's STI diagnoses as a consequence of promiscuity or sexual deviance. This perspective changes, however, when women receive a STI diagnosis themselves. Instead, the literature suggests that women in such scenarios shift their perspectives to internalize new feelings of self-blame and denial, which lead to shame. This shame is often experienced at a deep personal level upon the time of diagnosis and may cause physical and psychological burdens on the individual, which, in turn, places pressure and strain on intimate relationships (East et al., 2011). Research also suggests that there is a positive correlation between sexual conservatism and dissatisfaction with school-based sexual education with high levels of shame due to STI diagnoses (Foster & Byers, 2008).

The second component of STI stigma, sexual anxiety, occurs when a person fears sexual rejection secondary to his or her STI diagnosis. Sexual anxiety is category of sexual dysfunctions, defined as persistent impairment of sexual interest or response cycle. This dysfunction can be physiological or psychological (Adekeye, Sheikh, & Adekeye, 2012). It can create biological and interpersonal conflicts, and can be affected by stress, emotional disorders, ignorance of sexual function, and basic physiology (Adekeye, Sheikh, & Adekeye). Foster and Byers (2008) determined that people with more traditional values are more likely to associate STIs with stigma and shame and are more likely to experience sexual anxiety (Foster & Byers). This sexual anxiety, in turn, may facilitate lower levels of sexual pleasure and satisfaction (Brassard, Dupuy, Bergeron, & Shaver, 2013).

Social Desirability Theory indicates that humans retain an innate desire to please and be accepted by others. Social norms, perceived negative consequences, and fear of rejection all affect social desirability. The desire to remain socially desirable, in combination with fear of rejection, leads many people to resist seeking STI testing as well as disclosing STI diagnoses (Cunningham, 2009). A fear of rejection seems to serve as the common denominator between shame, sexual anxiety, and social desirability in relation to sexuality. This fear of rejection leads many people to avoid seeking STI testing, procuring STI treatment, and disclosing STI diagnoses to their partners. Lichtenstein and colleagues (2005) found that many people reported being embarrassed regarding their STI diagnoses, which contributed to the delay or complete avoidance of treatment for the same. Barth and colleagues (2002) asserted that people sometimes also avoid pursuing initial STI testing due to their own preconceived biases regarding what a STI diagnosis might mean. In their study of undergraduate students, they found that in an effort to avoid negative emotions, deny the possibility of even having a STI, or even a simple preference to not have such a hypothesis confirmed, some individuals would not participate in STI screenings.

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While the stigma associated with STI diagnoses is formidable, research demonstrates that the stigma associated with mental health diagnoses is stronger than that associated with physical health diagnoses (Corrigan, 2004). Further, the stigma associated with various mental health diagnoses seems to be further stratified by the perceived severity of dysfunction commonly allocated to a diagnoses (Stuber, Rocha, Christian, & Link, 2014). For example, those with psychotic diagnoses, such as schizophrenia, are typically evaluated more harshly than those with a more common mental health diagnosis such as depression or anxiety (Corrigan, 2004).

In line with the behaviors of those with suspected STI diagnoses, those experiencing mental health symptoms also often avoid or delay seeking clinical assistance. A systematic review of studies completed from 2008-2011 revealed that stigma was the fourth highest ranked barrier to help-seeking. Within the collection of studies reviewed, the potential to have one's mental health diagnosis revealed was the most notable stigma barrier (Clement, Shauman, Gram, & Maggioni, 2014). Via their study of undergraduate student experiences, Eisenberg, Downs, Golberstein and Zivin (2009) confirmed that perceived stigma or bias affected help-seeking behaviors. Corrigan, Druss, and Perlick (2014) also recognize mental health stigma as a primary barrier to care, but note that the dynamics involved in avoiding such treatment are not that simple. They suggest that one must also consider personal barriers (beliefs about treatment effectiveness, lack of a support network, lack of mental health literacy, etc.) and provider and system-level barriers (lack of insurance, financial constraints, staff incompetence, etc.) affecting the quest for care, too.

THE ROLE OF STIGMA IN PERPETUATING PREJUDICIAL BEHAVIORS AND DISCRIMINATION

Perpetuating Stigma

Stigma, regardless of its focus, is frequently fueled by media's attention on the negative attributes of a situation or diagnosis and via the public's subsequent understanding of the visible minority. For example, one only need to look at the coverage of mass shootings over the past decade to note the media's propensity to focus on whether or not the shooters associated with each horrific incident had some sort of mental health diagnosis. Rarely, did these outlets examine current the offender's stressors, ongoing drug abuse, extreme ideological beliefs, personal victimization, or other factors as potential root causes of their actions. Instead, more often than not, mainstream media often learned of these individuals' diagnoses and dismissed their extreme actions as the result of such diagnoses. Such conclusions fail to portray a comprehensive picture of the various intersecting factors likely propelling these offenders to such acts of horror. The news media's propensity to reduce and oversimplify the dynamics at play in these situations often portrays an inaccurate, or at very least, incomplete depiction of such events, which then leaves the consumers of this media with negative impressions regarding those with mental health issues. Further, due to their own fear of being the victims of such atrocities, those whom consume these media portrayals may feel an increased need to distance themselves from those whom they know or perceive to have a mental health diagnosis as a way to increase their perceived physical safety and in an unconscious effort to protect their own psychological safety (McGinty, Webster, & Barry, 2013). These beliefs trickle down into other areas of society as well. For example, researchers found that most employers report that they are less likely to hire someone with a known mental health diagnosis, as they

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assume such individuals are more likely to be absent, disengaged, dangerous, or otherwise unpredictable (Overton & Medina, 2008).

The perpetuation of mental health stigma is not the sole responsibility of a misinformed media, however. Research indicates that those within the medical profession also perpetuate stigma related to various physical and mental health diagnoses. In one study, up to 31% of patients surveyed believed that they were discriminated against by medical professionals secondary to their mental health diagnoses (Henderson, Boblett, Parke, Clement, Caffrey, & Gale-Grant, 2014). Crapanzano and Vath (2015) suggest that such discrimination could affect clinical decision making. For example, one's physical symptoms may be dismissed as a manifestation of one's mental health diagnosis, thus compromising a thorough diagnostic process or medical treatment regimen. Closely related to this, the researchers also found that medical providers who stigmatize mental health diagnoses often failed to provide appropriate referrals, were less likely to pursue inpatient hospitalization for their patients with known mental health symptoms, and also maintained the assumption that their patients with mental health diagnoses were less likely to be compliant with treatment recommendations. Corrigan (2005) asserted that the known presence of a mental health disorder may lead providers to provide substandard medical care, even if that is not the providers' intention. His conclusion echoes that of previous researchers whom concluded that those with mental health disorders rarely receive adequate treatment for their medical ailments in general practitioner environments (Wang, Demler, & Kessler, 2002).

Similarly, research indicates that some mental health professionals also maintain prejudicial ideologies pertaining to those they perceive to be 'mentally ill', which further perpetuates mental health stigma (Smith & Cahswell, 2010). Past surveys have found that individuals with mental health disorders often feel as if their mental health providers focus only on their diagnosis while dismissing them as people (Pinfold, Byrne, & Toulman, 2005). Other studies found that mental health professionals sometimes reinforce misnomers regarding the nature of mental health diagnoses by perpetuating the beliefs that the presence of a mental health diagnosis may be correlated with dangerousness or unpredictability (Kingdon, Sharmer, & Hart, 2004) or by insinuating the recovery from one's mental health symptoms is not plausible (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004). Smith and Cahswell (2010) suggest that a lack of training and preparedness among mental health professionals sometimes contributes to their negative attitudes regarding some diagnoses. Similarly, Crowe and Averett (2015) indicate that increased educational involvement improved mental health professionals' perspectives regarding likely recovery, effectiveness of treatment, etc. This coincides with research of the general public, which indicates that the more contact one has with those diagnosed with mental health issues, the less dangerous he or she would perceive those with mental health issues to be (Penn et al., 1994).

The patterns and impact of stigma associated with mental health diagnoses is similar to stigma accompanying potential STI diagnoses. For example, via their survey of men who have sex with men, Ross, Larson, Nyoni, and Agardh (2016) found that most patients felt that their health care providers were 'impolite' regarding their symptoms, which served as a barrier to seeking further or comprehensive treatment. Researchers also found that women seeking healthcare from a public health clinic for STI-related issues felt judged by medical staff. This disapproval, it seemed, was compounded in cases in which the patients did not view their symptoms as something to be ashamed of, but rather as a normative consequence of being sexually active (Lichtenstein, 2003). Similarly, a qualitative study conducted by Scheim and Travers (2016) revealed that medical providers' lack of competency regarding gender and sexual identity issues, coupled with lack of trust for those providers, negatively affected individuals' willingness to seek STI testing and subsequent treatment. Even in the instances in which patients desired additional

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medical intervention for their symptoms despite their perceptions of providers' attitudes regarding their symptoms, these treatments were not always offered or provided.

CHALLENGES AND SUGGESTED SOLUTIONS

The CDC (2017) offers a comprehensive outline that serves as a national response to the current STI epidemic. It suggests that numerous parties must be engaged to effectively treat current STIs and prevent the future spread of such diseases. First, the CDC suggests that all medical providers make screening for STIs a part of their regular medical care protocol. More precisely the CDC calls for physicians to 'integrate STD prevention and treatment into prenatal care and other routine visits' (CDC, 2016, p.3). Next, the public must discuss the topics of gender, sexuality, and reproductive health. There must be an open dialogue regarding the need for those whom are sexually active to receive routine STI tests and to practice mutual monogamy and engage in contraceptive use. Further, parents and medical professional are called upon to proactively discuss the topic of sexual health with younger people to provide them with the information they need to protect themselves and potential sexual partners. Sexual health literacy, in particular, is an important step in the quest to reduce stigma. The CDC calls upon state and local health departments to allocate resources and other support to those impacted by this epidemic. Another important step in reducing stigma is to maintain interpersonal contact with those perceived to be different. Exposure to people of varying backgrounds and statuses allow each individual increased insight into the commonalities held across people making their perceived differences less threatening and more valuable. A final component to reducing stigma includes social activism. Professionals and members of the general public alike are called upon to advocate for increased attention, funding, and care towards sexual and reproductive healthcare issues (Corigan, Morris, Michale, Rafaacz, & Rush, 2012).

CONCLUSION

The aim of this chapter was to introduce the role of stigma in the identification and prevention of STI diagnoses. As the content of the chapter indicates, STIs have the potential to greatly affect one's physical health, mental health, interpersonal relationships, and overall quality of life. As such, it is imperative that individuals are aware of their STI status as not to compromise their own health or that of others. A principal reason many people avoid addressing their STI status is due to the stigma that shrouds such diagnoses. There are a number of interrelated factors that contribute to stigma, including: group identity, perceived blemishes of character, and visible deformations of the body. Collectively, these elements service to differentiate those with a designation or stigma, from those whom do not. STI stigma, specifically, seems to persist due to an intermingling of factors, including shame, sexual anxiety, and social desirability, which are deeply embedded in one's culture. Stigma contributes to the oppression of those diagnosed with STI diagnoses, often resulting in prejudicial beliefs and discriminatory acts against those with them. As with other social justice issues, the most effective advocacy efforts towards STI stigma seem to include a recognition of such circumstances, an active dialogue regarding the same, and a commitment to increased education and funding towards sexual and reproductive issues.

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KEY TERMS AND DEFINITIONS

Bias: Prejudice against or in favor of a person, thing, or situation.

Institutionalized Stigma: Stigma that is embedded within organizational culture.

Mental Health Diagnosis: A collection of behaviors meeting the criteria set forth by the DSM-5, typically resulting in distress, dysfunction, or deviance.

Prejudice: A preconceived opinion regarding a person, thing, or situation based primarily on group membership.

Self-Stigma: Beliefs about one's self and one's status based on perceived stigma pertaining to a feature, group membership, or situation maintained by that individual.

Sexual Anxiety: Anxiety regarding the possibility of being sexually rejected.

Sexually Transmitted Infection (STI): An infection transmitted via sexual activity, either via anal contact, oral contact, or vaginal contact.

Shame: A social emotion tied to one's experiences or status.

Social Desirability: The innate desire to please and be accepted by others.

Stigma: Disproval based on perceived group membership.

Stigma by Association: Being the object of actual or perceived stigma secondary to a relationship with a person that maintains a particular group membership.

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Chapter 8
Muslim Worldviews:
Implications for Helping Professionals Providing Culturally Competent Care

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ABSTRACT

This chapter seeks to provide an overview of traditional and contemporary Muslim worldviews, specifically beliefs and attitudes that may relate to help-seeking and interaction with human services such as counseling, health services, educational systems, and social services. Traditional Islamic beliefs and views, combined with contemporary issues and the experiences of living as a religious minority, can impact successful interaction between members of the Muslim community and service providers. In addition, basic knowledge of Muslim worldviews can aid helping professionals in providing effective, culturally competent care. This chapter focuses on traditional Islamic concepts of health and illness, common lay beliefs that stem from traditional views, attitudes towards treatment, and help-seeking patterns. The interplay of religiosity, acculturation, gender, family dynamics, and other relevant factors on help-seeking and service utilization are also presented to provide the reader with a holistic perspective of prevalent Muslim worldviews.

INTRODUCTION

The area of culturally competent care is one that has been emerging not only for mental health professionals, but for all individuals involved in providing services within a multi-cultural, multi-religious society, including health care providers, mediators, educators, social workers, and providers of other social or community services. Cultural competence is an essential tool for helping professionals to effectively serve all facets of their community. Successful care relies on both the desire of the helping professional to learn about the cultural background and circumstances of the client, and the willingness of the client to share in an honest and open manner his or her perceptions of the situation leading him or her to uti-

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lize a service. For Muslims, who have long been viewed as outsiders in non-Muslim majority countries, lack of cultural competency can impact willingness to utilize available services in their community. In addition, a negative encounter with a service or helping professional can significantly reduce the chance that an individual and others in their community will seek out services in the future.

Islam as a global religion provides a distinct cultural narrative that is based upon Islamic doctrine, but is also influenced by the cultures, languages, and countries in which the practice of Islam exists. Islam provides a foundation for those who identify as Muslim and plays a strong role in influencing attitudes and behaviors, as Muslims tend to view Islam as an entire way of life. The Muslim worldview, like other worldviews, consists of sets of beliefs and assumptions that shape reality and therefore influence individual thinking and behavior (Koltko-Rivera, 2004). However, Muslims are not a homogenous group and therefore there is not one definitive Muslim worldview, but rather multiple worldviews that are shaped by both the level of adherence to Islamic theological concepts and other cultural and social factors. Thus, it must be cautioned that there is a great deal of diversity that exists within this unity, just like in any population.

The following chapter provides an overview of key aspects of traditional and contemporary Muslim worldviews as they relate to health and illness, social problems, and help-seeking behaviors, as well as how these worldviews are influenced by the context in which Muslims live in Western society. Topics covered include traditional Islamic views of physical and mental illness, attitudes towards help-seeking, gender and family norms that may impact help-seeking, and traditional Islamic forms of treatment. The chapter describes the usage of both biomedical and psycho-spiritual models of health by contemporary Muslims, and how lay conceptions often differ or co-exist with theological concepts of health and wellness.

Potential factors that influence willingness to use available services and seek help within a country include immigration status, prevailing attitudes towards Muslims in that country, the person's level of religiosity, fear of stigma from both within and outside of their community, language barriers, and the availability of same gender, same culture, or same religion service provider (Vu, Azmat, Radejko & Padela, 2016; Shafi, 1998; Pilkington, Msetfi & Watson, 2012). The cultural, racial, socioeconomic and educational backgrounds of the client must therefore be assessed or taken into consideration by the service provider. Beliefs and attitudes that are shaped by an individual's background can influence Muslims' use of available services to address mental and physical illness, addiction, disability, childhood issues, and trauma. The chapter includes descriptions of common Muslim social norms that may be important to help a professional avoid bias or misunderstanding and increase rapport with Muslim clients.

Traditional Islamic Views of Health and Illness

Traditional Islamic beliefs about health illness can be divided into three categories: (a) theoretical concepts developed by Islamic philosophers, religious leaders, and scholars; (b) theologically derived positions based upon the Quran and prophetic traditions (*Sunnah* and *hadith*); and (c) the lay beliefs of individuals and groups in traditional Muslim societies. Traditional Islamic perspectives on symptoms that correspond to physical and mental illness tend to assume a psycho-spiritual origin for these problems (Athar, 1993; Husain, 2006; Shafii, 1988). These beliefs include definitions of illness, causes and predictors of illness, classification of symptoms, and prescribed treatment methods.

The Qur'anic concept of the self does not adhere to mind-body dualism. A person consists of not just the body but also the mind and soul. These do not exist as separate and distinct units. The Islamic concept of illness echoes these fundamental beliefs about the dimensions of the self and the position

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of human beings within the context of creation. The Islamic conception of illness is that all mental and behavioral dysfunction has a psycho-spiritual root and can be directly tied to an individual's higher spiritual awareness of his or her Creator. An explanation of what constitutes dysfunction is elusive and has changed over time depending upon the cultural and social contexts.

"Sickness of the Heart" or "Diseases of the Heart" (in Arabic *amrad al-qalb*) are terms generally used in Islam to describe illnesses of a psycho-spiritual nature. A diseased heart results from desires and doubts that emerge when an individual fails to utilize knowledge of God, emerging as symptoms such as anger, ignorance, and greed. Within the Islamic mystical tradition, "Sickness of the Heart" refers not to the physical organ, but rather an aspect of the human spirit and personality (Nurbakhsh, 1992). Within traditional Islamic theology, all psychological disturbances are viewed as having a spiritual root. Emotional suffering originates from lack of spiritual consciousness (Shafii, 1988).

Competing ideas about illness arose in medieval times, around the 10th century, as Muslim physicians incorporated the Greek medical model into the diagnosis and treatment of illness in Muslim societies (Al-Issa, 2000). During this period, a combination of medical, psychotherapeutic, and Islamic treatments were utilized, as the conception of illness included humoral theories, the role of fear, grief, and obsessions in symptomology, in addition to spiritual and supernatural causes established in the early Islamic period.

"Mental illness," within the conception of early Islamic philosophers and spiritual figures, stems from desires that are in opposition to the spiritual potential of a human being and can result in behavior that fulfills animal impulses rather than the higher potentials of a human being. "Mental illness," affects emotions, thinking, intention, and behavior, resulting in undesirable actions that go against divine commandments. This mental and spiritual conflict causes deviance and a disintegration of mental health (Alawi, 1992). These traditional Islamic understandings of illness bear little resemblance to modern day problems that are categorized in contemporary Western texts as mental illness, with the exception of melancholia and symptoms such as obsessions, anxiety, depression, delusions, hallucinations, and hypochondria (Alawi, 1992; Al-Issa, 2000b; Husain, 2006; Shafii, 1988). However, they have similar outcomes such as social deviance, distress, and dysfunction for the individual and their social circle.

Islam also acknowledges environmental stresses caused by injury, traumatic events, and outside stressors as causes of illness, particularly anxiety and stress (Al-Munajjid, 2003; Athar, 1993; Husain, 2006). Distress, according to Al-Munajjid (2003), can result from mistreatment by relatives, chronic or serious diseases, and relationship problems.

Islamic tradition recognizes supernatural connections to mental illness. Prophet traditions (the *hadith* and *sunnah*) record various stories and activities that involve *jinn*, evil eye, and black magic. In at least one tradition, the Prophet Muhammad is recorded as treating a young boy for jinn possession, and in several traditions, it is recorded that he recited particular prayers to ward off evil *jinn,* the evil eye, and black magic. In addition, tradition records at least one instance where magic was used against the Prophet Muhammad during his life. The presence of these traditions has been, and continue to be, the legitimizing factor for supernatural causes of illness. In Islamic tradition, when an issue is discussed or acted upon by the Prophet Muhammad, the existence cannot be disputed.

Jinn possession, the use of black magic, and the evil eye (*nazar*, *Al-'Ayn*), are often attributed to severe symptoms of psychopathology, including hallucinations, nightmares, extreme lethargy, and physical symptoms with no known physical causes, as well as physical afflictions (Husain, 1998). The two life forms described in the Quran in addition to human beings are angels and *jinn*. Angels are often described as created from light and possessing no free will. The creation of *jinn* is often described as prior to that of man, with man's creation from mud or clay, and *jinn* created from smokeless fire. Quran and *hadith*

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identify the *jinn* as spirit entities capable of appearing in different forms, and of acting according to their own choice to torment or assist humankind, as well as choose to worship Allah or to deny Him. Islam teaches that the *jinn* can take the form of various life forms including birds, dogs, bees, and humans (Ameen, 2005). *Jinn* possession has been tied to delusions, depression, and anxiety (Ameen, 2005; Bali, 2004). Ameen (2005) describes the symptoms of *jinn* possession which include erratic behavior, seizures, paralysis of a limb with no medical cause, short temper, frequent crying, frequent headaches, nightmares, insomnia, and sleep talking. Speziale (2003) notes that despite the existence of medically grounded interpretations of psychiatric illnesses since the 10th century, supernatural interpretations of mental illness continue to co-exist with physical, environmental, and spiritual explanations within Muslim societies. The attribution of mental illness to possession by *jinn*, evil eye, and magic has been documented in the contemporary Arab Muslim population as well (Al-Adawi et al., 2002; Al-Issa, 2000).

In regards to preservation of life in the face of illness or disability, preservation of life is considered paramount. In the Muslim worldview the paramount purpose or meaning of life is to worship Allah. Within this context, Muslims should do everything possible to maintain their own well-being in order to achieve this purpose. Self-mutilation and self-harm of any form is not allowed. Euthanasia, physician-assisted suicide, and suicide are forbidden within the Islamic context. Providing artificial nutrition or hydration is decided in consultation with religious scholars, based on whether the efforts are causing harm or constitute a futile attempt at lifesaving (Alsolamy, 2014). Suicide is particularly stigmatized within Muslims societies. This may make it difficult for clients to discuss suicidal ideation or suicide attempts with a counselor, health care professional, or social worker, as the topic is still very taboo. In Western countries, as more campaigns seek to address mental health, Muslims have also started to address mental illness and suicide, though not on the same level as seen within other ethnic and religious minority groups. Despite the emphasis on preservation of life and the sacredness of human life within Islam, this has not translated to open discussion of disease prevention among religious leaders or lay Muslims, including public health campaigns for cancer screenings, and dietary or lifestyle changes. Muslims in Western countries have not benefitted in the same way from public health initiatives that have partnered with other faith-based communities. A service provider, working with a religious client, could frame behavioral changes within light of the worldview that life is sacred, the body should be taken care of, and the ultimate purpose of life is worship of the creator. Within this framework, it may be easier to convince a client to comply with treatment, engage in behavior change, or make healthier decisions.

Core Islamic beliefs, such as fasting during the month of Ramadan, can have important implications for health care providers and end of life care for Muslim patients. Devout Muslims fast from sunrise to sunset during the month of Ramadan, abstaining from food, drink, sexual activity, and smoking. Most Muslims would also include abstaining from any other bad behavior or bad speech as part of the fasting requirement. Usually fasting begins once an individual starts puberty. In some families, children will start fasting for a half day, or give up food in order to start preparing for the full fast. Religious Muslims will often adhere to fasting during Ramadan, even though there are religious injunctions freeing a person from this religious obligation if they are pregnant, nursing, menstruating, or ill. A desire to complete the fasts during Ramadan can lead some patients to be non-compliant with medications or timing of medication intake, put off therapy, or risk re-occurrence of symptoms while fasting. This is particularly seen in diabetic patients (Al-Balhan et al., 2018). Understanding the basics of fasting and being knowledgeable about the timing of Ramadan, which changes every year because it is based on the lunar calendar, can help providers discuss the implications of fasting with their clients. Planning treatments around Ramadan, when possible, can make clients feel more in control of their health care planning. Discussions of the

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importance of taking medications on time and consistently may be necessary, as well as emphasizing the potential side effects of non-adherence. Recognizing Ramadan and its importance for Muslim clients can further build trust and rapport.

As Islam clashes with many aspects of modernity, the concept of physical and mental illness and intellectual disability as a state that results from a failure to obey God's commandments through indulgence in forbidden practices, or failure to adhere to Islamic norms, continues to dominate the discussion of health in many Muslim religious circles. However, little is understood regarding how these moral and spiritual illnesses translate into physical or psychological symptoms and are then diagnosed and treated. Illness as divine punishment is not usually the interpretation, but rather illness as a test from God, or the will of God (*qadr*), or resulting in straying from God.

Traditional Islamic concepts of health and illness cannot be ignored, as they often serve as important foundations for an individual's understanding of their own health and wellbeing. The influence of the Quran in Muslim understandings of the role of the human soul and body has and continues to serve as the basis for Muslim interpretations of all forms of illness. In addition, external factors such as *jinn* possession, black magic, and the evil eye are acknowledged aspects of Islamic tradition that are clearly identified in the Prophetic literature as legitimate sources of human suffering. These traditional beliefs play a significant role in understanding both attitudes and behaviors related to health and illness among Muslim populations throughout the world.

Contemporary Beliefs of Health and Illness in Muslim Majority Societies

Islamic theological concepts of health and illness do not necessarily correspond with lay conceptions of the general population in traditional Muslim societies. Of particular interest is the attribution of mental illness to spiritual defects, as widely described by Islamic philosophers and Sufi figures (Alawi, 1992; Al-Munajjid, 2003; Ibn Taymiyyah, 1319-1320/2000) or the attribution of mental illness to supernatural causes, such as those described by traditional faith healers and contemporary religious scholars (Ameen, 2005; Bali, 2004).

Little research has been conducted thus far exploring contemporary conceptions of illness, particularly in traditional Muslim societies. Due to core beliefs in pre-destination and the transcendent and omnipotent nature of God, Muslims also tend to view mental illness as a test from God, God's will, and a form of punishment for sins (Husain, 1998). Contemporary Muslims living in Muslim-majority societies tend to make a distinction between the Islamic views of health and illness and the Western concepts of the origin of illness, though they may integrate both views into their beliefs regarding physical and mental health issues. For example, the parents of a child born with a physical or mental disability may accept the biomedical explanation for that disability, while also adhering to the belief that their child's disability is a test from God. How the problem is interpreted can influence willingness to seek out services for the child. Parents who believe that their child's disability is a test from God or the Will of God may use that notion to seek out the best services for their child. Others may view the child's disability as *qadr* (fate or destiny) and view this as a reason not to seek outside help to improve their child's condition. In addition, conceptualizing of illness, such as terminal illness, as God's will can act as a coping mechanism and a source of comfort for patients and their families (Hamdy, 2009).

Contemporary Muslims living in Muslim-majority societies have been shown to hold tightly to many of the traditional conceptions of mental illness, including attributions of psychotic behavior and physical illness to *jinn* possession, and depressive symptoms to the evil eye (Haque, 2004b; Weatherhead &

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Daiches, 2010; Kobeisy, 2004). Though not directly referred to as "mental illness," words in Arabic, Persian, and Urdu that refer to madness, insanity, possession, and the evil eye are most often used when referring to these specific illnesses. In South Asia, the word *pagal* is used to refer to a person who talks to themselves, has delusions, or exhibits symptoms of mental retardation. The word *junoon*, on the other hand, might be used to describe a person who is exhibiting obsessive thoughts or behavior, most often over another person (Al-Issa, 2000). These supernatural causes of physical or mental illness put the illness outside of the control of the person, absolving them to a certain extent of the stigma associated with deviant behaviors. As such, some researchers have documented better quality of life and outcomes for patients diagnosed with severe mental illness in Muslim countries (Watters, 2010).

Contemporary views of physical and mental illness and disability in predominately Muslim societies is complex with these conditions often interpreted as a combination of both supernatural and social factors. This has been documented by researchers in Malaysia (Azhar & Varma, 2000), Gulf nations (El-Islam, 2000), North Africa (Endrawes, O'Brien, &Wilkes, 2007; Fadlalla, 2005; Stein, 2000), and Pakistan (Mubbashar, 2000; Saeed, Gater, Hussain, & Mubbashar, 2000). Some of these researchers also note the continued presence of belief in illness as a direct result of the evil eye, God's will, or God's punishment (El-Islam, 1982; Fadlalla, 2005; Haque, 2010; Abu-Rabia, 2005). Abu-Rabia (2005) discusses belief in the evil eye amongst the Bedouin tribes and states: "Belief in the evil eye is constantly present in people's lives, alongside beliefs about spirits, *jinns* and other demons, and it has serious implications for how individuals perceive the world and their place in it" (p. 241). *Nazar,* the term for evil eye in South Asia, can be caused by anyone. Black magic (*jadoo*), on the other hand, can be conducted with the help of *jinn* or certain plants according to some faith healers (Ally & Laher, 2008). These beliefs seem to be moderated by factors such as level of education and exposure to Western psychological and psychiatric ideas.

The findings of contemporary research studies dealing with physical and mental illness in predominant Muslim countries continue to support a multidimensional model of understanding of health and illness as having supernatural, social, and biological causes (Arabiat, Al Jabery, Abdelkader, & Mahadeen, 2013). No one model is accepted within the various populations, and in many cases the supernatural model continues to dominate (Graham & White, 2015). For many individuals, interpretations of the cause or reason for an illness cannot be separated from the role of God as creator and ultimate commander.

Perceptions of Health and Illness Among Muslims Living in Western Societies

Though exploration of contemporary lay conceptions of mental illness in predominately Muslim countries has begun, we know little about the translation of these beliefs to Western contexts. Initial research suggests that, at least in the case of refugees and immigrants, conceptions of illness and trauma are preserved, rather than discarded. Beliefs in fate and God's will inform how many refugees view and process their trauma (Eltaiba, 2014). In a study of older Iranian immigrants, Martin (2009) found divergent conceptions of mental health as originating in the spirit (*ruh*) or the mind. The majority of participants referred to an illness of the *ruh*. They also expressed reluctance to seek mental health care, and a reluctance to use psychotropic medications. Martin (2009) concluded that older Iranian immigrants to the United States possess a holistic approach to health that they perceive as not present in the U.S. health care system. Having knowledge regarding religious views of life, death, health, and illness will therefore help health providers to understand the particular frame of view of these individuals. Other research on Muslim refugees residing in Western countries have found that high religiosity acts as a buffer for the trauma suffered during war and displacement (Molsa, Kuittinen, Tiiilikinen, Honkasalo, & Punamaki, 2017).

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Religious appraisals of traumatic situations can be both negative and positive and should be taken into account when engaging in trauma work (Bergenzi, et al., 2017).

Religious identity and practice impact how many Muslims perceive of personal illness, providing meaning, context, and coping mechanisms for diagnosis of illness and injury. Religious identity is rarely acknowledged by health practitioners and most Muslim patients also do not feel comfortable discussing the role of religious belief and practice in how they navigate illness (Mir & Sheikh, 2010). Health care providers may assume a patient is being merely non-compliant when it comes to recommended treatment, if issues like fasting, dietary regulations (i.e. use of gel tablets which may contain gelatin), and modesty are not taken into account. Beliefs about illness or disability as the will of God or predestination have also been shown to be prevalent within Muslims living in Western societies (Al-Khateeb, Al-Hadidi, & Al Khatib), which may impact an individual's motivation to proactively seek out care.

Numerous studies have now been conducted among sub-groups of Muslims living in Western countries, especially the United States, focusing on perceptions of mental illness. These studies have used a variety of methodological approaches and theoretical frameworks. Regardless of the particular racial or ethnic sub-group studied, research repeatedly showed that faith and spirituality informed interpretation of mental illness, understandings of symptoms of mental illness often varied in the United States from symptoms described in country or origin, and mental illness was often stigmatized (Pratt, Fadumo, Hang, Osman & Raymond, 2016). Belief in jinn possession, though not as prevalent as in traditional Muslim societies, has carried over and persists in most Muslim communities, especially communities of recent refugees or immigrants (Cheng, 2017; Bagasra & Mackinem, 2014). Beliefs regarding causation of mental illness in Muslim Americans shows a multidimensional understanding, embracing biomedical, environmental, and psycho-spiritual causes of mental illness and distress. All are viewed as equally legitimate explanations for psychological disruption in an individual's life (Bagasra & Mackinem, 2014).

Help-Seeking Beliefs and Behaviors in Diverse Muslim Populations

Little research has been conducted that refers to Muslim attitudes towards seeking professional psychological help. Studies of help-seeking behaviors of Muslims living in Western countries tend to focus on specific ethnic sub-groups within the population. Previous research has shown that perceptions and attitudes toward seeking psychological help were affected by religious, racial, and cultural identities (Haque-Khan, 1997; Aloud, 2004), and stigma played a major role (Raja, 2005) in willingness to see out help. In addition, knowledge about services and providers, length of time in the country, and previous experience with services influence both help-seeking attitudes and behaviors.

Studies have also found that individuals are more likely to choose family doctors before other resources for help with psychological problems. Attitudes amongst the Muslim community toward counseling and counselors range from positive to neutral or negative and counseling was only used when no other options were available (Kobeisy, 2004). Negative attitudes toward counseling tend to be a result of perceptions that are colored by religious and cultural beliefs. These perceptions include the equation of seeking counseling services with the stigma within Muslim society that is associated with a diagnosis of mental illness. Seeking counseling was also attributed as a sign of lack of internal family support. Negative attitudes can also stem from the view that seeking counseling services is a threat to the authority of the family to resolve internal conflicts. Lack of knowledge regarding the purposes and outcomes associated with therapy are another factor (Kobeisy, 2004; Aloud, 2004).

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Muslims living in Western countries may vary in their receptivity to formal services, and often continue to show a preference for informal help that comes from family and friends. Barriers to seeking formal services continue to arise from concerns over stigma, lack of knowledge regarding the purpose and process of services, particularly psychotherapies, and a fear of a lack of cultural understanding on the part of the service provider. These findings suggest that basic education of both practitioners and potential clients may serve to ease the reluctance to seek formal mental health services. Direct outreach to communities by service agencies or individual providers can increase knowledge and provide a connection.

Religious Based Treatments and Interventions

The use of alternative methods of treatment in contemporary Muslim societies continues to be prevalent. These include prayers, herbal remedies, dietary changes, and ritualistic practices including seclusion (Al-Subaie, 1994; Al-Subaie & Alhamad, 2000; Deuraseh, 2009; Mehrabi et al., 2000; Saeed et al., 2000). Traditional healing practices sought by those living in South Asia include homeopathy, naturopathy, traditional faith healing conducted by *pirs* and *hakims*, folk healing at Sufi shrines, and sorcery (Farooqi, 2006). Traditional healing practices in Malaysia include herbal medicine, the use of Quranic verses, talismans, and traditional healers called *bomoh* (Haque, 2008). *Al-Ruqyah* (Quran recitation) is a traditional healing method utilized in many Muslim countries. It has been found to be utilized and viewed as an effective method for the treatment of diseases caused by *jinn* (Deuraseh, 2009). Prayer, *dhikr* (remembrance of God), and Quran recitation, are frequently cited by Muslim physicians and psychotherapists as effective forms of treatment for stress (Athar, 1993; Haque, 2004a) and coping with diagnosis of illness. Dietary laws are also cited as a form of Prophetic medicine (Rahman, 1998). Thus, many common practices found within the Muslim community are associated with therapy and utilized as direct responses to physical and psychological illness.

These traditional treatments have been brought by individuals to many Muslim communities in various Western countries. The extent of their use and their incorporation with biomedical treatments, counseling, or other social services have yet to be fully explored. In addition, religious based coping is common. Using religion to cope with serious physical and mental illness in Muslim clients has been found to have a positive impact on health outcomes or the stresses related to simultaneous treatment (Shaheen Al-Ahwal, Al Zaben, Sehlo, Khalifa, Koenig, 2016)

Attempts have been made to develop forms of religious psychotherapy that seek to address the Islamic worldview (Azhar, Varma, & Dharap, 1994; Razali, Hasanah, Aminah, & Subramaniam, 1998; Hamdan, 2007) and include using cognitive techniques from the Quran, making lifestyle changes according to the *sunnah*, and using repentance if clients have developed a sense of guilt. Individuals with strong inclinations towards psycho-spiritual or supernatural causation of mental illness may be more likely to accept Islamically integrated psychotherapy options (Abu-Raiya, 2015). The practice of counseling continues to increase among Muslims (Ahmed & Amer, 2012), with a growth in the number of Muslim clinical psychologists and counselors over the past few decades. Additionally, Muslim counselors have formed their own clinics and professional organizations in acknowledgement of the increase in the practice of counseling that is designed to meet the needs and worldviews of practitioners of Islam. The intersection of Islam and counseling is widely accepted today (Abdullab, 2007)

Islamic-based counseling and Islamically integrated psychotherapy (York Al-Karam, 2018) reflect the growing revival of the application of Islamic psychology and traditional Islamic concepts of mental illness. Attempts to evaluate the effectiveness of incorporating Islamic forms of worship and religious based

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coping into counseling with practitioners of Islam demonstrate the positive impact in many therapeutic settings (Khalid, 2007; Hanin Hamjah et al., 2017; Zakaria & Mat Akhir, 2017). The contemporary use of religiously based therapy for treatment of mental illness for Muslim clients has been documented in Asian, Middle Eastern, and African countries (Ally & Laher, 2008; Al-Issa, 2000; Campion & Bhugra, 1998). Numerous researchers have proposed a method of religiously integrated psychotherapy for use with Muslim clients (Abu Raiya & Pargament, 2010; Abu-Raiya, 2015; Keshavarzi & Haque, 2013). This approach to the treatment of mental illness directly addresses dimensions of Islam that are relevant to the mental health concepts of Muslims, including Islamic methods of coping. Religious psychotherapy has been found to produce significant improvement in patients in Malaysia (Azhar & Varma, 2000) and has been introduced, to varying results, in other Muslim societies (Al-Issa, 2000). There is also ongoing research testing the effectiveness of adaptation of various therapeutic techniques within Muslim populations in both Muslim majority and Muslim minority countries. This includes cognitive behavioral therapy (Naeem et al., 2015).

Traditional Islamic forms of therapy are therefore dynamic and encompass multiple interpretations of the origin of illness and acknowledge the effectiveness of multi-modal approaches to therapy that include assessment, diagnosis, talking therapy, and specific actions . These practices are tied to evidence that is drawn from religious tradition and perceptions of mental illness within unique cultural contexts. The majority of research and testing of Islamic forms of counseling is occuring in the United States, the Middle East, and most prominently in Malaysia. Further research will determine the effectiveness of these varied techniques and their application to different Muslim communities.

The Impact of Stigma and Perceived Bias on Help-Seeking and Service Utilization

Stigma continues to be a significant factor impacting help-seeking and utilization of services among Muslims. This includes stigma associated with a specific problem (such as depression, marital discord, addiction, learning disabilities, etc.) and the stigma of seeking help from sources outside of the family. Stigma and ideas of shame and honor are attached to help-seeking outside of the family for issues such as child sexual abuse (Haboush & Alyan, 2013), intimate partner violence (Eunha & Hogge, 2015), and suicidal ideation (Heredia Montesinos et al., 2019). Stigma related to members of one's community finding out that has a problem or sought help outside of one's family can also decrease intention and actual help-seeking behaviors (Youssef & Deane, 2006). Stigmatizing attitudes toward mental health services and mental health problems within an individual's social network were found to be a deterrent to seeking help (Kapadia, Brooks, Nazroo, Tranmer, 2017).

Therefore, it is important for service providers to emphasize the confidential nature of services and outline ways that they maintain confidentiality (Hamid & Furnham, 2013). Perceived bias and the rise in Islamophobia are compounding the existing stigma. Anti-Muslim actions, particularly verbal and physical attacks on Muslims, have increased significantly in the United States, Europe, and Australia since 9/11. Latham (2016) outlines cases where mandatory reporting among social workers of perceived radicalization in the UK has led to nearly 80% of individuals referred for perceived radicalization not being deemed actual threats in need of intervention. These false accusations result in increased fear of social service providers among the targeted population.

Muslims are now suffering from increased religious and ethnic-based discrimination in many Western nations, further pushing community members to avoid airing issues or problems with those outside of

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their community, or a fear of being judged by non-Muslims. In the United States, rising Islamophobia has been connected to poor mental health, health behaviors, and low help-seeking behaviors (Samari, Alcala & Sharif, 2018; Samari, 2016). Studies conducted in Europe, Canada, and the United States indicate an increase in negative attitudes towards Muslims and increased experiences of discrimination by Muslims (Abu-Ras, Suarez, & Abu-Bader, 2018; Wilkins, 2018; Kaya, 2015; Giuliani, Tagliabue, & Regalia, 2018). This can further isolate communities from service providers and from the formation of partnerships between religious organizations and agencies that could improve overall public health.

The Impact of Religiosity on Help-Seeking and Compliance: Assessing Level of Religiosity in Clients

Like members of other religious groups, Muslims vary in their level of adherence to religious practice. Research suggests that level of religiosity may impact willingness to utilize services outside of one's religious tradition. More religious Muslims may rely heavily on Islamic-based treatments or utilize religious coping before considering other available resources. In many cases, they may not have considered outside resources at all and may be suspicious or concerned that non-Muslim service providers will not understand them or would be unwilling to meet their needs.

If a service provider is unsure of how religious a client is, or how much of an impact religiosity plays in their lives, there are a number of brief assessments that can be administered. These resources can help service providers/helping professionals determine whether they need to learn more about the cultural or religious background of clients in order to be effective providers, whether they need to engage in a "clergy consult", or whether it would be in the best interest of clients to refer them out to a same-religion or same-culture provider. One of the most well-known tools is the FICA. It has been utilized to assess spiritual beliefs in a variety of settings, including palliative care, nursing, and counseling. The FICA is recommended as a tool to use at the intake interview with clients (Keshavarzi & Haque, 2013). From a social work perspective, there are a variety of spiritual assessment tools that can be utilized, including spiritual histories, spiritual life maps, spiritual genograms, spiritual ecomaps, and spiritual ecograms (Hodge, 2005). Many of these can be applied to other helping professions.

There have been efforts to define religiosity and religious commitment and to formulate measures specific to the Muslim population (AlMarri, Oei, & Al-Adawi, 2009; Abu Raiya, Pargament, Mahoney, & Stein, 2008; Albelaikhi, 1997; Ji & Ibrahim, 2007a; Krauss, Hamzah, & Idris, 2007; Wilde & Joseph, 1997). Several of these scales have been tested in both Muslim-majority and Muslim-minority countries. Most scales focus on measuring adherence to Islamic beliefs and doctrines, the influence of Islamic doctrine on choices such as what to wear, and frequency of religious behaviors including prayer, reading Quran, attending the mosque, fasting, and giving to charity. Most of these measures are in the early stages of development and testing and may be too lengthy for a helping professional to use in their initial assessment interviews with a new client. However, it should be noted that religiosity scales specific to the Muslim population are available as a potential tool for professionals in addition to the FICA and other spiritual assessment tools. Using some form of cultural and spiritual assessment is viewed as essential to developing an appropriate intervention when working with Muslim clients (Ibrahim & Dykeman, 2011).

If you are working with a client who has been assessed as highly religious, and are having difficulty successfully communicating treatment options or navigating stigma around the situation, a clergy or chaplain consult may be an effective way to build rapport with the client, establish the legitimacy of the services, and obtain religious endorsement for treatments or services that the client views as sus-

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pect. An imam is the official title for a religious figure or clergy within the Muslim tradition. This is an individual who is recognized by the community as possessing religious learning, an ability to lead the daily prayers, and apply religious knowledge to addressing community problems. Other names for religious or spiritual leaders in the Muslim community include the title of *sheikh* usually given to a person of high spiritual status or religious learning, and *pir*, a term for a spiritual person that is often used in South Asia and mostly refers to individuals within the Sufi tradition. The role of the *imam*, like that of pastors and other clergy in Western countries, encompasses to some degree counseling, grief and grieving, and family and couples issues (Haddad & Lummus, 1987; Kobeisy, 2004; A.Ali, Milstein, & Marzuk, 2005). Most imams do not have formal training related to counseling or social work but have found themselves called upon to act in this role for community members to address issues mentioned above and increasingly to address the psychological impact of discrimination. Formal relationships with *imams* or chaplains can be established if practicing in an area with a large Muslim population. This type of partnership would encourage imams and Muslim chaplains to make appropriate referrals to service providers and provide a resource regarding religious beliefs and values for helping professionals. Imams can usually be contacted by locating the mosques in the area and calling the direct number for the local mosque or Islamic center. There are also Islamic associations who can help to connect you with a local imam. In addition, many large universities have a designated Muslim chaplain who provides religious knowledge and spiritual leadership to the campus Muslim community. These individuals can be reached through the campus directory.

The Impact of Acculturation on Health Outcomes and Help-Seeking

Many studies have been conducted linking acculturation to health outcomes in minority populations. Many of these studies have focused on the poor mental health of recent immigrants due to the stresses associated with the process of acculturation (Berry & Kim, 1988). Both low assimilation as well as high assimilation have alternately been linked to poor health (Padilla et al., 1985; Oh, Koeske, & Sales, 2002). Strong family ties and social support networks appear to act as a buffer, lowering the risk of mental and behavioral health problems (Eschbach, Pstir, Patel, Markides, & Goodwin, 2004), while lack of acceptance from the dominant or host society can lead to poorer health outcomes, especially for immigrants (Organista et al., 2003; Thomas, 2006). Acculturative stress experienced by Muslim populations has been linked to anxiety, depression, and overall well-being (Amer, 2005; Timazi, 2008; Khuwaja et al., 2007; M. Ali, 2007). Acculturation is often measured by the length of time the individual has lived in the country, and language use. These measures may not be very effective within Muslim populations, as they fail to take into account acculturation experienced by native-born Muslims, converts, and first-generation Muslims, who are often perceived by the society as foreign or other. Measures that look at level of conformity to local norms may be a more accurate measure of acculturation than language usage, length of time, and social interaction (Bagasra & Mackinem, 2019).

The degree of acculturation and assimilation of an individual can have an effect on his or her attitude toward health services and actual behavior in seeking help (Pilkington, Msetfi, & Watson, 2012). This may be influenced by a number of factors including education, rather than length of time within a country, and previous experiences with helping professions may be a larger determinant of help-seeking behaviors. A service provider may want to ask basic questions about length of time in the country if it is apparent that the individual is not native-born. They may also want to know if the individual is a refugee or asylum seeker, as this can impact the level of acculturative stress experienced with the process of

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trying to adapt to a new culture. Depending upon the type of service, other questions may be appropriate. For example, within the education system, a school counselor may need to know more about the family background of a child they have been assigned to work with. A child may quickly assimilate, or want to assimilate to the host culture, but may experience resistance or resentment from parents who are holding on to the culture of origin. This can create family conflicts that may be central to behavioral or mental health needs of a child. A child may also be serving as translator or taking on significant roles due to their acculturation status and language ability. Ability to navigate a new culture can be beneficial and burdensome. Similarly, adolescents trying to establish a personal identity may choose to strengthen their religious identity by wearing hijab or increasing participation in religious activities. This can create distress if family conflict arises, or an adolescent loses social support from family or friends. The bi-directional nature of acculturation, especially for children and adolescents trying to establish personal identity, can result in psychological, social, and physical distress. It is important for a provider to take into account the "story" of each individual client, which may include their journey towards a fuller embrace of the local cultural and social norms, or a careful examination of these norms in the face of their religious values or values of a culture of origin. For Muslim converts, they may choose a specific type of Islam to follow, or to adopt the cultural background of a specific Muslim country, such as wearing the traditional clothing of Pakistan or Morocco. The intersection of culture, religion, self-identity, and societal labeling creates a complex web of factors that a service provider may be able to acknowledge but not address, especially if interaction with a client is short-term.

The Impact of Gender and Family Dynamics on Help-Seeking and Service Utilization

Some Muslims, especially the highly religious or individuals coming from societies where strict gender segregation has been in practice, adhere to gender norms that may prevent a person from seeking health or social services from service providers of the opposite gender. Beliefs regarding being alone in a room with a member of the opposite gender can restrict access to some services, unless accommodation is made that allows a family member to be present during service rendering, or a door left open during the session. In some countries like Saudi Arabia, there are guardianship laws that require women to have permission from a *mahram* (this would be a biological male relative such as a father, brother, uncle, or son) to travel, work, go to school, or go to the doctor; access to services would only come through explicit permission from the male relative. Even though this is not law in many other Muslim countries, variations are in place informally. Though men are not restricted in the same way socially, it is considered inappropriate for men to also be alone with a woman who is not their biological relative or spouse. The presence of a relative during services may be an option but can be especially difficult for social workers and counselors, as confidentiality is a key aspect of their work. Gender segregation and family dynamics that restrict a woman's movement can have significant implications on help-seeking, especially for refugees and recent migrants who have not assimilated to gender mixing and freedom of movement found in most Western countries (Weatherhead & Daiches, 2015).

Modesty in dress for both men and women is an important belief for practitioners of Islam. Some Muslim women engage in various forms of *hijab*, which can range from wearing modest clothing and a head scarf, to wearing free flowing robes called an *abaya* or *jilbab*, to wearing a piece of cloth that covers the face called a *niqab*. Wearing of the hijab may reflect cultural or family norms, a desire to assert one's Islamic identity, strong beliefs in religious injunctions regarding modesty, or a combina-

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tion of these factors. Many religious Muslim women wear hijab, and many other women who consider themselves religious do not regularly wear the hijab. All Muslim women cover the body and head when engaged in formal daily prayer (*salat)*. Men are expected to be covered from the navel to the knee under all circumstances and to dress modestly. Clothing that features human figures are not to be worn when performing the daily prayers, and a Muslim should not face a human figure or pictures of human figures while in prayer. This can be important if providing a space for meditation or prayer in a practice or clinic.

Muslims will attempt to maintain modesty even in medical situations where it may be difficult such as labor and delivery, physical exams, and surgery. Muslim women consider the gender and cultural background of a health care provider as important, especially for reproductive healthcare (George, Terrion, &Ahmed, 2014). Differences in beliefs about modesty can be a barrier to seeking out health services (Yosef, 2008). Nurses and doctors working with Muslim patients can acknowledge norms of modesty and ask patients to communicate any discomfort. Efforts can be made to keep the patient covered as much as possible during a physical exam. When it comes to labor and delivery, women can bring modest gowns and robes to use to maintain as much sense of modesty throughout the process. Modesty norms and availability of same-gender care providers have been found to influence health behaviors, including mammography (Padela et al., 2016).

Making direct eye contact is also viewed as displaying lack of modesty, as men are admonished to lower their gaze in the Quran. Both men and women may avoid direct eye contact with a member of the opposite gender. Refusing eye contact is therefore not a sign of depression, dishonesty, or lack of respect for the service provider by Muslim clients. In the presence of a same gender service provider, lack of eye contact could indicate respect for an authority figure or alternately indicate a sense of shame or distress regarding the situation at hand. Cultural background can result in varied non-verbal behaviors in a clinical setting.

In addition to these norms, an individual may feel uncomfortable sharing their problems with a member of the opposite gender and a person outside of their family, as it would deviate from standard conduct. If a same gender professional is not available, and the individual is not comfortable disclosing information, considerations for referring out to a same-gender provider should be considered. If a referral is not possible, directly addressing discomfort and ways to address that discomfort in sessions may be useful.

Family dynamics, the presence of intergenerational conflict, and the impact of collectivist and patriarchal structures can all contribute to distress, social and psychological issues, and willingness to seek help for Muslim clients (Graham, Bradshaw, & Trew, 2010). The concepts of honor and shame have been noted as particularly salient for Muslim women who adhere to a collectivist framework (Helms, 2015). Both women and men who are afraid of being viewed as dishonoring or shaming their family by seeking out help for personal and interpersonal problems may be more reluctant to utilize available services, both from Muslim and non-Muslim providers. This is particularly true for domestic violence, victims of sexual assault, psychological distress, and behaviors viewed as socially deviant, including addiction and sexual behavior. (Helms, 2015; Oyewuwo-Gassikia, 2016; Cowburn, Gill & Harrison, 2015; Hamid & Furnham, 2013).

Family dynamics may result in an individual turning to family members for help first, before considering using a professional such as a doctor, counselor, or social worker. Advice from family members may be utilized as a first defense against problems. Once this resource has been exhausted, an individual may consider seeking outside help. Sometimes this is a matter of cost of services, stigma associated with exposing a problem to those outside of the family, and fear of how the problem will look to others (fear of being judged as well as fear of upsetting the image of a model minority).

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CONCLUSION

Islamic beliefs and behaviors, mediated by levels of religiosity and acculturation, and impacted by external factors such as culture, status, experiences with discrimination, and previous experiences with services, all play a role in how Muslim clients view health, illness, interpersonal problems and trauma. In turn, perceptions of problems often dictate attitudes towards available care options and help-seeking behaviors. None of these factors exist independent of each other and represent an ongoing and ever-changing dynamic.

This leaves the helping professional in the position of 1) showing dedication to learning the basic values and beliefs of a client in order to engage in culturally-informed care, 2) willingness to engage in communication with individuals who can assist them in gaining religious or cultural information that can inform their care plan and interventions, 3) assessing various aspects of the client including religiosity, acculturation status, and social and cultural norms that may prevent care or adherence to a care plan, and 4) addressing any pre-conceived biases or perceptions that the provider may unknowingly or knowingly harbor as it relates to Muslims. Islamophobia, as well as negative, stereotypical, or inaccurate media coverage of Muslims can contribute to implicit bias of service providers towards Muslim clients. Previous research by the author found some Muslim Americans who had experiences with mental health services reported bias, perceived discrimination, or offensive questions from professionals. These included suggesting that Islam was a source of stress for the individual, viewing the hijab as a sign that a woman is oppressed, and other forms of stereotyping (Bagasra, 2011). Muslims in North America, Europe, and Australia often view helping professions either through the lens of previous experiences with similar services in Muslim-majority countries, which may or may not accurately reflect the nature of the services offered in Western societies, or through the lens of previous experiences by themselves or other community members with such services. Negative experiences or the perception that they will be treated negatively by service providers, have a significant impact on willingness to seek out, utilize, or continue usage of available services.

In sum, culturally competent care requires understanding, willingness to learn and view individuals as distinct from prevailing stereotypes, and open communication. Education and partnerships with religious organizations in the local Muslim community, and communication with and endorsement from Muslim community leaders can help a provider establish a strong relationship built on mutual respect and understanding.

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KEY TERMS AND DEFINITIONS

Acculturation: Acculturation is a process that can occur for any individual or group trying to adjust or adapt to the dominant or host culture as a result of contact between cultures.

Evil Eye: Within the Islamic tradition, the evil eye is the belief that a person can cause misfortune, physical or mental illness, by placing a curse on another person as a result of envy. Often referred to as Nazar.

Jinn: Beings within Islamic theology made from "Smokeless fire" and distinct from humans and angels. Jinns can be bad and good and belong to different religions. Traditionally, it is believed that jinn can possess humans and cause symptoms of physical and psychological illness.

Qadr: Often translated as pre-destination or fate, it indicates Divine Will for followers of Islam. Allah (God) is unrestricted by time and knows the final outcome for each individual. The concept does not fully discount the idea of free will.

Religiosity Measures: Psychometric instruments that measure some aspect of religiosity or religious commitment either within a specific religion or measuring religiosity in general.

Religious Identity: The role of religion in personal identity, and the importance of religion in the person's group membership and overall self-concept.

Shame: Shame, honor, or izzat originates in the collectivist notion that an individual's actions reflect in their reputation and the reputation of their family and even larger community. Sinful behaviors, either committed by an individual or against an individual (such as rape, sexual abuse, or domestic violence) may all be viewed as bringing shame on an individual and household.

Spiritual Assessment: Oral or written questions designed to assess a client's spirituality or religiosity, to strengthen communication between a provider and a client, and elicit a better understanding of the role of spiritual or religious belief in the individual's life and decision making.

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Chapter 9
Mental Health:
A Global Issue Affecting the Pattern of Life in Kashmir

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ABSTRACT

Global health issues are a global burden and are relatively common in industrialized societies. The World Health Organization and researchers have developed and rebuilt tools to report the burden of disease affecting mortality and health of the people. Apart from America and Europe, which are at an average of global burden for mental health disease, in some regions it is a major priority to be addressed globally. In South East Asia, one of the affected regions is Kashmir, Northern Indian. Disasters have manifested in various forms encompassing the natural calamities of earthquake, flood, landslides and manmade calamities of violence. Trauma due to manmade calamities has taken over as a leading cause of morbidity and mortality among the most productive working age group of 12-35 years. The chapter aims to understand the patterns of resilience in people surviving war and conflict in Kashmir over last 60 years. The focus is on the young population of society. Generations in Kashmir have faced the psychosocial impact of ongoing political conflict since the 1980's.

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INTRODUCTION

A healthy mental condition is described as a normal standard of life in which a person realises his/her own abilities coping with the hardships of life, working productively and, fruitfully, and is able to contribute to his/or community ("world Health Organization," 2001d). Mental illness is an abnormal affair or health condition that is defined by any change in thinking, mood or behaviour associated with distress and/or impaired functioning ("US Dept. of Health and Human Services," 1999; Kessler et al., 2005). Mental disorders affect people from all countries and societies involving people from all age groups, men and women; poor and rich; urban and the rural populations. People living in conflict zones experience more mental disorders. Recently, the world has received an increased change in terms of warfare and violence to civil society resulting in unstable situations. Introduction of advanced weapons have resulted in grave human concerns. People are disappeared, tortured, forced to migrate, and starved to death. Globally, mental health disorders are among the leading causes of illness and disability. Mental illness leads to decreased productivity and has a negative impact on the quality of life of affected individuals and their families ("World Federation for Mental Health," 2015). Annually, over 450 million people have been reported to be affected by mental disorders, and only a few have access to cure. There are barriers to accessing the treatment created by social stigma and negligence. Mental health is determined by several factors of psychological illness and is influenced by society governed by political instability leading to number of events (Miller et al., 2010; Silove et al., 2014; Steel et al., 2009; Summerfield et al., 2000).

The chapter presents the support that strengthens the patterns of resilience in people who have survived war and conflict in Kashmir (India) over the last 60 years. Peace in Kashmir has been repeatedly interrupted due to conflicts between India and Pakistan. Generations in Kashmir have faced the psychosocial impact of ongoing political conflict from last 60 years. There are reports of human rights violations and their impacts. There has been research, though limited, on losses faced by the community, psychosocial impacts of exposure to violence and impact on mental health, socio-economic functioning and health service usage. In Kashmir, many women have lost their husbands to the conflict. Currently, it is believed that there is no reliable, comprehensive and factual survey about the number of widows and orphans in Kashmir. There are different estimates by different sources. Over the years, people living in Kashmir have been accustomed to the circumstances and have adapted themselves to survive in such situations. Gradually, the role of civil society becomes imperative to increase support systems, especially related to health services, children's needs care and persons with disabilities and women should be protected.

OVERALL POPULATION SCENARIO AND CONFLICTS IN KASHMIR VALLEY

The Kashmir Valley is situated in north region of the Indian state of Jammu and Kashmir between Jammu (to the south) and Ladakh (to the east) with the line of control (border with Pakistan) along its northern and western borders. It covers a geographical area of 15,948 km^2, with a population density of 430/km^2. The total population is 6.9 million, with 73% living in rural areas and 27% living in urban centers (2011 census). The majority (97%) of the population is Muslim, with Hindus, Sikhs, Buddhists and Christians making up the other 3% ("Human Rights Watch," 2006). Since partition of India in 1947, the Kashmir has faced political instability. Following three Indo-Pakistani wars (1947, 1965 and 1971) and one Indo-Chinese war (1962), the wars were consequences of an internal movement for determining freedom. In 1989, an insurgency began, resulting in 27 years of movement of gun-men group (fighting

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for self-determination) and military activity. By 2012, approximately 70,000 Kashmiris had lost their lives in the conflict and 10,000 people had been reported missing ("History of Kashmir," n.d.).

MENTAL HEALTH: INFLUENCE OF CONFLICT

Conflict influences lives of people and the society by having a negative impact. Irrespective of age, sex, career, residence the emotional and psychological effects of violence are deeply felt by many individuals. The conflict has brought about insecurity and breakdown of social relations, it has destroyed families in Kashmir and forced the youth of Kashmir to switch to drugs and to undertake anti-social activities. Kashmir has been regarded as "heaven on earth" for the nature and beautiful scenery. Over the past three decades, Kashmir has been affected with conflict and violence which has led to mental malfunctioning. Mental well-being is related to physical, social livelihood and economic disability. People who are affected by a conflict environment are burdened under mental and physical stress and suffer from post-traumatic stress problems (Amin et al., 2005; Amin et al 2004). Political instability creates an atmosphere of negativity, with long lasting effects on social, economic and livelihood of common people (Sack et al., 199; Amin et al., 2004; Margoob et al., 2006). A nationwide survey undertaken by the Ministry of Labour and Employment in 2012-2013 reported that Kashmir has the highest rate of unemployed people in India. At state level, the number of job seeking people increased by 190% between 2008 and 2013. Employment-generating sections like private sector, industry, agriculture, horticulture have been reduced due to present instability in region. Tourism was one of the main paths for employment among young people which has reduced in past 27 years. In 2011, a Kashmir-based report by Mercy Corps reported that unemployment leads to stress, social pressure, delay in marriages. The expression and behavior of people in such zones lead to stress, mental illness and tendency to suicide among youth ("Mercy Cops," 2011; Hassan et al., 2013).

For the past decade, a tremendous increase in mental illness has been reported in the Kashmir Valley. IMHANS, Institute of Mental Health and Neuroscience in the valley's capital, Srinagar, has a large number of patients being treated from an average of 100 per week in 1980 to 850 per week in 2016 (Dar et al., 2016). In 2005, in cross sectional study of 548 individuals in the districts of Kupwara and Badgam, researchers reported a prevalence rate of 33% for distress in patients having psychological effect (De Jong et al., 2008) In another study involving 3000 individuals from all districts in 2006, there was a prevalence of 7.3% for PTSD and a lifetime prevalence of 15.2% (Margoob et al., 2006). The year 2009, have shown a prevalence rate of 55.7% for depression in a study of 2728 individuals across all districts of the valley. A retrospective study on suicide demonstrated an increase of over 250% in suicide attempt cases between 1994 and 2012 (Shoib et al., 2012). Another study was reported on behavior of PTSD patients treated in Government Psychiatric Diseases Hospital in Srinagar reportedly having a lag time from symptoms occurred and treatment of such patients of 32 months in women and 48 months in men. The authors also stated that such patients seeking care was highly incongruent with the prevalence of PTSD in the community (Margoob et al., 2006).

As per the Kashmir Mental Health Survey Report 2015, a report prepared by MSF, Medecins Sans Frontieres, 1.8 million (45%) adults in the Valley had mental ill health symptoms. Approximately 1.6 million adults (41%) in the valley are facing depression with 415,000 (10%) susceptible to severe depression. An estimated 1 million adults (26%) in the valley are living with anxiety problems. Nearly 1 in 5 adults (19%) or 771,000 individuals are having PTSD symptoms, with 248,000 (6%) meeting the

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diagnostic criteria for PTSD. There are increased rates of co -morbidity depression, anxiety and PTSD symptoms found in adults in the valley. The districts of Baramulla and Budgam reported increased prevalence rates of mental ill health ("Kashmir Mental Health," 2015).

ARMED CONFLICT AND MENTAL HEALTH STATUS IN KASHMIR

Armed conflict is present in most of the Asian parts (Gates et al., 2012). War has catastrophic effects on health and well-being of human beings. Studies have reported that wars have long lasting effects on mankind, livelihood, households, and hunger. It affects the psychology of people involved, decreasing their working and social ability of a normal life. WHO reflects that 10% of the population are subjected to trauma or war having psychological effect and 10% of those exposed to war have behavioural problems (Laxaminarayna et al., 2006). Studies have shown that the common people including young and adults suffer from trauma and psychological disorders. The common symptoms found were mental disorder, anxiety and PTSD. The children in Gaza have been affected by psychological disturbance and sleeping disorders (Hein et al., 1993). Social supports for such affected people have played an important role but people are affected and destroyed in war zone areas. The social support would have acted as a buffering zone for conflict and psychological disorder if present ("Sustainable Development UNICEF," 2013).

Kashmir has been in conflict for decades now. Deaths, Disappearances, killings, and harassment have been an outcome of conflict in Kashmir. About 8000 persons are reported to be disappeared and more than 70000 persons have been killed, and more than 6000 have been buried in graves ("Alleged Perpetrators JKCCS," 2012). The most affected group is that of the young and children. About 97000 to 100000 children turned orphans. The widows are increasing in number from 16000 in 2000 to 32400 in 2008 (Double) (Rather et al., 2013). This has reportedly increased the number of deaths and mental disorders in Kashmir affecting the young population. As a result, psychiatric admissions to one of the hospital increased from 6 per day in 1990 to 250-300 per day in 2000. The total number of patients rose from 1760 in 1990 to 18000 in 1994, to over 50000 in 2003. In 2006, the number of patients had increased to 82000 (Wani et al., 2006). According to the report documented by MSF, it was shown that about 45% of the adults in Kashmiri have a mental disorder. About 41% in the valley are affected by depression, with 10% having more serious depression. Almost 26% population in the valley have anxiety disorders. About 19% of population is having PTSD (Gates et al., 2012). Exposure to trauma leads to behavioural problems, having psychological and emotional distress to population. However, a different prevalence rate is reported with respect to gender and location. The women are suffering from depression more (60%) as compared to men (51%). Women suffered from increased prevalence of depression in all the age groups, particularly among 26 to 35 years, the reproductive years of their lives. Besides depression, PTSD is common in Kashmir population with symptoms of depression associated with it (Amin Syed et al., 2009). The conflict is one of the main reasons for mental ill heath population (Margoob et al., 1993). In addition to this, suicide rates and drug abuses are on high rate (Yaswi et al., 2008). About 25% of people in Kashmir are having depression (Hassan et al., 2013). Measuring the levels of depression, anxiety among the groups exposed to such conflict is more than non-exposed groups. About 90% of the population who are affected by such psychological disturbance do not intend to return home because of fear of being accepted in society. There are major health issues like gastritis, headache, and weakness (Dilnaz et al., 2014). As a result, the children and youth develop a self-made mind governed by their rules and regulations and react on every small problem (Zahid et al., 2017). It results in children's who

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do not find their interest in education and normal livelihood, they wander after some self-made life and social set up.

USE OF WEAPONS IN KASHMIR AND IMPACT ON MENTAL HEALTH

The conflict has led to mental disturbance among children and youth. They do not look for jobs or education is not completed. They have psychological disturbances and mental disorders. They react inappropriately to any outbreak or cannot handle critical circumstances and have sleeping disorders. Their social life is affected. They are not able to cope up with normal social life, economically weak. They have lost hope of life, and have difficulty in concentrating on anything (Bilkis et al., 1996). Some of this may be linked to weapons use by law enforcement in Kashmir.

TERRORISM AND THE IMPACT ON MENTAL HEALTH

For the past three decades, 'terrorism' has spread and engulfed the entire world. In the face of escalating tensions created by terrorism and the after-shocks and trauma of violent crime, the psychological aspects of communities who confront terroristic incidents constantly and a terrorizing environment have mental imbalance. While cultures differ, it is amazing how many people are alike. Citizens of all cultures perceive threats to their security and safety in a negative manner. They long for stability and peace in their homelands. Most people want to be able to provide themselves with necessities, rather than fight. There is no dearth of evidences related to the worldwide terrorism. 4220 terroristic incidents were reported by the International Association of Chiefs of Police (IACP) worldwide for 1987. The data plainly indicate that terrorism is increasing and that multiple deaths and destruction are increasing enormously. Terrorism in India still occupies the center-stage in many parts of the country specially Jammu and Kashmir where it has dominated almost every aspect of the life of its citizen for years. Terrorism creates a state of mind where anxiety and fear dominate the people's thinking and behavior. Terrorist succeeded in creating such an effect in Kashmir for the last three decades. Most of the studies have emphasized the post-traumatic stress disorder (PTSD) of the people who have survived the terrorist attacks. Poor Mental health and Depression are highlighted in many related studies along with other related psychological abnormalities. A study was carried to report number of mental health of 58 refugees (18-64 years old) of war who were victimized by trauma. Study reported that 70.7 percent of the people had trauma. While a prevalence of psychiatric disturbance was found in 64.1 percent. Results inferred that age had a major factor related to mental disorder (Hassan et al., 2013). A study on terrorism, trauma and mental health suggests that the effects of violence lead to lack of hope, social ability and support. Another study was on psychology of terror and how this affects the livelihood of common people with lasting effects. One more study was on mental and behavioral problems associated with such outbreak of mental ill-health [39-40-53].

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CONCLUSION

Operational Possibilities in Case of Mental Health

It is widely recognized that women and young people are main population who are affected. In most conflict situations, gender plays an important role, women are more vulnerable than other groups including children, they are the primary care, education and home builders and once they are targeted, a family gets affected and which leaves a mark in society. It is evident that very few studies have focused substantially on the life of women in the cultural context of Kashmir, with conflict, and psychosocial interventions, as the primary background. Studies based on Social Work principles and mental health perspectives, hopes to address this gap.

Questions Need to be Addressed

1. What do young women and men from Kashmir have in mind about the current situation there?
2. What are the lifestyle patterns young women and men, from Kashmir, which help them, cope and survive in the conflict zone?
3. What are the similarities and differences in these patterns among young women and men in different age groups say for example 16-21years, and 21-26 years?

Mental Health and Psychosocial Support: Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder can be incorporated (Ashraf et al., 2008; Haji et al., 2018).

Interviews and Observation: Interviews should be held for these age group populations, observational studies on their behaviour, way of thinking, and pattern of living should be focussed. The data should be kept confidential. Further process of consulting experts, who have relevant experience related to gender and conflict, should be included. The data sheets should be prepared and analysed in the focussed age group. On the basis of these methodologies and data collection, mental health can be studied and evaluated in a conflict zone region. One can take necessary measures in order to prevent such disease affecting mental ill health and how they can be diagnosed by mood, behaviour, and distress. Mental, physical and social health, are vital strands of life that are closely interwoven and deeply interdependent and are important for normal functioning of body and livelihood. This needs to be protected as an important component of life for survival of a population in a region. There has been research, though limited, on losses faced by the community, psychosocial impact of exposure to violence, including impact on mental health, socio-economic functioning and health service usage. Further, the political and economic instability fuelled by unemployment has added to the mental disturbances in the valley. Gradually, the role of civil society groups has also grown in order to increase support systems, especially related to health services, children in need of care and protection, persons with disabilities, and women. Mental health disease is one of the fatal types to be measured and detected at an early stage. Educational set up and working settings need to be reformed to check behavioural parameters collaborated to lifestyle, its affect in community named as a mental illness (Price et al., 2018; Mohan et al., 2018; Soomro et al., 2019).

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KEY TERMS AND DEFINITIONS

Disorder: A disorder is a practical irregularity or trouble. Medical disorders can be characterized into mental illnesses, physical disorders, genetic disorders, emotional and behavioural disorders, and functional disorders.

Mental Health: Mental health comprises our expressive, psychosomatic, and communal well-being. It affects how we reflect, sense, and act. It also helps regulate how we handle anxiety, relate to others, and make selections. Mental health is significant at every phase of life, from childhood and adolescence through maturity.

Psychology: Psychology is the discipline of behaviour and awareness. Psychology comprises the study of conscious and unconscious occurrences, as well as sensation and thought. It is a theoretical discipline of immense scope. Psychologists seek an understanding of the developing belongings of brains, and all the variability of phenomena related to those emergent belongings, joining this way the wider neuroscientific group of researchers.

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Section 2

Development and Design Methodologies

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Chapter 10
Paradigm Shifts in the Theory and Praxis of Mental Health Counseling

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ABSTRACT

Clinical psychology used to view women's distress as biological and men's distress as externally induced. The psychology of gender relations has progressed to view gender as a principle of the social structure, but counselling practices continue to have an uncritical focus on the unequal gender relations existing in the society. Feminist psychology recognizes that the pattern of women's mental disorders is role related rather than organic/biological and that many gender differences are shaped by differing socialization of males and females. While addressing the mental health needs of the women population, the "subjective distress" in the context of their "subjective realities" is to be explored. Silencing the oppressed is the feudalistic way of resolving issues, but it fails to recognise the storm inside the oppressed minds. From outside, the family may seem to be calm and cool, but the turbulence inside the feminine minds may break out any time either in the form of a suicide attempt or in the form of a complaint to the police or the women's commission.

INTRODUCTION

Despite the fact that stress is a silent killer of the 21st century, the causes and impacts persist and get aggravated in the globalized society. Gender discrimination, gender division of labor, gender role perceptions and gender-based violence prevalent in various forms and extents throughout the globe add to women's stress and negatively implicate their happiness and well-being. Engendering health thus occupies a central point when we talk about women empowerment and gender mainstreaming. The engendering efforts often focus on physical health of women, especially maternal/reproductive health. Mental health of women is an area that is not given serious attention in developing countries like that of

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India. To facilitate women's active agency in development, appropriate support mechanisms to ensure their mental health are required. Here comes the relevance of this chapter that calls for paradigm shifts in the theory and praxis of mental health.

Mental Health and holistic wellbeing have received the focused attention of psychologists and those engaged in the study of human nature right from the beginning. The last two decades have witnessed an exponential growth in mental disorders of all types, all over the world. Studies across the world have shown that mental health issues such as depression and anxiety are more common among women. Database generated by many sources, including the WHO, comprises appalling statistics on women's deteriorating mental health. The gender disadvantage and physiological factors might add up to this vulnerability of women. Socio cultural factors varying from discriminatory socialization practices, denial of opportunities for higher education and employment, lack of property rights, decision making power, gender- based violence etc. all add up to the challenges of girls and women. Lack of gender sensitivity of medical practitioners, sociologists and mental health counselors result in overlooking the socio-cultural factors most often. Though the Bio psychosocial model is well accepted by mental health practitioners, its essence does not reflect in the practices.

Mental health is the normal state of wellbeing and defined as conditions and levels of social functioning which are socially acceptable and personally satisfying. There is no single authentic or certified definition of mental health. There are several misconceptions where mental health is equated with lack of mental illness. Cultural differences, subjective assessments, and competing professional theories affect the way mental health is defined. The World Health Organization defines mental health as a state of well-being in which the individual realizes his or her abilities, copes up with the normal stresses of life, works productively and fruitfully, and makes contributions to his/ her community. Different psychologists have emphasized different aspects of mental health in their definitions. According to Hadfield (1950), mental health is the full and harmonious functioning of the whole personality. Bernard (1961) writes (a) mental health involves continuous adjusting rather than a static condition and is, therefore, an ever- shifting progressive goal. It is an ability to cope up with the present and in all likelihood to adjust satisfactorily in the future too. (b) Mental health involves a point of view one takes through all phases of one's living. The White House Conference in its Preliminary Report,1930 defines mental health as "the adjustment of individuals to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness and socially considerate behavior and the ability to face and accept the realities of life".

Positive mental health is not merely an absence of illness or disorder but includes a positive sense of wellbeing; individual resources including self-esteem, optimism, a sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships and the ability to cope with adversities (Jenkins et al, 2011). It refers to a positive sense of wellbeing and a belief in one's own worth and the dignity and worth of others. Positive mental health includes the capacity to perceive, comprehend and interpret one's surroundings, to adapt to them and to change them if necessary, to think and speak coherently and to communicate with each other. Mental health is often taken as a behavioral process by which humans maintain balance among the various needs or between their needs and obstacles of their environment. Ryff and Keyes (1995) defines mental health as the combination of emotional wellbeing (presence of positive affect, satisfaction with life and absence of negative affect), social wellbeing (incorporating acceptance, actualization, contribution, coherence and integration) and psychological well-being (self-acceptance, personal growth, purpose in life and positive relation with

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others). Jahoda (1958) has identified categories within which the concept of mental health could be represented and describes it as follows:

- Mental health is indicated by the attitudes of individuals towards themselves.
- Mental health is expressed in the individual's style and degree of growth, development or self-actualization.
- Mental health is based on the individual's relation to reality in terms of autonomy, perception of reality and environmental mastery.
- Mental health is the ability of the individual to integrate developing and differing aspects over time.

GENDER DIFFERENCE IN MENTAL HEALTH

Depression is among the most prevalent and debilitating psychiatric disorders in the world and women are twice as likely to experience depression compared with men (Sloan & Sandt, 2006). Both community-based studies and studies of treatment seekers indicate that women are, on an average, 2–3 times, at greater risk to be affected by common mental health disorders (Thara & Patel, 2001). Gender differences have also been reported in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course of these disorders, social adjustment, and long-term outcome (Malhotra & Shah, 2015). Weller et al. (2006) analyses the gender differences in depression to determine whether differences in adults are also observed in children and adolescents. Before puberty, major depression occurs at approximately the same rate in both sexes (Birmacher, Brent, & Benson, 1996; Lewinsohn, Clarke, Seeley, & Rhodes, 1994). Once children reach adolescence, however, the rate of depression in females doubles (Weissman, Bland, Canino et al., 1996). Although adolescent males also experience a significant increase in depression at puberty, the rate of depression in females at this age far surpasses that of males. As a result, the female-to-male ratio of depression becomes 2:1 (Lewinsohn et al., 1994; Weissman et al., 1996).

Nolen-Hoeksema (2001) explains how gender differences in stress experiences and stress reactivity may interact to create women's greater vulnerability to depression. This increased prevalence of depression in females has been seen in different countries and ethnic groups (Hankin, Abramson, Moffitt et al., 1998). As young women enter adulthood, they are at a higher risk for early relapse following remission from a clinical episode of depression (Kuehner & Weber, 1999), have more severe depressive episodes, experience greater functional impairments, and develop a more chronic course of illness (Kornstein, 1997; McCauley, Myers, Mitchell, Calderon, Schloredt, & Trede, 1993) than men. Retrospective studies of depressed adults suggest that females more often experience negative life events, such as childhood sexual abuse, or negative social factors, such as poverty, poor education, restricted mobility, reduced employment opportunities, violence and fear of violence etc. (Hankin & Abramson, 1999; Nolen-Hoeksema, Larson, & Grayson, 1999). Cyranowski et al. (2000) report that over 70% of depressed females experienced a negative life event prior to the depressive episode, compared with only 14% of males. Kessler et al. (2003) asserts women to be 70% more likely to experience depression in their lifetimes than are men. According to Nolen-Hoeksema (1987), women experience the onset of depression more frequently than do men, they demonstrate relatively longer durations of depressed moods, and they are relatively more likely to experience a recurrence of depressed mood.

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Challenges of Puberty and its Role in Depression

There are dramatic changes in the expression of depression after puberty, but the reasons for these changes are not well understood. Both sexes experience an increase in depressive symptoms with puberty, at a time when they are faced with the pressures of forming an identity, dealing with emerging sexuality, separating from parents, and making important personal, academic, and vocational decisions. Teenagers also have to adapt with the physical, intellectual, and hormonal changes that occur during this period. All these stressors could have a potential role in causing depression (Reinecke & Simons, 2005). According to Parry (2000), hormonal factors related to the reproductive cycle may play a role in women's increased vulnerability to depression.

Females experience additional stressors as they reach puberty, these include biological changes like menarche and breast development and psychosocial stressors like increased concern with body size and image. No one factor may fully account for the observed increase in depression in adolescent females. Whether these stressors contribute to the rise in depression as young girls reach puberty should be determined. Mental health issues like depression in women and girls are often attributed to physiological changes which of course may be one among the various causal factors. Girls who fail to accept and adjust with their hormonal and physical changes are at a higher degree of vulnerability. Girls are expected to be docile, silent and confined both in the private space of home and public spaces like transport system, educational institutions and workplaces. Religious factors such as menstrual-related rituals, practices and restrictions are also reported to create mental stress, among the Hindu adolescent girls (Garg & Anand, 2015; Kirk & Sommer, 2006; NIPCCD, 2014). The religious instructions on dressing style affect Muslim adolescent girls more than their counterparts. Such restrictions on self-expression and mobility are further aggravated by religious dictums.

Numerous socio-cultural factors underline the vulnerability of girls leading to deep frustration and severe depression. In countries like India, noted for the male lineage preference, girls may be sidelined or fail to receive the due concern, or the kind of expectations from them is entirely different compared to boys. So, girls grow up with a sense that they are second-grade citizens in the family. And also, the roles assigned to them are different from that of boys in majority of the families. Girls are also more vulnerable to mental health issues because of violence and fear of violence. The chances of actual sexual abuse and attempts of harassment are much more among young girls compared to young boys. And if a girl tries to disclose or confides an abuse in her family she is not given the uncritical succor she needs; or if she tells someone and she is not believed - that again creates a trauma, which is a double vulnerability. Girls and women who are witnesses of such insensitivities are in turn likely to become vulnerable to frustration and depression (Jijila & Kuruvilla, 2019).

Gender Difference in Symptoms of Depression

Gender differences are reported in the symptom profiles of depression with depressive men more commonly having serious symptoms than depressive women (Poutanen, Koivisto, Mattila, Joukamaa, & Salokangas, 2009). Depressed women are more likely than depressed men to experience changes in appetite, weight gain, carbohydrate craving, sleep disturbances, increased sense of failure or guilt, somatization and increased anger (Carter, Joyce, Mulder, & Luty, 2001; Williams, Spitzer, Linzer et al., 1995). In addition, depressed women have greater rates of internalizing psychiatric disorders, such as anxiety disorders and eating disorders (Frackiewicz, Sramek, & Cutler, 2000). Men more frequently

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experience psychomotor changes, feelings of worthlessness, decreased concentration, and weight loss (Angst & Dobler-Mikola, 1984; Frank, Carpenter & Kupfer, 1988). Also, depressed men exhibit anti-social personality and substance abuse disorder more frequently (Simon, 2002). Depressed high school females often have anxiety disorders, eating disorders, and adjustment disorders, whereas depressed high school males often have disruptive behaviour disorders and eventually substance abuse disorders (Sloan & Kornstein, 2003). A two-tiered, school-based epidemiologic study of depression in 478 adolescents found that females reported higher levels of depressive symptoms on self-report questionnaires, even when prevalence rates for the two sexes were taken into account. This suggested a gender difference in the expression of depressive symptoms (Cuffe, Waller & Cuccaro, 1995).

Biological Theories of Increased Depression in Females

Several biological theories have been proposed to explain the gender difference in depression but evidence-based research to support these theories is limited. One theory suggests oxytocin (which increases in females with the onset of puberty) causes an increase in affiliative behavior and the need for emotional connectedness. In such a state, a broken bond with a friend, parent, or partner may be perceived as a loss and leads to depression (Frank & Young, 2000). The role of hormones such as progesterone, estrogen, and cortisol in causing gender differences at puberty has been evaluated. To date, there is only limited evidence to prove these hormones as significantly influencing the development of depression in females (Hankin & Abramson, 1999), however, neuroendocrine changes that occur at puberty are presumed to have an effect. These biological changes, combined with socio-cultural factors, may place teenage girls at increased risk for depression. Endicott (1993) reports increased risk of a depressive episode or worsening of existing depressive symptoms during the late luteal (premenstrual) phase of the menstrual cycle.

Stroud et al. (2004) theorized that sex differences in hypothalamic pituitary adrenal axis regulation emerge during puberty and lead to gender differences in depression. Sex differences in cortisol response to a corticotrophin - releasing hormone (CRH) infusion challenge were examined across pubertal stages in normal children 7 to 16 years of age. Tanner stages were determined by physicians for all subjects. Serum cortisol levels were measured at specific intervals throughout an infusion challenge of CRH. Cortisol response to CRH increased with increasing Tanner stages in girls while boys did not show this trend. The authors suggest that small differences in the effect of puberty on cortisol responses and pituitary regulation may play a role in the increased rates of depression in girls during this period (Stroud, Papandonatos, Williamson & Dahl, 2004).

Though some authors report a decrease in the prevalence of depression at menopause (Bebbington, Dunn, Jenkins, et al., 1998), the reason for the same is not fully justified. Women with pre-existing mood disorders, however, may be at increased risk for a depressive episode at menopause (Hay, Bancroft, & Johnson, 1994).

Psychosocial Reasons for Greater Depression in Females

There are many psychosocial theories to explain the gender difference in depression but most are theoretical and therefore difficult to prove by evidence-based research. Cognitive theorist, Beck (1983) suggests that females, who focus on sociotropy (interpersonal dependence) and rely on affiliation and support from others, maybe predisposed to depression. Males rely on autonomy (personal independence) and focus more on self-criticism and achievement expectations. Gender differences in cognitive variables

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were studied in a community sample of 856 white adolescents (Calvete & Cardenoso, 2005) to determine if they were associated with the development of depression or behavioral symptoms. Male and female adolescents were presented with different cognitive profiles, which could have accounted for gender difference in depression and delinquent behavior. Specifically, adolescent girls tended to doubt themselves, doubt their problem-solving abilities, and view their problems as unsolvable. All of these views correlated with depressive symptoms. Girls also focused on negative cognitions (such as self-blame and negative self-evaluation), expressed less-positive automatic thoughts, and needed a higher degree of approval and success than male counterparts. These factors correlated with internalizing problems and depressive symptoms. Males had higher scores on self-report items involving justification of violence and impulsive/careless styles that were more often associated with delinquent behavior. But why girls tend to have doubts about their abilities and need higher degree of approval than their counterparts is a matter of serious concern pointing to the need of further research with gender perspective.

Frackiewicz, Sramek and Cutler (2000) reviewed the artefact theory, which suggests that women seek help more frequently, visit health services more often, and are inclined to recognize mental illness earlier than do men. This theory also suggests that physicians are more inclined to recognize and treat depression in females and may even over-diagnose depression by 30% to 50% by misinterpreting symptoms of hypothyroidism, rheumatoid arthritis, and systemic lupus erythematosus as symptoms of depression.

Sands and Howard-Hamilton (1995) theorized that the increased sensitivity to societal expectations experienced by adolescent females might lead to negative feedback and feelings of depression. It is also difficult for some adolescent girls to maintain "proper behavior". For example, gifted adolescent females often struggle to maintain a balance between "achievement and sexual attractiveness" (Sands & Howard-Hamilton, 1995) because of conflicting messages from families, teachers, peers, and society. This struggle can be compounded by cultural and socioeconomic factors such as ethnicity, religion, or poverty. Thus, young women face many stressors that predispose them to depression. In the case of married women, broken marriages, indifference and desertion by the partner, lack of ownership of assets, lack of decision-making power etc. place a heavy toll on mental health unlike men. The responsibility of children poses an additional burden to the struggling mothers.

In societies with the practice of women blaming, girls and women are forced to suppress their feelings without even a chance to open up. In countries like India, a girl who is harassed cannot disclose the event fully, even to the judiciary as it may lead to severe blaming of the girl and her family, which most often extend for the lifetime of the girl. Due to the existence of dowry system, there will be several girls ready to marry a harasser but there are only very few men who dare to marry a harassed girl. Since chastity and marriage are overweighed in the lives of girls, the only option before a harassed girl or a survivor is to contain everything to self and suffer in silence. Families prevent any kind of reaction on the part of the girl, whereby the girl and the family are pushed into a trauma of life time guilt and sorrow and the harasser moves about freely without any guilt or contempt on his act. Such socio-cultural factors cannot be ignored while discussing women's mental health issues. As reported by WHO (2001), the morbidity associated with mental illness has received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.

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A FEW COUNSELING EXPERIENCES

Three cases that would best represent the grievances of Indian women and also the nature of counseling they receive are given here for facilitating discussion.

Case 1: *Nisha was totally shattered when she approached me. She was 29, a college lecturer and mother of a seven- year -old son. Her husband is employed in a private firm after his college degree. At the time of marriage, Nisha was not employed. Her husband supported her to study further. She passed JRF and got employed in a college within five years of marriage. With the pay revisions of the government, Nisha started getting a much higher salary than her husband. Her husband found it humiliating to earn lesser than his wife. Problems started soon after and their life became so miserable. Her husband wanted Nisha to resign her job which she reckons as a great achievement and the reward for her hard work. They had consulted a counselor earlier where she was advised to resign the job as per her husband's wish. The husband is loving, caring and neither a spendthrift nor with any unsocial behavior. The counselor in presence of her husband made some remarks that as long as the family is rich enough and the husband is ready to take care of all her needs it is not wise on Nisha's part to insist on going out for work against husband's wish. Now the husband is frequently quoting the remarks made by the counselor to blame Nisha. It was at this juncture that Nisha approached me with a broken heart. Nisha's argument is that the present job is the reward for her hard work, she completed her studies along with her pregnancy. She wrote the lectureship examination on the previous day of her delivery. She narrated the pains she had taken for completing the studies and writing the lectureship examination after travelling long hours. Now that she had started enjoying the fruits of her hard work, the better status in the society, the respect from students, she was not ready to give up all these.*

Case 2: *Suja, 42 is a head nurse working in the government sector. Her 50-year-old husband is a retired army man. They have two children, elder son in plus two class and younger daughter in tenth standard. Her husband had taken voluntary retirement from the army at the age of 40 and since then he has not gone out for any work. His only engagement is drinking liquor and finding fault with wife and children. Suja has to hand over her entire salary to husband. She is afraid of taking the night shift since her daughter has grown up and is worried about her safety. Being a staunch Christian, Suja accepts all the harassment of her husband as part of her unfortunate fate. Offering strong prayers and fasts, hoping for a change in her husband's behavior, she is holding on the relationship. Suja is increasingly worried about the elder son's misbehaving tendencies and husband's cruel comments and harassment. When she approached the counselor, she was told that she is doing the right thing in the right direction and was advised to go on stronger fasts whereby things would change for the better. She has become very pale and weak with her fasts and finds it hard to make both ends meet at the home front. The husband was taken to de-addiction centers several times by her relatives but such efforts were of no use as he would start drinking within a week. Nobody has ever thought of getting the man engaged in some or other work and the man himself has a feeling that he is not a person to go for silly jobs. The wife expressed her guilty feelings whenever she considered getting a divorce from him.*

Case 3: *Reena is 35, mother of three children and regularly battered by her alcoholic husband. Though he is employed, the family gets no financial or emotional support from him. Reena is struggling to manage the routine needs of the household with her meager earnings from the agency works she*

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is pursuing at the post office. The husband has gone to the extent of snatching the little money that she earns from the agency work. If she dares to protest, she is cruelly beaten up by him. Thanks to the intervention of some NGOs, the husband and wife approached a counselor. After hearing both of them, Reena was advised to keep silent when her husband comes home drunk. Reena argues that she never sees him without being drunk and how long is she supposed to tolerate his indifference towards the needs of children and family, how long can she subject herself to his merciless battering.

Just three instances of gender insensitive counseling have been narrated above. In the first case, the counselor seems to ignore the emotional and material needs of a woman. The woman is viewed only as a wife and mother. Her role as a career woman, her intellectual satisfaction, need for economic independence and sense of accomplishment are blatantly not taken into consideration. The counselor should have attempted to correct the negative socialization that the husband has received with regard to masculinity and power relations. In the modern world of stiffer competitions, getting a job that you prefer is a matter of chance and luck, and the salary depends on many factors that, one with lesser qualification may sometimes get a higher pay than one with higher qualification. Also, the pay package vary greatly depending upon the changing economic times, work sector and policies of the employer in the private sector. The age-old patriarchal notions, that a husband must earn more than his wife, imbibed by the husband needed correction which was not attempted by the counselor. Instead, the lack of gender perspective made the counselor opt for the usual practice of suggesting adjustments from the woman, to the extent of resignation of her cherished and hard-earned job. The traditional norms regarding gender roles and gender stereotypes are accepted as such while resolving the issue.

In the second case, the wife is considered as someone who is solely responsible for the family integrity and she is entrusted with the duty of clearing the mindset and changing the behavior of the husband. The alcohol addiction of the husband is blindly accepted as a norm and changes are demanded from the wife alone. For this, she is advised to gain strength and courage through prayers and fasts.

In the third case, all the blame for being battered by the husband is put on the wife. Her silence on the face of violence is the remedy advised to solve the issue. The neglect of responsibilities and cruelty by the husband is not addressed. Moreover, the stand of the counselor supports the usual societal attitude of blaming women and according sanction to the drinking habits of men.

None of the above counselors seem to find anything wrong with the attitudes and behaviors of the husbands. The wife is always placed as the culprit and all efforts are made to refine her attitudes and adjustments. This might be comparatively easier in a patriarchal society where the silence and suffering of women is reckoned as a preferred practice for the well-being and integrity of the family.

The present chapter is contextualized in this backdrop. The modern globalized society characterized by its extreme stiffer competitions, materialistic outlook and identity crisis calls for a proactive role for the counselors. The withering familial and interpersonal relationship is a matter of serious concern for the sociologists and psychologists. The need for gender justice and gender equality as a precondition for social health and national development has been highlighted by various state and international machinery. Hence a gender perspective is an essential requisite for those who dedicate themselves for the happiness and well-being, especially in tradition-bound societies like that of India. But there are occasions as mentioned in the three case studies, where women seeking guidance are pushed into further trauma due to lack of gender perspective in the counseling approaches. In this context a redefinition is called forth regarding the concepts of stress, stressors and mental health and a reorientation is required in the counseling practices.

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GENDER PERSPECTIVE IN THE THEORY AND PRAXIS OF COUNSELING

While addressing the mental health needs, especially of women population, the "subjective distress" in the context of their "subjective realities" is to be explored. Counseling practitioners should have a true understanding of the socio-cultural background of the individuals and the society which in turn demands correct perceptions regarding the gender roles and gender relations in a patriarchal society. Moreover, a counselor should be one who has firm conviction that an individual, irrespective of gender, must have a private sphere and public sphere of life and at no cost should one be sacrificed for the sake of another as it will definitely result in imbalances in personal and social spaces. 'Gender perspective' demands looking at the world through a gender lens, transcending both male and female gazes, allowing a better vision of reality. The oppressive and exploitative conditions of half of the human race could be transformed in a constructive manner only if this perspective becomes central to the thoughts and actions of all people, the basis of all policies and all activities. Instead of adopting a superficial approach of treating the symptoms it is high time that we go for a deeper approach of curing the root cause of issues. For instance, in the first case study, the husband considers it as a blow to his masculinity when he earns lesser income compared to wife. This being a clear case of defective socialization, it is the socialization pattern that needs urgent correction to foster a positive attitude towards egalitarian gender relations rather than pressurizing the wife to give up her job.

In the second case study, getting the husband to counseling sessions itself is a difficult task whereas advising the wife to adjust further is an easy solution. Silencing the oppressed is the feudalistic way of resolving issues which fails to recognize the storm inside the oppressed minds. From outside, the family may seem to be calm and composed but the turbulence inside feminine minds may break out any time either in the form of a suicide attempt or in the form of a complaint to the police or the women's commission.

Need for a Paradigm Shift in the Conceptualization of Stressors from Physiology to Socio-cultural Factors

Clinical Psychology views women's distress as biological and men's distress as externally induced. The psychology of gender relations has progressed to view gender as a principle of the social structure and as an inevitable analytical tool, but counseling practices continue to have an uncritical focus on the unequal gender relations existing in the society. Feminist psychology recognizes that the pattern of women's mental disorders is role-related rather than organic/biological and that many gender differences are shaped by differing socialization of males and females. As in the first case study mentioned above, how come the husband developed the notion that it is unfair for a wife to earn higher than the husband. Why do the husband and the counselor think that a wife need not work if the family is rich enough? It is all because of the gender division of labor existing in the society wherein man is considered as the breadwinner and the housewife role is considered as a better option for woman. As per the patriarchal notions, a woman's income is considered only as supplementary income. The right of the woman to work, mental satisfaction and sense of accomplishment of the woman from her employment etc are totally ignored. Ignoring the need for economic independence for woman, especially when the husband's family is rich enough, is a consequence of the incorrect gender role perceptions of the society. The goal of a woman's life is also misconceived as becoming wife and mother. The woman's aspirations to take up careers and leadership roles are underestimated or more often treated as trivial.

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In the second case study, the wife is expected to survive through the traumatic conditions at home with the help of prayer and fasts alone. Whatever suffering she undergoes, it is not the concern of the society. As the doctrines of most religions emphasize, the husband is to be corrected by wife through unconditional love, sufferings, prayers and fasts. But if the wife happens to err, the husband has societal sanction to correct her through several forms of violence. This is a typical case of double standards of morality for men and women. The husband who remains idle at home while the wife goes out for work is creating a lot of issues in several home fronts. The concept of a house husband is unknown and unacceptable in traditional societies. The trauma of the employed wife to fulfill her responsibilities at home and that of the workplace along with carrying the constant fear of the son being spoiled and the daughter being harassed by her father needs much more concern and understanding.

Role conflict of working mothers requires a detailed analysis in this context. In general, issues related to work- life balance is often conceived as a consequence of lack of proper time management while the need for equal parenting and equal sharing of household chores is ignored. The use of supporting mechanisms like crèches for childcare, household gadgets to reduce drudgery of homely chores or the assistance of a housemaid won't relieve women of their responsibilities regarding childcare, caring of the aged and homemaking. It is the responsibility that is to be shared rather than mere helping with some or other household chores. But such a gender perspective is lacking in the mindsets of people, especially in tradition- bound societies.

Lack of proper relations to confide upon and ventilate personal worries and tensions is also a cultural factor that affects women's mental health. Through her Response Styles Theory (RST), Nolen-Hoeksema has stressed the role of rumination on depression and emphasized that rumination does not have a stronger impact on depressive episodes experienced by women than men, but that because women engage in rumination more frequently, they are more likely to experience depressive episodes in the first place (Nolen-Hoeksema as cited by Lyubomirsky et al., 2015, p.7). More of focused researches are required to test the hypotheses that lack of confiding relations and fear of women blaming contribute to this increased tendency for rumination among women. Women who are confined within homes and those who lack networking facilities at workplaces are equally susceptible to frequent rumination.

The intersection of gender and poverty also influences the mental health of women and is dehumanizing. In the third case study mentioned above, the poverty experienced by the wife and children is not a matter of concern to the husband or the counselor. The luxurious and spendthrift nature of life that the man enjoys is not found problematic. The income earned by the husband is spent as per his whims and fancies. The right of the family over this income and the right of the wife over her hard-earned money are conveniently ignored. The poverty and ill health of the wife is socially accepted as a norm in a similar way as the alcoholism and battering of the husband is sanctioned and justified. This is supported by the patriarchal notion that a woman begets violence because of her "own fault". Here the "fault" is the way the woman questions and protests the husband when he is too indifferent of the family needs. So, the solution is that if she doesn't want to be battered, then she should *keep silent* even when the last penny is taken away. Whatever sufferings she undergoes, it is not the concern of the society. It is always said that 'one can hate liquor and drinks but shouldn't hate a drunkard'. Thus, the rights of the drunkard to get love and concern are well protected while the rights of the wife and children to live a life of peace and happiness are violated and turned a blind eye on.

Physiological reasons like menstruation and associated PMS, pregnancy and associated bodily changes, delivery and associated postpartum depression, menopause and related depression and hormonal changes etc. can have their impacts on women's mental health and stress. But when compared to

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the physiological factors, the socio-cultural factors have an overwhelming influence. The socio-cultural factors that induce stress in men and women vary to a great extent. In the case of women, in addition to those factors creating stress in men, the discrimination and bias entrenched in the traditions and culture also serve as stressors. Unlike men, women face poor nutritional status and anemia due to poverty and cultural practices. Women's overwork and undernourishment often go hand in hand in modern society. Lack of basic facilities like toilet and restroom as well as sexual harassment at workplace cause physical discomfort and mental stress to women than their counterparts. Fear of the gender-based violence is also more of a women-specific stressor. Thus, there is an urgent need for a paradigm shift in the focus of discussions and research on women's stress from their physiology to the socio-cultural factors.

FEATURES OF GENDER-SENSITIVE COUNSELING

Gender-sensitive counseling rests on the premise that unequal power relations exist between men and women in society. It necessitates an understanding of the oppression and discrimination that women face in all spheres of life, its underlying reasons and the implications of the patriarchal system on women's lives. The wife who is reluctant to open up in presence of the husband, the adolescent girl silent about the sexual abuse she is facing, the wife sustaining in a battered relationship, a woman attempting suicide after poisoning her kids, all share the common mindset of helplessness and hopelessness. Those who attempt at resolving their issues must keep in mind the underlying reasons for this helplessness. Girls from their birth onwards face discrimination and marginalization; helplessness is induced in them during their upbringing by the family, media and other socialization agencies. At the time they reach adolescence, the dos and don'ts become so intense that girls develop an inferiority complex and low self-esteem. As a consequence, girls fail to discover their true identity and boys fail to accept the individuality of girls. The tendency to view women as mere bodies and to narrow their mental horizons to looks and dressing are further strengthened by the media.

Educated girls have to plea with their brothers, parents, husbands or in-laws to get permission for taking up careers. Political and religious leaderships are still denied to women in most parts of the globe. Marriage and motherhood are considered as inevitable in the lives of women which in the case of their counterparts are not insisted to the same extent. Hence unlike men and boys, these conditions contribute to stress and mental health issues to girls and women. It is such a context that is responsible for the lowest mental health profiles of Keralite women in a country like India. Despite their highest literacy, high educational standards, best physical health indicators comparable to the developed western countries and favorable overall sex ratio, the highest suicidal rates are reported among Keralite women who also are the largest users of antidepressants in the country (National Family Health Survey [NFHS-3], 2006). Socio-cultural reasons like the lack of assets, lack of control over earnings, lack of decision-making power, drinking habits of men, domestic violence and fear of violence as contributing to women's deteriorating mental health are often overlooked.

Gender-sensitive counseling implies looking at things and events through a gender lens that requires an understanding of women's lives in comparison with that of men's lives in the respective age group, class and caste. A woman's life is a journey full of stress from womb to tomb. The disciplining with regard to dressing-walk-talk-smile and laugh during childhood, matters related to menstruation-PMS, dress code, concept regarding beauty –fair skin and body shapes during adolescence, restricted career options, partially /permanently denied aspirations, over-emphasis of marriage, dowry demands and so

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on during early adulthood are sources of stress specific to girls and women. After marriage, pregnancy, childcare, homemaking and old-age care are some of the women-specific responsibilities entrusted by the culture in patriarchal societies. If she is a working woman the role conflicts related to managing personal and professional roles add up the stress in women (Seema & Kuruvilla, 2016).

Due to the gender division of labor and traditional gender role perceptions rooted in the culture, maintaining family integrity, serving as emotional buffer for all other members of the family, refining the husband when he goes wrong and ensuring happiness of all family members and relatives are all considered as responsibilities of women. But the very same women face the issues of lack of decision-making power, lack of income, lack of employment and economic independence and lack of property rights. The demands placed on women are too high and the entitlements and sanctions given to them are the minimal. In the counseling sessions especially while dealing with couples and families, convincing men and women about the unequal power relations and the social construction of gender pose major challenges to the counselors. The Indian society is undergoing a rapid metamorphosis where the traditional conceptualization of institutions like marriage and family undergo frequent changes and women have started to come out in large numbers to the work front. Nuclear families and living together are rapidly replacing joint families and arranged marriages. The concept of a dominant husband as head of the household is also getting outdated. These are all new challenges that upset the equilibrium of families in the 21st century as the transformation is only halfway, a good number of men and women have adopted progressive attitudes regarding gender roles and men –women relations; while a critical mass still hold on to their traditional beliefs related to gender relations (Seema & Kuruvilla, 2014). In situations where conflicts arise due to the lack of mutual respect or democratic relationship within families, gender-sensitive counseling becomes inevitable. Otherwise, the status quo will be maintained and the conflicts may get temporarily suppressed for an immediate recurrence.

In family counseling, a gender sensitized counselor also has much to do in generating awareness among parents regarding the need for equal socialization of their sons and daughters. Instances where the daughters are denied professional education and treated as liabilities while sons are sent to high fee structured professional colleges are common in patriarchal societies. Sen (2000) highlights seven major inequalities between men and women in South Asian countries with regard to natality, mortality, basic facilities, special opportunities, jobs and professions, ownership of land and assets and in responsibilities related to household chores. When the underlying reasons for these inequalities are analyzed, the role of family and the defective socialization get exposed. Kuruvilla and George (2015) conclude that by the time children reach the school at the age of five years, they might have imbibed all the patriarchal values from the family itself. The girl children are being socialized from the early childhood to be good wives and mothers, at the same time boy children are socialized in the extreme opposite manner, that is, to be independent winners in life (Kuruvilla &Valasseri, 2015). Here comes the need for awareness generation among parents for equal socialization of their wards. When a counselor is confronted with a situation of conflict among family members with a daughter arguing for higher education while parents insist on getting her married and the brother takes a stand of supporting her studies after marriage, the gender perspective of the counselor matters a lot, especially in supporting the girl and convincing the family members.

Girls and women need to be reminded of their inner power while boys and men must be enabled to accept their counterparts as equally capable. Research has proven how girls and women fall easy victims to traps in the cyber world and sex rackets in the real world. The underlying reasons include lack of awareness regarding one's human rights, safety issues in the society and ineffective implementation of the

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protective legislations for women's safety. Women who are unaware of their rights and entitlements need much of consciousness-raising and assertiveness training to enable them survive in a dynamic world. Here also a counselor with gender perspective will be in a better position to support girls and their families.

Gender-based violence is yet another major factor that accounts for the differential stress experienced by women, with a heavy toll on their mental health. Violence against women takes different forms from very subtle ones like discrimination, insult, avoidance etc. to extreme forms such as female feticide and infanticide, wife-beating, mental torture, sexual exploitation, rape, forced pregnancy, dowry deaths and bride burning. Women face harassment and violence within the four walls of home, on the roads, in buses and trains, at workplace and offices, the list is endless. The National Crimes Records Bureau of India (2016) reports an alarming rise in the crimes against women. As long as culture, religion and media support men and blame women for the violence meted out on them, the scope of a violence-free society will remain a distant dream. As a result, a woman is always expected to be cautious and vigilant even while travelling in a bus or a train, as she is blamed for provoking men and inviting harassment. Sexual abuse of the girl child, rape, dowry murder, domestic violence etc. are all causing physical and psychological trauma to women and impede their further development.

Studies from throughout the globe report incidents of domestic violence to be more common among people with mental disorders (Friedman & Loue, 2007; Golding, 1999; Howard et al. 2010; Hughes et al. 2012). In a population- based study in León, Nicaragua, after controlling for other factors, researchers found that abused women were six times more likely to report experiencing mental distress than non-abused women (Ellsberg et al, 1999). Likewise, in the United States, women battered by their partners are between four and five times more likely to require psychiatric treatment than non-abused women (Stark & Flitcraft, 1996). Trevillion, Oram, Feder, and Howard (2012) in their systematic review and meta-analysis on experiences of domestic violence and mental disorders in 41 cases found consistent evidence that both men and women with all types of mental disorders report a high prevalence and increased odds of domestic violence compared to people without mental disorder, with women more likely to experience abuse than men.

Bringing about changes in the mindsets of people is often suggested as the panacea to prevent gender-based violence. A gender-sensitive counselor will have a crucial role to play in bringing about such a change through consciousness raising of the aggrieved. Women blaming happens not only in the context of gender-based violence but also in every aspect of life. If a man becomes a drunkard or a criminal, his wife /mother is blamed for creating a hostile environment at home, when employed mothers face role conflict, they are blamed for the lack of time management, the parenting skills of the mother is questioned when the academic performance of adolescent children becomes poorer. There is cultural support in the form of quotes from great philosophers and writers and also verses from epics and scriptures to the women demeaning/blaming process. As a result, in the tradition-bound societies like that of India, girls and women become voiceless and space less. Gender-sensitive counselors should prevent the tendencies for blaming women and should aim at social changes through women's emancipation.

NEW ISSUES AND CHALLENGES IN COUNSELING

With the technological revolution and the Me Too campaign, counselors are confronted with numerous instances of self-revelation related to sexual abuse. Those feelings hitherto suppressed are being opened up, yet the women fail to adjust with the traumatic experiences.

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Issues Related to Sexual Harassment

Case 4: *Lena was abused several times by cousins and uncles while being a child but she realized the gravity of abuse when she grew up into an adult of 22 years and got exposed to the experiences of other women in the Me Too campaign. Both her parents are high professionals and little Lena was most often left alone with grandmother at home. Cousins and uncles used to come and go and the smart and cute baby girl was a doll to be abused by them. The girl didn't tell anybody out of fear since the abusers used to threaten her that she and her parents will be killed if she said this to anybody. At present when parents started seeking marriage proposals for her, she is utterly confused about eligibility for a marriage wherein chastity and purity of the bride are mandatory prerequisites of the tradition-bound society. She is also confused about whether to disclose the matter to boys who come up with proposals and proceed further only when they agree to marry a sexually abused girl. This is the trauma of majority of the Indian girls where the purity of the bride is highly acclaimed while the promiscuity of the bridegroom is not a matter of concern. Ms Lena's parents just like their counterparts cannot imagine of a self-choice marriage and are compelling her for an arranged marriage. When she expressed her wish to speak and get to better know the boy before the "pennukanal ceremony"(literally means seeing the girl), the parents of both sides opposed it.*

In tradition bound societies like India, arranged marriage is a still preferred practice and "Pennukanal" is an inevitable event in it. The boy with parents would visit the girl's family and meet the girl in the presence of her family members. In some families, the parents would let the boy and girl speak in privacy for a stipulated time if both of them like each other from the first looks. In other families parents let children to speak over the phone after the "pennukanal" and let them get to know each other. But in the majority of families, the marriage decision is based on parental choices of compatibility in class, caste, family status and economic background. Even boys and girls with higher education and international exposure, are pressurized to give in to the parental choices and preferences of their partners. This, in several cases, ends up in a divorce when the issue of mutual compatibility between the actual partners spring up, in six months, one year or more. Here the young couples are sent to counselors to seek help for 'adjusted compatibility'. This is a confronting situation for the gender-sensitive counselor, who cannot play the role of a mediator to resolve the issues amidst couples and keep them going for the sake of the children born from the marriage or for their family's prestige and the happiness of the related kith and kin. Keeping aside the peace and happiness of the partners, a life of 'adjusted compatibility' dominates the family scenario.

Managing Postpartum Depression

Postpartum depression is often regarded as a normal consequence of delivery and associated hormonal changes in a woman's body. Cross cultural studies are required to assess the extent of postpartum depression in women in developing and developed countries. In a developing country context with gender division of labor, a mother is bestowed with the nurturing of the baby from the time of birth. Breastfeeding and sleeplessness, caring the baby and taking care of herself, the young mother most often may have to take care of the family responsibilities also in nuclear families. Young fathers are kept outside the room of the mother and baby or are not permitted to be with them during the early days of delivery. In later days, after the 90th day or so, when the father stays with mother and baby, they are conditioned

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to believe that the baby is a mother's responsibility. In such instances, torn between responsibilities of the baby...its father and other family members, the young mother reaches a phase of helplessness- sleeplessness - and hopelessness and it is quite natural for her to lose control over her thoughts and actions and become depressed. Leaving the young mother to her "biologically determined destiny" is actually a great challenge and threat to her mental health. An analysis of the following case studies provides testimonies to this argument.

Case 5: *Lisa was a 24 year old postgraduate when she got married to a rich graduate businessman belonging to a family that had extreme son preference. She delivered a girl baby against the expectations of her husband and in laws. Her life went traumatic with all kinds of violence targeted against her as a punishment for giving birth to a baby girl. She was even denied food and minimum health care. Nobody dared to care for the baby also as it was an unwanted child of the family. The husband started to depend on alcohol to forget the fact that he had fathered a girl. The blames and punishments continued. The telephone was cut off and Lisa was not permitted to speak to friends and relatives in the family and neighborhood. She became thin, pale, depressed, gloomy and finally decided to commit suicide after killing the baby. But on that day, just in between her suicidal efforts she was stopped by an old friend who came there unexpectedly, who reminded her about her strengths and talents and the need to fight a life for herself and the baby. Now both are alive in such positions so as to fulfill their mission of empowering less fortunate girls and women around them.*

Here had Lisa got the usual care, support and warmth from her husband and family, she wouldn't have faced any depression. The unfriendly approach of the people around might be the major factor that resulted in the postpartum depression rather than the physiological factors.

Case 6: *Monica was a career oriented girl who got married at the age of 25 and was not planning to have a baby for the next three years. Pregnancy was a blow to her career as she had to quit the job at a distant place owing to acute morning sickness. In the beginning she used to hate her pregnancy which she had to carry on as per the pleas of her husband and parents. The warmth, care and emotional support from her husband and parents made the pregnancy and delivery a memorable event for her. She often says, "I was treated like a princess and I would always cherish those days". Immediately after delivery by the 60th day she started working, enjoying her mom- life on one side and the career on the other. Lactation and sleeplessness were not issues for her as the baby was well taken care of by the nanny at nights and Monica was left to sleep peacefully as much as she wanted immediately after feeding the baby.*

Had she not received the warmth and care during pregnancy and childbirth and afterwards, Monica would definitely have hated the whole events and succumbed to postpartum depression. The healthiest man or woman if subjected to sleeplessness for three or four consecutive days, will have the chance of developing depression. In the case of pregnancy and delivery, the physiological toll is aggravated by socio-cultural factors of mothering and caring of the infant. Equal parenting of children by both mother and father, is something unimaginable for majority of people in traditional societies like India. The young father can take care of all the baby's needs other than breast feeding, but in the name of traditions, he is denied the opportunity to love and care for the baby. The sole responsibility of the helpless infant along

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with other responsibilities of the young mother and lack of sleep and proper health supplements are major reasons for postpartum depression in several cases.

Issues Related to Menopause

Issues of ageing women are yet another domain that poses a confrontation for the 21st century counselors. The menopausal transition is often marked by somatic symptoms such as aches and pains, myalgia, fatigue, etc., physiological symptoms including vasomotor symptoms of hot flashes and night time awakenings, other symptoms like sleep disturbances, sexual arousal disorders, and urino-genital complaints, and psychological symptoms such as irritability, anxiety and low libido (Bungay, Vessey, & McPherson, 1980; Holte & Mikkelsen, 1991). Generally, practitioners attribute such depression to the decreased estrogen and decreasing libido among menopausal women. Life stressors such as marital issues, changes in caretaking (e.g., children departing the home for studies/employment/marriage, aging parents) or career responsibilities, issues related to aging, and feelings of being "overextended" also have been linked to perimenopausal depression (Rasgon, Shelton, & Halbreich, 2005).

As Hunter (1993) reports, the most relevant factors influencing a woman's quality of life during the menopausal transition are her previous emotional and physical health, her social situation, her experience of stressful life events (particularly bereavements and separations), as well as her beliefs about the menopause. Here except previous physical health all other factors are related to psychosocial aspects which in turn are either culturally defined and/or socially conditioned. Women are conditioned to believe and develop pessimistic attitudes about menopause and their families take it up as natural events in women's lives. Definitely the estrogen reduction has a toll on woman's health for which remedies are readily available, but the attitude of the woman herself and her family members need a reshaping. This is not properly addressed by the medical as well as counseling world. The overburden of providing caring and nurturing never ceases in the lifetime of most women, especially in the traditional societies noted for gender division of labor. This needs to be changed and if women start to get care and nurturing at least by the time they approach menopause and if it is continued, majority of menopausal depression could be easily addressed. Unfortunately, women are treated as lifetime health care givers and not as takers. Even the retired hands among baby boomer women turn out to be baby sitters of grandchildren and supporters and care givers of their adult children. Here comes the interventionist role of counselors in spreading the message on healthy transition during menopause among women themselves, their families and the society at large.

Grey Divorce Among Menopausal Women

With advanced health care services and health-seeking behaviors, the life expectancy of men and women is showing a positive trend. But the number of divorce seeking among women after menopause is also increasing. According to Brown and Lin (2012) regardless of educational attainment, the divorce rate for couples aged 50 and older (grey divorce) has doubled since 1990, and it has more than doubled for married individuals aged 65 and older. Also, more than 55 percent of grey divorces involve couples who were married for more than 20 years. Though reported in the U.S context, such a phenomenon is becoming more and more visible in the developing country context of India, which is noted for its low divorce rates. The impact of menopause on Quality of Life (QOL) is a consequence of social, physical and mental changes. It is highly visible that socio-economic and cultural factors influence the menopausal

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transition. But it varies from region to region, country to country according to the prevailing culture. Menopausal depression among women is highlighted by practitioners as a major reason for grey divorce. But the counseling experiences of the author with menopausal women reveal the uncompromising demands from the husband, children and in-laws for caring and nurturing, in the form of timely food and other services that have been strictly followed over the years hitherto, and the inability of ageing women to meet them as major reasons for dissatisfaction among the menopausal women which prompt them to seek divorce from the partner.

Case 7: *Aruna, aged 62 is worried about the indifference and inconsiderate attitudes of her daughter as a serious blow over her mental health and well-being. Sleeplessness is a major problem for her, and her health in general is deteriorating that doctors fail to diagnose but she is assured of her tensions and depression owing to the frustrations thrown upon her by the grown up, unmarried and unemployed daughter. Mother of the family often serves as an emotional buffer to husband and children. But at a time when her own health shows a declining trend, especially after menopause, she needs love and concern from family members or at the least other members must stop throwing over their emotional outbursts upon her.*

As suggested by Clayton and Ninan (2010), recognition of menopausal symptoms, with or without depression, and effective management are important, given their potential impact on quality of life. Majority of menopausal women complain about the unmet socio-cultural and familial demands as putting much pressure on their physical and mental well-being. A gender perspective is needed in such contexts to make positive interventions and affirmative mindset changes during counseling. In countries like India, massive awareness is to be generated on the aspects of menopause so as to facilitate happy aging especially of the women baby boomers.

LIMITATIONS AND FUTURE DIRECTIONS

This chapter is based on the counseling experiences of the author in the socio cultural and politico legal context of India, especially the state of Kerala. The seven case studies are taken from Kerala only. Also, case studies of transgender and other sexual minorities are not included in this chapter as they are discussed in detail in yet another chapter. But the literature review was undertaken on studies throughout the globe. The real-life experiences related to sufferings of women, share more commonalities than differences, irrespective of their class, caste, ethnicity, locale and similar factors. The purpose of this chapter is to highlight the gender insensitivity of the mental health practitioners and the overwhelming need of having a gender perspective in all- health practitioners, development scholars and policy makers. It is high time researches in the area of mental health need to focus more on the socio-cultural factors than the physiological factors. Stressors that affect men are equally applicable in the case of women also as both genders are coming up to share responsibilities in the public sphere with the private –public dichotomy getting narrowed each day. At the same time factors that cause additional stress to women need to be more exposed. The impact of gender-based violence on mental health of women though well studied in western countries, are few in the Indian context. More attention of the development scholars are inevitable in the mental health area.

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CONCLUSION

Stress is part of life in the 21st century and the counselors have an overwhelming role to play to enhance individual and societal health and ensure harmonious and peaceful coexistence in the society. Women's stress and low mental health are often associated with their anatomy and physiology in the world of counseling psychology. Hence a gender perspective is need of the day to redefine and restructure the knowledge constructed about women's psychology which in turn would have its corresponding changes in the counseling practices for a gender just society. A paradigm shift is inevitable in the theory of conceiving women's stress as induced by psychosocial factors rather than by biological reasons alone. The delay in such a conception has led to the wastage of much time and effort in stress research focusing on women's physiology. Women's issues take new dimensions and new forms with the changing trends of society. For instance, the new economic policy and the associated phenomena of liberalization, privatization and globalization have had multifaceted impacts on the lives of women, in quite different dimensions than that of men's lives. It also has differential effects on women belonging to different classes, castes and races. Positive impacts of digital era such as the internet and smart phones have been overshadowed by the negative impacts due to their misuse in the form of pornography, voyeurism, stalking, morphing and subsequent cybercrimes and have differential impacts on men and women.

Thus while considering women's mental health, the focus needs to be shifted from individual and "lifestyle" risk factors to the recognition of the broader, social, economic, and legal factors that affect women's lives. Hence there is an urgent need to evolve women-centered counseling practices using gender-sensitive guidelines and standards rooted in the socio-cultural, economic and politico-legal realities of the respective societies. It is high time that gender perspective be central to the conceptualisation of stressors and counselling practices. Gender sensitisation of counsellors is essential to develop proper gender role perceptions which in turn would facilitate gender sensitive counselling approaches also. Gender perspective must also be made a mandatory component in counselling courses.

To treat the root cause of women's mental health issues, quality education, employment and economic independence, active role in decision making, respect from the opposite sex, egalitarian gender relations, violence free society, adequate health care and above all elimination of gender disparities in every sphere of life, need to be ensured. While lack of gender equality forms a major cause for women's poor mental health, ensuring better mental health of women facilitate improved contribution of women towards sustainable development. Thus, engendering the theory and practices of mental health forms an inevitable strategy of women empowerment for sustainable development.

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KEY TERMS AND DEFINITIONS

Dowry: The money handed over to the bride by her parents at the time of marriage.

Grey Divorce: It is the split or separation of couples above 50 years, who have been married for a long time.

Menopause: It is the time in women's lives when menstrual periods stop permanently.

Morphing: It is a form of cybercrime in which the face of a girl or woman is adjusted with someone else's body.

Natality: Related to birth, where female fetus is prevented birth right through sex selective abortion.

Postpartum Depression: A form of clinical depression related to pregnancy and childbirth. It manifests as mood disorders with feelings of intense sadness, worry and exhaustion following childbirth.

Stalking: Refers to repeated harassing or threatening behavior by an individual, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, etc. It is a criminal offense in India.

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Chapter 11
Multi-Criteria Decision Making Semantic for Mental Healthcare

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ABSTRACT

Healthcare systems play an important role in the well-being of patients; however, the diagnostic process generates a very large and varied types of data which makes the process of analyzing this data very complicated. More precisely, depression, which is one of the most common psychological disorders, contains a taxonomy of different symptoms, heterogeneous, and varied by data criteria, as confronted by clinicians to predict the degree of the disorder in patients with the aim of selecting the best treatment. To this end, the authors propose a decision architecture based on an approach that combines method ontologies, the Analytic Hierarchy Process, in the context of the prevention and monitoring of depression trends in patients.

INTRODUCTION

In the health sector, the volume of data collected for each patient is very varied and important ; however, clinicians usually face problems with analyzing this data and extracting the criteria relevant for a diagnosis. On the one hand, and more specifically, in the field of mental health, depression is one of the main causes of mental illness (American Psychiatric Association, 2015); indeed, it is one of the most common psychological disorders. In fact, the World Health Organization (WHO) (2018) predicts

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that depression will become the main cause of mental illness in the next 15 years. According to WHO, depression is one of the priority pathologies targeted by the Mental Health Gap Action Program (mhGAP) (WHO, 2018). The purpose of this program is to help countries expand services for people with mental disorders. On the other hand, at public health institutions, like the University Hospital Center Mohammed VI in Marrakech "(CHU)," cancer patients require permanent support and follow up during their oncology care, because they face major constraints while suffering and undergoing treatment, and other psychopathological reactions and symptoms that are identical to depression. Indeed the problem is defined: how can clinicians decide and select in a solid and automatic way the symptoms of depression, compared to other psychopathological reactions of the cancer disease? Due to the large number of patients, it is difficult to consider all these parameters to develop a relevant prevention system. In addition, the constraint of missing, unstructured, and noisy data adds more challenges ; therefore, the selection of relevant and personalized criteria (symptoms) for each patient remains an arduous task. Indeed, the major challenge facing clinicians is the problem of analysis of knowledge at the patient level. Moreover, to the multitude of diagnostic protocols, because they are diverse criteria, therefore the degree of uncertainty among clinicians increases.

In recent years, decision-making in medicine has taken a very important place in the science of medical informatics; indeed many approaches and methods stemming from Artificial Intelligence, assistance systems to decision-making, and mathematical modeling techniques, are gradually being introduced into mental health (Brunelli, 2014), in order to help decision-makers and health professionals make informed decisions based on solid foundations (Aoki, Uehara, Kato, & Hirahara, 2016). It is in this context we adopted the multi-criteria decision method of the Analytic Hierarchy Process (AHP), which is an analytical approach to support decision-making according to a multi-criteria approach. Developed by Thomas Saaty, it is basically based on complex calculations (Aoki et al., 2016), in order to extract the relevant diagnostic criteria. In addition, we proposed a hierarchical ontological model based on domain ontology, in order to exploit the preferences of each user (extracted by the diagnostic sheet and the test), and to be able to promote the integration of heterogeneous knowledge. The ontologies represent a very reliable and structured source of knowledge, and are robust means to represent and exploit the data and the knowledge of a field, and, more particularly, that of the medical field. Our case study is the modeling of the pathologies of depression based on the opinions of clinical experts and the DSM (American Psychiatric Association, 2015). In this context, this paper presents the intelligent decision framework to automatically monitor and predict the level of depression in cancer patients, so that clinicians can make the best decision to ensure better patient monitoring and reduce the impact of their suffering from the disease on their psychology.

This document is organized as follows: Section 2 describes some related work; Section 3 describes the methods used in this study. In Section 4, we present in detail the proposed system, the experimentation, and the results obtained.

RELATED WORK

In a world whose complexity is rapidly growing, making the best decisions becomes an increasingly demanding task (Brunelli, 2014). Indeed, optimal and relevant decision-making is a difficult task in all areas, especially in the health field. Physicians face several challenges ; however, many intelligent

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methods from artificial intelligence, applied mathematics, and operational research is useful for helping decision makers make relevant decisions.

The ontologies are widely used in medical informatics and health care to standardize the vocabulary and share knowledge on a particular domain.

Therefore, in recent years, many researchers have proposed work and research in the field of health, especially mental health, to help doctors make the most relevant and accurate decision. For example, a recent study described a new approach for diagnosing anxiety and depression in young children (Mcginnis et al., 2018). Furthermore Aoki, Uehara, Kato, and Hirahara (2016) presented a study that sought to develop an evaluation index of rugby players' psychological competitive ability as their mental aspects. Moreover, other authors treat the noises depression based on statistic analysis algorithm for kerma area product meter design (Hsieh & Chen, 2018).

Besides, in recent years, much research has been based on systems of decision support, using the Analytic Hierarchy Process (AHP). On the one hand, Ran's (2011) paper applied the AHP for evaluating the energy-indicators system for sustainable development. On the other hand, Ouyang's (2017) paper presented an adaptive, vertical handover algorithm based on the Fuzzy Analytic Hierarchy Process (FAHP). And Hong and Yongsai's (2017) paper put forward a method for evaluating the rescue-priority level of power lines post-disaster based on the AHP. Jaglarz's (2018) study presented the bathroom as a place for health care by applying intelligent technology systems, including Internet of Things (IoT) technologies, in a bathroom space, and Carroll, Richardson, Moloney, Reilly, and Carroll (2017) described how to bridge health care education and technology solution development through experiential innovation.

This paper presents the intelligent decision framework for automatically predicting the level of depression in cancer patients. The added value of this work relies on the selection, in a robust and automatic way, the symptoms of depression, compared to other psychopathological reactions of cancer disease. It is based on the multi-criteria, decision-making AHP approach, so that clinicians can select the best decision, to ensure a better follow up of patients.

SYSTEM OVERVIEW

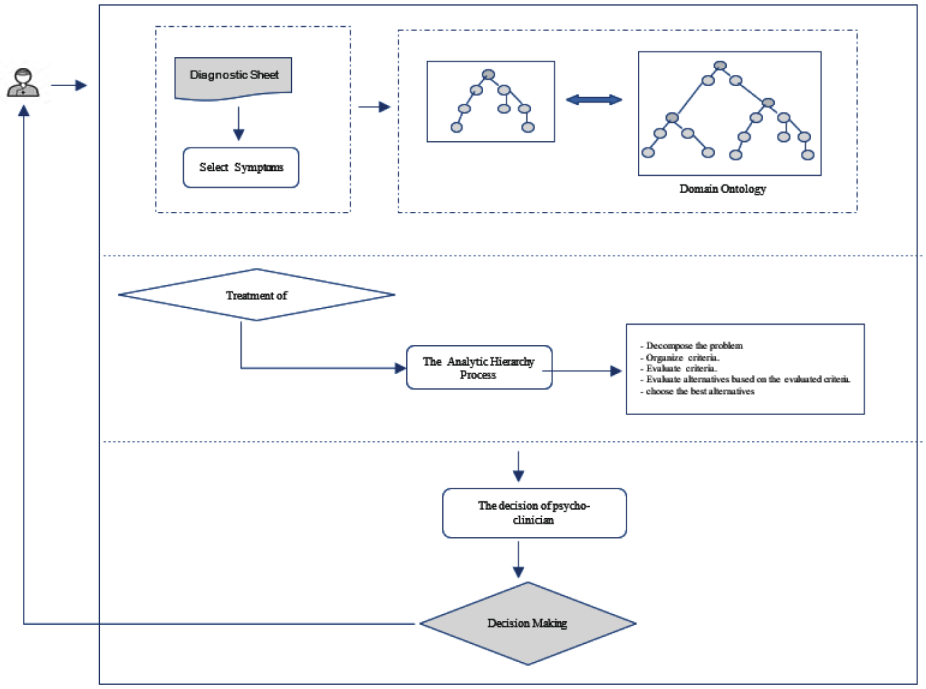
A medical-decision support system is an organized set of information, designed to assist the practitioner in his reasoning, with a view to identifying a diagnosis and choosing the appropriate therapy, by operating a dialogue between man and machine (Cléret, Le Beux, & Le Duff, 2001). However, the situation becomes complex when the decision maker faces choosing the best decision that best fits the patient context based on several criteria and alternatives.

On the other hand, in practice in public health—more specifically in oncology—clinicians and psycho-oncology practitioners face a constraint of automatically and rigorously distinguishing between the symptoms of depression and psychopathological symptoms that are identical to depression (which are reactions in the normal process of adaptation to cancerous disease). In this regard, this paper presents a decision support system. We opted for the AHP approach to help clinicians choose the best decision regarding the level of depression in order to ensure ubiquitous follow up of patients. We used the domain ontology in our case study, in order to standardize the vocabulary of the system and in order to improve and respond to the problems of heterogeneity and personalization of a diagnosis, adapted to the patient's symptoms.

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Figure 1 presents the proposed system steps for the purpose; we try to answer the problems encountered in practice within the "(CHU)" oncology and hematology center. On the one hand, regarding the data, the alternatives, and the criteria, we processed relevant data from the CHU diagnostic card to extract the main diagnostic criteria (we will detail them in Section 5); on the other hand, we used the AHP approach to choose the best alternative.

Figure 1. Architecture of the system



In this present work, we propose the architecture of the system, which is divided into three main steps:

Step 1: The collection of diagnostic criteria (symptoms) from a diagnostic CHU sheet.
Step 2: The representation of knowledge based on domain ontology.
Step 3: The treatment of symptoms based on the analytical approach AHP multiple criteria.
Step 4: Decision-making based on evaluation alternatives.

THEORETICAL BACKGROUND

Introduction to Analytic Hierarchy

At first, decision-making can be defined as a series of cognitive processes including evaluation, comparison, reasoning, and selection of possible alternatives (Jaglarz, 2018), based on relevant information, and optimized by maximizing utility Marwala (2014). Moreover, the AHP is a decision-support model

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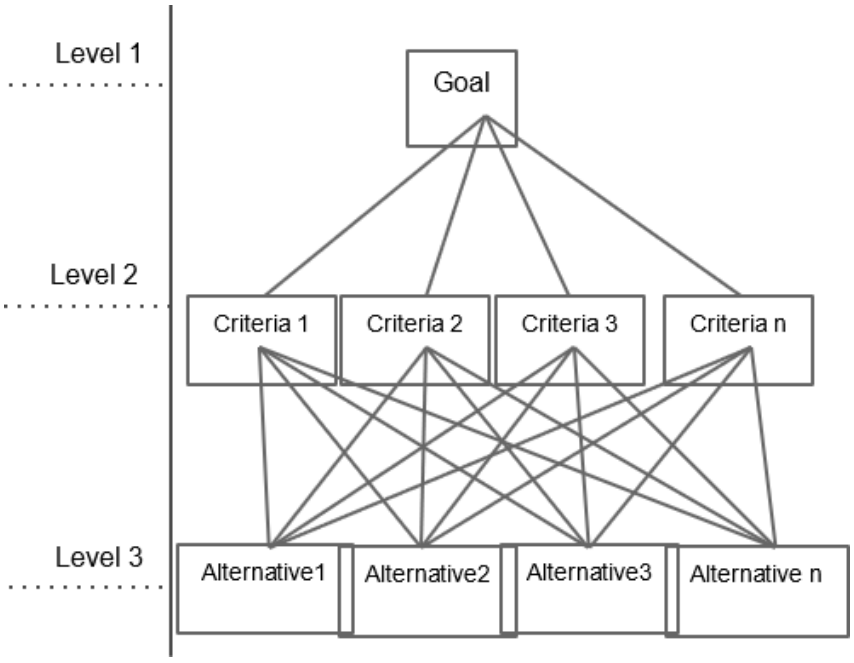
developed by Thomas L. Saaty of the University of Pittsburgh (Hong & Yongsai, 2017), which supports decision-making with a multi-criteria approach. The selection of a solution among alternatives, according to a certain number of criteria, when the decision maker has many evaluation criteria (Ran, 2011), is fundamentally based on complex calculations.

This method has been used in several areas, such as transport planning, energy rationing, risk management projects, comparative analysis of logistics operations, and quality management of services in hospitals, allowing users to decompose a complex problem in a hierarchical system (Brunelli, 2014). The hierarchical ranking of alternatives and criteria is defined by the decision maker.

The execution of the AHP method is based on the following main steps (Brunelli, 2014; Saaty, 1980):

1. Decompose down the problem by building a next hierarchy (see Figure 2). Determine the goal, criteria, and alternatives;
2. Define the weight of each criterion according to its priority, based on the Saaty scale (Saaty, 1980) (see Table 1), comparing in pairs each criterion; the second comparison is between the alternatives with respect to each criterion. Table 1 shows the different weights of the Saaty scale and their linguistic significance;
3. Determine an overall ranking of the alternatives related to the main objective of the decision, by calculating the weight of each alternative in relation to the criteria.

Figure 2. Structure of analytic hierarchy process



We present, in the following section, the experimental study of the AHP approach in our decision framework, related to the decision of degree of depression in cancer patients, in the oncology and hematology center of the University Hospital of Marrakech.

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Table 1. Linguistic variable scales

Saaty's Scale	Linguistic Meaning
1	Equal important
3	Moderately more important
5	Strongly more important
7	Very strongly important
9	Extremely more important
2, 4, 6, 8	Intermediate values of importance
Inverse	If, for activity "i" gets one number over activity "j," then "j" has its opposite value than "i"

Ontology

Ontology is a central concept of the semantic Web (Benfares, Idrissi, & Hamid, 2019). An ontology formally defines a common set of terms and concepts that are used to describe and represent a domain. An ontology is domain specific and is used to describe and represent an area of knowledge. There is another level of relationship expressed using a special group of terms: properties. An ontology is a representation of general properties of what exists in a formalism allowing automatic processing Kouame, A. (2018).

A domain ontology describes the terminology and relationships between terms in a specific domain. The ontologies can be written in different programming languages, to provide a formal description of concepts, terms, or relationships of any domain (Benfares et al., 2019). These languages are RDFS (Resource Description Framework Schema) and OWL (Web Ontology Language) (Benfares, Bouzekri, Idrissi, & Abouabdellah, 2017).

We used the ontology in our system to normalize the vocabulary of the system in order to improve and respond to the problems of heterogeneity and personalization of a diagnosis adapted to the patient's symptoms.

EXPERIMENTAL STUDY: DECISION-MAKING SEMANTICS FOR DETERMINE THE LEVEL OF DEPRESSION

In the present work, we present a model for smart decision-making, one side was based on relevant data from the Oncology and Hematology Center Hospital, and on the other side, we opted the AHP approach to help clinicians make a better decision. As we showed in the preceding section (system overview), to determine the criteria and alternatives forthe implementation of the approach in our case study, we used a diagnostic CHU sheet.

Ontology-Based Approach

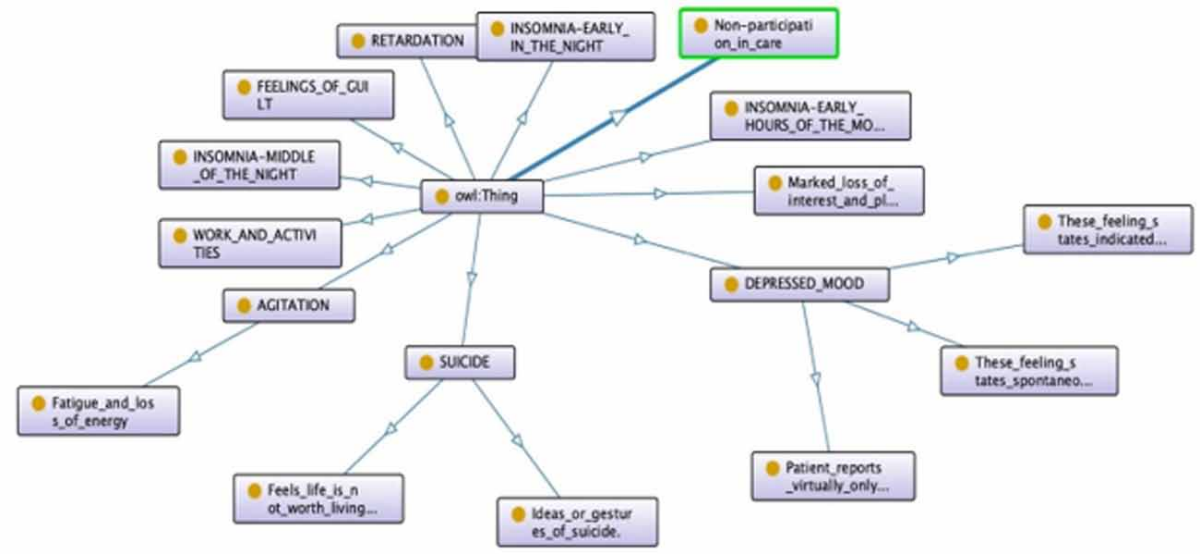
In this section, we present the ontology-based case study model. Knowledge modeling and representation is based on domain ontology, with the aim of facilitating and guaranteeing cooperation between clinicians and the diagnostic system. We used the ontology language OWL (Web Ontology Language) (a

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language used to define and instantiate Web Ontologies), because it allowed us to represent and exploit the knowledge of a domain in a very robust way.

In this work, we used Protégé (an open-source ontology editor and knowledge management system that provides a graphic user interface to define ontologies) ; we use a simplified ontology of symptoms of depression as shown in Figure 3.

Figure 3. Concept description from an "Ontology model of symptom"



The patient profile contains all the information necessary to design a relevant diagnosis, in order to personalize it. The patient profile contains personal data and the test information.

Decision-Making-Based on the AHP

In this section we describe all the steps involved in executing the Analytic Hierarchy Process approach in our decision framework as defined in the previous section:

1. Figure 3 presents the problem of hierarchy in our case study on the best alternatives in decision-making regarding the degree of depression in cancer patients:
   a. **The Goal:** Predict the degree of depression most appropriate for a certain patient;
   b. **Criteria:** Extract all the relevant criteria, based on the diagnostic sheet; they present the symptoms of depression. Table 2 shows the different criteria used in our case study;
   c. **Alternative:** Present the possible alternatives related to the degree of depression. Table 3 shows all the alternatives used in our case study.

The steps we followed from the AHP method (Brunelli, 2014) are as follows:

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Step 1: Decompose the problem and define the hierarchy.
Step 2: Establish the comparison judgment matrices.
Step 3: Determine the priority of each matrix.
Step 4: Calculate the 'Consistency Ratio' of each matrix.
Step 5: Derive 'Consistency' from judgments.

Tables 2 and 3 show the code for each criterion, and each alternative.

Table 2. Table code of criteria

Criteria	Code
Recurrent thoughts of death/suicide	S 1
Non-participation in care	S 2
Insomnia almost every day	S 3
Fatigue and loss of energy	S 4
Marked loss of interest and pleasure	S 5

Table 3. Table code of alternative

Alternative	Code
Mild depression	A 1
Moderate depression	A 2
Severe-moderate-depression	A 3
Severe depression	A 4

Comparisons Between Criteria

The first comparison matrix (see Table 4) between the criteria and the clinician (expert in psychology) evaluates each criterion based on its importance, using linguistic terms, which are then associated with real numbers; we based these on the scale of Saaty (see Table 1).

Table 4. Table comparison matrix between criteria

	S1	S2	S3	S4	S5
S 1	**1**	1/3	2	2	5
S 2	3	**1**	1	3	3
S 3	1/2	1	**1**	2	3
S 4	1/2	1/3	1/3	**1**	**2**
S 5	1/5	1/3	1/3	**1/2**	**1**

Eigenvector Calculation

After the establishment of the judgment matrices, the crucial step of the AHP is to derive a priority vector (see Table 5) for each pairwise comparison matrix. The most popular method for estimating a priority vector is that proposed by Saaty (Brunelli, 2014).

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Table 5. Table priority between criteria

	S1	S2	S3	S4	S5	Priority
S1	1	1 /3	2	2	5	0.264
S2	3	1	1	3	3	0.337
S3	1 /2	1	1	2	3	0.218
S4	1 /2	1 /3	1 /3	1	2	0.107
S5	1 /5	1 /3	1 /3	1 /2	1	0.069

Calculate Consistency Ratio

The consistency ratio (CR), is the rescaled version of consistency index (CI), given a matrix of order n. CR can be obtained by dividing CI by a real number (random index) (Brunelli, 2014):

$CR = \frac{CI}{RI_n}$; CI is Consistency Index

RI_n; Random index was developed by Saaty (see Table 6)

The calculation of the value of consistency ratio is more important, to show the coherence of the judgments of the calculated matrix. For this purpose, the value of (CR) must be less than 0.1 (10%) for the matrix to be consistent (Brunelli, 2014).

Calculate Consistency Index

CI is obtained from a large enough set of randomly generated matrices of size n. The values estimated for are shown in Table 5. The coherence index is calculated by the equation below:

$$CI = \frac{\lambda_{\max} - n}{n - 1}$$

n = number of criteria

Calculate Eigenvalue λ_{max}

The next step is to calculate the eigenvalue λ_{max} of each matrix. The elements of the vector of the weighted sum are divided by the corresponding priority for each criterion.

The λ_{max} value of the comparison matrix between the criteria of our case study is as follows:

$\lambda_{max} = 5.434$

In our case study, the calculation of the consistency of judgment between the criteria is as follows.

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Table 6. Random coherence index of Saaty

Number of Criteria	1	2	3	4	5	6	7	8
RI_n	0	0	0.58	0.90	1.12	1.24	1.32	1.41

The value of the eigenvalue is:

$\lambda_{max} = 5.434$

Consistency Index:

$$CI = \frac{\lambda_{\max} - N}{N-1} = \frac{5.434 - 5}{5-1} = 0.108$$

$RI_n = 1.12$

We have five criteria, so:

$$CR = \frac{0.108}{1.12} = 0.096$$

Regarding the consistency ratio, we conclude that the value of CR = 0.096, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

The following section presents the matrices of judgment, comparisons between the alternatives and each criterion, and the results of the priority and the consistency of each comparison matrix.

Comparisons Between Alternatives With Report to Each Criterion

We established the comparison judgment matrix between the alternatives, with respect to each criterion, by calculating the priority vectors, the coherence index, and the coherence ratio in order to check the consistency of the judgment.

The first comparison matrix between alternatives relative to the symptom 4 criterion is shown in Table 7.

We conclude that the value of CR = 0.055, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

The second matrix presents the comparison between the alternatives versus the symptom 5 (marked loss of interest and pleasure), as shown in Table 8.

We conclude that the value of CR = 0.056, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

The third matrix presents the comparison between the alternatives versus the symptom 2 (non-participation in care), as shown in Table 9.

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Table 7. Comparison matrix between alternatives according to symptom 4 (fatigue and loss of energy)

Symptom 4	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Severe-Depression	1	2	2	2	0.379
Severe-moderate-depression	1 /2	1	2	3	0.292
Moderate-depression	1 /2	1 /2	1	3	0.212
Mild-depression	1 /2	1 /3	1 /3	1	0.114
λ_{max}= 4.15		RI_n=0.90	$CR = \frac{CI}{RI_n} = \frac{0.05}{0.90} = 0.055$		CR= 0.055

Table 8. Comparison matrix between alternatives according to symptom 5 (marked loss of interest and pleasure)

Symptom 5	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Severe-Depression	1	3	4	4	0.519
Severe-moderate-depression	1 /3	1	3	2	0.240
Moderate-depression	1 /4	1 /3	1	2	0.135
Mild-depression	1 /4	1 /2	1 /2	1	0.102
λ_{max}= 4.153	$CI = \frac{\lambda_{max} - n}{n-1} = 0.051$	RI_n=0.90	$CR = \frac{CI}{RI_n} = \frac{0.051}{0.90} = 0.055$		CR = 0.056

Table 9. Comparison matrix between alternatives according to symptom 2 (non-participation in care)

Symptom 2	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Severe-Depression	1	2	3	5	0.458
Severe-moderate-depression	1 /2	1	3	3	0.29
Moderate-depression	1 /3	1 /3	1	4	0.174
Mild-depression	1 /5	1 /3	1 /4	1	0.074
λ_{max}=4.200	$CI = \frac{\lambda_{max} - 4}{n-1} = 0.066$	RI_n=0.90	$CR = \frac{CI}{RI_n} = \frac{0.066}{0.90} = 0.074$		CR= 0.074

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We conclude that the value of CR = 0.074, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

The fourth matrix presents the comparison between the alternatives versus the symptom 3 (insomnia almost every day), as shown in Table 10.

We conclude that the value of CR = 0.033, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

The fifth matrix presents the comparison between the alternatives versus the symptom 1 (recurrent thoughts of death/suicide), as shown in Table 11.

Table 10. Comparison matrix between alternatives according to symptom 3 (insomnia almost every day)

Symptom 3	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Severe-Depression	1	1	3	2	0.331
Severe-moderate-depression	1	1	4	5	0.429
Moderate-depression	1 /3	1 /4	1	3	0.154
Mild-depression	1 /2	1 /5	1 /3	1	0.083
λ_{max}= 4.09	$CI = \frac{\lambda_{max} - 4}{n-1} = 0.03$	RI_n=0.90	$CR = \frac{CI}{RI_n} = 0.0333$		CR = 0.033

Table 11. Comparison matrix between alternatives according to symptom 1 (recurrent thoughts of death/suicide)

Symptom 1	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Severe-Depression	1	1	5	7	0.440
Severe-moderate-depression	1	1	3	5	0.333
Moderate-depression	1 /5	1 /3	1	3	0.126
Mild-depression	1 /7	1 /5	1 /3	1	0.057
λ_{max}= 4.07	$CI = \frac{\lambda_{max} - 4}{n-1} = 0.023$	RI_n=0.90	$CR = \frac{CI}{RI_n} = 0.025$		CR = 0.025

We conclude that the value of CR = 0.025, so CR ≤ 0.1 or (CR ≤ 10%). So the degree of consistency of comparison is consistent (acceptable).

After establishing the criteria comparison matrix and calculating the weights, the last step is to calculate the weight of the alternatives. We used the following formula to determine a global ranking of the alternatives (the final weight for a given alternative is calculated as follows). Therefore, the goal is yielded by the best alternative score (Priority):

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$$S_i = \sum_{i=1}^{N} w_j \times e_{ij}$$

N is the number of criterion.

Table 12. Ranking of the alternatives

	Severe-Depression	Severe-Moderate-Depresion	Moderate-Depression	Mild Depression	Priority
Symptom 1	0.44	0.33	0.126	0.057	0.264
Symptom 2	0.458	0.29	0.174	0.074	0.218
Symptom 3	0.331	0.429	0.154	0.083	**0.337**
Symptom 4	0.379	0.292	0.212	0.114	0.107
Symptom 5	0.519	0.24	0.135	0.102	0.069

In this case study, we have relied on the techniques of the AHP method to provide a solution that exactly fits our problem of uncertainty about the choice of the best and relevant alternative. For this purpose, we have established the problem hierarchy of decision-making on the degree of depression, precisely in patients with "(CHU)" cancer at the Marrakech Oncology and Hematology Center. We applied the AHP multi-criteria analysis method, so that clinicians can make the best decision, in other words, choose the best alternative, to address the problem of distinguishing between the criteria of depression and other psychopathological reactions of cancer. In this study, we have studied five criteria and four alternatives, we have calculated the priority and the consistency ratio for each comparison matrix, and the results have agreed and are consistent, and all the judgments are logical and consistent, since the AHP relies fundamentally on complex calculations (Table 12).

CONCLUSION

The goal of the health systems is to ensure patients are followed up with in an intelligent way and to improve the diagnostic care to minimize the risks of the patients in terms of follow up and prevention. In this regard, in this work, we proposed a decision support system in the context of the prevention and prediction of the degree of depression in cancer patients in the oncology and hematology center of the University Hospital Center. An analytic hierarchy process analysis was used to evaluate the criteria and alternatives, and we used five criteria in this case study. In addition, we developed an ontology model to represent knowledge in order to capture the symptoms of each patient in a relevant way. The results of the simulation show that the model is weak and has provided satisfactory results.

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Chapter 12
mHealth as Tools for Development in Mental Health

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ABSTRACT

This chapter provides an assessment of studies on mobile health (mHealth) tools for development in addressing diseases relating to mental health, informs the current publications trends, identifies research gaps in the existing literature, and suggests a future research agenda that can help address these gaps. We, therefore, assessed empirical studies using a Systematic Mapping Study approach. We searched five academic databases as well as Google Search Engine and Google Scholar. Based on the inclusion and exclusion criteria, 54 full-text papers were included in this chapter. The findings suggest a growing trend in the use of various mHealth tools for mental health, such as mobile apps and text messaging. The findings also suggest that the responsibility of health monitoring and management can be shared between the medical practitioner and the patient in mental healthcare. Research gaps were identified and areas for future research are proposed.

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INTRODUCTION AND BACKGROUND

Mental Health

The World Health Organization (WHO) (2014) defines mental health as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." However, several conditions can greatly impact on the mental health of a person, including mental illnesses such as depression (Hellman, 2018), post-traumatic stress disorder (PTSD) (Bisson et al., 2015), schizophrenia (Rasool et al., 2018) and psychosis (Chan, 2017). Mental health is a serious health issue; however, countries have paid little attention to the burden of mental health (Tomlinson & Lund, 2012). Russell and Patrick (2018) emphasize the importance of addressing mental health issues as these cause a financial strain on health systems.

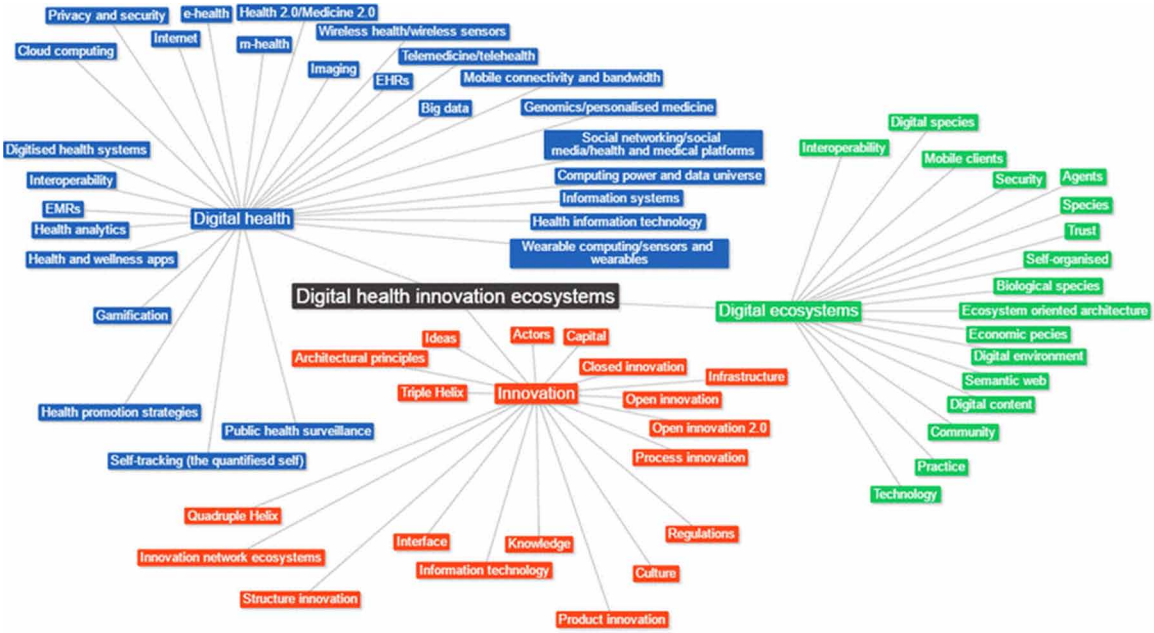
One of the United Nations' Sustainable Development Goals (SDGs) is to ensure that populations of the world live a healthy life as stated in the SDG 3, to maintain "good health and well-being" (United Nations Development Programme, 2016). To achieve these goals, countries have taken innovative approaches. Some efforts include the use of technologies in diagnosing, managing and aiding the treatment of diseases (Hoffmann & Svenaeus, 2018). Iyawa, Herselman and Botha (2017a) propose Digital Health Innovation Ecosystems as a practical approach for meeting these goals. Digital Health Innovation Ecosystems emphasize the use of digital health technologies in the delivery of healthcare services where both patients and key healthcare stakeholders interact in a digital platform with evidence of the "principles of innovation" (Iyawa et al., 2016a; 2017d, p. 433).

Iyawa et al. (2016a, p.249) define Digital Health Innovation Ecosystems as a "a network of digital health communities consisting of interconnected, interrelated and interdependent digital health species, including healthcare stakeholders, healthcare institutions and digital healthcare devices situated in a digital health environment, who adopt the best-demonstrated practices that have been proven to be successful, and implementation of those practices through the use of information and communication technologies to monitor and improve the wellbeing and health of patients, to empower patients in the management of their health and that of their families." This definition suggests that all healthcare stakeholders are involved in the healthcare process which includes both medical practitioners and patients. Involving patients in healthcare delivery processes have shown to improve health outcomes (Vahdat et al., 2014). While Herselman et al. (2016) advocate for a Digital Health Innovation Ecosystem for South Africa, Iyawa et al. (2017b) validate the components of a Digital Health Innovation Ecosystem in Namibia and present a framework for implementing such an ecosystem in the Namibian context (Iyawa, 2017c). Other studies on Digital Health Innovation Ecosystems highlight the benefits of implementing such an ecosystem. Some of the benefits include the sharing of information between healthcare stakeholders such as patients and doctors and improved healthcare services (Iyawa et al., 2017b; Iyawa et al., 2019).

Digital Health Innovation Ecosystems are important in ensuring that patients are involved in the healthcare process through digital health technologies with innovative approaches. Iyawa et al. (2016b) present the components of a digital health innovation ecosystem which includes digital health, innovation and digital ecosystems as shown in Figure 1. An example of digital health technologies is the use of mobile technologies for healthcare purposes (mHealth) as shown in Figure 1 (Iyawa et al., 2016b). The focus of this chapter is on applying a component of Digital Health Innovation Ecosystems, mHealth, for mental healthcare and explore how different healthcare stakeholders such as patients and medical practitioners make use of mHealth as tools for development in mental health.

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Figure 1. Components of a digital health innovation ecosystem (Iyawa et al., 2016b)



mHealth

mHealth is an element of digital health and Digital Health Innovation Ecosystems, which leverages mobile technologies in the provision of healthcare services (Botha & Booi, 2016; Vesel et al., 2015). While other definitions of mHealth suggest that mobile technologies and devices are included in the provision of healthcare services (WHO's Global Observatory for eHealth (GOe), Istephanian, Jovanov and Zhang (2004) explain that mHealth is not just about the application of mobile devices for health care but the application of sensor technologies as well. Sensors in mobile devices have provided a new dimension in improving the health and well-being of patients. Application of mobile technologies in improving the health of patients include the use of mobile phones for educating pregnant and postpartum women (Su et al., 2016; Alam et al., 2017; Iyawa & Hamunyela, 2019), the use of mobile phones for health promotion (Kaplan and Stone, 2013) and apps that aid identification of diseases (Jutel & Lupton, 2015). mHealth encompasses a wide range of mobile technologies including low-end tablets (O'Donovan et al., 2018), mobile phones (Zimic et al., 2009) especially in developing countries where the majority of the population may not have access to sophisticated mobile technologies. For the purpose of this study, mHealth is defined as the use of any mobile device including mobile phones, smartphones, mobile or phone-based sensors for providing and receiving healthcare services such as healthcare monitoring, diagnosis, management and prediction of diseases. One of the reasons why mobile technologies have been adopted for healthcare is the rapid expansion of mobile phone access worldwide, including in low-income countries (Davey & Davey, 2014). With this growing potential, mobile technologies have been adopted in the healthcare sector for health care purposes.

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mHealth and Mental Health

mHealth has been used to monitor and support mental health and mental illnesses. For example, managing mental disorders such as depression (Carswell et al., 2018), psychosis (Stamate et al., 2017), and schizophrenia (Ben-Zeev et al., 2016). Recently, there has been an increase in the use of mobile technologies in providing care to patients. From healthcare service delivery (DeSouza et al., 2015) to diagnosis and monitoring of diseases (Alepsis & Lambrinidis, 2013), mobile technologies have been incorporated in healthcare. One reason for the adoption of this technology is the accessibility of mobile technologies by a considerable proportion of the population, especially in rural and medically underserved communities (Sylvester, 2016; Afolayan et al. 2015). Campbell et al. (2015) also found that mobile phone usage among people with mental health issues was high and also recommended the use of text messaging as a technique to support patients with mental health problems. Despite reviews summarizing and evaluating these technologies in mental healthcare (Sedrati et al., 2016; Chandrashekar, 2018), there is still no study focusing on the current trends in publications of mHealth tools for mental health. This mapping study is useful in identifying research gaps in the literature regarding the use of mobile technologies in mental health and developing a future research agenda. This chapter provides an assessment of studies of mHealth tools for mental health conditions, assesses the current publications trends, researches gaps in the existing literature and identifies future research agenda that can help address the gaps identified.

RESEARCH QUESTIONS

For the main objectives to be achieved, the following research questions were posed:

- What are the publication trends in mental health mHealth research over the last decade?
  - This question aimed to investigate how many papers have been published on the application of mHealth tools for mental health purposes within the last ten years.
- In what ways are mHealth tools being used to address mental health issues?
  - This question aimed to investigate the different mental illnesses in which mHealth tools have been applied and how these technologies are being applied.
- What are the different types of mHealth technologies and applications that have been employed in mental health interventions?
  - This question aimed to investigate various mobile technologies and tools that are being used for mental health interventions.
- In what settings have mobile technologies been used in mental healthcare interventions?
  - This question aimed to identify the different settings in which mHealth has been applied in mental health.
- What are the main publication outlets for publishing research on mHealth for mental health?
  - This question aimed to identify the main publication outlets for publishing research on mHealth for mental health

A systematic mapping study approach was used to achieve the main aim of this chapter. Hence, this chapter contributes to the literature on mHealth for mental health by mapping out current trends of published research on the subject.

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This chapter is structured as follows: the research methodology is presented in the next section. Then, results and discussion of the findings are presented. Finally, this chapter concludes with recommendations and future work.

RESEARCH METHODOLOGY

The systematic mapping study review method was applied to assess mHealth studies in mental health. Other review methods have been used to assess empirical studies in mental health. Examples include, systematic literature reviews of mHealth for mental health services (Aldridge & McChesney, 2018; Karasouli & Adams, 2014), scoping review of the mental health of immigrants (Guruge & Butt, 2015; Goldner et al., 2015) and critical review of mental health policies (Wong et al., 2014). A systematic mapping study aims to "map out and categorize existing literature on a particular topic, identifying gaps in research literature from which to commission further reviews and/or primary research" (Grant & Booth, 2009, p. 97). Systematic mapping reviews have been conducted in different fields including wearable technologies (Iyawa, Velusamy, & Palanisamy, 2019) and software engineering (Petersen et al., 2008). The concept of systematic mapping reviews is to explain the trends of particular research (Grant and Booth, 2009) and is in line with the objective of this chapter. As such, the systematic mapping review was the appropriate methodology to apply in this context.

This systematic mapping review adopted guidelines for conducting systematic mapping studies as outlined by Petersen et al. (2008). This will be detailed in the subsequent sections.

SEARCH FOR RELEVANT PAPERS

Data Sources

We searched five academic databases, namely, IEEE Xplore, ScienceDirect, PyschINFO, Scopus and ACM. We also searched Google Scholar and Google Search engine. A total of 3887 papers were retrieved. After the removal of duplicate records, 3252 papers were identified. We conducted the search in three phases, title, abstract and full-text. We first searched for relevant titles and removed papers with an irrelevant title. In this process, 1822 papers were excluded. 1430 papers remained. These abstracts were read for relevance. In this process, 803 papers were removed. 627 full-text articles were analysed and based on inclusion and exclusion criteria, 54 relevant papers were included in this study. We conducted the search from February 2019 to April 2019.

Inclusion and Exclusion Criteria

- We included papers on mHealth specifically focusing on mental health
- We included articles published between 2009 and 2019
- We included journal articles and conference papers

Our exclusion criteria are listed as follows:

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- We excluded papers not written in English
- We excluded papers with mental health focus outside the context of mHealth
- We excluded papers which are not explicitly focused on the mental health of patients
- We excluded Masters and PhD theses

RESULTS

RQ 1: What are the Publication Trends in Mental Health mHealth Research over the Last Decade?

The findings show, in general, an increase in publications in mHealth for mental health research over the past decade. For example, in the first 5 years (2010-2015 inclusive), we retrieved 18 papers relevant to our study and in the second 4 years (2016-2019 inclusive), we retrieved 36 papers relevant to our study. For 2019, we retrieved data published till April 2019. The publication trends of mHealth studies on mental health are illustrated in Figure 2.

Figure 2. Publication trends in the last decade



RQ2: In What Ways are mHealth Being Used to Address Mental Health Issues?

The literature suggests that mHealth tools and technologies including mobile phones, smartphones, and mobile apps have been used to provide a variety of mental health services. The subsequent sections of this chapter explain the different ways mHealth is being applied to address mental health issues.

Determining the Mental State of a Patient

Mankodiya et al. (2013) assessed the feasibility of assessing emotions and the mental state of patients through the use of a smartphone camera to determine the presence of mental illnesses as early as possible. Chow et al. (2019) piloted the use of mobile apps to support the mental health of patients with breast cancer. Epp et al. (2011) developed a mobile app to support nursing trainees in understanding the processes of assessing the mental state of a patient. An evaluation of the app revealed that it improved nursing students' learning.

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Treatment of Patients With Dementia

Laird et al. (2018) evaluated the use of a mobile app to support patients living with dementia and the study found that it improved the mental health of these patients.

Early Prediction, Prevention, and Treatment of Depression

mHealth tools such as mobile apps have been used for treating depression (Osma & Plasma, 2014). Mobile apps have also been used to facilitate healthy living in patients with depression and diabetes (Hartzler et al., 2016) as well as support postnatal mothers suffering from depression (Sawyer et al., 2018). Apart from mobile apps, other techniques such as short message service (SMS) and text messaging have been used for the early prevention of depression and violence in young people (Chu et al., 2018; Ranney et al., 2018). A study by Lipschitz et al. (2019) shows that mobile apps can be easily adopted for the treatment of depression. Burns et al. (2011) developed a mobile app based on machine learning algorithms to predict the mood of patients, as such, predict depression in patients.

Suicide Prevention and Monitoring

Indigenous mobile apps have been designed and developed for specific communities in Australia, such as the Aboriginals for suicide prevention (Larsen et al., 2015). Nuij et al. (2018) investigated the possibility of using mobile phones to monitor patients that are at risk of suicide.

Treatment of Bipolar Disorder

Torri et al. (2015) explored the requirements of a mobile app to support the treatment of bipolar disorder. Sensor-based mHealth approaches have been used to monitor diseases such as bipolar disorder and depression (Seppala et al., 2019). Menon et al. (2018) evaluated the use of text messaging to ensure patients with bipolar I disorder take their medication. Prociow and Crowe (2010) utilized a mobile app to facilitate self-monitoring of patients with bipolar disorder.

Detection, Prediction, and Management of Psychosis

Smartphones (Stamate et al., 2017) and smartphone apps (Niendam et al., 2018) have been used to detect psychosis and report mental health symptoms of young patients with psychosis. Niendam et al. (2018) evaluated the use of smartphone apps to report health symptoms of young patients with psychosis. Välimäki et al. (2012) evaluated the Mobile.Net short message service (SMS) as an intervention to improve treatment for people with schizophrenia. The impact of the intervention is that it allowed customized messages to facilitate medication adherence and follow-up.

Maintaining Mindfulness

Maintaining mindfulness is one of the goals of researchers working on technology to support mental disorder. For example, Sanchez et al. (2015) developed a mobile app to help older people maintain mindfulness, while Wolf et al. (2016) investigated user actions on their phones to determine mindful-

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ness in depressed patients. Garcia et al. (2017) also developed an app to train people on mindfulness and improve their mental health. Lee and Jung (2018) evaluated the effectiveness of a mindfulness-based app ("DeStressify") to support university students with mental health challenges.

Monitoring and Management of Patients with Schizophrenia

Ben-Zeev et al. (2016) found that mobile phones can be used by clinicians to engage patients in the management of schizophrenia in distant locations. Wang et al. (2016) evaluated crosscheck, a mobile app for the early detection of schizophrenia.

Monitoring Patients with Parkinson's Disease

Cancela et al. (2016) proposed the development of a mobile app to support different specialists in monitoring patients with Parkinson's disease.

Monitoring of Anxiety

Lipschitz et al. (2019) indicate that patients are willing to use mobile apps for monitoring of anxiety. mHealth tools have also supported patients suffering from anxiety. For example, Firth et al. (2017) presented the use of smartphones to alleviate anxiety. Some mobile apps have been developed to support patients with anxiety, for instance, Stoll et al. (2017) and Almadovar et al. (2018) used a mobile app to manage anxiety in young people. Harrison et al. (2011) assessed the efficacy of mobile apps to improve anxiety and low mood, which contains an SMS reminder. Using a mobile app, Teng et al. (2018) enforced an attention training mechanism to improve anxiety symptoms among people between the ages of 20 and 35 years old.

Borderline Personality Disorder and Self-Injury

Lederer et al. (2014) developed a prototype for developing a mobile app for borderline personality disorder and self-injury. Stallard et al. (2018) evaluated BlueIce, a mobile app to encourage activities that boost young people's mood and as such discourage them from engaging in self-harm behaviours.

Cognitive Behavourial Therapy Sessions

A mobile app was developed to facilitate cognitive behavioral therapy sessions between patients and their therapists (Michelle, Jarzabek, & Wadhwa, 2014).

Rehabilitation

Rizia et al. (2014) developed a mobile peering app, iPeer, to aid in the rehabilitation of veterans to facilitate mental help.

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Improving the Quality of Care in Child Mental Health Treatment

mHealth tools have also been applied to the care of children with mental health problems. An example is the use of tablet technology to provide trauma–focused cognitive-behavioral therapy for children (Davidson et al., 2019).

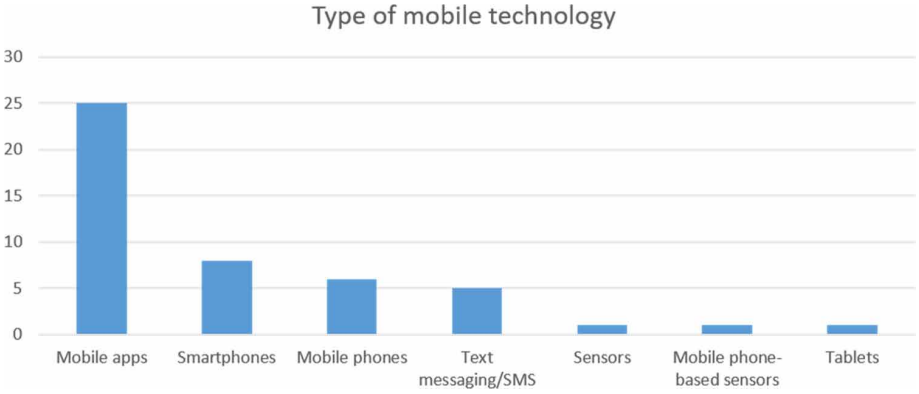
General Mental Health

Mobile apps have been used generally to support and monitor patients with mental illnesses (Tuli et al., 2016). Such apps include recording of disabilities caused as a result of mental health issues (Hebert et al., 2016). Washington et al. (2015) further suggest a method for conducting mHealth trials with mobile apps. Studies have evaluated how patients with mental health issues use mobile apps (Torous et al., 2018; Atallah et al., 2018) and it was identified that the use of mobile apps for mental health is low when patients are out of the hospital. The benefits and challenges of using mobile apps for mental health have also been discussed (Brian & Ben-Zeev, 2014; Jain et al., 2015). Feasibility studies on the use of mHealth apps for mental health in countries such as Finland and Palestine have been conducted (Simila et al., 2018; Ben-Zeev et al., 2017). A mobile app was community co-designed to assist the youth in addressing their mental health issues (Waterman et al., 2018). Other areas of study include the development of a mobile app to monitor side effects of psychotropic medications (Rojnic et al., 2018) and the use of a mobile app to aid the collection of research data for mental health research. Mobile phones have also been used to aid the treatment of patients with serious mental illness to support their full recovery (Noel et al., 2019), to reduce stress (Mak et al., 2019) and for mood reporting (Morris et al., 2010).

RQ 3: What are the Different Types of mHealth Technologies and Applications That Have Been Employed in Mental Healthcare Intervention?

To answer this research question, we grouped the technology types we identified in the literature. However, some articles we identified in the search did not state explicitly the type of technology used (Torri et al., 2015; Cancela et al., 2015). The mobile technologies which have been used to support mental health include mobile apps, smartphones, text messaging/SMS, mobile phones, sensors and mobile phone-based sensors. mHealth technologies and applications for mental health intervention are presented in Figure 3.

Figure 3. mHealth tools and technologies used for mental health intervention

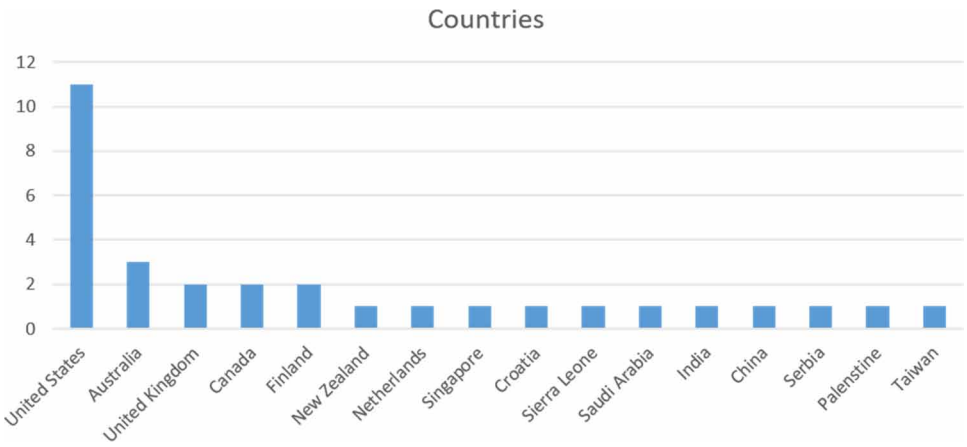


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RQ 4: In What Settings Have Mobile Technologies Been Applied in Mental Healthcare Intervention?

Several articles did not indicate the settings where the studies were conducted. However, some studies mentioned the United States (n=11), Australia (n=3), or the United Kingdom, Canada and Finland (n=2 for each). Other countries such as Taiwan, Singapore, Sierra Leone, New Zealand, Saudi Arabia, India, Croatia, China, Serbia, Palestine, and Netherlands were the settings for single studies exploring mHealth for mental health. The number of countries in which mHealth for mental health intervention have been discussed is illustrated in Figure 4.

Figure 4. Countries in which mHealth for mental health have been discussed



RQ 5: What are the Main Publication Outlets for Publishing Research on mHealth for Mental Health?

The majority of studies on mHealth for mental health have been published in journals (n=36), while other studies have been presented at conferences which are depicted in Table 1.

DISCUSSION

This chapter assessed literature on the use of mHealth tools for mental health conditions, to inform the current publications trends, research gaps in the existing literature and identify future research agenda that can help address the research gaps identified. This chapter, thus, contributes to the literature on mHealth for mental health by mapping out the current trends of published research on the subject.

This chapter found that research on mHealth for mental health has evolved over the last decade. The findings suggest there is a progressive growth in the mobile mental health research domain (Torous et al., 2018; Ranney et al., 2018; Chu et al., 2018; Niendam et al., 2018; Atallah et al., 2018). The findings on the publication trends in the last decade suggest a slight decline in 2012 and 2013. This could be as a result of our inclusion and exclusion criteria; as such, the authors could not find relevant papers for that period. This shows that research on mHealth for mental health is emerging. The findings also show that mHealth has been used to monitor and manage different mental health disorders such as depression (Osma & Plasma, 2014), schizophrenia (Ben-Zeev et al., 2016), anxiety disorder (Firth et al., 2017), psychosis (Niendam et al., 2018) and bipolar disorder (Torri et al., 2015).

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Table 1. List of publishing outlets

Outlet Type	Journal/Conference name	# Publications
Journals	JMIR Mental Health (7)	36
	Journal of Psychiatric Research (2)	
	Journal of Affective Disorders (1)	
	JMIR Research Protocols (3)	
	Computer Methods and Programs in Biomedicine (1)	
	Asian Journal of Psychiatry (3)	
	Geriatric Nursing (1)	
	Schizophrenia Research (1)	
	JMIR mHealth and uHealth (2)	
	International Journal of Medical Informatics (1)	
	Journal of Medical Internet Research (2)	
	Mental Health & Prevention (1)	
	Hong Kong Medical Journal (1)	
	Internet Interventions (1)	
	BMC Family Practice (1)	
	Personal and Ubiquitous Computing (2)	
	Clinical Psychological Science (1)	
	Journal of Mental Health (1)	
	Cognitive and Behavioral Practice (1)	
	Behavior Therapy (1)	
	BMC Public Health (1)	
	Procedia Computer Science (1)	
Conferences	IEEE 10th International Conference on Ubiquitous Intelligence & Computing and 2013 IEEE 10th International Conference on Autonomic & Trusted Computing (1)	18
	IEEE-EMBS International Conference on Biomedical and Health Informatics (1)	
	IEEE Global Humanitarian Technology Conference - South Asia Satellite (1)	
	IEEE International Conference on Collaborative Computing: Networking, Applications and Worksharing (1)	
	IEEE 3nd International Conference on Serious Games and Applications for Health (1)	
	Hawaii International Conference on System Sciences (1)	
	Annual international conference of the IEEE engineering in Medicine and biology society (1)	
	International conference on pervasive computing technologies for healthcare (1)	
	IET International Conference on Technologies for Active and Assisted Living (1)	
	International Workshop on Service Science for e-Health (1)	
	Annual International Conference of the IEEE Engineering in Medicine and Biology Society (2)	
	IEEE Global Humanitarian Technology Conference (1)	
	IEEE International Conference on Machine Learning and Applications (1)	
	ACM CHI Conference on Human Factors in Computing Systems (1)	
	ACM International Joint Conference on Pervasive and Ubiquitous Computing: Adjunct (1)	
	European Conference on Technology Enhanced Learning (1)	
	IEEE Annual International Conference of the IEEE Engineering in Medicine and Biology (1)	

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Mobile technologies have also been used for prediction of mental disorders as well as tracking compliance to medications as well as to identify the side effects of certain medications (Menon et al., 2018; Burns et al., 2011). However, there was a lack of studies on the use of mHealth for a variety of mental disorders, such as eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder and seasonal affective disorder. These areas of mental health disorders represent some of the mental health disorders where mHealth research is lacking. However, mHealth may be of potential value in monitoring and treatment of these mental disorders. Furthermore, there was a lack of research on using mHealth as a strategy for addressing the mental health and well-being of patients in displaced communities, victims of sexual and gender-based violence, especially in low-resource settings.

Various mHealth technologies and tools have been used to support mental health. Examples include text messaging/SMS (Harrison et al., 2011). This represents the easiest way of providing mental health service. Text messaging/SMS is often used to inform and remind patients of appointments or to improve drug adherence (Menon et al., 2018). mHealth can thus be used to facilitate medication adherence among patients, thereby improving the efficiency of mental health care. Mobile applications have also been heavily used for mental health care as evidenced by the findings. Mobile apps, thus, show great potential for development in mental health care. Mobile apps facilitate a wide range of activities such as tracking and early detection of mental illnesses. The difference between mobile apps and other forms of mHealth tools and technologies is that mobile apps are often programmed, to perform specific functions, using algorithms and models, such as machine learning and deep learning. The importance of such algorithms is that they are useful for diagnosis, prediction and prescriptive analysis, offering more capabilities for mHealth in mental health. However, such technologies can mostly be used in urban areas, where people have access to smartphones. Hence, more research should focus on improving the capability of basic mobile phones to perform specific functions to support mental health care.

Mobile phone-based sensors show great potential for mental health. However, the literature suggests that they are seldom used probably because it is a new and emerging area. Researchers can make use of mobile phone-based sensors to optimize mental health care as these sensors can be used to collect relevant data which can be helpful in the early diagnosis and detection of mental health problems (Wang et al., 2016).

Studies on mHealth for mental health has been conducted in various contexts, although the contexts were not mentioned in the majority of the studies. Countries, where mHealth for mental health have been discussed included the United States, United Kingdom, Singapore, Australia, Netherlands, New Zealand, Canada, Finland, Croatia, Sierra Leone, Saudi Arabia, China, India, Taiwan, Serbia, and Palestine. Nine of these countries represent high-income countries. Low-income countries should endeavor to carry out and publish research on mHealth tools for mental health care, as mobile phone penetration is high in these countries (James, 2010), and there is a great need for mental health support as the majority of developing countries often lack mental health resources such as skilled staff, health information systems and ability to capture data for research and mental health service improvement (Bruckner et al., 2011).

The findings of the study show that more papers on mHealth for mental health have been published in journals than conferences, which is similar to other fields where publications rates in journals are much higher than publications in conferences (Iyawa et al., 2019).

The application of mHealth for mental health shows that patients can be empowered to manage their health. This provides a different perspective on how the responsibility of healthcare can be shared between the healthcare practitioner and the patient. mHealth tools can significantly improve the healthcare

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process as patients are given the opportunity to take part in the diagnosis and monitoring of their health and provide early diagnosis and monitoring of mental health related diseases.

CONCLUSION

In conclusion, this chapter assessed the publication trends of studies exploring mHealth for mental health. The chapter also highlighted the years of active publications, countries in which active research on mHealth for mental health was conducted in the last ten years, areas of research on mHealth tools for addressing mental health disorders, specific mHealth tools and technologies, and publication outlets for disseminating the findings on the subject. This chapter, therefore, suggests that mHealth tools and technologies have indeed, been used for development in mental health as these tools have facilitated treatment and management of mental health conditions.

This study was, however, limited in some ways. First, our findings were based on a search from 2009 to 2019; as such, this might have put a constraint on the publications included in this study. We might have excluded relevant papers as we used only five academic databases. We might have excluded some essential findings from Masters and PhD theses as our inclusion and exclusion criteria did not permit these studies. The keywords we used might have also put a constraint on the papers retrieved.

The authors, therefore, based on the gaps and challenges identified in the current research, recommend mHealth research in other areas of mental health such as obsessive-compulsive disorder, post-traumatic stress disorder and seasonal affective disorder.

The findings from the literature search suggest that text messaging and SMS have been used for mental health intervention. Although mobile apps seemed to be more popular, text messaging and SMS could be a cost-effective approach and relevant in rural areas where the majority of the population do not have access to smartphones.

The findings of this chapter indicate that there is less research in the application of mHealth tools and technologies for mental health intervention in developing countries, and as such, researchers should focus on conducting research in these countries, owing to the huge potential benefits in reducing treatment gap in low-resource settings.

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KEY TERMS AND DEFINITIONS

Digital Health: Digital health is an "improvement in the way healthcare provision is conceived and delivered by healthcare providers through the use of information and communication technologies to monitor and improve the wellbeing and health of patients and to empower patients in the management of their health and that of their families" (Iyawa et al., 2016a, p.246).

Digital Health Innovation Ecosystems: Digital health is a "network of digital health communities consisting of interconnected, interrelated and interdependent digital health species, including healthcare stakeholders, healthcare institutions and digital healthcare devices situated in a digital health environment, who adopt the best-demonstrated practices that have been proven to be successful, and implementation of those practices through the use of information and communication technologies to monitor and improve the wellbeing and health of patients, to empower patients in the management of their health and that of their families" (Iyawa et al., 2016a, p.249).

Mental Disorder: A mental disorder is a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013, p. 20).

Mental Health: Mental health is "the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014).

Mobile Apps: Mobile apps refer to a software program designed to run on mobile devices.

Mobile Health (mHealth): mHealth is the use of any mobile device including mobile phones, smartphones, mobile or phone-based sensors for providing and receiving healthcare services such as healthcare monitoring, diagnosis, management and prediction of diseases.

Mobile Technologies: Mobile technologies refer to portable hand-held devices used for communication purposes.

Psychosis: Psychosis is the "presence of delusions, hallucinations without insight, or both" (Arciniegas, 2015, p. 717).

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Systematic Mapping Study: A systematic literature review aims to "map out and categorize existing literature on a particular topic, identifying gaps in research literature from which to commission further reviews and/or primary research" (Grant and Booth, 2009, p. 97).

Text Messaging: Text messaging refers to the use of mobile devices to compose messages which can be sent to another party through a telecommunication channel.

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Chapter 13
Kindness Makes a Difference: Assessing the Efficacy of Addy & Uno, an Off-Broadway Musical, and the Realabilities Educational Comic Book Series Curriculum in Enhancing Children's Kindness, Empathy, and Interest in Their Peers With Disabilities and Mental Health Disorders

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ABSTRACT

High quality interventions, which employ an extended contact model, wherein stories, roleplaying, and other appealing informational media are used to promote more positive intergroup attitudes, tend to be effective at enhancing the attitudes, intentions, and interests of typical children toward their peers with differences. The following four studies assess the efficacy of The Realabilities comic book series and the Addy & Uno off-Broadway musical, which promote kindness, empathy, and a stop-bullying platform while teaching about disabilities and/or mental health disorders. The studies include 1) a qualitative study of 19 fourth grade students from an elementary school in Paramus, NJ, who viewed the Addy & Uno off-Broadway musical and participated in the full Realabilities educational comic book series intervention; 2) a qualitative study of 20 high school students with diverse disabilities, who participated in the full Realabilities comic book series intervention; 3) a quantitative study of 76 students from a high

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school in Long Island City, NY, who read the first mental health-based Realabilities comic book; and finally, 4) a quantitative study of 66 students from a high school in Long Island City, NY, who read the first and second mental-health based Realabilities comics. The researchers used a coding system to find principal themes in the qualitative data and used modified versions of the adjective checklist (ACL) and shared activities questionnaire (SAQ), along with a knowledge measure, to assess quantitative changes from pre to post-testing of the comic book series. Study findings help support the efficacy of an extended contact model and suggest that programs like these may serve as useful antidotes to counter negative attitudes of children and adolescents towards disabilities and mental health disorders, respectively.

INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC) (Okoro, Hollis, Cyrus, & Griffin-Blake, 2018), 1 in 4 adults in the United States is currently living with a disability. Despite the fact that twenty-five percent of American adults have a disability, disabilities are rarely showcased favorably on TV and in the media. Unfortunately, when individuals with disabilities are depicted in the media, they are often being portrayed in an odd, pathetic or poor fashion. It is critical to change the landscape and to focus less on a deficit-based model of disability and more on the refined and unique abilities and strengths individuals with disabilities possess, since they are continuously seeking creative solutions and "work-arounds" to succeed in life (Respectability, 2018).

Children and Disabilities

Recent statistics suggest that from 2013-2014, 95% of all children and youth between the ages of 6 and 21, who were accommodated by IDEA, were enrolled in typical schools (National Center for Education Statistics, 2016). Moreover, the number of students who spent the lion's share of their school day (80% or more time) in regular education classrooms increased from 33% from 1990-1991 to 62% from 2013-2014 (NCES, 2016). This significant rise in just over a decade, suggests that regular education schools will need to be increasingly well-equipped to accommodate students with disabilities in the typical classroom. Research suggests that simply including children with disabilities in the classroom does not ensure that typical children will increase their interest, positive attitudes, intentions and socialization with individuals with disabilities. In contrast, high quality interventions that effectively educate typical children about disabilities and encourage children to befriend individuals with disabilities are critical towards fostering attitudes, intentions and promoting the socialization of typical children toward their peers with disabilities (Silton, 2015; Vignes et al., 2009). Moreover, if programs are not created to promote acceptance and social integration, then children with disabilities will be less accepted by their typically developing peers in the classroom (Favazza, Phillepson, & Kumar, 2000). Research consistently reveals that students with disabilities are not only more vulnerable to negative attitudes (Nowicki & Sandieson, 2002), but are less accepted, have fewer peers, socialize less frequently, and report more loneliness than their typical peers (Bossaert, Colpin, Pijl & Petry, 2011). Various research studies note the importance of establishing learning standards which focus on the development of social skills and social competence skills, rather than focusing exclusively on the acquisition of academic competencies like literacy and mathematics (Scott, Little, Kagan & Freelow, 2006; National Research Council, 2001)

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in the classroom. Asher and Coie (1990) reveal that peer interactions are key ingredients towards developing social skills during childhood.

Already by preschool, children can form and enhance their repertoire of peer-related social skills (Odom et al., 2006). Unfortunately, even in high quality inclusion programs, children with disabilities appear less likely to get selected when children's play partner preferences are not predetermined by the instructors' planned activities or by the program structure (Guralnick, 1999). This aligns closely with research suggesting that typical children are more likely to select a typical doll as a play partner than a doll with a disability (Odom et al., 2006). Since preschool-aged children are already capable of identifying a child with a physical disability compared to a typically-developing peer (Diamond, 1994) and since children's experiences in preschool are likely to inform their reasoning about inclusion (Diamond & Stacey, 2000), it is critical that interventions enhance children's attitudes, intentions and knowledge of disabilities as early and as effectively as possible.

Stigma Towards Mental Illness (Anxiety and Depression)

Current statistics indicate that anxiety disorders occur in 32% of adolescents between the ages of 13 to 18 and depression occurs in approximately 13% of adolescents between the ages of 12 to 17 (NIMH, 2017; SAMHSA, 2017). Similar to disabilities, individuals who present with a mental illness often experience stigmatization, in the form of negative attitudes, which can have adverse effects on their health, social identity, and overall quality of life (Silton, Flannelly, Milestein, & Vaaler, 2011). Stigmatization directed at individuals with mental health disorders can be communicated in numerous ways and can result in the stigmatized individual being socially isolated and labeled with unwelcome attributes that separate them (Goffman, 1963). Social discrimination and stigma towards mental illness remains an issue among adolescents (Corrigan, 2004; Corrigan, Dremming, Goldman, Slopen, Medansani, & Phelan, 2004). In fact, a common barrier for adolescents seeking treatment is the stigma associated with mental illness (Clement, Schauman, Gram et al., 2015).

Mental health literacy is defined as having knowledge and an understanding of mental illnesses which assist in preventing or managing disorders (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997). Mental health literacy has five major components: 1) knowing how to prevent mental illness, 2) recognizing the development of a mental illness, 3) knowledge of treatment opportunities, 4) knowledge of self-coping mechanisms, and 5) first aid skills to support others with mental illness (Jorm, 2012). Jorm (2012) notes that an integral part of mental health literacy, is to connect knowledge to action in order to benefit oneself or others. This relates to adolescents since research has found that adolescents who recognize mental illness tend to be more successful at seeking help and finding treatment (Wright, Jorm, Harris, & McGorry, 2007). The present authors have used the theory of mental health literacy to expand the goals and content of *The Realabilities Comic Book Curriculum Series* by including new comics on mental health disorders for adolescents, rather than solely developing comics featuring disabilities for children. The researchers added *Got Talent* (which teaches about Anxiety and Depression) and *The Carnival* (which teaches about Generalized Anxiety Disorder, Obsessive Compulsive Disorder, and Specific Phobias) to *The Realabilities Comic Book Series* and to the adjoining companion manuals.

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The Importance of Teaching Social Emotional Skills and Kindness to Children

Researchers have discovered that programming which aims to foster students' social-emotional skills can positively impact their academic, health and social outcomes. It is for this reason that school settings are now shifting towards teaching social and emotional and prosocial learning skills alongside traditional academics. Social Emotional Learning (SEL) involves identifying and managing emotions, caring about others, making good decisions, behaving ethically and responsibly, developing positive relationships and avoiding negative behaviors (Binfet & Schonert-Reichl, 2015). Similarly, prosocial behavior is important within school contexts, since schools are settings where frequent interpersonal interactions occur among individuals from diverse socioeconomic, social, and ethnic backgrounds and where interpersonal conflict can be prevalent (Binfet & Passmore, 2017).

More specifically, there appears to be an increased interest in examining the construct of kindness, since it is now deemed to be a "valuable socio-emotional skill" (Kaplan, DeBlois, Dominguez, & Walsh, 2016). For this reason, a variety of programs are now being developed to emphasize the importance of teaching kindness lessons in the school system. For instance, all of the following programs attempt to implement Kindness Education Programs: The Random Acts of Kindness in the Classroom Program (The Random Acts of Kindness Foundation, 2015), The Center for Investigating Healthy Minds' Mindfulness-based Kindness Curriculum (Flook, Goldberg, Pinger & Davidson, 2015) Think Kindness (Think Kindness, 2015), and The Ben's Bells Kindness Campus Program (Ben's Bells Project, 2015). More specifically, The Kind Campus Program, a widely-implemented school-based kindness education program that employs a bottom-up program framework, attempts to educate the full school community (students, families, faculty and staff) about the positive effects of kindness and to empower the community to cultivate kindness within and beyond the school walls. Using the Kind Campus Model, a study was conducted with a large number of school professionals and students from 50 schools in Tucson, Arizona to help develop school-based models to help teach kindness in schools. The research suggests that effective kindness education programs would afford students, faculty and staff a common language to discuss kindness and offer a framework that would encourage members of the school community to recognize acts of kindness occurring around the school and to practice kindness towards themselves and towards others (Kaplan et al., 2016).

An additional study specifically looked at the school kindness perceptions of 257 Kindergarten through twelfth grade teachers. Teachers were challenged to define kindness, to offer examples of kindness they had performed and received, to pinpoint key agents of kindness and to rate the quality of kind acts in their schools. Overall the findings revealed that teachers contend that they have a strong to moderate impact on shaping students' kindness and teachers' perceptions of school kindness tend to vary based on the grade they are teaching. Moreover, the research suggested that teachers' beliefs about prosocial behaviors, such as kindness, as well as practicing kindness as part of their professional role, may have far-reaching implications for teacher job satisfaction, and for teacher-student rapport, which could affect learning and the overall school climate (Binfet & Passamore, 2017)

Another study examined the psychometric properties of The School Kindness Scale (SKS) in a sample of 1,753 students from fourth through eighth grade, who were attending public schools in the large school district of Southern British Columbia, Canada. The researchers discovered that the School Kindness Scale (SKS) was significantly and positively associated with teacher reports on students' empathy, social skills and peer acceptance. With respect to gender and grade findings, girls perceived higher levels of kindness in school than boys and students' perceptions of kindness in school diminished from

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fourth to eighth grade, wherein fourth-grade students reported the highest perceptions of kindness in school compared to eighth graders, who reported the lowest levels of kindness. Moreover, the research revealed that the extent to which students perceive kindness as a commonly occurring aspect of school is a reflection of a broader learning context; wherein students' perceptions of kindness may indicate the level to which the school context fosters underlying conditions that support student development and learning (Binfet & Schonert-Reichl, 2015).

Moreover, a later study (Retnowati, Agoes Salim, & Saleh, 2017) examined whether or not picture books could help teach kindness to 31 five and six year old children from a Kindergarten in Bandung, Indonesia. The intervention was conducted by reading eight picture books to the 31 children over an eight day time frame. The storybooks helped describe kindness behaviors, including helping behaviors and cheering up friends. The storylines were simple, sequential, predictable, and offered clear examples of kind behaviors that could be performed every day. Kindness was measured by utilizing an instrument the researcher created, which involved showing nine colorful cards that described the kindness behaviors to children. Kindness was additionally assessed by reviewing the kindness tree and observation sheets the teachers filled out. Data analysis, employing the Wilcoxon Signed-Rank Test, revealed a significant positive change in the average score of kindness at the $p < .05$ level after the stories were read. Two weeks following the intervention, there were significant improvements on both the card test and on the kindness tree and observational sheets following the intervention (Retnowati et. al, 2017).

Similar to the success of the children's picture books in the aforementioned Retnowati et al. (2017) study, the present authors created the prosocial *Realabilities Comic Book Series Curriculum* to teach kindness and empathy to typical children and adolescents towards children with disabilities and towards individuals with mental health disorders, respectively. Pre and post-test assessments have been utilized at each stage of development to assess the efficacy of these literary interventions.

Key Ways to Enhance Kindness in Children

In addition to the benefits of literary resources, recent work by Harvard psychologist, Richard Weissbourd, who runs the *Making Caring Common Project*, suggests five key ways to raise kind children. A recent *Washington Post* article reviewed Weissbourd's work and shared his five essential ingredients for raising kind children, 1) Make caring for others a priority, 2) Provide opportunities for children to practice caring and gratitude, 3) Expand your child's circle of concern, 4) Be a strong moral role model and mentor, and 5) Guide children in managing destructive feelings.

With respect to the first ingredient, the research suggests that parents need to teach their children about the balance of their own desires and the desires of others. Parents should directly reinforce the importance of being kind and should ensure their children are acting respectfully, even when their children may be in angry or in upset moods. Parents can also visually express how to care for others by introducing children to additional adult figures in their lives.

In terms of the second ingredient of offering opportunities for children to practice caring and gratitude, the author suggests that children should practice being caring to others and showing others gratitude. A plethora of studies reveal that those who express gratitude are often more likely to be happier in life. Rather than rewarding children each time they do something positive, try to make "doing good" a daily activity and habit for children. Parents can also highlight expressions of kindness and caring on TV, in the movies and in books for their children.

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With regard to the third ingredient of expanding your child's circle of concern, the author stresses how important it is for children to care about individuals beyond those in their immediate peer group. Encouraging children to look outside of their inner circle will afford them a better perspective of caring for others in the world around them. It is especially beneficial to encourage children to be helpful to those who are most vulnerable (Joyce, 2019). In fact, a renowned twentieth century philosopher, Emmanuel Levinas (1905-1995) suggests that individuals can reach their highest ethical authority when they help those who are most vulnerable, "the widow, the orphan, the stranger," or those with other vulnerabilities. Showing children TV news, periodicals or other stories can teach them about the diverse problems children may encounter around the world (Joyce, 2019). *The Realabilities Educational Comic Book Series Curriculum* seeks to employ an extended contact model through which to increase positive intergroup attitudes by teaching typical children and adolescents about disabilities and mental health disorders to enhance their knowledge, attitudes and behaviors towards those who may not initially be in their inner circle.

The fourth ingredient of encouraging parents to be strong moral role models and mentors for their children suggests the importance of observational learning and Social Learning Theory. Children learn a number of diverse behaviors and attitudes from observing adults, especially their parents. Parents have an opportunity to showcase honesty and fairness to their children and to model how to volunteer and give back to the community (Joyce, 2019).

Finally, the author suggests that parents should guide children in managing their destructive feelings. For instance, children may become overwhelmed by negative emotions like anger or envy and parents have an opportunity to teach their children helpful coping skills to best address these emotions (Joyce, 2019). One coping skill might be to teach children how to breathe and remain calm, for instance to tell children to "breathe in the roses and blow out the candles" to better help children relax and address head-on the struggles of the day.

Empathy

In addition to kindness, empathy, another critical social-emotional construct, relates to stepping into the shoes of another person and to perceiving and understanding the emotions that other individuals are experiencing (Dziobek, Rogers, Fleck, Bahnemann, Heekeren, Wolf, & Convit, 2008). Empathy involves both cognitive and affective components. *Cognitive Empathy* refers to how well one can *comprehend* another's emotions and *Affective Empathy* relates to how well one can *experience* another's emotions (Van Noorden, Haselager, Cillessen, and Bukowski, 2014). Empathy enables individuals to perceive the world through their peers' lenses. The ability to understand the attitudes and feelings of others is paramount toward establishing meaningful relationships and successful, prosocial behaviors with others (Dziobek et al., 2008). Individuals with higher levels of empathy are often more likely to help others or to pursue prosocial acts (Eisenberg, Eggum, & Di Giunta, 2010). It is therefore critical to cultivate empathy during childhood, since this critical period of development can lead to life-long behaviors.

However, empathy is a fundamental human characteristic that can impact both prosocial and antisocial behavior. Unfortunately, bullying has become one of the most common antisocial behaviors in children. It is thought that the principal motivation behind bullying is the power imbalance that exists between the bully and victim. Bullying can be manifested through verbal, physical or relational means or through cyberbullying. Many believe that those who bully, struggle with lower levels of empathy and therefore, many bullying prevention and intervention efforts have sought to include empathy training.

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For instance, individuals with disabilities are unfortunately two to three times more likely to be victimized by bullying behaviors than their typical peers. This increased vulnerability may be due to a lack of empathy and understanding of the differences associated with disabilities or of what causes these differences. When children glean a clearer awareness and understanding of differences, they are able to enhance their knowledge and sensitivity and to improve their attitudes and intentions towards individuals with disabilities, mental health disorders or other differences.

Aligned with this notion, Van Noorden, Haselager, Cillessen, and Bukowski (2014) conducted a study to determine the relationship between cognitive (mental) and affective (emotional) forms of empathy and bullying behaviors. After a search of 40 empathy studies (24 cognitive and 38 affective) associated with four forms of bullying (bullying, victimization, defending, and bystanding), there appeared to be a negative correlation between empathy and bullying (the higher the empathy, the lower the bullying behaviors). *Bullying* was found to be negatively correlated with both cognitive and affective forms of empathy. More specifically, *defending* was positively correlated with both cognitive and affective empathy, *victimization* was negatively correlated with cognitive empathy and *bystanding* had mixed results. While future studies in this field would be helpful, the current study offered a foundation for improving bullying prevention and intervention programs (Van Noorden et al., 2014).

As an intervention, *The Realabilities Comic Book Series* and the *Addy & Uno Off-Broadway Musical* were created to enhance children's knowledge and empathy towards the unique life circumstances of individuals with disabilities and now mental health disorders, as well. The *Realabilities Curriculum* attempts to increase a child's level of empathy through the engaging lessons incorporated into each storyline that accentuate prosocial values through each character's inner strengths and abilities. Children, as readers and as musical audience members, are able to empathize, since they can envision themselves within the characters and within the rich character experiences. These immersive, empathic opportunities are achieved through the creative media of musicals and graphic storytelling, which align closely with the strength and efficacy of the extended contact model.

Extended Contact Model

Since even high-quality inclusion may cause segregation among typical children and children with disabilities or children with mental health disorders in a classroom, it is useful to consider additional forms of instruction to enhance typical children's understanding, attitudes and intentions towards their peers with disabilities or mental health disorders.

The extended contact hypothesis posits that knowledge that an in-group member has established a close relationship with an out-group member may promote more positive intergroup attitudes (Wright, Aron, McLaughlin-Volpe, & Ropp, 1997). Typical children can benefit strongly from extended contact, since it offers them knowledge of individuals with disabilities or mental health disorders (the out-group) without the anxiety that initial, direct contact may introduce (Pettigrew & Tropp, 2000; Stephan & Stephan, 1985, as cited by Cameron & Rutland, 2006). Stated differently, extended contact can enhance typical children's ("the ingroup's") positive attitudes and knowledge of individuals with disabilities or mental health disorders ("the outgroup"), before children with differences enter the mainstream classroom. In fact, Favazza and Odom (1997) discovered that extended contact had a significant, positive effect on outgroup attitudes (improved attitudes of typical children towards children with disabilities) but not on in-group attitudes (typical children towards typical children). Therefore, learning about differences before students directly interact with their peers with special needs or mental health issues can be more

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beneficial than actual contact since it reduces the potential for a "backlash effect," if typical children experience anxiety when they first meet their new peers with differences (Paoloni et al., 2004).

Similarly, in England, Cameron and Rutland (2006) explored the efficacy of an extended contact prejudice-reduction intervention in enhancing typical children's attitudes towards children with disabilities. The researchers learned that when group boundaries are maintained and typicality or similarity is emphasized, the extended contact model was more effective and led to the most robust change in typical participants' attitudes towards children with disabilities (Cameron & Rutland, 2006). Therefore it appears that an Intergroup Extended Contact Model, wherein typical children are taught about the realities of disability through story-telling, role-playing or drama (Campbell et al., 2003) that emphasize the similarities and strengths of their peers with disabilities (Cameron & Rutland, 2006) may be a critical antidote to the increasingly negative relationship between age and attitudes towards children with disabilities (Campbell, Ferguson, Herzinger, Jackson, & Marino, 2004; Bell & Morgan, 2000; Morgan & Wisely, 1996). This aligns with research that reveals that story-time is a naturalistic strategy for providing information about individuals with disabilities since it is a typical feature of the kindergarten class routine (Favazaa & Odom, 1997). In addition, activities like roleplays, drama and storytelling help students empathize with the "outgroup" and makes them more likely to disapprove of bullying (Silton, Arucevic, Ruchlin, & Norkus, 2013; Pepler et al., 1993).

The Benefits of the *Realabilities* Comic Book Series Medium for Effective Storytelling

It is instructive to consider the appealing and creative medium of comic books for relaying critical messages related to disability awareness, mental health awareness, and a stop bullying platform in and out of the school environment. Comic books have differentiated themselves from traditional books due to their appealing and creative characteristics. Children may struggle with motivation or may experience difficulty focusing on reading, which can challenge their retention of information from the text (Versaci, 2001). This can often cause the child to feel defeated and frustrated about reading. Comic books offer an engaging alternative to traditional books, since they capitalize on visual aids to enhance the accompanying text. The combination of text and images within comic books provide the dual processing of images and words for the reader, which helps the reader to gain the valuable skill of formulating an inference to follow the storyline (Versaci, 2001).

Comic books are valuable tools in and outside of the classroom, since they help children establish a foundation on which to build their literacy and critical thinking skills (Versaci, 2001). In addition, comic books enable creators to channel their boundless creativity throughout the design and layout of the comic (Silton, 2016). The immersive and creative nature of comic books coupled with their storytelling capacity and literary appeal, prompted the creation of *The Realabilities Comic Book Series Educational Curriculum*. Sharing the adventures of the *Realabilities* characters through the visual form of comic books encourages children to empathize or to immerse themselves in the characters' experiences and enhances their disability and mental health knowledge. This nuanced understanding of disabilities and most recently mental health disorders ultimately leads to more positive cognitive attitudes and behavioral intentions towards the protagonists with disabilities and mental health disorders in the series. *The Comic Book Companion* and *Disability in Depth Manual,* the teaching manuals that supplement the *Realabilities Comic Book Series Curriculum*, further extend these important lessons about disabilities

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and mental health disorders in the classroom and offer richer learning experiences and positive outcomes for typical students and students with disabilities and mental health disorders, alike.

Previous Peer Education Programs

Beyond literary works, a variety of creative peer education programs have been developed over the years in order to enhance typical children's knowledge and positive attitudes towards children with disabilities through direct or indirect exposure using storytelling, role-playing or other techniques. Another form of storytelling, puppetry, has been identified as a potential promising approach toward improving attitudes and knowledge towards disabilities due to its capacity to inspire a large number of students and to be relatively cost-effective (Bernier, & O'Hare, 2005). Additionally, Trimingham (2010) suggests that puppetry also has a host of other benefits. She intimates that puppetry has been exceptionally useful in explaining the etiology of maladjustment in childhood and serves as a significant therapeutic technique through which children can learn to comprehend the complexities of deviating behaviors and to discover more successful solutions. The researchers also note that puppets can help children confront an externalization of themselves, wherein their focus can shift away from their closed, inner worlds and can accommodate another to share in their perception of the world (Trimingham, 2010; Woltmann, 1951). Additionally, Felisa Weiss (as cited in Trimingham, 2010) suggests that "The puppet acts as an intermediary, the projective object that absorbs both the interviewer and interviewee's vectors." (Trimingham, 2010; Weiss, 1998) Finally, Schummann suggests that the material nature of his puppets makes the puppets speak for themselves. Thus the object of the puppet speaks and there is no distortion by the intruding ego of the performer (Trimingham, 2010).

Limited Efficacy of Previous Puppet Show Interventions

Despite the unique strengths of puppetry, previous puppet show interventions have either shown no or minimal effects in transforming typical children's attitudes towards children with disabilities. Rosenbaum, Armstrong and King (1986) conducted a randomized-factorial-design study to evaluate the impact of two interventions, 1) *A Buddy Program*- offering direct exposure to children with disabilities, and 2) *The Kids-on-the-Block (KOB) Puppet Show Program*-wherein puppets are utilized to discuss disabilities to foster positive attitudes and intentions of typical children towards children with special needs. The researchers revealed that while the Buddy Program appeared efficacious, the KOB Program had no significant effect on any outcomes and actually appeared to reduce the impact of the Buddy Program when used in concert. The researchers noted that this might be a result of the dissonance between the puppets in the KOB intervention and the real-life children with disabilities in the Buddy program. In a later study, Baker (1991) discovered a short-term positive impact of the KOB intervention on elementary school children's attitudes in third through sixth grades, but there appeared to be only minimal long-term effects.

That same year, Thios and Foster (1991) assessed the efficacy of *The New Friends Program,* which utilized life-sized dolls with disabilities to relay important information about disabilities three times per week (25 minutes per session) over a three-week period. The intervention presented four units, including, an introductory unit on differences and similarities, and units on hearing impairment, physical impairment (cerebral palsy) and learning impairment. The researchers discovered that that the New Friends' Program enhanced attitudes and knowledge of disabilities but failed to show robust changes in social interaction patterns towards children with disabilities (Thios & Foster, 1991).

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In 2014, Dunst conducted a metanalysis of 26 studies which explored the effects of the Kids on the Block (KOB) and/or *Count Me In Puppet Shows* on elementary school students' attitudes and knowledge of individuals with disabilities. The Kids on the Block (KOB) Puppet Troupe and Count Me In Puppet Troupes introduce puppets representing children with physical disabilities, intellectual disabilities, visual impairments, and hearing impairments. The forty-five-minute puppet shows included scripts to introduce each puppet in order to offer awareness of diverse disabilities and to correct common misconceptions of disability. The show also offered a fifteen-minute question-and-answer session after the show.

Dunst (2014) reviewed studies which included 5,302 participants in the intervention group and 2,642 student participants in the comparison group. The results suggested that the puppet shows had only a mild to medium impact on participants' knowledge and attitudes towards individuals with disabilities. More specifically, first and second grade students showed more robust changes in attitudes towards children with disabilities following the puppet show than their third through sixth grade peers and the effects of the puppet show were somewhat reduced over time. Moreover, students showed greater gains in their knowledge of disabilities than in their attitudes towards children with disabilities (Dunst, 2014). Finally, the researcher delineated the following study limitations, 1) There was a dearth of information pertaining to adherence or fidelity to the puppet show scripts, 2) There was minimal to no information regarding the schools or districts where the puppet show was performed, and 3) There was little description regarding the backgrounds of and manner in which the puppeteers performed the shows. Despite these limitations, similar to the notion of the extended contact model, Dunst (2014) intimated that puppet shows could be useful for transforming elementary students' knowledge of and attitudes towards individuals with disabilities, at least in terms of their initial exposure to individuals with disabilities before misconceptions and misunderstandings arise. Moreover, he recommended combining puppet shows with in-vivo or real-life, situated interactional opportunities with individuals with disabilities to offer an additive positive effect on typical students' knowledge and attitudes towards their peers with special needs.

The *Addy & Uno Musical* seeks to improve upon the Kids on the Block (KOB) and Count Me In Puppet Show Programs and research by offering real-life, situated interactional opportunities, information about adherence to the puppet show scripts, specific information pertaining to the location of the show performances, and a brief description of the puppeteers. *The Addy & Uno Musical* presents innovative, kid-friendly puppets with disabilities that are openly operated by the in-vivo, visible puppeteers, who are assuming the roles of individuals with disabilities. The *Addy & Uno Musical* also utilizes original music to foster children's understanding, recall and appreciation of their peers with disabilities. The puppeteers are also available after each show to answer a plethora of questions from audience members.

Moreover, researchers assessing the *Addy & Uno Musical* intervention and the *Realabilities Educational Comic Book Series Curriculum* are employing key valid, reliable and objective quantitative behavioral intention (The Shared Activities Questionnaire (SAQ); Morgan et al., 1996) and cognitive attitudinal (The Adjective Checklist (ACL); Siperstein & Bak, 1980) measures to evaluate the change in participants' perceptions from before and following the musical intervention and comic book series curriculum. They are also utilizing coding and other qualitative approaches to develop themes in order to attain a richer understanding of the program's impact on disability and mental health knowledge and sensitivity.

The four most recent *Realabilities* studies below include, 1) A qualitative study of 19 fourth grade students from an elementary school in Paramus, NJ, who viewed the *Addy & Uno Off Broadway Musical* and participated in the full *Realabilities Educational Comic Book Series Intervention*, 2) A qualitative study of 20 high school students with diverse disabilities, who participated in the full *Realabilities*

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Comic Book Series Intervention, 3) A quantitative study of 76 students from a high school in Long Island City, NY, who read the first mental health-based *Realabilities* comic book and finally, 4) a quantitative study of 66 students from a high school in Long Island City, NY, who read the first and second mental health-based *Realabilities Comics.*

STUDY 1: ASSESSING THE EFFICACY OF *ADDY & UNO*, AN OFF-BROADWAY MUSICAL AND THE *REALABILITIES* EDUCATIONAL COMIC BOOK CURRICULUM IN ENHANCING CHILDREN'S SENSITIVITY AND INTEREST IN THEIR PEERS WITH DISABILITIES USING A QUALITATIVE METHODS APPROACH

Participants

Nineteen fourth grade students, 9 males and 10 females from a Jewish Day School in Paramus, New Jersey participated in the two-part disabilities intervention of *The Addy & Uno Musical* and *The Realabilities Educational Comic Book Curriculum*. All of the students self-reported that they were White and Jewish.

Procedure

The fourth grade students viewed the *Addy & Uno Musical* and participated in *The Realabilities Educational Comic Book Series*. Following the Musical, the students penned qualitative letters to the creators of the musical and reflected on the following: 1) What they enjoyed most about the Musical, 2) What they learned, 3) Whether they felt differently about disabilities and bullying following the Musical, 4) Whether they enjoyed the Musical and 5) Whether or not they would see the show again. Additionally, after reading the 11 *Realabilities Comics,* the students were asked to respond to the following questions: 1) Do you believe it's important for kids to stop bullying? 2) Who was your favorite character in the comic series and why? 3) Which comic book was your favorite and why? 4) What would you like the characters to do in the next *Realabilities Comic book* and finally, 5) Would you buy a Realabilities comic? The students responded to all of the aforementioned questions and the responses were collected, stored in a secure database, coded and analyzed (Please see APPENDIX A for images of the *Addy & Uno Musical* and APPENDIX B for images of *The Realabilities Comic Book Series*).

Results

With respect to appeal, the fourth grade students shared that they most enjoyed "the puppets and thought they were very interesting," "they liked when the bullies decided not to be mean," and "liked when (they) learned a sentence in sign language (during the show)." Moreover, the students "liked when Uno's friends helped him not be nervous" and "enjoyed the songs in the play." Following the Musical, the students noted that they learned "not to treat people differently just because they are different" and that "people aren't as different as we think they are." A large majority of students remarked that they would love to see the show again because it was "AMAZING!" Students also wondered if a second show would be made or if all of the comic books would be incorporated into the show. Finally, the students shared whether or not they enjoyed the Musical and whether or not they would like to view a TV show version of the show

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again. The lion's share of students said they enjoyed the Musical because it was "funny," "interesting," and "it was fun to watch the songs." Furthermore, students added that the Musical "taught me not to bully" and "helped me to be nice to be people who are different." When asked if they would watch an *Addy & Uno TV show*, the majority of students responded "yes" because they "love the play and (comic) books," they "like Addy and Uno," and "because you can learn a lot from it." One student mentioned that he/she would watch the TV show because "it teaches people to stop bullying" and another student said that the TV show "would make people who have disabilities happy."

Following the comic book series, the majority of students shared why they believe it is important to stop bullying. For instance, some students noted that "bullying can really hurt someone, even if it's not physical," "it affects how the kid being bullied feels about himself," and "because it can hurt people's feelings and (make) it like they're not important to the world." The students also discussed which characters from *The Realabilities Series* were their favorite characters and why. The majority of people liked Addy since she is "energetic and happy" and "she is really nice to people and her friends." Uno was the next highly-rated character since he is "smart" and "likes math." "Math Mania," the comic portraying Uno's preparation for a math competition and the comic that most closely relates to the Musical, was the most popular comic among the students. Students also enjoyed "Math Mania" because "it's about math," "Uno overcomes his fear," and "Uno's friends are helpful and supportive." The next most popular comic the students endorsed was "The Real Goal" because the characters are "kind" and "it involved sports." When asked what the students would like to see the characters do in a subsequent comic book, the students discussed a number of possibilities including "have a pool party and enjoy life," "go to Mars in a real rocket that RJ moves," and participate in more sports like baseball, snowboarding, and basketball." One student also wanted the characters to "tell us how they got their disabilities." Finally, when asked if the students would purchase a *Realabilities Comic Book*, the majority of student participants said they would, while a smaller minority said they would not. A reason for not wanting to purchase a comic was because they "don't like comics." Whereas reasons for wanting to purchase a comic book included "because they are funny," "it teaches kids to stop bullying," and "it could teach you to be nice to people who are different."

Principal Conclusions

Thus, the researchers found that the combination of *The Addy & Uno Off- Broadway Musical* and *The Realabilities Comic Book Series Curriculum* significantly enhanced typical students' nuanced knowledge, interest and understanding of disabilities as well as the importance of promoting a stop bullying platform in their schools. Overall, the study results confirm that an extended contact model, wherein appealing storylines, role-plays and other engaging media can be highly advantageous towards teaching about an outgroup (in this case disability), prior to or in addition to successfully interacting with children with disabilities in and outside of the classroom.

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STUDY 2: THE IMPACT OF THE REALABILITIES COMIC BOOK SERIES CURRICULUM ON A SAMPLE OF STUDENTS WITH DIVERSE DISABILITIES

Participants

Twenty high school students with disabilities (fourteen males [70%] and six females [30%] from Manchester, New Jersey participated in *The Realabilities Educational Comic Book Intervention*. The majority of students identified as White (14; 70%), three (15%) as Other, two (10%) as Latino, and one (5%) as African American. Students presented with diverse disabilities, including autism, visual impairment, obsessive compulsive disorder (OCD), physical impairment, seizure disorders, intellectual disabilities, and/or with behavioral limitations.

Procedure

The students participated in the full *Realabilities Comic Book Series Curriculum* (11 comics featuring 11 disabilities, discussion questions and activities) and then responded to the following questions: 1) What did you learn from *The Realabilities Comic Book Series*? 2) Who was your favorite character in the comics and why? 3) Which comic was your favorite and why? 4) What would you like the characters to do in the next comic? and 5) Would you buy a *Realabilities Comic*? The students responded to all of the aforementioned questions and the responses were collected, stored in a secure database, coded and analyzed (Please see APPENDIX B for images of the comic series).

Results

Following the comic series, the students noted that they learned, "to never give up and to keep trying," "to not bully people," "to not judge people" and "that people have different strengths and weaknesses." In identifying their favorite characters, the majority of participants selected Beat, the African American character who stutters and dances, since she "resembles me," "is a good dancer," and is a "great singer." Uno, who presents with autism, was the next highly-rated character since he is "funny," "cool," and "smart." "Food Fight," the comic introducing Lexxy, a character with Down syndrome, and the comic that teaches about food allergies was rated the highest, because it "looks fun" and "teaches about allergies and shows there are ways to help." The next most popular comic the students endorsed was "Math Mania" because it was "funny," "cool," and "awesome." In a subsequent comic, the participants recommended that the characters "work on computers," "teach about the weather," "build a spaceship and go to the moon" "participate in basketball and football games" and do "more stuff that I can learn from." Finally, with respect to purchasing *Realabilities Comics*, the majority of students noted they would purchase them "because they were fun to read" and "are educational," while one participant remarked he wouldn't because he doesn't "read comics."

Principal Conclusions

Thus, the researchers found that *The Realabilities Comic Book Series* enhanced students' with disabilities nuanced knowledge of disabilities as well as the importance of promoting a stop bullying platform in their schools. Overall, the study results confirm that an extended contact model with appealing storylines

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and other engaging media can be highly advantageous towards teaching about diverse disabilities and that individuals with disabilities found the series both helpful and appealing.

STUDY 3: ASSESSING THE EFFICACY OF THE FIRST MENTAL HEALTH-BASED REALABILITIES COMIC AMONG A HIGH SCHOOL SAMPLE

Participants

Seventy-six students (44 males [61.1%] and 28 females [38.9%]) from an Information Technology High School in Long Island City, NY took pre and post-tests prior to and following the reading of the first comic book on mental health disorders in the *Realabilities Comic Book Series Curriculum*. In terms of grade, 71 (93.4%) of the students were enrolled in eleventh grade and five (6.6%) were enrolled in twelfth grade. The majority of students identified as Latino (50; 66.7%), nine (12.0%) identified as African American, five (6.7%) as Asian American, four (5.3%) as White and six (8.0%) as Other.

Procedure

The teachers administered brief Knowledge and Bullying Measures and Modified Pre and Post-Test Assessments of the Shared Activities Questionnaire (SAQ; Morgan et al., 1996), a behavioral intention measure, and The Adjective Checklist (ACL; Siperstein & Bak, 1980), a cognitive attitudinal measure, to students one day before and one day following the students reading through "Got Talent," the first mental health-focused comic of *The Realabilities Comic Book Series.* "Got Talent" introduces Celia with Anxiety and Kari with Depression. The students also noted whether they would view an episode of *Realabilities* or would purchase a comic. (Please see APPENDIX C for images of the new Mental Health-based comics).

Results

In terms of descriptive statistics, more than half of the participants (42; 56.8%) stated that they would purchase a *Realabilities Comic* and would watch an episode of the comic series (39; 50.6%) following the intervention.

Regarding principal study results, Paired Sample T-tests revealed that participants showed significantly more bullying knowledge, $t(76) = -2.296$, $p < .05$ and more stop bullying attitudes, $t(76) = -2.173$, $p < .05$ following the comic book intervention. The participants also showed more positive behavioral intentions (as measured via the Shared Activities Questionnaire [SAQ]) toward hypothetical peers with Anxiety on the SAQ Total, $t(76) = -2.514$, $p < .05$, on the SAQ Academic, $t(76) = -3.103$, $p < .01$ and on the SAQ Recreational, $t(76) = -2.164$, $p < .05$. Moreover, they showed more positive cognitive attitudes, as measured via The Adjective Checklist (ACL), towards hypothetical peers with Anxiety, $t(76) = -2.992$, $p < .01$ following the comic book intervention. Please see Tables 1 and 2 for Means, Standard Deviations and significance levels.

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Principal Conclusions

Thus, the researchers discovered that students who read the "Got Talent" Comic, which discusses Anxiety and Depression and is the first comic to focus on Mental Health Disorders in the *Realabilities Series*, appeared to show more bullying knowledge and more positive stop bullying attitudes following the intervention. Additionally, the participants displayed more positive intentions and cognitive attitudes towards a hypothetical peer with Anxiety following the comic book intervention. This study was novel in not only showing the efficacy of a comic in enhancing attitudes toward Anxiety, but in successfully employing a high school population for this subject matter.

STUDY 4: EVALUATING THE EFFICACY OF THE FIRST AND SECOND MENTAL HEALTH-BASED REALABILITIES COMIC BOOKS AMONG A HIGH SCHOOL SAMPLE

Participants

Sixty-six students (45 males [68.2%], 20 females [30.3%], 1 Non-binary [1.5%]) from a High School in Long Island City, NY took pre and post-tests prior to and following the reading of the first two comic books on mental health disorders from the *Realabilities Comic Book Series*. The majority of students were in eleventh grade (59; 34.7%), one (1.6%) was in ninth grade, two (3.1%) in tenth grade, and two (3.1%) were in twelfth grade. Most students identified as Latino (43, 68.3%), seven as African American (11.1%) and as Asian American (11.1%), five (7.9%) as White, and one (1.6%) as Other.

Procedure

The high school teachers administered brief Knowledge Measures, Modified Pre and Post-Test Assessments of the Shared Activities Questionnaire (SAQ; Morgan et al., 1996), a behavioral intention measure, and The Adjective Checklist (ACL; Siperstein & Bak, 1980), a cognitive attitudinal measure both before and after students read the two Realabilities Mental Literacy-based comics.

Results

With regard to principal study results, Paired Sample T-tests revealed that participants showed significantly more knowledge about obsessive compulsive disorder (OCD), $t(65) = -2.169$, $p < .05$ and Phobias, $t(64) = -2.408$, $p < .05$ following the comic book intervention. After the comic book intervention, participants also displayed more positive behavioral intentions towards hypothetical peers with Anxiety on the SAQ Total, $t(65) = -2.294$, $p < .05$, SAQ Academic, $t(65) = -2.288$, $p < .05$, and on the SAQ Recreational, $t(65) = -2.462$, $p < .05$. Additionally, participants demonstrated improved intentions towards hypothetical peers with OCD on the SAQ Total, $t(62) = -2.810$, $p < .01$, SAQ Academic, $t(65) = -2.558$, $p < .05$, on the SAQ Social, $t(63) = -2.149$, $p < .05$, and on the SAQ Recreational, $t(64) = -2.177$, $p < .05$. Moreover, the participants showed more positive behavioral intentions towards hypothetical peers with Phobias on the SAQ Total, $t(65) = -3.317$, $p < .001$, and on the SAQ Social, $t(65) = -3.753$, $p < .001$. Finally, Participants showed significantly improved cognitive attitudes (via The ACL) towards hypo-

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thetical peers with Anxiety, t (64) = -6.527, p <.001, Depression, *t* (64) = -2.802, p < .01, and OCD, t (64) = - 3.648, p <.001 following the comic book intervention. Please see Table 3 for Means, Standard Deviations and significance levels.

Conclusions and Discussions

Thus, the researchers found that students who read the "Got Talent" and "Carnival" Comics, which discuss Anxiety, Depression, OCD, and Phobias, respectively, enhanced participants' knowledge of mental health literacy and improved participants' cognitive attitudes and behavioral intentions towards hypothetical peers with mental health disorders. Additionally, similar to the aforementioned study, the research revealed that the *Realabilities Mental Health Literacy Comics* could be effectively used with a high school population.

General Discussion

In summary, the first study found that a combination of the *Addy & Uno Off- Broadway Musical* and *The Realabilities Educational Comic Book Series Curriculum* significantly enhanced typical students' knowledge, interest and understanding of disabilities as well as the importance of promoting a stop bullying platform in school. The second study found that *The Realabilities Educational Comic Book Series* enhanced students with disabilities' nuanced knowledge of disabilities as well as the importance of promoting a stop bullying platform in their schools. The third study found that typical students who read the "Got Talent" Comic, which teaches about Anxiety and Depression, appeared to show more bullying knowledge and more positive stop bullying attitudes following the intervention. Furthermore, students displayed more positive behavioral intentions and cognitive attitudes towards a hypothetical peer with Anxiety after reading the "Got Talent" comic. Finally, the fourth study highlighted how participants increased their knowledge of mental health literacy and improved their cognitive attitudes and behavioral intentions towards hypothetical peers with mental health disorders after reading the "Got Talent" and "Carnival" Comics, which discuss Anxiety, Depression, OCD, and Phobias, respectively. Moreover, the research revealed that *The Realabilities Mental Health Literacy Comics* could be effectively utilized with a high school population. Overall, all four studies confirmed that an extended contact model with appealing storylines and other engaging media can be highly beneficial when teaching about diverse disabilities and mental health disorders.

With respect to study limitations, the aforementioned studies would benefit from even larger, diverse student samples in order to enhance the study's generalizability and external validity. Future studies would also benefit from observable behavioral data, to examine how student participants might actually act, behave or respond to students with disabilities following the research interventions, rather than solely relying on self-report measures of behavioral intentions and cognitive attitudes. While a limitation of earlier studies related to a failure to include participants with disabilities in the research intervention, our second study sought to rectify this earlier limitation, by recruiting students with diverse disabilities to participate in *The Full Realabilities Educational Comic Book Series Intervention*.

Finally with regard to future directions, the researchers hope to expand upon the Musical and Comic Book Series in multiple ways. Currently, a sequel to the *Addy & Uno Musical* is being created and the research team is in the process of developing two more comic books focusing on mental health disorders and an additional comic book featuring additional disabilities (facial deformities and differences).

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The research team is also currently designing a research-based, isometric, first-person adventure video game to offer typical junior high school viewers an opportunity to better empathize and comprehend the strengths and limitations associated with the everyday life experiences of individuals with disabilities (please see APPENDIX D for images of the video game).

Taken together, all of these interventions seek to enhance typical children and adolescents' knowledge, attitudes, behavioral intentions, empathy and kindness towards individuals with disabilities and mental health disorders. With more knowledge, understanding and recognition of the strengths and realities of these differences, rather than solely a focus on limitations, *The Addy & Uno Musical, The Realabilities Educational Comic Book Series Curriculum* and *The Realabilities First-Person Adventure Video Game* seek to enhance the positive intergroup attitudes towards individuals with disabilities and mental health disorders to reduce stigma and promote the socialization and success of individuals with disabilities, mental health disorders and typical individuals, alike.

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KEY TERMS AND DEFINITIONS

Behavioral Intentions: A person's perceived likelihood or subjective probability that he/she will engage in a given behavior.

Bullying: Seeking to harm, intimidate, or coerce (someone perceived as vulnerable).

Cognitive Attitudes: The beliefs, thoughts, and attributes that we would associate with a person or object.

Empathy: Stepping into the shoes of another person and perceiving and understanding the emotions that other individuals are experiencing.

Extended Contact Hypothesis: Coined by Wright and colleagues in 1997, postulates that knowledge that an in-group member has established a close relationship with an out-group member may promote more positive intergroup attitudes.

Kindness: The quality of being friendly, generous, and considerate.

Mental Health Literacy: The ability to identify specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of access to professional assistance; and attitudes that promote recognition and appropriate help-seeking.

Social and Emotional Learning (SEL): Identifying and managing emotions, caring about others, making good decisions, behaving ethically and responsibly, developing positive relationships and avoiding negative behaviors.

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APPENDIX

Images From *Addy & Uno* Off-Broadway Musical

Figure 1.

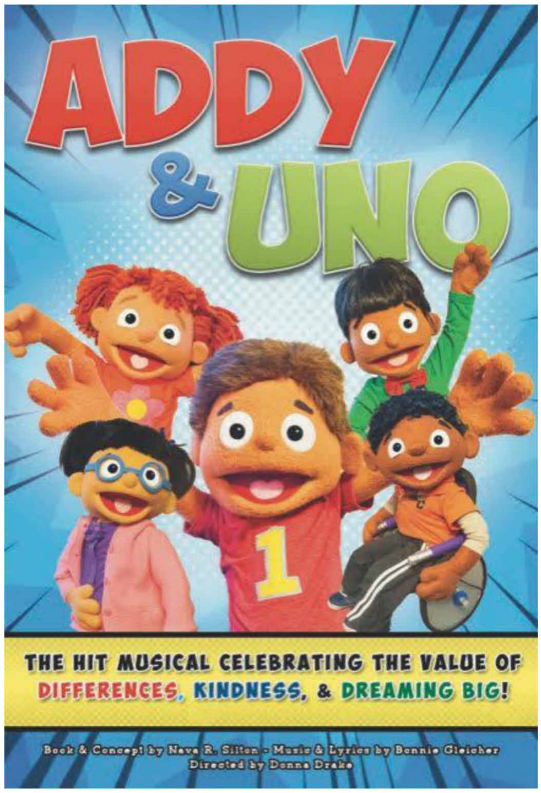


Figure 2.



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Figure 3.



Figure 4.



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Images of *Realabilities* Comic Book Series Curriculum

Figure 5.

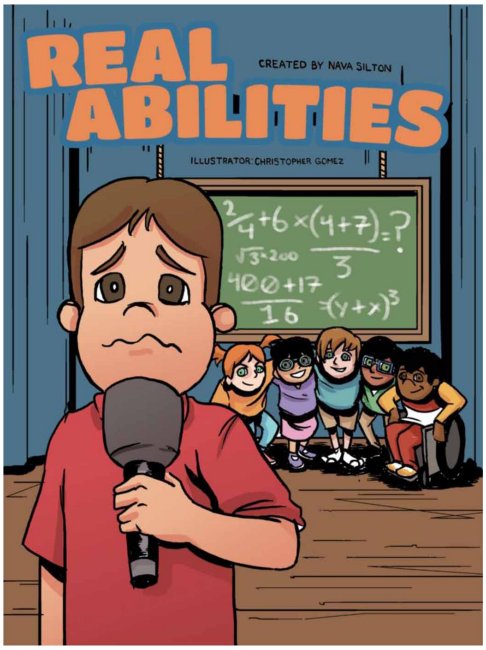


Figure 6.

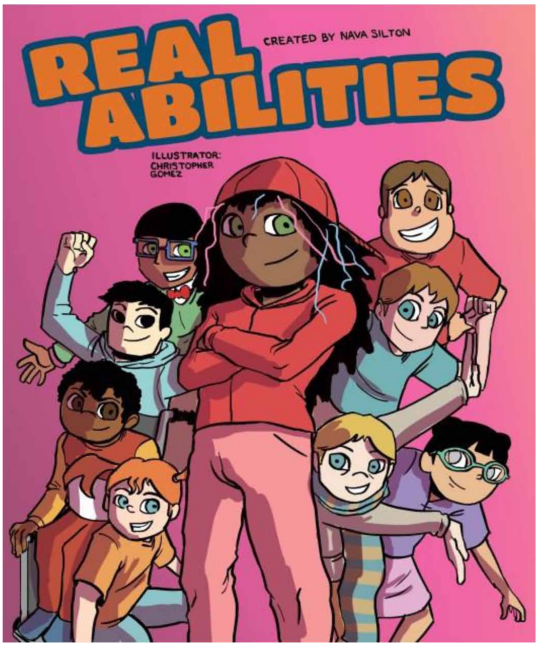
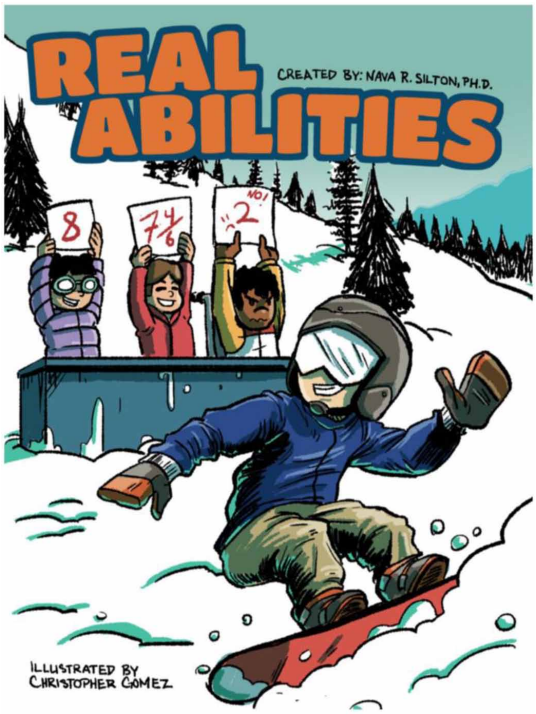


Figure 7.



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Figure 8.



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Figure 9.



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Figure 10.

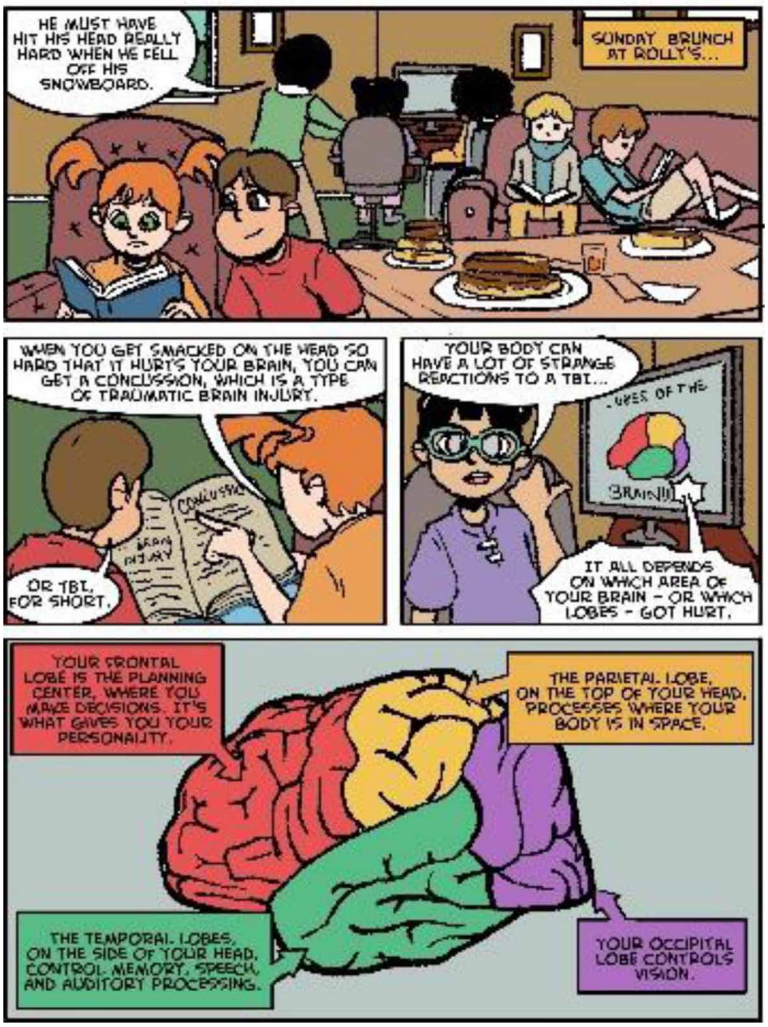


Figure 11.



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Images of the "Got Talent" and "Carnival" (The First Two Mental Health-Based Realabilities Comics)

Figure 12.

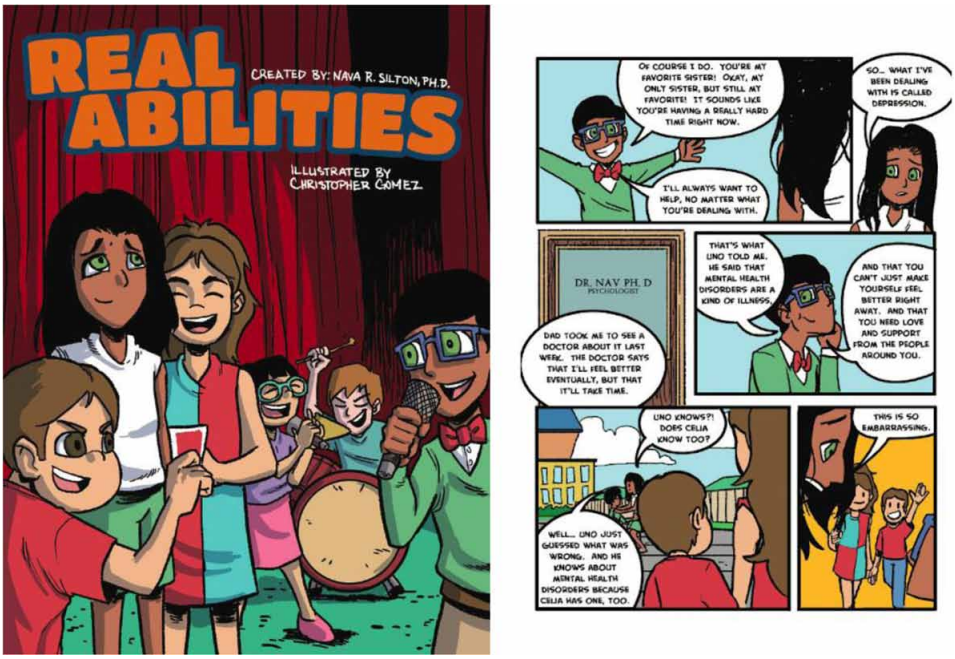
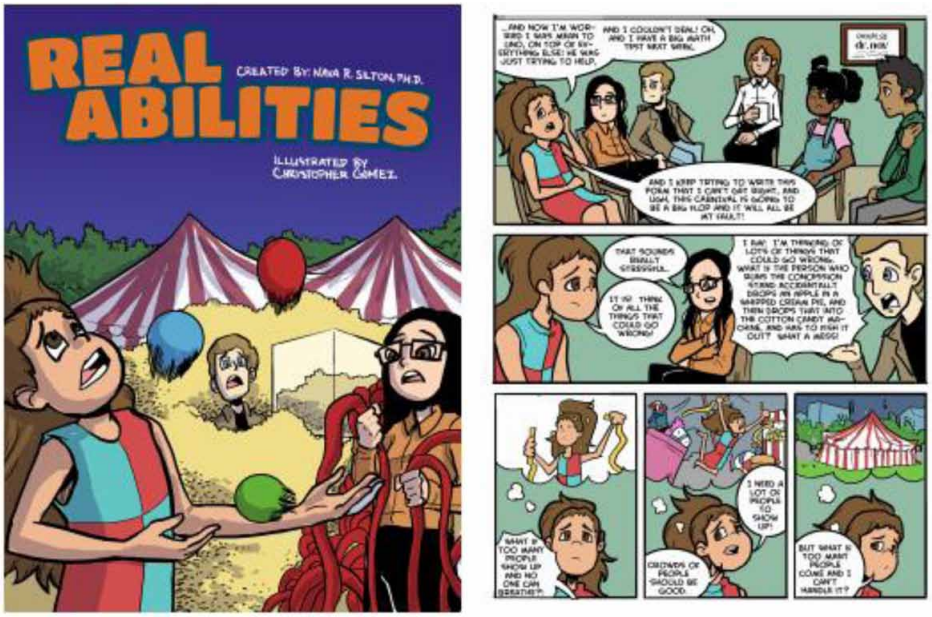


Figure 13.



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Images of the Research-Based, Isometric, First-Person Realabilities Adventure Video Game

Figure 14.



Figure 15.

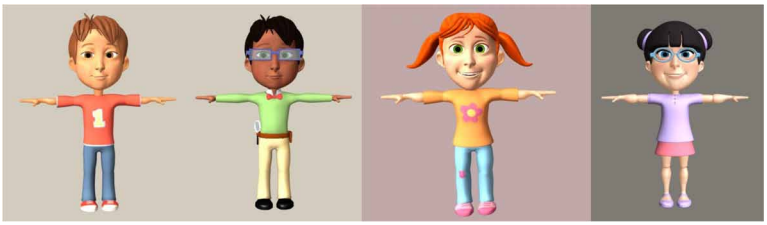


Figure 16.



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Figure 17.



Tables

Table 1. SAQ and ACL Paired Sample T-test Results of The Got Talent Comic Book Intervention.

	SAQ Total		SAQ Academic Subtest		SAQ Social Subtest		SAQ Recreational Subtest		ACL	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Anxiety (mean ± SD)	18.79± 3.98	19.87 ± 4.75*	7.03 ± 1.62	7.57± 1.84**	7.34± 1.75	7.64± 1.78	4.25± 1.29	4.59± 1.51*	6.04± 2.66	6.96± 2.89**
Depression (mean ± SD)	18.86± 4.77	19.55± 5.19	7.26± 1.76	7.49± 1.94	7.23± 1.95	7.52± 1.96	4.27± 1.49	4.53± 1.53	4.69± 2.31	4.79± 2.36

Asterisks indicate significance of pre- versus post-test results: *p<.05, ** $p < 0.01$; *** $p < 0.001$

Table 2. Bullying Knowledge and Bullying Attitudes Samples T-test Results of The Got Talent Comic Book Intervention.

	Pre	**Post**
Bullying: Knowledge (mean ± SD)	3.66± .66	3.78 ± .41*
Bullying: Attitudes (mean ± SD)	8.08± 1.73	8.80± 3.13*

Asterisks indicate significance of pre- versus post-test results: *p<.05, ** $p < 0.01$; *** $p < 0.001$

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Table 3. SAQ and ACL Paired Sample T-test Results of The Got Talent and Carnival Comic Book Intervention.

	SAQ Total		SAQ Academic Subtest		SAQ Social Subtest		SAQ Recreational Subtest		ACL	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Anxiety (mean ± SD)	17.62± 4.49	18.74 ± 4.90*	6.86 ± 1.84	7.30 ± 1.92*	6.92± 1.88	7.23± 1.99	3.83± 1.30	4.21± 1.48*	5.51± 2.34	7.31± 2.46***
Depression (mean ± SD)	18.82± 4.51	19.25± 4.65*	7.30± 1.68	7.52± 1.75*	7.22± 1.87	7.29± 1.83	4.33± 1.46	4.47± 1.41	4.28± 1.94	4.98± 2.15**
OCD (mean ± SD)	17.60 ± 4.71	18.83 ± 5.08**	6.85 ± 1.84	7.38± 1.94*	6.83 ± 1.92	7.19 ± 1.97*	3.91± 1.52	4.25 ± 1.57*	6.72± 2.57	7.71± 2.08***
Phobia (mean ± SD)	17.62± 5.06	18.97 ± 4.69***	7.00± 2.09	7.38 ± 1.94	6.68± 2.02	7.30 ± 1.78***	3.94 ± 1.46	4.21 ± 1.49	6.08± 2.20	6.72± 2.57

Asterisks indicate significance of pre- versus post-test results: *p<.05, ** $p < 0.01$; *** $p < 0.001$

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Chapter 14
Counseling Refugees

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ABSTRACT

This chapter discusses the plight of refugees, the challenges faced, and the psychosocial impact of said challenges. It further provides practitioners with a review of coping methods utilized by refugees throughout the refugee journey in order to highlight possible protective factors practitioners may build on in the provision of mental health services. Lastly, the chapter provides an overview of current therapeutic frameworks that are culturally sensitive for counselling refugees, the challenges in the provision of mental health services, and techniques utilized by practitioners in the delivery of mental health services through evidence of research and case-based examples.

INTRODUCTION

Being a refugee is usually considered a temporary situation (El-Sharaawi, 2015). Yet, due to political and environmental situations that impact the flow of migration around the world, being or living as a refugee is met with persistent instability and the consistent need to re-conceptualize a situation of exile and transit in an environment that places little within the direct control of refugees themselves. This also includes a suspension of future plans for education, financial security and building a family with no way of knowing when a durable solution will be reached. Currently, the United Nations High Commissioner of Refugees (UNHCR) has recorded the highest amount of displaced persons across the world since World War II (UNHCR, 2016). The rise of displaced persons and persons seeking asylum across the world has led to increased efforts to alleviate this growing crisis. However, although the crisis of refugees is not new, knowledge is still emerging on evidence based therapeutic frameworks and techniques in providing mental health and even social work services to this group of persons.

This chapter aims to provide a background understanding for mental health practitioners on the plight of refugees, the challenges faced and the psychosocial impact of said challenges. It further aims to provide practitioners with a review of coping methods utilized by refugees throughout the refugee journey in order to highlight possible protective factors practitioners may build on in the provision of

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mental health services. Lastly, the chapter provides an overview of current therapeutic frameworks that are culturally sensitive for counselling refugees, the challenges in provision of mental health services and implications for practice.

BACKGROUND

To date, there are 67.75 million displaced persons in the world, the largest number since the end of World War II (UNHCR, 2018a). A majority of this number is made up of refugees. Refugees are one of the biggest crises amongst modern day issues. Each day, masses of individuals and families seeking asylum are forced to leave their homes in search for safety. Some make a long journey on foot or are smuggled into vehicles across country borders. Others even brave the journey by sea in the hopes of landing on more welcoming shores. Many risk their lives and are separated from family and friends in the process.

The term "asylum seeker" and "refugee", although used interchangeably, have different operational definitions. An asylum seeker is an individual who is seeking international protection but whose claim has not been confirmed by the UNHCR (Phillips, 2011). For example, an individual escaping armed conflict in Myanmar may cross the border into Thailand or Malaysia seeking asylum and protection, however is not referred to as a refugee until he or she has completed a refugee status determination process by the UNHCR. On the other hand a refugee as defined by the United Nations 1951 Convention Relating to the Status of Refugees and the 1967 Protocol, is a person who

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable to, or owing to such fear is unwilling to avail himself to the protection of that country...or is unwilling to return to it. (UNHCR, 2010, p14).

Examples of these reasons include evidence of discrimination and violence towards ethnic minorities, LGBT community or even arrest and detention of individuals who voice opinions opposing that of the government in their home country. The convention also states that refugees should at the minimum be accorded the same rights given to foreign nationals living legally in a country (Arshad, 2005). However, in implementation, the likelihood that refugees have access to the same rights as foreign nationals is not only dependent on the migrant laws of a country but also each country's adherence to international humanitarian treaties and declarations.

The experiences that comprise the asylum seeker and refugee journey can be complex to understand. This journey involves the forceful uprooting of an individual or group of persons from their home country to begin an uncertain journey in the search for safety (Vogel, 2016). The journey of a refugee often involves a lack of certainty of a foreseeable future for a protracted period of time. Refugees can live for several years without recognized documentation, stable financial income and the ability to plan a secure future.

The refugee journey has been conceptualized by researchers in three stages; preflight, flight or asylum and resettlement (Gonslaves, 1992). Preflight is defined as the stage where refugees or asylum seekers are still living in their home country (Wessels, 2014). The flight period, on the other hand, is characterized by a physical relocation to a country of asylum where refugees await a long term solution (Bhugra & Jones, 2001; Wessels, 2014). Lastly, resettlement is the stage where refugees are relocated to a host country where they will be able to live in the long term (Wessels, 2014). However, resettlement is not

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the only option. There are three potential durable solutions for refugees; voluntary repatriation back to their home country, local integration into the country of asylum, or resettlement (Horyniak, Melo, Farrell, Ojeda, Strathdee, 2015). At the same time, only 1% of the world's refugees are resettled to third countries (Phillips, 2011). The question then remains, what is the fate of the remaining 99% who do not attain resettlement is an area of concern for both humanitarian and mental health groups? These individuals usually are faced with continued ambiguity and instability on the result of their status with no possibility of knowing when they will have a conclusion to their living their life in asylum.

Refugees are also at risk of developing mental health issues due to trauma and stress experienced throughout the journey. Research has suggested that 9% of adult refugees and 11% of child refugees have symptoms consistent with post-traumatic stress disorder, otherwise known as PTSD (Schweitzer, Brough, Vromans & Asic-Kobe, 2011). A meta-analysis of psychiatric surveys has shown that adult refugees living in Western countries are ten times more likely to develop PTSD, placing them at a higher vulnerability to substance abuse and suicide (Fazel, Wheeler, & Danesh, 2005). At the same time, the provision of mental health treatment for refugees across the world is met with various challenges due to the lack of interpreters and psychometric assessments that are available in relevant languages (Ullmann, Barthel, Tache, Bornstein, Licino, & Bornstein, 2015). The shortage in availability of a comprehensive and multicultural approach to providing mental health for refugees is also part of the issue that magnifies the challenges in ensuring refugees are able to access mental health services.

Psychosocial Impact

Throughout the journey of a refugee, refugees face various complexities. The constant state of limbo and lack of stability causes the experience of time to become an altered state where the future is uncertain and day to day living becomes unstable due to this experienced sense of limbo (El-Shaarawi, 2015). Refugees and asylum seekers alike face various issues of harassment, threat of arrest and detention, exploitation, discrimination and vulnerabilities to gender based violence and development of illnesses. Communicable illnesses, such as tuberculosis, have an increased likelihood of spreading due to overcrowded living spaces. Furthermore, refugees and asylum seekers typically have preexisting mental health conditions due to pre-flight trauma and experiences such as extortion by traffickers, abuse and harsh physical conditions during the long journey to safety (Mann & Fazil, 2006).

Protection Issues

What can further compound the stressors refugees face is that not all countries recognize refugees and asylum seekers. Although many countries are signatories of the 1951 Convention and the 1967 Protocol, there are still other countries who are not members to these conventions. In Southeast Asia, UNHCR works alongside various governments to address the issues of migration flows across sea and land. Unfortunately, most countries in Southeast Asia have are not signatories to the 1951 Refugee Convention and its 1967 Protocol. Countries who are not signatories include Thailand, Malaysia and Indonesia. This means that thousands of refugees in these countries live without the right to work and without the guarantee of protection and safety. Therefore, it leaves hundreds and even thousands of refugees and asylum seekers with a legal system that lacks the protection structure to ensure basic rights and safety for them. As part of providing a framework that all governments can use as a baseline governments have adopted and signed various international treaties The Bali Process on People Smuggling, Trafficking in Persons

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and Related Transnational Crimes as well as adaptation of the Child Rights Convention, Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Universal Declaration of Human Rights are some of the international treaties adopted by some Southeast Asian governments. However, countries as these are international treaties that do not carry legal consequences if not met, the majority of these countries often ignore the application of these treaties on migrants, particularly migrants who are undocumented or are considered illegal; a category that many refugees unfortunately fall into.

Although refugees living in asylum are removed from the immediate danger and violence of war in their home country, persistent challenges are faced as refugees experience restricted movement in camps and an uncertain future without work or the provision of education for their children (Farzana, 2016). At the same time, the experience of refugees in different asylum seeking environments may present refugees with varied concerns for safety and mental health. For example, refugee camps offer the possibility of greater safety and higher access to basic needs of food and shelter (Shakespeare-Finch, Schweitzer, King & Brough, 2014). Also, there may be other challenges refugees face in these environments. Asylum centres, for example, may increase the risk of ethnic conflict and the development of mental health issues due to the isolation and segregation within the centre (Lauritzen & Sivertsen, 2012) Additionally, the increased time spent waiting for a result at asylum centres made it challenging for asylum seeking children to develop positively in a space where safety and health are compromised. Furthermore, refugees in Southeast Asia typically live as urban refugees in cities and towns allowing them to blend into daily life amongst locals but without the same rights, access to services and protection as locals. Typically urban refugees were made up of single, young, male refugees (Crisp, 2017). However, urban refugees are increasingly made up of refugee community demographics including elderly, unaccompanied minors, single females and young families. This implies that there is an added risk posed not only in safety, but also in susceptibility to raids, arrest, extortion, gender based violence, and family cohesion.

Other protection issues can impact the mental health of refugees and asylum seekers. Isolation, fear of deportation and the possibility of being separated from family members caused the highest distress for refugees asylum centres (Sourander, 2002). Other mental health stress reactions such as depression, despair, anxiety, shame at surviving, anger were reported to be experienced during the asylum seeking period due to living with the constant threat of death and violence (Knezevic, Olson, 2014). The culmination of detention, ongoing discrimination and economic hardships can generate stress and a sense of hopelessness in refugees, which can lead to suicide (Vijayakumar, 2016).

Generating a Stable Livelihood

Creating a stable livelihood is another challenge faced by refugees in asylum that can contribute to mental health issues. Refugees tend to face difficulties in gaining employment whilst seeking asylum which may induce further psychological issues such as disturbed sleep patterns, low self-esteem, anxiety, depression and family violence (Mann & Fazil, 2006). Refugees living in a camp tend to find it difficult to gain sustainable methods in providing food and amenities due to an unemployment crisis experienced by refugees (Sarfo-Mensah, 2009). Refugees in camps usually have limited equal access to resources as compared to citizens of a country. Local organisations, including international and regional organisations, may be unable to provide sufficient support through provision of food and other basic necessities. Thus, providing a livelihood is not only an issue due to an individual holding a refugee status but also due to resource restraints of intervening organisations and the political climate of the relevant host country.

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Language Barriers

Language is one of the most common challenges refugees face once they have left their home country. Refugees who experienced more language difficulties report higher anxiety symptoms, indicating that issues with acculturation is one of the most salient factors in post-migration well-being (Kartal & Kiropoulos, 2015). This can happen at any point of the refugee journey once an individual has left his or her home country. With the lack of English communication skills to assist them in integration to a host country, many refugee parents instead rely on their children to provide translation for them when accessing services (Francis & Yan, 2016). Consequently, youths who had resettled with their families experienced a reversal of roles when it came to language and skills as the youths now had to provide communication support to their parents who had lower proficiency of the English language. This reversal of roles also meant that adult refugees lose the important social roles once resettled to a new country. This may include loss of roles such as a spouse, parent or child through separation or death or even occupational roles and cultural peacemakers or teachers (Goodkind, Hess, Isakson, LaNoue, Githinji, Roche, Vadnais, & Parker, 2014). As you can see, being a refugee can not only impact an individual's livelihood and protection but also the cohesion and wellness of the family unit, an area of life that could act as a protective factor but could serve as a perpetuating factor to stress or mental health issues.

Survivor Guilt

News of increasing conflict in their home country may also lead refugees to experience survivor's guilt as refugees may compare the dangerous circumstances loved ones in their home country may face to their own relative safety (Bemak & Chung, 2017). Many refugees naturally continue to be anxious about the safety of their loved ones who have remained in their home country. They may even feel guilty for not doing more to take their loved ones with them. Others may remember the experiences of violence they witnessed or have known to happen to their own loved ones. Still others may have the shock of finding out that a loved one has been arrested or killed by news on social media. These are issues that can complicate the process of grief, trauma and ultimately the mental health of refugees who have left their home country.

Coping Methods

However, despite the unstable circumstances surrounding refugees that continue for an unpredictable period of time, some refugees have found ways to cope with these difficulties. Being future oriented (Borwick, Schweitzer, Brough, Vromans, & Shakespeare-Finch, 2013; Mann, 2010), being able to utilize cultural traditions and community networks (Knezevic & Olson, 2014; Akinsulure-Smith, Dachos & Jones, 2013), and religious practice (Earnest, Mansi, Bayati, Earnest, & Thompson, 2015; Shakespeare-Finch, Schweitzer, King & Brough, 2014) are some of the factors that have helped refugees to cope with new environments. Although most of these coping methods are common amongst resettled refugees, similar findings were also found by the author amongst refugees in asylum, who also relied on community support, religion, self-directed coping and focusing on their future in order to cope with the long and dangerous type living in asylum (Nunis, 2017).

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Although the utilization of positive coping methods is widely reported, there also exist reports of negative coping methods amongst refugees. For example, Rohingya refugee youth living in a refugee camp in Bangladesh frequently became involved in drug usage, alcohol consumption and gambling (Farzana, 2016). Higher alcohol prevalence amongst male Middle-Eastern government assisted refugees than female government assisted refugees in British Columbia (Miremadi, Ganesan & McKenna, 2011). The impact of an unstable livelihood on mental health was also seen amongst female Iraqi refugees who were vulnerable to experiencing domestic violence if they had no finances upon arrival in a country of asylum and had borrowed money in Syria (Tappis, Biermann, Glass, Tileva & Doocy, 2012). Similarly, urban refugees working in a factory in Mizoram resorted to alcohol usage and family violence when male family members were unable to protect their families or provide basic necessities whilst seeking asylum (James, 2010).

The Situation in Malaysia

As of February 2018, the number of registered refugees and asylum seekers under the UNHCR mandate in Malaysia was at a total of 154, 400 (UNHCR, 2018b). However, it would be important for readers to bear in mind that this number is not inclusive of asylum seekers who are yet to receive recognition by the UNHCR as a person of concern to their mandate. A majority of registered refugees and asylum seekers are of Myanmar nationality, however, refugees and asylum seekers from Yemen, Somalia, Sri Lanka, Iraq, Afghanistan, Palestine and other countries also make up the total number. Additionally 40, 540 children of the total number are below 18 years old (UNHCR, 2018).

The phenomenon of refugees in Malaysia paints a different set of challenges for asylum seekers and refugees as Malaysia is not a signatory to the 1951 Convention Relating to the Status of Refugees or the 1967 Protocol Relating to the Status of Refugees (UNHCR, 2017a). Malaysia further lacks domestic law that details the rights and protection for an individual of an asylum seeker or refugee status. Instead this group of individuals is classified as illegal immigrants under the Immigration Act thus making them vulnerable to arrest, detention and possible deportation (SUARAM, 2014). Although holding a UNHCR card provides a measure of protection and the hopes of being resettled to a third country, it does not guarantee absolute protection or access to benefits in Malaysia (Alexander, 2008). Due to this, refugees in Malaysia determine the likelihood for safety and protection by negotiating their place of living, typically in either remote jungle areas such as plantations or pockets of the úrban sites' made up of low cost apartments (Nah, 2010). A country that faces a similar situation is Indonesia. Some of the major challenges faced by asylum seekers and refugees include financial difficulty, health issues, lack of security, gaps in continuing education for their children as well as mental health problems (Ali, Briskman, & Fiske, 2016). This then produces a domino effect of being exploited in and out of the workplace including exploitation by authorities and lack of access to education, medical attention and equal and fair work environment.

As Malaysia is not a signatory to the Refugee Convention or the 1967 Protocol, refugees in Malaysia are subject to being arrested and detained by authorities. Refugees are frequently subjected to raids at their workplace or residence, even in public areas, on a daily basis (Alexander, 2008). Rohingya asylum seekers and refugees in Kuala Lumpur have reported being stopped by authorities and having to pay bribes to avoid being arrested, with men being stopped to a higher frequency than those deemed vulnerable such as women, children and the elderly (Wake & Cheung, 2016). The lack of legal status also compounds the ability of refugees to earn a living whilst awaiting a long term durable outcome. Refugees frequently

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work in informal work areas in what the United Nations High Commissioner of Refugees has classified as 3D jobs – dirty, dangerous, difficult (UNHCR, 2011). Working in these fields further compromises the safety of refugees, in particular female refugees who are frequently sexually harassed and exploited by their employers (Buscher & Heller, 2010).

Furthermore, as refugees legally fall under the broad category of migrants, they are not privy to the right to health access (Health Equity Initiatives, 2010). Issues with communication due to language barriers at health facilities impede access to medical care. It was further reported that a number of refugees displayed PTSD symptoms such as flashbacks, difficulty sleeping and anger outbursts. Additionally, refugee children are not entitled to education in government schools in Malaysia due to their status as an undocumented child and as a refugee (SUARAM, 2015). Refugee children are however able to receive alternative education through community schools run by local NGOs or the refugee community that usually operate out of flats or shop houses (UNHCR, 2017b). However, these alternate routes of education frequently face resource constraints such as qualified teachers, salaries to pay teachers and materials to teach (Health Equity Initiatives, 2010).

Issues such as this can impede the emotional well-being of refugees as this places barriers in other social domains. A research by the author on refugees in Malaysia revealed that refugees face protection and psychosocial issues which impact their mental health well-being (Nunis, 2017). These issues include difficulties in ensuring safety for themselves, ensuring a sustainable livelihood and coping with the psychological impact of pre-migration factors and current living factors. The status as an undocumented person left urban refugees in Malaysia vulnerable to extortion, arrest, and to be taken advantage of by locals. The loss of education opportunities, high medical fees and low salaries were factors that made it difficult for refugees to provide a sustainable livelihood for themselves and their families. This led refugees within the sample to have a decreased sense of self and symptoms similar to post traumatic stress disorder and depression. While some refugees were able to depend on religion, family and community support as well as future oriented thinking to cope with the persistent instability and challenges, some instead turned to alcohol to numb their difficulties. Other families who are unable to gain a sufficient income to look after their families may give their children, particularly female children, to others either in marriage or for labor in order to better provide for the child who leaves and for those who remain.

Working With Refugees

While there have been increased efforts to study and produce evidence based practice for working with refugee clients, research is still in its emerging stages. Most research on the refugee journey and interventions highlight the experiential journey of refugees, particularly during the resettlement stage of the journey. Research has further focused on refugees based in Western countries. Few research efforts have focused on highlighting the delivery of mental health services and interventions through a multicultural lens. Thus, there is less emphasis on a coherent framework to interpret and apply multicultural sensitivity to the provision of mental health services for refugees.

There is no specific model applicable to all refugee cases. This is a group that is diverse, not only in sociodemographics but also in the type of migration experiences and reaction to these experiences, therefore being able to understand the nuances of each individual's journey is imperative in working with refugees. It would be first beneficial to conceptualize the social, legal, and psychological issues surrounding refugees. An example of an approach that would assist is the humanistic approach. Maslow offers a theory to understand this through the motivational theory of the hierarchy of needs (Corey, 2013).

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Humans would need to first adequately satisfy the basic needs of food, water and security in order to attempt to meet other psychological and self-fulfillment needs. the case of refugees, basic needs are consistently not adequately met, causing these individuals to cycle back and forth in an attempt to meet basic needs for their families and selves whilst also trying to maintain psychological needs. In the case of refugees, it is a daily struggle to meet their basic needs which are rarely consistently adequately met. Due to this, it may make it challenging for practitioners to work on addressing the emotional and cognitive impact of migration experiences as they may need to first address the stress and anxiety of dealing with current environment challenges within the host country. In fact, this may even deter refugees from seeking out mental health services as it is not deemed high on the list of priorities or needs.

Practitioner Self-Reflection

One of the first questions practitioners should ask themselves before working with a client from a refugee background is "How do I feel about migrants and refugees in my country?" and subsequently "What do I believe the government should do about unauthorized immigrants in my country?" (Villalbla, 2009). Without reflecting on their personal opinions and beliefs of these issues, practitioners may be in danger of being bias, hostile or insensitive to a refugee client which will impact the therapeutic alliance and wellbeing of the client. Practitioners would also need to prepare themselves by reading news articles on the developments specific to the country of origin before beginning an intervention. It would be useful to watch videos or read other resources on the cultural practice of a country, ethnic or religious group.

In today's fast paced virtual world, global news is readily available to the public through both print and social media platforms. These platforms make available both overt and covert political messages around the clock. (Bemak & Chung, 2017). Therefore, it may be possible for mental health practitioners to experience political countertransference which is a negative reaction towards migrants or refugee populations (Chung, Bemak, & Grabosky, 2011). Furthermore, heated debate usually surrounds the issues concerning migration and refugees which can give rise to a culture of fear of foreigners and the possibility that they may be terrorists (Bemak & Chung, 2017). This may affect mental health practitioners on a conscious or subliminal level thus inhibiting their work with refugee clients. Practitioners working with refugees must be keenly aware of their own political knowledge and value system in order to prevent buying into xenophobia and intolerance (Chung, Bemak, & Grabosky, 2011).

Adopting a Culturally Sensitive Lens

Therapy frameworks have long been criticized for being coined from a primarily Western and Caucasian perspective. While the core principles of these frameworks are important to understand in the application of techniques, it is also important to adapt strategies to fit multiple cultural backgrounds and issues. Over recent years, research has increasingly focused on identification of cultural variation in trauma and recovery models in order to make informed treatment approaches.

Cultural Formulation Interview

One of the results of this is the Cultural Formulation Interview (CFI) which has been included in the DSM 5. The CFI offers an assessment tool to assist practitioners during initial assessments in exploring cultural and social issues relevant to the client's cultural background (Crock, 2015). Although not

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all practitioners would utilize this but an understanding of the categories covered in understanding a person's cultural background would assist providing an example of factors to consider not only during the initial assessment but also throughout the therapeutic process.

Multiphase Model of Psychotherapy, Counseling, Social Justice, and Human Rights

The Multiphase Model of Psychotherapy, Counseling, Social Justice and Human Rights coined by Bemak and Chung (2017) is a framework that allows mental health practitioners to take into account various factors when working with refugee clients. This framework is made up of five phases; 1) the mental health education, 2) individual, group and/ or family psychotherapy, 3) cultural empowerment, 4) indigenous healing as well as 5) social justice and human rights. These phases may be used concurrently or sequentially. The MPM emphasizes the importance of core therapeutic principles including the introduction and education on basic therapeutic practice such as confidentiality, intake assessments, interpreter role and the counseling process. Although explained in the initial phase, these concepts may be reintroduced continually throughout the therapeutic process. The MPM further highlights the importance of practitioners being familiar with the difficulties in acculturation and to adopt a more case management approach in ensuring refugee clients are able to manage their practical problems such as transportation, medical care and housing. At the same time, practitioners need to be cautious of being totally absorbed in becoming a case manager but rather an information guide to support adjustment.

Mental Health Psychosocial Support Model

Humanitarian agencies have also recognized the importance of mental health interventions and psychosocial support, especially in emergency setting. The Inter-Agency Standing Committee (IASC) has created the Mental Health Psychosocial Support model which captures the importance of inter-agency collaboration in humanitarian emergencies. In this context, emergencies are not constricted to preflight but also the disruption of livelihood, family and community structures which plague the life of a refugee. An important point highlighted is the need to focus on local supportive resources and access to said resources instead of focusing solely on the pathology of an impacted group. Bridging a partnership alliance with community organisations and refugee communities can help to reduce isolation and increase social integration (Rousseau, Pottie, Thombs, Munoz, & Jurcik, 2011). Although geared towards humanitarian health workers, it is applicable for other agencies and persons working with refugees to have an understanding of the importance of engaging various organisations and most importantly communities in supporting mental health and psychosocial well-being during emergencies. Figure 1 shows the mental health and psychosocial support (MHPSS) intervention model recommended by the IASC.

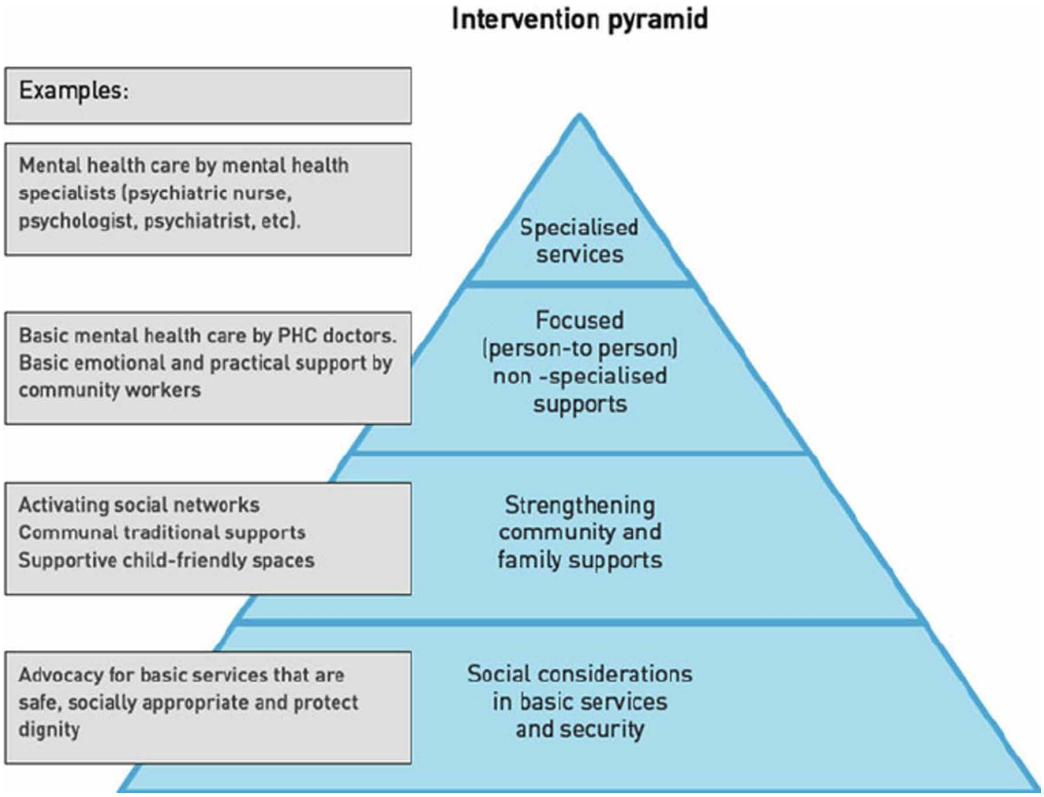
The IASC guideline has been found to be particularly useful in practice especially in areas where refugees live as urban refugees.

The Translator as Part of the Therapeutic Process

Working with a translator in delivery of mental health services will require more time allocation. Practitioners cannot ignore the importance the translator plays in building a therapeutic alliance with the client. In fact, research has shown that a good working alliance where all parties establish trust and team support built the foundation for successful therapeutic outcomes (Mirdal, Ryding, & Sondej, 2012).

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Figure 1. Mental Health Psychosocial Support (MHPSS) Model



Practitioners will need to take into consideration time constraints when planning each therapy session. It would be useful for practitioners to utilize an extra ten minutes at the beginning and end of each session to develop a working alliance with the translator. The pre-therapy session should be used to review the aim of the session, as well as to clarify technical terminology and cultural factors (Tribe, 2002). Furthermore, practitioners should remember that some translators may hold a refugee status themselves and can thus be vulnerable to vicarious trauma from listening to the client's story in therapy. Thus, it would be recommended to treat the post-therapy session as a debrief session for the translator and practitioner.

If practitioners are working with translators who also hold a refugee status, there is a possibility that practitioners may be able to enhance their knowledge on the current contextual issues and cultural beliefs that may be pertinent to a client. Maintaining openness to feedback from the translator and being curious about the client worldview can help to build a working relationship with the translator while also deepening knowledge of the refugee world. This can be done by utilizing extra time before and after a session for discussion. At the same time, some clients may not be comfortable working with translators who are from the same community as they may share the same living or community spaces which can cause clients to be unsure if information from the session will be divulged to other community members. Practitioners would need to be alert to any discomfort or less forthcoming clients for issues such as this.

It is important to bear in mind that the constructions of psychological health may be culturally different to those entrenched in psychological theories and modalities that are rooted in Western ideologies. For example, words such as "depression" or "self-awareness" may not have an equivalent in some Myanmar

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dialects. Often times, words such as this will need to be explained by the emotive content of the word or by using an analogy in order to be understood by the client. Therefore, attempt to use simple words in session. Instead of saying "That must be very depressing." You could choose instead to say "That must have made you very sad/ hurt you a lot." This will greatly assist the interpreter in explaining psychological constructs and the different levels of emotion to the client. Complicated words may confuse the client and could increase the power distance felt between a client and a practitioner who have varying levels of English fluency. Hence, it will also assist the client in understanding and explaining their concerns, thoughts and feelings and can contribute to a stronger therapeutic alliance.

As practitioners we are used to speaking seamlessly with our clients in a language exchange both practitioner and client are fluent in. Translators, however, are not necessarily as fluent in English or other mainstream languages a practitioner would be familiar with. Therefore, translators may not be able to remember all of what the practitioner says, especially if it has been said in long sentences with complicated jargon. Attempt to pause after two to three sentences. Translators need time to translate your thoughts and words to the client. It would also be helpful to keep sentences as short as possible in order to increase ease and efficiency of translation during the session.

Interventions and Techniques

In working with refugees, it would be difficult to ignore the external events and living conditions that take place in the everyday lives of refugee clients (Mirdal, Ryding & Sondej, 2012). The issues in gaining an income, acknowledged refugee status, and accessing health and education, as well as the possible experience of exploitation, discrimination and violence perpetrated by local citizens or within the community all contribute to the progress refugee clients can make within the limited therapeutic sessions we have with them. Hence, it is important to consider taking an integrated approach in order to meet the layered experiences and challenges faced by refugee clients. Commonly used approaches include cognitive behavioral, humanistic and psychodynamic approach (Schweitzer, van Wyk,& Murray, 2015). Additionally, cognitive behavioral therapy (CBT), narrative exposure therapy (NET), eye movement desensitization and reprocessing (EMDR) and testimonial psychotherapy have been recommended therapies for working with refugees (Ehnholt & Yule, 2006). However, though refugees come from a homogenous experience of fleeing persecution, each individual may have a very different experience and response to the experiences they have had. These techniques could also include expressive work such as imagery, metaphors, storytelling and psychodrama. An overview will be given for several of these approaches, however, practitioners should bear in mind that research is still emerging in this arena and that the following approaches are not the only ones that may be applicable for working with all refugee clients.

Humanistic Approach

As mentioned before, the therapist ability to connect with the client plays a major role in successful therapeutic outcome. Reflecting the core Rogerian conditions of congruence, unconditional positive regard and empathic understanding would be a basic foundation in working with refugees which need to be done in alliance with the interpreter. Being genuine and authentic have been shown to be the main underlying component in working with refugees which can be the foundations in providing a sense of safety to refugee clients who have had complicated experiences of loss, violence and trauma (Schweitzer, van Wyk, & Murray, 2015). Further, implementing equality between client and practitioner is impera-

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tive, particularly in working with refugees. A power distance would keenly be felt in this context where the practitioner is not only deemed more knowledgeable but is also an individual with more rights in the host country. Refugees may be more inclined to feel indebted or the need to comply or withhold information for fear of either not receiving further assistance or incurring other protection issues. Whilst implementing these core principles can assist in building a therapeutic environment favourable to a successful outcome, it would be important to note that practitioners may at times need to take on a more directional approach with refugees, particularly in crisis situations or in advocating on a larger sphere for refugee rights or access to basic needs.

Person Centered Therapy has also been expanded to include person centered expressive art therapy (Corey, 2013). This technique builds on the creative process as a way to transform and heal and ultimately personal growth by integrating the cognition, emotion, bodily and spiritual factors of an individual. Integrating expressive techniques with other therapeutic frameworks may be necessary especially if working with clients who find it difficult to verbalize thoughts and emotions. An overview of expressive techniques will be provided later in the chapter.

Behaviorism Approach

There are concerns that exposure techniques may not be best suited to treatment of trauma in refugees. Exposure techniques often focus on one traumatic event which is not applicable to refugees who have intersecting and complex trauma histories. Additionally, refugees typically receive treatment whilst still in unstable situations in new host countries which further complicate the ability to treat one issue whilst the client is facing a myriad of other threats. However, EMDR has shown improvements in PTSD rates amongst Syrian refugees who showed improvements on the Impact of Events Scale -Revised (IES-R) and Beck's Depression Inventory (BDI) (Lehnung, Shapiro, Schreiber, & Hofmann, 2017). At the same time, bear in mind that refugee clients come from different cultural background and may have difficulty in verbalizing their experience and emotions surrounding a traumatic event. Adopting a trauma-focused psychotherapy approach combined with art therapy has been shown to be more effective in reducing trauma symptoms than only relying on trauma-focused psychotherapy (Schouten, de Niet, Knipscheer, Kleber, & Hutschemaekers, 2014). Furthermore, it would be important to implement a phased method of treating PTSD. Phase one would first require a removal or minimising of risk of trauma, providing coping methods to reduce symptoms and skills training. Only then can the second phase of processing traumatic memories and third phase that focuses on social and psychological reintegration take place (Heide, Mooren, & Kleber, 2015). Whilst it may be challenging to totally remove the risk of trauma, practitioners can work on assisting clients to source for other networks that can provide some support for their basic needs. Examples include safer living spaces, supportive community organisations or members or medical assistance.

Cognitive Behavior Therapy

Culturally adaptive CBT model, or CA-CBT, may be more effective in working with refugee clients (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). This model highlights the role of arousal and somatic symptoms using an arousal triad to explain how physical symptoms are produced as well as a multisystem model to show how therapeutic techniques can improve physical symptoms. It may also be particularly useful in addressing PTSD amongst Southeast Asian refugees by explaining catastrophic

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thinking of physical sensations and the spiral of panic (Hinton, Chhean, Pich, Safren, Hofmann, & Pollack, 2005). Many refugee clients may not understand the physical distress and its link to other internal emotional and cognitive distress. This could be due to lack of mental health knowledge, literacy rate, access to education or cultural beliefs. An example of this is a young woman living as a refugee who was diagnosed with depression and generalized anxiety but who also experienced seizure like symptoms and tremors for many years. It was only after several sessions did she reveal that she had deep fear of being abandoned by her partner due to previous issues of infidelity. This also led to issues of not feeling worthy enough for her partner. Coupled with the unstable and harsh realities of living as an urban refugee and coping with separation from family, it had led to other relationship discord. This had a profound effect by manifesting as conversion disorder in order to gain affirmation in the form of care and attention from her partner. By working through the emotional and thought pattern she had and providing relaxation techniques, symptoms of seizure and tremors gradually decreased.

Mindfulness Therapy

The practice of mindfulness training has been shown to be effective in reducing PTSD rates (Marzabadi & Hashemi, 2014). By addressing health from a biopsychosocial approach by assisting an individual to understand their emotions, to accept experiences as it is and to focus their attention it assists refugee clients in building a holistic understanding of the experiences they have had. It also assists in better understanding physical symptoms and therefore a more coherent mindset towards leading a more efficient life outside of therapy. This may be a more appropriate technique in working with refugee communities who experience panic attacks, anxiety and to combat some PTSD symptoms as it introduces the concept of mental health and its effect on the body thereby affirming the manifestation of psychosomatic symptoms.

Narrative Therapy

As previously mentioned, exposure techniques may not necessarily be applicable to refugee clients as these techniques usually address one traumatic experience at a time. However, the creation of an exposure technique that combines individual narratives coined as Narrative Exposure Therapy (NET) has shown to be effective with refugees and asylum seekers. NET was originally designed to provide intervention for survivors of organized violence when faced with limited professional resources to address their needs (Hijazi, Lumley, Ziadni, Haddad, Rapport & Arnetz, 2014; Schaur, Neuner & Elbert, 2005). It is a short term therapy meant for individuals suffering from PTSD through emotional exposure to traumatic memories, and reorganizing said memories into a coherent and chronological narrative (Robjant & Fazel, 2010). Techniques include fusing emotional processing with expressive writing which may imply that clients whose cultural background value history telling may find this approach more socially acceptable (Hijazi et al., 2014). It has been found to be effective when used with both adults and children. At the same time, practitioners who are interested in employing this methodology may need to practice caution when working with refugee clients who live in a country that may not be socially or economically supportive of refugees as this may lead refugee clients to experience increased and consistent victimization and thus aggravate the original trauma experienced. The lack of medical attention, poverty, and malnutrition may restrict impact of any psychosocial intervention (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004).

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Expressive Techniques

Techniques utilizing art may be especially useful for clients who are less verbal and particularly for survivors of gender based violence and children. Providing clients with the space to express their emotions and thoughts in a non-verbal way will be useful. It can also provide clients a space to assert control of how they express themselves and a way to assert themselves. Art techniques utilized in therapy can also be a way for bridging the gap between refugee parents and their children communication especially when a family has newly arrived in a host country. Combining hope based theoretical framework together with art based techniques (producing a hope quilt, allowing children to take photographs of their lives) and then discussing these elements with the child and later their parents have helped refugee children and parents to be more aligned in hope and strength in order to assimilate better into a host country (Yohani, 2008). At the same time, art based techniques may need to be paired with other frameworks in order to facilitate the journey towards healing. There are several frameworks that have been found to be useful in combination with art techniques. One of them is solution focused art therapy (Moosa, & Koonrankot, 2017). Another is the usage of mandala art therapy in assisting refugees to find safety in a new host country by finding safety and reclaiming their identity and empowerment despite having traumatic migration experiences (Ely, Koury, Bennett, Hartinger, Green, & Nochajski, 2017).

Finding safety is a core issue for refugees living in asylum, particularly urban refugees who do not have the relative safety of a refugee camp to depend on. Previous group work utilizing art based techniques conducted by the author and a group of community health workers with a group of refugee women is an example of this. This group women lived in a high risk urban area that was known for high crime rate and densely populated with drug users. They spent most of the day alone at home with their children whilst their husbands were at work. Many had experienced assault and robbery. It was difficult for many of the group members to acknowledge difficult emotions including fear and even anger. One of the sessions included using plasticine to model their experience of being robbed or assaulted. Some art products included abstract forms and even prison bars. The emotions evoked during and after the activity were discussed and group members were then invited to do whatever they liked with it before collecting it into a basket. Some gently set it aside, others split it into two pieces thus showing the varying reactions each member had to their current situation. This was also processed. The activity allowed group members to acknowledge the emotions and stress they were experiencing towards their current context in a non-threatening and overly verbal way which is the beginning of finding emotional release and coping methods in the situation they were placed.

Implications for Practice

One of the first ideas you may have as a therapist working with refugees is to contact the respective embassy of your client. This is the least helpful approach to take. Many refugees have fled their home country for fear of their lives due to persecution at the hands of their government or fellow citizens. Thus, refugees are usually in fear that their embassy may locate them and taking action against them and their families (Tribe, 2002). Proceeding with this approach, especially without a client's consent, may impact the formation of therapeutic alliance and further deter the client from continuing to further sessions. Instead, consider contacting organisations such as United Nations High Commissioner for Refugees, and a range of local non-governmental organisations that cater to assisting migrants and refugees.

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A main point highlighted by many researchers and practitioners in the medical and psychology field is the importance of psychoeducation for refugee clients and community members (Giacco, Laxhman, & Priebe, 2017; Dotevall, Winberg, & Rosengren, 2017). Providing psychoeducation may increase the likelihood that refugees will access mental health services during asylum or resettlement. This is inclusive of providing brief information on psychological issues refugees may experience and how to seek help. It is particularly important to provide psychoeducation when it comes to treatment adherence of psychotropic medication. This may include the need to include family or community members who can assist the client in adhering to treatment. For instance, a client who is experiencing psychosis will not be oriented to time, date or place and will need assistance from family, friends or community member in adhering to psychotropic treatment in order to reduce psychotic symptoms. Similarly, a client who is elderly and experiencing depression may not only need assistance in taking the right dosage at the right time but also physical assistance and increased emotional support.

Practitioners may be inclined to place clients from the same country in the same therapy group when conducting group therapy. This may be a risky strategy as refugees may have been forced to flee due to reports on their religious, political and ethnic views thus leading refugees to have mistrust towards members of the same national background. Refugees may also be anxious that their personal information may fall into the wrong hands and thus endanger them or the lives of their family in their home country (Tribe, 2002). However, it is not impossible for group therapy or support groups to succeed. For example, due to the nature of political unrest in Sri Lanka, Sri Lankan refugees may have more challenges building a supportive environment even within a support group. One of the key elements that assisted members of this group to move beyond initial prejudices and fears was the sensitive practitioner who understood the nuances of the political situation in Sri Lanka and chose instead to build on commonalities within the group. Building on common experiences of loss, violence and challenges experienced living as a refugee helped the members of this group to extend emotional support to one another.

Additionally, practitioners need to be alert to the impact of cultural patterns, both positive and negative, on a client (Bala & Kramer, 2010). Whilst practitioners should be aware of cultural practices and differences of a client's background, it should not necessarily stop practitioners from addressing and even challenging the negative impact of cultural practices and beliefs. In order to do so, practitioners may need to consult with members of the same ethnic community, including trusted family members or friends of a client in understanding and possibly challenging certain beliefs and behaviors. For example, while some cultures may be more open to a husband physically reprimanding his wife, in many countries this is defined as domestic violence. Most Southeast Asian countries view this as a crime and have legal ramifications. Practitioners may need to confront the seriousness of these actions and its legal and practical implications in the host country. Likewise, some countries may be more open to indulging recreational use of drugs. Again, these are behaviors which can not only negatively implicate a client in the eyes of the law but can also induce negative coping methods which can lead to other mental health challenges such as addiction and drug induced psychosis. As a consequence of this, it can add issues in maintaining a job, income and also decrease the cognitive functioning of an individual. Additionally, it may affect the likelihood of resettlement as a durable solution for the client as countries of resettlement have strict criteria on the sociodemographic and health background of refugees accepted.

Furthermore, services and interventions for refugees are usually clustered within certain geographical areas. Most organizations offering medical, legal and protection services for refugees are clustered around major city centres. This is inclusive of UNHCR that may only have one branch office in some countries. This can leave many refugees with limited knowledge and access to much needed services.

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As an illustration, refugees who work in plantations or on fishing boats may have the tendency to have drug misuse issues as a result of working in lonely spaces for long hours. However, due to their far out location, they would have low knowledge on the signs on addiction and withdrawal and how to intervene in such cases. Besides this, refugees needing assistance would need to travel to these areas in order to access much needed service. This can cause many issues for refugees as their safety may not always be guaranteed when travelling, particularly if they are undocumented or living in a country that does not recognize refugees. It would also impact their finances as they would need to utilize their meagre salary in order to take leave from work for several days to conclude their appointment. Complications such as this can result in many refugees choosing to ignore health or mental health ailments until it has become too serious to ignore often times to the detriment of the individual.

In spite of the various experiences and challenges refugees face throughout their journey it is imperative to highlight that not all refugees, though having experienced major loss and even violence, will need therapeutic intervention. Although most refugees share similar experiences, not all experience significant mental distress as a consequence. It would be practical to first consider the individual's journey, current contextual factors and personality traits before concluding the existence of mental health issues. Drawing from the IASC's MHPSS system, it would be then important to draw on protective factors and preventive measures within the community and individual's life that can assist the client in coping with current challenges.

As mentioned earlier in this chapter, refugees themselves do endeavor to find ways to cope. Some of the factors practitioners may consider are community networks and religion (Nunis, 2017). Refugees typically have a network of contacts and even ethnic and religious organisations specific to their background. It would be beneficial to understand the network of refugee communities and build liaisons with them in order to work together on outreach and support in challenging cases. Local religious organisations are another resource a practitioner can tap into for both community and development support. Further, some refugees may have strong religious or spiritual beliefs. Having a firm belief and faith in God's plan has helped refugees, particularly refugees living in asylum, feel comforted and maintain a sense of hope (Nunis, 2017). These are examples of support systems and coping methods that may exist that can further assist refugee clients. At the same time, not all refugee clients may find these options helpful. Exploring a client's networks and coping mechanisms whilst being aware of cultural differences would be most important in order to help build preventive and supportive measures.

Practitioners would also need to take on a more assertive role in advocating for multi-lingual instrument measures, mitigating social and institutional discrimination, conducting culturally appropriate outreach and placing the client as the cultural expert (Villalbla, 2009). It would be difficult for practitioners to ignore the contextual issues that exacerbate the mental health of refugee clients whilst also attempting to provide services without first understanding the complexity of the social, health and community issues of the refugee client. Practitioners should be prepared to take on a more assertive in advocating for change whilst maintaining the confidentiality of the refugee clients they work with. This includes building networks with both local and international organisations, local refugee communities as well as promoting for the availability and access of services and safe spaces.

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FUTURE TRENDS AND CONCLUSION

Moving forward, practitioners would need to take on more assertive roles in ensuring that culturally appropriate interventions for working with refugees and migrants continue to reflect the diversity of the population they work with. More services and information on services should be disseminated to refugee communities and agencies. However, practitioners should keep in mind that not all refugees are fully literate therefore practitioners would have to find different ways of communicating this information, such as pictorial pamphlets or videos (Giacco, Laxhman, & Priebe, 2017). More importantly, practitioners should also be aware of culturally appropriate ways emotions are exhibited before being too quick to diagnose a refugee client.

In the current climate of heated political debate around the refugee crisis and migration policies, practitioners must endeavor to focus instead on the human behind the label of a refugee. Understanding the human aspect of various pre and post migration experiences and current contextual issues should be one of the main aims of practitioners. Practitioners would need to make consistent effort towards understanding patterns of migration, political background of refugee home countries and being adaptable when working with refugee clients. Further, increased efforts should be made in publishing culturally appropriate evidence based strategies in working with refugee clients in order for practitioners to be able to assist clients to cope and heal better throughout the migration journey.

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Chapter 15
"More Than Peer Support: Organizational and Relational Intervention Model": First Responder Assistance Program (F.R.A.P.)

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ABSTRACT

The chapter describes a replicable and innovative approach designed to assist first responder communities through the mental health challenges they face in their personal and professional lives. The First Responder Assistance Program (FRAP) strives to create a healthy environment, through a unified structure, three tiered organizational and relational intervention approach, inclusive of peer support, peer chaplaincy support, and clinician involvement. The FRAP Model establishes a direct correlation between organizational wellness, and the individual health of its members. It emphasizes a "top to bottom" organizational intervention, with the understanding that no matter how much help is provided to the individual, the environment must be addressed in order to obtain sustainable results. It stresses a "holistic" approach to healing with a focus on post traumatic growth and the systematic building of individual and organizational resilience.

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THE QUESTION

I was sitting in the Fire Chief's Office making a presentation about the needed expansion of our Peer Chaplaincy Program, when he asked a question for which I had no comprehensive answer, at least none that was satisfying to my own mind. "Why are we having more problems with first responder mental health now than we have ever had in the past?" The Chief continued with his line of questioning, not necessarily seeking an answer from me, but more in a rhetorical fashion, externally processing something that obviously he had been wondering for quite some time. He said, "The calls haven't changed. We used to run difficult trauma calls back in the day." As the conversation continued, some obvious possibilities, all with some merit, were posed as reasonable answers:

- Awareness has been heightened, so perhaps what was once hidden, now has come to light
- Maybe the stigma has lessened because we are talking more openly about mental health
- The advent of social media may not allow for a space to disconnect
- Perhaps it is the increase in the sheer volume and intensity of calls
- Or maybe the pace of present-day living is affecting our ability to cope

Now it is here that I must interject that neither the Fire Chief nor I (Chaplain Mario Gonzalez) are sociologists or researchers, but with over 60 years of combined experience as first responders, I think there is some merit and validity to our suppositions.

As we moved on to the task at hand, deciding we were not going to find a definitive answer in the time allotted for our meeting, the question continued to roam in my mind. Are traumatic calls truly adversely affecting and wounding first responders more today than they did in the past? Were former generations of first responders just tougher and more resilient than us, or were they just better at hiding their emotional pain and woundedness? The more I thought, meditated, and prayed about this, the more convinced I became that the answer to both questions is "yes". Perhaps first responders of yester-year, were both tougher and better at hiding their emotional pain than their contemporary brothers and sisters.

Now before I'm taken out to the woodshed by my fellow first responders for having made such a statement, let me just say that I believe we are plenty tough. A lot of what came out of my short impromptu brain storming session with the Fire Chief raised more questions than provided answers. I happen to believe that this is actually good. It is always in the space where hard questions are asked with integrity, that good answers are birthed. Yes, some good work is being done in the area of breaking down the ingrained culture of invincibility and stigma associated with seeking assistance in our first responder community. But are we being shortsighted in what we mean by changing the culture?

Yes, in most Departments, peer support is now considered as an important component in the battle for first responder mental health. But do we have measurable outcomes that our inventions are effective? Although PTSD and other anxiety driven mental health challenges are now topics of conversation in most first responder communities, are we looking at these topics from the most appropriate and helpful perspectives? Are Department administrations "being forced" to take reactionary measures due to new laws and incidents within their organizations? Are they willing to take the necessary steps to not only implement but institutionalize well thought-out support programs? Is their willingness to intervene, truly motivated by a desire to improve the lives of their most precious asset…their people?

In this chapter we will attempt to address some of these questions and provide the best answers from our optic, based on the many years of experience helping the public as well as then pivoting to help

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our own. In doing this, we believe that a replicable model of organizational and individual relational assistance will begin to appear as the best "wholistic" approach to helping our own.

THE CULTURE

Whenever the topic of changing the first responder community culture arises, the conversation inevitably defaults to the ingrained mindset of invincibility that comes with the uniform, and the stigma attached to seeking assistance. The firefighter, the police officer, and the alarm office call taker are at the receiving end of the most recognizable number in our country…"911". When that number is dialed, the expectation is that the cavalry is coming and help is on the way. But not only help--whatever the emergency at hand--that help had better be prepared to show up ready to have all the answers and provide appropriate assistance in a timely and professional manner. It is expected that the help is strong, courageous, and ready-to-respond at any hour of the day; immutable in the face danger; infallible in split second decisions, and lest we forget, courteous and level headed when faced with individuals who might be unruly because they are quite possibly going through the worst day of their life. Repeat that countlessly over a 25-30 year career, and is it any wonder that most first responders carry an imaginary "S" tattooed on their chest underneath the uniform? Expect Superman or Wonder Woman--that is who had better be showing up. For most of us, it doesn't take long to realize that these expectations are unattainable. However illusory avatars don't die easily, because the ingrained stigma attached to seeking help as mere mortals persists.

There is no denying that addressing this mindset needs to be a component of changing first responder culture, but to stop there would not only be short-sighted but ineffective. First Responder culture is a subculture of two other parent cultures; the organizational culture fostered in each individual Department, and the culture at large from which it draws its members. Together, these shape First Responder culture.

In addressing organizational culture, we must first asses from a management and training perspective, whether the organization is fostering a culture of authority and power or a culture of service. Foundationally at its core, first responder work is about service. The purpose of our profession is service. Service is what we are paid to do, and an attitude of service is what is expected of us. This being the case, it would stand to reason that internally we should be fostering and modeling a culture of service and self-care, for, and by each other. This congruence of expected external behavior and internal culture could be described as "Organizational Wellness". We consider this to be an integral and necessary function in the pursuit of the well-being of the individuals that make up the whole. We are indeed "our brother's keeper", and this attitude should permeate the entire culture of the organization from its highest levels and across all ranks.

This can only be accomplished by an absolute commitment from the administrative and training hierarchy, to implement and adhere to policies that foster this culture of care and service. It is also imperative to hold all positions of authority within the organization accountable to this higher calling of leadership. Sadly, in most organizations, this is not the case. In the day to day "battle" of running a para-military organization, too often pride, ego, and undisciplined behavior in need of adjustment, get in the way of the best intended efforts of creating and maintaining an internal organizational culture of service and care.

In an authority and power-driven culture, management tends to look at its members as unruly children who only respond to the hard line of punishment. Conversely, the rank and file look at management as uncaring parents. This antagonistic mentality leads to a mutual lack of trust and a feeling of administrative betrayal from the rank and file. This will always stand in the way and damage any attempt to create

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a healthy culture of internal service. The very real and valid administrative challenge of holding its members accountable to appropriate discipline when needed, should never offer up as collateral damage its attempt to create an internal culture of care and service.

On the other hand, a culture of administrative service and care looks at discipline as a constructive tool for improvement. It understands that the well-being of the one leads to the betterment of the whole. It stands by the principle of assistance before discipline and it holds all of its members accountable on an individual basis without using a shotgun approach to disciplinary policy. Organizationally, this is by far not only the harder road, but also the road less traveled. Nevertheless, if we are to truly address the needed change of culture within our industry, we must first endeavor to honestly asses, and then be willing to take the hard steps to improve this aspect of our organizational culture.

Turning our focus to the influence the culture at large is having on first responder culture, it doesn't take long to identify the advent of social media and the rapid growth of portable technology as a major contributor to decreasing interpersonal and relational connection. Fire Station dining rooms and day rooms are not the bevy of relational interaction that they used to be. In fire stations, breaking bread as a family used to be commonplace. Although you can still find pockets of this important tradition in many of our houses, we are slowly experiencing its demise, much in the same way we have witnessed it in the American home. Even when we manage to get together for meals, the unwelcomed presence of technology alarmingly interferes with and disconnects us from being present with each other.

Increasingly, the conversations--when they do happen--are not about our personal lives, so much as they are about the popular entertainment choices of the day. We are becoming so comfortable with the imaginary worlds presented to us by our own inventions, that connecting to the reality of being present is becoming increasingly difficult. From a completely non-clinical and anecdotal evidential perspective, this to me cannot be conducive to the well-being of our mental health, especially when it is challenged by the harsh realities of our profession. I am not saying that technology and entertainment are the root of all our mental health challenges, but we ignore this topic to our own detriment.

Another area where cultural thinking seems to have shifted, and is also affecting the first responder sub-culture, is the notion that life should be easy, and that problems when they come should be resolved at the drop of a hat. Hardship somehow has become an interruption, rather than a normal possibility. The ease and rapid access to all things comfortable inclusive of service, information, and climate control, to name just a few, have made us an extremely impatient society when it comes to dealing with hardship or discomfort.

In our chosen profession, the first responder is regularly confronted with the disruption of these expectations in the life of those he or she is sworn to protect. The constant exposure to these events can begin to intrude into an idyllic expectation of life, especially when it touches too close to home. For example, the death of a child, ran by a paramedic who is a new parent himself; a deadly assault on an elderly couple handled by a police officer dealing with the death of his or her parents; or a nursing home call handled by a rescue crew in which one of its members just placed their mom in an assisted living facility.

This collision of worlds accentuates and opens our eyes to the reality that we have little to no control over the outcome of most things happening around us. This "reality check" to someone who has been living under the illusion that their life journey should always go as they expect or have planned can be terrifying. Again, I am not saying that first responders live in some sort of unrealistic panacea, but the fact is that the culture we live in tends to expect and almost demands quick solutions to problems and ease of life. Accept it or not, our personnel are made up of a microcosm of the society surrounding us. We must do a better job educating our internal culture as to the normalcy of pain and hardship, and the

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opportunity for growth when confronted with both of these challenges in our everyday life. If we fail to understand what changing first responder culture should look like and miss the mark in truly making a difference in this important task, we will constantly be in a reactionary mode when it comes to the mental health of our people.

With respect to changing the culture, in an organization, education and awareness can become the fertile ground where culture change is plausible. But for this to happen, it must occur in the context of Departmental support and participation across all ranks. Any educational intervention must be accompanied by an administrative/leadership modeling of the behavior being promoted. The educational focus should also address the wider topic of how the culture at large is affecting the internal first responder community as just described.

THE SPIRITUALITY OF HEALING

It has been said that we are all recovering from something. The wisdom of this statement is at once both humbling and sobering. No one goes through this life without experiencing pain, disappointment, or heartache in some way. Our journey to healing and wholeness invariably has its starting place from a realization that we have been broken. Like participants in a high-speed game of bumper cars, we are constantly in need of forgiveness either given or received. Acceptance of brokenness, gratitude for where we are in the journey, and our need of forgiveness are prerequisites for healing.

This involves two important linchpins needed on the road to healing; humility and vulnerability. If humility and vulnerability start us on the road, the unflinching search for truth, in our need for love, is where the hard work is done. We are all relational beings. We are in a relationship with ourselves, our present situation, our past events, the world around us, each other, and if we are open to it, the existence of the spiritual and the source of all things created…God. We share the same world, but with each of us experiencing different and unique realities. Our experiences color and filter the way we see the world, but the one constant, whether we are able or willing to see it, is truth.

The addict trapped by his or her addiction, experiences the reality of transient relief through their substance or behavior of choice, but the truth is that they are on the road to deepening their pain. In the mind of a person feeling the paralyzing anxiety which connects a past event to a possible future, nothing could be more real, but is it truth? Recorded in the eighteen chapter of the Book of James, a 1st Century Roman Precept in Judea asked a very important question, but his pride and impatience did not let him wait for the answer…What is truth? It is in the answer to this question, and our alignment with this most elusive concept, where the proverbial rubber meets the very real road in our journey to wholeness.

Indeed, whether you ascribe to his claims of divinity, are a follower of his way, or think he was just a historical anomaly, that most famous of all Galilean carpenters truly put His finger on the pulse of the question of healing and wholeness when he made the following statement. "And you shall know the truth and the truth shall set you free." In meditating on the intersection between spirituality and healing, I decided to pose the question to a trusted friend with a long career of helping people on their road to healing as a successful therapist. I am grateful to my friend, Flora del Cueto LMHC, for her thoughtful and insightful answer to this question. How then do healing and spirituality relate to each other?

"My experience as a clinician has revealed that those who have a relationship with God, a spiritual leaning, are more likely to surrender in the process of recovery and healing particularly from significant traumatic events. That is, those people with a spiritual leaning, or close relationship with God, are less

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likely to have emotional resistance as they explore the thoughts and memories associated with trauma and or abuse. In contrast, persons who have animosity towards God and or no spiritual leanings, tend to have a greater resistance to emotional healing and the exploration of those events that are emotionally painful" - Marie Guma MS. PsyD (ABD)

THE NEED

In order to try to answer the chief's rhetorical question that spontaneously created quite a conversation between him and Mario, I (Marie Guma MS. PsyD (ABD)) must dive a bit into the history of behavioral health or synonymously coined, mental health. According to the World Health Organization, mental health is:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.1

Mental health is no longer solely defined as the absence of mental illness. Neither of these concepts are new to modern society. As early as 1500 BC the Egyptians depicted emotional turmoil in their drawings. They believed that mental illness was due to spirit possessions. The Greeks attributed mental illnesses as rage inflicted by the gods. During the Dark Ages, the cause of mental illness was ties to being possessed by the devil. During these times, a person who did not get better was thought to have weakness in their faith.

Witchcraft was thought to be the cause of mental abnormalities during the 15th and 16th centuries. The chosen treatments during this era were purging, bloodletting and removal of organs that the doctors believed could get infected. Mentally ill citizens were placed in mental hospitals that were primitive and the care was brutal. The patients were mixed with criminals and given the same treatments, where punishment was meant to sway their behaviors. They did not have adequate food, beds or toilets. The patients were placed in isolation or chained. They were not cared for by doctors or nurses but by warders.

During the 18th century, Philippe Pinel reformed the care for the mentally ill. Asylums were directed by doctors and nurses. Kindness replaced the penalizations administered in caring for this community. By the 19th century sedatives came into the picture as did Freud with concepts of mental processes and development. In the 1920's shock therapy and insulin comas were being administered in asylums. In the mid 1940's Moniz began the practice of lobotomies in treating mental illness. By the time Moniz passed in 1972, lobotomies were still in practice.

As is evidenced, the concept of mental health is not new but understanding it as another physiological system in our body and how to treat it, is. In fact, in 1949 the lobotomy won the medical Nobel Prize for treating mental health. This is significant because it explains the current attached stigma on anything related to mental health and mental health treatment in society. If we add to this stigma Mario's perspective on the first responder's personality, culture, and the stress levels inherent to the career, one can clearly understand why these ingredients have been a recipe for disaster. The disaster we are seeing today, where every 18 hours a firefighter is completing suicide in the United States. First responders are signing up and accepting the fact that these careers are dangerous and have high probabilities of death;

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but first responders' suicide rates are doubling and even tripling line of duty deaths. This is a disaster and an injustice for these men and women.

RESILIENCE AND POST TRAUMATIC GROWTH

Recently, I asked a group of firefighters who have been retired a minimum of 18 years, to define *resilience* in the fire service. They were all in agreement that resilience was synonymous with being tough, not allowing things to affect you, being able to suck it up and do your job and do it well. I poised the rhetorical question, "So if you feel that you need to suck it up and not allow things to affect you, are you also admitting that the possibility of things affecting you are part of the job?" They all smiled as if I had caught them with their hand in the cookie jar and finally one said, "We saw things no one should ever have to see. Letting it affect us, or letting others know it affected us made us weak."

I explained to the group that what they were calling "weak" was being human. They understood that being human was equivalent to having feelings, both negative and positive feelings. They understood that asking firemen, police officers, EMT, correctional officers, dispatchers or soldiers to not let things affect them was also asking them to not be human, to go against their nature. I went a bit further, I wanted them to fully grasp the understanding that being human is not just a pretty concept to excuse a crying grown man but an actual physiological process in their body over which they have absolutely no control.

I began by explaining our command center: the brain, how it controls both physical movements and emotional responses. I described how the brain gets information from the external world and how it reacts with neurochemicals. I described feelings in terms of some of these neurochemicals for them to understand that feelings are not an abstract concept but an actual neurobiological reaction in our bodies. They finally understood that creating a culture in an entire industry where you are deemed "successful" if you go against your nature, over which you have no control, was asking for more than anyone could truly handle.

One of these great men said, Marie, we did not tolerate the ones perceived as weak and teased them because sometimes it was all we could do to keep from being weak ourselves. Keeping the attention on others kept it off me. We did do somethings right though. We weren't lazy. We shared as a family at the kitchen table. Now a day's guys at the station are on their phones and barely know their brothers' names. They all have separate rooms and only see each other during a call. Pardon my French but I knew who had farted just by the smell.

After this group understood what is meant by being human as a physical concept, I went on to correct their definition of resilience. I validated some of their definitions in order to avoid having them leave the conversation. I confirmed that it was definitely about mental toughness, but not by denying what they felt but instead by accepting it and being able to recover or bounce back from it. Resilience is the ability to recuperate functioning after setbacks, barriers, trauma, or difficulties. They were able to understand that if a first responder is spending his or her energy on hiding their human nature, fighting their normal reactions, or not accepting that it is ok not to be ok, than they are wasting time in which they could be getting the assistance they need to be able to bounce back in the arena they love so much.

It's like a pulled muscle or broken leg injury of a football player during a game. What if for years football players traditionally had "sucked it up" and continued playing injured? What if they did not get the rest, physical therapy and assistance they needed to be able to make a full recovery? They would be playing in pain, their careers would be shortened dramatically, their injuries would progressively

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get worse, their self-confidence and abilities would suffer, and they would begin to cope with numbing agents to be able to get through a day.

Today first responders are numbing their expected reactions to what they see and do every day with alcohol, drugs, sex, gambling just to name a few. When we are fighting something we have no control over and is a normal process within our bodies, we are setting ourselves up for failure. Accepting these processes in and of itself is a sign of resilience as well as the first step in being resilient or recovering from misfortune.

Post traumatic growth (PTG) is the next step above resiliency. PTG is the ability to bounce back from a traumatic event but land in a higher, happier, and more appreciative state then previously in. It is becoming more self-actualized. According to Abraham Maslow, self-actualization represents growth of an individual toward fulfillment of the highest needs. The needs that give meaning to life. Thankfully, after a traumatic event, it has been found that most people are resilient and bounce back to their prior state. It is a small subset that never recovers or grows to a higher level of resiliency or PTG.

What if I were to say to you that first responders have the highest ability to be the most self-actualized humans on earth? It is said that an average person experiences 5 traumatic events in their entire life. First responders, depending what areas you serve, at the very minimum experience at least 5 traumatic events a week, thus giving these industries the experiences needed to find more meaning and more happiness in one's life.

When two holocaust survivors were interviewed together, one stated, *"It is indecent to ever be happy again after going through what I went through and watching the suffering of those in concentration camps." The other replied, "I feel it is indecent to never be happy again. To appreciate that we are still alive and have the ability to keep living."* Post traumatic growth has been found to increase maturity, meaning in life and happiness in individuals that achieve it. So why is the opinion of these two survivors so different? An underlying characteristic in PTG is the ability to recalibrate the experience and your perception of it. For example, being able to change a first responder's opinion of their job from being a thankless, tiresome, traumatic filled, bureaucratic, soul crushing experience to the luckiest job in the world where you have the ability to experience things that are the paths to more fulfilling and happier lives, it recalibrates their perception of the inherent trauma surrounding their careers.

Factors that have been found to affect the possibility of experiencing post traumatic growth include the person's personality pre-trauma. Costa and McCrae's five factor model of personality (FFM;1992) consists of extraversion, neuroticism, openness, agreeableness and conscientiousness dimensions. In 2015, a study found that neuroticism is correlated to a pathogenic outcome after a traumatic event, whereas extraversion was highly associated to positive post-traumatic outcomes.

Those who exhibit openness use cognitive strategies that correlate to PTG. Individuals who were agreeable were more likely to perceive positive changes after a traumatic event and conscientious individuals were characterized with more self-control, more meticulous and pursued goals with tenacity thus facilitating PTG. Another factor that influences PTG is the levels of psychological resilience of the individual as well as the amount of psychological damage caused by the event.

People who have attained PTG have reported that being in relationships where they felt nurtured and validated were essential to their growth. Being able to connect with people who can give them professional assistance during this time and feel genuinely accepted by them were two other factors that highly contributed to PTG. It is important to mention here that post traumatic growth is not only an outcome but also a process. One can experience distress as well as growth simultaneously. A professional placing emphasis on PTG too soon may cause the individual to feel like their trauma is being minimized.

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Professionals dealing with individuals who have experienced trauma need to understand that PTG is not always an outcome and need the mention of growth to initially come from the person struggling.

Post traumatic growth comes at a big price. Following a traumatic event, one must experience high levels of distress, vulnerability, and an increased awareness of one's mortality. The price is counterbalanced with the rewards. A firefighter from San Diego Fire Rescue experienced multiple stabbings from a homeless man while he was trying to assist the homeless man's friend on a call. This firefighter states that what shocked him the most was the speed in which the attacker took his knife out and stabbed him multiple times. This firefighter now knows how fast he can be attacked and feels much better prepared where and how he places himself in relation to others on a call. Another reward of gaining PTG is an increase in self-confidence. Individuals who bounce back or attain growth after a traumatic event gain insight into their strength, become proud of themselves and what they have been able to overcome, and become confident in being able to prosper against any obstacle.

Those who attain post traumatic growth also experience more fulfillment in their relationships, clarity in their purpose and meaning, and are grateful for what they have. It has been reported that growth creates a new resistance or resilience, individuals are more prepared for future traumas, they bounce back quicker, feel they have stronger minds, can assess current situations better by using their past. Many who attained post traumatic growth have reported they worry less because they know things can be a lot worse.

Going back to the conversation between Mario and his chief and the big question as to why mental health issues seem to be more prominent in today's first responder industry, I am reminded of my conversation with the retired firefighters. I agree with the driver engineer who boasted, they did some things better back then. He admitted they did not understand mental health nor give it any creditability. He admitted that the culture accepted and even required the men to remain silent and suffer alone, but he says confidently, *"We knew each other. We talked. We connected. The kitchen table was our family, therapist, judge and jury."*

The word "connected" brought me back to my doctoral education, where we are taught that social connection can strengthen one's immune system, helps you recover from disease faster and may even lengthen one's life. Connectedness reduces depression and anxiety, increases self-esteem, increases empathy, trust, and cooperation with others which in turn causes others to cooperate and trust, generating a positive feedback loop of social, emotional and physical well-being.

The lack of connection has shown to be a greater detriment to our health than obesity, smoking, and high blood pressure. The lack of connection leaves us more vulnerable to anxiety, depression, antisocial behaviors and suicidal behaviors which create a further negative loop of isolation. Reports of connectedness in the United States are dropping in alarming rates. In 1985, Americans were asked how many people in their lives they felt they could turn to or feel comfortable sharing a personal problem. At that time, Americans claimed an average of three people they could confide in. The same study was repeated in 2004 and this time Americans reported having an average of zero people they could confide in.

One could be bewildered by these numbers and question how this could be in our current society where our ability to reach someone is the easiest it has ever been. It does not matter where you are, you can reach someone by pressing one button. We are in an era where you don't just talk to someone by pressing one button, but you can see them as well—a technology easily accessible to most in the world.

The issue with these devices is they have created delusion of connection. When we send text messages that include an emoji to replace an entire paragraph, not only are we allowing for misinterpretation, but we are going back to an era of communicating through pictures. We are also excluding the ability to express ourselves, read body language, listen to tone. What we see of our outside world are the fake

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superficial lives on our devices of those around us. The worlds they have created through pictures that are cropped and filtered to make us look the way we wished we looked. Notifications on our phones have conditioned our brains to abnormal amounts of increased dopamine, thus creating the need for constant hits which you try to attain by constantly checking your phone while you are in the outside world where you would've been connecting to someone, but instead looking at your phone for a dopamine fix.

Recently, Microsoft admitted that our attention span in the digital world has dropped to less than 8 seconds. That is less than a goldfish. We no longer analyze and interpret information giving depth and meaning to our lives, instead we have opted for practicality in our devices that also cause shallow thinking.

In the fire industry, the inclusion of personal smart devices is not the only cause of the decreased sense of connectedness within the fire houses. Fire stations' layouts have changed. Private rooms with TVs have replaced the large room with cots. Kitchen tables are used just for meals, they are no longer the safe base after a tough call or a good cry in your brother or sister's arms. The private rooms give firefighters the ability to suffer alone while social media helps them escape their reality or numb their pain. The layouts, lack of kitchen table talks and the use of smart phones all attribute to the lack of connection in the fire industry.

They are also responsible for the increase of post-traumatic stress disorder (PTSD) in this service. PTSD is simply defined by the treatable malfunction of certain biological, specifically neurobiological, mechanisms. To simplify this even more, without minimizing the disorder's ability to absolutely render someone to the point of being debilitated, it is a glitch in your brain. In order to be functioning first responders, the stress reaction of fight, flight or freeze must be automatically triggered while doing your job. This reaction is what allows first responders to be cool, calm and collected to do their jobs in crisis situations.

Physically what this reaction looks like is: the primal part of the first responder's brain is revved up to 100%, specifically the hypothalamic, pituitary and adrenal systems (HPA). This signals the first responder's body to be in survival mode, focused and ready to go, thus heart rate increases, breathing increases and glucose increases through the release of norepinephrine, adrenaline and cortisol. As the HPA is ignited, the prefrontal cortex area of your brain shuts down for efficiency and survival. The prefrontal cortex of your brain is the last to develop (between the ages of 23-25 years old) and is responsible for all our executive functions like planning, judgement and impulse control. Since this area of the brain shuts off, first responders train extensively in order to make all their procedures instinctual.

The glitch that occurs in PTSD is when that trauma, event or call is not processed into the thinking part of our brains and it remains stuck in the primal brain, which is why someone with PTSD reacts to triggers as if the event is occurring at that very moment because the brain has not processed it or brought it to the part of the brain where it can rationalize it. It is why virtual reality therapy, EMDR and exposure therapy have been so successful in treating PTSD, because these treatments eliminate the firewall or glitch not allowing the event to be processed in your cortex. Going on a traumatic call, not sitting at the kitchen table to allow the call to be processed, isolating oneself in a private room, escaping into social media, and lack of connectedness have contributed to PTSD.

Although the battle against the stigma of mental health is in full force and the culture is changing through education and awareness, the lack of connection needs to be addressed further within the first responder industries. Peer support has played a monumental role in connection but usually it is with first responders that are already suffering. Listening to the retired first responders, getting back to some of the roots of connection in the firehouse, incorporating the systems they were using to keep each other healthy may be a great start.

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ORGANIZATIONAL AND RELATIONAL INTERVENTION MODEL

First Responder Assistance Program (FRAP)

I (Dr. Bernardo Gonzalez) believe the failure to address systemic conditions within a First Responder's organizational culture can have substantial negative effects within the First Responder community (First Responder personnel and family). Equally important is the fact that the negative impact created also directly influences and shapes a First Responder's on the job behavior and level of service. More specifically, how First Responders connect and relate to the people and communities they serve.

The heartbreaking reality is that First Responders are not only impacted by on the job stressors, but also the scars, experiences, and in cases deep unresolved trauma carried from their past. With this in mind, most First Responder Departments address these issues in a reactive manner, sending employees to Employee Assistance Programs (EAP) for help, only when the situation or behavior is flagged by someone (usually a supervisor), or when the employee acts out in a manner that puts in question their mental wellness.

In most situations, whether medical or when dealing with mental wellness, the earlier we address a situation the greater the chance for healing. Using a simple analogy, one does not wait to treat an injury from a fall until there is an acute infection in the body. If one does, this delay in treatment severely impacts the healing process and also increases the level of pain and suffering for the person. In the same manner, a reactionary position when treating the mind can produce the same level of increased pain and suffering for the individual who is left untreated.

Equally important, the organization's response to these situations can set in motion a negative cause and effect scenario, as it relates to employee and management relationships. The employee perceives that they are not being valued by the organization and commences to isolate themselves and mistrusts the administration. From my professional experience, this reactionary response and delay in providing assistance can obstruct constructive growth and healing for the organization and individual.

Organizational Intervention

As we examine the existing organizational culture, we can see the incredible impact stress (both on the job and personal) has on the First Responder Community. Anyone having any experience in the field (First Responders) can also attest to the fact that First Responders are already coming with, and are significantly affected by, trauma and stressors caused by Adverse Childhood Experiences (ACE). Unfortunately, as noted, most First Responder Departments fail to proactively engage with this reality and for the most part are solely connecting with on the job stressors relating to Post Traumatic Stress Disorders (PTSD). Interestingly enough some of the work and research accomplished in the military (Ken Falke and others) point to a significant connection existing with Adverse Childhood Experiences and PTSD.

This is an important point to understand due to the reactionary response and focus of most First Responder Departments. Although not a clinician myself, I can attest from my academic, personal, and professional experiences, that First Responders create mental frameworks or elaborations that screen out rational cognition. These elaborations if not properly processed internally, can create negative projections of the future. When these negative projections are left unchecked, the First Responder utilizes these self-created elaborations, that are now separated from facts and the original situation, to shape their values, plans, and actions. If organizations fail to address the negative elaborations being created,

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the behavior generated from these unhealthy mental constructs can commence to erode and poison the health of an organization.

Moreover, the organizational culture in directly dependent and is built on the thoughts, mental framework, and behavior of its employees. Further, if left unrestrained these unhealthy thoughts and elaborations in time are passed on as unhealthy values and behavior, becoming fused and part of the informal and at times formal organizational culture. This is why, in my professional opinion, it is important for First Responder Departments to be proactive regarding the mental health and wellbeing of their personnel.

As an example, a First Responder Department may very well have a formal culture that has respect and fairness as two of their organizational values, while unfortunately at the same time the informal culture is living and breathing values of unhealthy competition, unfairness, and ruthlessness. It is imperative for First Responder Departments to assess the health and overall wellness of their formal and informal cultures, as well as their people. How are our employees shaping their internal values, plans, and actions? What thinking process is influencing their decision-making practices? The root of an action is directly connected to one's thinking process.

That being said, all professional behavior (healthy or unhealthy) is also connected to this process. For First Responder Departments to proactively engage and positively influence this thinking process would not only help to modify and enhance employee behavior but also heal the organizational culture, and in the process help to preserve its future. In my professional opinion organizations make a grave mistake if their main attention to wellness is centered around PTSD, solely focused as it relates to on the job stressors.

The following example demonstrates my assertion. A Fire Rescue personnel commences his/her career with a past history of family abuse and alcoholism. Unknown to himself/herself and the organization, the scars from his/her childhood experiences commence to affect personal and on the job relationships, as well as negatively impact his/her behavior on the field. Additionally, the barrier and self-defense mechanism created is so ingrained that he/she fails to see the erosion occurring inside. For years his supervisors have counseled him/her as to his discourteous comments and lack of empathy while servicing the community.

However, being a good test taker, he/she makes rank and progresses through the ranks encouraging unhealthy behavior. His/her behavior, now as a supervisor and leader, commence to advance and advocate a dysfunctional and unhealthy informal organizational culture. One can see how ignoring these types of situations can produce negative outcomes for the health of an organization. Equally important, the negative impact for the organization is dependent on how many individuals are affected by significant past experiences that are left untreated. If that number is high, and these types of situations are left untreated, then the impact on the organization, especially the informal culture, will be serious. From my optic, organizations pay a heavy price ignoring this reality.

FRAP Model

The First Responder Assistance Program/Model (FRAP) encompasses the following three Foundational Pillars:

1. Organizational and Individual Inner Healing
2. Positive and Constructive Organizational and Individual Growth
3. Fostering of Organizational and Individual Relationships and Resiliency

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With this in mind, FRAP's mission is to help transform First Responder Communities (Organizations and Individuals) from a culture of isolation, distrust, fear, and unhealthy behavior, to a culture of organizational and individual healing, positive and constructive growth, and fostering of healthy relationships and resiliency.

Methodology

- In order to change a resistant culture, one must transform and modify the system from within (Organizational Intervention)
- The FRAP will first help identify unhealthy institutional and behavioral patterns hampering positive growth within First Responder Communities (Assessment of Formal and Informal Cultures)
- The FRAP will work hand in hand with First Responder Communities to implement and institutionalize a systemic progression of care that focuses on Pre-Situational, Situational, and Post-Situational responses, structured within a unified framework and system:
    - Peer Response and Follow-Through
    - Faith-Based Chaplaincy Support
    - Integration of Mental Health and Substance Abuse (Clinicians)

FRAP Modules

The FRAP Modules were created to ensure that First Responder Departments implementing the model understand the necessity to utilize the modules in support of enhancing the formal and informal organizational culture. The FRAP believes that an organizational intervention is not only the best manner in which to change the organizational culture, but also to provide the assistance and support needed to First Responders on the field. The FRAP Modules is comprised of the following:

1. Educational Module

The Educational Model facilitates awareness, understanding, and learning to the following stakeholders:

1. Executive Level Personnel
2. Operational Personnel
3. Support Personnel
4. Families and other Support Groups

The Awareness and Understanding Component of the Educational Module is composed of drills and interactive learning, utilized to retain knowledge and develop pertinent skills and good habits, as it relates to Peer Response, Chaplaincy, and Mental Health Clinicians participating in the FRAP.

The Informational Component of the Educational Module focuses on the importance of communication. The FRAP will work with First Responder Departments to create newsletters, videos, and online communication aimed to facilitate learning and reinforce skills related to Peer Response, Chaplaincy, and Mental Health Clinicians working within FRAP. The most critical element of the Educational Module is to enhance the existing organizational culture (both formal and informal).

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2. Training Module

The Training Module facilitates organizational efforts to develop or enhance skills, improve performance, and inculcate individual self-fulfillment for the following stakeholders:

1. Executive Level Personnel
2. Operational Personnel
3. Support Personnel

The Formal Training Module utilizes best practices in the field to provide quality training at the Basic Level (all Departmental personnel), Intermediate Level (Peer Response Personnel), and Advance Level (Chaplaincy Personnel and Mental Health Clinicians). Chaplains and Mental Health Clinicians participating in the FRAP are required to also attend the Basic and Intermediate Levels of training to have a thorough understanding of the mindset and training received by Departmental personnel and peers.

3. Process Module

The Process Module examines the formal and informal organizational culture to determine systemic areas needing enhancement. The Process Module focuses on the following organizational and systemic areas:

- Assessment of Organizational Culture
  - Formal and Informal Culture
- Enhancement of Organizational Culture
  - Formal Culture
    - Enhancement of Policies, Procedures, Guidelines, Strategic Plans, Selection Process, Evaluation Process, Discipline Structure, and Promotional Process
  - Informal Culture
    - Fostering a healthy thinking process and modification of employee behavior
- Implementation and Institutionalization of FRAP
  - Critical Incident Peer Response and Follow-Through
  - Faith-Based Chaplaincy Support
  - Integration of Mental Health and Substance Abuse (Clinicians)

4. Mental Health Module

The Mental Health Module provides oversight and a sense of security and confidence to ensure that internal and external Clinicians are adhering to clinical best practices. Equally important the FRAP utilizes clinical oversight to seamlessly integrate the work being done by peers and chaplains. With this in mind, Clinical Oversight focuses on the following two areas:

- Clinician integration to Peers and Chaplains
- Check and balance related to therapeutic practices
- Clinician awareness training of First Responder culture

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FRAP Step by Step Process and Methodology

FRAP personnel will work hand in hand with First Responder Departments to fully implement and institutionalize the FRAP Model within their internal organizational framework. FRAP personnel will also assist the Departments to fully implement **the four** FRAP modules (Educational, Training, Process, and Mental Health Oversight). The following depicts the implementation methodology utilized by the FRAP:

1. Assessment of organizational formal and informal culture
2. Work with stakeholder community (First Responder Department) to individualize the FRAP Model and reach a final consensus of the areas to be implemented and institutionalized
3. If desired by First Responder Department, selection of Pilot Project (Organizational Department, Section, or Entity)
4. Commence to work with selected department/organization to set up their own internal model integrated with best practices, as it relates to the progression of care (Chaplaincy Program, Critical Incident Peer Response System, Chaplaincy support, and Mental Health and Substance Abuse Clinician integration
5. Ensure selected department, section, or entity is incorporating Post Traumatic Growth (PTG) components within Pre-Crisis, Crisis Response, and Post-Crisis First Responder progression of care
6. Fully implement the FRAP Model in Pilot Project (organizational department, section, or entity)
7. Evaluate model as well as the Pre-Crisis, Crisis Response, and Post-Crisis Follow-up system of care (Pilot Project)
8. Fine tune any areas needing enhancement
9. Implement the model Department-wide
10. Fully institutionalize the model
11. Replicate model and implementation within other First Responder Departments and communities

FRAP Organizational Pillars

Foundational Pillar:

- Organizational and Individual Inner Healing
- Positive and Constructive Organizational and Individual Growth
- Fostering of Organizational and Individual Relationships and Resiliency

Structural Pillar:

- Peer Response System, Faith-Based Chaplaincy Support, and Mental Health and Substance Abuse Progression of Care fused within FRAP's Foundational Pillars (Organizational and Individual Inner Healing, Positive and Constructive Organizational and Individual Growth, and Fostering of Organizational and Individual Relationships and Resiliency)

Supporting Pillar of FRAP:

- Pre-Situational
    - Building Resiliency through Education, Communication, and Awareness aimed at enhancing organizational formal and informal cultures

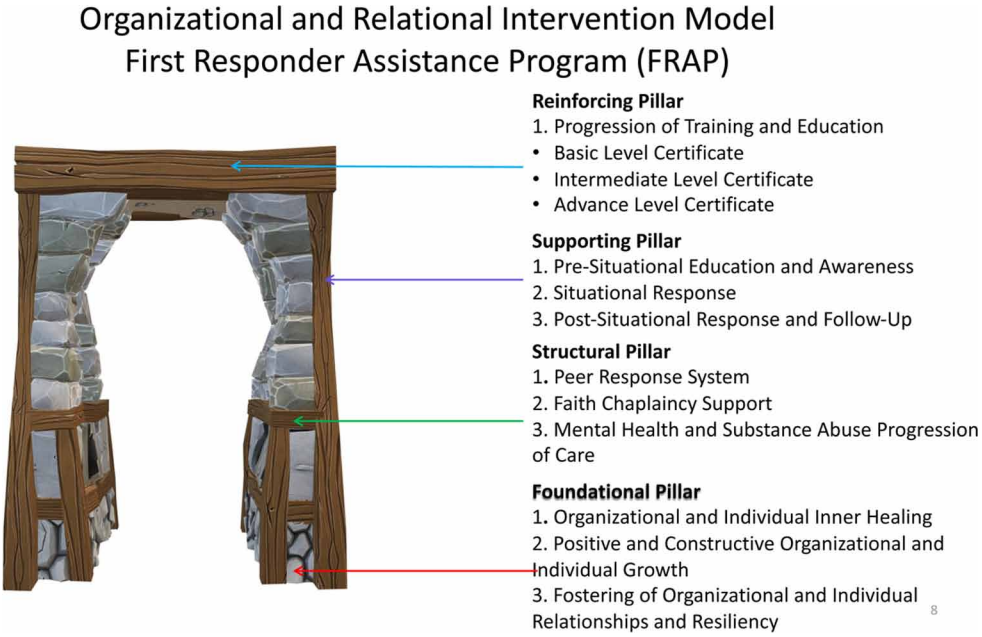
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- Situational Response
  - A response that is Timely, Appropriate and accomplished by Trained personnel
- Post Situational Response
  - Continuum of Care and Follow-Through at the Organizational and Individual Levels inclusive of possible clinician participation when needed or requested

Reinforcing Pillar:

- FRAP's Peer Response, Faith-Based Chaplaincy, and Mental Health and Substance Abuse Clinicians provide a continuum of care encompassing:
  - Education
  - Training
  - Experiential Involvement
  - Support Groups
  - Processes (Policies, Procedures, Guidelines, Strategic Plans)

Figure 1. Organizational and relational intervention model First Responder Assistance Program (FRAP)



SUMMARY

As has been shown, the organizational culture, both formal and informal, can produce both positive and negative effects on First Responders. In part, a First Responder's inner healing and growth is directly impacted by their organizational reality. If a First Responder's organizational reality demonstrates a culture of isolation, distrust, fear, and unbalanced behavior, it would be logical and expected for the First Responder's inner healing and growth to be severely impacted.

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If one compounds this reality with a First Responder's past experiences and childhood significant events, as well as on the job meaningful stressors, it should not surprise anyone to see the data reflect a high percentage of suicides, substance abuse, domestic violence, and divorce from the First Responder Community. It is also prudent to deduce that if a First Responder's behavior reflects this type of pain and suffering (based on the data) in their personal life, one should not be surprised to find their quality of service as it relates to their profession also diminishing in return. The FRAP focuses on the organization, with its overall mission to:

1. Foster Organizational and Individual Inner Healing
2. Foster Positive and Constructive Organizational and Individual Growth
3. Foster Organizational and Individual Relationships and Resiliency

The FRAP Model if properly implemented and institutionalized can greatly enhance an organization's formal and informal culture. Additionally, by integrating a unified structure and progression of care encompassing Peer Response, Chaplaincy, and mental health clinicians within the formal organizational culture of First Responder Departments, the FRAP can go a long way in bridging the gap that exists among management and First Responders. The implementation and institutionalization of FRAP clearly display an organizational culture that values its First Responders. FRAP's overall mission is to enhance the organizational culture of First Responders as well as to validate the values associated with the First Responder profession.

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Chapter 16
Attitude Training for Police Cadets:
Addressing the Problem of Arresting Suspects With a Mental Illness

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ABSTRACT

The news has not been good for mental health training programs for police in Australia, Canada, the U.S., and the UK. Police training is seen as inadequate to prepare police officers to identify and deal with persons with a mental illness. This chapter describes one approach of writing a proposal to conduct a comparison of attitude-training programs with police cadets. The main aspects of writing a proposal are covered: the background, problem statement, hypothesis, and the design of the treatments for comparison. Isolating the main features of each treatment requires designing some instruction based on factors that can influence police attitude toward suspects with a mental illness. Contemporary design guidelines are recommended, which should be informed by the designer's personal assumptions about how people learn from multimedia.

BACKGROUND AND CONTEXT OF THE PROBLEM

Defining a critical problem in law enforcement begins with describing the background and context. Thirty-two years ago, police in the U.S. were *more likely* to arrest suspects if they knew they had a mental illness (Teplin, 1984). Seventeen years later police officers were *less likely* to arrest suspects if they knew about their mental illness (Engel & Silver, 2001). Three years after that, a prediction that information about a subject's mental illness would have a significant effect on officers' responses, was in fact, *not supported* (Watson, Corrigan & Ottati, 2004). Among the possible reasons for inconsistencies in findings among these studies include: a disconfirmatory response pattern, an expertise reversal effect, or Type III error.

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Among the possible reasons for inconsistencies in findings among these studies include a *disconfirmatory response patterns* among learning objectives, or even prerequisite relationships on a hierarchical instructional analysis flowchart (Bart & Airasian, 1972). A disconfirmatory response pattern is one in which an individual achieves mastery of a high level task but fails to master a lower level task. This requires revisions of the instructional analysis flowchart.

A second possible reason for inconsistent findings is *expertise reversal effect.* An expertise reversal effect is a result indicating that an instructional technique that was effective with below-average police cadets loses some of its effectiveness and even becomes ineffective with average and above-average cadets. If, for example, the experimental materials are not difficult enough to split attention, the reason may be due to expertise reversal (Kalyuga, Chandler & Sweller, 1999; Witteman & Segers, 2010). Whereas novices' dominant cognitive activity require appropriate instructional supports, experts tend to retrieve and apply available long-term memory knowledge structures to handle situations and tasks within their area of expertise.

A third possible reason for inconsistent findings is *Type III error*. Type III error, consistent with Gary Henry's formative evaluation of rival explanations, point to erroneous inferences about program outcomes due to implementation flaws (Henry, Smith, Kershaw & Zulli, 2013, p.467). Michael Dawes offers two definitions for a Type III error (Dawes, 2010): When a study provides the right answer but for the wrong question or research hypothesis. For example, when the results support a different question; or when a possible explanation of the failure to demonstrate an effect might be the failure to consider interactive effects of the interventions.

General or Specialized?

Whereas the majority of police academies already provide some kind of specialized training for police cadets, not only in lecture form, but also through scenarios and simulations, there are still notable gaps, including the common failure of neglecting people with mental illnesses in the development and delivery of the instruction. Some jurisdictions have only basic recruit training (e.g., Saskatchewan Police College). Others offer extensive recruit training (e.g., Edmonton Police Service) with online courses, hands-on practice with mental health professionals, and a 5-week Police and Crisis Team Training (e.g., Calgary) (Yasmeen, Krameddine, DeMarco, Hassel & Silverstone, 2013). A report of Police Sector Council determined that not all police applicants perceive 'policing' as an 'honourable profession', nor as 'employers of choice', nor even as 'progressive' (Police Sector Council, 2007). "Specialized training and education in mental health is important… Sensitivity, empathy, and communication, are key" (CBC News, 2018).

Two attitude training treatments (i.e., TEMPO and CIT programs) will be considered for use with a sampling of police cadets, and; a prediction on the probability of similar effects occurring with different samples of police cadets under similar conditions. Could these methods become a template for replicating this research with different samples of police cadets? Replication of the research is the main criterion for a good methodology.

Mental Health Training Programs

Grant Edwin McLeod died in 2008 during the arrest by the Defendants RCMP members due to excessive and deadly force applied and failure of the said defendants to provide first aid care to McLeod after applying excessive and deadly force to him (*Carlick v. Canada (Attorney General), 2013)*. Justice Veale

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concluded that there was no evidence from the plaintiff to raise a *bona fide* issue that the RCMP officers knew they were acting unlawfully and that such conduct would harm Mr. McLeod or Ms. Carlick. The evidence could support a claim in negligence and wrongful death but that claim was filed after the expiry of the limitation period and dismissed as previously discussed. So a procedural error had the case against the RCMP dismissed.

The *attitude* of a police officer can affect their performance. Attitudes, in this context, can be described as a person's likes and dislikes, with roots in social, emotional, behavioral, and cognitive experience. Attitudes can also be value-laden (e.g., moral or religious beliefs, pride, or a strong work-ethic), self-concept (e.g., academic, personal, professional), or motivational (e.g., goals, interests, perseverance). A positive attitude change by police toward persons living with a mental illness would be a spoken or written statement saying that *they want* to know how to recognize mental illness, how to deal with psychotic behavior in police suspects who are coping with a mental illness, how to handle violence or potential violence among persons living with a mental illness, and what to do when a mentally ill person is threatening suicide.

Krameddine and Silverstone take a different view; that training programs should focus on behavioural changes, not attitude change. The authors admit however, that *some studies show improvements in police attitudes and stigma toward mentally ill individuals and positive behavioral changes after training* (Krameddine & Silverstone, 2015, p.3).

The predominant view in this research therefore, and in current police training, is that if police attitudes toward mental illness can be made more positive, then behaviours will change accordingly. Changing attitudes is the challenge, because once attitudes, stereotypes, or biases are established, they are difficult to change. For this reason, current training programs are focusing on changing attitudes through educational technology.

Preliminary evidence shows that focusing on attitudes and assumptions might maximize the likelihood that police will use their pre-existing factual knowledge appropriately (Coleman & Cotton, 2014, p. 72).

It is clear from the literature that contemporary training programs for police personnel in Canada must adequately address the attitude of police personnel toward persons living with a mental illness.

Having the officers trained allows them to appropriately respond to individuals with a severe and persistent mental illness. The training helps with public safety and gives the officers additional insight when responding. When they are called to the scene, they are able to de-escalate the situation (Herbst, 2018).

Statement of the Problem

Problem statements (about police training methods) should be concise and identify only the key factors in the proposed study (Wiersma & Jurs, 2008, p.34). The problem in this proposal has been previously documented, namely: some facets of police training related to interactions with suspects living with a mental illness can be improved. Whereas the majority of police academies already provide a kind of education, not only in lecture form, but also through scenarios and simulations, there are still notable gaps, including the common failure of neglecting people with mental illnesses in the development and delivery of the instruction.

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LITERATURE REVIEW

A good literature review about the attitude of police toward suspects living with a mental illness includes influential theories and previous experiments of the variables proposed in the new study (Wiersma & Jurs, 2008, p.56). There are a few cautions on reviewing the literature in educational technology when comparing contemporary online attitude-training programs for police cadets. Experimentally, a classroom lecture, for example, is another treatment, not the control group. Classroom work should be integrated into all experiential treatments to avoid bias, namely: the de-motivating effect of one group using a computer while another uses a pencil and paper. Finally, although tempting, experiments of training programs that require using a computer should not compare it to a classroom method.

Police Attitude Training

Police officers face significant challenges when responding to a person with a mental illness. Police and clinicians (e.g., counselors, therapists) see these challenges from different perspectives, particularly in situations involving noncriminal behavior that is symptomatic of the mental illness (Schulenberg, 2016). Schulenberg's study also suggests that an indirect procedural bias exists due to situational constraints, a disjuncture between policy and police culture, and limited mental health resources that lead to response strategies that contribute to criminalization of the mentally ill. Hoffman's Ph.D. research determined a disconnect between research and practice, namely: that whereas police officers tend to focus on dangerousness and public safety, clinicians are concerned with indicators of disordered thought (Hoffman, 2013).

Boyd and Kerr conducted a document analysis of four Vancouver Police Department policy reports on 'Vancouver's mental health crisis' from 2008 to 2013 (Boyd & Kerr, 2015). The value of their report lies in the exposure of challenges that Vancouver Law Enforcement face every day that are significant for policy-makers and public health professionals in and outside of Canada. The report highlights some of the negative discourse about deinstitutionalization, mental illness, and violent behaviour that can contribute to further stigma and discrimination of persons with mental illness.

This issue is not new to police. As the population grows and ages, so will the number of persons with mental illnesses. A growing challenge for law enforcement will be dealing appropriately and effectively with persons with mental illness. Most noteworthy in their research perhaps, is their belief that individuals experiencing acute symptoms of mental illness may respond differently than what front-line officers expect. Thus, persons with mental illness raise risk issues regarding intervention, strategy, and program framing.

Moreover, media reports from Vancouver Police Department between 2008 and 2013 linked the challenges of working with persons with mental illness with lack of policing resources and presence, and failure of the mental health care system. This kind of reporting has contributed to a widening net of social control, rather than to the betterment of the lives of people living with mental illness (Boyd & Kerr, 2015).

The reality is that these things unfold very quickly. This is one of the reasons I have tended to go more for training. The reality is that it's going to be the uniformed officer in the vast majority of the time dealing with the person in crisis (Chambers, 2016).

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The CIT Approach

The essential goal of the Crisis Intervention Teams (CITs) approach is improving partnerships between police and community mental health resources (Coleman & Cotton, 2010; Watson, Corrigan & Ottati, 2004). The CIT includes instruction about:

- The causes, signs, symptoms, and treatment of mental illness
- Substance abuse
- Psychotropic medication
- Information on commitment criteria and procedures
- Consumer rights
- Personal stories from "consumers" and family members
- Visits to mental health treatment providers
- Information about treatment modalities
- Training in communication and de-escalation skills.

The CIT program has been widely studied (Compton, Bahora, Watson, & Oliva, 2008), which is an indication that the CIT has high *face validity* among police departments in Canada. CIT training includes information on signs and symptoms of mental illnesses, mental health treatment, co-occurring disorders, legal issues, and de-escalation techniques. The CIT curriculum may also include content on developmental disabilities, older adult issues, trauma, and excited delirium. Police officers can volunteer to receive forty hours of training provided by mental health clinicians, client and family advocates, and police trainers (Watson & Fulambarker, 2012). Moreover the CIT has been applied variously in multiple police settings to good effect, also accounts for high, or at least good, *reliability*.

CIT's positive outcomes are described as improved knowledge about mental illness, awareness of community resources, and improved identification of mental health calls. Nonetheless, "there is little outcome research or data-based evidence to inform the exact nature of an effective program, and research that does exist *does not provide guidance as to which components of a learning program are most effective"* (Coleman & Cotton, 2014). Furthermore, it was found that *the majority of all training programs only train specific members,* thus not the whole service is getting the knowledge and skills necessary to deal with mental health calls on a daily basis. CIT has been broadly used by police forces in the United States, but it is clear that more research of this program's potential effectiveness is needed (Compton et al., 2008).

The TEMPO Approach

Training & Education About Mental Illness for Police Organizations (TEMPO) is not a training method *per se,* but an umbrella approach that police organizations can use as a framework to assess their own progress to identify gaps in their existing training (Coleman & Cotton, 2014, p. 10). In 2008 the Mental Health Commission of Canada (MHCC) conducted a review of recruit training at Canadian police colleges concerning police interactions with people with mental illnesses. In 2010, the MHCC conducted a follow-up review of police training at the in-service or continuing education level within Canadian police organizations. Based on these reviews, an aspirational model of police education and training

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was developed, described, and disseminated, called "Training and Education about Mental Illness for Police Organizations" or TEMPO.

Seven years after the initial report from the Mental Health Commission of Canada, the decision was made to focus only on police education and training to the exclusion of policies and community supports (Coleman & Cotton, 2014). The recent report covers two of the three challenges at once namely: training programs, and policy, and practice. Police learning materials are to be designed and delivered by a combination of police personnel, adult educators, mental health professionals, mental health advocacy organizations and people living with mental illness. People living with mental illness will be involved in the delivery of training.

Required Tasks

The procedure for determining required tasks is called a task analysis that is either displayed on a flowchart or in a decision table showing the *inputs* (goals), *processes*, and *outputs* specifying how an expert (not the cadets) would carry out the tasks. When confronted with a suspect with a mental illness, what tasks would an expert law enforcement officer complete to initiate the correct attitude? It's best to consider everything possible, such as basic skills, any gender or cultural concerns, vocational aspects, and personal skills such as time management or goal setting.

Task Sequence

Once the task analysis has been determined, an instructional analysis is developed showing the learning objectives displayed on a hierarchical flowchart (Gagné, Briggs & Wager, 1992). The flowchart serves as a stepwise arrangement of learning objectives and prerequisite requirements for police cadets to follow. Prerequisite knowledge and skills are critical to behavioural scientists, especially in their quest to determine the causal relationships between learning objectives.

Hypotheses

A hypothesis is a conjecture or proposition about the solution to a problem, a relationship of two more variables (Wiersma & Jurs, 2008, p.42). In this study of police training programs, two hypotheses are written about possible solution to the problem, a null hypotheses (H_0), and an alternative (aka alternate) hypotheses (H_1).

H_0: There is *no difference* between the attitude of police recruits toward offenders with a mental illness after completing the TEMPO training, and of police recruits who complete the CIT training. "Attitude difference" can be operationally defined as a change on the *Police and Community Attitudes Toward Offenders With Mental Illness Scale* (PACAMI-O) before and after training (Glendinning & O'Keeffe, 2015). This *null hypothesis* is based on the published opinion of Coleman and Cotton's review of police training programs in 2010 that focused on changing attitudes, and showed questionable effectiveness due in part to the poor quality of the research design testing their effectiveness (Yasmeen *et al,* 2013). The authors also noted differences in the existing training programs across Australia, Canada, the United States, and the United Kingdom.

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H_1: The attitude of police recruits toward offenders with a mental illness *will perform significantly* better after completing the TEMPO training, than that of police recruits toward offenders with mental illness who complete the CIT training. "Attitude difference" can be operationally defined as a change on the *Police and Community Attitudes Toward Offenders With Mental Illness Scale* (PACAMI-O) before and after training. This is an *alternate hypothesis,* based on the published opinion of Coleman and Cotton's review of police training (Morgan, 2011).

Design Guidelines

Online course development means different things to different people. Whether active teaching staff (i.e., the Lone Rangers) or the university support staff (i.e., the Posse) will develop an online course based on a preferred design guideline. The design guideline can be associated with a supporting assumption about learning from multimedia (Mann, 2009). There appear to be at least eight different design guidelines for designing a course for learning from multimedia.

Table 1. Summary of design guidelines and supporting assumptions about learning from multimedia

Design Guideline	Supporting Assumptions
• Whatever works	Þ Intuition of the developer
• Design-by-type	Þ Role in the software taxonomy
• Favourite feature	Þ Technology preference
• Favourite method	Þ Teaching method preference
• Balance-the-input	Þ *Logogen* & *imagen* connections
• Maximum impact	Þ Auditory-visual sensations
• Cognitive load, first	Þ Intrinsic & extrinsic load
• Structured sound function	Þ Three attentional networks

(Mann, 2009, p.3).

The choice of one of eight guidelines for designing the experimental treatments should be informed by the assumption behind the guideline. Then, learning objectives and instruction can be written consistent the different approaches in each treatment, opportunities provided to practice, feedback on the practice, and a method of assessing learning. A central feature of this part of the study resides in finding the main features in each treatment (i.e., CIT and TEMPO) that are likely to influence police attitude toward suspects with a mental illness.

METHODOLOGY

The problem in this proposal has been previously documented, namely: some facets of police training related to interactions with suspects living with a mental illness can be improved. Whereas the majority of police academies already provide a kind of education, not only in lecture form, but also through sce-

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narios and simulations, there are still notable gaps, including the common failure of neglecting people with mental illnesses in the development and delivery of the instruction.

Participants

In a comparison of attitude-training programs, the participants being studied are police cadets, most critical of all, their *attitude* – critical, because it is the *dependent variable* under investigation in this research. Experienced officers might possibly produce a different outcome. Attitudes can reveal a person's likes and dislikes, might reflect their goals, religious beliefs, and their work ethic. Under ideal experimental conditions, the police cadets would have similar experiential backgrounds (e.g., a family life, leisure time, a social and educational background), and the attitude of every police cadet *before training* would be uniformly neutral toward persons with a mental illness. Moreover, the *attitude* of every instructor would also be uniformly neutral toward persons with a mental illness. This is, in fact, possible in the study, because every cadet and instructor would have been screened for any bias before being admitted to the police.

The *capacity* of the learners (e.g., police cadets) concerns their innate abilities (as opposed to achievement). The definition of 'capacity' includes intellectual abilities (e.g., verbal, mathematical, artistic, and social capabilities), as well as cognitive (e.g., perceiving, remembering, thinking, apprehending, sorting, and utilizing information) and physiological (e.g., perceptual development and motor dexterity) development.

The *competence* of each police cadet is defined by his or her prerequisite skills (e.g., information processing skills, basic skills, and content prerequisites) as well as experiential background (e.g., family, leisure time, social, vocational and educational background). Competence is the result of conscious activity, either a learning experience or another life event. Although competence is limited by an individual's natural capacities, it is influenced by their attitudes and general profile characteristics.

Most researchers also like to collect *demographic data* to apply to their analysis. Data can show differences among the learner performances when they are categorized on the basis of such variables as age, sex, and cultural background.

Practical limitations to the comparison of attitude-training programs, would dictate that the population would need to be limited to local population of police cadets (i.e., males and females in their mid- to late-20's), randomly assigned to one of two treatment conditions. Notably, the cadets would be brand new recruits. Access to personal information about the cadets in the study would be confidential and would therefore require permission from several authorities as well as from the cadets themselves.

Research Ethics

Ethical standards are critical to experimental research, not only to prevent harm to the participant's health (e.g., by negligence), their career, reputation or income, but also to avoid violations of their basic human rights (e.g., confidentiality) and ethical.

Research that requires ethics review includes studies involving living human participants. Human participants are those individuals whose… responses to interventions… are relevant to answering a research question.[1]

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Prior to the start of the study, *ethics approval* would be required of the participants themselves to conduct experimental research on the attitudes of these police cadets, followed by approval from the Interdisciplinary Committee on Ethics in Human Research. Cadets would be informed that they could withdraw from the proposal without penalty at any time.

Sampling and Random Assignment

The sampling method for this proposal, under ideal experimental conditions, should comprise the population of *all* police cadets from *all* of the police training colleges across Canada. Ideally, the training programs would be exactly the same - same facilities, same instructional materials, administered in the same, strictly controlled. However, time, budget, logistics, and local organization constraints being what they are, would nevertheless be difficult to obtain an ideal experimental condition.

Since time and budget would be limited, the study would have to be restricted to a sample of convenience or *"haphazard sample"* of police recruits from the 2016 graduating class. Convenience sampling is the least desirable of all sampling methods, yet probably the most common, especially in training adults where whole classes of individuals are readily available cadets.

If time and budget permitted, the much preferred option to determine the better training program would have been to select participants for the study from *all* police cadets at *all* of the police training colleges across Canada by either a *simple random selection, quota random*, or *stratified random sample selection. Simple random sampling* from *all* police cadets at *all* of the police training colleges across Canada would mean there was an equal probability that any cadet at any police training college could be selected to participate in the study, without consideration of their gender, ethnicity, or prior background. Simple random sampling is the easiest to understand.

If instead, *quota random sampling* was used to select police cadets from *all* of the police training colleges across Canada, the cadets would be categorized based on, for example, police cadets who had personally experienced family members living with a mental illness vs. those who had not. Other categories could be gender, or ethnicity. These categories are then treated as samples of convenience.

Finally, if *stratified random sampling* were used to select police cadets from *all* of the police training colleges across Canada, a ratio of the population of the many thousands of police cadets would be selected within each of the police training colleges, subdivided into subpopulations on the basis of supplementary information. The criterion for stratifying the subdivisions could be, again, say, police cadets who had experienced first-hand, family members who were living with mental illness vs. those who had not had that experience. Other subpopulations could be gender, or ethnicity. Any of these sampling choices would have the excellent benefit of being able to speak with authority about the better training option for all police cadets in Canada.

Random assignment takes place following the selection of participants for the study. Random assignment is a method of assigning cases to groups for the purpose of making comparisons. All participants in the sample are randomly assigned to either the TEMPO or CIT training programs. Random assignment is a simple procedure of assigning even numbers from the unique number code issued to each police cadet (to ensure their anonymity) to one treatment and odd numbers from the number code to the other treatment.

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Design of the Proposed Research

The design of this program comparison is a quasi-experimental pretest-posttest design, adapted from a controlled study on the effectiveness of an anti-stigma intervention in a basic police officer training programme at Umeå University in Sweden (Hansson & Markström, 2014). Quasi-experimental research involves the use of intact groups of participants, rather than a random selection and assignment of participants to experimental treatments. The design of the proposed comparison of two police training programs (i.e., CIT vs. TEMPO) will require one or more hypotheses, sampling method information, and the variables under consideration (dependent, independent).

The *unit of analysis* in this study would be the individual police cadet. The unit of analysis refers to the major entity that is being analyzed in a study, the particular type of unit a researcher uses when measuring. The *independent variables* would be the police training program (i.e., TEMPO and CIT) *operationally defined* as classroom instruction, scenario training, and simulations that include people with mental illnesses. The *dependent variable* is "attitude difference" operationally defined as a change on the *Police and Community Attitudes Toward Offenders With Mental Illness Scale* (PACAMI-O) before and after training (Glendinning & O'Keeffe, 2015).

Instrumentation

Instrumentation refers to the methods used in measuring cadet attitude (e.g. written test, time stamps, dribble files, interview questions, written work, segmented verbal protocols, etc.). In this comparison, data is collected from both experimental conditions (CIT and TEMPO) using the PACAMI-O instrument shown in Table 1 (see Appendix). The PACAMI-O scale is adequate for measuring attitudes towards its targeted sample, and has shown utility with a professional group (police officers and custody sergeants) who potentially face such offenders. It therefore has practical implications in assessing attitudes with other groups within forensic mental health.

Materials in the Study

The materials in the comparison can comprise any online tools, software utilities, workbooks, writing materials, verbal instructions, etc. In this proposal, the materials from the training programs are different from one another: the *Crisis Intervention Training* (CIT) program originated in 1988 in the U.S. and has been widely studied (Compton et al, 2008), the newly-developed *Training and Education about Mental Health for Police Organizations* (TEMPO) is untested.

The CIT Approach: "Intervention Training"

In the CIT program, selected officers undergo 40 hours of specialized training in mental health issues. At least two CIT officers are on duty each shift so that at least one is available 24 hours a day, 7 days a week. In collaboration with local mental-health authorities, emergency psychiatric services include a no-refusal drop-off facility and/or a mental health mobile crisis team that can assist officers during CIT calls (Lord, 2008).

The preference is to focus more on police training instead of the broader systems and policies that affect interactions between police and people with mental illnesses, such as the ride-along nurse or

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counselor. The police themselves think that they lack adequate training to manage this segment of the population. They want to know how to recognize mental illness, how to deal with psychotic behavior, how to handle violence or potential violence among these persons, what to do when a person is threatening suicide, and when to call the specialized mobile crisis team. They also want to know what community resources are available and how to gain access to them.

Mental health training is needed for all police officers, not just for those who are part of the specialized mobile crisis teams. Psychologist Dorothy Cotton and retired police chief Terry Coleman examined how police basic-training programs across Canada prepare future police officers to respond to people with mental health problems. They found a range of approaches.

The TEMPO Approach: "An Umbrella"

TEMPO places particular emphasis on nine course goals:

1. Understanding symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, dis-inhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problems
2. Knowing about mental illnesses, sufficient to make an assessment about how much control the subject is likely to have of their behavior
3. Communication skills and de-escalation techniques for defusing and calming volatile situations involving a person with a mental illness
4. Deciding whether a person with a mental illness is capable of understanding and responding to the directions given by police
5. Knowing that the standard police procedures that would typically disarm a non-mentally ill person, stabilize the situation, and lead to co-operation, might have the opposite effect with a person experiencing a mental health crisis
6. Having an understanding of the relationship between mental illness and likelihood of causing physical harm
7. Being able to accurately assess risk of suicide, know how to contain the situation, and when to intervene
8. Knowing how to apply problem-solving methods in the police/mental health environment
9. Knowing how to apply ethical decision-making and to exercise of police discretion

Under ideal experimental conditions, the materials from the two training programs (TEMPO, CIT) would be identical except for the variables under investigation. The *scope* of both programs would be the same, which means to say the type and timing of the training materials would be the same. The *sequence* of the training would also be the same in both programs, the instructors would be the same, or at least have the same preparation, and the presentation of the learning experiences would be the same. Furthermore, the content itself would need to be of the same level of difficulty.

Procedure

Readers of an experimental comparison should be made aware of the step-by-step procedure, in this case adapted from a controlled study by Hansson and Markström (2014, p.3). In the first step the course

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administrator would approach the police cadets, inform them of the purpose of the proposal and ask for their informed consent. No data would be collected from cadets who chose not to participate. The cadets would be given written information about the proposal and informed about anonymity and procedures of the data collection. No monetary compensation would be offered. Once written authorization was granted by a Research Ethics Board, participating cadets would be issued a unique code, to ensure their anonymity, to be used during data collection and analysis.

Next, the attitude instrument (Glendinning & O'Keeffe, 2015) would be administered as a *pretest,* in advance of mental illness training interventions. This would be followed by the mental illness training interventions delivered separately in the *treatment groups* (i.e., CIT and TEMPO). Finally, the same attitude instrument would again be administered as a *post-test,* after the mental illness training interventions. Under ideal experimental conditions, the procedure in both groups (i.e., CIT and TEMPO) would be exactly the same. More likely however, the procedure in this proposal would be developed in conjunction with, and in consideration of the instructors' course schedules.

Expected Results

The expected results section is a report on whether the *null hypothesis* will be supported or rejected. In this proposal, it is expected that the null hypothesis would be rejected. By implication, this means that the alternate hypothesis would be supported; that the differences in *post-test attitude data* collected from the TEMPO and CIT groups would be statistically significant from chance, and from one another. A further test of the experimental data called a *post hoc analysis* would then be conducted on these data to determine the direction of the cadets' attitude toward persons with a mental illness. Summaries of the statistical testing would relate directly to these research hypotheses. The Scheffé test (Scheffé, 1959) is a common method of comparing significance levels that can be used for test any number of post hoc comparisons, not just pairwise differences.

The convention is to report *descriptive statistics* first. Descriptive statistics typically include the mean or arithmetic average that can be strongly affected by extreme changes in values, and the standard deviation from the mean, or the average difference of between all the scores and the mean. It is expected that the mean (M) would be higher the TEMPO data than in the CIT data, and the standard deviation (SD) in both groups would tend to cluster around the respective means because the population of cadets would be a homogeneous grouping of mostly Caucasian males and females in their mid- to late-20's.

Inferential statistical testing usually follows a brief summary and table of the descriptive statistics, to determine the probability, beyond chance, of making a correct inference about the degree of difference between the two training programs. Inferential statistics rely on probability theory to test a hypothesis formally, permit inferences from a sample to the greater population, and test whether the descriptive results are likely due to random factors or to a real relationship. Under ideal experimental conditions, inferential statistics would be used to interpret (i.e., generalize) the results from an analysis of the attitude data from the cadet sample to the greater population of *all* police cadets from *all* of the police training colleges across Canada. Conditional statements could be quite telling, conditional because the statements would have to depend on the sampling method that was implemented.

In this comparison, it is expected that inferential statistics would reveal first of all, that *differences on pretest attitude data* would be statistically non-significant beyond the 0.05 level of probability; that is to say, that all the police cadets would state a neutral attitude toward persons living with a mental illness. Second, it is expected that inferential statistics would reveal that *differences on post-test attitude data*

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would be statistically significant beyond the 0.05 level of probability. It is expected that further analysis of the significance levels using Scheffé's post hoc comparisons would reveal that cadets in TEMPO training would show more improvement in their attitudes and stigma toward mentally ill individuals, than those learning from the CIT curriculum.

Discussion

The *discussion* is the section where the findings are interpreted and tied back to previous studies. If the results of the *analysis of variance* reported statistical significance between the two conditions, then it is reasonable to expect, beyond chance, that police cadets would indeed show more improvement in their attitudes and stigma toward mentally ill individuals after TEMPO training than if they had learned from the CIT curriculum. If the null hypothesis is rejected and the alternate hypothesis supported, then this result could bode well for phasing-out CIT training in favour of more support for the TEMPO program. If however, in the event that the null hypothesis is supported and the alternate hypothesis rejected, this result may still be important information for policy makers about whether to spend more money on the TEMPO program.

Limitations

There should be a word about the limitations of the study to avoid *Type I* or *Type II errors*. *Type I error* occurs when a significant relationship is reported when none exists, that is to say the null hypothesis was falsely rejected. Experimental research is constantly susceptible to Type I error. *Type II error* occurs when no significant relationship is reported when in fact one does exist, which means the null hypothesis was falsely accepted. It is quite likely for example, that the grand statement made above, namely that inferential statistics would reveal that differences on *pretest attitude data* would be statistically non-significant beyond the 0.05 level of probability, may in truth, be a false assumption because the PACAMI-O *instrument* used to measure attitude of the comparison, even if the study comprised the entire population of all police cadets across the U.S. or Canada, may, in fact, be too blunt to get at the underlying likes and dislikes of the police cadets.

Then why use it? The answer is that while it may not be a therapist's standardized inventory of patient attitude, the PACAMI-O was nevertheless used, tested, and published in a similar study to this one, and could therefore be used to good effect, ensuring good *validity* (i.e., has a similar purpose) and good *reliability* (i.e., has similar participants) – not *the* ever-evolving truth perhaps, but valid and reliable nonetheless.

Philosophically speaking, statistical tests should not be seen as the truth of the premises in an argument, but rather as the conclusion of an argument in a research hypothesis located at the beginning of a study. The truth of each premise in an argument may be difficult to isolate and therefore difficult to control experimentally, due in part perhaps to the dynamic nature of police work, changing environmental factors, cultural or religious factors and so on. Add to these uncontrolled variables, learner factors, training delivery factors, parts of which may be omitted in some training colleges, as reported earlier, or run at different times in the training program. What of missing data - those cadets who dropout, or instructors who retire or quit (aka *mortality)* affecting the truth of the premises? These are all possible threats to the internal validity of the comparison.

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As for the police cadets themselves, what of *maturation,* their changing goals and beliefs over time, of police cadets in all of the police training colleges across Canada? Experimental comparison by its design seeks to corroborate its own methods and measures with outside sources, to justify its own – not seek the dynamic and multi-faceted truths about changing cadet attitudes toward suspects living with a mental illness.

Summary

It should now be clear why the proposal was limited to police cadets at a local college, and *not* police cadets from all of the police training colleges across Canada – because the variables would be too difficult to control, and because experimental study by design aims to take a valid and reliable snapshot of cadet attitudes in a controlled environment. Conditional statements may be all that are left, and great care when interpreting statistical data into generalizations about police cadet attitudes toward persons living with a mental illness. The writing of this proposal has opened many questions that could, and perhaps should, some day, be elaborated by qualitative research. What follows (Table 2) is a summary of criteria for designing a proposal to compare police attitude-training programs.

Table 2. Criteria for designing a proposal to compare police attitude-training programs

1. Describe the research question or problem in the introduction - the dependent variable(s) – E.g.: Finding a problem in law enforcement to study begins with describing the background and context.
2. Summarize in your own words orally or in writing the gist of the literature review, including the theoretical framework to support the questions, problem, or need.
3. Describe the gist of the methodology, including:
a. The participants [e.g., level, prerequisites, prior knowledge of the dependent variable under consideration, motivation to learn (intrinsic better job, etc.)]. Know your participants. Know what they will do - are they sent the materials or do they need to access the materials? Are they all text or i there speech (cues or narration)
b. The materials in depth [e.g., online, tools, software utilities, workbooks, writing materials, verbal instructions, etc.]
c. The research design [e.g., hypotheses, sampling method] variables [e.g., dependent, independent]
d. The instrumentation [e.g., written test, time stamping, dribble files, interview questions, written work, method of segmenting protocols, etc.]
e. The procedure [e.g., "the procedure in this study followed those suggested in previous studies of this kind (reference)," and summary]
4. Describe the gist of the expected results, including:
a. The methods to be used in collecting the data
b. The methods to be used in analyzing the data
c. Expected results
5. Write a brief Discussion:
a. Linking previous research to the results arising from the analyses of the data
b. Expected conclusions of the study
c. Implications of the study
6. State whether or not the references in text and in the list follow the current APA standard.

(Mann, 2006).

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APPENDIX

Table 3. Police and Community Attitudes Toward Offenders With Mental Illness Likert Scale (PACAMI-O) measures "attitude differences"

1. As soon as an offender shows signs of mental disturbance, he should be hospitalized.
2. More tax money should be spent on the care and treatment of offenders with mental illness.
3. An offender with mental illness should be isolated from the rest of the community.
4. The best therapy for many offenders with mental illness is to be part of a normal community.
5. Mental illness is an illness like any other.
6. Offenders with a mental illness are a burden on society.
7. Offenders with a mental illness are far less of a danger than people suppose.
8. Locating forensic mental health facilities in a residential area downgrades the neighbourhood.
9. There is something about offenders with mental illness that makes it easier to tell them from normal people.
10. Offenders with a mental illness have, for too long, been the subject of ridicule.
11. A woman would be foolish to marry an offender who suffered from a mental illness, even though he seems fully recovered.
12. As far as possible forensic mental health services should be provided through community-based facilities.
13. Less emphasis should be placed on protecting the public from offenders with mental illness.
14. Increased spending on forensic mental health services is a waste of tax money.
15. No one has the right to exclude offenders with mental illness from their neighborhood.
16. Having offenders with mental illness living in residential neighborhoods might be good therapy, but the risk to residents is too great.
17. Offenders with mental illness need the same kind of control and discipline as a young child.
18. We need to adopt a far more tolerant attitude towards offenders with mental illness in society.
19. I would not want to live next door to an offender who has been mentally ill.
20. Residents should accept the location of forensic mental health facilities in their neighborhood to service the needs of the community.

(Glendinning & O'Keeffe, 2015).

[1]Panel on Research Ethics (2016)

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Section 3
Tools and Technologies

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Chapter 17
Real-Time Mental Health Monitoring: The Indian Scenario

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ABSTRACT

Mental disorders have been identified as one among the leading causes of the global disease burden. Despite being one of the first nations in the world to identify mental health as an important indicator of personal well-being and having adequate plans and policies for ensuring the same, one in every seven Indians is affected by mental disorders of varying severity. Through this manuscript we try to analyze how real-time mental health monitoring has helped improve productivity among the global workforce as well as prevented deterioration of individual mental health across the globe. Our main plan of this study is to identify the significant efforts in mental health monitoring across the globe and then chalk out a real-time mental health monitoring framework for India. We also propose a real-time mental health monitoring smartphone-based framework for India we name as SmartMHealth. We describe the basic components of this framework in this study itself.

INTRODUCTION

As per the World Health Organization estimations varied mental health issues cost the world economy approximately an annual $1 trillion loss in global productivity ("India is the most depressed country

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in the world," 2018; James, 2019). About 450 million people globally experience some form of mental health disorders ("Augmented Mental Health," n.d.). $467 billion is the burden of mental disorders on the US economy annually. Given these startling estimates it is important to realize that a mentally healthy population is a key contributor in the success of any nation. Mental health is a key marker of the emotional, psychological and social well-being of an individual. As per World Health Organization (WHO) estimates, at least 6.5 per cent of the Indian inhabitants experiences some type of severe mental disorder, with no distinctive rural-urban discrepancy (World Health Organization, 2007). Positive mental health is a significant indicator of an individual's well-being at each stage of life (Vihan Sanyal, 2018). In fact, it is a fact that good mental health is one the underlying facets to prolonged and fruitful human life. Varied factors like stress, depression, social anxiety, drug addiction, obsessive compulsive disorder and other personality disorders may add to mental health issues leading to mental illness ("Mental health in India," 2017).

Hence, in the current times when competitive, technologically-driven social life is governing most people it has become imperative to verify the inception of mental illness to retain normal life balance. In an era when augmented mental health is emerging as the new paradigm in mental healthcare through data and digital therapeutics. Achieve early detection and prediction of human mental health is no longer a distant dream. Several machine learning algorithms and artificial intelligence have and can be applied for this realisation (Gurjit & Neena, 2006; Hillestad et al., 2005; Kumar & Hancke, 2015; Paul et al., 2018; Price et al., 2014). Such application when applied in real time shall profit the society at large by serving as a monitoring and control tool to identify onset of deviant or malicious behaviour among otherwise healthy and productive individuals.

The rest of the manuscript is structured as follows: Section I discusses the current scenario of world mental health. Section II highlights the need of effective mental health monitoring solutions. Section III stresses and analyzes the varied available mental health monitoring mechanisms. Section IV details the Indian state of affairs in mental health monitoring. Section V proposes SmartMHealth framework for real-time mental health monitoring. Section VI concludes the discussion.

Need of Mental Health Monitoring

As per global statistics (Kamdar & Wu, 2017), Neuropsychiatric or mental disorders along with cardiovascular diseases, cancer and other communicable diseases are a major contributor to the global burden of diseases and disease-related mortality. Table 1 below lists certain major neuropsychiatric disorders that are currently daunting the human race.

Though these disorder types contribute more than 10% to the prevalent disorders and diseases, however, research in monitoring or control of these disorders is still lagging behind (Kamdar & Wu, 2017). As per WHO estimates many developing and developed nations across the world are bearing the burden of mental disorders. Outcome based monitoring and feedback systems on therapeutic mechanisms have become popular in recent times and have been implemented by several health care providers all over the world. However, these don't seem to be implemented widely in mental health care ("India is the most depressed country in the world," 2018) (Birla, 2019). Mental healthcare as opposed to other non-communicable diseases requires continuous monitoring on a regular basis. Patients with psychiatric disorders may suffer behavioral symptom on a relapsing basis. Hence, to provide optimal care to such patients it is important to have some low-cost, widely available, real-time monitoring mechanisms in

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place. Table 1 above establishes that there are direct relations between physiological/behavioral and mood states. Wearable sensors are hence, suitable mechanisms to continuously monitor mental conditions in an unassuming mode (Garcia-Ceja et al., 2018).

Table 1. Classification of Neuropsychiatric Disorders(Garcia-Ceja et al., 2018).

S. No.	Disorder Class	Signs & Symptoms
1	Mood Disorders like depression, unipolar and bipolar disorders	Hypoactive Electrodermal Response, Reduced Motor Activity (Chang et al., 2014; Sarchiapone et al., 2018; Todder, Caliskan, & Baune, 2007; Volkers et al., 2003), Cardiac Autonomy Disregulation (Chang et al., 2014)
2	Anxiety-Related Disorder (Anorexia, Eating Disorders, OCD (Obsessive Compulsive Disorder), Panic Disorder, Post-Traumatic Stress Syndrome)	Sleep Problems, Heart Palpitations, Unable to stay calm and still
3	Schizophrenia	Reduced Motor Activity (Winograd-Gurvich, Fitzgerald, Georgiou-Karistianis, Bradshaw, & White, 2006)
4	Dementia	Memory Problems, Depression, loss of ability to do everyday tasks
5	Substance Use Disorder	Disorientations

As clear from table1 there are multiple neuropsychiatric disorders plaguing humans. However, detection and monitoring of these disorders majorly rely on descriptive criteria. Limited clinical tests or medical devices are available for mental health monitoring (Kamdar & Wu, 2017). Information used by physicians in treating such patients is episodic relying on patient's visit. Tools and mechanisms for continuous, real-time data collection are desirable for such patients. EEG and video monitoring-based mechanisms though effective are insidious and do not allow incessant data collection. Further, output of these methods may not always be easy to interpret. Hence, more robust and patient-friendly mechanisms are desirable to improve the state of mental health monitoring as well as care.

Mental Health Monitoring Mechanisms

Globally current mechanisms to supervise mental health engage the prolific use of wearable technologies (Kamdar & Wu, 2017). Advances in EEG and video monitoring have lagged far behind due to the difficulty involved in their widespread use (Pantelopoulos & Bourbakis, 2009). Wearable technologies have surfaced as an emerging, omnipresent mechanism for providing uninterrupted, quantitative data about an individual (Pantelopoulos & Bourbakis, 2009). These mechanisms allow for easy, passive accumulation of quantitative data enabling proactive mental health management and better treatment. The wearable devices market has grown exceptionally in the last few years. As per Transparency Market Research, "the global wearable technology market is expected to grow from US$750 million in 2012 to US$5.8 billion in 2018" (Wei, 2014). This expansion and growth in the hardware device market forecasts creation and implementation of efficient mechanisms for wearable devices-based mechanisms for real-time mental health monitoring. It is important to note that these products can be easily empowered to measure varied attributes related to the surrounding environment, human physiology and activity. Hence, data can be easily collected passively without interfering the day-to-day activities of the user. Sentiment analysis on such data streams provides more accurate results as compared to surveys. Development and imple-

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mentation of wearable-device based mental health monitoring frameworks shall enable early diagnosis of unidentified users providing chances for preventive care as well as better diagnosis and treatment for diagnosed patients. Table 2 below details some notable mental health monitoring mechanisms applied in different perspectives.

Table 2. Notable Mental Health Monitoring Mechanisms

S. No.	Title	Ref.	Description	Achievements
1.	PRISM: A Data-Driven Platform for Monitoring Mental Health	(Kamdar & Wu, 2017)	Recapitulates user-reported ratings of their emotional state through applying supervised and unsupervised learning to PRISM — Passive, Real-time Information for Sensing Mental Health. Integrates motion, light and heart rate data obtained from smart watch application along with user interactions and text obtained from a web application.	Platform enables collection of incessant streams of passive data for near the beginning diagnosis or regular monitoring of patients with mental disorders.
2.	A Zigbee-Based Animal Health Monitoring System	(Kumar & Hancke, 2015)	An animal health monitoring system (AHMS) for checking the physiological parameters like rumination, body temperature, and heart rate with neighboring temperature and humidity has been developed. The system can also analyze the stress level corresponding to the thermal humidity index (THI).	The device has proved to be helpful in low-cost health care of livestock.
3.	Consume: A Privacy-preserving authorization and authentication service for connecting with health and wellbeing APIs	(Wetzels et al., 2018)	Current proliferation of Internet of things (IoT) enabled devices in health and well-being domain empowers individuals to monitor their health. However, the variety of devices leads to complexity of data aggregation and scattered overviews. Consume facilitates the integration of these APIs and data aggregation over a common platform.	Consume promises to aid researchers in development of personalized healthcare systems. It has provided the base for a universal data aggregation system for varied APIs. Thus, it shall accelerate development of new health monitoring as well data collection devices.
4.	Mental Health Monitoring with multimodal sensing and machine learning: A survey	(Garcia-Ceja et al., 2018)	Surveys research work in mental health monitoring systems through the use of ubiquitous sensing technologies for data collection and machine learning to predict the related user contextual information.	The papers surveys all research works on mental state monitoring through sensors that gather wearable data. The classification given is helpful in understanding the basics.
5.	Complexity Index from a Personalized Wearable Monitoring System for Assessing Remission in Mental Health	(Lanata, Valenza, Nardelli, Gentili, & Scilingo, 2015)	Introduces PSYCHE, a t-shirt with embedded sensors for monitoring electrocardiogram heart rate variability (HRV) series, respiration activity and activity recognition for patients suffering with mental disorders.	Continuous interface between clinicians and patients advances the quality of life of patients aiding the clinicians in the analysis and preventing relapses.
6.	Ginger.io Commercial app (The Ginger App)	(Matheson, 2014)	The app passively analyzes mobile data to detect if a patient with mental illness is acting symptomatic. The symptoms may vary from lethargy to infrequent texts. On detecting an unusual pattern the app sends messages to the patient as well as their health care provider.	The app is currently being used by thousands of patients at more than 25 health care institutions and academic centers across the United States. The app has also been applied for research at a number of universities across the globe.

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Real-Time Mental Health Monitoring for India

As per WHO estimates, India was the initial nation globally, to identify the need for incorporation of separate mental health services along with general health services at the primary level (Agarwal, Goel, Ichhpujani, Salhan, & Shrivastava, 1946). The National Mental Health Programme (NMHP) was launched as early as 1982, to treat mental disorders among the community with the available care services. However, as a nation we somehow lagged behind in proper mental health monitoring and treatment of our mental disorder affected population. These mentally ill patients are seen more as a social stigma and are abandoned by their family and community. Our policy and community failure was highlighted in 2001, when an asylum fire in Ramanathapuram district of Tamil Nadu killed 26 mentally ill patients residents of this asylum (Agarwal et al., 1946). Following this incident, the Directorate General of Health Services in May 2001 undertook a Current Situation Analysis (CSA) survey in order to evolve a inclusive plan of action to reenergize the NMHP. As a result, the NMHP was re-reviewed and reoriented at district level also known as District Mental health Programme (DMHP) with an outlay of approximately 190crore in the 10th Five Year plan. The DMHP plan now aims to cover every district across the country to reorient mental colleges and hospitals to establish high standards of care and treatment. The plan receives a huge grant in each of the five year plans and is to be re-reviewed in 2020, as NMHP 2020 (Agarwal et al., 1946). However, despite the long presence of this national policy framework, India as a nation has failed to eliminate the stigma of mental disorders from its society. As per records, Kerala one of the most literate and high life quality states in the country reports rising incidence of suicide cases amongst its population (Agarwal et al., 1946; Bachani & Srivastava, 2012; Manoranjitham et al., 2010). Such is the state of affairs despite the fact that India has a well-laid policy framework for mental health in the form of NMHP and the plan is well-aided financially. It is notable to mention here that it costs Rs. 500/ day to maintain a patient in a mental hospital whereas the per capita national expenditure on health is only Rs. 200/year. Gujarat spends more than Rs. 37.2 million on its 4 mental hospitals with a total bed strength of only 680(Agarwal et al., 1946). These facts bring to light certain important observations, which we list below:

- Mental disorders in India are associated with unwarranted social stigmas and superstitions resulting in abandonment of mentally ill patients by immediate family and community. As a result, cost of maintenance of such patients goes up. Destigmatisation of mental disorders is important.
- India should realize that mental health is not related to the purse but to the mind.
- It's time to call for a spirit of invention of practical solutions empowered with available technical skills to accomplish real-time mental health monitoring and care. IoT enabled services and smart devices can be used as a basis to design a framework for continuous mental health monitoring of our able population as well as mentally-ill patients to enable early identification of disorders and ensure their proper prevention and treatment.

Globally lot of notable work has already been conducted in smart health monitoring through m-Health applications as well as through wearable biosensors (Berrouiguet et al., 2018; Chandrashekar, 2018; Chen, Ma, Song, Lai, & Hu, 2016; Pantelopoulos & Bourbakis, 2009)

Some of these applications also monitor the varied mental disorders of patients providing them a close loop monitoring and interaction with their physicians. However, recognizable volume of this work especially in general mental health assessment and analysis of seemingly normal population but on

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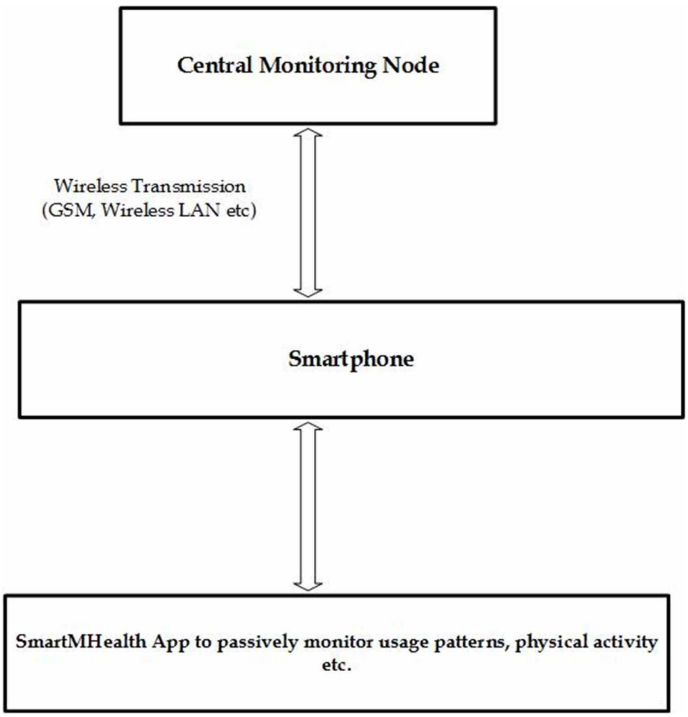
risk of mental health disorders is missing especially in India ("Mental health in India," 2017). As per WHO, "Vigilant monitoring and assessment of a nation's mental health policy and plan are essential for improving services, healing and care and for guiding future policy directions"(World Health Organization, 2007).WHO under its Mental Health Policy and Service Guidance Package has laid down clear guidelines to assist nation's in laying down policies and plans to assist nation's in improving the mental health of their populations. Mental health remains the elephant in the room in the formidable corridors of corporate India. Of the country's 1.1 million active registered companies, only 1,000 are estimated to have a structured employee assistance programme (EAP) for mental health (James, 2019). Notable studies have already been conducted on varied aspects related to mental well-being of Indian population (Hasumi, Ahsan, Couper, Aguayo, & Jacobsen, 2012). However, practically efficient solutions are still a distant dream.

SmartMHealth: Real-Time Mental Health Monitoring Framework for India

Our SmartMHealth framework aims at the development of a low-cost smartphone based, unobtrusive solution for continuous mental, emotional and activity status monitoring of individuals. The proposed system shall provide real-time feedback about an individual's mental health. This continuous data when shared with a central monitoring unit (node) or self-checked by individuals can alarm in case of possible imminent mental health threatening conditions like stress, increased cardiac activity etc.

The proposed SmartMHealth App shall be a smart phone-based app to monitor physiological, emotional signals as well as physical activity rate of its user. Figure 1. depicts the major components of the proposed SmartMHealth framework.

Figure 1. Architecture of Smartphone based SmartMHealth App



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Figure 1 visualizes the concept of a possible SmartMHealth app that could passively monitor the user's usage patterns and send alarm signals to the central monitoring node in case of any deviation. However, this should not be considered as standard system design, as actual implementation may vary significantly. As can be seen from Fig.1 of all possible smart wearable devices we have chosen SmartMHealth as a smartphone enabled app. It can be argued that any other low-cost smart device can also be used, however smartphone was a natural choice as almost 94% of the world population are cell phone subscribers and Internet users irrespective of external factors like place of residence, level of education, etc. (Chan, Estève, Fourniols, Escriba, & Campo, 2012; Vashist, Schneider, & Luong, 2014). Further, behavioral health analytics startup Ginger.io has also identified smartphones as "automated diaries" that can provide valuable insight into the mental well-being of any individual including mentally ill patients (Matheson, 2014). Smartphones inherently produce significant behavioral data regarding an individual in the form of location, calling and texting records as well as app usage history. This data can be easily used to map a user's daily patterns. A deviation in this pattern is enough to raise an alarm. The alarm can be transmitted to the individual under observation as well as their health care provider as well as the central monitoring node. The central monitoring node with the help of appropriate machine learning algorithms can help analyze the humongous passive health data collected to usable information for passive health care monitoring of healthy individuals. The details of the smartphone-based apps, required resources for creation of the central monitoring unit as well as the machine learning algorithms are being worked out at the time of this writing and shall soon be discussed and implemented. This tool would be effective in realizing the world of augmented mental health.

CONCLUSION AND FUTURE SCOPE

As per our analysis, for effective solution of mental disorders India actually requires a paradigm shift from the hospital care to community care. This also calls for an early diagnosis of alarming mental conditions and thus shifting from treatment to prevention. As a country, we need to rise and realize that mental health is not a social stigma, it is not a government policy initiative and neither just a personal initiative. Instead mental well-being and health is more of community care and monitoring.

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Chapter 18
Appreciative Inquiry and Mental Health Improvement:
A Review on Applicative Potential at Individual Level

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ABSTRACT

Appreciative inquiry is an 'asset-based' approach that focuses on the positive things of life. Through its 4D cycle and principles it generates transformation of organization. AI when practiced goes through 4D cycle of discovery, dream, design, and destiny. An individual gets the scope to rediscover and reorganize when passing through these four phases. This liberates the mind through exploration and introspection. Interventions of AI even clarify the 'shadow' area of the human mind. The chapter tries to establish AI as a potential tool that can be used at individual level to aid in up gradation of mental health awareness through reviewing existing literature in this field.

INTRODUCTION AND CONCEPT OF APPRECIATIVE INQUIRY

The concept of appreciative inquiry was propounded by Cooperrider and Srivastava in 1986 but it has its origin in the theory of social constructionism (Berger & Luckmann, 1966). David Cooperrider conducted his doctoral study on physicians engaged in leadership position at United States medical centre. They were asked to tell stories about their victories and failures (Cram, 2010). Coghlan et al, (2003) in their research article mentioned that "He was amazed at the level of positive cooperation, innovation, and egalitarian governance when they were at their most effective". This led Cooperrider and his guide Dr. Srivastava to think that emphasis upon the strength and positive sides of an organization can be transitional based on the logic that "organizations move toward what they study" (Cooperrider, Whitney & Stavros, 2003). This process of AI involves 4D cycle of discovery, dream and design to shape the future

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and effort to transform the destiny (Whitney & Trosten-Bloom, 2003). Culture of employee engagement can be built, and it should be fabricated through the tenacious efforts of managers and leaders in the organization, deliberate efforts can be made to build culture, positive work environment leads to positive outcome of performance (Chakraborty & Ganguly, 2019).

Conventional approaches in order to bring organizational changes were criticized by many researchers, then this new approach came into being which included both social and psychological perspective (Gergen 1982, Gergen 1990, Bushe & Coetzer 1995). Appreciative inquiry is research method which focuses on organizational change though positive attributions i. e. appreciative inquiry emphasizes on exploring the strength of the organization in lieu of weakness for its growth and prosperity. In the recent past the application of appreciative inquiry in the organizations has grown brilliantly (Dick, 2004).

BACKGROUND

Appreciative inquiry was created to provide an unconventional approach to solve organizational problem and was an alternative for problem solving approach (Beattie, 2018). Problem solving method mostly deals and focuses on what is not doing well or wrong in the organization, where as appreciative inquiry deals and encourages the positive things as capable components behind organizational development. Watkins et al (2016) described appreciative inquiry as an efficient tool to change social system. They also depicted that it is also capable of bringing change in complex human world. According to Bushe (2007) the method of appreciative inquiry is not only limited to positive characteristics but a pursuit of novel ideas, theories, models that discover and manifest cumulative desires. Many researchers also commented that AI should not just merely be treated as a tool for organizational development but an ideology and inclination which can reform and reshape primarily the process of organization learning, design and development (Watkins & Mohr 2001).AI is more about "both a philosophy and a worldview, with particular principles and assumptions and a structured set of core processes and practices for engaging people in identifying and co creating an organization's future" (Coughlan et al, 2003). The applicative potentials of AI are vast. The method and principles of appreciative inquiry were thoroughly investigated by many researchers. For example- Van Buskirk (2002) conducted his research on urban catholic schools and found satisfactory transformational results. AI was proved to be useful even in enhancing personal relations (Klem, 2005) of the individuals. Kaye et al (2008) in their research also explained that AI interventions provides the opportunity to its participants -to explore and depict the best experiences of life, assessment of life giving components and to express the tales of their personal eminence. Laertius & Yonge, (2006) described that AI principles are reinforced by the psychology of adult development through introspection or knowing oneself and actualizing one's innate strengths. These avenues of self reflections through narrations become the pillar for transformation even at individual level. Appreciating the good things in life, being content, grateful and interpersonal resilience improves one's sense of well being. These factors can even contribute positively towards the improvement of participant's mental health.

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CONNECTION BETWEEN APPRECIATIVE INQUIRY AND POSITIVE PSYCHOLOGY

Positive psychology is another approach which also emphasizes on the strength instead of the weakness to study human behaviour, thoughts and actions more systematically. Positive psychology started its journey with Martin Seligman (2003). Positive psychology focuses on happiness, joy, gratitude, resilience, compassion, inspiration etc. Peterson and Park (2014) defined "Positive psychology is the scientific study of what makes life most worth living". The outlook of positive psychology is optimistic in nature. Peterson (2003) articulated that this leads to the accomplishments of the desired and relevant circumstances. According to Seligman "The field of positive psychology at the subjective level is about positive subjective experience: well-being and satisfaction (past); flow, joy, the sensual pleasures, and happiness (present); and constructive cognitions about the future—optimism, hope, and faith" (2005). This psychological approach also works on individual as well as in 'group level'. There it functions as civic righteousness and institutions which encourages individuals towards better "citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic" (Seligman, 2003). Just like positive psychology appreciative inquiry also is optimistic in nature thoroughly focusing on the positive aspects of what is doing well and doing more of it. Many researchers have suggested that appreciative inquiry approach is influenced by the concept of positive psychology (Seligman et al, 2005). Kobau et al (2011) in their research promoted the importance of mental health in public health. To conduct the research they focused on the principles of positive psychology. They concentrated on positive attitudes, psychological capital and strength of the individuals and how these factors can contribute towards the growth as a whole. They found that positive emotions has multidisciplinary effect on improving the overall well being of human life staring from physical health, professional endeavors, family and financial conditions. This asset based approach of positive psychology can be used to boost up resilience and promoting mental health.

Positive psychology and AI both disciplines deal with appreciation of the present situation, which incorporates gratitude, resilience, optimism and hope. The psychology of appreciation or being grateful to the things a person have is closely associated with both the fields. Positive psychology gives way to progress in a manner where pivotal point is optimism. Appreciative inquiry also gives the opportunity to liberate one's own desire and thought to bring a dynamic change. To describe the process of positive psychology Seligman referred that "there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several. Much of the task of prevention in this new century will be to create a science of human strength whose mission will be to understand and learn how to foster these virtues in young people." (2003). AI can be regarded as that 'science of human strength'. Therefore the synergy between positive psychology and appreciative inquiry can bring about a dynamic change in the promotion of importance of mental health and its awareness.

The aim of this article is to establish AI as an efficient positive approach for the improvement of mental health among individuals through transformation. This will also try to decipher how appreciative inquiry can be coupled with other existing intervention of the same field for the above said purpose.

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APPRECIATIVE INQUIRY AND MENTAL HEALTH

Appreciative Inquiry (AI) is an approach to organizational change, or more generally- a change in human systems, which has gained increasing popularity among practitioners and has sparked the interest of the academic community over the last 20 years (Whitney & Trosten-Bloom, 2003). David Cooperrider and Suresh Srivastava developed the theory of AI in the year of 1986 for his doctoral dissertation. Hence, the most often cited definition of AI is that of Cooperrider, Whitney and Stavros (2003):

Appreciate Inquiry is the cooperative, co-evolutionary search for the best in people, their organizations, and the world around them ... AI involves the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. (Cooperrider, Whitney & Stavros, 2003)

Coghlan, Preskill and Catsambas (2003) describe AI as "both a philosophy and a worldview, with particular principles and assumptions and a structured set of core processes and practices for engaging people in identifying and co-creating an organization's future." AI has been described by observers in several ways such as: a paradigm of conscious evolution geared for realities of the new century (Hubbard, 1998); as an offspring and "heir" to Maslow's vision of a positive social science (Chin, 1998; Curran, 1991); as the most important advance in action research (Bushe, 1991) and so on.

A study done by Clossey, Mehnert and Silva (2011), showed that AI has been found to facilitate recovery in mental illness, as it empowers individuals and creates a supportive, client-centered environment. AI seeks to overshadow "what went wrong and who is at fault" and focus on "what can be done to make things better". This creates an environment which enables an individual to discover, dream, design and deliver their desired behaviour. In a study conducted by Julia L. Hennessy (2014) discusses and explores the possibility of AI being a research tool for mental health services. In this four-stage model, each stage has its respective inquiry (Cooperrider, Whitney & Stavros, 2003; Whitney & Trosten-Bloom, 2003):

- **Discovery:** Questions asked here are: "What gives life? What is good about our past and present?" This stage focuses on discovering and valuing what the organization already has.
- **Dream:** It involves envisioning what might be to what has already been discovered.
- **Design:** Based on the previous stage, organization members identify which ones of their stories and dreams will be transferred into reality.
- **Destiny:** Here, the organizational members collectively commit to and set out to create what they desire.

There are five core principles of AI:

- **The Constructionist Principle:** Organizations are human constructions, that is, organization's reality is constructed by the questions people ask.
- **The Simultaneity Principle:** Change begins the moment the present is questioned. These questions become the stories out of which the future is conceived, discussed and constructed.
- **The Poetic Principle:** Like a poem, the organization's past, present and future are endless sources of learning, inspiration and interpretation.

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- **The Anticipatory Principle:** One's present behaviour is influenced by the future anticipation. The more positive and hopeful the future image is, the more positive the present action will be.
- **The Positive Principle:** The more positive the questions are used to guide a change process, the longer lasting and effective the change becomes.

Researchers have shown that positive imagery evokes positive emotions and positive emotions move people towards a choice for positive actions (D.L. Cooperrider, Whitney & Stavros, 2008). To achieve positive imagery, it is important that every individual in the organizational team has a positive and balance mental health state. In a study of teams, it has been shown that cognition dominated by negative imagery proved to be an impediment in the teams' performance (D. Cooperrider, 2000). AI is a powerful way to change an organization's cognition from being negative to being generative and creative (Bushe, 2000). It is so because AI views organizations as living human systems and change is done by the process of cognitive shift (Nilakant & Ramnarayan, 2006); Lewis, Passmore, & Cantore, 2008). AI does not revolve around hiding or fixing the weaknesses. It rather focuses on strengthening the areas of strength and promoting positive change.

Mental health is not referred to as the absence of any mental illness but to our emotional, psychological and social well-being. In 2011, a case study conducted by Lea Waters and Mathew White was done on K-12 private boys' school in Australia. The aim of this study was to study the effect of implementation of a strategic plan of fostering student well-being. This school established a three-year old strategic plan where the goal was to build a dynamic and comprehensive wellbeing program for its students. The Senior Leadership Team (SLT) decided to adopt AI as a guiding approach to develop, implement and monitor this wellbeing strategy in the school. Towards the end of the three-year old plan, several changes took place, such as:

- A positive psychology interest group was formed which brought together 70 people across the school who didn't have much contact due to role difference and geographical separation.
- At the first parent-teacher meeting for senior years, every student's mentor discussed on the student's well-being, character development and academic accomplishment.
- The Physical Education Department volunteered to start weekly well-being activities such as yoga, mindfulness, and Tai Chi.
- The teachers and counselors started working together towards a common goal of boosting students' wellbeing, and so on.

These findings show that when members of the organization unite to work around an appreciate topic, it breaks down traditional barriers and promotes mental health.

A study done by Anthony Scerri, Anthea Innes and Charles Scerri (2016) investigated the results of using method of AI in dementia patients in hospital wards. AI was used to implement the person-centered dementia care in the hospital. Since life is challenging and difficult for not only the individual with dementia but also for the doctor, nurses and staff members, this study implements a number of action plans in accordance to AI. Using AI approach, the staff attitudes towards individuals with dementia improved. Furthermore, inter- professional collaboration was also enhanced. Engaging in AI workshops not only brought big positive changes in the organization in hospital wards, but also small changes in staff practices were observed and noted.

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Another study done by Jaclynn L. Glasgow (2008) aimed to discover successful teaching practices of a low socio-economic elementary school that met the standards of excellence. One of the methods used for this qualitative study was the AI method for discovering positive aspect of this organization. As stated by Thatchenkery (1999), AI seeks to discover and heighten the "life-giving-forces". AI is a team learning method where the participants are brought together to bring about a positive change. The findings of this research suggested that AI has the "potential" to change teachers' educational practices and empower the participants and spark a new vision of hope, optimism and a passion for teaching.

"AI emphasizes empowerment and encourages participants to see their organization as a community that can envision and create a positive future, emphases that are compatible with the philosophical stance of the recovery model." (Clossy et al, 2011, p-261).It is a process which encourages the appreciation of things which add values to human system while functioning at their best. It enables analysis of strength, success, values and aspiration at individual as well as in organizational level through asking questions or narrative storytelling. It emphasizes that human being alone and collectively has distinctive virtues and skills which can lead to a better subjective world through moving away from problems and concentrating more on the relevant positive ideas and imaginations (Moore, 2008).

According to World Health Organization (WHO, 2014) mental health is "... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Medilexicon's medical dictionary defines mental health as "Emotional, behavioral, and social maturity or normality; the absence of a mental or behavioral disorder; a state of psychological well-being in which one has achieved a satisfactory integration of one's instinctual drives acceptable to both oneself and one's social milieu; an appropriate balance of love, work, and leisure pursuits." Nordqvist (2017) in an online article described that mental health is a combination of an individual's cognitive, behavioural and emotional well being. It comprises of how an individual 'think, feel and behave'.

AI helps in bringing a positive change in organizational structure utilizing its resources. This is done through structured or semi structured interviews of the participants. Participants explore themselves as well as the situations through the different stages of 4D cycle of Discovery, Dream, Design and Delivery or Destiny. Passing through each phase of this cycle an individual can also re-discover himself and his internal motivation is increased through unleashing the facts that he can dream, design and implement to bring about a significant positive change in his life. This process of self discovery is very important for improving the mental health of any individual. Hennessy & Hughes (2014) in their research described the utility and challenges of AI. They investigated that AI can be used as a research tool for mental health services due to its transforming nature. They also said that it can bring positive changes in mental health consumers. Bushe (2010) described AI as a life giving process. "AI builds on and amplifies this natural tendency by explicitly inviting people to collectively inquire into their system's life-giving properties and positive anticipatory images of their common future. AI theorists argue that while engaging in these joint activities people are building new generative connections that bring a feeling of joy, aliveness, hope, caring, and potential, leading people to create more and new things without being told or asked to do so" (Verleysen et al, 2015, p-5). This explanations along with the operative principles of AI implies that if it is properly administered it can play a pivotal role in upgrading the mental health of individuals. Acosta & Douthwaite (2005) in their research concluded that interview sessions of AI gives participants the opportunity and freedom to express their positive experience and contribution making them more confident in empowering a difference. The storytelling sessions teaches appreciation of human values and potential as important notion for changes. They also depicted that AI helps in building

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a strong self image and enables the individual to be achievement oriented through its existing principles and cycles as it transforms the best past into effective present and future. The positive approach of AI also contributes in self-organization (Bushe & Kassam, 2005) which can boost up the metal health at individual level. According to Chakraborty & Mishra (2019) exercising AI in individual level creates self motivation, liberated attitude, effective learning. This attributes makes a person more intrusive in their search for strength and optimism which makes them more successful and creative in life. From the existing literature of this field it can be said that AI interventions are extremely useful for improving mental health of an individual collectively as it unleash the hidden motivation to do better in life as well as improving coping strategies. Thus along with the organizational development, application AI interventions in upgrading the mental health at individual level can be proved to be beneficial and must practiced elaborately.

APPRETIAVE INQUIRY AND SHADOW AREAS OF HUMAN PERSONALITY

Karl Jung (1968) deciphered that there are certain trait among individuals which they tend to deny or do not accept. In his terms shadow is "everything that the subject refuses to acknowledge about himself, for instance, inferior traits of character and other incompatible tendencies" (p. 284). Kolodziejski (2004) in her doctoral research explored the concept of shadow more meticulously at different arenas of inter-intra personal, group and organizational level. She expressed shadow " as that which is feared and suppressed, that which is considered inappropriate and shunned, that which is unbearable to hold consciously and denied" (p. 64). She also described shadow as a broad spectrum of hidden desires and cognition starting from suppressed potentials capabilities to insubstantial emotions. It includes both positive and negative characteristics to be identified by self or others. Sometimes the concept of shadow is misinterpreted as negative action but is just the byproduct of the same. AI mostly focuses on strength which in turn creates awareness within the individual regarding their own potentiality hidden in the shadow area (Fitzgerald et al., 2010).AI can reveal the repressed strength of an individual justifying the differences which paves the way for their individual development. The measurements of AI can also be used to uncover the shadow area of human mind to bring it into light through transformations.

THE TRANSFORMATIVE ASPECT OF APPRECIATIVE INQUIRY

Many researchers have successfully proved that appreciative inquiry can create and transform changes at both organizational and individual level. It imparts transformational learning. This transformative nature of Cooperrider's AI has some similarities with Mezirow's (2000) components of transformative learning. "Mezirow (2000, p. 22) suggested that transformation usually occurs in some form of the following 10 stages: 1.A disorienting dilemma 2.Self examination with feelings of fear, anger, guilt, or shame 3.A critical assessment of assumptions 4. Recognition that one's discontent and the process of transformation are shared 5. Exploration of options for new roles, relationships, and actions 6. Planning a course of action 7. Acquiring knowledge and skills for implementing one's plans 8. Provisional trying of new roles 9. Building competence and self-confidence in new roles and relationships 10. A reintegration into one's life of conditions dictated by one's new perspective" (kaye et al, 2008, p- 635-636). Mezirow concentrated on desynchronizing dilemma. Based on which Allen (2007) wrote that,

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abashment of dilemma enables an individual to perceive himself, the world and personal relationship in better polarized manner. Reduced confusion enables an individual to make better decision; they become more constructive by using the cues of excellence from their past life. The proper execution of AI can also modify a person internally. Being an action oriented approach AI allows a person to introspect and be a responsible part for future success. Denovan et al (2007) illuminated the complementary nature of both AI and transformative learning for human growth. Both disciplines allows self reflection through narratives and stories which leads to transformation by digging out the positive strength and aspiration which may work in positive direction towards uplifting the mental health of an individual. Barrett (1995) suggested that 'appreciative approach' is an ability to perceive life beyond its existing problems. In this context Fredrickson et al (2003) reported that positive emotions prevent depression and helps in building optimism, resilience and improves relationship. It enhances individual well being, and AI focuses mostly on positive aspects of life which in a nutshell can be narrated as 'assest'.

FEW RESEARCHES DONE ON MENTAL HEALTH USING THE INTERVENTION OF APPRECIATIVE INQUIRY

The researches on AI were more focused on organizational development and collective improvement. It is a strength based method, which encourages and explores positive feedbacks by contributor (Reed 2006, Reed *et al.* 2008). However, by using the methods and principle of AI benefit at individual level can also be ensured as it allows one individual to liberate his thought and actions. This process is can be considered fundamental by psychologists to improve the mental health of any person.

Shiner et al (2008) also used appreciative inquiry method to improvise the well being of the patients with severe mental illness which impairs the overall functioning of an individual. It was a health promotion programme of the persons with severe mental illness. Semi structured qualitative interviews were conducted using AI principles. Participants had severe mental illness like chronic major depression, bipolar mood disorder and some were under the spectrum of schizophrenia. The interviews were conducted regarding their positive experiences about the IN SHAPE programme, the subjective quality most which were most appreciated and considered important for the success of the programme. They were also encouraged to share their views on core components and suggestions for the betterment of the programme .The interviews were recorded and transcribed. The result vividly reported that the In SHAPE programme and interventions of AI helped them to focus on a healthier life style, which most of the patients with severe mental disorder ignores. Through the interviews of AI it was established from their perspective that exercise, social interaction and boosting up self confidence aided the individuals suffering from severe mental disorders and it also paved their way towards physical as well as psychological well-being.

Moyle et al (2010) conducted their research on old age population to measure their mental well being through resilience. They applied multinational appreciative inquiry approach to study these parameters. The participants were from Germany, Australia, UK and South Africa. The minimum age of the participants was restricted to 65 years. Present researchers followed the 4D method (Discover, Dream, Design, Delivery) developed by Cooperrider et al (2003) for appreciative inquiry. This study shows us that instead of concentrating on negative sides of life mental health can also be improved through focusing on the positive aspects. The results based on the interview of the respondents revealed that being active through various brain gym, healthy family set up, social connection, community get together, more responsibil-

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ity, self determination improves mental health of the elderly people and keeps them satisfied in life. Allen (2008) also supported that old age people can maintain their well being based on active life style, spending time with grand children, through exercising, volunteering in social activities etc. Resilience was proven as key factor behind well being of older people in both the studies.

Bonham E. (2011) explored the 4D model of appreciative inquiry in his research upon the youth offenders. Amalgamation of impulsive behaviour expectations influenced by culture was observed among the subjects. The detained youth under juvenile justice system were summoned to find openings to express their own stories and life experiences that can make their future better. The qualitative nature of interview pattern and stories were analysed with the help of 4D cycle Cooperrider & Whitney, 2001). The result proved to be beneficial for juvenile offenders as they were able to perceive self empowerment and envision positive changes in their life.

Daskivich et al (2015) conducted their research on a group of physicians. Whether in training or in practice this community faces a lot of psychological troubles in terms of stress, depression and anxiety resulting in increased number of the suicidal cases. The objective of the research was to find out and impart available current strength or resources by the trainee and residents physicians to enhance their sense of well being and establish a stress free functional learning environment. The ACGME Council of Review Committee Residents comprising of 29 participants conducted an appreciative inquiry session. The focus was to find available resources, envisage constructive learning environment to aid in wellness, to modify the existing infrastructure to help in that process of improvement. The suggestions were analysed and common point of concern were indentified. The result which came out through appreciative inquiry suggested that interventions like more awareness in the areas of stress and depression management, treating depression with care, thorough guidance by senior members, supportive work culture and more knowledge about mental health area of depression and stress management can lead to better well being of the resident/ trainee physicians. Considering this profession as both rewarding and challenging the tangible goals reached through appreciative inquiry had all the potential to deal with the mental trauma of the resident physicians.

From the above cited researches it is evident that AI has all the potential to be used as a tool for generating awareness about self and re-discovering it. These features of AI can be a boon in the mental research areas if executed thoroughly. But, unfortunately very fewer studies were carried out by the researchers at individual level. This article can highlight the need and usefulness of AI to enhance the mental health at individual and group level. More relevant researches in this area are required.

Though AI being practiced as an 'asset-based' approach and its benefits were highly appreciated by many researchers, still its pitfalls were also discussed by some. One of the customary disadvantages of this approach is that it completely ignores the shadows or problems. In this context Ellis & Davidi (2005) commented that learning experiences from both success and failures enables a person to modify his mental models. Thus, it may be said that focusing on some negative points are also important sometimes depending upon the need of the situation.

CONCLUSION

Appreciative Inquiry is such a domain which follows the path of positivity. Embracing positive approach can solve a lot of existing problems of human life. The process of AI is pain free in nature, thus it has an in build essence of happiness. It focuses on the successful experiences of the past to make the future

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better. Acknowledging and being grateful towards the events of life brings the sense of accomplishment in individual which in turn is capable of enhancing one's over all well being. In this context the work of Froh et al (2008) is very relevant. They conducted a study on the role of 'counting blessings' in terms of gratitude to enhance the subjective well being of the adolescents. The result of the research suggested that being grateful or having a positive outlook towards life is associated with satisfaction in life and it also helps in reducing negative experiences.

Implications

In this paper an attempt was made to prove AI as an important approach to improve the mental health of an individual. The success stories of AI as a potential factor for the organizational transformations and development are plenty in number. However, the process of AI includes participant and gives them the opportunity to explore their inner qualities, strength which can boost their motivation and confidence (Chakraborty & Mishra, 2019). Thus, this approach of AI must be practiced more in mental health improvement at individual and group level. Unfortunately elaborative researches are yet to be done in numbers. This paper furthers points out the need for more researches on this field. The present article also suggests a relevant area of research by exploring the effect of exercising different model and principles AI to improve or upgrade mental health at individual level. For example, is the adherence of action towards positive changes remained intact after the intervention of AI got over? This approach is capable of bringing a dynamic change in the arena of mental health awareness.

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Chapter 19
Digital Heath Interventions in Mental Health

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ABSTRACT

Technological renaissance of the last century stimulated the application of digital interventions in the healthcare domain. Digital healthcare interventions (DHIs) could be implemented through smartphone applications (apps), remote monitoring and tracking devices, and wearable computers. Technology is positioned to transform how mental healthcare is delivered and accessed. In fact, remote active and passive monitoring of parameters, such as mood, activity, and sleep, could be integrated with therapeutic interventions. However, the transformation entails combined conscription of science, regulation, and design. Implementation, adoption, and evaluation of DHI present special challenges. This chapter presents brief history of DHIs in mental health and frameworks an evaluation strategy in terms of the appropriate methods required for appraisal of DHIs.

INTRODUCTION

Defining Digital Health Interventions [DHIs]

Twenty years ago digital health interventions [DHIs] were nothing but a distant impossibility. The revolution of information technology [IT] in the last century means that technology can be utilized to confront pressing healthcare needs. The range and scope of DHIs and digitally delivered healthcare services have evolved rapidly since Eysenbach's (2001) initial description of Internet-enabled or computer-enabled interventions. (Hollis et al., 2017) Early DHIs in the mental health field were based on static content with limited interactivity and were 'fixed' in terms of access (e.g. via a PC or laptop, requiring a wired Internet connection), whereas users were required to be in a specific location to access the intervention. Examples of these DHIs include computerised cognitive behavioural therapy typically mimicking, face to face (FtF) delivered CBT sessions by providing a series of discrete modules that users complete (Hollis et al., 2017)

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Initial approaches are often referred to as 'tele-health', 'tele-medicine' or 'tele-psychiatry' and fall within the broad description of 'eHealth. (Hollis et al., 2017) Over the last decade, the increased popularity and availability of mobile digital technologies, such as smartphones and wearable technologies, has led to the development and evaluation of mobile DHIs, also known as 'mHealth' (see Table 1 below). (Hollis et al., 2017) mHealth DHIs include devices such as smartphone applications ('apps'), remote monitoring and tracking devices, and wearable computers (e.g. smartwatches, virtual reality headsets). Remote active and passive monitoring of parameters, such as mood, activity and sleep, are now being integrated with therapeutic interventions. Hence, the distinction between mHealth digital monitoring and interventions is likely to become increasingly blurred. (Hollis et al., 2017) (Murray et al., 2016) Mental health DHIs target a range of psychological disorders and differ in design and functionality. (Chandrashekar, 2018) National institute of mental health (NIMH) categorizes mental health DHIs into six categories based on: 1) functionality: 2) self-management; 3) cognition improvement; 4) skills-training; 4) social support; 5) symptom tracking; and 6) passive data collection. (Chandrashekar, 2018) Evidence indicates that technology present a tremendous opportunity for delivery of high-efficacy mental health interventions in domains of anxiety, depression; and schizophrenia. Considering scarcity of accessible mental health care professionals. and lack of mental health care access in rural and urban areas, DHIs have emerged as a practical tools that may bridge the mental health treatment gap. (Chandrashekar, 2018) Technology is well-poised to transform how mental health care is delivered and accessed, however the transformation requires the combined conscription of science, regulation, and design. (Chandrashekar, 2018)

Table 1. Glossary of common terms and abbreviations used in the field of digital healthcare

Term	Definition
Digital health intervention (DHI)	Interventions that provide information, support and therapy (emotional, decisional, behavioural and neurocognitive) for physical and/or mental health problems via a technological or digital platform (e.g. website, computer, mobile phone application (app), SMS, email, videoconferencing, wearable device)
eHealth (Electronic Health)	Internet-based healthcare delivery/anything health-related that uses information and communications technology (Blackwell et al.), incorporating computers or Internet in its delivery
Internet, online/web-based interventions	Computerised program or service delivered through the Internet (e.g. a website), designed to create a positive change in behaviour or health status with different levels of support (e.g. completely unguided, human-supported)
Computer-based/computer-delivered interventions	Similar to Internet-based interventions, but usually refers to a program delivered via a computer: the intervention may be via the Internet or an offline computerised program (e.g. CD-ROM, or installed software). Includes psychoeducation and psychotherapy packages, 'serious' games and neurocognitive 'brain training' interventions
Computer, Internet-based or mobile-based CBT	Delivery of Cognitive Behavioural Therapy (CBT) via computer (cCBT), Internet (iCBT) or mobile devices or applications (mCBT). Collectively may be referred to as electronically delivered CBT (eCBT)
mHealth (Mobile-delivered Health)	Subdivision of eHealth focusing on delivering healthcare-related information, interventions and monitoring through portable electronic/mobile devices and technologies, such as smartphones, tablets and wearable devices. Examples of mHealth for mental health include smartphone applications ('apps'), text/SMS-delivered interventions and patient monitoring devices
Telehealth, telepsychiatry and telemedicine	Delivery of health services and treatment via telecommunications technology (e.g. videoconferencing/SMS/email), including: online counselling and therapy that may be synchronous (e.g. real-time videoconferencing) or asynchronous (e.g. email /SMS).

*Note: Adapted from: (Hollis et al., 2017)

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Generally speaking, DHIs are complex interventions with multiple intertwined components, and typically have multiple aims, including; 1) enabling users to be more informed about their health; 2) share experiences with others in similar positions; 3) modify perceptions and comprehension around health, 4) remotely assess and monitor specified health states; 5) titrate medication; 6) realize health priorities and reach congruent treatment decisions; and 6) improve communication between patients and various healthcare professionals [HCPs]. (van Beugen et al., 2014) DHIs have been heralded as revolutionizing access and equity of care including the ways in which individuals monitor and improve their health behaviors by improving outcomes, reducing costs, and improving the patient experience and increasing patient engagement. DHIs vary widely with respect to clinical range, format, functionality and mode of delivery, including mechanisms through which they aim to change mental health and well-being.

Clinical Range

Devices and programs using digital technology to support behavior change are increasingly ubiquitous, being adopted for use in patient diagnosis and treatment, remote monitoring and self-management of chronic diseases. (Michie, Yardley, West, Patrick, & Greaves, 2017) In fact, DHIs have been utilized to: 1) promote healthy behaviors such as smoking cessation (Free et al., 2011); and physical activity (Vandelanotte, Spathonis, Eakin, & Owen, 2007); 2) improve outcomes in people with long-term conditions such as heart failure, (Hunting G, 2015) hypertension (McLean et al., 2016) and diabetes (Pal et al., 2014); 3) provide remote access to effective treatments (van Beugen et al.); 4) improve mental health conditions. (Zhuo et al., 2015)

Available DHIs vary in the breadth of psychopathology that they address. Typically, they tend to be disorder-specific but a few are even more precisely targeted such as one designed for people with suicidal thoughts. (van Spijker, van Straten, & Kerkhof, 2014) On the other hand, some are "transdiagnostic" in scope and have a broad clinical range indicating a great potential clinical effectiveness.(Craske et al., 2009; Titov et al., 2011) There are well established DHIs for depression; anxiety disorders and insomnia. Most have been designed as self-help programs that are meant to be used on their own or with some form of support. These treatments vary markedly in their content, clinical range, format, functionality and mode of delivery. (Andersson & Titov, 2014)

Format

DHIs designed to address mental health conditions vary in their format. Interventions can be designed as face-to-face treatment that may entail having regular weekly sessions. Others modify the format to match the way that websites or apps are meant to be used. (Ben-Zeev et al., 2015) Typically, modified format results in briefer, more frequent, sessions compared with face-to-face treatment, and often the overall length of treatment is shorter. (Ben-Zeev et al., 2015) Further, DHIs may vary in their structure. Some are linear, progressively leading users through the intervention step-by-step, whereas others have a variety of modules which may be applied with some flexibility. (Ben-Zeev et al., 2015)

These interventions often require some level of personalisation or so called "tailoring". Tailoring can imply little more than matching the text and clinical examples to the user's demographic group [e.g., gender specific - female]. meanwhile others go beyond by incorporating algorithms that generate a treatment which matches aspects of the user's psychopathology. (Abdullah et al., 2016) These algorithms may be acquired from strategy specific to the treatment or the recommendations of experienced

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clinicians. It is likely that, machine learning may be used for this in the future. (Abdullah et al., 2016) An alternate to tailoring is permitting end-users to pick out elements of the intervention that match their specific concerns. (Abdullah et al., 2016) Additional studies are required to evaluate which of the tailoring approaches lead to improved patient outcomes.

Functionality

During infancy DHIs compromised of text and thus resembled printed self-help programmes. This is changing. As technology matures, additional attention was devoted to their appearance, appeal and ease of navigation. Nowadays, most DHIs may embrace features such as: 1) learning exercises; 2) self-monitoring tools; 3) progress reports; 4) downloadable documents; 5) audio- and video-files; 6) audio- and video-feedback; 7) avatars; 8) quizzes and games. Currently there are multifaceted and technologically sophisticated DHIs to address social anxiety disorder (Stott et al., 2013) and post-traumatic disorder (Wild et al., 2016); meanwhile several interventions have been designed game format, a form that may particularly suit younger users (Merry et al., 2012). Further, novelties that may likely to gain ground in the near future are: 1) the use of virtual reality-based procedures as the equipment required is becoming more readily available; and 2) artificial intelligence-informed communication with the end-user. (Fairburn & Patel, 2017)

Mode of Delivery

DHIs in domain of mental health are provided via websites and can be accessed on a wide range of devices. However, some may not suitable for viewing on the small screen of the typical smartphone. (Donker, Petrie, et al., 2013) Others interventions are app-based and have been designed specifically with smartphones in mind. Whether interventions are website-based or app-based impacts the form that they can take and the functions that can be used. Some DHIs engage both modes of delivery; such as a website-based intervention with an accompanying app for purposes such as self-monitoring or planning ahead. (Donker, Petrie, et al., 2013)

The Promise and Challenges of DHIs in Psychiatry

Evidence suggests that DHIs are increasingly being adopted by individuals living with mental illnesses such as schizophrenia and bipolar disorder, as a means of better understanding and managing their condition.(Biagianti, Hidalgo-Mazzei, & Meyer, 2017) The portable, connected nature of wearable devices pragmatically supports remote and valid capture of clinical information in various settings—both actively, such as self-rated assessments, and passively, using instruments to size objective markers of social, emotive and cognitive states, meanwhile ensuring reduced user burden. (Biagianti et al., 2017) Information can be transferred back to the users and and clinical teams in real time, offering the opportunity to facilitate self-management, and ensure timely, preventative interventions. (Biagianti et al., 2017)

However, majority of DHIs in mental health have only been evaluated in small studies focused on short-term feasibility, albeit with mostly positive findings.(Firth & Torous, 2015) (Lewis & Wyatt, 2014) This has raised questions around interventions' long-term impact in more diverse patient groups. (Biagianti et al., 2017) It is imperative to accumulate scientific evidence on DHIs impact on mental health using rigorous evaluation frameworks meanwhile considering heterogeneous patient population and long

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term impact. (Lewis & Wyatt, 2014) (Chan, Torous, Hinton, & Yellowlees, 2015) (J. B. Torous, Chan, Yellowlees, & Boland, 2016) This will be required to ensure alleged benefits are realised, and to warrant that benefits outweigh potential harms such as breaches of security and privacy. (J. Torous & Roberts, 2017) At present, it is unclear as how: 1) to optimise the process of designing effective DHIs focused on mental health domain that are both timely and cost-effective;2) to select methods to ensure the optimal clinical dimensions to be targeted; creating interventions that may adapt to a shifting and ever-changing technological landscape, while retaining their core functionality; 3) to optimally determine as to what degree to integrate end users in the design process.

As suggested by Biagianti et al. [2017], the following dimensions should be considered when designing DHIs in arena of mental health: 1) Define the intervention based on unmet clinical need; 2) Develop meaningful partnership; 3) Ensure user-centered design; 4) Determine the appropriate software platforms; 5) Assess the use of appropriate grade devices. (Biagianti et al., 2017) Each one of these is described in substantial detail.

Define the Interventions

The first step is to define an intervention and mitigate the potential that technology is deployed solely for the purpose of implementing technology alone, rather than being applied to target specific clinical problems. (Biagianti et al., 2017) At the initial stage, it is vital to ensure that a specific clinical dimension and unmet need drive the research question; including definition of essential parameters and key variables. Clinical researchers are uniquely positioned to guide development of research questions and DHIs by learning from patients, recognising areas of unmet clinical need, and then considering which of the various properties of DHIs might be most appropriate. As the field develops further, tools should be merged into multidimensional, modular and more flexible platforms. (Biagianti et al., 2017)

Develop Partnerships

Interdisciplinary partnerships among clinicians, patients, big data scientists, software engineers and user experience designers are essential in ensuring that an intervention meets scientific and technical standards. (Biagianti et al., 2017) During this phase it is critical to apply 'team science' principles (Borner et al., 2010). The principle entails regularly scheduled meeting and initiatives that would promote interdisciplinary dialogue, and ultimately the formation of a collective knowledge base. Prior to any collective work, it is critical for agreement to be reached between collaborators on issues of payment/financial support, academic credit, authorship, intellectual property, and data ownership, storage and security. (Biagianti et al., 2017)

Ensure User-Centered Design

Evidence suggests that interventions are more likely to be adopted for long-term use when they provide inherent value for the 'user' in managing their condition, or improve critical aspects of their functioning and well-being. Bottom-up approach, involving end-users [i.e. patients/caregivers] in the co-development of DHIs has therefore become central to this goal. Yet, it is unclear as to how this should be implemented, as only a limited number of studies to date have reported user-involvement during the DHI development.

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(Killikelly, He, Reeder, & Wykes, 2017) End-users must remain integral to forming the research agenda, clinical focus and technology selection over the entirety of the development cycle. (Biagianti et al., 2017)

Native vs. Existing Software Platforms

Native software platofrm requires up-front expenditures of time, energy and capital. Yet, it allows adhoc modifications to address specific difficulties of people with mental conditions to be taken into account, including cognitive impairments, poor technology literacy and text reading level.(Rotondi, Eack, Hanusa, Spring, & Haas, 2015) Nonetheless, potential risks associated with building native technology such that rapid technological advances may make the prototype for the intervention already obsolete and uncompetitive by the time the development process is complete. This may have profund implications on the acceptability and scalability of the intervention. (Rotondi et al., 2015) This can be overcome by outsourcing design and development to established firms, so that the intervention is regularly maintained and enhanced. This may entail supplemental costs and such may be unaffordable to early stage researchers. (Rotondi et al., 2015)

An alternate is to capitalise on available solutions if these: 1) meet specific needs and goals; 2) are secure; and 3) adhere to current ethical and clinical governance structures. (Biagianti et al., 2017) Advantages include a significant reduction in costs and the possibility to promptly test the feasibility and acceptability of the technology in the clinical population. However, researchers may have limited control over design and development process. Further, they may need to adapt DHIs to the rapidly changing features of the tool, which may lead to difficulties associated with consistency of study procedures and replicability of findings. (Biagianti et al., 2017)

Regardless whether one opts for naïve versus existing platforms, allowing interoperability between mobile operating systems is desirable, particularly android and iOS systems, in order to maximise the reach and generalisability of the intervention. It is desirable to employ software that could be freely downloaded regardless of the device. (Biagianti et al., 2017)

Consumer vs. Clinical Grade Devices

A key objective is to design and develop DHIs that are affordable and acceptable for prolonged use. Devices are to be validated in clinical populations. In the case of wearable devices, data may be preprocessed on the device using unpublished algorithms, to which the research team may have access. The process may raise concerns regarding validation, data quality, replicability and scientific acceptability. (Naslund, Aschbrenner, & Bartels, 2016; J. Torous, Kiang, Lorme, & Onnela, 2016)

Albeit very useful, consumer devices convey some limitations. Although technology needs to be 'good enough' to address the clinical question, it may not represent the most innovative technological option. Although, one attempts to curtail variability between devices by ensuring all participants are equipped with standardised study devices, and by primarily examining longitudinal within-person variation. This may not always be possible. Considering swift development cycle of consumer devices, each platform should be designed as to integrate with novel technologies devices as they emerge, thus 'future-proofing' the intervention. (Biagianti et al., 2017)

As the technological landscape rapidly advances, new opportunities will arise for delivering DHIs for mental health. Strong collaboration between academic and industry partners are required to fuse the

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advantages of consumer and clinical grade technologies in the design and development of devices that assimilate into the users' lives, while delivering clinical-quality data. (Biagianti et al., 2017)

The Contribution of DHIs to Psychological/Psychiatric Treatments

DHIs, including digital technology in general, have been heralded as presenting massive potential as scalable tools to improve outcomes, to widen access and meet the increasing demand on mental health services. As a result of the widespread availability of digital technology, treatments of mental health conditions has been undergoing momentous changes Most of DHIs are forms of cognitive behaviour therapy that have been modified from existing face-to-face treatments or from self-help books based upon them. (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014) Some may represent a simplified versions of the original treatment and are little more than collections of "tools. Others preserve both the treatment's procedures and the strategies that govern their use. At large, DHIs in mental health domain seem to make more use of behavioural than cognitive procedures and contain a prominent educational component. It has been popular for DHIs to present themselves as educational programmes rather than treatments, and deliver the intervention in "lessons", instead of "sessions" (Andersson et al., 2014).

There are digital versions of psychotherapy including: acceptance and commitment therapy (Pots et al., 2016); behavioural activation (Ly et al., 2014); interpersonal psychotherapy (Donker, Bennett, et al., 2013); mindfulness interventions (Spijkerman, Pots, & Bohlmeijer, 2016); and problem-solving therapy (Kleiboer et al., 2015). However, these variations have received less research attention than the cognitive behavioural ones. Similar to cognitive behavioural interventions, they vary in the range to which they retain the strategies and procedures of the original treatment

Truly novel DHIs are few and far between. Examples include: positive cognitive bias modification to treat depression (Blackwell et al., 2015); virtual reality based exposure in the treatment of anxiety disorders (Valmaggia, Latif, Kempton, & Rus-Calafell, 2016) and persecutory delusions (Freeman et al., 2016); and the use of robotic technology to improve social interaction in autism spectrum disorders and dementia (Riek, 2016). The use of a computer game to block the reconsolidation of intrusive traumatic memories remains at the experimental stage (James et al., 2015).

THE APPLICATION OF DHIS IN PATIENT POPULATIONS

DHIs for Children and Young People With Mental Health Problems

Recent advances in computerised technologies and programming has created the possibility of more interactive and adaptable cCBT that may fit the needs of young people though use of gamification and 'serious games'. (Hollis et al., 2017) Typically, it has been presumed that children and young people (CYP) will prefer DHIs considering their ubiquitous digital activity. Yet, evidence remains inconsistent as to whether: 1) DHIs for CYP are clinically and cost-effective; 2) CYP prefer DHIs to traditional services; 3) DHIs widen access to treatment: 4) traditional evaluation and adopted methods are the most appropriate. (Hollis et al., 2017)

The assessment of effectiveness of DHIs has been based on evidence from RCTs, with the majority conducted on CBT focused in domains of depression and anxiety in adolescents and young adults, with significantly less research focused on other clinical areas and therapeutic interventions. Generally speaking,

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there is limited support for the role of computerized cognitive behaviour therapy (cCBT) in improving symptoms of depression and anxiety in CYP. Further, there is evidence from 'head to head' trials that therapist-guided (remote) cCBT is as effective as face to FtF CBT. (Sethi, 2013) Trials have typically focused on older adolescents with mild and moderate symptomatology. Thus, it remains unclear as to whether DHIs are useful for CYP who present with more severe symptomatology typically found presenting to mental health services. (Hollis et al., 2017) Evidence indicates that trials with active comparators demonstrate reduced benefit of DHIs than those with non-active controls. There is some evidence that human support, either in the form of a therapist's guidance or researcher contact, may be favourable in terms of adherence and effectiveness. DHIs for Attention deficit hyperactivity disorder (ADHD), Autism Spectrum Disorder (ASD), eating disorders, psychosis and post-traumatic stress disorder (PTSD) demonstrate limited benefits. Also, there is a notable lack of evidence concerning the cost-effectiveness of DHIs in CYP. To summarize, the heterogeneity of DHIs and limited quality of many studies make it difficult to draw definitive conclusions about the effectiveness of DHIs and the role they should play in mental health services for CYP. (Hollis et al., 2017) Past research highlights a plethora of valid research questions and methodological issues that need to be considered for the field to move forward.

DHIs for Adults With Mental Health Problems

There are increasing numbers of DHIs available for use in adults with severe mental issues. Published literature unveils strong evidence for the feasibility of using smartphones to augment the care of people with schizophrenia (Firth & Torous, 2015). In fact, a systematic review of five studies focused on using smartphone apps for treating symptoms of schizophrenia demonstrated app retention was 92%, and approximately 3.95 patient-app interactions took place each day. (Firth & Torous, 2015) Self-reported patient experience survey results revealed high adherence, positive user experience, and broad-ranging clinical benefits. High rates of engagement and satisfaction with an array of apps indicates the nascent potential of this technology. Yet, overall evidence regarding the efficacy of such interventions remains limited. (Firth & Torous, 2015) Further, a meta-analysis of 18 randomized controlled trials (RCTs) covering 22 mobile apps demonstrated that using apps to relieve symptoms and self-manage depression significantly reduced patients' depressive symptoms compared to control conditions ($g=0.38$, $P<0.001$). (Firth et al., 2017) Authors noted that smartphone-based therapies yielded the most benefits for individuals with mild to moderate, rather than major, depression. (Firth et al., 2017) Findings from systematic review indicate that overall short-term usability and feasibility of technology are high in the SMI population, implying the potential utility of digital technology for incorporation into treatment of SMI. (Batra et al., 2017) Authors note that real-world, naturalistic studies using larger samples will further facilitate the integration of digital technology into everyday mental health care, meanwhile evaluating its long-term effectiveness.

DHIs for Seniors With Mental Health Problems

Evidence suggests that older adults (65+) have the potential to use tailored smartphone interventions to self-manage their illness. A group of researchers from Dartmouth developed a smartphone-based intervention using an adaptive systems engineering framework and principles of user-centered design. (Fortuna et al., 2018) The findings noted that a peer-delivered and technology-supported intervention designed to improve medical and psychiatric self-management is feasible, acceptable, and is potentially associated with improvements in psychiatric self-management, self-efficacy for managing chronic health

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conditions, hope, quality of life, medical self-management skills, and empowerment with older adults with serious mental illness (Fortuna et al., 2018). They found that even patients with limited technical abilities could use this app successfully (Fortuna et al., 2018). Evidence indicates that DHIs are associated with several advantages compared with traditional psychosocial interventions, such as: potential for individually tailored, just-in-time delivery along with wide dissemination and high population impact (Fortuna et al., 2018; Whiteman, Lohman, Gill, Bruce, & Bartels, 2017). But the process of adapting an existing psychosocial intervention to a DHIs mandates an adaptation for a high-risk group with limited health and technology literacy (Whiteman et al., 2017) and should be evaluated with studies containing larger and more representative population samples.

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Chapter 20
Mental Health Clinical Decision Support Exploiting Big Data

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ABSTRACT

The complexity of clinical decision-making is immensely increasing with the advent of big data with a clinical relevance. Clinical decision systems represent useful e-health tools applicable to various tasks within the clinical decision-making process. This chapter is devoted to basic principles of clinical decision support systems and their benefits for healthcare and patient safety. Big data is crucial input for clinical decision support systems and is helpful in the task to find the diagnosis, prognosis, and therapy. Statistical challenges of analyzing big data in psychiatry are overviewed, with a particular interest for psychiatry. Various barriers preventing telemedicine tools from expanding to the field of mental health are discussed. The development of decision support systems is claimed here to play a key role in the development of information-based medicine, particularly in psychiatry. Information technology will be ultimately able to combine various information sources including big data to present and enforce a holistic information-based approach to psychiatric care.

INTRODUCTION

The objective of this chapter is to discuss clinical decision support systems, their benefits, the importance of big data for clinical decision making, and their analysis within clinical decision support. Particular attention is paid here to psychiatry, namely to its specific features preventing telemedicine tools to become more widely spread or to specifics of statistical analysis of psychiatric data.

First, general principles of decision support systems together with their potential and limitations will be described. Recommendations for the design, implementation and validation stages are given, stressing that clinical decision support systems may bring new unexpected sources of errors which must be anticipated. While modern technology undergoing a dynamic progress allows a more effective diagnosis and therapy, the increase in effectiveness does not necessarily imply higher safety of patients and thus the criteria of effectiveness and safety must be considered jointly.

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The interest in clinical decision support for the particular field of psychiatry penetrates throughout this chapter. While decision support systems are generally acknowledged to have potential for increasing the quality of healthcare, they have not apparently penetrated to a routine usage in psychiatry yet. Therefore, distinctive challenges for the development of telemental healthcare tools are discussed based on literature research on recent references. Decision support systems contribute to the shift of clinical practice to the ideals described as information-based medicine, which will include the analysis of big data as its integral part. Within psychiatry, there will be a need to overcome specific and rather serious barriers before the mental healthcare can reach the ideals of the information-based psychiatry.

CLINICAL DECISION SUPPORT SYSTEMS WITHIN CURRENT HEALTHCARE

Medical decision making can be described as a process of selecting an activity or series of activities among several alternatives integrating uncertainty as one of its intrinsic aspects with an influence on healthcare (Zvárová & Zvára, 2011). The physician solves the medical decision-making task based on knowledge and data connected to the cognition and determination of diagnosis, therapy and prognosis (Berner, 2016). Decision support systems can be described as very complex systems with a potential to compare different possibilities in terms of their risk. Thus, they represent potentially very useful and powerful e-health tools for the clinical decision-making process, capable to solve a variety of tasks, to analyze different information components, to extract information of different types, and deduce conclusions from them. While the first systems based only on expert knowledge were not sufficiently successful, improved performance has been obtained with systems learning the knowledge from clinically relevant data.

Up to now, clinical decision support systems have established their place as inherent part of e-health with an indisputable ability to improve clinical decision making and with a facility to contribute to a further transformation of clinical medicine (Hanson & Levin, 2013; Lech et al., 2014). There are specialized decision support systems focused on finding the diagnosis within individual clinical fields or prescription of medicaments. However, the search for the appropriate therapy is more complex and depends on many factors and only a few decision support systems aiming at therapy have been sufficiently evaluated up to now. There has been even less attention paid to decision support systems for prognosis, while there are still obstacles to apply decision support systems in healthcare routinely, although everyday healthcare would greatly benefit from reliable interdisciplinary and multidisciplinary systems.

DEVELOPING CLINICAL DECISION SUPPORT SYSTEMS

Designing and implementing a decision support system is a very complex and demanding process. The usage of decision support systems is strongly dependent on factors of legal, social, technical, economical and ethical environment. If the systems should offer a truly unobtrusive and easy-to-use interface, they must meet the needs of the particular healthcare providers and therefore their introduction requires changing organizational and workflow issues of hospitals as well as their healthcare specialists. Also, it is important to realize that adopting a foreign decision support system typically requires translating the system to the local language together with accommodating all details to the local environment.

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A clinical decision support system acquires data from a variety of input sources (manual input, interface with a different software, data import from electronic health record). Because the data may be massive, effective tools for storage are needed, as well as communication platforms allowing interoperability with other e-health devices. Particularly, a communication platform between the electronic health record and decision support system becomes a necessity, because there exist so many different versions of electronic health records (Moja et al., 2014).

The implementation of a decision support system should start with a pilot version, which can reveal some weaknesses of the first plan. In addition, the process of implementing a reliable decision support system requires an intensive and long-range validation. The system must also allow for an effective but sufficiently thoroughgoing configurability and parameter tuning. The system should be evaluated at different healthcare providers (e.g. in different hospitals as well as at different self-standing physicians) under a variety of different conditions. In a validation mode, the system should be repeatedly exposed to a cycle form formulating requirements, proceeding to proposing the design (or modifications of the last version), implementation of modifications, and multi-level testing under artificial conditions, and ending with testing in real situations. The evaluation cannot be based entirely on statistical evaluation of the correctly classified diagnosis or prognosis, but also on patient safety and seriousness of misclassifications.

Each decision support system in real healthcare applications requires a permanent and laborious monitoring and maintenance. This is especially important immediately after introducing the system to real applications. Concurrently, the feedback from physicians is very important. The physician should immediately contact the supplier if having doubts about the precision of the recommendations of the decision support system. The supplier must remain open to proposals for improving the system and prepared to correct all mistakes quickly. This practice is opposite to hospital information systems, which are typically delivered as closed systems without a simple possibility of modifications.

In the course of operating the system, actualizations must be also implemented with the aim to adapt the system, taking into account possible errors, new results of medical research, availability of new technologies, or actualizations of the electronic health records. Also, medical guidelines become outdated quickly and it is necessary to follow their recent trends. Actualizations performed while the system keeps working also require consideration of patient safety issues. Big systems require more essential actualizations, especially if they were developed more spontaneously rather than as a result of well-considered preparations with a sophisticated design.

BENEFITS FROM CLINICAL DECISION SUPPORT SYSTEMS

A clinical decision support system improves the quality of the provided care. This section summarizes various positive effects of clinical decision support systems. At the point of care, they allow to exploit medical devices fully not only from the medical, but also from the technical point of view. They also allow an economic evaluation of any planned therapy or care and thus a significant reduction of financial costs. The ability of the systems to perform healthcare planning may be beneficial for health authorities. The systems may potentially incorporate patients' beliefs, which remain neglected across clinical disciplines but become increasingly interesting in the subjective health with cognitive and emotional components (Ortendahl, 2007).

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The system brings benefits also to the physician, ensuring more comfort, a higher effectiveness and more time for the patient, and also a reduction of errors. It may be especially favorable during stress (e.g. at an emergency ward) or for treating complicated patients. Particularly (but not only) a less experienced physician may benefit from using a decision support system, which exploits the level of knowledge reflecting the latest developments even in a narrow domain of medicine (Kalina et al., 2013). The system may save human resources or reduce the implicit bias of healthcare professionals (FitzGerald & Hurst, 2017). The available data allow to remind the physician important aspects of family and personal history or diagnostic examinations, to warn about side effects or possible addictivity (e.g. of painkillers), to propose new alternatives not immediately apparent to the physician, or to prevent mistaking different samples. Still, it is the physician who remains to carry the responsibility for the medical decision-making processes in combination of scientific and empirical knowledge to infer the interpretation in all steps of healthcare provision. It is also only the physician, who can exploit non-quantified knowledge obtained through education, experience and intuition.

The medicament management can be greatly improved by a decision support system, which computes the amount of medicament or transmits an alert or warning signal about an incorrect prescription. It can evaluate critical situations and offer notifications and reminders with the ability to react quickly in life-threatening situations. It can warn the physician that a particular patient requires an alternate medicament dosing, e.g. because of higher age and/or a joint usage of other medicaments. It can identify patients with the risk of medication overdose, misuse (in patients with dementia) or abuse (in patients with schizophrenia). The decision support system is also helpful at transfers from one medicament to another. It reminds possible contraindications or avoid superfluous operations in the process of therapy planning or evaluate risk assessment.

From the data management point of view, clinical decision support systems can connect and aggregate various data types and search for their associations (e.g. between genetic information and fMRI brain images) for an individual patient. They can also screen over very large databases of medical images, which can be subsequently evaluated by an expert. A major advantage is the ability to visualize the available data chronologically, presenting a nice and well-arranged graphical output. The systems also have the ability to handle measurements performed by different medical devices, which measure in different units or on different scales.

The systems may access rigorous scientific knowledge by searching references in external information sources. If connected to a web search machine for extracting clinically valid information in large bibliographic databases of research articles, they save the physician also a time-consuming search for knowledge across free text. Decision support systems also have a potential to search automatically for previously performed clinical trials on a given topic in databases.

CLINICAL DECISION SUPPORT SYSTEMS AND PATIENT SAFETY

Improving healthcare quality requires to integrate a correctly and effectively determined diagnosis together with patient safety, where the latter is not automatically guaranteed by medical procedures, even if they reflect the most recent scientific knowledge. On the other hand, defensive healthcare with a sole focus on safety cannot ensure effective results. While the concept of patient safety is not primarily concerned with improving the effectiveness of healthcare, a correct diagnosis is crucial for achieving a higher level

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of patient safety. The ability of clinical decision support systems to improve patient safety by removing adverse effects of healthcare was appraised e.g. in the review by Gebru et al. (2015).

It is possible to distinguish between two different basic types of errors in healthcare. The first type is caused by limitations of current technologies or level of medical knowledge. These errors can be eliminated only in the future after discovering new scientific facts. The second type of errors are adverse effects of healthcare caused by human factors or system failures. A wrong diagnosis determination can fall into any of the two categories. An example of a wrong diagnosis resulting from an error of the second type is a physician's failure to carry out important clinical examinations of a particular patient, causing a superfluous time in the hospital or even death of the patient.

Patient safety as a field within healthcare considers only the second type of errors: preventable medical errors under the current level of technologies and medical research. Patient safety can be understood as a freedom for the patient from unnecessary harm or potential harm associated with healthcare. It studies not only diverse effect of healthcare, but also proposes ways for preventing or reducing medication-related errors or errors in diagnosis and allows to save also human and financial resources as a consequence. All this means that e.g. an ineffective therapy of a rare disease or even a lack of available therapy for severe rare diseases (e.g. Huntington's chorea) does not represent an issue for the area of patient safety.

Clinical decision support systems prevent medical errors and reduce the risk of treatment complications or redundant deaths of patients. They would not expose patients to redundant clinical studies, but rather save them from an unnecessary burden. By increasing the speed of the decision making the physician obtains more time and the probability of medical error decreases. The systems also look for inconsistencies, errors and omissions in the treatment plan. There exist even small decision support systems designed primarily for improving patient safety or healthcare quality control, which can yield patient-specific, evidence-based recommendations. However, the future seems not to be in specialized self-standing decision support systems designed only for patient safety, but primarily in multifunctional decision support systems covering the patient safety as one of their areas. In the current fast pace of development, big and reliable systems can be created only by large suppliers.

Patient safety may be threatened by any new technology and decision support systems do not represent an exception, as they may contribute to new (possibly unexpected) opportunities of errors or accidents. The sources of errors include a computer collapse, data overload, automated actions without the knowledge of the physician, the change of the system or software update, latent or system errors, entering the data incorrectly, misusing or losing sensitive data, or data protection violations. In case of collapse of the decision support system, the physician is not removed from ethical and legal responsibilities. The human factor is another source of problems, and the correct usage of the decision support system requires a well-educated physicians or healthcare professionals with a proper level of statistical literacy as well as computer literacy, who are free from fear of being limited by computers in the decision making process.

CLINICAL DECISION SUPPORT SYSTEMS IN PSYCHIATRIC CARE

Combining Various Types of Psychiatric Data

Like in other clinical fields, the amount of data relevant for psychiatric care rises enormously. Massive data of various sources and types represent a valuable capital for bringing new psychiatric knowledge, so far underutilized with a potential for a dramatic change of current practices of healthcare. This was

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documented by the review paper by Stewart & Davis (2016), who cited 198 references on applications of big data in mental health research. So far, big data in the psychiatric context are measured primarily for research purposes, while they also have potential to contribute to improving both the efficiency of clinical decision making as well as patient safety (Monteith et al., 2015).

The knowledge used by decision support systems may be integrated from an expert system created by top-class experts, but this knowledge should be validated on real data. Medical guidelines that describe recommended procedures for diagnosing specific diseases and/or their treatment represent an additional source of knowledge. A list of examples of various data types, which are relevant in psychiatry, together with particular examples includes:

- Numerical data, e.g. data on family and personal history, results of clinical and laboratory examinations in various forms (including gene expression measurements)
- Data measured by e-health tools for patient monitoring, e.g. non-stop wearable sensors
- Signals, e.g. analysis of EEG
- Voice records, e.g. detection of schizophrenia relapse in smartphones applications or detection of depression due to voice changes in a speech record
- 2D, 3D or 4D brain images, e.g. diagnosis of schizophrenia from facial images
- Using fMRI images, e.g. study of irreversible physical changes in the brain due to Alzheimer's disease
- Text in natural language, e.g. description of symptoms and signs, unstructured medical reports in the electronic health record, or analysis of computerized databases
- Molecular genetic data, e.g. study of genetic predisposition to bipolar disorder or mood disorders, genetic networks, or corresponding epigenetic mechanisms (Mahgoub & Monteggia, 2013)
- Social networks, e.g. diagnosis of a depression relapse or automatic mood detection of a facebook user (Appelbaum & Kopelman, 2014)
- Biochemical or biophysical brain models using differential equations (Anticevic et al., 2015)
- Time series, e.g. pharmacokinetic models for ethanol in the brain of an alcoholic, or drug efficacy models

From the statistical point of view, clinical decision support systems learn and apply classification rules allowing to assign a given (new) patient to one of given groups. It is a complex task to learn this classification rule from various input sources. The analysis of psychiatric data is difficult not only because of the plethora of various data types listed above, but also complicated by other common data properties:

- Different data types, including numerical data (continuous or categorical), together with other data types (text, images, videos, graphs)
- High dimensionality of data, i.e. a high number of variables (features), while its adverse effect is denoted as curse of dimensionality
- Different formats of the output as the cause of using a proprietary software by various suppliers
- Different units or different scale of different variables
- Small number of samples (patients)

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Telemedicine in Mental Health: Potential and Barriers

This section describes the beneficial impact of decision support systems in the field of mental healthcare. In general, all positive effects of decision support systems described above are valid in psychiatry as well, but other specific benefits will be analyzed in this section. Numerous telemedicine tools are currently under development for psychiatry for remote decision making on diagnosis, therapy and prognosis, but also for psychiatric management or care. Until recently, clinical decision support systems seemed not to be extensively used in psychiatry, although their potential becomes already more acknowledged (Koposov et al., 2017). Various attempts for diagnostic decision support systems have produced frustrations (Bergman & Fors, 2008). This is true also for the rare examples of decision support systems proposed for finding the correct therapy for psychiatric diseases. Nevertheless, telepsychiatric or telemental health services become popular in developed countries, where they contribute to transforming the psychiatric care (Deslich et al., 2013) and help to increase access to mental healthcare.

Particularly, telepsychiatry enables to offer the psychiatric care also to patients with substance abuse problems, who would otherwise dare to search for a clinical intervention, or to highly sensitive individuals. Thus, telemedicine contributes to destigmatization of the psychiatric care (Maulik et al., 2015). Further potential can be found in reducing medication-related expenditures or providing intensive attention. Examples include online monitoring of biochemistry results, managing suicide attempts, video-consultations between a psychiatrist and patient, or mobile smartphone apps for schizophrenic patients. A promising area for decision support systems can be described as management of depression care (Fortney et al., 2010).

Only realizing the barriers for decision support systems in the psychiatric context will allow to overcome them. Sometimes it is claimed that the main limitation of clinical decision support systems is the health information technology itself (Deslich et al., 2013), without acknowledging limitations also in the clinical dimension of the task. However, also intrinsic limitations of psychiatry must be kept in mind. Therefore, it is possible to divide possible barriers of clinical decision support systems in psychiatry to four clusters:

Intrinsic barriers

- Decrease of work productivity (i.e. a need for additional time)
- System not fully automatic
- Insufficient technical support
- Inferior results (e.g. results on diagnosing mental disorders compared to an experienced psychiatrist)
- Negative effects on patient safety

Environmental barriers

- System not adapted for a particular physician/hospital
- System not able to obtain important data (e.g. not integrated with a particular hospital information system)
- The current status of the legislation worldwide still remains to be a big obstacle of a wider usage of decision support systems, particularly the requirement of paper-based healthcare record keeping

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Barriers in the psychiatrist-system interaction

- Unrealistic expectations of the psychiatrist (e.g. no tolerance to software errors) or distrust of the system
- Often, the psychiatrist hesitates to change opinion due to prejudices
- Possible aversion of the psychiatrist to ideas of personalized healthcare, preference of one-size-fits-all approaches
- Complicated interpretation of the classification rule (i.e. if etiology of the disease is immensely complex, but the physician expects a fast, simple, comprehensible and justified answer)
- Subjective interpretation of the system instructions, which may depend on text understanding
- The success is also determined by the personality of the psychiatrist (mainly his/her age, sex, sociocultural background and experience), experience with psychiatric diagnosis making and with the system itself, while the performance of the system is improved if the physician is trained (Bergman & Fors, 2008)

Barriers due to specific aspects of psychiatry

- Unclear or unknown cause of the most common psychiatric illnesses
- Controversy concerning the classification of psychiatric diseases (Thornton, 2013)
- Various shapes and forms of the same disease (e.g. dementia), with a multitude of complex and heterogeneous symptoms and signs
- Current models based on genetic information fail to exploit the potential of epigenetics, while the activation of gene functions or their silencing plays a crucial role in the pathophysiology of psychiatric diseases (Mahgoub & Monteggia, 2013)
- Too many factors are relevant for diagnosis making
- A purely biological perspective may ignore environmental stimuli (stress, hectic lifestyle, sleep deprivation, anxiety causes, somatic symptoms, non-clinical factors with cognitive and emotional components, risk, worries, some other unexpected issues), which play a major role in the development of civilization diseases (Ortendahl, 2007)
- Subjective health dimensions (beliefs or quality of life of psychiatric patients) may not be realiable due to disrupted boundaries between imagination and reality
- Psychiatric guidelines suffer from vagueness or indeterminacy in formulations (e.g. level of cognitive impairment, delusion);
- Complete lack of guidelines for specific tasks, e.g. for work ability evaluation for a mental health patient (Kemppinen et al., 2014)
- Determining the diagnosis based on objective checking a list of individual and conceptually independent symptoms and signs, while a skilled diagnostic judgment may be an exercise of tacit knowledge

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STATISTICAL ASPECTS OF CLINICAL DECISION SUPPORT

Statistics vs. Machine Learning or Data Mining

Solving the classification task of clinical decision support systems is commonly performed by exploiting multivariate statistical methodology. This is able to capture the multivariate structure (i.e. correlation structure) of biomedical data, but at the cost of technical and often strong assumptions. Nevertheless, data analysis practitioners often adhere to machine learning tools or heuristic data mining approaches. In this respect, the methods or heuristic tools are commonly used without verifying the statistical assumptions. When these are fulfilled, statistical methods are more powerful compared to machine learning or data mining tools. This section has the aim to explain their differences and to discuss advantages of the (bio)statistical methodology.

In contrary to (multivariate) statistics, machine learning is commonly believed to contain universal (or universally valid) methods. Although often neglected, its methods including artificial neural networks or support vector machines do require certain (at least implicit) statistical (i.e. probabilistic) assumptions in order to solve classification tasks. On the other hand, machine learning methods do not commonly require a specific probabilistic distribution, which makes them more flexible tools compared to statistical methods.

Data mining can be characterized as a process of information or knowledge extraction from a dataset, revealing and investigating systematic associations among individual variables in a much more heuristic way compared to traditional statistics (Dziuda, 2010). It combines established methods for exploratory data analysis (EDA), descriptive modeling, classification and regression with heuristic principles, while classification together with regression are commonly denoted as predictive data mining. The concept of data mining can be described as the analytical part of the overall process of extracting useful information from empirical data, which is traditionally called knowledge discovery.

There are various advantages of statistical methods in comparison to machine learning approaches. Unique properties of parametric estimation in the multivariate normal model compared to machine learning techniques include:

- Comprehensibility
- Available diagnostic tools (together with remedies for the situation with violated assumptions)
- Efficient computation
- Available modifications for high-dimensional data (e.g. lasso-type regularization);
- Possible modifications robust to outliers (Kalina & Schlenker, 2015)
- Available hypothesis tests
- Less tendency to overfitting
- Confidence interval for parameter estimates
- Confidence band (region, ellipsoid) for the whole set of parameters

On the whole, statistical methods can be rather easily accompanied by additional tools for verifying the assumptions or for modifying the methods for non-standard situations.

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Principles of Biomedical Big Data Analysis

Learning the classification rule for clinical decision support systems requires to pre-process the available biomedical data, i.e. cleaning and preparing for subsequent analyses. If the data are big, this pre-processing may actually represent the most time-consuming part of their analysis. The exploratory analysis includes primarily visualization tools (histograms, box plots or quantile-quantile plots for individual variables, or scatter plots for pairs of variables). If individual variables are measured in different groups, then descriptive statistics (quantiles, means and variances) or test statistics (of the F-test or chi-square test) are useful to evaluate the difference among the groups.

Recently, specific statistical and machine learning methods have been proposed for the analysis of big data, which is often denoted as big data analytics. This is true also for data with the number of variables p exceeding the number of observations n, which are commonly denoted as high-dimensional. Traditional statistical methods seem improperly used for big data, while on the other hand, principles of EDA seem still undervalued. Particularly, hypothesis tests are unsuitable as they have a too large power for a large number of observations (Terwisscha van Scheltinga et al., 2013).

Dimensionality reduction (variable selection, feature selection) methods are generally recommended to simplify subsequent analysis of big data. It can (perhaps surprisingly) improve the result of a consequent analysis in spite of losing some relevant information. On the other hand, it would be too strict to reduce the set of variables to a too small number of relevant ones.

Therefore, intrinsic variable selection ensuring sparsity (ignoring redundant variables) seems as the most promising approach, optimized for the supervised task (Matloff, 2017). It is recommended to ensure sparsity by regularization tailor-made for the classification task, so the analysis does not require any variable selection prior to the classification task itself.

Even recent biostatistical research papers continue to critically discuss statistical and data mining methods for big data or high-dimensional data (Matloff, 2017). Experience of researchers is critical mainly to neural networks or support vector machines for not being as good as presented in theoretical papers on simulated data. A list of such aspects of high-dimensional data, which are continuously debated by experts and their opinions seem dramatically different from one paper to another, will be now presented:

- Suitability of particular methods (and method selection) for the particular data, because no data analysis method is uniformly optimal for all available datasets
- Model choice (i.e. reduction of a model to a suitable sub-model)
- Quantifying model performance (standard concepts of reliability or validity have a tendency to a false optimism for big data due to overfitting, i.e. models can appear predictive even if the data are completely random)
- Assumptions of individual methods
- Recommended sample sizes
- Suitability of standard classifiers for data observed under matched case-control studies (standard approaches completely ignoring the paired structure of the data are suboptimal, e.g. in the study of features obtained in brain images by Balasubramanian et al. (2014))
- Efficient algorithms for computation (some of the methods, although theoretically suitable for data with a large n, are implemented in commercial software in a computationally inefficient or numerically unstable way)

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- Comprehensibility of the results, which must be clearly interpretable from the point of view of the medical research topic; otherwise the methods are not suitable e.g. for patient critically ill or at highest suicide risk

There are numerous open problems concerning the analysis of big and high-dimensional data. Especially methods combining effectiveness with reliability are highly desirable (He & Petoukhov, 2011). Intensive attention has been also paid to sensitivity of existing methods to the presence of outlying or wrongly measured observations in the data (Kalina, 2014).

Specific Statistical Challenges of Analyzing Psychiatric Data

Statistics represents an essential aspect of medical informatics (Scotch et al., 2010) and a standing service for achieving its tasks. Apart from data quality issues, specific analytical challenges characteristic for psychiatric data will be considered in this section. Possible challenges in the analysis of psychiatric data mostly follow directly from the discussion of various sources of data presented above.

- No clear interpretation of the methods, while a clinical interpretation is crucial in psychiatry (Terwisscha van Scheltinga et al., 2013)
- The data structure is often complex, e.g. longitudinal or repeated measures data are very common (Gueorguieva, 2017)
- The data show trends or more complicated patterns across time
- Specific properties of magnetic resonance images of the brain (small effectiveness, non-homogeneous signal-to-noise ratio, spatial autocorrelation) or other medical imaging devices
- Noisy images contaminated by outliers (Kalina, 2018)
- No systematic comparisons of performance of various data mining methods across various biomedical applications
- Difficulty to combine measured data with tacit knowledge, which can be described as context-dependent practical knowledge based on a complex evaluation of the patient's psychological whole (Thornton, 2013)

The most common tasks of analyzing data in psychiatry seem to be classification or clustering. Most researchers in psychiatry or neuroimaging are unaware of recent methods for the analysis of big or high-dimensional data and the arsenal of these methods only starts to penetrate to these research fields. This may be explained by unreliability of newly proposed methods implemented in commercial statistical software, or delay with their implementation.

THE DAWN OF INFORMATION-BASED MEDICINE

The concept of evidence-based medicine (EBM) is nowadays widely accepted as a unifying idea describing the ideal practice of medicine. In this section, it is explained that the clinical practice is gradually undergoing improvements towards more advanced ideals which may be denoted as information-based medicine. This vision of future medicine emerges from the established principles of EBM and goes far beyond it.

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The pioneering approach to EBM originally proposed by Guyatt et al. (1992) spread out quickly as a progressive idea during 1990s. The concept of evidence had primarily the meaning of current best evidence in making decisions about the care of individual patients (Sackett et al., 1996) and was later refined as a thorough, unique, and critical use of the best objective and most topical proofs in the process of decision making about the diagnosis, therapy, and prognosis for individual patients. The practice of evidence-based medicine integrates clinical expertise of individual physicians with these proofs, i.e. clinical evidence acquired within systematically performed clinical research.

The cornerstones of EBM require that physicians demonstrate their capability to use up-to-date research results and exploit them in their everyday clinical practice. This includes e.g. searching and systematic critical evaluation of clinical research publications, analysis of activities, risk analysis, or analysis of ethical and legal consequences of using a given approach. By considering economic analysis of costs (Kemppinen et al, 2014), EBM contributes also to healthcare effectiveness.

Clinical trials remain to be the main source of medical knowledge within EBM. This is true in spite of their serious disadvantages, which include artificial conditions or averaged results obtained by statistical methods for an averaged (virtual) patient, without reflecting his/her individual situation. From the statistical point of view, principles of personalized care require to consider clusters of patients or quantiles (even multivariate quantiles) instead of averaging the results. The entire dataset in a clinical trial is also typically forbidding to draw more precise conclusions for an atypical (statistically outlying, extreme) patient. Decision support systems may help to decide whether a new clinical study should be performed. While each clinical study must undergo an ethical review process, many of current clinical studies are superfluous. The same studies are namely carried out repeatedly or have an inappropriate design, which does not allow to generalize the results to be valid also under different conditions.

Criticism of current practice of clinical trials includes the data collection or risk of unintentional avoiding some important variables (James et al., 2015). Besides, proponents of personalized healthcare promote clinical trials with small sample sizes, i.e. performed on small groups of specific patients. In reality, there is however a tendency for clinical trials to be ceaselessly bigger and more expensive. In addition, the behavior of patients is known to be influenced by their sole presence in a clinical trial.

While numerous e-health tools are appealing primarily as commercial products, their dynamic development can be accelerated only after new results of basic research become available. This is true e.g. for the whole segment of m-health. The market of available applications has been denoted as selective without a clear roadmap of the m-health domain and a first systematic ontology for the field was proposed only recently (Cameron et al., 2017).

Current clinical practice is constantly enriched by quickly emerging new results of basic (i.e. not only clinical) research obtained by the analysis of large datasets measured by new biomedical technology. Beyond the EBM, the clinical practice is hoped to gradually converge to an ideal state characterized by the model of information-based medicine (Borangíu & Purcarea, 2008), connecting basic biomedical research with patient-specific information. The role of tools of medical informatics is to perform the integration of knowledge from various sources, primarily from basic research (i.e. understanding diseases on a molecular level), epidemiological studies, and examinations of an individual patient. At the same time, basic research together with information technology and big data analysis extend the possibilities for a targeted healthcare solution beyond the current concept of EBM and allow to overcome its limitations.

The concept of information-based medicine as a recent and perspective medicine paradigm describes the effort to transform the evidence for the (imaginary) averaged patient towards a real individual participative patient based on his/her individual data with clinical as well genetic or metabolic parameters.

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The concept starts to find first applications, such as the study of Senders et al. (2018) exploiting artificial intelligence in clinical decision making.

INFORMATION-BASED PSYCHIATRY

The current paradigm of evidence-based medicine in the specialty field of psychiatry has been called by various synonyms, including evidence-based medicine in psychiatry, evidence-based clinical practice in psychiatry, evidence-based mental health, or evidence-based practices for mental health (Hanson & Levin, 2013; Lech et al., 2014).

Clinical decision support systems together with other e-health tools and with results of the basic research (e.g. in neuroscience or molecular genetics) strongly contribute to bringing new sources of medical knowledge (and thus the decision-making process) closer to an individual patient, improving the effectiveness of therapy and patient safety. The availability of big data together with a new biomedical knowledge, as described in the visionary paper by Monteith et al. (2015), may allow to make the therapy efficient, compared to the current state when the therapy of common diseases aims only at easing the suffering of patients. Integration of molecular medicine with clinical psychiatry will be of course a demeaning task due to a large gap between the two fields and a transform of psychiatry will be able only by means of a paradigm shift (Demkow & Wolanczyk, 2017).

Currently, an on-going transform of psychiatry can be anticipated, which is enabled by a vast number of technological tools recently introduced for psychiatric care. The fast improvement of technology and rise of big data of various types and formats from unthinkable sources have a potential to contribute to clinical usage. For all these reasons, the paradigm of evidence-based psychiatry should be replaced by deeper ideas going more beyond and the information-based medicine can be expected to develop also in the area of psychiatry. Thus, it is possible to introduce the concept of information-based psychiatry (IBP) intended for the ideals of information-based medicine within psychiatric practice. Some emerging directions of psychiatry have been already described under different concepts in available literature:

- Predictive, preventive, personalized and participatory medicine (Auffray et al., 2010), where predictive healthcare is often denoted as predictive analytics, i.e. stands on big data and their analysis for prediction for an individual patient;
- Evidence-based pragmatic psychiatry (Paulus, 2017), which exploits an empirically based decision making;
- Computational psychiatry, which has been introduced as a concept for computationally demanding approaches to analyzing data measured for psychiatric patients (Maia, 2015; Demkow & Wolanczyk, 2017);
- Precision care (Stein & Smoller, 2018).

Decision support systems may also contribute to shared (collaborative) decision making in routine mental healthcare (Fortney et al., 2010). As a by-product, the transform of healthcare will go hand in hand with the transform of nursing towards information-based nursing. A particular evidence of the drift of psychiatry towards participative healthcare is also the current international transition of mental health services towards community-based services (Slade, 2017), applying patient (client)-centered approaches in healthcare.

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One might have the feeling that information technology restricts the physician by limitations of hardware and software. However, it is exactly the information technology, which offers to capture a human body and subsequent healthcare in a holistic approach, because it has the capacity (if correctly organized) to store all available data (including big data) and information, to analyze them, and search for associations. In this way, information technology performing a holistic approach to information (Zvárová, 2014) encompassing the subjective data, especially useful in psychiatry, may capture the full bio-psycho-socio-spiritual model of health. This has the potential to incorporate a high quality of diagnostics with principles of patient safety.

Contribution of the Work

The amount of clinical data relevant for clinical decision making rises enormously and so does the amount of biomedical knowledge obtained as result of basic research. This naturally complicates the process of clinical decision making. This chapter discusses general principles of clinical decision support systems mainly for diagnostics and therapy, together with specifics in the field of psychiatry. Numerous benefits of decision support systems for physicians and for an individual patient at all levels of care are characterized in the chapter. If appropriately implemented, the systems reduce the burden for patients and also reduce costs, which is important not only in psychiatry, where the number of patients as well as the financial demands have increased remarkably world-wide.

Clinical decision support systems can be characterized as prospective e-health tools with a unique ability to extract information from various sources of (big) data. Their importance increases, as the systems unlock tremendous potential to improve both the healthcare quality and patient safety and also may combine objective and patient-subjective data with expert knowledge. They may successfully exploit also the most recently proposed tools for big data analytics, even in spite of high computational demands.

The vision of information-based psychiatry together with discussing its assumptions or barriers preventing its development represent also a contribution of this chapter. The development of telemedicine tools in psychiatry is currently slowed down or complicated mainly by unrealistic expectations and barriers, including general barriers or barriers in the interaction between e-health tool and the psychiatrist. Specific barriers typical for the field of psychiatry have obtained the least attention so far. Reliable statistical or data mining procedures for learning a reliable classification rule for the decision support system are highly desirable. Again, for the particular context of psychiatry, tailor-made methods for the data analysis (e.g. in the form of brain images) are required for extracting relevant information from big data coming from various sources in various formats.

Big data as a still underutilized capital for clinical decision making represent a key accelerator of improving the efficiency of clinical decision making as well as patient safety. Reflecting the dawn of big data in clinical medicine and their analysis, the popular concept of evidence-based medicine is surmounted by the vision of information-based medicine formulated in this chapter. The most recently initiated transforms of psychiatry towards information-based principles are described here as perspective and progressive, although limited by various specifics of psychiatry and thus incessantly slowed down compared to the higher pace of development acquired within other clinical fields. E-health tools contribute to psychiatry transformation and development of information-based psychiatry, i.e. psychiatric care based on information-based principles. However, its ideals assume also a fundamental progress of basic research in molecular genetics and particularly in neurosciences in order to perform an individualized healthcare based on individual clinical, genetic or structural brain imaging parameters.

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PROJECT DESCRIPTION

A large portion of the presented work in the field of clinical decision support stems from the project Robust analysis of high-dimensional data in the years 2014-2016. The project was financed by the Neuron Fund for Support of Science, a private fund in the Czech Republic.

The cross-disciplinary part of the project focused on applying methods to particular high-dimensional data. An important research direction was the research of modifications of resting-state brain networks of schizophrenic patients (Kalina & Hlinka, 2017). The spontaneous brain activity of patients was measured and compared with that of healthy individuals. The analysis of the high-dimensional fMRI measurements was performed by robust classification methods. The final robust classification rule is able to find the diagnosis of a new individual very reliably.

Within the project, a cardiovascular genetic study was also analyzed, extending the results of Kalina et al. (2013). The very aim was to find a relatively small set of genes responsible for the development of cardiovascular disease. Diagnostic tests were investigated, which are based entirely on gene expression measurements of individuals. Another practical result is a robust pre-processing procedure for images obtained by Illumina BeadChip microarrays (Kalina, 2018).

Theoretical interests of the project were devoted to such statistical procedures for the analysis of high-dimensional data, which are robust (resistant) to the presence of outlying measurements (outliers) in the data. The particular interests of the project were devoted to robust classification for clinical decision support (Kalina, 2014) or to robust dimensionality reduction by means of a minimum redundancy maximum relevance criterion (Kalina & Schlenker, 2015).

Jana Zvárová passed away in July 2017. After the end of the project, Jan Kalina continues the research focused on connecting classification and decision support with robustness. The methods are applied within in the field on machine learning, particularly (again) to fMRI measurements of patients with mental disorders.

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Chapter 21
Socialization or Social Isolation?
Mental Health Community Support in the Digital Age

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ABSTRACT

This research project specifically examines the experience of online community support groups as reported by users. The project began out of concern that healthcare providers in the Global North are directing people with mental health problems to online services, without seemingly understanding the impact that this may have on the individuals. The research findings will be of particular interest to mental health practitioners and service providers in the UK and elsewhere in the Global North, and aims to influence decisions made for policies around developing new online mental health services.

INTRODUCTION

There are many people living and surviving in the community with mild to severe mental health problems who do not have easy access to professional health and social care services. Globally, we have started to see a demand for more choice in how healthcare provision is provided, however constant cuts to healthcare budgets in the Global North mean that options such as telehealthcare and online services are seen as a cheaper alternative, and are often billed as a more effective solution (Chambers *et al*., 2016). This is despite much research showing that there is little to no benefit of this method of support, particularly that of peer to peer online support communities (Eysenbach *et al.,* 2004).

This chapter specifically examines the experience of online community support groups as reported by users. Twenty-five participants answered between one and six open questions posted on three different mental health forums. The research began out of concern that healthcare providers in the Global North are directing people with mental health problems to online self-care or peer to peer support services, which may not be suitable for all mental health patients. Despite a paucity of research showing completion rates of professional online therapeutic support interventions are rare (Simco *et al*., 2014),

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those that do complete the set programmes have been found to benefit from the support (Learmonth *et al*., 2008). However, statistics released in January 2017 by NHS Digital (the UK National Health Service) show that more people than ever are turning up at hospital emergency departments in the UK to receive support for mental health issues (NHS Digital, 2017). Since 2011, the numbers of people going to emergency hospital departments because of their mental ill health has increased by over 50%, and this is also the case for those under the age of 18 (NHS Digital, 2017). This shows that despite a growing number of professional and peer to peer online support services, there may still a growing need for face-to-face intervention.

This chapter suggests that through the identification of positive experiences of online mental health support forums, suitable resources can be developed cheaply and effectively in order to reduce the effects of mental illness, and support those who are unable to find support elsewhere.

BACKGROUND

Worldwide the spending is disproportionately low on mental health (between approximately 2 and 50 USDs per capita), and the lack of financial support has resulted in cuts to services, especially public sector services that support people with mental health problems within their local communities (WHO, 2015). Others are unable to access such support, perhaps due to living arrangements, or because of the negative stigma associated with mental health (Corrigan *et al.,* 2005; Link *et al*., 1999; Star, 1955). Globally, one in ten people are estimated to have a mental health issue, yet up to two thirds of these do not access any type of support services (WHO, 2015). It is of great concern that budget cuts and negative attitudes to mental health issues may lead to an increase in people isolated through lack of professional service support, so it is vital to understand the social factors that shape the way people may seek support in different formats.

The wellbeing of people with mental ill health is highly related to the experience of social isolation and the lack of social support (Corry 2008; Steptoe *et al*. 2013). More recently, there has been a shift in thinking when it comes to treatments with many patients (in general) taking an active role in deciding on the best method of healthcare provision for themselves (Allen *et al*., 2016). Brown and Calnan (2016) found that the level of trust between providers and service users was of vital importance. If trust is lost, it can exacerbate mental health issues and increase isolation (Heyes, 2017). However if trust is fostered, then the result is likely to be positive and isolation is reduced. Therefore, it is important that service users have a choice regarding their preferred method of care in order to get the best possible outcome for the individual (Allen *et al*., 2016; Heyes, 2017).

User-led initiatives (which can also be organised around other health and lifestyle issues), such as cancer support groups and bariatric surgery patient support groups, are part of a wider sociological phenomenon of social movements around self-care and peer patient support (Das & Faxvaag, 2014; Tanis, 2008). These groups are usually informally created, such as individuals with mental ill health issues setting up their own peer to peer support groups, or backed by non-governmental organisations. The central aim of these is to bring users together for mutual support and to reduce isolation (Barak *et al*., 2008; Mind, n.d.). Therefore, there is a need to examine the specific mechanisms that make up social support to understand who is benefitting from the current provisions (Kawachi and Berkman, 2001; Eysenbach *et al*., 2004). There are also a great deal of online mental health professionally led community support groups, although there has been less analysis of these (Eysenbach *et al*. 2004). It is

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apparent that there is a paucity of academic knowledge in this area, which demands research attention in order to maximise the effectiveness of such groups in the wider context of social and health care support (Eysenbach *et al*. 2004).

Political Framework

Understanding a particular political framework when discussing mental ill health is important, as it is often the case that the whole discourse around mental health is a result of political decisions (WHO, 2005). UK social policy focuses on enabling people to live and manage symptoms, as far as possible, within the community and providing that they have the mental capacity to cope (Mental Capacity Act, 2005; The Care Act, 2014; The Mental Health Act, 2007). However, the majority of people with mental ill health living 'within the community' do not benefit from the resources available to them (Morris, 2012). Isolation from meaningful community engagement often leads to loneliness and further co-morbidity issues, such as depression or substance misuse, particularly if subjected to discrimination and abuse (Link *et al*., 1997). Crabtree and Haslam's (2010) study on positive and negative implications of group identification demonstrated that a group support setting could reinforce supportive frameworks, and that this could outweigh the negativity felt by stigmatisation by non-group members. They recommended that a qualitative study should be conducted to explore the causal variables of relationships within the group settings and the effects that these may have on each individual (Crabtree and Haslam, 2010). There is a vast amount of knowledge about how community support groups are perceived by service users, whether they find them useful and in what ways they are helpful (Cruwys *et al*., 2013; Steffens *et al*., 2016; Welbourne *et al.,* 2013), yet there is still little understood about how people utilise online support for mental health issues. Welbourne *et al.,* (2013) suggest that this may be because motivations are often different for other online peer to peer patient groups, so research findings in one online health support area may not necessarily translate to others.

The most recent policy in the UK, The Care Act (2014), was launched on 1st April 2015. The Act focuses on the wellbeing of the individual with care needs, and also that of the carer (as long as they are not a paid service). By signposting these individuals to face-to-face community support services, there is a reliance on creating sufficient support systems in the local area. The cost objectives to creating these communities is to save money in the long run through 'fixing' problems that could arise from isolating people with care needs initially. Often carers of people with disabilities (physical or mental) suffer from mental health problems or physical ill health as a result of their caring role, consequently having to seek expensive health provisions for themselves (paid for through public funding) (Whybrow and Heyes, 2016). Therefore, social connections are important in preventing further or future health issues.

A study by the NIHR (Pinfold *et al.,* 2015), focused on the effects of communities on individuals with severe mental health issues (SMI). This exploration found that the family network can be viewed in many different ways, and these are not always positive, despite good intentions. The findings suggest that those with little familial interaction, but regular interaction with stable service providers (social services/ support worker/ priest and so on) were the happiest in their environment, and were likely to have a better health outcome than those with close family ties and/ or inconsistent relationships with service providers (Pinfold *et al.*, 2015). The lack of understanding around mental health has also lead to some people being segregated from family and friend connections, which could lead to further isolation or seeking identity in other ways, such as within online communities (Link et al, 1999; Pescosolido, 2010).

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Isolation and Stigma

Isolation continues to be a significant risk factor for morbidity, across the age spectrum (Holt-Lunstad *et al*., 2015). There are many people for whom isolation is not an option, but something that is forced on them through age or ill-health, and a vast number of those people may not get the help they need (Hawkley and Cacioppo, 2010; Uchino, 2006). Online support may mean that vastly more people get access to the support they need as and when it is required rather than having to wait for a GP or counselling appointment (Learmonth *et al*., 2008).

The stigma surrounding mental ill health is still concerning, particularly as it has been found to have a detrimental effect on help-seeking (Clement *et al,* 2015). Recent data collected by Schomerus *et al.* (2016) showed that even when members of the general public expressed understanding of mental ill health, attitudes towards acceptance of people with mental health issues are not altered. Although this experiment was a relatively small sample (n=1679), the findings show how important it is for mental health professionals to approach public attitudes in the future. Similarly, a recent study by NSUN (National Survivor User Network) for mental health in the UK (Beresford *et al*., 2015), found that service users believed that stigma was still evident in social dealings on a daily basis. The general belief held, was that stigma around mental health was formed by an outdated understanding of the medical model (Beresford *et al*., 2015).

Mental health issues, tend to be predominantly diagnosed using the medical model of the Diagnostic and Statistical Manual of Mental Disorders (DSM), however there are many people living and surviving in the community with mild to severe mental health problems who do not have access to medical or psychological support and/or would not welcome professional labelling or intervention. It is not fully understood what causes mental illness, or indeed if mental illness really exists (see Szasz, 1961, for arguments around this). Frances (2013) argues that the DSM is a way of creating control within society and of the medical profession, maintaining governance over what is normal and abnormal. The DSM is not necessarily an accurate portrayal of mental ill health, but it is generally accepted as the diagnostic criteria for most of the world's mental state (Frances, 2013).

Medical approaches to treating individuals with mild to moderate mental ill health issues in the UK can vary from involuntary incarceration, to providing signposting information about charitable services that can help with grief or suicidal thoughts, medication, and referral to counselling or online support services. However, Evans-Lacko *et al.,* (2013) argue that despite this range of possible medical actions, in general, medication is relied upon in general practice and in hospital care. They go onto note that mental illness should be treated as seriously as physical illness and that this need for dealing earnestly with mental health issues is increasingly important (Evans-Lacko *et al.,* 2013). However, there is a dominant and continuing lack of will in treating and understanding mental ill health, both socially and medically (for example see Maclure, 1988; Cuijpers, 2003; and Frances, 2013). It is therefore important to understand how individuals feel about their own mental health, and their choices and preferences in how they want to receive help and support (Heyes and Whybrow, 2016; The Care Act, 2014).

Health research is also still fixated on the idea of the medical model, with little psychological research into online mental health forums utilising a social constructionist approach (Burr, 2015). However, some health researchers (Link et al, 1999; Pescosolido, 2010), focus on interpersonal dynamics and social networks which highlight the issues of social withdrawal and link to community theories. Yuill et al., (2010) advocate the idea that a true perspective on health can only come from a consideration of both medical and social models for mental health, creating a pathway for multidisciplinary research in mental health.

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Online Communities

Online forums have become commonplace amongst internet users worldwide. The number of worldwide users hit 3 billion in 2014, and is now approximately 3.5 billion in 2017, which is approximately 46% of the world's population (internetlivestats.com, 2017: online). Several hundred thousand forums now exist on the internet, with the number growing exponentially on a daily basis (Carroll, 2014). In Japan in 2007, the top discussion forum, 2-channel, was receiving in excess of 2.5 million posts per day (Carroll, 2014). This has since closed down, but currently one of the most popular worldwide sites, Reddit, receives approximately 1.5m users per day, with around 40,000 subscribers to their mental health threads (Reddit.com, 2015: online).

The idea that society has easy access to everything because it is on the internet may be a misnomer. The NHS in the UK (for example) puts information on the internet to make sure that it is easily and readily accessible, most businesses have websites that are 'user friendly', and adverts tell us to look online for further information. However, it is not easily accessible to the 54% of the world's population that do not have internet access. There are also varying reasons as to why the 46% that could in theory access the internet, may not. Illiteracy, learning difficulties, and fear, are just a few reasons that may prevent online activity. Those who are comfortable with using the internet are therefore given options about how to utilise the choice given to all consumers, whether that is which healthcare services to use, or where to buy their groceries. The people in society that may already be able to gain information from multiple sources are choosing whether to consume information online, and this can be for convenience, personal preference, or accessibility. However, those who do not find online information accessible may miss out, as it may be assumed that information has reached everyone because of its online presence.

Patient forums have gained in popularity (Blank and Adams-Blodnieks, 2005; Neal *et al*., 2007). The idea of the expert patient in the UK means that those with health needs are encouraged to learn about their conditions so that they can be best placed to manage them (Coulthard *et al*., 2013; Davidson *et al*., 2012). There are now many thousands of Mental Health community support groups online, and they provide various methods of information and support. The majority of the specialised forums will link (via 'click through' hyperlinks) to easy to read information produced by public health bodies. However, some rely on the information provided by their members, with potential problems such as misinformation being an issue (Neal *et al.,* 2007). Consumer choice means that people can search the various forums and decide which one they wish to participate in. In order to participate, the consumer must feel as though they will learn to trust the forum, trust the other users, but most importantly, they need to feel as though they can participate and get some support (Easterbrook and Vignoles, 2013; Hornsey and Jetten, 2004; Guo and Cheng, 2016). Noelle-Neumann's (1974) Spiral of Silence theory states that people within society needed to gauge public opinion in order to understand how they can interact on a similar level to avoid isolating themselves. Therefore, it is imperative that the forum chosen by the consumer is one that shares similar ideas and opinions as themselves. As with offline support groups, if the user does not feel as though they are part of the ingroup, they may refrain from the group, and isolation may continue (Tajfel and Turner, 1979). The similarity to offline groups can also mean that those who struggle to participate in offline face-to-face interactions may also struggle to participate in online communities.

Definitions of community vary greatly, however they tend to focus on community being a group of people with a common interest or that are geographically linked (Delanty, 2010, McMillan and Chavis, 1986). Using a virtual platform that does not feel as constricted as face to face contact may enable vulnerable people to explore support systems that they may feel unable to access in the 'real' (offline) world

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(Bell, 2007). For example, those who hide their mental health issues in everyday society may feel as though they can be open and honest with those in a virtual capacity due to the anonymity of the sphere (Suler, 2004). Most beneficial to users is the anonymity of being online (Daine *et al.,* 2013), particularly if the stigma of having a mental health problem is something that they are trying to escape. However, forums that are receiving 1.5 million hits per day tend to have so many threads added every minute, that it can be difficult for all posts to be seen by users. The consequences of this could be that someone who is asking for help for the first time may be missed, and they will think that they are unwelcome, ignored and therefore, become further isolated (Daine *et al*, 2013).

Woong Yun and Park (2011) looked at the relationships of participants of online communities, and found that often people act the same way within forums as they would do in offline ('real') life. This means that if they are open and trusting in the offline environment, they will be the same online. However, Schiel (2005) states that a person who is not really known to us cannot be a friend and therefore must not be trusted. Blanchard *et al.,* (2011) believed that trust was an important aspect of fostering relationships within virtual communities, and generally, people followed normal social practices expected in an offline community. They found that sanctioning behaviours when someone had acted inappropriately were also an important aspect of fulfilling normal social practices, so when members could rely on others to sanction inappropriate behaviour, trust within the community would grow (Blanchard *et al.,* 2011). However, trolling has become an issue in recent years, particularly within social media, and along with this research, has been shown to decrease trust within virtual spheres, and therefore may increase negative online experiences for users (Herring *et al.,* 2002; Heyes, 2017; Phillips, 2015; Rafferty, 2011).

There is, however, a sense of community created by a shared identity (Ren *et al.,* 2012). In the case of mental health forums, people may be seeking information and advice from people who have had similar experiences (Ren *et al.,* 2012; Tate and Zabinski, 2004). This help may boost self-esteem if the individual has found a community that they can identify with (King and Moreggi, 1998; Ren *et al.,* 2012). The 'field' of virtual community support groups may therefore be a platform that can replicate face-to-face community support groups, and the security of the individuals' identity within this (Tate and Zabinski, 2004; Wood, 1989; Yalom and Leczcz, 2005).

Although the study of online community support groups is somewhat different to the offline groups, the comparison between online and offline is necessary in order to fully understand if there are significant differences. Richardson (2015) ascertains that online and offline should not be considered as completely different entities, as both are communities built through complex multi-dimensional relationships. The on and offline segregation should perhaps therefore be reconsidered as different ways of forging relationships, these being within different social spaces (online) and via different modes (through forums, blogging sites or social media). These different fields may then require different research methods, or the adaption of existing methods in order to revolutionize community psychology and social theory research (Kozinets, 2010).

Baym (1995) had been a participant of an online group before deciding to conduct her research. Over three years she asked questions, took surveys and analysed the text, her method being an ethnographic one that progressed over time, alongside her own understanding of the group. The idea of virtual research evolving as it happens is also supported by Chandler (2016). She found that the lack of rich data in some forums meant that her data collection methods needed to evolve alongside the researchers understanding of forum participation. Chandler (2016) found that in order to maximise the participants to her work on self-harm, she utilised the mass forum Reddit. This provided an inordinate amount of participant responses and yielded some interesting and good quality data. This type of ethnographic research has

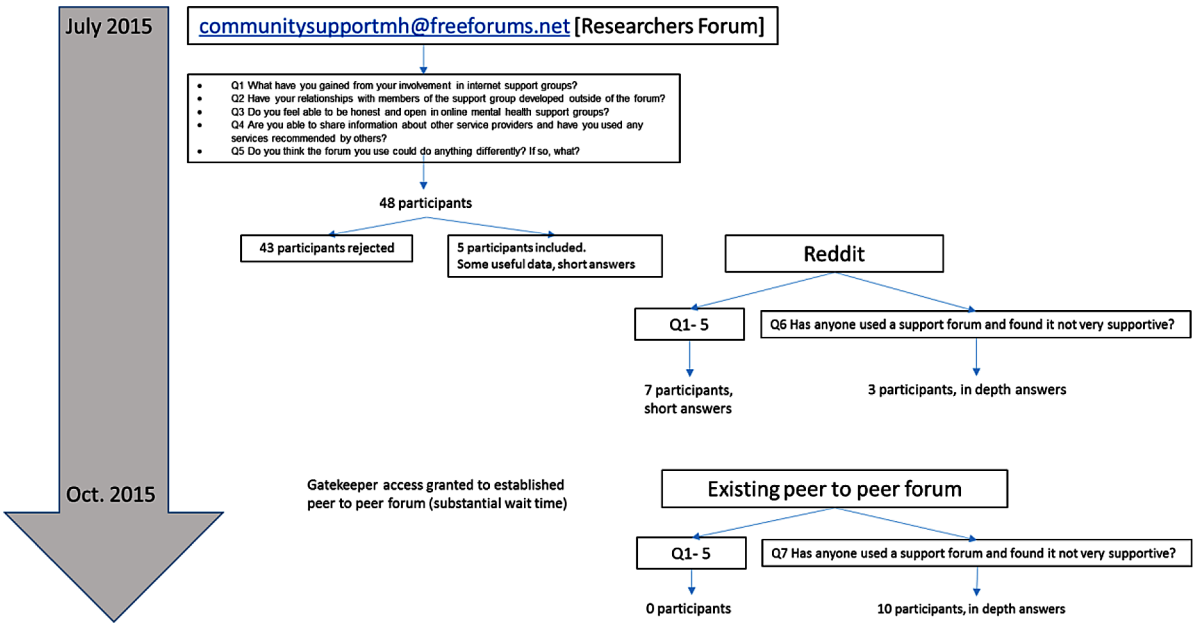
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been termed virtual ethnography, and is a growing phenomenon in online research (Rheingold, 2003). In this particular research (Heyes, 2017), virtual ethnography also involves the idea of the researcher being a 'tolerated observer' (Hine, 2010: 10), a presence that is apparent to the participant, but does not hinder the information given. Markham (2004) believes that ethnographic research in general has flaws, however, the lack of physical cues in virtual ethnography could actually add to, rather than inhibit the analysis of the research.

METHOD

A virtual ethnography study was conducted over a three month period between July 2015 and October 2015. Sixty-five participants answered between one and six questions on one of three forums: 1) a forum created for the purpose of the research called communitysupportmh.freeforums.net; 2) threads set up within Reddit's mental health section; and 3) a peer to peer community support forum that wished to remain anonymous (See Figure 1). No further information was taken about the participants, and there was no follow up contact (apart from to remind them that they could withdraw from the study if they wished). Forty-three participants were disqualified from the research due to giving identifying features or not meeting the criteria (i.e. when asked what they gained from being part of a support forum, replied that they had never used one). Gender was not deemed an important factor within this research, and as such, names of the participants were anonymized using an online name generator (http://myusername-generator.com/) to avoid gender bias. Open questions were posted as individual threads on each forum in order to create free flowing dialogue. Ethical approval was granted by Manchester Metropolitan University Ethics committee in July 2015.

Figure 1. Method timeline

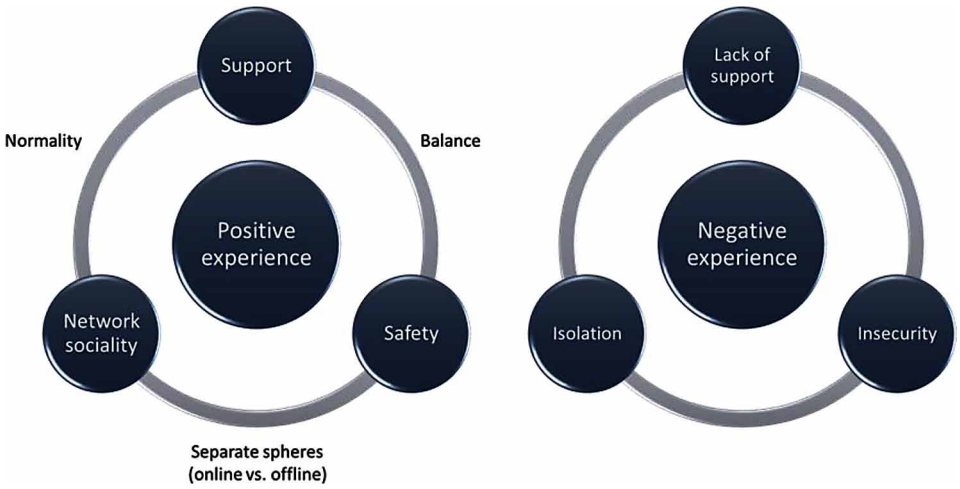


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FINDINGS

The research data was analysed manually using thematic analysis (Boyatzis, 1998; Braun and Clarke, 2006), and second coded using NVivo 11. Through coding, several themes began to emerge. These were reduced to three main issues: safety; support; and network sociality. Minor themes included balance, normality and separate spheres (of offline and online worlds). It emerged that if at least one of the main themes was in place, the participant was likely to have a positive experience of online community support, and therefore, an increased feeling of socialization. If all of the themes were negative, the experience is likely to be negative, and the result would be an increase in social isolation. The minor themes were present in the positive experiences; however, further research needs to be conducted to find the relationship between these themes and the negative experiences (see Figure 2).

Figure 2. A model of online support experiences



DATA ANALYSIS

The analysis of the themes that emerged can be put into three main categories: Safety, Security and Network Sociality. These encompass a number of other areas that were brought up, including trust, the balance between on and offline life, and how normal the person feels. This section shows how the data were analysed in order for the researcher to defend these three main themes.

Safety

As discussed in the literature review, and confirmed by Brown and Calnan's. (2016) study and Blanchard *et al.*'s (2011) model, trust can be an issue for members of online communities, however, this does not necessarily deter them from online social engagement. Not being able to participate in real life means that alternative methods of group participation are sought, however it may not be identified as 'true'

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interaction but a 'disembedded subjectivity that is somehow 'lifted out'' (Giddens, 1984, cited in Wittel, 2001: 51), a concept that can help some of the participants feel safer.

Online communities are an unknown entity, and trying to build a sense of a shared social space can be difficult when the participants may have different notions of culture and societal norms (Ostrum, *et al*., 1993). Safety therefore comes from a sense of 'good' culture within an online mental health community: one that is supportive; offers help and advice; and has participants with similar (perceived) social capital.

However, even when praising one of the forums, many participants still brought up issues and bad experiences they had had previously with other forums. The majority of people still struggled to trust other online participants, being wary of 'exploitative' and 'sneaky people', whilst also expressing defeatist attitudes towards expecting policies to be followed, or for moderators to do anything. The shared culture of the community can then turn into a bad experience and threatens the individual's idea of a safe environment.

Part of online forums is the fact that there are moderators or senior members keeping users safe from harm, which in Urowa's case (names are generated from an online name generator) did not seem to help or keep the participants from harm. Some of the participants gave examples of forums that had started well, but then went on to destroy the trust that people had in them. Unayi, describing it as:

Unayi: *[A forum] was 100% anonymous. The sneaky people trying to squeeze people for personal details happened every few sessions I connected to in the last few weeks it was open. Creepy. Trusting anonymous people on the internet is not recommended in any situation.* [Reddit, Q6]

The experience of having their safety compromised reminded several participants of experiences of offline interactions. Seven of the participants stated that they do not trust people outside of the internet either, with Unayi admitting that they would not trust their spouse or their friends 'to act in my best interest'. Schiel (2005) agrees, stating that people cannot be treated as friends if they are an unknown entity. The idea that the online community is made up of people that may have no real similar offline capital, means that they could never be trusted as they probably have an ulterior motive (Schiel, 2005).

However, there were many participants who felt as though it was easier to trust people on the internet that those offline, particularly on the basis of their shared identity (Tate and Zabinski, 2004; Suler, 2004):

Udefwl: *(I am) More honest than I can be face to face with people* [Researchers Forum, Q3]
Poufi: *Far more honest than I could be with friends and family* [Researchers Forum, Q3]
Vafez: *I have made some really nice friends on here and they have not judged me for being different.* [MHF, Q7]

Those who feel unable to be open and honest in their offline relationships (perhaps due to the nature of their mental health issues), can find it easier to be open and honest with strangers who share similar health issues, and also easier to offer support. The safety of these interactions comes from the anonymity that may make other people fearful of online interaction (Daine *et al*., 2013; Guo and Cheng, 2016), and this can cause conflict for the participants when trying to find a safe community in which they feel comfortable enough to become a permanent part of. If they do not feel a sense of safety in online interactions, they are unlikely to feel supported in an online community support forum.

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Support

Participants offered their comments as helpful support, even if they had no 'real' (professional) insights to offer. This could be that by providing a support mechanism to others by offering encouragement actually makes them feel better about themselves, rather than directly seeking help for their own issues. They do not feel that they are burdening others with their own stories and have the associated positive feelings of altruism (Brown and Calnan 2016). One of the participants specifically noted that writing their own posts made them feel anxious, but commenting on other people's posts made them feel good.

Other participants did not realise that they were participating to feel better about themselves. An example of this kind of interaction is that of Jaqdudi (Reddit), who had participated and lurked in several forums, was sceptical of the support that they offer. Some of these interactions were trying to show that they were actually part of 'normal' offline interaction, they were just passing by and happened to stop to comment.

Jaqdudi: *I don't honestly have many problems that can't be solved by Googling a specific question or maybe talking to my friends.* [Reddit, Q6]

However, interwoven in between this scepticism of receiving support through forums, they also try and act as though they would still be ok with receiving support – when asked if they have thought about using the forums for more than they already have, the reply was 'Sure, if the need arises'. It is interesting that they have felt the need to be lurking on a mental health forum, and also felt compelled to answer the research question even though they deny the need for support. Jaqdudi was one of the people that posted the most in terms of discussion about the use of forums, but also seemed to be unable to express (perhaps even unaware of) how they use support forums. Through being helpful and answering research questions and supporting others, they may not perceive themselves as needing support at all.

This need for reassurance of being normal was also seen in some of the other participants, expressing how many close friends or family members they have in the offline world, trying to give an air of flippancy to their answers. This guarded behaviour shows that participants such as Jaqdudi, like to be part of a community, but do not feel as though they can ask for support. This may be due to a lack of trust, or that they may be cautious about giving too much information about themselves on a platform that users are often told to be wary of giving too much information to, due to the few that abuse the system. This could drive the participants into becoming part of the out-group in the online communities, resulting in them becoming segregated from the community. However, it could also mean that they are receiving personal gratification through supporting others, and therefore do not need to divulge personal information in order to benefit from being part of the community (Welbourne *et al.,* 2013).

Network Sociality

Being social is something that comes naturally to some people, and as discussed in the literature review, is difficult for those who are seen as being deviant from dominant social norms around their health and wellbeing. Network sociality is not so much wanting to be part of a social community, but is the need for interaction in order to understand one's own identity (Wittel, 2001). Those seeking online health support communities generally want to find or exchange, informational and/ or emotional support (Welbourne *et*

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al., 2013). This identity and support seeking is evident throughout the data, and this section will explore isolation, identity and consumerism through the over-arching concept of network sociality.

Through the analysis, it is clear from the number of participants that had been part of multiple forums (at least 8), that the choice afforded by the amount of community support forums subjects users to (at least) as much consumerism as they would be offline. They can decide how many forums they wish to engage in, and whether to lurk, participate or go elsewhere. These choices are helpful to those who may not want to seek advice from a GP or offline services, however the possibility to use orthodox health and wellbeing services is still there for those who may wish to do so, and if necessary they can chose whether to use them concurrently. However, trying to find a supportive community that is right for the individual can prove difficult for people with mental ill health. The stigma of having a mental health problem in offline communities can be the cause of individuals seeking solace in the online world (Goffman, 1963; Link, *et al*., 1997). Therefore, participating in any community, online or offline, can cause feelings of anxiety and uncertainty about how one's posts will be received and responded to by others.

As one participant states:

Ripem: *Writing about my own issues as a new post gives me anxiety (probably the vulnerability aspect) [sic].* [Reddit, Q1]

The idea of disclosing personal information for someone with mental health problems can be fraught with fear of the consequences. For an individual to decide to disclose this type of information to a new community can be seen as a huge risk. This leads participants to describe a process of 'lurking' on the forums before actually making that crucial first post and connecting to an online community.

One participant mentioned quietly evaluating forums, prior to actively being involved through posting. Although the actual numbers of those who lurk online in forums and never post personal information is not known, the activity is commonly discussed in literature about the use of online forums (Schneider *et al.*, 2013; Rafaeli *et al.*, 2004). The participants want to become part of the community, so lurking can help them to assess if the people already contributing are similar to them, reducing the possibility of alienating themselves from the offset (Blanchard *et al.,* 2010; Bourdieu, 1990; Noelle- Neumann, 1977). Six of the ten participants of the established Mental Health Forum expressed that they were constantly fearful about isolating themselves from the offline world, rather than worrying about not fitting in with the online world.

Three of the participants were unclear on the role of online relationships within the context of broader social experiences, they noted the aim for online forums is to enhance interactions with others. Similarly, Jawodaza notes that interaction with others is important, but s/he struggles with friendships in the 'real world', so utilises the forum as a method of interaction and support without the emotional ties of friendship. S/he also states that having this form of interaction is better than nothing at all:

Jawodaza: *If you feel up for having 'real' company, but are choosing to go online instead, it probably is worth giving yourself a boot up the backside and start getting out a bit more.*
But sometimes it's not that straightforward. I don't have many friends, the friends I do have are older and have their own families/lives.
Though even if I had people to socialise with, sometimes it's really difficult.
So for me it's better to be on here than have nothing. X [sic] [MHF, Q7]

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Getting the balance right between online and offline interaction was a common concern amongst the participants on all three forums. Argyle (1969) argues that human interaction is a necessity and Steptoe *et al*. (2013) back up this contention by stating that those who are isolated from physical interaction have a higher risk of mortality. However, Kendall (2002) and Hine (2004; 2008) believe that technology has moved on considerably in recent decades and that limited human face to face interaction may not be as mortifying as it once was. Younger generations have grown up with online social relationships, and therefore, these types of interaction may prove to be more beneficial than having no offline contact at all. Kendall (2002) also states that most people do not use the internet instead of living offline, blending the online and offline worlds provides benefits, without having to worry about one type of interaction dominating one's life.

In line with Kendall's (2002) vision of the benefits of a 'blended world', thirteen of the participants stated that they felt comfortable with a blending of worlds, by utilising online support when they feel as though they are unable to cope with human interaction:

Kabeegi and Exogu both expressed that they found it difficult to talk to people in the real world, particularly if they do not have experience of similar mental health issues. By seeking support online, they feel more comfortable and are able to be honest about their feelings. This could be due to the shared values created through previous interactions on the forums, or a shared illness (and therefore understanding of what each other may be going through).

However, two of the participants saw the interactions between offline and online as separate spheres that provide an alternative place to air feelings and ideas, with no other agenda:

Vafez: *…cant mix with real people outside,…. this forum is great and a life saver for me* [MHF, Q7]
Jaxuq: *i find them helpful as i cant do real interaction with ppl [people] except my parents who work [sic]* [MHF, Q7]

These posts from Vafez and Jaxuq, emphasise interaction online and offline as separate arenas, the online space providing unique opportunities for mental health discussion. There is an interesting theme here, which also emerged elsewhere in the data, of online interaction not being 'real'. However, it clearly is real in the sense that it achieves interactional imperatives in terms of relating to another person and is valued by these respondents. Being online though allows a sense of 'playing at' interaction and experience, the stakes are not so high as face to face. This idea of 'playing' at being online is similar to those who utilise online games to help escape from the real world into a fantasy one (Hine, 2004; Calleja, 2010). Escapism could be therapeutic, allowing some relief from mental health issues, and summoning up support from those who appear to understand you, in a non-threatening way (Calleja, 2010).

However, choosing a forum in which to participate can itself be a difficult task, and one that is not as simple as just lurking until the right one is found because of the emergent and fast-changing nature of these social spaces:

Unayi: *…good ones [forums] can go bad quickly. [A forum] was originally brilliant, then it started to fill up with [..] assholes along with exploitative people…* [Reddit, Q6]
Urowa: *Most of the listeners [through support chat on the forum] did their best to change the subject. Then there was one who first started telling me who I can and can't consider a friend and then gave me a nopology [opposite of apology] when I confronted him.* [Reddit, Q6]

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The participants reported that forums could quickly change and 'go bad' with changes in who was using them, arguments and disagreements, breaking out or trolling. Participants were asked if they had had any negative experiences of forums and to expand on why these were not good. Four participants, similar to Unayi and Urowa's experiences in the quotes above, expressed that they had on occasion had disagreements with other forum members and were dissatisfied with the way that it was handled. In these cases, they typically went on to describe how they no longer trusted anyone online or offline, despite the fact that they claimed to have good friends and other social relationships. Urowa however, described their experience as unfortunate rather than confidence destroying, and was disappointed with the way that their particular issue was handled. In this case, the site moderators did not want to get involved, despite having a clear behaviour policy on the site. This is ultimately an illustration spanning all three of the main themes, and showing that they are indeed linked to whether or not a person has a positive or a negative experience of online community support.

Despite these difficulties, eight of the participants argued that identifying with the people in a community support forum can be the key to success and were positive about their experience. Knowing that there were other people having/ or had been through similar experiences seemed to give the participants a sense of relief in having found 'normality':

Imeifl: *I've gained happiness in finally reading about other people like me. I've heard they exist, but until I discovered [a forum], I could never know for certain* [Researchers Forum, Q1]

Thoqwhon: *For me, I can be the 'real me' on here. … I find it near impossible to let [my friends and family] know that I'm not good and I try to be smiley to deflect concerns.* [MHF, Q7]

These participants seemed to have found a sense of identity authenticity that they could not display elsewhere. Having a sense of being like others and sharing issues is important. They feel accepted within this community and they no longer have to pretend in order to fit into offline society's idea of normal. In the online support forums, the majority of the participants feel that they have become part of an in-group (Tajfel and Turner, 1979; Yalom and Leczcz, 2005; Tate and Zabinski, 2004; Wood, 1989; Bourdieu, 1985) which can boost self-esteem and reduce feelings of anxiety and isolation (King and Moreggi, 1998).

CONCLUSION

This research sought to investigate and clarify what was important about the interactions within virtual mental health support groups and to provide an insight into these communities in order to influence policy and practice. By assessing the impact of online support networks for people with mental ill health, it has become clear that there are gaps in social policies and health care provision. Social constructions that surround mental ill health make it easy for vulnerable people to become invisible in society due to isolation (Corry, 2008; Steptoe *et al.*, 2013), and people can be reluctant to look at alternatives, such as online sources. Face to face mental health support groups, or negative experiences in online community spaces may have detrimental effects on people with mental health issues seeking alternatives.

The research found that there were benefits to most of the participants in terms of creating support networks that would take the place of, or supplement offline communities, and therefore as a result would reduce isolation. There were some negative consequences however, and the reluctance of some participants to fully immerse themselves into online communities meant that they used multiple sites

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without any affiliation to a particular community. This could make the individual feel further segregated from being supported by a community, and therefore more isolated than before initial online contact.

Users of the community support groups are generally positive about the support that they receive, and find it beneficial to communicate with people with similar experiences. However, the few who have had negative experiences reported that they no longer have any trust in the groups. Those with security issues however, keep using forums but err on the side of caution by not giving away too much personal information.

Good quality online support groups with a high level of peer support seem to be difficult to find, despite the number available. Forums that are successful usually have hundreds or even thousands of users daily, which makes them susceptible to exploitation. In turn, they either close down, or users may leave to find alternatives. They are useful in creating network sociality, providing a community in-group, and helping to boost self-esteem, thus enhancing quality of life for those who are isolated in offline communities. These are however, difficult to set up and can take a long time to attract members, which can be problematic in terms of creating the ideal solution for online community support for mental ill health. The model of online support, in Figure 2, aims to help with building understanding of the impact of this type of social support, although further research needs to be completed in order to recognise how this can be used to influence policy and practice.

One issue that should be addressed around information provided on the internet, is the assumption that everyone accesses it. With around 56% of the world's population still without access to the internet, this assumption can leave vulnerable people without the help they need. However, to those that are able to access it, the amount of information about mental ill health available online can be valuable to people, especially as cuts to funding look set to continue despite numbers of people diagnosed with mental health conditions rising. Lengthy waiting lists for counsellors and specialists may force people to seek alternatives, and those with access to online services may find their consumer prowess is vital in receiving alternative care. However, more research into the effectiveness of this is necessary, and will be a continual process over the coming years as the nature of the consumer changes.

It is also imperative that we do not assume that because the individual has access to the internet, that they will then wish to utilise this as their main method of treatment. Some people will continue to use face-to-face methods as their preference, or they may decide to refuse any treatment at all. Through offering choices in healthcare provision, we must ultimately respect the decision of the individual.

FUTURE RESEARCH DIRECTIONS

The idea of community being similar online to offline is something that has not been explored in great detail within social or community psychology, and it is therefore difficult to ascertain how best to utilise these communities or engage those who are still isolated. The changing nature of online also means that research needs to stay current. The changes in technology and the increase in the use of social media, predict that the interwoven nature of online and offline will become more complex, particularly when vulnerability such as mental ill health is taken into consideration, and where the individual is at in their life stage (Hine, 2008; Third *et al.*, 2014). Bridging to other support mechanisms has not been something that has been found within this research, and it is important that when seeking alternatives to conventional methods of support (i.e. offline), the participants of online support forums need to be careful that they are not self-diagnosing, or hiding a problem that needs medical attention. Therefore, the next stage of

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this research will be to conduct in depth interviews with users of online mental health community support to understand why they utilise online support, and if they felt it was beneficial.

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KEY TERMS AND DEFINITIONS

Ethnography: A method of research that involves non-participatory observation of participants in their normal environment, for example, at a weekly group meeting.

Expert Patient: The empowerment of a user of healthcare services, through the education of their condition and treatment.

Lurking: When users of online spaces watch, read or look at, but do not contribute to the discussion.

NHS: The National Health Service. This is the healthcare service that is provided in the UK. It is paid for with Government funds and is free at the point of access to residents of the UK.

Offline: Anything that happens when not connected to the internet.

Online: Anything that is accessed through, or actions taken, whilst connected to the internet.

Peer to Peer: Discussions or connections that happen with people of the same perceived status, such as users of forums. Medical doctors for example, may be a professional rather than a peer when participating in forum discussions.

Stigma: A negative association with social characteristics, traits or health issues.

Trolling: A means by which individuals attack others online through inflammatory comments.

Virtual Ethnography: A method of research that involves observation of participants in their online environments, for example, an internet chat room.

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Chapter 22
Virtual Communities, Machine Learning and IoT: Opportunities and Challenges in Mental Health Research

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ABSTRACT

Mental health challenges such as stress, anxiety and depression are on the rise worldwide. Health virtual communities (VCs) is a rising paradigm that has proven to be efficient and effective in delivering mental health interventions that address self-management, diagnosis and treatment targeting people facing mental health challenges. However, current Health VCs have limited application; they lack the ability to provide access to coordinated services and to continuously collect and integrate data originating from different devices in a streamlined manner. The Internet of Things (IoT) and machine learning represent a unique opportunity to expand the Health Virtual Community applications in the mental health domain; however, they represent a unique situation where challenges arise. This article will discuss the opportunities and challenges that virtual communities, machine learning and IoT represent for mental health research.

INTRODUCTION

Health informatics is at the verge of a profound technological change that will have a deep impact on the healthcare system in term of processes, policies and jobs. This article aims to explore the impact of Machine Learning, the Internet of Things and Virtual Communities on Mental Health research.

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MENTAL HEALTH: A GLOBAL EPIDEMIC

Mental health is a global crisis with over 80% of people suffering from mental-health disorders living in the Global South (Ngui et al., 2010). The World Health Organization (WHO) considers depression as a global crisis (2018). In 2015, a study from the Canadian Mental Health Association showed that roughly one out of every five Canadians (at some point in their lives) will be diagnosed with a mental disorder, usually in the form of an anxiety disorder or depression (Canadian Mental Health Association, 2016). In the USA, 31% of college students experience mental health challenges (American College Health Association, 2009) and the numbers are similar in Europe (World Health Organization, 2014). The total economic cost of mental health in Canada amounts to more than $14 Billion per year (Stephens & Joubert, 2001). In 2013, the United States spent around $201 billion on mental disorders (e.g. stress, anxiety, depression). One cannot underestimate the need to provide continuity of care, including a myriad of related social services, to the people with mental illness.

THE ROLE OF INFORMATICS

While non-medical based therapeutic interventions, such as mindfulness, Acceptance and Commitment Therapy (ACT) (Caset et al., 2018; Hoffmann et al., 2018; Ostergaard et al., 2018), and Problem Solving Treatment (Gojani et al., 2018; Ghasemi et al., 2017), exist and can address mental illnesses (e.g. anxiety, stress), they cannot be provided in face-to-face manner for every person in need for them for the simple reason of lack of large specialized professional body; besides, face-to-face solutions can be extremely costly. Informatics can play an important role in scaling up mental health intervention for the provision of professional mental health care, set management of mental illness, and mental health promotion and prevention.

Moreover, individuals with mental illness, do not only need health professional care but also associated social services. Indeed, people face social economic barriers when dealing with mental health; some of these barriers are related to accessibility, lack of financial and professional resources, and social stigma (Perlick et al., 2010), lack of available services (Kaur et al., 2018), help seeking avoidance (VanHeerwaarden et al., 2018), and cultural barriers (Leong & Kailbatseva, 2011). Hence, the need for technology-based solutions to overcome economic and social barriers in relation to mental illnesses is high. Indeed, technology can be built to be accessible, provide ability to reach remote services, allows discovery of available services in a certain geographic location, encourages overcoming cultural barriers and stigma by connecting people from the privacy of their rooms to online services, and it support a sense of anonymity and privacy (Morr et al., 2017). Hence, technology-based programs open the door for alternative solutions to provide therapy targeting those who would otherwise not have the ability to seek out or receive services.

HEALTH VIRTUAL COMMUNITIES: A RISING PARADIGM

Virtual Communities or online communities are a group of people with shared interests and goal, specific roles, and connected through an information system and a myriad of devices (Rheingold, 2000; Nonnecke et al., 2006; Preece, 2000). When the members are connected through a mobile technology then

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the virtual community is said to be mobile. Mobile Virtual Communities is different than just mHealth by the community aspect; a community interaction and reciprocity are part of any virtual community application an mHealth can be individual and do not allow interaction between users.

Health virtual Communities have proved to be an efficient way to connect people to health care professionals including therapist, doctors, nurses address health challenges effectively, this includes diseases such as cancer (DuBenske et al., 2014), chronic kidney diseases (El Morr et al., 2014), Peripheral Arterial Diseases (El Morr et al., 2016), pulmonary hypertension (Matura et al., 2013), and mental health (El Morr et al., 2017) on local and global levels (El Morr et al., 2014). Recent research on mental health VCs, particularly applying online mindfulness techniques, has also showed promising results (El Morr et al., 2017).

However, two items are still not on the current agenda of Mental Health VCs: Coordination of services and Integration of data from ambient environment. Coordination of services is paramount for the people with mental illness (Guerrero et al., 2016; Morre et al., 2016), such as housing (Shah et al., 2018), employment (De Moortel et al., 2018), and food (Maritnex et al., 2018; Maynard et al., 2018).

IoT and Machine Learning represent two opportunities to address those two missing agenda items within the virtual community research in mental health.

THE ROLE OF IoT AND MACHINE LEARNING

Mental Health Service Coordination

Health Service coordination is a challenge in healthcare (Alfredsson et al., 2017; Diez-Canseco et al., 2018; Leung et al., 2018; Ramanuj et al., 2018; Wakida et al., 2017; Yi et al., 2016); in particular, mental health services are scattered and disintegrated (Braithwaite, 2008; Piper, 2013), which creates a system where it is complex for patients to locate what services are availability and where. From the healthcare (and social service) providers perspective the system is disintegrated in another way: providers cannot access all the pieces of data related to their patients. The overall situation makes mental health illness one of the most challenging situations within and across services (e.g. healthcare, social).

The continuum of care for mental health extends beyond the point of care to the social services; people with mental health illness usually have other challenges mainly social (e.g. housing, income), and those social aspects influence mental health in their turn (Compton & Shim, 2015), hence the term "social determinants of health" (Raphael, 2016). However, the current eHealth tools target the healthcare delivery within a strict biomedical model of health that excludes the social determinants of health; the result is translated in inefficiencies and higher cost. While mental health VCs exit, they usually address education or symptom management; they do not address the myriad of individuals' needs: social as well as medical.

IoT provide an opportunity for a connected experience including (1) the exploration of options and services available, and (2) the integration of care (medical and social). Indeed, IoT allows collection of interconnected and up-to-date data emanating from different service providers (medical and social), which provides an opportunity to fill a huge void in care: streamlining the coordination of care within and across services.

Once data is available through IoT, predictive analytics allows this can be achieved by matching the patients' needs with available services, automating appointment scheduling, and addressing individual

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context while streamlining the process. The result would be the delivery a holistic service to patients while cutting operation cost. The perspectives of positive impact of IoT and machine learning to provide an integrated interconnected experience are limitless and an open field of research within the virtual community context (and arguably outside that context).

Diagnosis, Prevention and Promotion

Diagnosis of mental health challenges at an early stage can help overcome them much sooner and cheaper; while Apps provide many ways to detect physical (e.g. number of steps walked) and mental (e.g. mood entered by user) health data, we do not have ways to access those data in a continuous way that does not require and error prone user active intervention.

IoT represent an opportunity to collect seamlessly data feeds originating from the different devices and integrate it within Electronic Health Records (EHRs) or personal health records (PHRs); sensors, for instance, can capture indicators of mental health, such as heart rate variability (Davila et al., 2017; Insoo & Bhagat, 2016; Pirbhulal et al., 2015; Sugita et al., 2015) and use them to monitor mental health state. The result is a myriad of measurements that can serve as input for machine learning algorithms.

Diagnosis Analytics provide an opportunity to detect and recognize (i.e. diagnose) mental health illnesses (e.g. stress, anxiety) when they occur (Hu et al., 2015); while predictive analytics assist in predicting their occurrences which allows providers to take necessary steps to avoid progression of illness in a disease prevention effort.

Finally, IoT also can provide an opportunity for mental health education; members connected by a virtual community (permanent or ad-hoc) can receive suggestion of materials to read, exercises to do (e.g. breathing techniques) or even food to eat, to the different "objects" in their environment (e.g. fridges, smart watches, TVs, tablets). The total experience aims at providing community members with a connected mental health promotion opportunity (Marquez et al., 2016).

CHALLENGES

While IoT provides an important opportunity to address mental health challenges on the individual and the population levels, it presents major technical and non-technical challenges that innovators and researchers in technology need to address appropriately; among these challenges we will discuss: privacy/confidentiality and safety.

The main question for a "connected" person is how her/his right for privacy protected and how professionals accessing her/his data respect their obligation of confidentiality. IoT represents a challenge for privacy (Duan et al., 2016; Nieto et al., 2018), as the interconnected devices can be ad-hoc, and would be present in private (e.g. at home) as well as in public spaces. Creating privacy policy framework for IoT would be crucial for health and non-health applications. Organizations (similar to TRUSTe for websites) that guarantees the level of trust individuals can put in the "things" around them would be of major importance in order to drive innovation and adoption of IoT in healthcare. As breaches of privacy/confidentiality would need to be investigated, policies that provides framework for IoT-Forensics.

Data security is a permanent challenge in IT; however, in IoT and health (and mental health in particular) the virtual community members' own safety is very sensitive: hijacking of a mental health related "object" could be very harmful and possibly fatal for any individual.

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Machine learning is a challenge too, scientists inventing AI algorithms have raised concern in relation to the way algorithm learn and make decisions. Mechanisms that makes algorithm decision transparent to health professionals need to be in place and are currently missing.

Finally, while technology provide opportunity for better health they are also a source for safety concerns; research has shown that once IT is embedded in a health environment it is a safety challenge as it can introduce unforeseen modes of interaction and failures that affect patients' safety (Coiera et al., 2017; Hodgson et al., 2017; Magrabi et al., 2016; Wang et al., 2017; Wang et al., 2017). IoT and Machine Learning safety is important factor to investigate.

CONCLUSION

Information and Communication Technologies (ICT) has changed the way people communicate, interact, educate themselves and others, and deliver health care. The IoT and machine learning are creating new ways of interaction between individuals and objects around them, which will impact how individuals interact with their health professionals and among themselves. The Internet of Things and Machine Learning can provide a wholistic mental health ecosphere that connects community members and health professionals in real time if needed. Both, IoT and Machine Learning, are expected to improve disease diagnosis and prevention and health promotion efforts in matters of health and mental health in particular. New possibilities to provide connected care using IoT, Analytics and VCs, appear to be an opportunity that can lead to innovative applications in mental health; however, a new model that maintains privacy/confidentiality and patient safety is needed.

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Chapter 23
Efficacy of Telemedicine in Psychiatry and Mental Health Nursing

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ABSTRACT

Adoption and implementation of telecommunication services which allow psychiatric services to be delivered have increased availability of care to patients in remote areas. Past studies have suggested that telepsychiatry services are comparable to traditional face-to-face services; and patients typically considered telepsychiatry an acceptable alternative. The purpose of this research was to examine and describe the efficacy of psychiatric care delivered via telemedicine (telepsychiatry) to determine whether telepsychiatry could improve outcomes for patients. Seven electronic databases were utilized with a total of 22 articles that were referenced as a basis for this literature review. The findings suggest telepsychiatry is an effective alternative compared to traditional methods. Future research should include controlled experiments that compare telepsychiatry to face-to-face psychiatry and incorporate newer technologies into the research.

INTRODUCTION

The adoption of telemedicine technologies used for delivering psychiatric treatments has been slower than in some areas of conventional medicine, however its use in this arena is making gains; an evidence-based treatment in which therapists can record psychotherapy sessions and make them available to patients through mobile devices and allow patients to review the sessions later (Luxton, et al., 2011). Treatment compliance can be improved by apps that record and date-stamp treatment homework review, track therapy appointments, and send patients or providers alerts related to treatment needs or crisis management

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(Luxton, et al., 2011). It can clearly be seen that there have been successful and useful implementations of telepsychiatry with alleviating problems of workforce shortage and lack of facilities in underserved areas. Some findings also suggested that mental health services delivered using telepsychiatry were comparable to services delivered face-to-face, and there was no evidence that such services caused harm to psychiatric patients (Krupinski et al., 2002; Saeed et al., 2011). But, in order to truly implement this, mental health care providers need to know if the outcomes are comparable. Therefore, the purpose of this research was to examine and describe the efficacy of psychiatric care delivered via telemedicine (telepsychiatry) by conducting a literature review of the past research and uses of telepsychiatry. That is, this research will strive to answer the question, "Does telespychiatry equivalently or to a better extent fill the gaps in lack of availability in mental health care services?" Consequently, this research was also useful in determining whether telepsychiatry could improve outcome measures for mental healthcare patients.

BACKGROUND

Telepsychiatry, the provision of psychiatric care to remotely located clients and electronic exchange of mental health care information across distances, has the potential to revolutionize patient care (Norman, 2006). There are two major problems area that telepsychiatry can improve. One is access to mental health services where patients have difficulty due to lack of appropriate facilities such as rural, urban (Hilty, Luo, Morache, Marcelo & Nesbitt, 2002). Secondly, numerous literature sources suggest that telepsychiatry has the potential to alleviate health care workforce shortages in remote and underserved locations (Antonacci, Bloch, Saeed, Yildrim & Talley, 2008; Grigsby, et al., 2002; Krupinski, et al., 2002; Saeed, Diamond & Bloch, 2011).

According to the National Institute of Mental Health (2008) in the Strategic Objective 3 of the 'Strategic Plan,' it is important that adaptive designs which include patient preference be applied to psychosocial and biomedical intervention research. The strategy also aimed to adopt novel approaches in research models that identify new brain-behavior-environment research objectives that center on the functioning of the individual(s) as a whole. Telepsychiatric services were shown not only to be acceptable, but also even preferred by some mental health patients (Krupinski, et al., 2002; Saeed, et al., 2011).

With new developments in information and communication technologies, many online and mobile applications (apps) are now available to support mental health, including a wide spectrum of electronic interventions (e-spectrum), which have the potential to expand and enhance the scope of patient-centered mental health care interventions. One of the earliest examples of such e-therapies was an internet-based program called MoodGym, an online cognitive behavioral therapy approach designed to help people identify symptoms of depression and teach them coping skills (Rickwood, 2012). Since then we have seen many other technological advances. For example, the use of smartphones have seen dramatic growth: in 2008, only 10% of mobile phone usage in the U.S. occurred via smartphones, but by the end of 2010, the iPhone alone accounted for 55% of the mobile internet traffic in the country. Such devices have revealed numerous opportunities for using mobile apps for a variety of behavioral healthcare tasks (i.e., monitoring symptoms, treatment progress and compliance) (Luxton, McCann, Bush, Mishkind & Reger, 2011; Shepard, Rahmati, Tossell, Zhong, & Kortum, 2010).

Along with mobile applications, there have been other technological advances that have enhanced mental healthcare through telemedicine. According to Deslich, Stec, Tomblin & Coustasse (2013), highly interactive audiovisual teleconferencing systems – such as the unified communications systems

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developed by Polycom, Inc. – have been very successful in addressing the needs of both patients and providers who have engaged in telepsychiatric approaches to mental healthcare. Not only does such a system give patients greater ease and more options for interacting with healthcare providers remotely but can increase the flexibility and utility for providers by providing desktop videoconferencing and real-time access to a patient's Electronic Health Record (EHR), as well as to other computer applications (Deslich, et al., 2013). Also, according to Cucciare, Weingardt & Humphreys (2009), researchers have also studied the efficacy of internet-based systems for monitoring outcomes and making improvements in traditional treatments for Substance Use Disorders (SUDs), which would allow clinicians to obtain feedback in 'real time' from outpatients, on measures related to substance use and treatment satisfaction.

EFFICACY OF TELEPSYCHIATRY

Methodology

A literature review compiled findings published between 2002 and 2013, in an attempt to stay current in research. Twenty-two scholarly sources were used to assess the use of telepsychiatry in mental healthcare treatment. The following search terms/combinations were used to narrow the search criteria: 'telemedicine' OR 'telepsychiatry,' OR 'telehealth,' OR 'eHealth,' AND 'substance abuse,' OR 'mood disorder,' OR 'depression,' OR 'treatment compliance.' Only academic peer-reviewed journal articles or Health Information Technology (HIT) practitioner literature were included. All of the relevant research that was used came from the electronic databases: EBSCOhost, MEDLINE, psycARTICLES, psycINFO, PubMed, Google Scholar, or the American Telemedicine Association website.

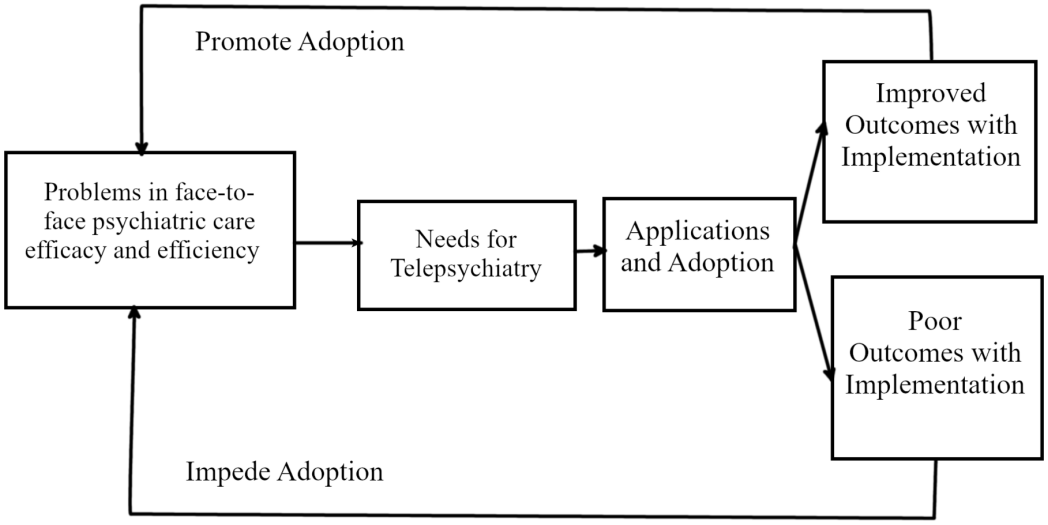
References were reviewed and were determined to satisfy the inclusion criteria if the material provided accurate and reliable information about telemedicine with a particular focus on psychiatric care or mental health nursing. This research followed the systematic search steps and a modified research framework utilized by Yao, Chao-Hsien and Li (2010). The use of this conceptual framework is appropriate as the focus is on the sub-area of telemedicine application to psychiatry. To research how telepsychiatry can be utilized to improve psychiatric care, it is first necessary to recognize the existing problems in psychiatry and issues that drive and impede adoption of telepsychiatry. Yao, Chai-Hsien, and Li argue that problems in face-to-face psychiatric care demonstrate needs for telepsychiatry, which in turn lead to applications and adoption. Improved outcomes promote adoption; poor outcomes impede adoption (Figure 1). Figure 1 depicts the process of telepsychiatry adoption in mental healthcare.

Results

This section will examine the literature of various outcome measures for patients who were treated with either Telepsychiatry or Face-to-Face Psychiatry that are summarized in the following Table 1 in the appendix. An open, uncontrolled trial study conducted across family practices in Montreal, Canada, during 2010-2011, investigated the feasibility of using telephone therapy delivered by psychiatric nurses in conjunction with a behavioral informational self-care media toolkit to provide telepsychiatric support to eligible patients, aged 40 or older, who met the criteria of having at least mild depression based on

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Figure 1. Conceptual framework: Mental healthcare treatment via telepsychiatry



a score of 5 or greater on the 9-item Patient Health Questionnaire (PHQ-9) (McCusker et al., 2013). A six-month follow up on the participating patients revealed evidence of improvements in depressive symptomology: clinical significance measures on the PHQ-9 change over baseline measures indicated that 57% of participants demonstrated at least a 50% decline in their PHQ-9 scores (McCusker et al., 2013), (Table 1).

The efficacy of a telemedicine-based care model was developed to allow small clinics that do not employ on-site psychiatrists to deliver evidence-based collaborative care via telepsychiatric care (Fortney, et al., 2007), and a randomized, controlled trial was conducted for 365 Veterans Affairs (VA) Primary Care (PC) patients whose PHQ-9 scores were 12 or greater (indicating Major Depressive Disorder). Participating VA patients were randomly assigned to either the intervention group whose cohorts received treatment remotely; or to the control group whose patients received traditional on-site psychiatric care for depression. Multivariate analyses results indicated that cohorts in the intervention group had greater adherence to treatment at six months follow-up, as well as at twelve months follow-up. Furthermore, the intervention group cohorts were two times more likely than control patients to respond to treatment by six months, and they were 2.4 times more likely to have reached remission by twelve months (Fortney, et al., 2007), (Table 1).

A 16-week randomized, controlled trial conducted in 2003-2004 evaluated the efficacy of telephone-based cognitive-behavioral psychotherapy for depression against a strong control consisting of face-to-face therapy, in Multiple Sclerosis patients recruited via Kaiser Permanente of Northern California's database; and via the National Multiple Sclerosis Society (Mohr et al., 2005). The study was employed for 127 patients who met the eligibility criteria. Improvements in major depressive disorder frequency were statistically significantly higher for the telephone-based cognitive-behavioral therapy treatment group over the control group; the treatment group also had significantly better scores than the control group on the Depression Rating Scale, and on the Positive Affect Scale (Mohr et al., 2005) (Table 1).

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Table 1. Results of various outcome measures for patients who were treated with either telepsychiatry or face-to-face psychiatry

Finding #1 - McCusker, et al., 2013	
Design • Open, uncontrolled trial study • Family Practices in Montreal, Canada • Eligible patients with Depression, age ≥ 40 • n=53	**Intervention/Measure** Telephone Therapy delivered by Psychiatric Nurses in conjunction with Behavioral Self-care Media Toolkit PHQ-9 Scores at Baseline and 6-month follow-up
Finding Clinical Significance Measures on change at 6-month follow-up over Baseline for PHQ-9 Measures: 57% of the Patients showed decline in PHQ-9 Scores ≥ 50% (i.e., Improvement)	
Finding #2 - Detweiler, et al., 2011	
Design • Open, uncontrolled trial study – 12 months (2008) • VA Medical Center in Salem, Virginia and Fort Bragg Healthcare Clinic • Soldiers being treated for combat-related mental health problems • (n=120)	**Intervention/Measure** Interdisciplinary telepsychiatry service for all soldiers in the study Daily functioning measured via Global Assessment of Function (GAF) score GAF measured at baseline and 12 months
Finding Statistically significant increase in GAF from 58.0 at baseline to 62.3 at final visit ($p < 0.001$)	
Finding #3 - Montes, et al., 2010	
Design • Randomized, controlled trial study – 16-week trial • Schizophrenic outpatients at 198 community health centers across Spain who were clinically stable and being treated with a single, oral antipsychotic medication (n=960)	**Intervention/Measure** Intervention group received telepsychiatric nursing care remotely Control group received routine face-to-face psychiatric nursing care Evaluation of treatment adherence compared for both groups at baseline, every 30 days, and at week 16
Finding No significant difference between intervention group and control group at baseline (88.2% and 90.0%, respectively) Significant improvement in treatment adherence from baseline through week 16 for intervention group (88.2% to 96.7%, p=.007); but not for control group (90.0% to 91.1%) Progressive increase in adherence over time for intervention group: Month 1 = 92.2% Month 2 = 94.3% Month 3 = 95.7% Month 4 = 96.7	
Finding #4 - Mucic, 2008	
Design • Satisfaction survey • Mental health services patients in Denmark and Sweden who participated in an international telepsychiatry service from May 2006 – October 2007 • (n=23)	**Intervention/Measure** Survey questionnaire measured patients' level of acceptability and satisfaction regarding telepsychiatry Each patient answered eight questions at the end of the 18-month study Questions were designed to measure a patient's perceptions of usefulness, comfort level, achievement of treatment goals, and satisfaction with quality of care related to the telepsychiatry treatment received (see Table 2)
Finding 87% of the patients reported willingness to recommend telepsychiatry to a friend Only four percent of patients reported feeling uncomfortable after received care via Televised methods When asked if patients received enough information about telepsychiatry: 83% said yes in high degree; 17% said yes in some degree 83% reported achieved treatment goals via telepsychiatry in high degree; 17% reported achieved goals to some degree	

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Table 1. Continued

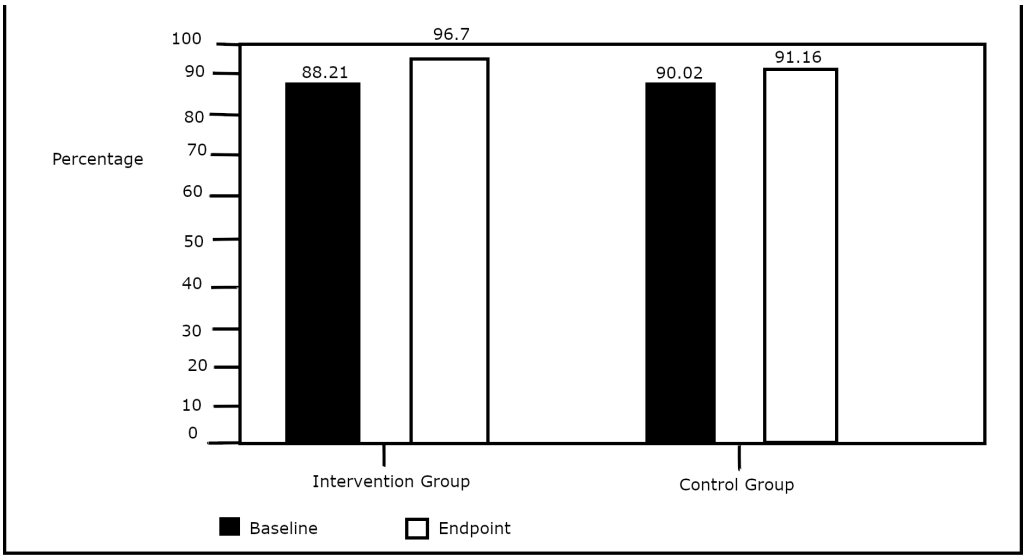
Finding #5 - O'Reilly, et al., 2007	
Design • Randomized controlled trial study – four months (2007) • Patients at the Thunder Bay Regional Hospital in Ontario, Canada, who had been referred by their PC physician for psychiatric consultation • Only included patients with baseline BSI scores that fell into dysfunctional range • Intervention group n=138 • Control group n = 148	**Intervention/Measure** Intervention group: patients received telepsychiatric consultation and follow-up via Polycom 512 View Station and large screen monitor Control group: patients received face-to-face psychiatric consultation and follow-up GSI and MH scores collected at both baseline and four-month follow-up CSQ measure collected at four-month follow-up
Finding No significant difference was found between intervention group and control group on change from baseline to four-month follow-up for either GSI or MH measures* No significant difference was found between intervention group and control group on CSQ measures at four month follow-up* *See Table 3	
Finding #6 - Fortney, et al., 2007	
Design • Randomized, controlled trial study • Arkansas VA Primary Care patients with Major Depression (PHQ-9 Score ≥ 12) • Telemedicine-based care model developed for small VA clinics in Arkansas that lack onsite psychiatrists • Intervention group (n=177) • Control group (n=218)	**Intervention/Measure** Intervention group cohorts received treatment via offsite telepsychiatry Control group cohorts received traditional onsite psychiatric care Multivariate Analysis employed to compare measures on adherence to treatment and Depression Scale scores at 6-month and 12-month follow-ups
Finding Greater adherence to treatment for intervention group than controls at both 6-month follow-up (Odds Ratio [OR]=2.1, p=.04), and12-month follow-up (OR=2.7, p=.01) Intervention cohorts two times more likely than Controls to respond to Treatment (PHQ-9 Score < 12) by 6 months (p=.02) Intervention cohorts 2.4 times more likely than controls to have reached remission by 12 months (p=.02)	
Finding #7 - Mohr, et al., 2005	
Design • Randomized, controlled trial study – 16-week trial • MS Patients with Depression recruited via Kaiser Permanente of Northern California and regional chapters of the National MS Society (n=127)	**Intervention/Measure** Intervention group received telephone-based supportive emotion-centered therapy, 16 weeks Control group received traditional face-to-face supportive emotion-centered Therapy, 16 weeks Both groups measured on Depression Rating Scale and Positive Affect Scale
Finding Intervention group had statistically significant improvement over controls for: (1) frequency of major depressive disorder (p=.02) (2) Depression Rating Scale (p=.02) (3) Positive Affect Scale (p=.008)	

A four-month, randomized, controlled trial study conducted at 198 community health centers in Spain from October 2006 to November 2007 examined the efficacy of a telephone-based psychiatric nursing strategy for increasing adherence to antipsychotic medication treatments among schizophrenic clients (Montes, Maurino, Diez & Saiz-Ruiz, 2010). Outpatients at the participating community mental health centers who met the eligibility criteria: patients who had a Diagnostic and Statistics Manual of Mental Disorders, Fourth Revision-specified Schizophrenia diagnosis and were 18 years of age or older, were deemed to be clinically stable, and were being treated with a single, oral antipsychotic medication were recruited to participate. The participants were randomly assigned to either the intervention group who

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received telepsychiatric nursing care remotely, or to the control group which received routine face-to-face psychiatric nursing care. Intervention group patients were contacted by a psychiatric nurse via telephone; the patients received standardized treatment instructions and information regarding the treatment, and were assessed about knowledge of their medication regimen, missed doses and incomplete adherence. Baseline and week 16 evaluations of both experimental groups by a psychiatrist revealed that although there had been no notable difference in adherence between the intervention and control groups at baseline (88.2% and 90.0%, respectively), by the completion of the study, there was significant improvement in treatment adherence from baseline through week 16 for the intervention group (88.2 to 96.7%); but not for the control group (Figure 2).

Figure 2. Change in the percentage of patients who were considered adherent to treatment over baseline between the intervention group and the control group



* **Change from baseline to endpoint was statistically significantt for intervention group only**

In addition, there was a progressive increase in adherence over time for the intervention group after each telephone session: 92.2% at month 1, 94.3% at month 3, 95.7% at month 3, and 96.7% at month 4 (Montes, et al., 2010), (Table 1).

An open, uncontrolled trial study conducted in 2008 employed an interdisciplinary telepsychiatry service which connected the Veterans Affairs (VA) Medical Center in Salem, Virginia and a health care clinic at Fort Bragg army base, in order to better manage soldiers being treated for combat-related mental health problems (Detweiler, et al., 2011). The study investigated the efficacy of the telepsychiatry services for a group of 120 soldiers during the first 12 months of the service's operations. Overall improvement in daily functioning was assessed using the mean global assessment of function score, demonstrating a significant increase from 58.0 at baseline to 62.3 at the final visit (Detweiler, et al., 2011), (Table 1).

A satisfaction survey was conducted with mental health services patients in Denmark and Sweden who participated in an international telepsychiatry service over an 18-month period beginning in May 2006 and extending through October 2007, to measure the patients' level of acceptability and satisfac-

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tion regarding telepsychiatry (Mucic, 2008). The patients who participated were given a questionnaire at the end of the 18-month study with eight questions designed to measure patients' perceptions of the usefulness, comfort level, achievement of treatment goals, and satisfaction with the quality of care related to the telepsychiatry treatment they received (Table 2).

The results in Table 2 summarize the responses for the 23 patients who completed the survey; in general, patients expressed a relatively high degree of acceptance and overall satisfaction with the telepsychiatry treatments. Only four percent of the patients reported feeling uncomfortable receiving care via televised methods. Furthermore, most of the patients (87%) reported that they would recommend telepsychiatry to others (Mucic, 2008), (Table 1).

Table 2. Telepsychiatry acceptability and satisfaction questionnaire results

	Respondents (n)	**Yes, in High Degree (%)**	**Yes, in Some Degree (%)**	**No, Only in Less Degree (%)**	**No, Not at All (%)**	**Don't Know (%)**
Did you get enough information about telepsychiatry?	23	83	17	-	-	-
Do you perceive 'contact via TV' as uncomfortable?	23	4	4	22	70	-
Did you feel safe under telepsychiatry contact?	23	78	22	-	-	-
Were you satisfied with the sound quality?	23	96	4	-	-	-
Were you satisfied with the picture quality?	23	87	13	-	-	-
Did you achieve your goal via telepsychiatry/could you express everything you wanted?	23	83	17	-	-	-
Would you recommend telepsychiatry to others?	23	87	13	-	-	-
Would you prefer contact via a translator in the future?	22	5	18	-	77	-

Source: Mucic. (2008).

A randomized controlled trial at the Thunder Bay Regional Hospital in Ontario, Canada (2007), investigated the effectiveness of telepsychiatry versus face-to-face psychiatry on patients who had been referred by their PC physician for psychiatric consultation. Outcome measures included the Global Severity Index (GSI) subscale of the Brief Symptom Inventory (BSI), the Mental Health (MH) subscale of the 36-item Medical Outcomes Study Short Form, and the Client Satisfaction Questionnaire (CSQ), (O'Reilly, et al., 2007). Only those patients with baseline BSI scores that fell within the dysfunctional range were included, and randomly assigned to either the telepsychiatry group or the face-to-face group. Psychiatrists and patients in the telepsychiatry group interacted via a Polycom 512 View Station and a Sony Trinitron large screen monitor. For the face-to-face group, the psychiatrists were flown to the Thunder Bay Hospital and provided in-person care. Psychiatrists in each condition of the study (telepsychiatry versus face-to-face) were assigned an equal number of patients and provided psychiatric consultation and short-term follow-up to the patients. GSI, MH and CSQ outcome measures for patients in both groups are summarized in Table 3.

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Table 3. Follow-up results on outcome measures – GSI, MH and CSQ – for patients referred for psychiatric consultation: Telepsychiatry versus face-to-face

Measure	Baseline Score		Four-Month Score	
	Mean	SD	Mean	SD
GSI[a]				
Face to face (N=148)	56.5	10.1	49.7	13.3
Telepsychiatry (N=138)	56.9	10.2	49.7	12.6
MH[b]				
Face to face (N=148)	24.0	12.4	30.9	15.7
Telepsychiatry (N=138)	23.8	12.0	31.7	14.2
CSQ[c]				
Face to face (N=129)	-	-	23.0	5.7
Telepsychiatry (N=125)	-	-	22.7	6.0

[a]Global Severity Index of the Brief Symptom Inventory. Possible scores range from 30 to 80, with higher scores indicating more distress.
[b]Mental health subscale of the 36-item Medical Outcomes Study Short Form. Possible scores range from 0 to 100, with higher scores indicating higher functioning.
[c]Client Satisfaction Questionnaire. Possible scores range from 8 to 32, with higher scores indicating higher satisfaction.
Source: O'Reilly et al. (2007).

The results showed no significant difference between the telepsychiatry group and face-to-face group for GSI and MH scores at both baseline and four-month follow-up. In addition, the mean CSQ measure collected at four-month follow-up did not differ significantly for the two groups. The results suggested that psychiatric consultation and short-term follow-up provided via telepsychiatry was as effective as that which was provided face-to-face (O'Reilly et al., 2007) (Table 1).

CONCLUSION

Use of Telepsychiatry has shown benefits to patients in a number of patient care contexts and healthcare settings. The study findings cited in this paper suggest that telepsychiatry is at least as effective for delivering psychiatric care as more traditional face-to-face methods; and in some cases telepsychiatry showed greater efficacy in promoting improvements in depression ratings and adherence to treatment than face-to-face psychiatric care. Additionally, telepsychiatry was generally well-received and satisfaction survey scores were high on average. The findings reported by Montes, et al. (2010) suggested that telepsychiatric nursing care delivered to schizophrenic patients who were clinically stable improved treatment adherence. It is possible that in general, mental health patients who are less compliant to treatment that is given face-to-face, due to stigma or feeling uncomfortable when interacting directly with caregivers, might demonstrate increased adherence to treatment when it is delivered remotely via telepsychiatry.

According to García-Lizana & Muñoz-Mayorga (2010), telepsychiatry might provide a reasonable alternative to more traditional, in-person treatment approaches, for situations where arranging face-to-face assessments are impractical or burdensome; however, the authors stated that further study was required to determine whether telepsychiatry can be a suitable replacement for ongoing psychotherapy.

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This statement was echoed by O'Reilly, et al. (2007), in the study cited in this paper which suggested that telepsychiatric consultation and short-term follow-up were as effective as face-to-face methods; but with the caveat that such findings did not imply that other forms of mental health services, such as psychotherapy, would have the same efficacy when provided via telepsychiatry.

The benefits of using telepsychiatry were readily apparent for situations in which patients that lived in remote areas, or had limited access to transportation, were able to access needed mental health services that may have been difficult or impossible to obtain otherwise.

The studies involving telepsychiatry for patients with depression seemed to provide relatively clear outcome measures from standardized depression scales such as PHQ-9, and all but one included more homogeneous samples of patients than studies that used broader inclusion criteria; this helped to reduce the chances for extraneous factors to have affected the outcome measures.

The high percentages of patient acceptability of telepsychiatry services in the study by Mucic (2008) suggested patients felt comfortable interacting with the telemedia, and in general found the telepsychiatric experience to be acceptable, at the least.

The open, uncontrolled trial study by McCusker et al. (2013) could have been improved by inclusion of a control group. Another limitation with this study was related to the selection criteria in which patients had a comorbid condition; it is possible that spurious relationships between the comorbid variables and the intervention may have affected changes in the PHQ-9 follow-up measures and served to confound the relationship between telepsychiatry and changes in depression scale measures.

This literature review had limitations related to the search strategy employed, and researchers' and publication bias might have affected the quality and availability of the research material selected. In addition, the conceptual framework utilized for this study was adapted to telepsychiatry applications and has not been specifically tested with telepsychiatry.

This research is consistent with the past belief that telepsychiatry has been shown to be a safe and effective method for delivering psychiatric care and has the benefit of offering patients that reside in remote areas greater access to mental healthcare providers. In terms of the efficacy as a complete replacement or alternative, the study findings cited in this paper suggest that telepsychiatry is at least as effective for delivering psychiatric care as more traditional face-to-face methods. There were some areas of telepsychiatry, such as promoting improvement in depression patients and adherence to treatment, which showed greater efficacy than face-to-face psychiatric care. Further research is necessary to study the use of interactive technology through controlled experiments. This research will be useful for gathering additional evidence for the benefits associated with telepsychiatric approaches to mental healthcare.

Future Telepsychiatry Research

Existing evidence that telepsychiatry can vastly increase the provision of needed behavioral healthcare services to patients with limited access should be supplemented with new evidence. Future studies should include more controlled experimental trials with diagnosis-specific groups, and double-blind designs to increase the likelihood that the study is valid; and should include telepsychiatric methods which go beyond telephone-based and videoconferencing systems, such as those which are EHR-linked, or incorporate interactive computer simulations such as 3-D virtual worlds.

According to Gorini, Gaggioli, Vigna & Riva (2008), 3-D virtual worlds function as three-dimensional social networks which provide novel means for developing social skills, socializing, and interacting with others via realistic, 3-D animated avatars. The potential for interactive health networks, virtual patient

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support groups, and a host of other interactive patient services are practically limitless. Therefore, research projects which center on telepsychiatric services that incorporate such virtual worlds are warranted and should be highly encouraged.

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Chapter 24
Social Media for Mental Health Initiatives

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ABSTRACT

Social media has added a new dynamic for those living with mental illness. There are several benefits to using social media to obtain information and support for mental health issues, but there are also new challenges and drawbacks. This chapter explores social media for mental health initiatives, with a focus on two case studies: Facebook's suicide prevention tools and the Bell Let's Talk campaign. These case studies highlight the unique ways that social media can be harnessed to raise awareness and provide support and resources to vulnerable populations, while also providing insights into the challenges of utilizing these platforms.

INTRODUCTION

The proliferation of social media platforms has inevitably had an impact on online help seeking for mental health issues. Asynchronous message boards have been used since the early days of the Internet for mental health support and information seeking, but social media platforms have added a new dynamic. On the one hand, these platforms can be heralded as welcome ways to break down the barriers for those seeking help in several ways due to the accessibility, convenience, and geographical reach of these platforms. Some social media sites also offer user anonymity, which can potentially alleviate some of the fears around stigma. On the other hand, however, there are several problematic aspects to using social media platforms for mental health initiatives, including the potential for trolling, bullying and other negative interactions, and the potential for online communication to increase isolation through minimizing face-to-face social interactions. There are increasing concerns that use of social media may in fact be *contributing* to mental illness, especially among vulnerable youth.

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In light of these challenges, several social media platforms have initiated mental health initiatives for users. Other organizations have decided to harness the power of social media to increase awareness and dialogue on mental illness. In this chapter, the evolution of some of these initiatives is discussed, with a particular focus on Facebook's suicide prevention efforts and the Bell Let's Talk campaign. In the summer of 2016, Facebook made its updated suicide prevention tools available globally. Users of the platform can flag posts from friends if they are worried about the potential for self-harm and several options then appear in a drop down menu (including a list of resources, sending a message of support or having the post reviewed by someone at Facebook who can then reach out with helpful information). This initiative and some of the responses to it are examined in this chapter.

The Bell Let's Talk campaign is also explored. This campaign has generated a massive amount of support in Canada each January through the use of social media platforms (and in particular hash tags) to open up the dialogue on mental health (and ultimately raise money for mental health programs with each social media share or post using the #BellLetsTalk hashtag). These two particular case studies provide insights into the involvement of social media in mental health initiatives, both the positive aspects and the criticisms arising from them. The chapter concludes with a look ahead to what is needed and how there may be a continuing evolution in how these platforms are utilized for mental health initiatives.

USE OF SOCIAL MEDIA FOR MENTAL HEALTH INITIATIVES

While social media adds new dynamics and possibilities for mental health initiatives, the use of the Internet has long had strong appeal to people with stigmatized illnesses who wish to obtain information or assistance (Klein & Wilson, 2002; Berger, Wagner & Baker, 2005). Some forms of stigma can be avoided through anonymously seeking information online about mental illness. There are social media sites that build on this appeal by allowing created identities if the user desires (including Twitter, Instagram and Reddit) while others seek to remove anonymity (including Facebook, where users are strongly encouraged to use real names and have friends and family attached to their account who can see their posts and Facebook-related affiliations).

Now not only are those living with mental illness using social media to obtain information and support, but health care providers are also turning to these platforms. Most major mental health organizations have some form of presence on social media and use these platforms for outreach. Research into how social media can be utilized by health practitioners and organizations is also gaining in popularity. The National Institutes of Health in the U.S. has awarded several million dollars in research funding to explore using social media to advance prevention and treatment of addiction (National Institutes of Health, 2014). This builds on previous research in this area, such as that from a team of Microsoft researchers who explored how social media posts could be used to detect depression in users. De Choudhury, Gamon, Counts and Horvitz (2013) found that social media posts made by Twitter users in their study contained useful information to identify the onset of major depression—opening the possibility for the development of tools for use by healthcare agencies or individuals. Their study indicated that volunteers with moderate to severe depression were more likely to post negative messages, were less socially active on Twitter and were more concerned with health and relationships.[1]

There are some clear benefits to using social media for mental health initiatives. According to the Pew Research Centre (2017), 77% of adults in the U.S. own smartphones (for adults under age 49 this percentage is much higher). This means many people have smartphones on them at all times, allowing

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them to access social media platforms at all times of the day. Seeking support and information through these online platforms does not limit one to conventional business hours, meaning that support and information is accessible when conventional resources are not available. The ubiquitous nature of smartphones with access to social media platforms also means that the geographic reach of mental health initiatives can be expanded to remote and underserved communities.

As noted above, much research has found that online resources are particularly attractive for individuals with stigmatized identities, as help-seeking and socialization in face-to-face situations are associated with high levels of stress for members of such groups (Parr, 2008). Many social media platforms allow for stigmatized individuals to seek help in an anonymous fashion without face-to-face interactions. The use of social media in mental health initiatives can also be viewed as empowering. Social geographer Hester Parr believes that envisioning a person living with serious mental health problems "as technically proficient, intimately networked, emotionally nuanced and socially competent challenges stigmatizing conceptualizations of the damaged, alienated and pathologized patient-subject" (2008, p. 159). Social media also allow for a unique peer-to-peer sharing that can offer those living with mental illness a sense of comradery that cannot often be found in a practitioner-patient setting. A study conducted by Hughes and Cohen (2011) indicated that those with lived experiences offer meaningful information to people with similar conditions through online forums. This sense of community can be an important aspect for those who turn to social media for information and support.

There are, of course, challenges with these open and fluid discussion-based platforms on social media. Since the early days of the internet, problems with open communities where anyone can join and comment existed. For instance Sandy Stone (1999) documents the rise and subsequent demise of CommuniTree in the early days of Internet-based discussion forums in her work *The War and Desire of Technology at the End of the Mechanical Age.* She discusses the hard lessons about what was and what was not possible in an unstructured and unprotected conferencing environment, painfully learned through direct experience with the "system bashers" (p. 117). Similar problems still exist today and have even multiplied with the advent of Web 2.0. What we would now call trolling is a major problem for those seeking support online who participate in open groups or ones linked to social media like Facebook that do not allow for more anonymous forms of online existence. There has been increasing media attention to cases surrounding cyber-bulling and suicides, as well as the fears provoked by tragic cases such as that of Nadia Kajouji, the Canadian university student who was encouraged to kill herself in 2008 by a man in an online discussion group posing as a fellow suicidal female. These are ongoing challenges for social media platforms offering mental health support: usually anyone can participate and potentially make the situation worse.

The Samaritans, a well-known British suicide prevention group, introduced an app in 2014 that alerted users whenever someone they followed on Twitter posted troubling phrases that could indicate a potential risk for suicide—only to quickly disable the app a week later when it became evident that this data could easily be used to prey on vulnerable people. The app gave no notification to those being monitored and while there was potential for people to intervene when it appeared someone was in distress based on their Twitter posts, that also meant there was potential for vulnerable people to be identified and targeted. Using social media posts to diagnose depression or identify suicidal individuals is fraught with danger. As Munmun De Choudhury, a former member of the Microsoft team studying depression, points out, "we have to think very carefully about who gets access to these tools and what the boundaries are for technology used to make judgements about individuals" (as quoted in Singer, 2014, para. 29). The Samaritans app led to public outcry over their assumption that anyone and everyone

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had the appropriate training and expertise to monitor social media accounts using these experimental algorithms that ultimately labelled Twitter users. There were also concerns over who had access to this information and how it could potentially be used against someone by employers or even insurance companies. This case indicated the great need for much more research on monitoring social media for intervention opportunities. The fear of being labelled by one of these algorithm-based tools is part of the larger concern around stigma and identity online when it comes to mental illness. In a Canadian study, researchers found youth interviewed about using social media to seek mental health information worried about being judged and discussed the connections between social media, bullying and stigma (Rasmussen-Pennington, Richardson, Garinger & Contursi, 2013). For these reasons, the youth in the study preferred *not* to use social media to access mental health information.

In addition to these drawbacks and concerns, there are those who question the helpfulness of social media all together and some even blame these platforms for increasing mental health issues, especially involving vulnerable young people. Technology critic Sherry Turkle (2011) laments how technological devices such as smartphones have ultimately resulted in us being "alone together" - shutting out the people right in front of us in favour of staring at a screen, where "the performance of connection seems connection enough" (p. 9). Pantic, Damjanovic, Todorovic et al. (2012) found in their study of high school students that there was a statistically significant correlation between symptoms of depression and the amount of time spent on social networking sites. Other research has indicated that some social media pose risks for potential addictive behaviour (La Barbera, La Paglia & Valsavoia, 2009; Kuss & Griffiths, 2011) or can have a negative impact on self-esteem (Mehdizadeh, 2010). While these type of studies are often picked up by media to "sound the alarm" over social media use by youth, it must be noted that there are conflicting studies and some research has actually indicated that use of Facebook can enhance self-esteem (Gonzales & Hancock, 2011) and that online communication with friends and family through social media sites is associated with a decline in depression (Bessiere, Pressman, Kiesler & Kraut, 2010). These studies do not offer conclusive evidence one way or the other, leaving the impact of social media on mental health a topic of much debate.

SUICIDE PREVENTION MEASURES ON FACEBOOK

Several social media platforms have launched their own built-in mental health initiatives to assist users. Facebook's suicide prevention initiatives are explored here, but Facebook is not the only platform to launch this type of program. The popular photo sharing platform Instagram launched a new tool in 2016 to alert them to users who may be in distress. Once a user has flagged a post for showing signs of possible self-harm or depression, Instagram then sends a message to that person with resources to offer support. They also have banned some hashtags that promote self-harm or eating disorders, and searching for other concerning hashtags will automatically bring users to a support page. The microblogging site Tumblr launched an initiative in 2015 called Post it Forward to encourage users to share their stories of bullying, mental illness and other similar issues and to post messages of kindness and encouragement in a variety of media formats. The goal of the project is to reduce stigma and encourage a positive and supportive online environment. Programs like these show that it is not just researchers and mental health organizations that are turning to these platforms, but the platforms themselves that realize they can play an important role in promoting mental health initiatives. It should be noted that while these initiatives are

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undertaken by private companies, they often work in partnership with government-funded organizations and charities that provide services and resources (such as Facebook's partnerships discussed below).

Facebook is one of the largest and most well-known social networks, with more than 1.23 billion daily active users worldwide as of December 2016 (Facebook Newsroom, 2017). While there are numerous studies that examine the potential imitative effect of reports of suicide in traditional media,[2] the effects of suicide notes posted to online platforms like Facebook on predisposed individuals have not been studied in any depth. As Ruder *et al*. (2011) point out, suicide notes posted to Facebook are instantly available to a large number of individuals, quite different from traditional suicide notes. This instant access by a variety of people provides opportunity for Facebook users to intervene directly or seek help from emergency services. There have been cases of individuals posting their intent to attempt suicide on Facebook as a status update, which has then prompted friends or family to take action after seeing such a post online (with some able to successfully intervene, while others were sadly too late). Examples include: a 28-year-old man in Switzerland posted his intent and the location where he planned to jump to his death but unfortunately after notifying the police his friend arrived at the location too late (Ruder et al., 2011); in Israel a police search located a 44-year-old man injured but still alive after a suicide note he posted on Facebook the day prior alerted friends (Levy-Stein, 2009); a former contestant on the television show American Idol posted what appeared to be a suicide note to Facebook, spurring his family and friends to contact the authorities, track him down and have him evaluated at a nearby hospital (Dunkerley, 2014). These examples indicate that there are cases of Facebook users actively seeking to intervene in suicide attempts of other users.

In 2011, Facebook began their partnership with the National Suicide Prevention Lifeline and the Substance Abuse and Mental Health Services Administration. This marked the first time that users who saw a suicidal comment by a friend could report this to Facebook. In March 2016, Facebook announced an update to their suicide prevention tools, including streamlined reporting, integrated suicide prevention tools to help people in real time on Facebook Live (the platform's live video streaming service), and perhaps most importantly, live chat support from crisis support professionals through Facebook's Messenger (the platform's direct messaging and live chat service). Facebook reviews content reported them and prioritizes reports of suicide. Once a post is reported as a potential suicidal statement, Facebook then sends a message to the user encouraging them to call the National Suicide Prevention Lifeline or to join a confidential online chat session with a crisis worker. The site offers "pre-populated text messages to make it easier for people to start a conversation" (Callison-Burch, Guadagno & Davis, 2016) when trying to reach out to a friend. Users of Facebook Messenger have the option to message with a crisis support worker directly through the Messenger app. The organizations partnering with Facebook to offer this service include the National Suicide Prevention Lifeline, the National Eating Disorder Association and the Crisis Text Line. Users watching live videos on Facebook Live can reach out to someone directly who they believe is in distress or the video can be reported to Facebook. The person sharing the video that was reported will then see a set of resources on their screen: choose to reach out to a friend, contact a help line, or see tips. All of these measures may potentially reach a suicidal individual and encourage them to seek help right away.

Facebook has also now started to pilot the use of artificial intelligence to identify posts that likely include thoughts of suicide. For now this is only limited to the U.S. Once a post has been identified by the algorithm, the Community Operations team then reviews these posts and determines whether to provide resources to the person who posted the content. As mentioned earlier, algorithms that identify suicidal or depressed individuals are fraught with ethical issues. First, they are in their infancy and require a great

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deal more research and testing. Second, who may have access to the data gleaned by these algorithms is controversial—information that someone may have a psychiatric disorder or be suicidal can have negative consequences for employment, housing opportunities and international travel, among other aspects. Privacy protection of this data is important and having potential information about someone's mental health (whether assumed or accurate) in the hands of a for-profit company raises concern. While suicide prevention is an important goal, the ethical layers must be carefully considered with all technology-based interventions, including these updated tools available through Facebook.

BELL LET'S TALK

Perhaps one of the most common uses of social media in relation to mental health initiatives is for raising awareness. The large reach instantly available through social networking sites make them very attractive tools for stigma reduction campaigns and encouraging greater understanding of mental illness. Using social media for these campaigns bypasses an initial reliance on traditional media because news outlets usually only pick up on the content once it has already achieved a large and widespread audience. Whether through viral videos shared on YouTube or hashtags that quickly trend on Twitter (such as #StopTheStigma and #WhatYouDontSee), there are a variety of ways to use social media to increase awareness and dialogue on mental illness. The Bell Let's Talk campaign is perhaps one of the largest and most successful of the campaigns utilizing social media for this aim.

Bell Media is part of the massive Bell Canada Enterprises (BCE) media conglomerate. The company spans both media content (owning radio stations, television stations and web sites) and media distribution (providing wireless, cable, internet and home phone services). In 2010, Bell launched the Let's Talk Campaign with the purpose of opening up the national dialogue on mental health and to generate funding for mental health programs. Social media is a key component of the campaign, with the idea being that through online social networks, individuals have the power to spread a message that can potentially change minds. It also allows those living with mental illness a chance to share their own experiences. The biggest component of the campaign is a dedicated day each year in January—the Bell Let's Talk day. During this 24-hour period, Bell pledges to put 5 cents towards mental health initiatives for every call or text made on their network by Bell subscribers, as well every time a post is made on Twitter and Instagram using the #BellLetsTalk hashtag, anytime a Snapchat user sends a snap using the Bell Let's Talk geofilter, and anytime a Facebook user watches one of the Bell Let's Talk videos.

There has been a steady increase in the number of interactions on Bell Let's Talk day each year since the campaign began. Starting with 66,079,236 interactions in 2011, the campaign grew to 131,705,010 interactions in 2017 (Bell Canada, 2017). The campaign features a variety of celebrity ambassadors and has received support through the social media accounts of notable people, including the Prime Minister of Canada, pop star Justin Bieber, comedian Ellen DeGeneres and actor William Shatner, as well as dozens of other celebrities, professional athletes and Canadian politicians. As of 2017, the campaign has generated 729,065,654 interactions, raising over $86 million for mental health initiatives (Bell Canada, 2017).

There is no doubt that the Bell Let's Talk Day is an incredibly successful social media campaign and the need to talk openly about mental health problems is a message that has been spread wide and far. Not only does the campaign aim to open up dialogue and reduce stigma, but the tangible effect of raising money for actual programs makes this a very popular initiative for millions of people to get involved in. With the ease of simply retweeting or using a hashtag, social media users can participate and

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contribute. Going beyond awareness and emphasizing the importance of community support programs for those living with mental illness allows the campaign to escape much of the criticism of other initiatives dubbed "slackivism", whereby social media users do very little to actually contribute to concrete solutions. Social media allows for new forms of dialogue on mental health and the Bell Let's Talk Day perfectly harnesses the power of this medium.

However, this does not mean it is completely free of criticism. Each year, there are those who use the day to disparage the company behind this campaign and highlight some of the problematic aspects of this campaign. When a massive telecommunications company is behind a campaign that encourages people to use their telecommunication devices to participate, it justifiably raises some suspicions. It must be noted that the campaign and its corresponding hashtags and social media mentions are not generic—it is not "Let's Talk" but instead "*Bell* Let's Talk". The company's name is uttered in every single tweet and share. This is no doubt a massive marketing campaign, not just a campaign for mental health. Perhaps this is one of the more intriguing aspects of this campaign, as it not only raises awareness and money, but it also gets the company's name out there and attaches goodwill to their name. As the employee who oversees the Bell Let's Talk campaign told *The Globe and Mail*, the campaign has "also helped people see Bell in different, more positive light and made them think about giving Bell a second chance" (as quoted in Ladurantaye & Krashinsky Robertson, 2013, para. 5). Whether it be frustrations as a Bell customer or animosity towards the company in the increasingly concentrated Canadian mediascape, these concerns seem to be put aside by many people each year who participate in the campaign. The very tangible element of raising money for mental health programs and research no doubt helps move this beyond a marketing and awareness campaign so that more people want to participate. The hashtag does inevitably get used each year by some who are displeased with the company[3], but the vast majority are genuine interactions and participation with the campaign. As with the Facebook suicide prevention initiative, the Bell Let's Talk campaign involves a private company partnering (or in this case, providing funding) to publicly-funded organizations and programs for those living with mental illness.

LIMITATIONS AND FUTURE RESEARCH

This chapter is by no means a complete look at the current landscape for social media and mental health initiatives. Facebook's suicide prevention tools and the Bell Let's Talk campaign were used as case studies here to highlight some of the issues at stake, but there are certainly many others that warrant research and discussion. Larger studies that look at impacts of these media tools and campaigns are required—the financial outcomes are known for the Bell Let's Talk campaign but potential impacts on stigma reduction are much more difficult to measure and assess. Potential future research projects could involve surveying individuals who have sought mental health treatment and support to find out how they were directed to that service and what role, if any, social media played. While incredibly difficult to navigate both logistically and ethically, it would provide highly interesting and necessary data if individuals who have attempted suicide could also be surveyed to find out what role, if any, social media has played in their lives and whether it resulted in early intervention for suicide attempts. As mentioned earlier, the studies that have been done about the impact of social media on mental health are limited, conflicting and do not offer conclusive evidence that there is necessarily any harm being done or that these tools are beneficial, leaving this a topic of much debate.

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CONCLUSION

The use of social media by those living with mental illness continues to expand, as it offers a new way to connect to seek community, support and information. Naslund, Aschbrenner, Marsch and Bartels (2016) argue that online peer-to-peer connections through social media give individuals living with mental illness a chance to challenge stigma through personal empowerment and providing hope. Individuals can learn from their peers online, provide mutual support and help promote treatment across a wide demographic (Naslund, Aschbrenner, Marsh & Bartels, 2016). Social media also appeals to health practitioners, mental health organizations and researchers. These new forms of communication can help to monitor, identify and treat mental illness, potentially changing how psychiatry is practiced in the future (Peek, 2015). While these encouraging aspects must continue to be harnessed to benefit as many as possible, it is critical that the ethical implications that come along with this use of Web 2.0 are addressed. Privacy and the safety and well-being of everyone involved must be at the forefront of any discussions about how to use social media to benefit mental health initiatives.

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KEY TERMS AND DEFINITIONS

Algorithm: A set of rules or procedures a computer program carries out to complete a task. Each algorithm is a sequence of instructions.

Hashtag: A user-generated method of categorizing content on social media. By placing the # symbol before a keyword or phrase, users categorize their content into easily searchable content areas.

Mental Illness: A range of health conditions that involve thinking, mood and behaviour. Examples include depression, anxiety disorders, addictions, eating disorders and schizophrenia.

Peer-to-Peer: Can refer to decentralized computer networks sharing information between them, or (as in the case of this chapter) people who provide information or support to others with whom they share a common identity. Peer-to-peer information or support is direct between the participants and does not involve outsider experts or authority figures.

Social Media: Web site that allow users to generate content and share with others. Online forms of communication that allow for large-scale sharing, networking and discussion.

Stigma: Negative feelings, beliefs or associations to something. Can be unfair and inaccurate beliefs, but often widely held. Literally means a mark of shame.

Suicide Prevention: Efforts to intervene in the actions of a suicidal person to cease harm or potential death, or to stop suicidal thoughts from being acted upon.

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ENDNOTES

1 When this type of initiative was put into actual practice, there were, however, negative consequences and public outcry (see the discussion of the Samaritans app later in the chapter).

2 See, for example, Phillips 1974, 1979; Barraclough, Shepherd & Jennings, 1977; Berman, 1988; Bollen & Phillips, 1982; Kessler & Stipp, 1984; Gunnell, 1994; Fekete & Schmidtke 1995; Hassan, 1995; Stack 1996, 2002, 2005; Etzersdorfer & Sonneck 1998; Pirkis & Blood 2001; Hawton & Williams, 2002; Pirkis et al., 2002, Gould, Jamieson & Romer 2003; Au, Yip, Chan & Law 2004; and many others.

3 For example, on the day of the January 2017 Bell Let's Talk day, CBC published a damning article about a Bell employee who claimed to have been fired for her mental illness (Weldon, 2017, January 25). Sharing this article using the #BellLetsTalk hashtag showcases some of criticisms launched at the campaign and the company behind it. The year prior, another scathing article was published by a former Bell Media employee who claimed her job with the company was incredibly stressful yet her contract did not grant her access to the employee benefits package to seek mental health support (Ho, 2016). This was also shared using the #BellLetsTalk hashtag.

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Chapter 25
Virtual Reality as a Tool for Mental Health and Conscious Living and Death:
Immersive Contemplative Approaches to Existential Anxieties

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ABSTRACT

In this chapter, the authors look at the possibilities of impact of VR in the mental health and wellness area through the lens of contemplative practices and immersive experiences. The area of existential anxieties is often stigmatized or difficult to address directly. Death is the most transformative journey possible but may not be viewed this way. Immersive experiences designed to encourage and allow for non-dual experiences can support this transition. They are difficult to design since non-dual experiences by their very nature are both deeply personal and yet totally impersonal at the same time. Yet, the authors examine how existential anxieties are the perfect framework for a non-dual experience. The wellness app StarflightVR serves as an explorative tool. We mention a past study in this area, which revealed that it is possible to mitigate depression by addressing anxiety on a daily basis through this immersive contemplative VR experience. The authors build on this study with existential fear mitigation examined through an online workshop experience and StarflightVR.

INTRODUCTION

In this chapter, we first focus on Virtual Reality (VR), and its positive impacts on mental health. It has been shown to have therapeutic benefits, offering a bridge between transpersonal psychology and the latest technology (Carvalho, Freire, & Nardi, 2010; Chirico et al., 2016; Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009; Diers et al., 2015; Freeman et al., 2014; Glantz, Rizzo, & Graap, 2003). VR has been

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shown to improve quality of life (Anderson, Rothbaum, & Hodges, 2001), reduce post-traumatic stress disorder (PTSD) (Cukor et al., 2015), and to be effective as a tool in psychotherapy (Rizzo, 2010). The use of VR to work with anxiety disorders is ideal because of its immersive quality. Immersion can be defined by the ability to get into a different point of view. It has also been defined as taking on another story: "A Zen-like state where your hands just seem to know what to do, and your mind just seems to carry on with the story" (Brown & Cairns, 2004).

Immersion is especially promising if mixed with testing physiological mechanisms of the anxiety response as well. Physiological measures such as heart rate, brain waves changes, respiration rate, and skin conductance in response to a virtual environment can be easily and objectively measured. This in turn contributes to an objective assessment of anxiety and depression (Wilhelm & Roth, 2001).

VR may well prove to be a major mental health tool in the future. Immersive virtual environment technology has already been used in therapy for phobias (Côté & Bouchard, 2008; Wiederhold et al., 2002), stress (Bouchard, Baus, Bernier, & McCreary, 2010, Riva et al., 2006; Villani, Preziosa, & Riva, 2006), anxiety (Harris, Kemmerling, & North, 2002; Repetto & Riva, 2011), exercising (Bryanton et al., 2006), and memory problems (Brooks & Rose, 2003; Klinger, Chemin, Lebreton, & Marié, 2006). Additionally, the effects of VR on anxiety symptoms has been examined. In their study, Gorini et al. (2010) concluded that VR for relaxation represents a promising approach in the treatment of general anxiety disorder (GAD). This is because VR enhances the quality of the relaxation experience through the elicitation of the sense of presence generated within the immersive experiences. Slater et al. (1994) define presence as a psychological sense of being in a virtual environment. This sense of presence is that which supports the quality of the relaxation. These types of studies underline the fact that clinical cases such as GAD can also benefit from the VR treatments.

Over the past few decades, VR has been used successfully in a myriad of psychotherapeutic applications. For example, VR has a long history of use for the treatment of PTSD within exposure therapy (Cukor et al., 2015) which reintroduces the patient to the traumatizing event. VR-based therapies allow the clinician to present compelling and controllable scenarios which can be immediately stopped or de-escalated if patients become too anxious during treatment (Kwon, et al., 2009).

VR is also useful for habit training within behavioral therapy. Iribarren, Prolo, Neagos, and Chiappelli (2005) listed the following evidenced-based psychotherapeutic methods for treatment of PTSD: Cognitive-behavioral psychotherapies (i.e., systematic desensitization, relaxation training, biofeedback, cognitive processing therapy, stress inoculation training, assertiveness training, exposure therapy, combined stress inoculation training and exposure therapy, combined exposure therapy and relaxation training, and cognitive therapy), psychological debriefing, pharmacotherapy, and eye movement desensitization reprocessing therapy (EMDR). According to Iribarren et al., evidence-based practice (EBP) is a clinical approach requiring that decisions about health care be based on the best available, current, valid, and relevant evidence. These practices are a conglomeration of the best available resources in clinical treatment (Dawes et al., 2005).

Conversely, VR is also useful in the mental health arena due to its ability to generate a relaxing experience that stimulates the senses while it integrates with the polyvagal system (Porges, 1995, 2009). Porges is vastly cited in this field for his polyvagal theory. The polyvagal theory proposes that the evolution of the mammalian autonomic nervous system provides the neurophysiological substrates for adaptive behavioral strategies. It further proposes that physiological state limits the range of behavior and psychological experience. This vagal integration therefore, can help to provide a deep sense of relaxation and give patients the ability to build vagal muscle. This in turn facilitates autonomous stress

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regulation. VR is also key in delivering Mindfulness practice. By focusing a person's attention through the immersive qualities of VR, the sense of being there is more easily achieved (Navarro-Haro et al., 2017; Rice & Schroeder, 2017).

Another compelling aspect of VR is that one's visual system's ability to interpret the surrounding environment is duped into accepting the provided visual stimuli as real. This leads to repercussions in the body, and therefore in one's psychophysiology as well. The viewer reacts as if this is happening here and now. This psychophysiological connection is important for the mental health field because it is the basis for permanent behavior change. Antonio Damasio (1996), scientist, researcher, and expert in neuroscience, proposed the somatic marker hypothesis which describes the capacity of the ventral medial prefrontal cortex and the amygdala to monitor the body's past and hypothetical responses through somatic markers. These markers are located in the brainstem and the VS/nucleus accumbens (reward center) for the involuntary system and the higher cortex for the voluntary system. Both systems are a part of the upward and downward loops within the body to and from the brain. According to Damasio (2010), "the brain's protoself structures are not merely about the body. They are literally and inextricably attached to the body. They are resonant loops that connect back to the brain and then back to the body. A body brain bond." (pp. 470-473). If these loops are broken, such as with PTSD or chronic anxiety, then the person will not be able to integrate the exterior information properly. However, equally important, if these bonds are reconnected permanent behavior change becomes possible. In other words, exposure therapy is effective because the VR environment exposes the whole person to an event, which they can then process and integrate psychophysiologically.

If continuously exposed to in small doses, VR can help to shift one's whole countenance, approach to life, and provide a platform for transformation in their lives (Weyers-Lucci, 2016). VR has been used for healing in other ways as well. VR in combination with EEG technology has been shown to heal certain neural imbalances such as stroke, aging, and autism. Studies that employed brain-computer interface (BCI) technologies and VR included using this interface for rehabilitating stroke (Lechner et al., 2014), the motor-imagery BCI for stroke rehabilitation (I Badia et al., 2013) and paraplegic patients (Donati et al., 2016), and the use of BCI for training normal aging subjects (de Tommaso et al., 2016) as well as those subjects with autism disorder (Amaral et al., 2017) and attention deficit hyperactivity disorder (Rohani & Puthusserypady, 2015). Additionally, VR has shown a capacity to reengage and/or build multiple cortical functions (Baumann et al., 2003; Carrieri et al., 2016; Lin et al., 2008; Schedlbauer et al., 2014) and showed a capacity to optimize the coding efficiency of the sensory cortex (Ansuini et al., 2006; Keller et al., 2012; Ravassard et al., 2013; Schindler & Bartels, 2013; Sofroniew et al., 2015).

Currently there is a need for more research focused on the therapeutic process within VR and not purely on its effectiveness. Maples-Keller, Bunnell, Kim, and Rothbaum (2017) proposed investigating factors such as emotion processing, psychophysiological markers during exposure, and the therapeutic alliance. Their view is that research testing hypothesized mediators and moderators of VR-based treatment will prove informative in the future. This ongoing research study will be focusing on this need.

Working with VR enables mental health practitioners and researchers to create the environment necessary for an immersive, whole body experience that could mimic the state of these feelings of knowing (FOK), a type of metacognition coined by Damasio in his neurocognitive approach of whole body sensing (2010). An example of whole body experience of the feelings of knowing could be a Gestalt or a felt sense (Oleary, 2013; Gendlin, 1992, 1994). This is another aspect that makes VR uniquely suited for working with existential fears.

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STARFLIGHTVR AS A NEUROAESTHETIC/ NEUROPHENOMENOLOGICAL TRANSPERSONAL EXPERIENCE OF DEATH/LIFE

StarflightVR is a mobile VR experience set up to engage a whole body experience of a contemplative, non-dual state of death/life. It was designed using hypnotherapeutic principles focused on dehypnotization (Casey, 1987 and Elias, 2006) and neuroaesthetic principles of the integrative and meaning making power of art (Pelowski, et al., 2017). It is an immersive experience that is visually and auditory-based and is meant to give the illusion of letting go into the unknown, very much like it would be to let go into an entirely different state such as a nondual experience, or an experience resembling a near death experience (NDE) like a mindfulness-induced NDE (van Gordon et al., 2018). It is used in this study as one of the immersive experiences.

StarflightVR is also based on the "perceptual illusion of non-mediation" (Lombard and Ditton 1997), which proposes that the illusion becomes reality for the user. In this case, it is the disappearance of the body that actually reinforces the feeling of being fully present in the moment within oneself. Therefore, while experiencing letting go into this environment, flying and without a physical body it becomes possible to experience a state similar to a non-dual state, a meditative state, an egoless experience, or a near-death experience (NDE).

This hypnagogic-based design of a space also impacts emotions according to aesthetic perception, which has been shown to activate the bilateral insula which we attribute to the experience of emotion (Cupchik, 2016). In this case the emotions are soothed, and the ability to observe their fluctuations is supported.

Tracking the movement of the eyes is optional in the experience but could be used to track a participant's focus, whether open or closed focus (based on mindfulness meditation principles). This has a direct effect on brain integration. Deliberate eye movements in therapy have been demonstrated to induce a state of relaxation, or decreased psychophysiological arousal (Shapiro, 2014). One hypothesis is that this relaxation response is a reaction to changes in the environment, part of an orienting response that is elicited by the shifts of attention caused by the repeated bilateral stimulation, which links into processes similar to what occurs during R.E.M. sleep (Shapiro, 2014).

Within the StarflightVR experience there are five chapters or function: sleep, energize, guided meditation, story, and experiences. The sleep experience will be used for the current ongoing research study.

The sleep experience itself can be described as follows: The cadence and design of the star field and the accompanying audio track helps bring the user into a state of flow and calm. The background at first appears to be static and the user is encouraged to observe this with a non-critical mind. It evolves in both color and pattern first into a green and golden background, as if one is in the center of the galaxy, and then gradually, through a color progression, into a calming violet field.

These immersive visuals are able to provide a safe environment to experience a shift of state. The visual and auditory experience can become a whole body experience:

When we relax into our senses, and into our body sensations we are able to access the full picture of the situation at hand. From a neural perspective this means that we are using our lamina1 nerve information from the body and integrating that in various ways into the brain. (Siegel, 2012. p. 172)

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Users can open their focus to the field and or choose to follow an object as it glides by. Alternatively, they can observe the quasars with their peripheral vision as those appear and become absorbed into black holes.

Virtual Reality allows for a 360º experience, and therefore allows full peripheral vision to help attenuate existential anxieties. The use of peripheral vision has been shown to be an excellent method for shifting from the awake, aware state into calmness and quiet (Lachenmayr, 2006).

StarflightVR's audio track is designed to resonate with a heartbeat at rest, giving hypnotic cues to settle the sympathetic nervous system (Elias, 2006). It helps shift the brain, and therefore the psychophysiology, into the alpha, alpha/theta state of deep, restful relaxation helping to encourage and enhances the sleep experience (Weyers-Lucci, 2016). This technique induces the breathing to automatically synchronize with the visual and audio flow.

The Greater Good Center in Berkeley completed a recent study on awe and its benefits to human health (Keltner, 2003). The practice of noticing moments of awe is in itself an amazing healing therapy for inflammation, and other stress-related diseases. The momentary experiences of awe stimulates wonder and curiosity (Keltner, 2003). In this case travelling through space in StarflightVR, gently rocked by the rhythm of the heartbeat at rest supports this sense of awe. Awe, in itself, also automatically invites the experience of the present moment. In this way it has the effect of binding social collectives, and enabling more collaborative actions.

From a transpersonal perspective the link existing between art and the artist are examples of transpersonal connection. Ultimately, this is the point of immersion. The painter of an artwork for example, and the viewer are engaged not only in the process of making sense of the existing reality, but they are also linking to an engagement and a transformational property. This is a form of absorption (the ability to be immersed in inner imagery) (Luhrmann, Nusbaum and Thisted 2010) and is important from a pedagogical as well as an artistic perspective. The relationship of the viewer to the painting is similar in some way to that of the relationship of the artist to the painting, however, the viewer becomes the observer in this case and the painter becomes the creator together they are then, as Steiner would qualify it, "the knowing doer" (Steiner, 1964). The knowing doer of Steiner, is also the psychologically mature individual who has attained "embodied consciousness" under Assagioli (1965), who is also the person who has become aware of his own depths and shadow formations as with Jung (1959). In other words, once internal imagery is expressed harmoniously and clearly as an outer form, the sense of presence in everyday life is reflected in a sense of flow.

From a neuroaesthetic perspective such an experience is a complex artistic process that crosses cognitive, kinesthetic and emotional functions, (Pelowski, et al, 2017) and sparks the activation of mirror neurons while the individual is "connecting" with art (Schott, 2015). The reaction or resonance that is established with a work of art or a specific relationship and connection reminds one of the *participatory spirituality* (Ferrer, 2017), approaches. In conjunction with the painting the viewer can possibly attain higher levels of self-awareness:

Most religious and spiritual endeavors, we should stress here, are aimed not so much at describing or explaining human nature and the world, but at engaging and transforming forming them in creative and participatory ways, and may therefore call for different validity standards than those emerging from the rationalistic study of the natural world. (Ferrer & Sherman, 2000. p.150-152)

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Therefore, in this case, both the creator and the viewer engage not only in the process of making sense of the existing reality, but also linking to an engagement and a transformational property.

A symbol using abstract visuals supports a transcultural approach that is based in archetypal imagery (Jung and Franz, 1964). The abstract approach itself can be seen as a lack of cultural interpretation or methodology of presentation and reception of information. The cultural code, or subcontext, is left open and therefore interpretation becomes transculturally rooted:

The visions of the Jewish mystic are not entirely constituted by his or her subjective imagination, but actually reflect ontological realities that have the capacity of being seen within the imagination of the visionary. This is so because the imagination is...the organ that puts one in contact with spiritual realities that are perceptible to each individual according to the dominant images of one's religious and cultural affiliation. (Ferrer & Sherman, 2000. p.150-152)

This transcultural approach informs the way colors are used in StarflightVR. Distinct wisdom traditions and theories around color differ in their approach yet converge in interesting ways. For example, the colors of sleep within StarflightVR reflect a progression through the color system and are designed to be experienced in an immersive and symbolic manner. This approach to color therapy is grounded in transpersonal psychology. Distinct wisdom traditions and theories around color differ in their approach, yet converge in interesting ways. Rudolf Steiner, founder of Anthroposophy (a philosophical system, and a base for healing methodologies, and other systems such as pedagogy and agricultural systems), was less interested in providing a steep ladder for awakening methodologies, rather than to "awaken at a higher level," meaning a higher level of psychological maturity so that the humans become "stronger souls." (Steiner, 1995). His priority in his approach towards transpersonal phenomena and higher levels of consciousness was directed towards a training of the senses, and a targeted methodology and pedagogy to achieve embodiment, and psychological maturity. Therefore, his way of handling color is entirely different from for example the point of view of the Kabbalah (Lancaster, 2011) or Wilber's pyramid where color is a reflection of a state of consciousness and an energy (Wilber, 2006). Or as Sufi Junayd would say, "the water takes on the color of the cup," (Ferrer & Sherman, 2000, p.150-152). Therefore, wherever the person is, in terms of transpersonal development, they reflect that particular state as a color. The inner maturity reflects in the level of consciousness, which in turn reflects a color (Wilber, 2006). How the individuals interpret, live, and evolve within that color scheme is very personal. Yet Steiner also proposes that there is an aura color specific to every individual. This color is exuded as part of the personal color scheme within the four temperaments in Anthroposophy, and reflects the soul state of being (Steiner, 1995). Allowing for an immersion in color in StarflightVR then mimics this transformative potential. In the end, the intent is to unite, to bring together that which has been held as separate into one non-dual experience of life/death.

Ultimately, the intention of StarflightVR, from a neurophenomenological perspective, is to produce the same changes and transformation in the human brain that is triggered by mindfulness states (Davidson et al., 2003; Hölzel et al., 2011; Kilpatrick et al., 2011). These have important clinical implications, such as reducing automatic affective processing, altering one's relationship to pain and addiction, and leading to the cultivation of compassion (Farb, Anderson & Segal, 2012, pp. 6–7, Garland et al., 2018). For the purpose of mental health it is not necessary to experience death/life as in the Mahasi Sayadaw tradition of Vipassana for example, where there are the stages of insight, called "dukkha nanas," which can generate fear of death and terror (Koster & Oosterhoff, 2004). The proposition here is that of gen-

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erating an experience which gives a taste of the non-dual state while gently supporting transformation and neurogenesis. Instead of working with mindfulness-induced NDEs, we are working here with VR-induced NDEs. StarflightVR's content was created to be gentle and avoid any possible negative side effects of VR exposure therapy.

FEAR OF DEATH AND IMMERSIVE EXPERIENCES

Immersive experiences are uniquely effective in inviting transformation because they work on a deep-rooted phenomenological level and may also integrate socially. Therefore, they can address both individuality and social transformation. Diana Eck, a professor of comparative religion at Harvard University, recognizes in her work that the diversity of cultures is a demographic fact and shares in *Death Makes Life Possible*, a research project and book by Dr. Marilyn Schlitz and Deepak Chopra which takes an immersive approach to coming to an understanding about death (Schlitz & Chopra, 2015):

Because pluralism allows us to celebrate the differences in an effort to find our own deeper truths and paths of meaning, engaging in the world's traditions approach to death and existential anxieties also engages the individual to become more fully human and reflect and examine their own lives and world-view (ibid., p. 93)

An immersive experience in which we engage with the conversation of death and its surrounding myths, archetypes, and psychology can be an incredibly powerful experience.

This integration of different sensing and perceptive methodologies mimics a case study on the same subject of an immersive six-week experience of the *Gestalt of Death* (Weyers-Lucci, 2018). The study was set up with a regular weekly online Zoom meeting rhythm with two participants and myself. Every online meeting included meditation, reflection, sharing, and support in the same order. Discussion points were based on *Death Makes Life Possible* (Schlitz, 2015), NDEs that both participants revisited and shared, as well as other inner and outer experiences related to existential anxieties or feelings of wellness and growth. Sensing, inner knowing, spiritual co-creation also known as *participatory spirituality*, (Ferrer, 2017), and deeper experiencing were a part of every meeting. Other elements included the journaling exercise. All participants continuously practiced focusing on the *Gestalt of Death* for those six weeks. This is the manner in which Anderson (1998a), for example, approached her methodology of intuitive observations: "Each cycle contains both intuitive and analytic activities that invite the researcher's psyche to roam freely within the boundaries set by the cycle. The researcher's psyche roams freely but not aimlessly" (p. 244).

In this example, the participants were also involved in the same activity. We used steps delineated by Claire Petitmengin-Peugeot (1999) to set up an environment for intuitive knowing, or focus. She described four "interior gestures" (p. 246) that pervaded her research: (a) the gesture of letting go, slowing down, and of interior self-collection; (b) the gesture of connection with a person, object, problem, or situation; (c) the gesture of listening with senses and awareness open and attentive; and (d) the intuition itself (in Anderson, 1998). We also discussed and shared diary entries and photography. At the end of the six weeks, both participants made a collage of their journey into death and rebirth. The organic inquiry brought out the need to discuss rebirth as an integral part of the *Gestalt of Death*, rather than a separate area. Ferrer (2017) stresses this type of experiencing when he speaks of *knowing by virtue of*

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being. This for him entails a rejection of the subject-object dilemma that is, according to him, part of the Cartesian worldview. In his view of "bringing forth" an experience, rather than a point of view that is divided between object and subject, it is rather something that happens in unison and is never divided. In this case, both the participants and the researcher became absorbed into the experience of death and rebirth as a continuum.

An immersive experience then, resembles a meditative training in which skills are learned that encourage the individual to change habit patterns and neurological/epigenetic expression and engage in life in a transformed manner. Stages of transformation such as those proposed by Wilber (2006) can be applied here. It is through a phenomenological pattern of insights that transformation can occur because it leads to self-knowledge and dehypnotization in a regular rhythmic fashion of perception and expression. Essentially this is based in a non-dual approach:

The action of meditation can be very simple. It is perceiving the process of becoming, with its wanting, desiring, pushing, and pulling. You can just be aware of all that because it is not Being. The more you are aware of this movement of becoming and allow yourself the possibility that it is not working regardless of what it is moving towards, the more you can observe and experience the gap directly. And if you don't follow any movement, attitude, or reaction to it, you may find yourself to be complet (p. 93, Almaas, 2000)

Or as Elena Avila, practitioner states (cited in Schlitz, 2015):

Healing is remembering who we are—re-remembering, not being dismembered, but remembering. We are already given to the power that rules our fate, and we cling to nothing so we have nothing to defend. We have no thoughts, so that we can see. We have no fear, so that we can re-member ourselves, detached and at ease. We will dart past the ego to be free. (pp. 173-174)

USING A GESTALT RESEARCH APPROACH WITH IMMERSIVE EXPERIENCES

Gestalt is a German term signifying a particular formation, patterning, shape, or even person that is perceived as holistic unit over its component parts. Every gestalt is unique, as is every person or situation. Listening to a gestalt is then feeling the particular flavor of the essence or uniqueness of a person, situation, or process. This essence could be seen as being a reflection of consciousness itself (Almaas, 1986). This unique sense, or gestalt, emerges in the immersive environments. The gestalt will manifest differently for every participant, yet certain types of data will reflect a group process accompanied by physiological data underlining state changes from an objective, biological, and existential perspective.

Gestalt therapy was founded by Fritz Perls (Encyclopedia Brittanica, 2012), who was born in Germany and was a student of Sigmund Freud. In gestalt therapy, the client learns to listen into one's own unique sense of what is true using the same skills as the integrative research skills listed above. It is concerned with developing a client's ability to connect with what is true, and in expressing this authentically to others in everyday life (Perls, 1951). In gestalt, therapy finding the "unique sense" of something is called "finding your unique contact boundary" (Oleary, 2013, p. 24). Gestalt is a relational therapy: congruence, authenticity, and honesty are some of the key terms describing the relational capacities that are fostered in this approach. In the same way, using gestalt principles in research aims toward the discovery of the *unique contact boundary* (Oleary, 2013) of the research matter and how it influences itself and

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its surroundings, as well as how it expresses itself in the world. Working with gestalt means enhanced awareness of sensation, perception, bodily feelings, emotion, and behavior in the present moment. It is, in effect, taking research skills and using them intentionally to bring out a specific "shape" of something, (in this study, for example, the gestalt is that of death). In gestalt, relationship is also emphasized along with contact between the self, the environment, and the other. It is about finding the connections between the points within the research and letting them emerge from the unconscious as well as from the subconscious and conscious. To do this, it is possible to work with two types of emergence that are related to the kinesthetic and proprioceptive skills and, in that way, to the gestalt of something. These are the lightning flash of recognition and the slower coming to of inspired knowing. The flash can be described in the following manner:

Brilliancy arrives at insight in one shot, at a glance, as if intuitively. It doesn't need to go through the various correlations. It is fast and breathtaking. However, it does not see the details of interactions and relationships between the various elements of the situation. We arrive at insight, but most of the time we don't know how we got there. There isn't as much perception, understanding, or knowledge in the process of arriving at the insight, which often makes it difficult to communicate it to others. However, since the Diamond Guidance has Brilliancy as an aspect, it can use the capacity for direct illumination by simply seeing the **gestalt** *without also seeing how the illumination came about. (Almaas, 2000, p. 412)*

The researcher can slow the process and delve into more somatic aspects, or make use of the *Felt Sense* approach (Gendlin, 1992), to inquire into the details of the experience of gestalt and the way the participants are *touching* this essence and the way they are being *touched* by it. This *sensing* quality also ties back to Damasio's *Feelings of Knowing* mentioned earlier (Damasio, 1999).

This gestalt approach to the research may also be useful to address the difficulties that can arise through encountering difficult emotions or feelings:

Some people can withdraw from reality by means of profound spontaneous trances, usually secondary to stress or psychological trauma, and create a fantasy experience by narrowly focusing their attention on imaginary structures or remembered traumatic events while blocking out external reality. (Castillo, 2003, pp. 13-14)

These trances, or unconscious and subconscious overlays, cut off the ability to inquire more deeply and effectively stop the ability to see things as they are.

This is the same phenomenon looked at earlier from the different perspectives of neuroscience, existentialism, and transpersonal psychology. Grounding through feeling the sensation of the body in the moment is helpful in seeing things more clearly, as in *focusing* (Gendlin, 1992). Playfulness, added onto kinesthetic and proprioceptive, is a welcome tool as well. Playing with a gestalt or a sense of an essence through the body could help with triggers and difficult emotions as they may emerge while dealing with topics like death.

From the perspective of neuroscience and neuroplasticity, applying gestalt therapy principles and combining them with immersive experiences and virtual reality exposure is an opportunity to create behavioral changes that could be permanent (Rizzo, 2017). The connection between gestalt and immersive experiences from this perspective lies at the heart of the visual and perceptive networks—those networks from without and those generated on their own from within, those attention-demanding tasks, and the

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stimulus-dependent tasks. The network associated with attention-demanding tasks is referred to as the task-related network, and the network associated with stimulus-independent thought during the resting state is referred to as the default mode network (DMN). The two networks are believed to be negatively correlated (Josipovic, 2016).

There are, however, challenges in observing and collecting data about the DMN because by definition, it is activated when the brain is not triggered by any outside factor. According to Lifshitz, Cusumano, and Raz (2013), it is challenging to manipulate the DMN in experiments since it activates spontaneously when there are no external task stimuli. Actually, the brain is capable of generating a whole independent universe of conscious experiences when it is disconnected from an outside environment; that is, the brain generates this universe without the task network activation (Nir & Tononi, 2010). How does the visual system then activate without external stimuli? It seems that sensory deprivation increases neuroplasticity, and that therefore the state of sensory deprivation within meditation is also an area of interest. Dehypnotization is essentially the act of self-remembrance. The common aspect to meditative practices from different traditions is the element of progressive dis-identification from thought (Walsh, 1979). Walsh (1979) posited that the normal state of being revolves around thoughts and cognitive constructs, which are layered to produce a hypnotized or trancelike state. From a transpersonal psychology perspective, meditation is a tool in the process of self-remembering (Walsh and Shapiro, 2006, Casey, 1987).

The visual system operates by distinct rules; it is an interoceptive system, driven by the subconscious with distinct patterning. A gestalt is a phenomenological shape incurred through internal perception and underlined by neurophysiological expression (Varela, 1995). The sum of a vision is not just the image produced in the eye when one is looking at something, but it is also influenced by the internal gestalt. When looking at an image, the visual networks only register a fraction of this same image. The rest is aggregated through information from the past and the networks of memory and past experience (the hippocampus comes into play here. This processing of information may be the root cause for continuous negative interpretation of the environment in depressive subjects. As shown by Dainer-Best, et al. (2018), sustained attention for negative stimuli in subjects suffering from depression symptoms shows how what is seen is sustained by the perception of the information provided by the visual sense. This sustained attention seems to alter what is perceived from person to person. This change in perception, of self and of the people and things in the world around one, is what changes behavior.

The visual sense is also social, since there are instances of similar brain activity when watching the same movies. The inter-subject correlation analysis used in the Hasson study (2010), for example, shows the impact or control that a given movie may have on the brains of spectators. The analysis measured similarity in brain activity amongst participants. One hypothesis is that certain visual stimuli are processed in the same manner, and that the integration of these particular signals are also similar between people. These universals would be the same universals as the signals of fear and fear of death, especially in crowds or larger audiences. The neurological connection between humans affects the field of vision as well it seems. This fine attunement is the basis for mirror neuron theories (Siegel, 2006) and attachment theory (Bowlby, 1982, 1988). It is also a possibility for transformation, as shared from the research of DMLP and *Living Deeply* (Schlitz, 2015, Vieten, Amorok and Schlitz, 2007). And like others who have reported having near-death experiences, renowned remote viewer, Joseph McMoneagle found a doorway into personal growth that leads away from a primary focus on self-enhancement and toward supportive and meaningful social behaviors. As research on the positive trajectories of terror management and worldview transformation suggest, the experiences guided him to reprioritize intrinsic over extrinsic goals and priorities. "It shifted his view from a small "me" to a larger interconnected "we.'" (ibid., p. 54).

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It seems that most visual signaling is interpreted from the subjectivity of the first-person perspective, and from the memories attached to that particular body mind, as well to the viewpoint coming from its subconscious structure. What is not known is where are these networks of activity and sensory information integrated?

According to Cavanna and Trimble (2006), some visuo-spatial imagery studies suggest the involvement in internally guided attention and manipulation of mental images, as well as the integration of mental imagery from the first-person perspective (i.e., introspective integration). These studies support the hypothesis that the precuneus (area of the brain involved in a variety of complex functions, which includes recollection and memory, integration of information (gestalt) relating to perception of the environment, cue reactivity, mental imagery strategies, episodic memory retrieval, and affective responses to pain) is the center point for this integrative activity, and for the visual network as well. Is it possible to postulate that the fear of death is likely to be seen in the brain as a lack of integration? If so, brain structures such as the precuneus would be smaller and structures such as the amygdala would be larger in subjects with chronic, unconscious existential anxiety and depression.

The sense of sight is also of primary importance in embodiment, in other words, the sense of being in a body. Sight seems to have an integrative function in self-perception of the body, coupled with the vestibular system. This system is divided into visual exteroception—the visual perception of the location and movement of the limbs (Crook, 1987)—and visual proprioception and kinesthesis. This combination makes gestalt a powerful tool to work with when researching existential fears and their brain and body maps.

EXISTENTIAL PERSPECTIVE ON THE FEAR OF DEATH

The existential psychotherapist and writer Yalom (1980) outlined what he considered to be the ultimate concerns of humankind: (a) death, (b) isolation, (c) meaninglessness, and (d) freedom. As a psychotherapist, Yalom was primarily interested in how these existential concerns inform the therapeutic process. He believed that psychological difficulties stem from an inability to reconcile with these existential concerns. Thus, his sessions included a thorough examination of the way every individual accommodates these concerns. Yalom believed that the liberation of suffering and sorrow would occur once the client has made peace with their circumstances.

According to psychodynamic theory, Yalom's view represents the specific tension of dual instincts of ego and libidinal instincts (Greenberg & Mitchel, 1983). The demands of the external and internal environments are the birthplace of the superego. This is the force that manages interpersonal demands and the need of the child for approval from their security-providing adults. Failure to find balance among these demands may freeze life-enhancing movement forward that resides in the libido. Character structure rests in part on the role of the superego. The superego manages the safekeeping of its owner. According to Greenberg (1983), "Growth is always compromised for the sake of security" (p. 107). Therefore freezing, whether it be muscles themselves or the lack of movement that comes from a suppressed libido, could easily lead to frozen expressions, frozen muscles, and frozen facial traits. In other words, frozenness itself becomes a "being" (Greenberg, 1983, p. 107), blocking movement forward as growth is compromised for security. Greenberg (1983) stated, "In Freud's revised view, meaning is determined by the ebbs and flows, and a complex interplay of life and death instincts" (pp. 552-553). In the end, Yalom (2009) provides a solution to the existential psychologists' dilemma:

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A denial of death at any level is a denial of one's basic nature and begets an increasingly pervasive restriction of awareness and experience. The integration of the idea of death saves us; rather than sentence us to existences of terror or bleak pessimism, it acts as a catalyst to plunge us into more authentic life modes, and it enhances our pleasure in the living of life. (pp 89-91).

A denial of death causes stress, anxiety, and possibly depression in the individuals experiencing this *death denial*. The physiological effects of denial should become measurable because stress stimulates the sympathetic nervous system while inhibiting the vagus nerve (Porges, 1995; Sahar et al., 2001). Therefore, typical stress-related brain wave patterns and their relaxed counterparts could clearly demonstrate a stress state or a parasympathetic-based state. These can be analyzed to understand the effects of the fear of death, and of relaxation/natural flow. It seems possible to defreeze individuals by having them be immersed in a gestalt of death experience. This invites an examination of the possible effects of immersive experiences, including VR, as a psychotherapeutic tool for existential anxieties.

FEAR OF DEATH AND EXISTENTIAL ANXIETY AND DEPRESSION

As mentioned previously, fear of death/existential anxiety is considered to be a basis for anxiety and depression in existential psychotherapy (Yalom, 2009), cognitive based therapy (CBT) (Lazarus, 1997; Scherer, 2005), and terror management theory (Becker, 1973). At its core, the existential perspective proposes that dread is the basis of human emotional life. This theory stipulates that it is the fear of death that motivates our reality, and is the core of human experience, which results in existential anxiety. This anxiety in turn sets up a filter to create a specific experience of reality. However, the processes associated with the creation of filters are typically nonconscious.

Nonconscious fear processes themselves cannot not be approached in the same manner as conscious fear processes (LeDoux, 2014) and may require a different approach to managing uncontrolled fear states. Existential psychotherapy focuses specifically on the fear of death (Yalom, 2009). Fear of death is considered to be at the basis of unconscious, uncontrolled fear states (Beck & Weisshaar, 1995; Lewis, 2014; Ottens & Hanna, 1998). The distinction between conscious and unconscious is important because the predisposing factors for each may be different and therefore need to be addressed in a different manner (LeDoux, 2014). Fear conditioning is one form of Pavlovian conditioning that has received considerable attention (Fendt & Fanselow 1999, LeDoux, 2000) and has been studied extensively. Pavlovian fear conditioning posits that certain environmental stimuli predict certain aversive events. Pavlovian conditioning forms neural representations of the conditioning itself and, therefore, an alteration in the perception of the subjects who are conditioned (Maren & Holt, 2000).

One experiment that clearly shows this is the *Little Albert Experiment* (Watson, 1920). The researcher, Watson, presents Albert, a human infant, with a novel white rat. Albert responds with curiosity and reaches out to touch the animal. Watson then subsequently pairs appearances of the white rat with a loud and aversive noise. Watson again presents Little Albert with the white rat after the rat had been paired with the loud noise. Unlike his initial reaction of curiosity to the rat, Albert now responds to the rat with fear. He moves away from the rat and cries. The circuits associated with this conditioned response are not the same as those that respond to natural threats occurring in the environment (LeDoux, 2014). The unconditioned fear response is one that responds unconditionally, naturally, and automatically to fear

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triggers. An unconditioned fear response could, for example, be rats who are exposed to a predator odor (trimethylthiazoline), to elicit unconditioned freezing behavior.

Terror management theory associates an increase of self-esteem when confronted with death with a reduction of death anxiety (Becker, 1973). The existential approach proposes that it is the fear reaction to mortality that causes social reactivity and hatred towards unaccepted population groups. There seems to be a hierarchy of fear reactions, that goes from attachment patterns (Bowlby, 1988) to social worldview and acceptance into social groups. Acceptance into social groups then entails existential fear reactions based on perceived threats to the group worldview. According to Freud the individual literally rescinds their individuality and becomes a barbarian. A group Freud claims, is impulsive, changeable and irritable, and is led almost exclusively by the sub conscious (Freud, 2005).

The fear of death or existential anxieties is deemed to be a basis for general anxiety disorders and therefore depression, lack of self-esteem and other psychological and social pathologies (Becker, 1973; Yalom, 2009; Schlitz, 2015; Sapolsky, 2001).

Is it possible to attain a more objective, clearer view life through an immersive six-week experience of the gestalt of death? The elemental movement when faced with death is a reactive, instinctual race into safety. The fear of death is a deeply wired biological reaction to threat faced by an organism. As Solomon, Greenberg, and Pyszczynski (2015) mentioned in their analysis of the fear of death in *Worm at the Core*, "The fear of death is one of the primary driving forces of human action" (ibid., p. 119-120). This natural driving force, however, can flip into a chronic state. According to Sapolsky (2001), being stuck in the state of chronic anxiety can lead to other psychological and physical imbalances such as depression.

Psychological pathologies related to existential anxieties that could be addressed are to name a few: General Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD), Seasonal Affective Disorder (SAD), Panic Disorder (PDA), Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), as well as other anxiety-related disorders. Developing a tool for patients or people with these disorders is of prime importance. The current figures for these existential anxiety-related disorders are alarming, nationally within the U.S., and on a world scale.

According to a global study by the World Health Organization (WHO; 2017), GAD affects 6.8 million adults, or 3.1% of the U.S. population, yet only 43.2% are receiving treatment. Women are twice as likely to be affected as men. GAD often co-occurs with major depression. PDA affects 6 million adults, or 2.7% of the U.S. population. Women are twice as likely to be affected as men. SAD affects 15 million adults, or 6.8% of the U.S. population. The leading cause of disability in the U.S. for ages 15 to 44.3, MDD affects more than 16.1 million American adults, or about 6.7%of the U.S. population age 18 and older, in a given year.

The figures worldwide are equally concerning. Depression is the leading cause of disability worldwide. Almost 75% of people with mental disorders remain untreated in developing countries with almost 1 million people taking their lives each year. In addition, according to the WHO (2017), one person in 13 globally suffers from anxiety. The WHO reports that anxiety disorders are the most common mental disorders worldwide with specific phobia, major depressive disorder, and social phobia being the most common anxiety disorders.

Virtual Reality (VR) and/or an immersive experience of the gestalt (phenomenological form/shape) of death may prove to be a unique, comforting, and supportive approach to treat these existentially based anxieties and provide a microcosmic, detailed, and scalable approach to a global problem. Even though mental health is crucial for all development (economic, educational, labor, etc.), the WHO notes that

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based on the WHO Global Health Expenditure database (2017), the global median of domestic general government health expenditure per capita in 2015 was US $141, thus making government mental health expenditure less than 2% of global median of government health expenditure.

Additionally, low-income countries are faced with a lack of resources that is apparent in the distribution of mental health tools nationally. However, responses vary significantly across income groups with 85% of high-income countries reporting that income support is provided compared to only 11% of low-income countries.

As clinical psychologist Dr. Daniel Freeman says, there is "something beautiful" (Freeman et al., 2016, p. 63) about how VR works. Findings show that patients report satisfaction with VR-based therapy and may find it more acceptable than traditional approaches.

Researching VR and other immersive techniques, such as an experience of the gestalt of death in a workshop, is friendly to the research participants and can eventually be successfully implemented as a future treatment modality. An early study on virtual reality exposure (VRE) for patients with post-traumatic stress disorder (PTSD) due to motor vehicle crashes demonstrated that patients reported very high satisfaction with VRE. In a sample of 150 patients with specific phobias, the refusal rate for VR exposure (3%) was lower than for in vivo exposure (27%), providing preliminary evidence that VR-based exposure may be more acceptable to patients.

One study in a PTSD sample found equivalent satisfaction between VRE and imaginal exposure, while another found increased satisfaction for VRE (Delarosa et al., 2012). In a sample of 352 post-9/11 US soldiers, the majority reported that they would be willing to use most of the technology-based approaches for mental health care included in the survey (e.g., VR; Wilson et al, 2008). Additionally, 19% of those who reported that they would not be willing to talk to a counselor in person reported being willing to use VR approaches to access mental health care, suggesting that VR may potentially address some barriers to treatment (Wilson et al., 2008).

A combination of different approaches, including technological, and non-technological, need to be examined as well. For example, a small-scale RCT ($n = 20$) study used VR in conjunction with biofeedback for patients to practice relaxation exercises during treatment (Kim et al., 2008). Patients were randomly assigned to VR with biofeedback, VR without biofeedback, or wait-list control condition. Although the study did not have enough power to examine between group differences, it provides preliminary support for the feasibility of using VR for patients with GAD. Thus far, this study has been the only one to examine the use of VR in treating GAD in this manner. In the same way, there needs to be additional research done on non-technologically based treatment immersive methodologies in the area of existential anxieties (Cukor et al., 2009).

The dearth of studies may be due to the difficulty associated with creating standardized VR scenarios that are able to capture the numerous, varying, individualized worries of patients with GAD. Given this complication, VR-based treatment programs could focus on some of the more common worries among patients with GAD (e.g., health anxiety, something happening to a loved one). Alternatively, or if a patient's worries are not readily addressable with such scenarios, VR- based treatment could serve as a visual guide for breathing exercises and for practicing relaxation or mindfulness-based approaches. Another interesting area is the study of the use of avatars in immersive experiences and how they shift our deepest perceptions of self (Bailenson, 2018; Bailenson & Kim, 2007).

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CONCLUSION

The aim of the current study on the effects of immersive experiences on the fear of death is to understand the individual's personal gestalt of death, and then apply this understanding to the individual's fear of death/existential anxieties. The mental health imbalances associated with these existential anxieties will be addressed in this manner. The research encompasses the applicability of technology such as VR to help mitigate and/or measure symptoms of existential anxiety (depression and neuroses). The rhythm and structure of the study is based on the natural or organic process of insight (Clements, 2004), the cognitive loop process of transformation through perception/expression (Perceptual Shift Hypothesis) (Weyers-Lucci, 2018), or clear thinking as per the scientist, academic, and nondual teacher (Almaas,1986). This loop of insight enables access to a gradually increasing *objective* or clear view of internal and external processes. As Almaas described:

We mean seeing things, seeing internal or external things as they are, instead of subjectively. Subjective is the antithesis; it means according to our positions, feelings, filters, beliefs and attitudes. So objective perception means pure perception, free from all positions, bias, filters, conflicts, intentions etc. It is perceiving whatever it is without any obscuration or intermediacy, so we see it just the way it is in itself. (ibid., p. 5)

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Chapter 26
Mental Health and Cognitive Behavioral Therapy:
Advanced Issues and Approaches

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ABSTRACT

This chapter reveals the important perspectives on mental health, mental illness, and technology utilization; mental health education and mental health nursing; the overview of Cognitive Behavioral Therapy (CBT); CBT, depression, anxiety, and insomnia; CBT and Obsessive-Compulsive Disorder (OCD); and CBT and heart failure. Mental health strengthens the individuals' ability to have healthy relationships; make good life choices; maintain physical health and well-being; handle the natural ups and downs of life; and grow toward individuals' potential. Mental health is associated with higher productivity, better performance, more consistent work attendance, and fewer workplace accidents. CBT is a goal-oriented psychotherapy treatment that takes a practical approach to problem-solving skills. CBT involves recognizing the unhelpful or destructive patterns of thinking and reacting, thus modifying or replacing these patterns with more realistic or helpful ones.

INTRODUCTION

The severity and high levels of disability associated with mental illness have led to the increased global efforts to address the mental health problems, in particular those targeted at prevention (Martin & McKay, 2014). Health problems often track from youth to adulthood, indicating the requirement to effectively understand the overall health of young people with mental illness (McCloughen, Foster, Huws-Thomas, & Delgado, 2012). The emerging mental illness increases the existing stress and contradicts the expectations of this stage, as many young adults encounter physical and emotional weakness for the first time and divert from intended plans (Cameron, 2014). As health information becomes available through the Internet and the Web 2.0, mental health professionals are able to develop the strategic plans for taking care of their patients (Prasad, 2017).

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With the advent of the Internet and the Web 2.0, mental health services have led to an increase in the presentation and care of mental health patients in generalist health settings (Brunero, Jeon, & Foster, 2012). There is an abundance of research available about the utilization of information and communication technology (ICT) in mental health (Namle, Ghapanchi, & Amrollahi, 2016). The rapid application of technology offers the potentially innovative approaches to promoting mental health among young people, addressing a significant public health challenge (Burns, Blanchard, & Metcalf, 2013). Technology designed specifically for health has proved useful as a complementary form of providing the mental health services (Marks & Bowers, 2015). Mental health patients need to be able to reintegrate in the community to achieve the full normality (Cooper, 2010).

The advances in modern technology have created a diverse field of applications for the care of people with cognitive impairment (Georgakopoulos, Chatzidimitriou, & Tsolaki, 2015). The web-based CBT has several benefits compared to the face-to-face treatment, including high treatment reliability, increased convenience, reduced cost, and scalability (Newby, Twomey, Li, & Andrews, 2016). CBT is a relatively efficacious intervention for a range of psychological disorders when delivered in the well-controlled research trials (Levita, Duhne, Girling, & Waller, 2016) and refers to a collection of therapeutic techniques and strategies that are used to alter behavior by teaching individuals to actively participate in understanding their own thoughts and behaviors (Cajanding, 2016).

This chapter is based on a literature review of mental health and CBT. The extensive literature of mental health and CBT provides a contribution to practitioners and researchers by revealing the advanced issues and approaches of mental health and CBT in the health care industry.

Background

Research into mental health has resulted in a wide range of information and publications covering different aspects of mental health and addressing a variety of problems (Hadzic & Dillon, 2010). In the health care industry, the contemporary models of mental health care emphasize the importance of multidisciplinary approaches in supporting the recovery for individuals (Rosenberg & McDermott, 2016). There is an important relationship between physical activity and mental health (Happell, Platania-Phung, & Scott, 2011). It is essential to have a fundamental shift in the context of the provider–service user relationship to effectively facilitate service users' engagement in their mental health care (Newman, O'Reilly, Lee, & Kennedy, 2015).

Mental health is the successful performance of mental function that results in productive activities, fulfilling relationships, the ability to adapt to change, and the ability to cope with adversity (Matthews, Doherty, Coyle, & Sharry, 2008). Mental health issues often become obvious as adolescents emerge into young adulthood (Albritton, Angley, Gibson, Sipsma, & Kershaw, 2015). Mental health promotion is concerned with achieving the positive mental health and well-being in the general population as well as addressing the needs of those at risk from mental health problems (Wand, 2011). The number of children experiencing mental health issues is underreported, as children, especially younger ones, are often below the threshold for diagnosis because they do not yet meet the criteria (Graham, Killoran, & Parekh, 2016).

CBT is an integration of two theories that were separately born to respond to psychological disorders (i.e., behavioral theory and cognitive theory) (Selene, Omar, & Silvia, 2016). Behavioral theory in its strictest form, focuses only on observable and measurable behavior and ignores all mental events. Cognitive therapy focuses on the role they play and how these cognitions determine feelings and behaviors (Ledley, Marx, & Heimberg, 2010). That is why cognitive behavioral approach aims to understand all

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knowledge, skills, and psychological techniques that are able to solve all those psychological complications that arise in the course and treatment of the disease.

CBT is based on the premise that since cognitions can be intentionally modified through a process called cognitive restructuring, it is possible to transform the negative and irrational thinking into the rational and balanced thoughts (Deacon, Fawzy, Lickel, & Wolitzky-Taylor, 2011) toward leading to more productive behaviors, healthy emotional responses, more positive appraisals, and the relief of feelings of anxiety and depression (Dimidjian & Davis, 2009). CBT intends to encourage thinking focused on positivism and hope in how patients perceive their disease process until the end of their lives (Selene et al., 2016).

ASPECTS OF MENTAL HEALTH AND COGNITIVE BEHAVIORAL THERAPY

This section provides the important perspectives on mental health, mental illness, and technology utilization; mental health education and mental health nursing; the overview of CBT; CBT, depression, anxiety, and insomnia; CBT and OCD; and CBT and heart failure.

Important Perspectives on Mental Health, Mental Illness, and Technology Utilization

Mental health is one of the leading causes of morbidity worldwide (Fleury et al., 2012). Mental health services for children and adolescents in low-income and middle-income countries are extremely scarce and greatly limit access to the appropriate mental health care (Morris et al., 2011). In recent years, policymakers in high-income countries have placed an increasing concern on the value of maintaining good mental health toward improving the quality of life (McDaid, Knapp, & Raja, 2008). In practice, people managing mental health difficulties struggle to improve their quality of life (Kidd, Kenny, & McKinstry, 2015). Medications lessen or attempt to control the symptoms of mental illness (Bathory, 2015).

In the Western world, there is an increasing concern regarding the ability of health care professionals to meet the physical health care needs of those diagnosed with mental illness (Walker & McAndrew, 2015). Supporting both mental health and well-being is an important aspect of primary care (McKinlay et al., 2011). Public mental health deals with the promotion of mental health, the prevention of mental disorders, the reduction of mental health inequalities, and the organization of mental health service provision (Wahlbeck, 2015). Public mental health efforts are needed to raise caregiver mental health literacy in health care settings (Mendenhall & Frauenholtz, 2015).

Adolescence is the period of highest risk for the development of mental illness (Plaistow et al., 2014). The relationship between childhood maltreatment and adolescent aggression is well-documented (Hoeve et al., 2015). People with serious mental ill health suffer the excessive physical illness (Collins, Tranter, & Irvine, 2012) and have increased the rates of physical ill-health and reduced the contact with primary care services (Happell, Platania-Phung, & Scott, 2013). They often prematurely die from the common physical illnesses, such as cardiovascular disease and diabetes (Happell, Scott, & Platania-Phung, 2013).

Mental intelligence of an individual is important to all humans (Hashim, Kaur, Bahar, & Ismail, 2016). People with intellectual disability (ID) experience higher rates of major mental disorders than their non-ID peers, but in many countries have difficulty accessing the appropriate mental health services (Evans et al., 2012). A positive relationship between the mental health consultant (MHC) and early care

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and education staff is important for achieving the positive early childhood mental health consultation outcomes (Allen & Green, 2012). Infant and early childhood mental health consultation has emerged as one of the most effective strategies for supporting young children's socioemotional development (DeNatale, 2013). Mental health consultation can increase individuals' competence in specific areas related to children's socioemotional development (Heller et al., 2011).

The Internet allows mental health organizations to provide the mental health services to more people through the new models of care (Calvo et al., 2016). The rapid growth of information technology (IT), such as the Internet, smartphones, and videoconferencing, has improved the access to mindfulness therapies, which focus on enhancing individual's awareness of the present moment toward improving mental health (Krolikowski, 2013). Mobile tracking is the latest burgeoning area in the field of technology in mental health care with mobile apps, SMS protocols, and new devices used to track mood and behavior in order to improve both mental health and well-being (Kauer & Reid, 2015).

Mental Health Education and Mental Health Nursing

Education is an important approach to attracting students to the field of mental health nursing (Happell et al., 2014). Professional education and policy strategies increasingly emphasize the need for service users to be involved in the education of all nursing students, including students undertaking mental health field programs (O'Donnell & Gormley, 2013). The educational preparation of mental health nursing students in higher education must address the philosophical, conceptual, social and ethical dimensions of contemporary mental health care practice (McKie & Naysmith, 2014).

Collaboration between school-based and community-employed professionals is critical to the success of school mental health (SMH) programs (Weist et al., 2012). However, the changes to the educational preparation of the nursing workforce in mental health continue to have the profound effects on the availability of sufficient numbers of skilled graduates willing to work in this field (Happell & McAllister, 2014). Nurses working in mental health settings are placed to provide the exercise advice for people with mental illness (Stanton, Reaburn, & Happell, 2015). Accessing mental health services is a critical step toward reducing the burden of mental illness (Dardas & Simmons, 2015).

The nursing profession must have a responsibility to the global community to ensure that registered nurses are educated to meet the health challenges and the needs of the health consumer in the 21st century (Wynaden, 2010). Hamdan-Mansour et al. (2011) stated that the changes in mental health services have an impact on the practice of mental health nurses. Clinical placements in mental health are the significant preparation for undergraduate students to maximize the improvement in the positive attitudes to the care of people diagnosed with a mental illness and to mental health nursing (Happell & Platania-Phung, 2012).

Mental health nurses have a significant role in improving the physical health of people with a serious mental illness (Robson, Haddad, Gray, & Gournay, 2013). An approach focusing on reducing underinsurance for all mental health services among rural residents may help reduce the unmet mental health needs among the rural residents privately insured (Ziller, Anderson, & Coburn, 2010). Rural nurses represent the skilled mental health toward helping the capital in their local communities and providing the early mental health services in the rural communities (Wilson & Usher, 2015).

School nurses play a critical role in the provision of mental health services in the school environment and are the significant members of the coordinated student mental health team (Bohnenkamp, Stephan, & Bobo, 2015). Mental health nurses have the potential to make a significant contribution to enhancing the access to mental health care through the flexible and innovative approaches (Happell, Palmer, &

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Tennent, 2010). Mental health nurses who are older, have more clinical experiences in mental health care, and demonstrate the greater empathy expressed more positive attitudes toward people with mental illness (Hsiao, Lu, & Tsai, 2015).

Negative attitudes of mental health professionals have been identified as a major barrier to achieving the effective mental health service delivery (Byrne, Happell, Welch, & Moxham, 2013). Through recovery-focused support aimed at avoiding deteriorating physical health, mental health nurses can significantly contribute to improving the current rate of premature death experienced by people with enduring mental illness (Hardy & Thomas, 2012).

Overview of Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a type of psychotherapy that helps individuals identify and teaches skills to modify the unhelpful thinking patterns, feelings, and behaviors (Eapen & Walter, 2016). CBT interventions include many behavioral interventions and incorporate various cognitive strategies toward identifying, challenging, and altering the counterproductive thoughts (Cassin et al., 2016). The individuals' cognitive processes play an essential role in the development and maintenance of their emotional and behavioral responses to them (González-Prendes & Resko, 2012). Freedland et al. (2015) indicated that CBT is effective in improving mood and reducing anxiety.

Research on process factors in psychotherapy can be divided into two perspectives: one emphasizing specific and unique factors for the specific treatment orientation, and other emphasizing trans-theoretical mechanisms, frequently termed common factors (Messer & Wampold, 2002). Researchers emphasizing the specific factors in the treatment hypothesize that the therapist's adherence to and competence in delivering treatment in accordance with the specified theoretical and technical model are important in explaining psychotherapy outcomes (Haug et al., 2016). Higher therapist competence is related to the better treatment outcomes in the CBT of depression (Kuyken & Tsivrikos, 2009).

CBT can improve the outcomes for youths with chronic pain in research trials (Kashikar-Zuck et al., 2012) and in clinical settings (Lynch-Jordan et al., 2014). CBT is of importance in the pediatric chronic pain populations given the potential risks and side effects of pharmacotherapy for pain (Cunningham et al., 2016). CBT for chronic pain typically utilized the combination of cognitive strategies (e.g., distraction, thought modification, and problem solving) and behavioral approaches (e.g., activity pacing and relaxation training) to improve the functioning and reduce the pain symptoms in youths.

Cognitive Behavioral Therapy, Depression, Anxiety, and Insomnia

CBT is viewed as the first-line treatment for both depression and anxiety disorders, as a stand-alone intervention for the mild-to-moderate cases, or in combination with pharmacological treatments for more complex cases and those with comorbidities. Depression and anxiety disorders represent two of the top five leading causes of disability worldwide and have high comorbidity rates, share many similar symptoms, features, latent structure, and vulnerability factors (Goldberg, Krueger, Andrews, & Hobbs, 2009). Tully et al. (2014) suggested that CBT may have the significant impact on alleviating the cognitive symptoms among HF patients with a depressive comorbidity.

Understanding the nature of the anxiety facets that are relevant to the delivery of CBT elements is important for two primary reasons: the identification of clinicians who will need the additional support to deliver the specific elements of the therapy and the planning of interventions to support those clini-

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cians (Farrell, Deacon, Dixon, & Lickel, 2013). The therapist competence/adherence and the working alliance have contributions to the outcome from CBT for anxiety disorders (Haug et al., 2016).

Insomnia is a common clinical condition with an annual prevalence of 10-20 percent (Buysse, 2013) and approximately 6 percent with a chronic trajectory, such as persisting for more than 3 months (Ohayon, 2002). Chronic insomnia is associated with a number of negative health outcomes (e.g., obesity and metabolic dysregulation) and increases the risk of myocardial infarction (Palagini et al., 2013), susceptibility to infections (Patel et al., 2012), and depression (Staner, 2010). Sleep-specific CBT appears to be efficacious and feasible in treating posttraumatic stress disorder (PTSD) symptoms (Ho, Chan, & Tang, 2016).

Cognitive behavioral therapy for insomnia (CBT-I) has been found efficacious in improving sleep outcomes (Okajima, Komada, & Inoue, 2011) with acute effects comparable or superior to those found for pharmacotherapy (Smith et al., 2002) and these effects have been maintained for up to 3 years. While CBT-I is desired by many patients preferring non-pharmacological approaches (Espie, Barrie, & Forgan, 2012), the challenge remains to make it accessible to meet population needs regarding the limited availability of trained therapists (Perils & Smith, 2008). The web-based CBT-I can improve insomnia severity, sleep efficiency, subjective sleep quality, wake after sleep onset, sleep onset latency, and total sleep time (Zachariae, Lyby, Ritterband, & O'Toole, 2016).

Cognitive Behavioral Therapy and Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is the highly debilitating disorder, in which many patients inadequately respond to the standard outpatient care (Dowling et al., 2016). CBT, consisting of exposure and response prevention (EX/RP), remains the most prominent psychological treatment for OCD with substantial empirical support (Abramowitz, Taylor, & McKay, 2009). Specialized EX/RP alone, or in combination with serotonin reuptake inhibitors (SRIs), can be equally effective for improving OCD symptoms (Foa et al., 2005), and is more effective than placebo, stress management training (SMT), antidepressant monotherapy (Simpson et al., 2008), or antipsychotic augmentation (Simpson et al., 2013).

Patient scan experience the significant improvements to OCD symptoms and psycho-social functioning with large effect sizes (Veale et al., 2016). Knopp et al. (2013) indicated that while factors associated with treatment outcomes within these settings are highly varied, OCD symptom severity, marital status, hoarding pathology, and alcohol misuse are recognized as the predictors (Veale et al., 2016). The intensive doses of EX/RP serve as an opportunity to address the previous difficulties and optimize the response to CBT (Dowling et al., 2016).

Cognitive Behavioral Therapy and Heart Failure

The diagnosis and complications associated with heart failure have been well-established to adversely impact an individual's physical and psychosocial well-being, and interventions (e.g., CBT) have demonstrated positive benefits among patients with HF (Cajanding, 2016). Heart failure significantly impacts an individual's physical and emotional functioning (Burke, Jones, Ho, & Bekelman, 2014), increases psychological distress and negatively affects mood (Moser et al., 2010), disrupts psychosocial adjustment (Carels et al., 2004), and leads to the significant impairment in an individual's quality of life (Samartzis, Dimopoulos, Tziongourou, & Nanas, 2013).

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Cardiac rehabilitation and disease management programs appear to be useful in improving the functional capacity, exercise tolerance, quality of life, and mortality among patients with heart failure (Austin, Williams, Ross, & Hutchison 2008). Cardiac rehabilitation programs targeting psychosocial factors in the form of CBT has been previously shown to improve the outcomes among patients with cardiovascular diseases, including those with coronary heart diseases (Gulliksson et al., 2011) and heart failure (Freedland et al., 2015).

FUTURE RESEARCH DIRECTIONS

The classification of the extensive literature in the domains of mental health and CBT will provide the potential opportunities for future research. Health information technology (health IT) makes it possible for health care providers to better manage patient care through the secure use and sharing of health information (Kasemsap, 2017a). Health literacy is about how patients understand health information about health and health care, and how they apply that health information to their daily lives, utilize it to make health-related decisions, and act on it (Kasemsap, 2017b). Health professionals must commit to promoting for improved health literacy in health care organizations and should establish the specific health care goals toward improving health literacy in strategic plans, performance plans, programs, and educational initiatives (Kasemsap, 2017c). Critical thinking is the unbiased examination of assumptions underlying current beliefs to assess their correctness and legitimacy, and thus to validate or invalidate the beliefs (Kasemsap, 2017d). Problem solving is the process of working through the details of a problem to reach a solution (Kasemsap, 2017e). An examination of linkages among mental health, CBT, health IT, health literacy, critical thinking, and problem solving would seem to be viable for future research efforts.

Neuroscience is the field of study encompassing the various scientific disciplines dealing with the structure, development, function, chemistry, pharmacology, and pathology of the nervous system (Kasemsap, 2017f). Cognitive neuroscience is the study of higher cognitive functions in humans and its neural foundations (Kasemsap, 2017g). Considering the associations among mental health, CBT, neuroscience, and cognitive neuroscience should be further studied.

CONCLUSION

This chapter explained the important perspectives on mental health, mental illness, and technology utilization; mental health education and mental health nursing; the overview of CBT; CBT, depression, anxiety, and insomnia; CBT and OCD; and CBT and heart failure. Mental health strengthens the individuals' ability to have healthy relationships; make good life choices; maintain physical health and well-being; handle the natural ups and downs of life; and grow toward individuals' potential. Mental health is associated with higher productivity, better performance, more consistent work attendance, and fewer workplace accidents. Employers can strengthen and safeguard their businesses by choosing employee health plans with strong mental health benefits.

CBT is a goal-oriented psychotherapy treatment that takes a practical approach to problem-solving skills. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel. CBT involves recognizing the unhelpful or destructive patterns of thinking and reacting, thus modifying or replacing these patterns with more realistic or helpful ones. CBT works

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by changing people's attitudes and their behavior by focusing on the thoughts, images, beliefs, and attitudes that are held and how these processes relate to the way a person behaves, as a way of dealing with emotional problems. During CBT, patients learn the specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors.

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KEY TERMS AND DEFINITIONS

Anxiety: The uncomfortable feeling of worry about something that is happening or might happen in the future.

Behavior: The response of an individual or group to an action, environment, person, or stimulus.

Cognition: The utilization of conscious mental processes.

Cognitive Behavioral Therapy: The treatment for individuals suffering from mental illness that tries to change the way they think and behave.

Depression: The state of feeling very unhappy and without hope for the future.

Insomnia: The condition of being unable to sleep, over a period of time.

Mental Health: The condition of individuals' mind and whether or not they are suffering from any mental illness.

Mental Illness: The illness that affects the individuals' mind.

Therapy: The treatment that helps individuals feel better and grow stronger, especially after an illness.

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Chapter 27
The Role of AYUSH in Mental Well-Being

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ABSTRACT

Mental wellbeing was the centerpiece of the Indian system of medicine. Many healthcare issues are resolved by the peace of mind and brain stimulating processes. Of late, Government of India adopted many systems of medicines that are complementary to the modern allopathic medicines and named it AYUSH system of medicine. In this Ayurveda, Yoga, Homoeopathy, Siddha, Unani, Swa-rigppa, and additional healing systems are represented. There is also a great need for psychological wellbeing due to the rapid increase in stressful life situations. The current modern medical care is not adequate to provide mental health services in the society. At the same time, many indigenous and AYUSH system have come into action and solve the problem the best way it possible. The chapter focuses on the role of AYUSH system in catering to mental wellbeing in India. The policies of the government of India are to promote mental health and wellbeing in society. The specialties of various systems of medicine in curing the mental health conditions have been elaborated.

BACKGROUND

The AYUSH services are used by Indian population very widely over a period of time. The Care and cure is assured in many aspects of healthy life in the population which otherwise deprived from the modern biomedical system of medicine. The modern biomedical system of care is very costly and difficulty to reach by masses in India. The faith of people is always with the AYUSH system of medicine due to its services in millennia of Indian culture and society. The AYUSH services are always targeted in a holistic manner and there is less barriers to access by the people for the services. The Indian system of medicine

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look at various mental health ailments with harmony in the system which causes less side effects and cure for many diseases. The body and mind are taken as a whole while prescribing medicines in most of the cases. So, there would be cure at mental level.

The World Health Organization defined traditional medicine as the combination of the knowledge, skills, and practices based particularly on the theories, beliefs, and experiences which are indigenous to different cultures irrespective of explicable or not, and helping in management of health, prevention, diagnosis, improvement or treatment of both physical and mental illness (World Health Organization, 2000). The use of traditional medicine in various mental ailments is widely practiced in the world for the benefit of the patients. In India different system of traditional medicines were in use since ancient times with proven results for cure and prevention of mental health ailments. The traditional medicine services were usually accessible to the members of the society widely across time. So, these are the first line of treatment for the community even in unorganized community for mental health services. Moreover, the social and cultural cohesion among members of the society help in dealing with many issues of mental health in the community itself instead of modern day hospital facility which help in recovery of many mental health conditions.

The therapeutic cure of each system of medicine is also well documented by the practitioners of the respective particular system. Many of the practitioners receive training in informal way without going to formal training in the designated institutes in ancient time. The knowledge also transmitted from one generation to other very first in the informal way of training and capacity building by proper handholding. Many of the knowledge are tacit in nature and can be learn by close observation and treatment by the healers. Latter on with the help of codified ancient knowledge many things transmitted easily through generations. These treatment procedures are also many a time evidence based and the method to capture evidence is quite different from the modern laid down guidelines.

Latter on with the trust of the people and requirement of alternative system or complementary system governments start adopting these methods in the system of common public services. It has been found that there is also need of curative system for all mental health ailments. Whereas, the modern system has limited medication for limited mental health ailments. Which necessitates the requirement of alternative system of medicines to provide full coverage for wide rang mental health conditions. At this juncture, the alternative systems comes into picture with their age old curative actions which thy otherwise practiced in the process of cure along with winning the trust of the community.

A large number of people take alternative medicines exclusively or along with the modern biomedicine for many acceptable reasons like faith and cultural acceptability, low cost, and firm belief on the systems of medicine. Moreover, India have starkly very low number of specialists available in the field of psychiatric which provide systematic modern biomedicines for cure of mental health cases (Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., ... & Nichter, M. (2016).

Methodology

This study reviewed various types of reports like existing policies of AYUSH, various guidelines of AYUSH services implementation, and reports of AYUSH systems of medicine in different states and central government. The literature reviewed policy and programme documents, and un-published grey literatures in the form of notes and reports at relevant sections. This is a secondary analysis to elaborate the existing policies and implementation of AYUSH services, and its' loopholes in implementation in mental health services. The opinion and experience of AYUSH care providers are also taken into con-

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sideration while treating mental health cases in the respective places. This article describes the existing policies and procedures of mental health services in hospital and community by providing AYUSH medicines in mental health. The details of efficacy of each system of medicine is explained in various sections based on evidences found in literatures directly and indirectly relating to their system. The scientific studies were taken from indexed databases like PubMed, Scopus, and Web of Sciences. The evidences were found out for various mental health ailments and explained the situation and readiness to incorporate those in the mental health programs. The philosophy of each alterative system of medicine is discusses based on the context of mental health services. Ethical approval was not required as all data are used from secondary sources. However, the opinions and arguments of implementing staffs have been gathered without harm to them.

FINDINGS

Mental Health policy in India

Mental Health policy 2014 in India has a vision for improvement of mental health conditions. The policy primarily focus on promotion of mental health care, prevent mental health illness, accelerate recovery of mental illness, and de-stigmatization of mental health conditions. Additionally, it focus on the inclusion of various socio-economic groups for the treatment of mental health. Steps are also taken for increase in accessibility and affordability of quality mental health services throughout the life of a person in the community. The important goals are reduction of distress and disability among mental health patients. The reduction of premature mortality caused by mental health need to be addressed according to the policy. A country wide campaign can be initiated for better understanding of the mental health conditions which would allow creation of awareness in the nation. The creation of stewardship and leadership are desparately needed at various level of governance like national, state, and district levels (Ministry of Health and Family Welfare, Government of India (2014).

There are various acts in India from time to time enacted for the creation of good health in the community. Among them acts and regulations like Mental Health Act-1987, National Mental Health Programme-1982, District Mental Healthcare Mode, District Mental Health Programme-1995, Persons with Disabilities Act-1995, Right to Persons with Disabilities Bill-2002, Mental Healthcare Bill-2013, National Mental Health Policy- 2014, and The Rights of Persons with Disabilities Act- 2016 played crucial roles and responsibility (Kaur, R., & Pathak, R. K. (2017).. All these acts and regulations have their own advantage and weakness in the implementation process. However, still optimal mental health services are not achieved in the community due to poor implementation and lack of adequate resources at various levels.

The policies usually consists of a set of values well organized, having principles and objectives for the improvement of improving health along with reduction of disease. (Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE. Charlson FJ, Norman RE, Flaxman AD, Johns N, Burstein R, Murray CJ. Vos T (2013). Whereas, a specific program is all about setting interventions with specific objective to promote the health along with prevention, treatment and rehabilitation. The program also well monitored and evaluated for further improvement and funding purpose (6. Mental health policy, plans and programmes—updated version 2 (2005) [6]. All these transformative aspects in mental health program implementation played a role for transforming the society in achieving desired targets. The vi-

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sion by the policy would lead to take strong steps in building capability of mental health through various programs in the community. Over a period of time stewardship is supposed to be there for creation of health care facilities in grass roots level.

Mental health issues including suicide considered to be serious problem globally. As usual India is the largest country for adolescent population which group need more attention for mental health. Evidences found that there preventive care can be provided by peers to the population of mental health adolescents (Roy, K., Shinde, S., Sarkar, B. K., Malik, K., Parikh, R., & Patel, V. (2019). Among the age group of 10-23 years almost 22.9% people live with years lived with disability (YLD). The problems have significant effect on the individual, their family and society at large.

Historical Development of AYUSH System in India

Ancient india have its own system of medicine deeply entrenched in the sciences of Vedas where atharva veda deals with Ayurveda and healing art for the mankind. In British India though there was many people depend on the Indian system of medicine still then very less patronage was there from the British India government. Only princely states provide some shorts of patronage that to trusted few on the provision of medical care relating to indigenous systems. However, people use indigenous medicines at their own trust and resources including mental health. The Government of India through high level committees like Bhore (1946), Mudaliar (1961), and Srivastava Committee (1975) try to reform the health care system in which additional effort were also exerted for improvement of Traditional Complementary and Alternative Medicine for the care of common people in an institutionalized manner [1-3]. Whereas, the National Health Policy (1983) envisaged a phased integration of indigenous medicine with modern medicine for both preventive and cure of various diseases at grass roots level which also include healthy living [4]. With the aim to improve the alternative systems of medicine government create a separate wing known as Department of Indian System of Medicine and Homeopathy (ISM&H) in 1995. The department latter on renamed as AYUSH for stronger emphasis in the year 2005 with more focus to cater many people in the community. In the year 2005, the National Rural Health Mission (NRHM) tried to mainstream AYUSH in many parts of the country in which a lot of AYUSH health centers were opened for the wide spread services of the population with the help of doctors, medicines, and procedures of the respective AYUSH system of medicine [5-7]. The NRHM focuses more on many non-communicable diseases to be cured at AYUSH centers in the county which also focus on mental health. Mental Health conditions are a serious concern at the grass roots level where availability of psychiatrist is highly constrained. However, in 2014 the real change happen when Ministry of AYUSH was established to independently take decisions without much consultation with the ministry of Health and Family Welfare for the propagation of alternate medical systems. The ministry have additional work of stressing on medical education, quality control, drug standardization, and research and development for the wider dissemination of services [8].

Further, the National Health Policy 2017 (NHP-2017) focused more on independent functioning of AYUSH centers in the county for wide rang e of services along with challenging disease conditions which are otherwise difficult to cure in the current biomedical systems. The NHP-2017 make targets for achieving good health including mental and spiritual health among the population within a time fram. It also make provision of funds for functioning of various programs in india with a defined target and time line.

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Role of AYUSH System in Mental Health in India

AYUSH system played an important role in serving mental health cases at various level. This is palpable from the trust of the community and evidences gathered by various scientists and clinicians or healers. There is also an ongoing process of evolution of the treatment procedures in alternative system of medicines along with proved and established processes. All the evidences are documented in ancient scripture, and ethnographic evidences in the community. Though clinical trial and many other systemic issues are still exists in gathering evidences, still many aspects in bits and pieces are already proved in the system. AYUSH system is recognized by World Health Organization for cure of many diseases. Indian government also recognize the AYUSH system as a proper interventions for various health conditions including mental health specialization. Various research wings of AYUSH ministry like Central Council for Research in Homoeopaty (CCRH), and Central Council for Indian Medicine (CCIM) invest in conducting research in mental health to address the steepening issues in mental health in India. Further, a lot of investment happen in provision of manpower, medicines and hard infrastructure in provision of mental health services to patients in public health services.

Ayurveda

Ayurveda has its origin in Vedas more than 5000 years ago dealing with art of healing. It classify Tridosha (ie, three bioforces, vata, pitta, and kapha) which is embedded in the theory of humor in the body for maintenance of healthy life. Medications usually involves natural substances, special diets regimen, purification rituals, and some surgical procedures for cure. Mental health uses many of these procedures for prevention and cure in the society by adopting various prosedures (Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., ... & Nichter, M. (2016).

Mental illness and mental health found in Indian texts like the Atharva Veda and other Vedic texts along with traditional system of medicines of Siddha, Unani, and Ayurveda where the detailed explanation is found on mental health and disorders. Latter on the mental hospital found ‘chemical revolution’ in psychiatric management which is a measure departure from the existing treatment of mental conditions especially in early part of nineteenth century (Sundaram, S.K., Kumar, S. (2018). Ayurveda stil played a big role in management of mental health in India by catering to masses despite the presence of modern-day psychiatric in different hospitals.

Studies shows that there is link of gastrointestinal system and mental health in Ayurveda which is also linked with depression. These age old findings also corroborate with the modern biomedical concept of health. Major Depressive Disorder (MDD) is associated with gut dys-regulation which ultimately linked with mental health (Steer, E. (2019). So, when treatment of mental conditions are taken into condition the entire gastrointestinal system is given importance in addition to preventive care.

The control of various dermatological diseases according to ancient medicine systems (e.g. Ayurveda, Yoga, and Unani) are practice of meditation, exercises, and related practices. The branch of psychodermatology takes care of many dermatological problems by keeping the mind healthy. The integrated approach to skin disease involves taking care of mind, skin and psychological stress (Shenoi, S. D., & Prabhu, S. S. (2018). Thias care and cure is very evidenced from the scientific data and have good impact on the health care system.

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Ayurvedic psychiatry help a lot in treatment of many diseases relating to psycho-social concern. It also supplement allopathic and vernacular concerns it high degree of pragmatism (Lang, C. (2018). So, mental health concerns are addressed in the course of time in various branches of traditional medicines to get cure. The specialized branches of Ayurveda have fair dealings with the emerging concerns.

An six day intensive program having holistic instruction and experience in the sphere of mind-body practices usually develop to a remarkable and sustained shift in the overall perception of self-awareness which is part of favorable well-being (Mills, P. J., Peterson, C. T., Pung, M. A., Patel, S., Weiss, L., Wilson, K. L., ... & Chopra, D. (2018). All these proven evidences shows that the Ayurveda have propor regimen for the treatment of the diseases of mental health origin. The systems also help in achieving many aspects of the diseases as an early response.

Neuropsychiatric and neurodegenerative disorders like Alzheimer's disease, Parkinson's disease, schizophrenia, epilepsy, depression and anxiety are posing serious concerns in the society. Whereas, Ayurveda is having solution for treatment along with various nootropic herbs having multiple bioactivities in different disorders. Scattered information is available pertaining to traditional Ayurvedic remedial options for various mental disorders (Sharma, R., Kabra, A., Rao, M. M., & Prajapati, P. K. (2018). Ayurvada helps in cure of many diseases of old age and related to mental health with sharp menthod of treatment in the system. There is also holistic approach for care and cure which is evident from the system of medicine.

Siddha

The Siddha system is contemporary of Ayurveda and mostly flourished in south India. Many of the procedures relating to practice of medicine is similar to the ancient Ayurveda and mostly found in Tamil literature. So, the diagnostic and treatment follows concepts of mind for cure. Siddha help in care and cure of largely south Indian people with the treatments mostly aligned with herbal systems of medicine. The Indian systems of medicine mostly take care of many aspects of care among the mental health patients which is evident from the studies. There are established methods for cure of mental health diseases and certified by the concerned board for the cure of patients. The contribution of Siddha as a system of medicine towards the care and cure of mental health cases is immense. People of certain region also impose faith on the methods of cure without having any detrimental effects.

Yoga

Yoga embodies the unification of a person's consciousness with universal consciousness for achievement of goal of life with a healthy living. There is absolutely no intervention of pharmaceutical regimen for the health of a person. Rather various postures (Asanas), breathing control mechanisms (Pranayama), and Meditation procedures (Dhyana) are adopted as practices to get cure or maintenance of health (Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., ... & Nichter, M. (2016). There are many findings confirm the cure or relative wellbeing of patients by practice of Yoga in different cases and particularly mental health cases.

A therapeutic review of Neti kriya confirm that many disease conditions relating body and mind were cured and especially help in many disease of respiratory tract. Jala neti (Nasal water irrigation) help in enhancing presence of mind, intelligence and improve vision (Meera, S., Rani, M. V., Sreedhar, C., & Robin, D. T. (2019). All these aspects help in mental wellbeing of a person in different situations. Energy

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is gatyered by practicing Yoga which is very useful in maintenance of health for long period of time in the case of human being. Yoga is not just practices in India but also spread in the entire globe for the benefit of the people in various countries. The mental health remain good among the Yoga practicing people.

In United States of America practice of Yoga practices with special focus on mindfulness helps in safe and effective intervention for paediatric groups. Evidence also found that yoga can control mental health issues among the adolescent populations (Stephens, I. (2019). All these achievements of yogic practice help in solving many issues of Adolescent groups.

Laughter Yoga (LY) is found to be useful for cure of symptoms of depression within short term period. The LY also help in reduction of residual mood, anxiety and stress symptoms among adults. The LY can be used as a method to reduce depression and improve quality of life (Bressington, D., Mui, J., Yu, C., Leung, S. F., Cheung, K., Wu, C. S. T., ... & Chien, W. T. (2019). The form of Yoga may differ but the effects are always found to be positive if practiced in life for improvement of mental health.

The Mind-body exercises in the form of Yoga offer good cure for the rheumatoid arthritis (RA) patients which leads to improvement of both physical and mental health. In adult worker participating in Yoga have better physical function and mental health can be created by the practice (Greysen, H. M., Hong, O. S., & Katz, P. (2019).

The Yoga is becoming a popular approach for the improvement of the quality of life (QoL) among women with breast cancer as a supplementary care practice in addition to the modern medicine. A meta-analysis was done to assess yoga-specific effects relative to other physical exercise intervention (eg, aerobics) with breast cancer. The study found that yoga is effective as other exercise interventions in improving the QoL of women (El-Hashimi, D., & Gorey, K. M. (2019). The quality of life can be improved even among the patients with critical conditions by practice of Yoga. These thighs are now ad days very popular in different hospitals as additional methods of care due to efficacy.

A study has been conducted among the patients with chronic hemodialysis those suffer from an increased cardiovascular disease, deconditioning, fatigue, sleep disturbances, anxiety and depression, and decreased health related quality of life. Here Yoga is reported to have positive effects over distress and functional performance among the chronic diseases. Interestingly Yoga help in improvement in quality of life, reducing pain, reducing fatigue, solving sleep disturbance, and improving physical functions (Kauric-Klein, Z. (2018). Overall yoga found to be a complementary methods of treatment for the people having many diseases. Mental health and Yoga help in improvement of the system to a great extent.

Naturopathy

The very science of naturopathy advocates for effective use of five fundamental materials like earth, water, fire, air, and ether (space). There is strong advocate of use of these concepts both internally and externally and requirement of changing lifestyle and diet for cure. Pharmacological medications are not advocated for use and practice of spirituality is highly encouraged. Naturopathy provide a scope for going natural. Our system always finds a natural concept to remain healthy both physically and mentally. There are trainers suggests how to go natural way of life. For cure of many ailments. The nature provides many methods without biomedicine for care and cure in the society. The natural processes are always helping in many aspects of human being for the care and cure.

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Homoeopathy

Homoeopahy as a system put primacy on mental symptoms for cure and care. Many diseases show mental symptom due to various reasons and can be cured by interventions of medications having cure for mental diseases. The mental symptoms guide a lot to achieve cure in different form in homoepathy. The usual mental conditions like hallucination, depression, illusion, outburst, excessive happiness or sorrow, craving for something, headstrong etc. are some of the important conditions for interventions by homoeopatic drugs.

Contrary to the biomedical model of health homoeopathy considers entire body in a holistic manner and provide services in a broader view with much responsibility. Homoeopathy takes care of the physical, mental and emotional aspects of people for cure. Whereas, other alternative practices like yoga, hypnotherapy and meditation put primacy on 'functional' spiritual practices in which the responsibility in fixed on the person for individual care (Bell, F. (2000).

Evidences found that homoeopatic drugs improve 'sensation of well-being', and support the working of ultra-high dilution effects which otherwise cannot be proved by the existing laboratory methods (Kuzeff, R. M. (1998).

A study found that the sleep disorders among alcoholic is reduced by taking homoeopathic medicines. The homoeopathy treatment can be used to help clients in breaking the cycle of alcohol dependence (Rogers, J. (1997). There are many more diseases can be cured by the method of homoeopathy especially of mental diseases for complete cure. This is trusted methods of treatment in hundreds of countries for the treatment of several diseases. Today the diseases have different concerns for cure and homoeopathy help in many of cases.

Unani

Unani methods way back to the practice of medicines and teaching of Hippocrates and Galen in medicine which is also known as Greco-Arabic (Unan means Greece) medicine.

Though it is established in the Middle Age with the patronage of Arabian and Persian kingdoms and their doctor, but latter on Mughals make it their court medical system with sufficient patronage. So, it become a part of Indian medicine and people adopt it with enormous faith. Unani system of medicine based on the idea of various humours like blood components, phlegm, and both yellow and black bile. It usually adopt similar process like regimental therapeutic procedures, special diets regimen, medicines from available herbs and surgery (Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., ... & Nichter, M. (2016).

The Unani medicine is very ancient and tested by Greek civilization almost 2500 years ago. The Unani medicine aims for near no disease condition in leading a healthy life. The Unani medicine advocate clean and fresh water, clean air and consumption of fresh food for maintenance of disease free life. There is also requirement of maintenance of balance on body and mind for metabolic activity to maintain the evacuation of wastes. The system of medicine largely advocate for promoting health, preventing disease and achieving cure through various regiments and diet therapies (Lone, A. H., Ahmad, T., Anwar, M., Sofi, G., Imam, H., & Habib, S. (2012).

In medicine systems like Ayurveda, Unani, or Chinese traditional medicine the imbalance of different 'elements' and factors for disease are important. Rectification of those imbalances pave the way to cure (Bhuiyan, P., Khatun, Z., Jahan, S., Morshed, T., Rahman, S., Afsana, N. A., ... & Rahmatullah, M. (2013).

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There is lack of treatment of patients due to various causes in psychotherapy. Whereas, almost four-fifth of population of India in one way or other depend on Ayurvedic and Unani systems of medicine along with religious treatments consisting of prayers, fasting and various witchcraft and magical rituals (Bagadia, V.N., Shah, L.P., Pradhan, P.V., Gada, M.T. (1979). The faith of Indian people is obvious for the systems of medicines. The cure and care is beyond doubt for mental health conditions.

Malankholia (Melancholia) a condition having mental health concerns like constant grief, fear and dubious aggression is cured by Unani medicines and regimen. This has been well explained in ancient book of "Kitab Al-Havi." The detailed management of diagnosis and treatment of melancholia has been described in the Unani system of medicine by this the suffering of humanity can be mitigated to a great extent (Ahmed, N. Z., Alam, A., Khalid, M., Sheeraz, M., & Qamri, M. A. (2015). Many mental health conditions are well explained in the treaties for cur eof mental health conditions.

Sowa-Rigpa

Sowa-Rigpa is a method of cure well known as the science of healing and otherwise called Amchi medicine. It's also well known as Tibetan medicine which is recognized by government of India for its efficacious cure and provision of services to a section of Indian society. The system of medicine is practiced mostly in Himalayan region by both Tibetan and Indian people especially by tribal and Bhot people. This system adopts many nuances of Ayurveda by adopting predominantly the pharmacological (herbal) interventions (Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., ... & Nichter, M. (2016). There are many codified method of cure for mental health conditions.

The policies of the government of India are to promote mental health and wellbeing in society is discussed thoroughly.

The specialties of various systems of medicine in curing the mental health conditions have been elaborated.

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Chapter 28
Answering the Call for School-Based Mental Health:
Culturally Competent Intervention and Support

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ABSTRACT

A largely unmet need exists for school-based mental health services by students who are of an ethnic minority and who may not have insurance, access, and/or the knowledge of mental health services. These same students may not receive effective, culturally sensitive counseling services, interventions, or valid/accurate measures of psychological testing. In order to resonate and connect with these students who need the most help and support despite these barriers to accessing quality treatment, what is the school-based mental health provider to do? This chapter will initially discuss a comprehensive review of culturally competent interventions for school-based mental health providers as well as recommendations for culturally competent training for mental health providers and school staff to ensure that culturally competent collaboration and appropriate support exists for all students.

INTRODUCTION

It has been well documented that students who are receiving education in 21st century schools are facing an incredible number of social emotional stressors; including but not limited to: Poverty, violence, harassment, substance abuse, depression, anxiety, and difficulty in their family relationships. It has been estimated that 20% of students have a diagnosable psychiatric disorder, but less than one quarter of these students are receiving any sort of specialty mental health services; most of which the school provides. For example, in California as of 2010 and the introduction of AB 2632, which shifted the responsibilities of providing school mental health services from county agencies to schools, required that the burden of responsibility fell upon school districts to ensure proper support was met for the social and emotional

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needs of their students (Beam, Brady, & Sopp, 2013). However, the method and determination of who (i.e., if it is the responsibility of school counselors, school mental health providers, school psychologists, and/or licensed marriage and family therapists or social workers) is to provide these services is still largely up to the school district's discretion. The following section will separate some key distinctions of the professionals who provide counseling services within the schools, whose roles and titles will be used interchangeably throughout this chapter, who are often recruited to provide such services (this may change by state; examples given are mainly within California):

- **School Counselors:** Typically hold graduate degrees and a credential. Trained in various counseling techniques, often with an emphasis in academic and career/vocational counseling.
- **Marriage and Family Therapists:** Typically hold graduate degrees and a license in the respective state(s) they practice within. Trained in various counseling techniques, often with an emphasis on working with the family system.
- **School Psychologists:** Typically hold graduate degrees and may hold an additional license as Educational Psychologists. Trained in various counseling techniques, often with an emphasis on psychoeducational testing.
- **School Social Workers:** Typically hold graduate degrees and a license in the respective state(s) they practice within. Trained in various counseling techniques, often with an emphasis on working within organizations (e.g., hospitals; clinics) utilizing the appropriate community resources to assist their clients.

A greater unmet need for these mental health services exists for students who are of an ethnic minority and who may not have insurance, access, and/or the knowledge of mental health services. Additionally, these same students may not receive effective, culturally sensitive counseling services, interventions, or valid/accurate measures of psychological testing (Dana, 2007). Researchers have pointed out that there are few studies which have looked specifically at racial and ethnic disparities in mental health; and: "Racial and economic minorities are at elevated risk of persistent mental disorders into adulthood, even though they demonstrate similar or lower prevalence rates in adolescence" (Alegria, Green, McLaughlin, & Loder (2015, p.1).

KEEP IN MIND: THE HISTORY OF COUNSELING

School personnel need to remember the history of counseling in general, specifically where at the outset, upper class Caucasian males were offered privilege not known to other ethnic groups to receive what we currently refer to as mental health treatment. Counseling in and of itself often carries the assumption that professionals are offering what is seen as normative, ideal behavior or adherence to a uniform idea of what is considered less desirable or pathological. The Western world seems to be addicted to the idea of measuring, quantifying, sorting, and logically organizing. The ideas cast into the shadows of our society appear to be disorganization, chaos, qualifying, or acceptance of the unknown. Of course, both ways of perceiving the world—as rational and irrational as well as logical and illogical—are necessary; the question seems to be, why can we not have both? (Goodchild, 2012; Starr, 2015).

Researchers Constantine & Sue (2005) add, "Historically in psychology, the perspectives of racial, ethnic, cultural, and sexual minorities have been marginalized or ignored in mainstream theoretical and

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empirical work" (p. 39). This may be in part due to the premise that study of psychology is seen in large part from the Western perspective as an evidence-based, logical science that measures human behavior. Author Laungani (2002) argued, "By denying and denigrating the contributions of philosophy, religion, art, literature, all of which go toward constituting a culture, a psychology was created that was sterile and fragmented" (p. 389).

Questions for professionals within the discipline of psychology to consider include:

- Can behavior really be operationalized, observed, measured, manipulated?
- Can we understand the true nature of the soul with this perspective?
- Are we taking into account the self that we present to the world and our inner selves that we remain private?

Certainly psychology also needs to take into account its own shadow material and what cannot be seen or measured (Starr, 2015). Additionally, Laungani (2002) pointed out that historically, many premises and assumptions about individuals from a supposed cultural background that have been made about other cultures were not even witnessed by the authors who did not go so far as to even physically travel to the countries about which they were writing. This is certainly a testament that school counseling professionals should not be using the positions of making wide generalizations or assumptions from which to counsel students. There is another example from the literature where a community resource worker referred a Chinese family who had recently relocated to the United States to a Buddhist temple so that they could experience a sense of belonging outside of the school they were attending; without realizing that the family actively practiced Christianity (Ingraham, 2000).

Upon reflection, a student working in school mental health provided some insight into her experience working with students from a culture different than her own:

I used to think, 'Why is there a Black History month? There isn't a White History month.' Now I see that every day, every month is White History something…Now, I make sure to speak up in school meetings about White privilege…Now, I include issues of privilege and oppression in my case notes and write-ups. (Singh, 2010, p. 560).

In Westernized societies, this same tradition where principles of individuality and independence are often emphasized as positives; whereas reliance on the collective, and also members of the person's support group, is often underemphasized (Hobson & Kanitz, 1996).

The construct of what exactly defines student success within the schools have been defined historically from a male, Caucasian perspective (Fraise & Brooks, 2015). A school based example can be seen where a high school track coach complained about a student from a Native American background who would never finish a race without letting the other students catch up to him so that they could all finish the race at the same time. The coach did not see that the teen valued collectivism over individualism (Herring & Runion, 1994).

Various cultures may have different interpretations of how to resolve conflicts, attitudes towards whom and how much to disclose in counseling, and approaches to knowledge. In Western society, conflicts are seen as least desirable, but the resolution to conflict is often discussing the conflicts face to face – as in, but not limited to, counseling. However, in places such as Micronesia, open conflict is viewed as demeaning and inappropriate.

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In Western society, it is somewhat common to reveal personal information and one's feelings, whereas in other cultures, it may not be commonplace or even seen as appropriate (Uehara, 2005). In European cultures, information that can be measured is seen as more valid than ways of learning through oral tradition, as is commonplace in many countries outside of Europe and the United States (Uehara, 2005).

Additionally, it should be taken into account that the interpersonal practice of counseling: "Provokes a range of dynamics given the nation's sociopolitical reality. People, the counselor and the [student] come together in a sociopolitical reality to address any number of life-impacting dilemmas or issues" (Arredondo, 1999, p. 103). Therefore, it is imperative that counselors also partake in non-counseling based interactions, such as community events, celebrations, groups, and clubs to facilitate their perspective of minorities as being less of an exercise, and more inclusive (Arredondo, 1995).

Counselors can advocate for systemic change, if needed, in order for students to interact collaboratively towards a common goal without barriers. For example, students should be able to all participate in after school activities and the school can come together as a whole to ensure that access to uniforms and transportation is a possibility for any student who wants to participate. Counselors can also encourage intergroup friendships to increase meaningful relationships between students on campus, reduce prejudice, and dismantle socially constructed barriers of race, ethnicity, and culture. In turn, this can help to reduce bullying and violence and create a more positive school climate (Pica-Smith & Poynton, 2015).

Consider the History of Education

Just as school counseling staff will have to remember some lessons about the history of psychology, they will also have to remember the history of education and how this juxtaposes with their duties as helping professionals working within the context of schools. Many students from cultural backgrounds other than White were historically denied access to education. Languages other than English were not allowed or taught in schools. Assimilation was forced, diversity was not tolerated, and monolingualism was encouraged (Noltemeyer, Mujic, & McLoughlin, 2012).

Similarly, the concept of emotions was not considered to fit into the paradigm of learning as it was conceptualized by school administrators; just as many Eastern theories of healing were left out of what is currently referred to as Westernized helping perspectives. Specifically with regard to emotions, which are at the cornerstone of most counseling theories and interventions, the helping professional must remember that emotions have historically not had a place within the educational framework. Research highlighted by Coss (2013) has pointed out:

Emotions are of paramount importance in students' reflections on beliefs, norms, values, and assumptions of their own culture, though they have been traditionally omitted from education for sustainability frameworks. (p.21).

Perhaps there is a fear that exists about emotions not being measureable, or controllable, so this fueled the motivation to prevent them from becoming an integral part of the discussion, but it is our job as counselors and mental health professionals to bring about what is not being attended to. We have the difficult job because it is our duty to partake in and often begin conversations that are often viewed as difficult.

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Further Cultural Considerations

School professionals will need to be sensitive to the issue that perhaps neither individualism nor collectivism should be viewed as superior to one another, and utilize caution that they are not favoring one principle over another in their relative counseling approaches and treatment of students and their families. Many Western schools take pride in promoting individual achievements and may not promote enough exposure to collectivistic rituals. School professionals should keep in mind that many parents of students who come from diverse backgrounds have viewed school as "a very unwelcoming place. Work will be needed to ensure that a warm and open environment is created" (Suzuki, Alexander, Lin & Duffy, 2006, p. 436).

Some ideas for schools to incorporate a more welcoming environment include involving outside community spiritual leaders and healers (e.g., clergy, rabbis, local curanderos), oral history traditions, cultural exchange programs, and/or cooperative learning (Ponterotto, Mendelowitz, & Collabolletta, 2008). Professionals should strive to assess a student's presentation in various contexts; including but not limited to: Generational history, English-language fluency, acculturative stress, social economic status, and sexual orientation so that, "They can understand the subjective world of the [student] and eliminate the potential of personalizing societal and institutional problems; e.g., blaming the victim" (Constantine & Sue, 2005, p. 42). Families may also need to be given explicit knowledge about the school (e.g., culture, expectations, methods to access services, strategies to develop successful relationships with school personnel, and ways to support their child's learning) (Ingraham, 2000). Researchers Gerstein, Rountree, & Oronez (2007) pointed out that professionals should balance the interrelationships and totality of the multiple levels of a student's experience at the individual, group, and universal level; as well as within the contexts of that experience (i.e., individual, family, and cultural).

School counseling staff need to keep in mind that students from lower social economic backgrounds and/or diverse backgrounds may not have access or awareness to the same technology or other resources as their classmates and offer resources to assist them as needed (Hughey, 2011). They need to consider the impact of the media, and specifically technology – including the Internet, television, and social media as influences upon what dominant messages or mainstream cultural norms are being stressed to students, which undoubtedly have an impact on the behavior and attitudes of students (Uehara, 2005). They will also need to consider the relative influence of parents, authority figures, and peers on student's perceptions, emotions, and behaviors (Starr, 2015).

Counselors can collaborate with teachers and have students write reflections upon viewing movies or video clips to expand their awareness about different cultures. Questions for reflection may include:

- *Where do these people live and how are their homes similar and different from yours?"*
- *Would it be easy to get to know and make friends with people your age who come from this group?*
- *What would make it difficult to get to know and make friends with students about your age from this group?*

Counselors can also collaborate with teachers about ways that a particular classroom might be able to adopt another classroom from a different country and digitally exchange information about important public figures, holidays, events, family and classroom life from each culture (D'Andrea, 1995). Counselors can encourage teachers and staff to talk openly about students' lives and experiences and incorporate discussions around difference, culture, and race rather than ignoring them (Ullicci, 2009).

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Research has also shown that students from diverse backgrounds with differing learning abilities who actively engage in cooperative, small group learning activities tend to foster more positive attitudes towards teachers and other students, improve race relationships, and support relationships of students with disabilities, including emotional and behavioral disorders. It is also helpful for students to engage within organizational structures such as school council committees and to be involved with the school's decision-making process. This can also foster greater connectedness within the relationships that students have with school staff (Rowe, Stewart, & Patterson, 2007).

Power Dynamics in Counseling

There is also the issue of the power differential as it relates to the counseling process. Depending upon various influences, including the theory or approach the counselor subscribes to practicing as well as the counselor's background that also plays a part in how much power or influence they have over a session (Ingraham, 2000). The special rights, privileges, and/or advantages some people may receive as a result of belonging to certain racial, gender, or social groups as well as the relationship of privilege to power and oppression are important concepts for counselors to be aware of and teach to their fellow staff and inform their work with students (Patrick & Connolly, 2009). DeVaris (1994) provided the following recommendation for helping professionals [note that use of the word 'patient' can also be applicable for working with students]:

They should sensitize themselves to their own power issues by exploring the roots of their own sense of helplessness and powerlessness to ensure that they are not acting out unresolved power needs in their treatment relationships…They should examine their treatment strategies for potential sources of harm. They should explore their own personal biases and prejudices honestly and consider professional or personal activities that will challenge these assumptions…the process of effective psychotherapy gives considerable power and respect to the patient. It activates a patient's self-curative capacity and their active participation in the change process. (591-592).

The counselor's own belief system about how effective they believe they are with a multicultural population of students needs to be taken into account when it comes to effective and ethical school counseling. Researchers went so far as to introduce what they refer to as *Nice Counselor Syndrome* or *NCS*, which essentially illustrates the school counseling professional's fear to take a stance of social justice because they are, "Fearful of being disliked and can be targets of professional ostracism when they do not conform to the traditional role of being noncontroversial, nice, supportive, and friendly helpers in the school setting" (Bemak & Chung, 2008, p. 375). Counselors must also keep in mind that many cultures, such as within the Sikh community, believe that seeking help can be a sign of weakness (Singh & Singh, 2019).

Counselors may believe that they are powerless to do anything to change the status quo within their school communities, which then may lead to a combination of feelings, including but not limited to anger, guilt, anxiety, apathy, and feeling paralyzed to deal with any issues because they are seemingly larger than the role of one person at one school site. Collaboration and recognition of these feelings amongst professionals is key to processing these emotions so that school mental health professionals at all levels can feel safe to develop an attitude that what they are doing through advocacy and/or taking on social justice does indeed matter for all students (Bemak & Chung, 2008). Maintaining a strengths-

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based approach, where counselors, "Search for the assets of the school constituents and build on those assets to develop effective academic and social programs for students and families" (Galassi, Griffin & Akos, 2008, p. 178) is essential for promoting the best future outcomes. Providing written, verbal, situational (e.g., allowing the student to contribute to the situation) and/or gestural encouragement for students, keeping in mind of some students who may have sensitivity in these areas due to their culture or experiential background (Herring & Runion, 1994). For example, many African American families are noted to have cultural strengths in the areas of domestic harmony, cohesive extended family, spirituality, religion, and survival skills.

A solution-focused approach allows the person coming in for help to be the expert of their situation. This may help to stabilize the power differential that often exists within the counseling dynamic. Utilizing a strengths based approach can help decrease the stigma of mental illness and the idea that a mental illness may shame the family name, as is common within Asian and Latino cultures. An example is where Sarah, a 17 year old, was meeting with the clinician and her parents following her re-entry into school after being hospitalized on an involuntary hold. Instead of emphasizing the negative emotions or focusing on how,

…Fear of shaming the family might have negatively affected Sarah or dwelling on the complaints of the parents, the clinician emphasized the parents' positive intention of protecting Sarah from the unhelpful gossip and led the parents to notice their strengths in handling Sarah's illness by focusing on what the parents found helpful in the process (Lee, 2003, p. 391).

Additionally, researchers Harvey, Harvey, & Shera (1995) introduced the idea of *learned hopefulness*, or what they term: "The flip side of helplessness…Learning and employing problem-solving skills successfully and exerting positive control during various learning experiences leads both to a sense of actual control and to an ability to cope personally and effectively with daily events, daily stress, and daily problems" (Harvey et al., 1995, p. 43). Similarly, the hope for this chapter is that the reader is able to find helpful and applicable resources to have a starting place in order to promote an effective, evidence based, culturally informed practice for work with the students, families, and staff within the context of schools.

Best Practices for Schools

According to best practices for school counseling, there is a need to be, "Recognizing and responding to the central role of culture 'as a predominant force in shaping behaviors, values, and attitudes in schools" (Lindsey, Roberts, & Campbell Jones, 2005, p. 22). Researchers Ponterotto, Mendelowitz, & Collabolletta (2008) also provided the important reminder, "There is a growing body of research supporting the link of multicultural exposure, perspectives, and interactions to academic achievement, school connectedness, career achievement, and quality of life, particularly in adolescents and young adults" (p.98).

School based counselors need to remember that the school campus in and of itself constitutes a culture; and need to be able to reflect upon how the school culture on campus may coincide with a student's cultural background, beliefs, experiences, and values. They also need to reflect upon the role that their own culture, background, beliefs, experiences, and values (whether conscious or not) factors into how they view their school environment and the students who attend the institution. These factors all come into play when it comes to the delivery of appropriate school based mental health services, since the understanding of one's environment is crucial to being able to offer the needed assistance to a student.

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All staff who provide any type of classroom instruction and intervention should also be involved in this conversation, as "integrated lessons can assist students across curricula" (Schellenberg & Grothaus, 2011, p. 223).

Schools are the bridge when it comes to connecting parents and the larger community; therefore, mental health services and interventions should seek to also connect these larger systems together in a way that enhances cohesiveness and fosters cultural understanding (Schellenberg & Grothaus, 2011). A sense of connectedness characterized by strengthened social relationships in schools has been shown to bolster mental and emotional well-being (Rowe et al., 2007). At the large-scale level, otherwise referred to as the macrolevel, stakeholders should also consider the influence of public initiatives, politics, government perspectives, and funding for education at both the federal government and local levels that may be influencing the policy and practice of the school system (Arthur & McMahon, 2005). Schools should be aiming to enhance their social capital, which is characterized by, "Strong social bonds, high levels of interpersonal trust and norms of reciprocity" (Rowe et al., 2007, p. 528). Members of the school community have great influence over policies and procedures within the school setting; including but not limited to:

- Codes of discipline
- Standards of behavior
- Democratic systems of school governance
- Mutual respect and attitudes about how staff treat one another
- Attitudes about how the larger community may be involved within the school, and
- Attitudes adopted by staff towards parents and students.

Schools and districts must also consider the physical space of their building and classroom layout, appearance including classroom lighting, space, use of color, and functionality of spaces (Rowe et al., 2007). In contrast, actions that may be considered blatantly oppressive and contribute to unwelcoming school conditions include having access to limited educational resources, unsafe buildings, and overcrowded classrooms (Borrero, Yeh, Cruz, & Suda, 2012).

Academic and cultural contexts are often at odds with one another for youth of Color. Borerro et al. (2012) pointed out that for example, "Many African American youth believe that in order to become academically successful, they must 'become raceless' or 'act white'. Some Middle Eastern and Latino/a youth believe they have to give up their ethnic identity in place of an academic identity" (p.2).

Working Models of Culturally Competent Services

Working to understand the intersections of these principles can help all students initially to engage with the curriculum offered by the school and with their larger community, similarly to the MTSS (Multi Tiered Systems of Supports) or RTI (Response to Intervention) model, where at the first tier, all students are given access to culturally competent services in order to facilitate optimal social and emotional, and ultimately improve their ability to function academically. If the student continues to struggle despite being exposed to universal strategies, then the second level of interventions is introduced, wherein the student may participate in pull out groups or receive more intensive group level interventions. If these interventions prove to not be sufficient, the student may be referred for tertiary level interventions, which may include intensive individual strategies (Schellenberg & Grothaus, 2011). Early response is critical;

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as the longer the student goes without intervention, the more they are at risk of failing and ultimately, these so-called "failures" (e.g., being sent to the office for discipline issues, not grasping material due to lack of sleep or access to a private sleeping area at home) may lead to decreasing their worldview that the educational system wants to help them to succeed in academics; and ultimately, at life (Heavner, 2015).

Programs have been developed to standardize and facilitate delivery in the schools in terms of their duration and content in a "one size fits all" approach, but often fail to realize the individual risk factors, cultural backgrounds, and unique needs of every student. Additionally, school based counselors and mental health providers may not be adequately meeting the needs of students if the program offered is not the right fit for their unique set of circumstances and lead to less participation in the intervention(s) offered and students potentially to dropping out of the intervention altogether. The school based practitioner may also need to reflect upon whether a student may be appropriate for a group based intervention, or if they need more individualized support.

Research has supported programs such as a SMART [Sequential Multiple Assignment Randomized Trials] design with two tracks of interventions, an initial Tier 1 intervention and two possible Tier 2 interventions. One track of the SMART design features behavioral support strategies and the other track offers socio-emotional learning [SEL] training. According to the researchers, "The SMART design is implemented in multiple stages with individuals randomized multiple times to various intervention options across stages…thereby balancing participant characteristics" (August, Piehler, & Miller, 2018, p. 89). Despite much of the current research regarding school-wide systematic tiered intervention to target students with mental health needs, there still remains work to be done in this area, as culturally and linguistically diverse students continue to be overrepresented within special education, discipline actions, and the juvenile justice system (Graves & Castro-Olivo, 2018). The interventions that are successful in an upper middle class school district with a primarily Caucasian student population may not see a similar outcome in an inner city school district with a primarily working class Latino student population. School staff should all take the aforementioned factors into account when planning mental health interventions that best suit the students they are trying to serve.

Varying Degrees of Counselor Education

Another discrepancy in emphasizing a collaborative approach when providing culturally informed best practices of mental health delivery in schools comes to understanding the gap in education between the various stakeholders both at school and within the greater community. For example, an educator takes different classes in a graduate school program than a social worker in order to become credentialed to work in the schools or in the community. The educator may know more about teaching and learning, but a social worker may hold more knowledge about whole child development and youth mental health. Even more complex is the community based mental health provider, who may measure a student's need based on current psychopathological indicators or symptoms, versus a school psychologist or school based mental health professional, who may view the severity of a student based on their ability to perform at school from an academic or social perspective. Researchers Ball, Anderson-Butcher, Mellin, & Green (2010) emphasized the importance of all stakeholders coming together and setting up systems from which all members could learn about each other's profession and gain a mutual understanding of the viewpoint of the particular culture of not only the practitioner's lens but also to develop a mutually agreeable framework about the cultures and backgrounds of the students they serve within their respective communities. Researchers Lewis, Hartwell, & Myhra (2018) point out: "Professionals need to be

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aware of the potential for harm to marginalized clients due to implicit bias, stereotyping, and dominant social systems such as heteropatriarchy and racism" (p. 330).

All stakeholders in a child's education need to be not only taking ongoing trainings related to cultural competency (knowledge), but also need to be reflecting upon how their presence when working with students may unknowingly and unintentionally bring these biases into the interventions they provide [awareness] and then be able to apply appropriate procedures to address these disparities [skills] (Lewis et al., 2018).

Importance of Completing a Needs Assessment

Since every school district and even individual school site can vary greatly in terms of diversity and cultural need, the first course of action at any site level should be for designated members of the school staff to explore and research which cultural groups, languages, and norms are represented in their respective communities and on their individual campuses. The use of a needs assessment can be useful in this planning phase in order to identify existing services offered in comparison to materials, services, and staffing configurations that may be needed; and then in the future to address ongoing needs (Johnson, 1995). The wider lens of international relationships must also be addressed, since technology and study abroad programs make travel more possible than it ever has been, and students will need to be prepared for increased interaction with diverse groups of people in and outside of the school environment (Ponterotto et al., 2008). Approaching the needs assessment as well as examining existing counseling programs from a strengths perspective; wherein current resources are promoted from a "deficit reduction to a strengths-identification emphasis" would be imperative to effectively foster collaboration and a cohesive school community (Galassi, Griffin, & Akos, 2008, p. 180).

Importance of Collaboration

Collaboration within schools, as well as within the wider community can be helpful in order to facilitate connections where outside experts, including but not limited to parents and families, community stakeholders [e.g., outside service providers], interpreters and/or translators may be needed for meetings, gatherings, or other school activities (Klotz & Canter, 2006). Incorporating collaboration into a social justice program within a class or as a separate class where conflict mediation skills can be taught and embraced, offering parents education classes, as well as implementing an onboarding process for students who may be new to the district and the area can be important stepping stones to increased levels of belonging and diversity amongst all parties (Johnson, 1995). It may be important to set time aside to follow a process known as BID (Briefing, Interaction, and Debriefing) so that all parties are educated as to the reason(s) they are meeting together, any professional or culturally specific terminology, and sufficient time be made to follow up following the interactions so that a plan may be devised to plan the best possible outcomes (Langdon & Saenz, 2016). Incorporating family and cultural community members who have what is known as 'resonance' to the student can be helpful; in other words, that these individuals have shared similar life experiences or represent valued life experiences so that they can experience a definitional ceremony in order to form a reflecting team that can provide an authenticating experience (Bitter, Robertson, Roig, & Disqueact (2004).

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The more groups, norms, and languages of a school are explicitly known once a needs assessment is completed, the greater possibility that a comprehensive district in-service or training may be helpful to train school staff in how to best work with the population which is represented in their school(s). Staff must avoid also applying blanket strategies or cookbook methods, wherein they apply the same practice to multiple individuals from a similar cultural group without considering individual differences or the student's worldview (Nastasi, 2006). They must also employ strengths based strategies where possible, so that a foundation for helping students from preschool through their high school years and beyond is established (Galassi et al., 2008). Modeling positive intercultural relationships among staff for the students can be an excellent intervention in promoting attitudes of acceptance and belonging (Buhin & Vera, 2009). Examining which lenses may be most helpful in providing assistance to various students from diverse backgrounds. Researchers Jackson, Holt, & Nelson (2005) cited four types of general helping models: The Moral model, where a person is responsible for creating and solving their problems; The Compensatory model, where a person is not responsible for creating their problems but is responsible for solving them; The Medical model, where a person is not considered to be responsible for creating their problems nor are they responsible for solving them; and the Enlightened model, where a person is considered to be responsible for creating their problems but is not responsible for solving them. For example, many Latino cultures believe in the external locus of control, or that there are problems that they are not individually responsible for, which may ultimately clash with a Westernized ideal and the Moral and/or Compensatory model of helping. The researchers also discussed the idea that the models of helping may be influenced by the social economic status of the schools in which professionals practice; e.g., "The Compensatory or Moral models would be characteristic of more affluent schools, whereas counselors working in poor schools would subscribe to the Enlightenment or Medical models" (Jackson et al., 2005, p. 208). In addition, the researchers also found that more Latino counselors endorsed the Enlightenment or Medical models, placing more external responsibility on factors outside the student's control in their study (Jackson et al., 2005). Researcher Uehara (2005) provides a social justice guidance strategy curriculum for groups spanning 13 weeks; including:

- An introduction session outlining the rules for the group,
- Students learning to introduce themselves,
- Creating self-portraits,
- Experiential activities focusing on the element of trust and emphasizing tolerance between families,
- Using bibliotherapy and reading a story centralized around the theme of tolerance and awareness,
- Bringing in community individuals to speak about their diverse experiences within the community,
- Watching videos about prejudice and discrimination,
- Listening to music that has lyrics about a topic relating to a multicultural theme,
- Participating in an experiential exercise to teach and appreciate similarities across cultures, an experiential exercise to highlight examples of discrimination and for students to relate to their own lives,
- Participating in a creativity project using hands of different fabric or drawing to illustrate friendship and diversity, and
- A closure activity (e.g., a potluck highlighting foods from various cultures) for elementary school counselors to implement at grades two through four because students may be the most impressionable in this age bracket (Uehara, 2005).

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In addition, learning about music and/or playing styles of music different to which students may be accustomed allows them the opportunity to, "Place themselves into the lived experiences of cultures distant from their own. Music serves to address cultural diversity…build intercultural relations and understandings" (Cox, 2013, p. 23).

Exercises for Developing Cultural Competence Among School Staff

Staff must recognize that developing cultural competence is considered as, "A life-long process of professional development…and reflective practice" (Nastasi, 2006, p.9) as staff must recognize that they too identify from a particular cultural background which, if not made conscious or explicit as an integral piece within the counseling process, can lead to bias when counseling the student. For example, a school counselor may think nothing of simply inviting a student's parents to a school meeting to address grades; when in fact this may be seen as an insult to the student's family if the counselor does not also invite the extended family to weigh in on the matter (Ponterotto et al., 2008). Authors Harvey, Harvey, C.M., & Shera (1995, p.45) added:

By focusing both on the natural resources of the [student] and on a natural partnership for empowering [students] and their families, the helpers' perceptual 'set' shifts from the exclusive to the inclusive where the seekers and their families have active roles in enabling, empowering, and functioning.

Researchers Bemak and Chung (2008, p. 373) suggest counselors ask and reflect upon the following question:

Do I genuinely believe that all children can achieve and learn at high levels; and if I do, how can I foster greater academic success by helping reduce the academic achievement gap that disproportionately affects poor youth and students of color?

Other helpful exercises and training principles for in-service training for school staff about best multicultural counseling practices include role playing, examining media imagery about journeys of immigrants or refugees, and reviewing articles and research findings pertaining to multiculturalism and diversity (Constantine & Sue, 2005). Experiential activities are especially helpful; as one participant in an exercise noted, "You can read all you want about white privilege, but until you experience lack of privilege you can't really understand it" (Patrick & Connolly, 2009, p. 125).

School staff can also learn about the importance of modeling a caring affect for developing a positive working relationship with students (Hughey, 2011). The use of games as experiential methods of instruction have been shown to be effective in enhancing participant's learning, such as the game entitled *Bafa Bafa*, wherein the group of participants is divided into two separate cultural groups, the Alpha and Beta cultures. Each culture learns about their own set of norms, rituals, and traditions; and then goes about to communicate and observe the other culture. The two groups engage in a follow up discussion to debrief about their experience.

Another possible game is that of the *Step Forward Step Back* exercise, where either the participants create an identity using a character with varying cultural demographics (e.g., race/ethnicity, gender, sexual orientation, socioeconomic status) or they participate as themselves, and either step forward or back depending upon whether the person or the character is a member of the dominant, more privileged

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culture. More suggestions for experiential games in the area of training include Multicultural Jeopardy or Cultural Bingo (Kim & Lyons, 2003). A metaphorical activity for participants to complete was suggested by Singh (2010, p. 557) whereby participants would:

Utilize everyday objects (e.g., magazine cut outs, photographs, found objects around your home or workplace) to create a 'social justice quilt' that represents the most salient aspects of your identity (e.g., race/ethnicity, gender, sexual orientation) and history of personal social justice advocacy that shape how you view social justice theory, the nature of human challenges and resilience, and the reasons you have chosen a helping profession.

School Counseling Professionals as Change Agents

School staff who are counseling students from a multicultural lens also need to incorporate social justice advocacy into their work, whereby they work with students and communities to "remove barriers and promote change" (Cook, Krell, Hayden, Gracia, & Denitzio, 2016, p. 176). School counselors are often referred to as *change agents* within their respective school sites, as they are in a position to, "Affect attitude through changing awareness, providing necessary knowledge and skills, and enhancing opportunities that foster respect for cultural differences" (Uehara, 2005, p. 46). They should be asking themselves the following types of questions when it comes to implementing competent, multiculturally sensitive counseling interventions: "Is this intervention reflective of the student's cultural experience? Would other members of this culture recognize this intervention as a positive representation of the culture? Would you recommend your intervention with this cultural group to other professionals based on your experience?" (Suzuki et al., 2006, p. 435). In order for a school culture to ultimately be realized, the conclusion needs to be made that culture outside of the school, just as the dynamics and culture within school, are forever changing and should be frequently updated and revised as the need arises (Fraise & Brooks, 2015).

Importance of Establishing a Working Alliance

One of the key aspects to establishing an effective counseling relationship is that of the therapeutic working alliance. Many ethnic minority students may not experience the therapeutic alliance, perhaps because of the cultural misunderstandings and miscommunications that may occur between counselor and students because of stereotyping or shaming (whether unconscious or conscious on the part of the helping professional). The counselor should avoid using stereotyping or assuming and instead use their clinical judgment to assess a student's level of acculturation, developmental level, ability or ease of providing insight to their current needs, as well as their cultural values, behaviors, interpersonal relationships, and expectations (Roysircar, 2009). Many Western notions of counseling are accustomed to a direct approach to building a working alliance. Counselors may need to adjust this mode of delivering services to indirectly connect, e.g., take a nondirective stance when aligning with the student or family and allowing them to direct the conversation (Singh & Singh, 2019). While teachers are not counselors, the counselor and/or mental health professional staff can provide training for teachers on how to build relationships with their students that are in the spirit of productive, working alliances in order to foster positive, supportive school connections.

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Researchers Cook et al. (2016) also suggest partnering with local universities to promote multicultural fieldwork for counselors, and receiving support and ongoing training with university faculty. Training and practice in universally important counseling skills such as empathy, genuineness, openness to learn from students who have different cultural background and experiences from that of the clinician, and the importance of not making generalizations about the student's background and being able to maintain a stance of curiosity about learning more. For example, a student shared that he had a sibling, and the counselor assumed the student's sibling was his twin; when in fact the student shared that her sibling had a different mother (Cook et al., 2016). Researchers Ponterotto et al. (2008, p. 94) added that the principles of *social initiative*, which involves, "Embracing and initiating cultural interactions in a wide variety of contexts"; as well as flexibility, which involves, "Cognitive resiliency that promotes seeing new cultural situations as a positive challenge rather than as a stress marker" are inherent to the practice of multicultural counseling. Researcher Bemak (2005) outlined the important principle of empowerment for consideration from school professionals, whereby:

…An individual gains control over their lives and decisions. In order to accomplish this, those who typically make the decisions must relinquish their power and authority, as the previously disempowered gain greater control to manage their own lives. (p.403).

The concept of flexibility in adjusting to the styles of student's personalities and cognitive styles should be taken into account by school counseling staff for better student retention and improved attitudes about school culture. Helping students to gain flexibility in the way that they cope cognitively and improving communication, problem solving, and coping styles as they compare and contrast with traditional and modern cultures to maximize, model, and encourage a stance of flexibility (Trusty, 1996). Teaching self-advocacy skills can be helpful to teach students how to be self-motivated to set goals for current and future outcomes (Hughey, 2011). Taking on the stance of the learner themselves and maintaining curiosity about the types of food, traditions, and games can be helpful to building rapport with students of diverse backgrounds (Suzuki et al., 2006).

A perspective entitled the Culture Specific Pedagogical (CSP) counseling model can also be taught to educators to enhance their knowledge of applying helpful multicultural interventions (Marbley, Bonner, McKisick, Henfield, & Watts, 2007). According to the authors, the CSP model is, "Designed to address the construct of diversity-sensitive training as a possible factor for the P-12 prospective teachers' lack of efficacy toward teaching culturally and racially diverse students" (Marbley et al., p.8). The CSP Model embraces three theoretical approaches – multicultural counseling and therapy (MCT), culture-specific pedagogy, and counseling and continues over time. Pre-and post-surveys are given to participants to monitor baseline and ongoing levels of staff's comfort levels with their multicultural development throughout the process. Growth groups led by a trained mental health professional focus on the following: "Feelings and interpersonal engagement, learning through action instead of just dialoguing, and on the present rather than the past" (Marbley et al., 2007, p. 13). The researchers recommend that at least one facilitator of the counseling group be representative of that of the dominant culture of the group they are facilitating – for example, if the majority of the group is Caucasian, then one of the facilitators should also be Caucasian. The third step within the CSP model is for teaching staff to have classroom experiences around multicultural awareness and sensitivity, including but not limited to readings, experiential exercises, class discussions, and community experiences. The last step of the model is centered around a process involving termination and a debriefing discussion where the diversity experience is reflected

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upon and follow up counseling can be offered if needed. It is important that counselors provide a safe, confidential space where the participant's emotions can be processed without judgment (Marbley et al., 2007).

CONCLUSION

This chapter has reviewed the disparity that continues to exist around providing culturally competent counseling within the confines of a school environment to meet the needs of diverse student populations. This disparity may be due to a variety of factors; including but not limited to:

- Differences in education levels and experiences of school counseling staff,
- Differences in training of school staff towards adopting a multicultural framework for working with diverse students,
- Potential biases that may exist towards certain cultural groups,
- Power differentials that may exist between staff and students,
- A lack of awareness of available services which seek to accommodate the various modalities by which students from various backgrounds effectively learn,
- The history of counseling and education, and others (Beam, Brady, & Sopp, 2013; Patrick & Connolly, 2009).

This chapter has reviewed some potential starting points for school counseling staff to learn about the various levels of training for school counseling professionals as well as explore ways to integrate their expertise to form a school climate. It has aimed to demonstrate how school counseling staff can serve as change agents for their relative school sites through fostering educational opportunities for staff and continued professional and personal growth, and provide culturally appropriate ways to integrate parents, families, and communities together for the benefit of helping students effectively navigate their educational journeys (Uehara, 2005). At first glance, students may not always initiate or seem as if they need help, but if their needs are understood from a multicultural lens, more can be done to promote early intervention. Ultimately, this can promote greater overall student well-being and foster success in many lessons taught within and outside of the traditional classroom. After all, if schools are truly the bridge to the wider community, then a greater effort needs to be put forth to understand the unique needs and cultural representation of the students who are members of the student body. A conscious policy and procedure of openness, awareness, and flexibility from all who belong to the school community can be made possible in order to establish and serve the culture of the school itself.

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Chapter 29
The Mental Health Interpreter:
The "Third Space" Between Transference and Counter-Transference

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ABSTRACT

This chapter aims to provide an interpretation of the role of the mental health interpreter, using the concept of "third space" taken from the field of cultural translation and the psychoanalytical concept of transference/counter-transference. Such interpretation provides a unique and novel analysis of the work of the mental health interpreter through the perspective of the "third space", thus enabling a broader view of the interpreter's role in the therapeutic session. The authors' insights are based on a reflective journal written by the first author while working as an interpreter during a parental training in a public mental health clinic in Israel. By reviewing the different roles, powerplays, and challenges in this third space, the authors will suggest some practical recommendation regarding the training and supervision of mental health interpreters, allowing them to serve as competent and ethical mediators between the patient and the therapist.

INTRODUCTION

The literature on interpreters in public services (including mental health interpreting) has long been recognized the interpreter-mediated session as an interaction (Wadensjö, 1992) in which not only the main parties have distinct voices (e.g. "the Voice of Medicine" and "the Voice of the Life-world", as Mishler [1984] refers to them) but also the interpreter. Brisset and colleagues (2014) have found that collaboration with a competent interpreter helps the healthcare provider to better listen and understand the patient's lifeworld (Leanza, Bolvin & Rosenberg, 2013). Such examination of the interpreter's dynamics

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in public service settings challenges "the myth of the uninvolved interpreter" (Bot, 2003) and assumes a more present, active and involved role for her (Hseih, and Nicodemus, 2015). The dynamics in the triadic encounter are even more significant in mental health settings, as will be further elaborated later on.

This paper aims at analyzing the work of the mental health interpreter from a new perspective – that of the "third space", thus enabling a broader view of the interpreter's role in such settings. The authors base their insights on a reflective journal written by the first author while working as an interpreter during a parental training in a public mental health clinic in Israel. She interpreted between Hebrew and Italian throughout 20 sessions that took place between January and August 2016. With the background of a mental health worker and a trained interpreter, her observations refer to the linguistic, cultural and psychological aspects of the interpreted session.

BACKGROUND

Language, Interpreting and Health

The importance of the mother tongue in psychotherapy is extensively discussed in the literature (Amati-Mehler, Argentieri & Canestri 1990, Santiago-Rivera & Altarriba, 2002). The centrality of words in psychoanalytic psychotherapy is crucial as a pathway to analysts' and patients' access to the content and effect of pathogenic unconscious, fantasy, memory and complexes and contribute to an effective therapy.

A meta-analysis of 76 studies found that therapies offered in the patient's mother tongue were twice more effective than therapies offered in English (Griner & Smith, 2006), with more effectiveness being measured when the therapy included culturally adapted measures. In the macro level, patients who are not proficient in the country's primary language may encounter barriers to the use of mental health services (Sentell, Shumway, & Snowden, 2007), as well as higher rates of treatment dropout, recurrent and longer hospitalizations, poor adherence to medication and treatment recommendations, lower client satisfaction. Naturally, all these barriers may contribute to health disparities among fragile populations.

When patient-therapists language concordance is not possible, the session should be mediated through an interpreter (Brisset et al., 2014). Based on understanding of the importance of language in psychotherapy, some therapeutic models, e.g. the Cultural Consultation Service (CCS) in Canada, suggests considering the social, cultural and political context of the patient's behavior and symptoms, to provide better diagnosis, assessment and treatment plan (Kirmeyer et al., 2003). In such cases, cultural mediators (sometimes referred to as cultural 'brokers') eliminate not only the language gaps, but become go-betweens who sensitize clinical practitioners to patients' belief systems and encourage patients to "trust" the institutional system. According to Miklavcic and Leblanc (2014) who studied the Canadian CCS mentioned above, cultural brokers can help in assimilating the immigrant's point of view to the healthcare system and broader society, by offering a more inclusive two-way exchange of the other's perspective.

Since the triangular encounter of the therapist-patient- interpreter requires specific expertise and preparation, many providers often lack the appropriate training to effectively use interpreters during therapy. For example, a survey among mental health providers in Montreal, Canada, revealed that even when linguistic resources such as interpreters were available, many providers were not aware to issues like the dynamics in the triadic encounter, the possible roles of the interpreter, and key elements for a successful interpreter-mediated intervention (p. 1245).

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The Complexity of Mental Health Interpreting

Interpreting in mental health settings requires special knowledge, awareness and skills. Interpreters in mental health have a responsibility for the co-construction of meaning, which is one of the basic and most important process acquiring within a therapeutic encounter (Leanza, Bolvin, and Rosenberg, 2013). The interpreter's choices, even on the renditions of small, allegedly non-informational utterances, may either exclude or marginalize the principal participants. Successful mediation, on the other hand, may help building an emotional rapport (Farini, 2013).

In addition to general linguistic and interpreting skills, the mental health interpreter should be able to identify meta-linguistic issues, such as unusual linguistic choices or unique forms of languages, that may be important for an accurate diagnosis and treatment (Registry of Interpreters for the Deaf, 2000; Santiago-Rivera & Altarriba, 2002). Mental health interpreters should also be aware of extra-linguistic factors, such as the nature of the session (for example, an intake interview) and the setting (i.e., the combination of concrete and subjective elements in the psychotherapy framework that are set up to provide continuity, consistency and containment). For example, the length of therapeutic sessions may affect the ability of the interpreter to keep focused.

Another important element is the interpersonal dynamics in the room (Hlavac, 2017). Interpreters must be able to cope with silence, anger, tears and mistrust. Moreover, their feelings that things are not going according to their own common sense regarding the nature of the conversation and patient-therapist dynamics, may leave the interpreters confused and frustrated. Anderson (2012), a mental health interpreter, accurately phrased the effects of these emotions: "When the interpreter silently questions the course of therapy, subtle emotional overtones may be disruptive to the therapeutic relationship. […] Their innate responses can add some emotional nuances to the interaction that were unintended by the therapist, and eventually to subtly degrade the quality of trust and rapport between therapist and client". That said, the interpreters' performances have interpersonal and clinical consequences on the shifting boundaries of task, identities, and relationships in therapist-patient interactions (Hseih & Nicodemus, 2015)

Despite the fact that interpreters can be emotionally affected by their mere presence and involvement in therapeutic sessions, studies addressing issues of emotions in interpreter-mediated encounters are few and quite limited (Hseih & Nicodemus, 2015). Similar cultural background or past experiences may evoke significant emotional impact (Miller et al., 2005; Tribe & Morrissey, 2004), as well as the fact that the interpreter usually speaks in the first person. On the other hand, studies have shown that such exposures could also lead to substantial personal growth among the interpreters (Hseih & Nicodemus, 2015; Splevins et al., 2010). In any case, most interpreters do not receive supervision[1] or support, and may be at risk of developing secondary or vicarious trauma (Splevins et al., 2010).

The following chapter is aimed to shed light over the need of therapists and interpreters to identify and acknowledge such emotional impact, and be prepared to handle its implication, both for the success of the therapy and the interpreter's emotional well-being and his/her proper professional conduct.

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THEORETICAL FRAMEWORK

The Third Space no. 1: The Cultural Translation Perspective

Almost all aspects discussed so far regarding the interpreter's position in the consulting room are generally framed as "problematic", often used to highlight the difficulties that this service presents to all involved parties. However, the authors would like to suggest a different view of the role of the interpreter in mental health settings, which points out, next to the difficulties and "traps" it creates and faces, the potential added value that his/her presence can bring to the table of successful therapy. To this end, the authors will rely upon the sociolinguistic concept of "third space" articulated within the theory of cultural translation by the scholars Homi Bhabha (Bhabha, 1994) and Judith Butler (Butler, 2012).

Bhabha is one of the pioneers of post-colonial studies of literary criticism. In his thinking, identity is shaped by a complex and uninterrupted negotiation that finds its most fertile ground in hybrid and intermediate spaces. The latter, better known as "third space", is the theater of cultural translation (Buden et al., 2009), a platform to the development of identity and the creation of cultures. Engaging into the relationship with the other means to take the risk of his unconscious, of the displacement of the point of view, to identify with the untranslatable (Bhabha, 2016). In such a condition of liminality and paradoxes, people are constantly in motion, engaging in dialectical processes and exchanges: "It is in this space that the authors will find those words with which we can speak of ourselves and others" (Bhabha, 2006, p. 157).

In the wake of Bhabha's thought on cultural translation, Judith Butler (Butler, 2012), a comparative literature researcher who specializes in moral philosophy and gender studies, identifies the place of the meeting with the other as the third space, which forms the basis of the ethical relationship par excellence: "a relation to alterity […] as constitutive of identity" (Butler, 2012). In other words, translation is not merely the interpretation that a translator performs on a literary or social script; rather, the translation itself – and particularly its encounter with otherness – becomes a model for ethical and political action (Bermann, 2014). The very title of Butler's book, *Parting Ways* (Butler, 2012), alludes to a constant transformative and translational movement, and is in a perpetual duality between belonging and detachment, which she "solves" by suggesting the uncertainty of ambivalence as a guarantee of ethics. Only then, in the ethical encounter that implies a continuous transition between worlds and in the departure from the origin, religious, spiritual, and cultural content can be reworked and translated into renewed and relevant ethical resources for the here and now. Furthermore, Butler's ethical responsibility implies listening to often "remote and foreign" human voices (Butler, 2013, p. XII), and to the abandonment of certainties to the unknown: "Translation cannot be a simple assimilation of what is foreign into what is familiar; it must be an opening to the unfamiliar, a dispossession from prior ground, and even a willingness to cede ground to what is not immediately knowable within established epistemological fields" (Butler, 2012, p. 12). Thus, Butler's account on cultural translation concerned with cultural differences echoes Bhabha's, as both are seeing the introduction of foreign elements into another culture as potentially conjuring something 'new' out of the encounter between two competing 'languages' (Lloyd, 2007, p. 153).

Bahadir (2004) addresses the post-colonial ethos in order to deal with the cultural, social, political and professional identity of public services interpreter: "Interpreters, too, are engaged in a borderline activity, producing other cultures against the background of their own cultures, and creating a new space, a third culture, 'something like culture's 'in-between', as Bhabha would put it." (Bahadir, 2004, p. 816). In the

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globalization era, when profiles are multiple and easily subjected to hybridization, Bahadir stresses the need of resistance to the fascination of the one-dimensional dehumanizing ideal of the interpreter as an invisible, transparent, neutral and objective agent. This expectation of being impartial and factual clashes with her being a third party in between, "steadily moving from involvement to detachment, and back" (Bahadir, 2004, p. 807). In performing this back and forth act that recalls Butler's fluctuating dynamic, the interpreter should be self-critical and self-reflecting, sufficiently aware of his/her own culture and of the fact "that seeing, reading, writing (i.e., translating) the other culture to mine means incorporating it into 'my world' in order to make it comprehensible and thus, 'digestible'" (Bahadir, 2004, p. 807).

Bahadir encourages interpreters to focus on freedom, responsibility and visibility as vital elements for professional ethics for interpreters experts in intercultural communication. Hence, in addition to the bag of "duties" implicated in his/her job, the interpreter working in the consulting room has many powers that still need to be identified. As Levinas put it, the interpreter plays the role of both a witness and a judge (Levinas, 1961), acting as a moral authority over therapist and patient. Paradoxically, it is a passive, mirror-like power, as the interpreter will not actively purge the contents of the dialogues; instead, his/her presence pushes the parties towards greater ethical and critical content.

This aspect of the third space, then, refers to the negotiation and mediation functions the interpreter's role entails. By acting as an influential author of tension between ethics and justice, a bit like a tennis court's net, the presence of the interpreter can stimulate both interlocutors in the consulting room to pass over only those contents that are sufficiently "high" to go above the net. The interpreter, who is serving as a "host" during the session, much like a referee, can act as a witness to the truth, an impartial judge and ethical guarantor of intimate exchanges.

The Third Space no. 2: The Psychoanalytical Perspective

Since the therapist in the presented case study operated in a psychodynamic psychotherapy framework, the interpreter's experience will be conceptualized using the notion of transference/countertransference, that is central to psychoanalysis theory and practice (Racker, 1968; Searles, 1978; Laplanche, 1988). The concept of the third space is also a prominent part of the psychoanalytical discourse, viewing the analytic session as a third space (Winnicott, 1971), which is the place transference and countertransference take place.

As first conceptualized by Freud (Freud, 1895), one of the conditions that makes analysis possible is the establishment of a two-way relationship, called 'transference' and 'counter-transference', between patient and therapist. This is a living relationship, in which there are constant movements and changes (Joseph, 1985). As Joseph noted, "everything of importance in the patient psychic's organization based on his early and habitual ways of functioning, his fantasies, impulses, defenses and conflicts, will be lived in some way in the transference (Joseph, 1985).

Notably, the concept of transference has undergone significant changes and developments since Freud, through the contributions of analysts like Winnicott (Winnicott, 1956), Kohut (Kohut, 1968) and others (Mitchell 1988). Nonetheless, contemporary therapists still agree that much of the therapy's potential depends on the ability to work with transference and counter-transference (Nissim Momigliano, 1984).

Having examined the theories mentioned above, one can assume that the differential between those psychoanalytical transference flows is actually the third space of cultural translation. In the presented case study, there is a guest in this third field: the interpreter. In this triadic exchange, the interpreter sits

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between therapist and patient so that they maintain visual contact with each of the participants throughout the session. In order to guarantee an easy flow, the interpreter has the responsibility of delivering the contents from one side to the other with great precision and sensitivity, as well as to fulfill his/her task paying attention to all the details.

Although one could say that the translation process is fundamentally mechanical and immediate, it almost always involves an interpreter's choices, which rely on his/her linguistic and cultural background, as well as her personal experience. Thus, it is reasonable to assume that the sentence translated to the recipient will not be identical to the one offered by the originating interlocutor, especially in circumstances where the emotional burden is considerable. In that case, the interpreter is at risk of being entangled in the transferential relationship, which may push him/her to modify the text, even unconsciously.

In order to explain this possible implication of transference on the translation process and product, the concept of 'lateral translocation' should be introduced. Initially discussed in the context of group psychotherapy (Yalom, 1975), lateral translocation describes the way that transference within the group is always in movement[2] (Baranger & Baranger, 2011), and becomes possible engines of development and transformation for all participants. Besides the main patient-therapist transference, a part of the projections is directed towards the other participants who make up the relationship with the therapist. The therapeutic alliance in the group retains the participants in a joint care project, where they perceive reciprocal feelings of closeness and solidarity. Despite the differences between group dynamics and an interpreted intervention, the mental health interpreter, too, is involved in the therapeutic alliance (Chiappano & Ferruta, 2012). Therefore, it may be assumed that interpreter is not immune to the development of such transfer and empathy experiences towards other members.

CASE STUDY: INTERPRETING IN MENTAL HEALTH

Israel is home for about 8 million people, shared by diverse linguistic and cultural communities. The largest linguistic group is Hebrew, seconded by Arabic and Russian. In total, there are about 30 languages spoken (or signed) in Israel – by either native minorities, Jewish immigrants, work migrants and asylum seekers – mainly from African countries (Ethnologue, 2018).

Despite this linguistic diversity, training of interpreters in mental health services is extremely limited. A directive from 2011 by the Ministry of Health requires all healthcare institutions to provide culturally and linguistically competent services (Ministry of Health, 2011). Although the ministry offers telephone interpreting services for medical institutions, these are mainly used in general hospitals, as well as in primary and secondary care. Since 2013, initiatives by the NGO – the Jerusalem Intercultural Center, in cooperation with mental health centers, have started offering focused medical interpreting skills training for bilingual workers of the hospitals. However, these initiatives did not last long; apart from these local initiatives, no special training was offered to interpreters in mental health. In fact, most requests for interpreting services in this area were addressed on an ad-hoc basis.

This was the case in the current therapy, too, since Italian is a very marginal language in the country[3]. In January 2016, the first author was offered to interpret in a series of parent training sessions, for Italian – Israeli parents of a 12-year old girl. The author was never specifically trained to provide interpreting services in the mental health field. However, since she has the background of both translation (Ph.D. studies at an Israeli university) and mental health, she felt as she could take this assignment, and allow the family the access to mental health services.

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The parent training took place in a Children's and Adolescents' Clinic, which is part of the Public Mental Health Service in one of Israel's largest cities. The sessions took place once a week, besides Jewish holidays and a few cancellations made by the patient herself. The insights described here were documented in a reflective journal written by the first author, in which she wrote down mostly personal impressions and feelings after each session. All personal details, including the child's name and the location of the therapy, have been changed here to prevent identification.

The individual therapy of Rebecca and the parental training were initiated by Rebecca's school. The family immigrated to Israel from Italy when Rebecca was 10. She presented adaptation and learning difficulties, partly due to language barriers and partly to emotional challenges of different nature linked in some measure to tensions at home. A report issued by the school discussed the possibility of domestic physical violence. Therefore, Rebecca was placed under an individual therapeutic program first, and then in peer group therapy, while both parents were invited in parallel weekly training sessions. While Rebecca was able to master Hebrew well enough in order to undergo therapy, her parents, who had difficulty with the language, had to use an interpreter. It should be noted that is no formal arrangement for Italian-Hebrew medical (or other) interpreters. However, due to the Ministry of Health's directive regarding language accessibility to health services (2011), the relevant function in the mental health system made an effort to find an interpreter to take part in the therapeutic sessions.

Except for the first meeting, which both parents attended, only the mother participated in the remainder of the sessions. As a result, the parental training phase was, for the most part, a series of individual therapeutic session with the mother. Thus, there were three participants in the room: the psychologist, Rebecca's mother (herein referred to as "the patient") and the first author, serving as the interpreter (hereafter "the interpreter"). The intake sessions have been conducted by a male psychologist, but after a couple of sessions, he was replaced by a female psychologist. The therapy was never formally ended, but rather abruptly stopped, due to some financial difficulties of the parents.

The descriptions and reflections reported in the first author's reflective journal were analyzed to understand her role as an interpreter, her involvement and the dynamics in the room, all in light of the "third space" concept.

DISCUSSION

The Interpreter as an Agent in the Cultural Third Space

The interpreter, as a guest in the consulting room, must be transparent enough to avoid disturbing the intimacy of the therapeutic encounter and patient's sensitivity, while also able to provide the therapist with all the necessary information. This double chore requires facilitating verbal and nonverbal communication, as well as mediating concepts and cultural practices, as warranted by the circumstance.

The family, consisting of the father, mother, and their two children, came from a large Jewish community in Italy, and whose members belonged to different social spheres and economic classes, as in the case in most Jewish communities in Central and Northern Italy. Having immigrated for Zionist and religious reasons, once in Israel, this family was faced with a number of social acceptance difficulties, especially in terms of employment, with resulting financial challenges.

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Awareness by the interpreter of intercultural gaps, such as different systems of values, roles of family members, taboos, authorities and educational systems, is likely to be an added value. Therefore, interpreters, especially in community settings, are sometimes acting as "cultural interpreters" or "cultural mediators" (Albertini & Capitani, 2010). In our case study, this cultural mediation was manifested in a number of ways. First, when the interpreter had the impression that the translation was not able to communicate all the subtle details and feelings, she felt the need to add some more information in order to make the therapist aware of the gap.

In order for the therapist to understand the social context, the interpreter was often elaborating on the social structure gaps, as well as the dynamics within the Jewish community in Italy. These features included, among other things, a difficulty to openly discuss some issues with other community members, feelings of shame due to economic difficulties and some miscommunication between the more and the less affluent community members. These dynamics may have led to feelings of isolation and loneliness, in a community that is a minority in Italy. Another cultural issue that had to be clarified, in the opinion of the interpreter, are family dynamics (e.g., family roles and everyday dining habits), as well as discourse patterns in typical Jewish families.

Such difficulties and frustrations would have likely impacted the domestic environment. It is important to point out that in Italy, even today, and certainly as it pertains to older generations, the possibility of using "moderate physical violence" against children as an educational and corrective method is still socially tolerated. The Italian law does not explicitly establish whether it is lawful to slap one's own children (Codice penale, Articolo 571 - Article 571 c.p. -Abuse of the Means of Correction or Discipline), as the jurisprudence has not yet been established in a secure and predictable manner. Thus, where the border between legal correction and abuse appears blurred, the law prefers to leave it to each individual case. This attitude is also a significant cultural gap that the therapist had to be made aware of by the interpreter.

Another cultural aspect that should not be underestimated is the respect for privacy and confidentiality of information. At the beginning of the therapy, the psychologist took care of introducing the interpreter to the patients, while emphasizing that her presence will not in any way undermine the secrecy and confidentiality of the sessions. However, the risk that the interpreter may, even involuntarily, establish family connections through the local community network was high. As the Jewish-Italian community is so small, the interpreter in our case actually knew the patient's employers, and it just so happened that she ran into them at a circumcision party at the end of therapy. Anticipating that this could happen, the interpreter consulted with the psychologist before taking part in the event, agreeing to keep as much physical distance and discretion as possible, as not to embarrass or making the patient uncomfortable.

Indirect cultural mediation was also performed outside the therapy room. One of the psychologists initiated a debriefing meeting with the parents and the interpreter present, after the first session. During this conversation, the parents had quarreled in Italian. The therapist noticed that the interpreter found herself in a very complicated situation, having too much power in her hands that she did not know how to use ethically. Thus, he suggested to talk things over with the interpreter after the session, so she could express her personal impressions and any relevant information that would help him understand the situation or the patient. The therapist listened attentively, though it was not officially defined as supervision. At some point, the second psychologist started to join these meetings, bringing this kind of open-hearted conversation to an end. From that moment on, the therapists-interpreter conversations became very concrete and informative, mainly focusing on language gaps. This type of events raises an ethical question: is confidentiality limited only to people outside the therapy, or also referring to the relationships between different members within the room? This area is considered a kind of a grey zone,

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indicating the need for more explicit roles to regulate the interpreter's work, and protect not only the therapist but also the interpreter – who do not enjoy the same legal, professional and ethical protection as psychotherapists get.

When no fixed rules regarding the supervision of interpreters exist, certain dynamics are being left to the discretion of the subjects involved. The interpreter, in this case, found it very useful to exchange information with one of the therapists after the sessions, during which she provided the latter with some clarification on the family background. These short conversations helped her, in return, to better her understanding of certain attitudes and responses. However, while the first psychologist in charge of the family always made himself available to accept short feedback from her, the second therapist was hastier and less available.

The biggest challenge for the interpreter was to find a way to be active in the communication while letting the patient and therapist remain the main actors. In order for this latter condition to occur – to act as a supervisor in transparency and professionalism – the interpreter must be able to manage production and awareness of the emotional content she conveys, so as not to become too entangled nor empathic, risking, in both cases, an involuntarily manipulation of the content she is supposed to deliver. This brings us to the discussion regarding the development of transference and counter-transference by the interpreter herself.

The Interpreter's Transference Within the Psychoanalytical Third Space

Acting in the third space of the intersection between the transference and counter-transference, or in the differential between the "flows" coming from both the therapist and the patient, the interpreter is exposed to the risk of excessive identification, rescue fantasies or, at least, of developing over-empathy toward the patient. Thus, it is crucial that the interpreter be placed in the condition of managing her involvement and emotional burden in the session. Otherwise, she might develop lateral transfers or extreme empathy that could compromise the "sterility" of the therapeutic setting.

Following Joseph's advice stating that "everything of importance in the patient's psychic's organization […] his fantasies, impulses, defenses and conflicts will be lived out in some way in the transference" (Joseph, 1985), the first author's reflections (taken from her private journal written during that time) shows she did cope with complex fantasies, impulses, defenses and conflicts while interpreting the therapy. The risk of identification presented itself in different ways. For example, the patient spoke of an "unresolved relationship with the absent maternal component" and, like the interpreter, "had gone to a non-Jewish school where she had been the victim of episodes of anti-Semitism that influenced her choice to emigrate to Israel", as the interpreter recalled thinking during the session. These common childhood experiences in the same motherland have challenged the first author in terms of identification, and, using the first-person while interpreting, made it even stronger. Notably, the risk of identification tends to be more evident when the patient and interpreter belong to small communities.

Another thought that crossed the interpreter's mind was related to the family's financial situation: "The patient was also living in a condition of financial deprivation, akin to the circumstances in which one of my close acquaintances was living as a result of bankruptcy procedures". Personally exposed to some financial difficulties of Italian friends recently immigrated to Israel, the interpreter had a hard time separating her personal experience from her professional ones, resulting in greater empathy toward the patient. At the same time, other notes demonstrated the sensitive subject of wishing to have a closer alliance with the therapist, risking a situation of "inferiority" and isolation of the patient:

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"In addition, within what is already an asymmetrical dynamic, i.e., the therapeutic encounter, the fact that I perceived greater intellectual and social affinity with the therapist could have caused an implicit alliance between the latter and me…".

The interpreter's personal experience undergoing psychoanalysis seemed to show up and "disturb" the course of the interpreting. After one of the sessions, she wrote to herself: "By chance, the patient had the same name as my personal analyst. I wonder how it could affect fantasies of inversion of roles, where I to identify myself with the therapist, or worse, going above her." Other notes show that situations when the therapist answered differently from what the interpreter would have imaginably done were a constant cause of frustration for her.

These examples demonstrate the effect of the mediating role on the interpreter, such as feelings of over-identification, anger, and empathy, alongside the willingness to bridge the language and cultural gaps, even when this is not necessarily required. The strong influences of the transference and counter-transference on the interpreter, just like those experienced by the therapist, require great awareness and self-control, in order to avoid taking professionally inappropriate decisions.

CONCLUSION AND CLINICAL IMPLICATIONS

Based the concept of 'third space' elaborated in cultural translation by Bhabha (1994) and Butler (2012), the authors suggest looking at the interpreter in the consulting room as a special guest acting in the third hybrid and liminal space, which is placed in the intersection produced by the transference and counter-transference between patient and therapist. In doing so, the interpreter could provide a significant contribution to the therapeutic process. However, for this to happen, it is crucial that the interpreter will be able to manage his/her own involvement and emotional burden in the session. Otherwise, lateral transfers or excessive empathy might compromise the quality of the interpreting, thus "contaminating" the content and the triadic dynamic of the session.

Such delicate complexities emphasize the need for tailored supervision for interpreters, "built-in" in his/her professional work routine, incorporating both classic therapist training and interpreting studies theories. An effective clinical supervision should address the multiple aspects of emotions expressed by the patient and provider, and the culturally, linguistically and professionally appropriate ways to handle them (Hseih and Nicodemus, 2015). Moreover, it could help the interpreter to manage the personal emotional burden, allowing him/her to not only provide an impartial service as possible but also to better develop greater awareness, self-criticism and self-reflection in the therapeutic situation. These were stressed by Bahadir as essential skills of the interpreter, improving him/her to function as a linguistic and cultural broker in the session.

Reviewing the set of dynamics within the third space, it is also suggested that interpreters would receive the appropriate tools to make a judgment in situations of moral dilemmas resulting from their space in the room, as well as from the triadic relationship. The interpreter might – consciously or unconsciously – make interpreting-related decisions that will affect the therapy. This ability, to decide whether to deliver a message, or even slightly change it (even though a different tone of voice, or the addition of physical gesture) carries with it tremendous powers. Thus, interpreters must be aware of the powers they hold and their possible implications on each of the participants (including themselves) and the therapy as a whole.

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FUTURE RESEARCH DIRECTIONS

As the acknowledgment of the interpreter's involvement in the emotional aspects of psychotherapy is relatively new, many questions and arguments raised earlier require further research. Here are some issues directly stemming from the current analysis: what is the potential influence on the interpreter in other therapeutic frameworks, such that are not based on working with transference/counter-transference? To what extent should the interpreter be informed on the patient-provider dynamics in the room? On the one hand, such knowledge will help him/her be more aware, and be able to transmit faithfully even the slightest nuances. On the other hand, such a background may "contaminate" the translation or hamper her neutrality. Such issues should hopefully be explored in future studies, contributing to our understanding of the interpreter's place and role in mental health settings.

LIMITATIONS

This chapter is based on the experiences during a therapeutic process of a single family, by a specific interpreter. The emotional responses of the interpreter described above may have been influenced by the therapist's choice of therapeutic framework. The insights and model proposed here should be further examined in various types of therapies, involving interpreters from diverse personal and professional backgrounds.

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ENDNOTES

1 The term "supervision" in this context refers to conversations between professionals, aimed at enhancing one of the professionals' effectiveness at work (Dean, Pollard, & English, 2004).

2 Baranger and Baranger (2011) introduced the concept of a bi-personal field to describe the dynamic process of analysis, the location of the projections and cross introjections and counter-identifications between analyst and patient.

3 According to recently published data, the Italian community in Israel is composed of approximately 15,000 people, most of whom probably have proficiency in Hebrew (Della Pergola, 2014).

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Chapter 30
Narrative Therapy to Address Trauma for Emergency Medical Services and Firefighters

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ABSTRACT

First responders, including Emergency Medical Services personnel and firefighters, support community members in times of crisis. When responding to emergencies, first responders often experience both direct and vicarious trauma. Over time, the pace and intensity of a career as a first responder leads to poor health habits and high risk for mental health issues including posttraumatic stress disorder. Due to concern about peer perception and mental health stigma, these professionals are less likely to seek mental health supports to manage and process trauma. This chapter explores Narrative Therapy as an ideal option for mental health treatment of first responder trauma, providing a collaborative approach to therapy using the natural coping strategy of storytelling.

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INTRODUCTION

First responders, including Emergency Medical Services (EMS) personnel and firefighters, have increased risk of mental health issues due to exposure to trauma over a career (Jones, 2017). More specifically, first responders have increased risk of mental illness symptoms including PTSD, depression, anxiety, sleep issues, substance use, and suicidal ideation as compared to other helping professionals and the general public (Martin, Tran, & Buser, 2017). Risk for such symptoms increase for first responders located in rural areas, working longer shifts, and those without social supports at home (Jones, Nagel, McSweeney, Curran, 2018). Mental health supports, such as Employee Assistance Programs (EAPs) are critical for addressing the high risk for Posttraumatic Stress Disorder (PTSD) and suicide among first responders (Heightman, 2016). This chapter explores storytelling as a natural coping strategy for first responders, and proposes use of Narrative Therapy as means of trauma-informed mental health counseling for this population.

BACKGROUND

Emergency Medical Services (EMS) includes Emergency Medical Technicians (EMTs) and Paramedics. The scope of practice outlined by the National Highway Traffic Safety Administration defines the roles and training of EMS (USDOT, 2007). In this scope of practice, EMTs focus on basic life support (BLS) services which encompass treating and transporting stable patients not in imminent harm of death or disability. Beyond the training of EMTs, Paramedics represent the highest level of certification for EMS. Paramedics oversee the work of EMTs and direct firefighters on scene in the interest of prioritizing patient health outcomes. Paramedics perform invasive medical procedures for advanced life support (ALS) services addressing life-threatening emergencies during patient treatment and transport (USDOT, 2007). Nationally, 70% of EMS personnel are EMTs, and only 24% are Paramedics (USDHS, 2017).

EMS as a field is generally young. The Highway Safety Act of 1966 established the Department of Transportation (DOT; NHTSA, n.d). This marks early organization and development of the EMS system as represented today, with DOT tasked with regulation and implementation of training standards (NHTSA, 2011). Mainstream media representation of EMS dating back to the 1970s, primarily with the television show *Emergency,* began to create both public awareness of 911 services, as well as public misconceptions about emergency support in communities (NHTSA, n.d). EMS often work closely with, or cross train as firefighters. Nationally, 40% of EMS work directly with fire departments (NHTSA, 2011).

Early firefighters in the 1800s in the US were largely volunteers (Kenlon, 1913). Later, through central government regulation, firefighters established a fraternal order or "brotherhood" still recognized today in response to early rivalries between volunteer firefighting communities. In modern firefighting, the United States Fire Administration (USFA) trains, supports, and governs firefighters as a division of the Federal Emergency Management Agency (FEMA), first established in 1973 to address fire prevention (Kruger, 2018). Firefighters focus on fire prevention and response in the community (USDHS, 2017). Training for firefighters includes Firefighter I and Firefighter II certifications (NFPA, 2019). Both levels of certification include foundational training including response to alarms, tools and equipment for fire management, navigating environments safely to address fires, and helping rescue fire victims. The Firefighter II certification includes further skills training with a wider variety of equipment than Firefighter I.

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Nationally, 71% of fire departments are staffed by volunteers, and as such, 56% of all firefighters in the US are volunteers (USDHS, 2017). While less common, 17 states also use volunteer EMS (USDOT, 2007). Volunteer first responders often receive no pay for their services or are paid per call (NVFC, 2014). While volunteers still experience camaraderie and the culture of first responders, they may experience this culture differently than career first responders. Further, volunteer first responders experience trauma and stress without as many supports and benefits. For example, it is rare for volunteer first responders to have access to benefits, including EAPs (Heightman, 2016). As such, volunteers may be more likely to experience mental health issues with greater barriers to treatment in coping with exposure to trauma inherent in emergency support services (Stanley, Boffa, Hom, Kimbrel, & Joiner, 2017).

IMPACT OF CAREER ON FIRST RESPONDER WELLNESS

First responders experience high risk for various health issues as a result of their career. Some risk for physical and mental health issues relate to the inherent stress of supporting community crisis. For example, prolonged stress and exposure to fire-related incidents creates high risk for heart disease for firefighters, with nearly half of deaths while on duty caused by cardiovascular events (Kales, Soteriades, Christophi, & Christiani, 2007). EMS routinely experience risk of harm including exposure to communicable diseases, and performing medical procedures in a vehicle traveling at high speed without wearing a seatbelt (Blau, Eggerichs-Purcell, & Bentley, 2012; Weaver et al., 2015). For first responders, the unpredictable nature of a typical shift, when it is unknown when the next "call" will come, does not support much focus on personal wellness. As a result, EMS and fire personnel report poor overall personal health habits both at work and during personal time including speeding, smoking, drinking, and poor eating habits (Pirrallo, Levine, & Dickison, 2005). Further, alcohol and tobacco use represent significant health risks for first responders (Carey, Al-Zaiti, Dean, Sessanna, & Finnell, 2011). For example, firefighters use smokeless tobacco products at a higher rate than the national average, many of whom only starting use after becoming a firefighter (Jitnarin et al., 2017). Beyond high stress, sleep deprivation, poor health habits, and the unpredictable nature of a typical shift, trauma experienced during community crisis represents perhaps the highest health risk for first responders.

Trauma and Mental Health Stigma

First responders experience trauma both directly through potential for physical or emotional harm, or through repeated exposure to traumatic experiences of patients and their families known as vicarious trauma (Trippany, Kress, & Wilcoxon, 2004). This exposure to trauma is inherent during routine job duties responding to community crisis for both firefighters and EMS. Sleep disturbances due to shift work and unpredictable calls represent high risk for mental health issues, suicidal ideation, and unhealthy alcohol use (NEMSMA, 2016; Vargas de Barros, Martins, Saitz, Bastos, & Ronzani, 2013). Routine and repeated exposure to trauma also increases risk of PTSD for firefighters and EMS personnel (Klimley, Van Hasselt, & Stripling, 2018). In response to training and experience, first responders focus on the needs of patients and victims on the scene, disregarding the impact of the chaotic and emotionally charged environment in the moment to fulfill the responsibility of supporting community members (Palm, Polusny, & Follette, 2004). Further, as part of first responder training, experienced personnel often haze or push new EMS and firefighters to "toughen up" and not react to trauma exposure on the job. Thus

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following these traumatic events, firefighters and EMS often experience thoughts and mental images (e.g. flashbacks, dreams) related to vicarious trauma but may not have a supportive outlet to process them (Jahnke, Poston, Haddock, & Murphy, 2016). Over time, repeated exposure to trauma without adequate mental health supports leads to increased risk of PTSD and suicide among the first responder population (Martin et al., 2017; Stanley, Hom, & Joiner, 2016).

First responders experience a strong camaraderie, which encourages fire and EMS personnel to depend mainly on peers for support (Regehr, Hill, Goldberg, & Hughes, 2002; Stanley et al., 2016). While common coping for work-related stress and trauma are social supports, due to stigma and first responder culture, there is aversion to using peers as supports in interest of preserving a reputation and image at work (Lanza, Roysircar, & Rodgers, 2018). To address critical incidents experienced in the field, the first responder population can benefit from mental health treatment conducive to the unique population and impact of experiences in the field (Jones, 2017). Prevention focusing on locus of control and developing resilience to promote healthy coping can help mitigate risk factors. Also, interventions that are trauma-informed are critical (Kleim & Westphal, 2011). Mental health stigma and barriers to mental health treatment prevent first responders from seeking supports for mental health issues. First responders experience fear in seeking mental health supports, as counseling carries a perception weakness by coworkers (Vogel, Cohen, Habib, & Massey, 2004). Further barriers include scheduling appointments around shifts and lack of knowledge about supports available (Haugen, McCrillis, Smid, & Nijdam, 2017). First responders often believe mental health practitioners do not understand first responder culture, or the experiences of EMS and firefighters which deters them from seeking professional support (Heightman, 2016).

First responders experience critical events in the field, which represent direct and vicarious trauma (Martin et al., 2017). This experience occurs throughout a career, as typical work duties include attending to community crises. For example, Jahnke (2018) described the typical shift as attending to community members on the worst day of their life. Over time, first responders become desensitized and cynical as means of coping (Jahnke et al., 2016). Tempered emotional reactions become even more difficult when having to navigate expressing compassion and empathy for victims on scene, but avoiding emotional reaction after the emergency is over (Boyle & Healy, 2003). While peer supports represent a protective factor, fear of retribution or tarnishing of reputation deter first responders from processing trauma within the first responder community (Stanley et al, 2016). With no safe outlet, eventually, emotional avoidance becomes a survival tactic leading to burnout and compassion fatigue (Regehr, Goldberg, Glancy, & Knott, 2002). Often first responders turn to use of alcohol as a socially acceptable means of coping with trauma (Gallyer et al., 2018). Substance use, especially alcohol, to cope with trauma leads to high rates of addiction within the first responder community (Fjeldheim et al., 2014; Jahnke, 2012; Poston, 2012). Dark humor represents another commonly accepted means of catharsis to manage emotional reaction to vicarious trauma (Scott, 2007; Tangherlini, 2000). Along with dark humor, first responders often use storytelling as a natural coping strategy to process experiences with peers (Tangherlini, 2000).

SOLUTIONS AND RECOMMENDATIONS

Created by White and Epston, Narrative Therapy's premise is that clients build narratives based from their perceptions of self and others (White, 2007). These narratives, referred to as dominant narratives, are socially constructed, based on language, and are a way that clients' construct their reality (Combs

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& Freedman, 2012; White, 1995; 2007). Dominant narratives, often confirmed or modified based on interactions with environment, become clients' absolute truth regardless if they are positive or problematic (White, 2007). Problematic dominant narratives are socially, culturally, and politically induced and are the cause for clients' problematic behavior and/or mental health concerns, especially when are incongruent with their lived experiences (Brown & Augusta-Scott, 2007). In Narrative Therapy, clients are the owners, authors, and experts of their own subjective narrative and counselors are the experts in Narrative Therapy (Combs & Freedman, 2012). Narrative Therapy involves four non-linear, free flowing cyclical steps that requires active collaboration between the client and the counselor (White, 1995).

The first step in Narrative Therapy is identifying the problematic dominant narrative that is causing the client distress (White, 1995; 2007). During identification, clients also determine their memberships and association with the dominant narratives in the past, present, and future (Vorster & Phipps, 2009; White, 1995; 2007). Counselors' role in this stage is to provide the space for clients to tell their story. The second step is deconstructing the dominant story. During the deconstruction process, clients break down their dominant story into manageable parts and explore what parts contradict or support each other (Payne, 2006; White, 2007). Counselors support this process by inquiring about their culture and experiences that support the dominant narrative and determining the conception of the problematic narrative (Carr, 1998; Payne, 2006). During the deconstruction process, counselors also help clients to externalize the problem. White (1995) believed that a problematic narrative is powerful because it becomes entrenched in clients' identity; thus, clients become unable to separate themselves between their selfhood and the problem. Clients externalize the problem by objectifying it as something outside of themselves, and often assigning a name to this problem (Carr, 1998; White, 2007). After assigning a name to the problem, clients explore the problems' power and influence over their lives (White, 2007). Externalizing the problem helps empower clients to take control of the problem and visualize the problem as something more manageable (Payne, 2006).

The third step involves reauthoring and re-membering the dominant narrative. In this stage clients revise their problematic dominant stories into stories that are more congruent with their lived experiences (White, 2007). Parts of the problematic dominant narratives either neglected or conflicting, represent "unique outcomes" or "exceptions" (White, 2007, p. 61). White (2007) described that clients are often fascinated by unique outcomes and by placing emphasis on the exceptions or neglected parts, counselors can start the process of reauthoring (Combs & Freedman, 2012). Clients also revise their membership and re-engage in neglected identities and resources that clients want to re-integrate into their narratives (White, 2007).

The fourth step includes performing definitional ceremonies. Definitional ceremonies involves a ritual where clients can share their new and more congruent narrative (White, 2007). Some ceremony options include letter writing (Combs & Freeman, 2012), performance in group therapy (Duba, Kindsvatter, & Priddy, 2010), or the use creative arts such as artwork (Bennett, 2008), music or video recordings (Combs & Freeman, 2012). Definitional ceremonies thicken and strengthen the new narrative and provide meaningful connections to the future (Combs & Freeman, 2012).

Narrative Therapy has gained momentum as a holistic and widely used intervention for diverse populations. In a simple literature search, there are over 5000 articles on Narrative Therapy, and almost 3000 in the last 10 years alone. Narrative Therapy has been proposed to treat trauma (e.g., Bullen, 2015; Cloitre, Garvert, & Weiss, 2017; Lee, 2017), grief (e.g., Hedtke, 2014; Turns & Macey, 2015), anxiety (e.g., Horner & Tully, 2016), and depression (e.g., Lopes, Gonçalves, Fassnacht, Machado, & Sousa,

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2014; Rodríguez Vega, Bayón Pérez, PalaoTarrero, & Fernández Liria, 2014). These issues represent key mental health concerns for EMS and firefighters (Martin et al., 2017).

First responders possess a number of natural coping skills, including the use of storytelling as a means of processing and understanding experiences (Tangherlini, 2000). Narrative therapy similarly utilizes storytelling to deconstruct and reconstruct experiences (White, 2007). By starting with the telling of stories, Narrative Therapy draws on the existing coping skills of first responders and can aid in the building of trust and rapport with the first responder population. Given the enduring stigma of help-seeking behavior among the first responder population (Vogel et al., 2004), it is critical to utilize trauma-informed practices that reduce stigma. Narrative Therapy emphasizes the externalization of the problem, highlighting the idea that the person seeking services is not weak or broken, but is a healthy person faced with a problem (White, 2007). The attribution of problems to experience rather than to the person can help to destigmatize the help-seeking experience. The first responder occupation is often an integral part of the first responder's identity and the first responder culture undoubtedly impacts the perception of self and others. Narrative Therapy considers and identifies how the role of culture and context impact the dominant discourse (White, 2007). The emphasis on the constructed narrative and the role of cultural context may help to mitigate the feeling that mental health professionals do not understand first responders. The following example provides illustration of Narrative Therapy with the first responder population to support trauma while addressing stigma.

Example of Narrative Therapy

Marc is a 28-year-old, Caucasian, cisgender male who is currently working as a firemedic in an urban setting. In this role, he has cross trained as a firefighter and a paramedic, providing primarily medical support for patients but fire support as needed during calls. He has worked as a firemedic for approximately 4 years. Marc lives with his girlfriend of two years and identifies this relationship as supportive.

Recently, Marc experienced a traumatic call in which a young child died after drowning in a swimming pool. Marc performed CPR at the scene but was unable to resuscitate the child. Marc's supervisor, per department protocol, required him to see a counselor after the critical incident on his last shift. At first, Marc reports he feels fine, and that events like the child's death is simply "part of the job." After some prodding from the counselor, and reminding about the confidentiality of their discussion, Marc reluctantly shared he has been having trouble sleeping and had a few nightmares about the event in the week since the call. He has noticed feeling more irritable and is dreading returning for his next shift, which is unusual as Marc takes great pride in his identity as a first responder. Marc's girlfriend had also encouraged him to use the counseling supports provided by his county benefits, as she noticed an increase in arguments with Marc since this most recent incident. He reports that he is coming to therapy to appease his girlfriend and supervisor but is reluctant to talk about the recent traumatic event. He acknowledges that he has been more irritable lately but feels that he needs to just "get over it" when asked about vicarious trauma. Marc reports he had seen a counselor in the past under recommendation from his job after another instance of trauma but did not find it helpful. He felt that the counselor did not understand him and wanted to give him a diagnosis, which he worried would impact his job or his coworkers' perceptions of him.

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Identifying the Narrative

In initial therapy sessions, the counselor focuses on building rapport and highlighting the therapy process as non-judgmental and collaborative. The counselor shows genuine interest in Marc's experiences in the field, and asks questions about what it is like to be a firemedic. Marc, feeling passionate about his career, answers her questions and then naturally begins to tell her about different calls he has experienced during his career. Drawing on his natural coping strategy of storytelling, the counselor invites Marc to further share his storied experiences as a firemedic. Marc is initially reluctant to talk about negative work experiences but speaks of his positive relationships with coworkers and sense of camaraderie in his work. Marc discusses how his family supported his desire to become a firemedic, and talks about looking up to his father, who worked as a police officer. After building a foundation of trust and collaboration in early sessions, Marc begins to open up about some of the trauma he has witnessed, including the most recent incident with the child's death.

Even as Marc tells stories of being a witness to significant and intense trauma, the counselor notices that he tends to shy away from emotional language when describing his experiences. When the counselor asks about this disconnect, Marc responds by explaining that expressing emotions is not helpful, and that his he is more effective in his job when disconnected emotionally from patients. He expresses a need to "get over" and laugh about his experiences rather than discuss his feelings. From discussion of how Marc has responded to repeated exposure to trauma, Marc and his counselor are able to identify a dominant narrative in his life in which he feels he must shut down his emotional responses and act as though the traumatic events he witnesses do not impact him.

Deconstructing the Dominant Story

Finding that he enjoys telling stories with the counselor, Marc continues to see the counselor. He asks the counselor not to tell his supervisor that he continued to come to sessions after his required "check-in" following the critical incident with the child. In the process of deconstructing the dominant narrative of emotional detachment and being "tough", Marc is able to recognize that the culture of first responders as well as the culture in his family of origin shape this narrative. Marc discusses his father's career as a police officer and his stoicism. Marc finds that his father instilled the idea that men did not express emotions related to traumatic events, especially men who served the community. Men who serve the community must be strong and tough for others who need them. In remembering how his father interacted with other police officers, he remembered their jokes with each other and habit of getting together for a beer after shifts and telling stories. Marc learned from his father that, as a man, the way to deal with trauma was through isolation, dark humor, and alcohol use; these coping strategies further reinforced through his own work as a first responder.

A critical piece of the deconstruction process of Marc's narrative was the externalization of his response to vicarious trauma. Marc believed that his emotional response to vicarious trauma indicated that something was wrong with him or that he was too weak to handle his work. The feelings of helplessness he experienced as a result of being unable to save a child led Marc to view himself as inadequate for his work. Through the process of externalization, the counselor helped Marc to readjust his view of himself and the issue of trauma, emphasizing that the problem was the ongoing trauma experienced as a result of his occupation, rather than a personal weakness in not being able to cope with the trauma. The counselor highlighted normal responses to vicarious trauma and emphasized how Marc's reaction to trauma was

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common. Over time, Marc was able to distance his concept of self from his response behaviors to trauma and was able to recognize that his experiences were a typical response to a problematic experience, the frequent exposure to trauma. He found validation in knowing that he was not broken or unable to serve his community because of these trauma responses.

Reauthoring and Re-Membering

In the reauthoring process, the counselor encouraged Marc to identify how he would like to see himself respond to ongoing stressors and create a narrative of healthier coping mechanisms and support. In his original dominant narrative, Marc saw himself as inadequate, weak, and helpless when he struggled to deal with ongoing vicarious trauma. Through the restorying and reauthoring process, he was able to identify exceptions to these feelings; remembering times when he performed his work capably, helped others, and gained a sense of purpose and gratification from his work. Marc was able to identify how he ideally wanted to deal with stressors, including involving his girlfriend in his coping rather than pulling away from her. Marc identified wellness activities he would like to use to cope, including fishing with his father. Rather than conceptualizing his inability to tolerate ongoing trauma as a personal weakness, Marc was able to alter his narrative to highlight his strength in caring for others and engaging in emotionally and physically challenging work. As the original problematic narrative was prominent at work and often exacerbated by work culture and peers' coping mechanisms, Marc and the counselor talked about how his new narrative would fit with his peers at the fire station. He processed that although he feared that his peers would not accept his new narrative, in time, he could model for them better coping mechanisms and help them seek support when he saw signs of trauma.

Definitional Ceremony

As Marc and his counselor approached the end of their work together, the counselor asked Marc to engage in a definitional ceremony, celebrating and sharing his new narrative. Marc elected to write a letter to his future self, who would undoubtedly encounter more trauma throughout his work. In this letter, Marc reminded his future self of his inherent strength and ability to cope with the trauma he would encounter. He highlighted the positive aspects of his work and his stories of strength and caring for others. Marc encouraged his future self to utilize healthy coping strategies and seek support from those around him. Marc asked his girlfriend to attend a therapy session with him and shared this letter with her, inviting her to share in his experience and identifying how she could continue to support him. Through the Narrative Therapy process, Marc came to view himself through a preferred narrative in which he encountered problems but did not ascribe the problems nor his reactions to them as an inherent weakness. Marc was able to utilize storytelling, a natural medium, to tell new stories about himself, his world, and his experience. Through the therapy process, Marc felt respected and empowered as the author of his experiences rather than pathologized and stigmatized. In terminating therapy, the counselor reminded Marc she was always available to him if he needed to come back. Marc left feeling the counselor genuinely cared and was interested in his work, comfortable with returning if his trauma again became overwhelming in his career.

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FUTURE RESEARCH DIRECTIONS

The previous example provides an outline for how the principles and processes of Narrative Therapy integrate specifically with the work of first responders. Though the first responder population could undoubtedly benefit from mental health care to address the effects of exposure to ongoing trauma, stigma around help-seeking behavior creates a significant barrier to receiving care (Vogel et al., 2004). When first responders have received treatment that has felt ineffective, this can further dissuade them from seeking therapy. As in the example, many first responders may feel that practitioners do not understand their experiences and may feel judged (Heightman, 2016). Further, first responders often feel misunderstood and unappreciated by community members (NHTSA, n.d). The collaborative and non-judgmental experience and the emphasis on the client as the expert and author of experience may help to engage first responders in the therapy process. This collaborative process using a natural coping skill of storytelling may also help overcome the perception that community members do not care about first responders.

After establishing a foundation of trust and collaboration, the four-step process of Narrative Therapy can unfold. The above example illustrates how a first responder client may engage in Narrative Therapy. By beginning with the telling of stories, Narrative Therapy taps into the innate storytelling mechanism that many first responders use to process and understand experiences (Tangherlini, 2000). By creating a comfortable space for the client to tell stories, the counselor allows for the expression of positive and negative stories as a dominant narrative emerges regarding the work, culture, and experiences unique to first responders. Through the process of deconstructing the dominant narrative, first responders are able to externalize the problem, mitigating the stigma of trauma responses and the tendency to attribute typical reactions to personal weakness (Lanza et al., 2018). Externalizing the problem can also involve naming the problem to help separate the problem from the client's personhood. In Marc's example, he could have named the problem "*get over it"*. In further deconstructing the narrative, as seen in the example, first responders are able to identify how their experiences and culture may support or contradict the dominant narrative. Additionally, first responder clients could explore exceptions to the dominant narrative as part of the deconstruction process. Although not seen in the example, Marc could have explored when he felt competent at his job, despite patient loss, or when he or his coworkers discussed openly job traumas and their struggles with loss without engaging in avoidant coping mechanisms. Findings exceptions to the dominant narratives helps first responders demystify the strength of dominant narratives and naturally leads to the reauthoring process.

Through the reauthoring process, first responders are able to identify exceptions to the dominant narrative and create new stories of themselves that are more congruent with their lived experiences. Regarding trauma, first responders are better able to conceptualize trauma and trauma reactions as external, no longer tied to internal conceptions of strength or weakness. This helps combat stigma in seeking supports outside of their work community. As seen in the example, first responders are encouraged to identify a new narrative of coping and managing the ongoing trauma encountered in their work. Through definitional ceremonies, the client solidifies these new narratives (White, 2007).

It is important to remember that the deconstruction and reauthoring of experience is a cyclical and non-linear process (White, 1995). Though the above example highlights these steps in a particular order, the therapy process often involves a constant deconstruction and reconstruction of narratives that may intersect and overlap. In examining, deconstructing, and reauthoring experiences through Narrative Therapy, counselors can work to build trusting and collaborative relationships with first responders that may serve to mitigate the stigma of help-seeking and create lasting change in the first responder culture.

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CONCLUSION

First responders experience strong stigma against help-seeking behavior, like attending counseling, despite repeated exposure to trauma throughout a career. Without adequate mental health supports, first responders face high risk for compassion fatigue, PTSD, and suicide. Mental health providers have an obligation to find evidence-based and effective ways to reach this population of clients to address trauma experiences. Narrative Therapy as an approach using the natural coping skill of storytelling presents an opportunity to connect with and support the first responder community while addressing underlying mental health stigma.

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KEY TERMS AND DEFINITIONS

Compassion Fatigue: The gradual loss of the capacity to care for the suffering of others after repeated need to support others over time.

Direct Trauma: An unusually stressful event happening directly to an individual.

Dominant Narrative: The common story, lens, or perception of the principal societal group.

Externalization: A mental health tool of imagining issues or symptoms to be an independent idea instead of an ailment or affliction of the individual.

First Responder: A common term for professionals including emergency medical services personnel and firefighters trained to respond to community emergencies.

Posttraumatic Stress Disorder: A stress-related disorder occurring after a traumatic event characterized by symptoms including sleep disturbance, distressing dreams, avoidance of reminders of the traumatic event, negative mood, and emotional reactivity for at least one month after the traumatic event.

Stigma: The shame perceived or expressed by others when an individual is associated with a certain group, need, or condition.

Vicarious Trauma: The impact of exposure to unusually stressful events experienced by others over time.

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Section 4
Utilization and Applications

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Chapter 31
Individual Funding for People With Mental Health Issues:
Opportunities, Tensions, and Outcomes

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ABSTRACT

This chapter outlines the key features of individual funding programs and examines their suitability for people with mental illness. This is a contested area with some writers concerned that mental illness is different from other types of disability and unsuitable for individual funding. The recovery model and the episodic nature of mental illness are seen as conflicting with individual funding eligibility criteria for consistent and permanent disability. The counter view is that flexible individual funding is ideally suited to meeting the fluctuating needs of people with mental illness: its key principles of empowerment and self-direction being consistent with the recovery paradigm. Evidence from Australian and international studies is reviewed, suggesting that successful outcomes can be achieved if the necessary supports and resources are available to meet people's needs.

INTRODUCTION

The past four decades have seen a marked increase in individual funding models internationally and in Australia, particularly in disability and aged care. Individual funding aims to shift choice and control to people using services through flexible budgets in a services market, with the option to self-direct arrangements if preferred. This chapter explores the implications of these approaches for people with

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mental illness. Factors influencing choice, control and access to services will be considered, given the episodic nature of mental illness and principles of the recovery paradigm. The authors consider key debates, opportunities and risks for people with mental illness and the ensuing challenges for individual funding policy, implementation, and practice. These challenges have been scrutinised in Australia as the National Disability Insurance Scheme (NDIS) rolls out and grapples with ways to respond to the needs of people with mental illness. This major reform offers important lessons for Australia and elsewhere regarding mental health service and support systems. The chapter concludes with recommendations for policy, practice and further research.

BACKGROUND

Individual funding is linked to the broader personalisation agenda in disability and aged care, seeking to promote greater choice and control for people using services in a competitive market model. Individual funding has emerged in response to the shortcomings of previous block funding models where service users were tied to one provider, restricted to services the provider offered, and did not know the budget allocated for their support. From a government's perspective, the previous model provided limited accountability for public funds, as service providers had discretion to distribute funds between running costs and participants' supports.

Individual funding was seen as a mechanism for overcoming these limitations; giving people with disability more choice and control over services, and therefore in their lives. Disability advocates, particularly from the field of physical disability, lobbied for its introduction, as did western governments interested in potential cost savings and finding a way of meeting their obligations to give rights to people living with disability (Dickinson, 2017). Individual funding was seen as a mechanism to encourage creative planning and provide a wider range of supports to meet individual needs and preferences. People with reduced decision-making capacity would be assisted by family or professionals as appropriate. Importantly, individual funding was to place the person at the centre of the decision-making process: to choose their supports and give them greater independence and improved quality of life (Alakeson, 2008; Croft & Parish, 2016).

Individual funding programs reportedly commenced in the 1960s and 1970s when parents of children with disabilities in Canada (Hutchison, Lord, & Salisbury, 2006), and Vietnam veterans with disabilities in the US (Yeandle & Ungerson, 2007) lobbied for community living. Subsequently an array of individual funding programs has emerged in disability and aged care services, with many different structures, administrative arrangements and names. Self-directed support (SDS) has emerged as the most common name being used in Scottish legislation (2013), by the United Kingdom (UK) advocacy group *In Control* (2017), and by the *Cash and Counseling* program in the US (RWJF 2010). Under the umbrella term of self-directed support, the UK has personal budgets and direct payments (Hamilton, Tew, Szymczynska, Clewett, Manthorpe, Larsen, & Pinfold, 2016). Other terms are used elsewhere with some European countries referring to 'cash-for-care' (Da Roit & Le Bihan, 2010) and Australian aged care using the term 'consumer directed care' (CDC).

These programs have core features in common despite their various names and configurations. An assessment of personal needs is undertaken, a budget is allocated to purchase services and supports, and the person has a degree of control over what is purchased. There is an important difference between programs that expect the person with individual funding to self-direct their budget by arranging their

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supports, employing staff and managing their accounts, and programs that offer support to assist or undertake all these tasks. The UK Direct Payments program is an example of the former, and the US *Cash & Counseling* program an example of the latter.

Much research demonstrates positive outcomes for people with mental illness in the US programs; the strongest evidence of the benefits of individual funding for this group coming from the *Cash & Counseling* program. Evidence based on randomised controlled studies with large numbers of people across 15 states showed that people could self-direct their budget with appropriate support, achieving a wide range of positive outcomes (Barczyk & Lincove, 2010; Shen, Smyer, Mohoney, Simon-Rusinowitz, Shinogle, Norstrand… del Vecchio, 2008).

Other research identifying positive outcomes includes an Australian study that looked in depth at the experience of 16 people using individualised funding who had consistent contact with managers in positive person-centred relationships. This study found there were practical and psychological benefits for consumers and that consistent support for self-direction enabled their growth and capacity to build hopeful lives (Peterson, Buchanan, & Falkmer, 2014).

In a systematic review of the international literature Laragy, Sanders, and Brophy (2015) also found positive outcomes for people with mental illness using individual funding models. These included less time in psychiatric hospitals and criminal justice settings, creative use of funding to facilitate independent living, continued education or work, more personal relationships, and improved social life. Importantly there were no adverse outcomes for participants when they were given appropriate support (Laragy, Sanders, & Brophy, 2015).

These international findings suggest that individual funding programs have the potential to give people with mental illness more choice and control. Better outcomes are achieved if adequate support for planning and management is provided and appropriate support services are available (Croft & Parish, 2016; Simon-Rusinowitz, Croft, Loughlin, & Mahoney, 2013).

Other studies have identified mixed outcomes. In particular, the National Direct Payments Survey (NDPS), a collaborative project of three UK research teams, highlights a range of challenges for mental health users as well as reports of direct payments significantly improving lives (Glasby & Littlechild, 2016). In their summary of the NDPS, Glasby and Littlechild (2016, p. 54), identify a number of barriers for people with mental illness in the program. These include:

- The underuse of advance directives (a statement which outlines the person's treatment preferences should they become unwell) to support people with episodic mental illness when planning for crisis situations;
- Limited resources to meet people's needs as care packages for mental health fail to delineate financial responsibilities between the clinical, mental health and social care sectors;
- Lack of specific mental health expertise in those providing support to people in establishing or managing direct payments.

The differences in program outcomes raises the question: do program characteristics impact on their outcomes? While this is an emerging field and more research is needed, the evidence to date suggests they do.

It has been difficult to produce a rigorous evidence base regarding the effectiveness of individual funding models because they are so diverse (Dickinson, 2017). Despite the limitations, studies have identified a range of factors that appear to impact on outcomes. An important and recurrent theme is

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that the way a model is implemented has an impact on the outcomes achieved (Dickinson, 2017; Laragy & Ottmann, 2011). Evidence suggests that well designed self-directed support models, when properly implemented and resourced, have the potential to facilitate consumer control and produce better outcomes for all participants, including people with mental illness (Alakeson, 2008; Barczyk & Lincove, 2010).

Two systematic reviews have identified the following as necessary conditions to achieve positive outcomes in individual funding programs:

- Choice to participate in self-management or traditional service delivery;
- Provision of appropriate cognitive, physical and cultural supports for active participation in planning, choice making, and support co-ordination;
- Flexible and adequate funding to meet needs and goals;
- Flexible and responsive review mechanisms and processes;
- Culturally appropriate, accessible and targeted information about program policies, spending guidelines, and services;
- Culturally appropriate services;
- Support to manage administrative demands;
- Peer support;
- Organisations and staff working from an empowerment and rights-based approach;
- Adequate workforce conditions;
- Support and oversight to manage risks;
- Access to a developed market which can offer appropriate services (Dickinson, 2017; Laragy & Ottmann, 2011).

An important debate relating to the conditions in which individualised funding takes place concerns access and equity and the limits of market approaches to provide adequate social supports for marginalised and disadvantaged groups (Fawcett & Plath, 2014). In particular, there are concerns that individual funding approaches do not invest in the collective structural reforms required to address deeply embedded social inequality. There are concerns that this will reproduce disadvantage for vulnerable groups, particularly in the absence of adequate supports to engage and participate (Dodd, 2013). Related to this critique are concerns regarding 'thin' markets where services do not exist to meet diverse and complex needs (Croft & Parish, 2016). These risks are likely to be particularly high in rural and remote areas. There are concerns for marginalised groups, including those with mental illness, and those with limited social supports and/or capacity to advocate for their needs when required supports are not available (Bigby, 2013; Miller & Hayward, 2017).

Despite these debates, Australia reflects international trends in adopting individual funding as a central component of the NDIS reform. It is suggested that Australia's experience can offer key insights into the particular needs of people with mental illness and how individual funding models can best respond. The following section describes key features of the NDIS and the integration of mental health.

THE NATIONAL DISABILITY INSURANCE SCHEME

The NDIS is based on individual funding in a fee for service market based model (Productivity Commission, 2017). The scheme was introduced in trial sites around Australia in 2013, full transition began in July

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2016, and by 2019 it is expected to support 456,900 people with disability, referred to as 'participants' (NDIA 2015). The scheme has 64,000 participants identified by the NDIS as having a psychosocial disability (Joint Standing Commitee, 2017). The *NDIS Act 2013* is based on rights and principles outlined in the United Nations Convention on the Rights of Persons with Disabilities (UN General Assembly, 2007). It stipulates that participants have choice and control in the pursuit of their goals, and the planning and delivery of their supports. The legislation uses the term 'psychosocial disability' when referring to mental health issues that result in 'severe effects and social disadvantage' (Joint Standing Commitee, 2017, p. 3). The introduction of the NDIS received bi-partisan political endorsement, support from the disability and community services sectors and significant support and commitment from people with disabilities and their carers (Bonyhady, 2014). It is widely considered to be having a significant social and economic impact nationally.

Prior to the NDIS, state based disability individual funding programs offered varying levels of choice and control through different options for funds administration (Purcal, Fisher, & Laragy, 2014). Some allowed participants to hold the funds, employ their own support workers, purchase support from a wide range of sources and account for spending. Others were individual funding in name but were little different from traditional block funded services (Laragy, Fisher, Purcal, & Jenkinson, 2015).

The NDIS model of support is based on a plan being developed with a facilitator, approved and funded by NDIS administrators. The support and choice model offers participants three options for controlling and administering their individual package. These are full self-management, management through a financial intermediary, or management through the NDIA. The person's capacity and their interest in having administrative responsibility and greater choice and control determines the model used. In June 2017, 8% of NDIS participants fully self-managed; 10% partially self-managed; 13% had their plan managed by a paid service; and 68% had their plan managed by the National Disability Insurance Agency (NDIA 2017, p. 21).

Integration of Mental Health Into the NDIS

Representatives of the physical and intellectual disability sectors lobbied for reform in disability funding and services and the establishment of the NDIS. Some commentators argue that the design of the NDIS is better suited to people with a physical or intellectual disability than those with mental health problems (McGorry & Matthew, 2016; Mental Health Australia, 2016; Williams & Smith, 2014). Contentious issues include the fact that people with psychosocial disability face barriers accessing the NDIS because they do not identify as having a disability; and because the concept of permanence, a key eligibility criterion for an individual funding package, conflicts with key principles of the recovery model (Bonyhady, 2014; Brophy, Bruxner, Wilson, Cocks, Stylianou, & Mitchell, 2015; O'Halloran, 2014). Other arguments suggest that programs such as the NDIS continue to promote a biomedical model and 'categorise' people with disabilities through clinical diagnosis (Davies & Gray, 2015; Slade & Longden, 2015).

These concerns about supports and outcomes for people with mental health issues in the NDIS have been reflected in initial reviews and studies. The NDIS has commissioned an extensive evaluation and has released its *Intermediate Report* (Mavromaras, Moskos, & Mahutea, 2016). The findings are based on quantitative data and interviews in the five trial sites with participants, family members and carers (N=62), NDIS registered disability service providers (N=25), senior personnel in workforce organisations (N=15) and NDIS staff (N=46). While the quantitative and qualitative evidence indicated improvements in the choice and control NDIS participants experience and better outcomes overall, this was not the case

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for people with mental illness. People with mental illness and psychosocial disability reported that the portal used to communicate with the NDIS was difficult to navigate, they had less choice and control over their supports since becoming NDIS participants and some received fewer supports.

Similar findings for NDIS participants with mental illness were reported in a smaller study conducted in one of the trial sites (see Warr, Dickinson, Olney, Hargrave, Karanikolas, Kasidis, . . . Wheeler, 2017). After conducting 47 interviews with participants they reported:

- Participants with diverse needs and circumstances, including people with mental illness and those from socioeconomic disadvantaged backgrounds need more support;
- Plans are not sufficiently flexible to meet people's fluctuating needs, including people with mental illness, and 'contingency plans' are needed to purchase services, equipment and support on an ad hoc basis;
- Services were 'thin' in some areas and did not meet diverse needs, especially in rural areas;
- Rural participants spent a significant portion of their funding allocation in travelling to services;
- When participants were unable to access services listed in their plan, the item was deemed to be unnecessary and it was removed at the next review.

These findings highlight some early deficiencies in the NDIS model for supporting people with mental illness. The findings are also reflected in submissions to two public enquiries into the NDIS, both of which raised concerns about the eligibility criteria and the lack of support to engage with planning and choice. One enquiry dealt specifically with the provision of services to people with psychosocial disability (Joint Standing Commitee, 2017) while another examined Costs (Productivity Commission, 2017). Despite these early implementation issues however, reports from both enquiries agreed that the NDIS presents significant opportunities for people with mental illness if the necessary supports are provided.

TENSIONS AND DEBATES

This section reviews the experience of the NDIS transition and the international literature to better understand key debates and tensions for mental health consumers, advocates and services providers in the context of individual funding reform. Consideration is given to the principles of choice, control, access and equity and the policy and practice implications of enacting these principles for those experiencing episodic mental illness.

Choice, Control, and Episodic Mental Health

Self-directed approaches have been described by some commentators as consistent with personal recovery principles (Davies & Gray, 2015). However, there are also well documented concerns regarding the limits of market forces in promoting self-direction and equitably meeting diverse needs (Fawcett & Plath, 2014; Glendinning, 2008; Lymbery, 2014).

The recent NDIS experience shows that a range of barriers can limit choice, control, and self-direction for people with mental illness (Joint Standing Commitee, 2017). Barriers include lack of mental health expertise among those in assessment and planning roles, barriers to engaging 'hard to reach' groups, and lack of appropriate mental health services including community based early intervention supports. The

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evidence highlights the point that choice and control is mediated by a person's circumstances, resources and capacity to advocate for needs, comprehend complex information and navigate complex information and service systems (Dickinson, 2017; Warr, Dickinson, Olney, Hargrave, Karanikolas, Kasidis, . . . Wheeler, 2017). This has significant implications for people with episodic conditions, fluctuating needs and capacity, and those who are socially isolated.

For people with mental health issues, fluctuating conditions and unpredictable change in needs can limit capacity to engage with complex systems and manage self-direction in a services market. The evidence suggests that support planning processes and review systems often fail to respond quickly or flexibly to fluctuating needs. The Joint Standing Commitee (2017) reported that the NDIS planning approach, established at the point of entry to the scheme, failed to sufficiently build in early intervention supports to help engagement and choice making and to prevent relapse (2017). Research into the experiences of NDIS participants in the Barwon trial site also found that people with fluctuating conditions, such as those with both physical and psychosocial disabilities, had 'no scope' for a 'contingency plan to purchase services, equipment and support on an ad hoc basis' (Warr, Dickinson, Olney, Hargrave, Karanikolas, Kasidis, . . . Wheeler, 2017, p. 8).

An evaluation of the UK direct payments model also found that mental health service consumers desire more accessible contingency funding to ameliorate mental health crises, in order to maintain their choice and control (Spandler & Vick, 2006). Furthermore, the authors of this study recommended advance directives as a possible mechanism for providing greater flexibility in payments and self-directed support during crises. This evidence supports recommendations that assessment, planning and delivery choices need to be flexible, giving due regard to the implications of episodic and fluctuating conditions and changes in people's needs (Glendinning, 2008; Mitchell, Bruxner, & Brophy, 2014).

Access, Eligibility and Recovery Principles

A key debate concerns the lack of fit between recovery principles and the language of permanent disability central to NDIS eligibility requirements. Recovery has been described as a self-defined, non-linear journey involving hope, social inclusion, and fostering psychological, physical, emotional, and spiritual wellness (Anthony, 1993). It has been argued that self-direction is a key tenet of recovery and that individual funding programs provide an opportunity to put 'recovery principles into practice' (Simon-Rusinowitz, Croft, Loughlin, & Mahoney, 2013, p. 5). However, the language of permanence central to individual funding eligibility across many programs has been described as being at odds with the concept of hope central to the recovery paradigm. Related to this is the requirement for a clinical diagnosis which reflects a medicalised approach focused on symptoms rather than a personal notion of recovery (Davies & Gray, 2015; Slade & Longden, 2015).

In their literature review on mental health and the NDIS, Nicholas and Reifels (2014) examined a cross-section of Australian and international health services to determine the language used to regulate eligibility. Their findings reveal that the term 'permanent' as an eligibility requirement is used in a range of jurisdictions including Australia, New Zealand, the UK and the US, whilst terms such as 'long-term', 'indefinite duration' or 'not expected to improve' are used in Canada.

People experiencing episodic disability who shift between periods of illness and recovery do not fit standard categories; consequently, disability classification becomes problematic (Fulcher, 1989; Lightman, Vick, Herd, & Mitchell, 2009). This episodic phenomenon is proving a barrier to service access for people with psychosocial disability in the NDIS. Submissions to the Joint Standing Commitee (2017)

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identified that many people experiencing 'severe and functionally disabling mental ill-health' were found to be ineligible for individual funding (2017). This included young people for whom it would 'not be possible (or clinically advisable) to diagnose the illness as a "permanent" condition' (Joint Standing Commitee, 2017, p. 11). The inquiry also described the reluctance of many medical professionals to diagnose symptoms as a 'particular illness' or to assess it as 'permanent or likely to be permanent' (p.11).

The requirement for a clinical diagnosis also fails to take into account negative identity issues associated with stigma and shame. Some people experiencing mental illness avoid the association with disability as the assignation of labels can compound the effects of stigmatisation (Forrester-Jones & Barnes, 2008; Goffman, 1963). Studies have found that people with mental illness can be 'trapped in unsatisfying situations in order to avoid [mental illness] disclosure' and fear of being 'found out' (Stuart, Arboleda-Flórez, & Sartorius, 2012, p. 9). Simon-Rusinowitz et al. (2013) concluded from their literature review of self-direction in mental health that these approaches require 'a paradigm shift from the medical model of illness and disability to the more holistic recovery model' (p. 10) and that critical principles of self-determination and person-centredness are at risk if funding and support models are compromised by eligibility limitations.

A contrasting position argues that diagnosis, particularly for those with invisible disabilities such as mental illness, is an important process for appropriating supports and obtaining medical acceptance (Shakespeare, 2014).

As noted previously, the way programs are implemented is critical. In Australia, the speed of NDIS implementation has impacted on the quality of assessment and planning with implications for people with mental illness (Hallahan, 2015). Pressure to meet targets has disadvantaged those who may require more time and support in the eligibility and planning process, who are least informed about their rights within funding systems, and who are least able to navigate complex service systems and choices (Productivity Commission, 2017).

NDIS participation rates indicate early problems with eligibility for this group with 19% of those with psychosocial disability who applied being rejected. This eligibility rate was the lowest compared to other disability categories such as people with intellectual disability who had an acceptance rate of 97.5%. Furthermore, during 2016-2017, the rejection rate of people with psychosocial disability increased compared to other primary disability groups (Joint Standing Commitee, 2017, pp. 15-16).

IMPLICATIONS FOR POLICY AND PRACTICE: SOLUTIONS AND RECOMMENDATIONS

The review of the NDIS and additional evidence presented above lead to the following policy and practice implications.

Promoting Choice, Control, Access and Recovery

The principles underpinning individualised and self-directed approaches are consistent with the self-determined and highly personal nature of the recovery paradigm. However, research indicates that there is sometimes a gap between policy intentions and implementation. To ensure that people with significant mental ill-health can enjoy greater choice and control in their lives, specialised supports are required to facilitate assessment, engagement with services, and to support choice making.

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Clinical and symptom based assessment and eligibility criteria can act as a barrier to service access. A clinical conception of recovery can negatively impact on service participation and progress toward recovery goals. Concerns regarding the limits of clinical diagnoses to identify eligibility and inform planning may be addressed by assessment tools which focus instead on functional capacity. The Joint Standing Commitee (2017) recommended this approach for the NDIS, suggesting the development of a validated 'fit-for-purpose' assessment tool which would better accommodate the needs of people with psychosocial disability (Rec. 4).

Building the service sector capacity and knowledge of recovery principles is also key to the successful implementation of individual funding in a mental health context. Equipping authorities, decision makers and practitioners with the appropriate professional development, supervision and tools can be an effective means of creating a shared understanding. Examples include recovery learning modules via interactive webinars and websites such as those commissioned by the NDIS (Mental Health Coordinating Council, 2017).

Primary health professionals also need to be suitably informed about mental health services to ensure they can provide timely and accurate information about funding and support options. Specialised supports need to be provided by appropriately trained staff experienced in mental health.

It is evident that people who are better resourced and who can self-advocate, or who have someone who can advocate for them, do better in individualised funding programs where supports are purchased from a services market. People already marginalised or less able to negotiate and co-ordinate their supports are likely to be further disadvantaged in this context. They require appropriate and timely information and assistance to engage and make informed choices about market based supports.

Assertive outreach designed for people with mental illness is needed to support people with mental illness who may not identify as having a disability and who therefore will not access programs like the NDIS. This approach should include face to face contact and other strategies designed to engage 'hard to reach' groups. Outreach might also be needed to engage the person's supporters and family carers who are navigating services.

Community capacity building strategies have also been identified as important in building confidence, influencing community attitudes toward disability and mental health, and increasing access, inclusion, and choice. Strong evidence supports co-design approaches to capacity building and strategies which build on the lived experience of mental health consumers (Williams & Smith, 2014).

Giving people with mental illness choice and control also relies on access to a 'thick', diverse and mature market, ready and able to provide quality and culturally appropriate services across a continuum of needs. Historically, a funding and service gap in mental health has resulted in a distinct lack of meaningful choice. Many are doubtful that market approaches will be able to address complex and fluctuating mental health needs (Gooding, 2016). Governments may need to intervene strategically in market dynamics to ensure a minimum level of service in 'thin' market areas, such as rural and remote regions which have traditionally struggled to provide adequate mental health supports.

Optimising Opportunities to Promote Recovery

The individual funding model is an enabler to recovery if properly executed with adequate supports, and when aligned with the principles of person-centredness. Assisting the person to develop a plan appropriate to their needs has been shown to be important to the success of the self-direction process. In contrast to the traditional medical model, person-centered planning focuses on strengths and capabili-

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ties, integrating family and social network supports with mental health services. A team approach with all those involved working from an empowerment and person-centred perspective has been shown to be important. With these supports people with mental illness are better able to participate in decisions regarding provider and service choices.

Because eligibility criteria requiring the demonstration of permanent disability can be in tension with recovery principles of hope and optimism, there is a strong argument for review of this language and related policy. Such review would seek to better reflect recovery principles and reduce barriers to proving eligibility (Joint Standing Commitee, 2017). The Joint Standing Committee (2017) called for a review of the NDIS Act 2013 to revise permanence as an eligibility provision and consider if the term 'psychiatric condition' is required.

Finally, there is a need for more rigorous long term research into the experiences of people with mental illness using individual funding (Webber, Treacy, Carr, Clark, & Parker, 2014). Data needs to be collected showing the numbers of people experiencing mental illness who do not identify as such, and who need assistance to seek help. This data will highlight gaps and support positive change in policy and practice.

CONCLUSION

This review has shown that there is no simple answer to the question, 'do individual funding programs result in positive outcomes for people with mental illness'? This is because programs are complex, they have various designs, they provide different levels of support, they operate in diverse contexts, and they can be implemented to different standards. It is clear that successful outcomes can be achieved for people with mental illness if programs provide the necessary support and if required services are available. It was noted that the NDIS and other programs that use 'permanent disability' as eligibility criteria need to reconsider this approach. The concept of a permanent disability is misplaced because mental illness fluctuates and people work to a recovery model. The problems identified in the research are not insurmountable; programs that provide good support achieve positive outcomes. As individual funding programs are widely used to provide supports to people with mental illness, there is an imperative to ensure that issues are resolved and the rights of people with mental illness are upheld.

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Chapter 32
Interpreting and the Mental Status Exam

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ABSTRACT

The necessity of engaging qualified interpreters to work in partnership with mental health clinicians when serving patients with a limited English proficiency (LEP) is gaining widespread support. Numerous research studies have documented improved patient health and satisfaction outcomes in this regard. Psychiatric practice often involves complexities of thought, language, and communication that clinicians and interpreters must appreciate. One such topic is engaging LEP patients in the mental status examination (MSE). This chapter describes the nature of the MSE, challenges when interpreting for the MSE, strategies for handling such challenges, and approaches for effective collaboration between interpreters and mental health clinicians regarding the MSE and cross-linguistic mental health care more broadly. The current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena also are discussed.

INTRODUCTION

There is growing evidence that individuals with limited English proficiency (LEP) experience obstacles to safe and high-quality healthcare (Wu & Rawal, 2017). Language barriers between patients and medical clinicians are common, and are associated with poorer quality of care, misdiagnosis, medical errors, and lower patient satisfaction (Flores, 2005; Divi, Koss, Schmaltz, Loeb, 2007; Ku & Flores, 2005; Ngo-Metzger et al., 2007; Woloshin, Schwartz, Katz, Welch, 1997). Language assistance provided by qualified interpreters has been shown to increase healthcare utilization as well as improve clinical outcomes and patient satisfaction (Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007). Generally LEP patients view the availability and quality of interpreting services as crucial;

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the use of interpreters and the perceived quality of interpreters' translations are strongly associated with the quality of care overall (Baker, Hayes, & Fortier, 1998; Dang et al., 2010; Green et al., 2005; Kline, Acosta, Austin, & Johnson, 1980; Kuo & Fagan, 1999; Lee, Batal, Maselli, & Kutner, 2002; Moreno & Morales, 2010; Ngo-Metzger et al., 2007).

Many oversight bodies recommend that healthcare clinicians working with LEP patients engage the services of professional interpreters to safeguard quality of care, patient safety, informed consent, and appropriate patient participation in healthcare decisions (Joint Commission, 2009; Registry of Interpreters for the Deaf (RID, 2007a). The use of interpreting services also is gaining advocacy within healthcare systems (Sleptsova, Hofer, Morina, & Langewitz, 2014). An interpreter provides an important linguistic and cultural link between the patient, clinician, and the healthcare system itself.

The use of qualified interpreters early in the sequence of *mental health* service interventions also is associated with better clinical practice and has been shown to be more cost-effective in light of the potential fiscal consequences of inadequate diagnosis and poor referral decisions (Bischoff et al., 2003). As healthcare systems develop and increasingly adopt policies regarding LEP patients and interpreters, it is important that interpreters and clinicians alike understand key issues in psychiatric practice that impact the nature and quality of interpreting work, such as how clinical interviews are optimally mediated by interpreters, including the mental status examination (MSE). The remainder of this chapter describes the MSE (and its variants), common challenges when interpreting for the MSE, tips for managing such challenges, strategies for effective collaboration with medical clinicians, and concludes with information regarding the current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena.

BACKGROUND

What is the Mental Status Exam? The MSE is an important component of many clinical interviews. Its results can inform the patient's history, diagnosis, and treatment plan (Barnhill, 2014). All medical clinicians are trained to do the MSE, but it is most often used by clinicians in the mental health field. Its frequent use and value are comparable to taking a patient's vital signs in other fields of medicine. So why does this matter for interpreters? A patient's preferred language and culture must be taken into account when conducting and interpreting the results of the MSE. Linguistically and culturally, the patient must be able to understand the MSE questions and communicate their answers, while the clinician must be able to interpret the patient's responses in light of potential linguistic and cultural differences between clinician and patient (Pollard, 1998a; Norris, Clark & Shipley, 2016). Interpreters play a crucial role in ensuring that these linguistic and cultural elements are accurately conveyed and considered in this important phase of a patient's clinical assessment and care.

The MSE can be thought of as a broad cross-sectional assessment of a patient's cognitive and emotional state and capacities. While the MSE most frequently is conducted with patients being served in mental health settings, MSEs also may be conducted in primary care and other medical settings – whenever a patient's cognitive and emotional state and capacities are in question or simply must be documented. The MSE will most certainly be conducted during a mental health clinician's first contact with a patient and may be repeated frequently with the same patient, particularly in emergency or inpatient psychiatric settings. The interaction that comprises the MSE can vary considerably in length – being briefer when the MSE is repeated with a patient whose previous MSE results already have been documented or when

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a clinician has little question that a patient's basic cognitive and emotional state are intact and unremarkable. An effective MSE can provide crucial data for immediate diagnostic and treatment decisions and inform more longitudinal mental health perspectives (Barnhill, 2014).

The assessment of mental status begins the moment the clinician meets the patient – at least it has begun in the *thought world* (Dean & Pollard, 2013) of the clinician. While some aspects of the MSE may include specific questions posed to the patient, for the most part, MSE data is gathered through observation and seemingly casual conversation, where the clinician is attuned to listening for key MSE information as the patient relays their story or answers broad questions (Robinson, 2008).

Though at times seemingly informal, the MSE nevertheless is a multifaceted clinical tool that involves a set of standardized observations and inquiries that reveal information regarding multiple domains: sensorium and cognitive functions, perception, thinking, feeling, and behavior (Robinson, 2008). Table 1, based, in part, on Robinson (2008), lists specific topic areas that are assessed under each of these domains. Almost always, a clinician's formal MSE documentation will address each of the topics listed, via the data gathered through observation, informal dialogue, and formal questions.

Table 1. Domains and topics assessed via the mental status exam

Domain	Topics Assessed
Sensorium & Cognitive Functions	• Level of consciousness • Attention • Concentration • Orientation to person, place, date, and situation • Memory (short and long-term) • Fund of knowledge • Intelligence • Capacity for abstract thinking • Reality testing
Perceptual Anomalies	• Hallucinations • Delusions • Illusions • Depersonalization or derealization
Thought and Language	• Quality of speech • Thought content • Thought form • Suicidal and/or homicidal ideation • Insight • Judgment
Emotional Status	• Affect (shorter-term emotional states) • Mood (longer-term emotional states)
Behavior	• Appearance (e.g., hygiene) • Posture and gait • Motor activity • Degree of openness regarding the interview • Attitude toward the examiner

While clinicians will document most or all of the above topics in the patient's medical record after conducting the MSE, to an untrained observer (including many interpreters) the interview that yields MSE data may not appear to be an "examination" at all. If open-ended questions do not yield some of the

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desired MSE data, the clinician will usually ask more specific questions that focus on key MSE topics. Sometimes, patients will be asked to respond to specific MSE-related questions (e.g., "What is today's date?") or perform certain tasks (e.g., copy a drawing or follow a written command). (More on this topic in the next section.) Some clinicians use MSE checklists to gather key data in a more structured manner.

MAIN FOCUS OF THE CHAPTER: INTERPRETING FOR AN MSE

Assuming that interpreters are familiar with the complications and nuances of working in a bilingual-bicultural environment and working in mental health settings in particular (Pollard, 1998a; Tribe & Lane, 2009; RID, 2007c, Vernon & Miller, 2001), interpreting for the MSE when it is conducted in a conversational manner should not be particularly difficult. Of course, any time a translation challenge or relevant cultural issue arises, one should inform or educate the clinician about that challenge or issue. Asking a clinician to rephrase a question that was difficult to translate or explaining why a translation is difficult or noting how a question or topic bears particular cultural relevance are common choices an interpreter might make in such situations. But bear in mind each of the topics presented in Table 1 since the clinician will desire specific data regarding them.

For example, communication regarding, emotions, mood, unusual thoughts or sensory experiences, are particularly important to convey because they are not easily observed. Also not easily recognized by the clinician will be relevant characteristics of *how* the LEP individual is communicating. Is their speech (or sign language) unusually fast or slow or odd in other ways (see the section on "dysfluency" below)? Are the thoughts expressed by the patient (e.g., communications with the spirit world) possibly considered unusual in the clinician's culture but common in the patient's culture? Anticipating these important possibilities before they arise is the best preparation for interpreting during the MSE.

Specific Questions and Procedures Sometimes Used During the MSE

Beyond what may appear to be typical conversation about a patient's emotions, life difficulties, etc., there are many specific questions and procedures that may come up during the MSE. Each of these questions or procedures relates to one or more of the topics listed in Table 1. Interpreters should be prepared to encounter these questions and procedures, some of which may seem unfamiliar or strange. Some patients express surprise or even annoyance that these questions or tasks are asked of them, especially when they feel that the clinician is digressing from addressing the concerns that brought them to the facility. It is usually sufficient for the interpreter (or better yet, the clinician) to explain that these questions or tasks are presented "to everyone" or otherwise convey that, in mental health settings, these questions or tasks are common.

Regarding the topic of orientation, clinicians may ask the patient to state who they are, where they are, the day and date, or even ask questions that should involve common knowledge such as who the president of the United States is.

Regarding attention and concentration, clinicians may ask patients to do arithmetic problems in their head (not on paper) such as a task known as *serial 7s* (Teng, 2018). Here, a patient is usually asked to subtract 7 from 100 (the correct answer is 93) but then continue subtracting by 7s (e.g., 93 – 7 = 86, 86 – 7 = 79, etc.) for a short while. Another common technique is to ask the patient to spell a familiar word backwards. Often, the clinician will choose the word "world" (where the correct answer would be

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d-l-r-o-w). However, if one has translated the word "world" into the patient's preferred language (e.g., "mundo" in Spanish), the task would be problematic or not make sense at all unless the clinician was informed that the word "world" was changed to another word via the translation. In the video accompanying *Mental Health Interpreting: A Mentored Curriculum* (Pollard, 1998a), a Spanish language interpreter encounters this problem and asks the clinician if he wants the patient to spell *world* or *mundo* backwards.

Regarding short-term memory, clinicians may ask patients to remember a short list of words, then recall them perhaps 20 minutes later. In some cases, when a patient has difficulty recalling one or more of the words, the clinician may give them a hint (e.g., "It was a color.") or even offer multiple choices (e.g., "Was it red, blue, or green?")

Other procedures are intended to investigate the patient's language functioning. One such strategy is asking the patient to comply with a sequence of verbal commands (spoken or written) beginning with one-step commands (e.g., "Close your eyes") and progressing to more complex commands with multiple steps (e.g., "Point to the ceiling, then point to the door, and then to the main source of light in this room"). Another technique may involve asking a patient to read aloud from a paragraph or from a list of single words. Patients may be asked to spontaneously generate a written sentence. When these language-based MSE tasks are administered, especially involving reading or writing, LEP patients may not be able to respond or respond inappropriately which could be mistaken for symptoms of cognitive impairment. Interpreters should immediately discuss with the clinician any potential challenges in assessing patients using these language-based techniques, including how translation of spoken instructions (or responses) might affect the results.

Other MSE tasks may involve writing, drawing, or other motor functions. Patients are sometimes asked to copy a drawing that is shown to them, using another piece of paper. These drawings are usually geometric figures such as two oblong hexagons that intersect. Sometimes, patients are asked to perform an imaginary motor function such as threading a needle. A common procedure is to ask patients to draw a clock (that is, an analog clock face, not a digital clock) and set the hands of the clock at "ten past eleven". This specific wording, in English, is critical to the task; saying "ten minutes past eleven o-clock" would disrupt the information the clinician is looking for. This part of the clock drawing command presents translation difficulties in many languages and the clinician should be informed of this.

Finally, in assessing abstract reasoning, it is common for clinicians to ask patients to explain the meaning of a proverb. English language proverbs such as "people who live in glass houses shouldn't throw stones" or "a rolling stone gathers no moss" might be presented. Here, the clinician is looking for an abstract versus a concrete explanation of the proverb's meaning. While some LEP individuals may be familiar with the proverb(s) presented or be able to figure out an abstract explanation even if they are not familiar with the proverb, it is typical for LEP individuals to be unfamiliar with proverbs in a language in which they are not fluent. Again, clinicians should be alerted to this problem if a proverb inquiry is made during the MSE.

Other Potential Complications When Interpreting for the MSE

The Bilingual, Bicultural Environment and Fund of Information

Interpreters know that, frequently, differences between two languages cannot easily be bridged, especially in a word-for-word way. Unfortunately, clinicians who are monolingual may not understand this and erroneously presume that whatever is said in one language can be mapped, in a direct fashion, to words

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that have similar meaning in the other language. Dean and Pollard (2005) offer useful guidance to readers who do not fully understand the nature of interpreting work which sometimes requires translation strategies that are unknown, even unexpected, by monolinguals.

Interpreters also make translation and behavioral decisions based on cultural and contextual variables in the service environment, as well as their own experiences as members of an LEP community (since most interpreters' first language is the non-English language with which they were raised). Interpreters are usually the only person in the room who truly understand the bilingual, bicultural factors at play. This information could directly impact a clinician's ability to achieve the objectives of a MSE and/or other evaluation and treatment goals and must be openly discussed (Raval, 2003). Differentiating between bilingual, bicultural factors that are truly relevant to the situation from those that may reflect the interpreter's own personal themes, biases and assumptions – especially in mental health settings – is a valuable outcome of such frank discussions (Tribe & Lane, 2009).

LEP individuals may be immigrants, refugees, or deaf persons who have had difficulty acquiring a spoken/written language such as English (which is common in the deaf population). One consequence of limited proficiency in a majority culture's language, or less familiarity with that culture itself (as is often the case with immigrants and refugees) is a lower "fund of information" (Pollard, 1998b) regarding the country or culture in which they now live, regardless of one's intelligence or educational attainment. Fund of information deficits are the result of multiple factors that impede access to information in the majority language (e.g., radio, television, magazines, overheard conversations, etc.). When LEP or deaf patients "don't know things" that a clinician assumes are common knowledge, errors in MSE conclusions can result. Deficits in fund of information also can hinder a patient's understanding of, and cooperation with evaluation and treatment in mental health and other medical settings. Gathering information about communication and learning history in both family and school contexts can help to differentiate between fund of information gaps, limited intellect, and mental health symptoms.

Dysfluency

It is not unusual in psychiatric settings to encounter patients whose primary language is not fluent or even proficient (i.e., their language is "dysfluent"). Certain mental illnesses and neurological conditions can interfere with individuals' thought processes, language abilities, or both. For example, psychotic illnesses, mania, strokes, dementia, drug or alcohol intoxication, and certain developmental disorders all may cause language dysfluency symptoms. Dysfluency generally takes one of three forms: (1) a general lack of language proficiency that significantly impairs communication with the individual or (2) specific, disruptive errors in language use that are atypical of average users of that language, but which do not significantly impair communication, or (3) language articulation problems that are not suggestive of a thought disorder per se (e.g., slurred speech). All of these forms of dysfluency are important to notice and convey to clinicians – the interpreter is typically the only person in the room who has the ability to notice such language problems.

Since virtually all (hearing) persons are proficient, if not fluent, in their preferred language, even seemingly minor dysfluent language events *might* be indicative of important psychiatric or neurological impairments. For this reason, mental health clinicians are taught to attend to even the subtlest of language dysfluency events. Andreasen (1980) describes no fewer than 20 specific types of language dysfluency that may be observed in psychiatric settings, giving examples of each type (as manifested by native English speakers with psychiatric disorders).

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Here is an example of obvious, general dysfluency, directly quoted from a native English-speaking patient with schizophrenia who was responding to a psychiatric interview captured on film in a training video series for mental health clinicians (Wohl & Csernansky, 1994):

Well there the before on the clock, that's the 6, 7, 8, 9, 10, 11, 12, 1, 2, 3. They go by those numbers of the clock. And when you do the 25 after that's the after side of the clock. We go by the 1, 2, 3, 4 and 5 of the clock and the 5 you go right left to 7 number on the clock is the 5 number. You go right left to that number. That's what the 25 is. If you don't do something they tell you to do and Jesus makes the shotgun sound and then phone rang not to answer the phone or the doorbell.

This language sample is so disturbed that it would be nearly impossible to translate accurately. There is simply not enough logic or structure in the patient's language to convey sufficient meaning to the interpreter to allow her/him to form a coherent translation into the target language. (In the interpreting field, we denote that interpreters are receiving an utterance in one language, the "source language," and translating it into another language, the "target language"[1]). Dysfluent language of this severity is most certainly evidence of significant psychiatric or neurological impairment. If the interpreter translated only those parts of this utterance that she/he understood, in effect, "cleaning up" the language sample and failing to convey to the clinician the severe dysfluency that was otherwise evident, critical diagnostic information would be hidden from the clinician's awareness. The key here is to note that the patient's language, in large part, is not coherent. An interpreter's assumption of, or search for meaning in this language sample would be both fruitless and counter-productive. Below, we will address what an interpreter still can do to be helpful to the clinician, even when confronted with such severe language dysfluency.

Here is a different language sample demonstrating a much *less* severe degree of dysfluency that is nevertheless significant enough to have diagnostic relevance. It is also a direct quotation from a native English-speaking patient from the same diagnostic interview film series cited above. She is discussing the death of her mother. This patient was filmed during the manic phase of bipolar illness.

She had cancer of the spinal cord when I was 11-years-old and they had to take out her back, eight inches of her back out to kill the cancerous tumor. So that means she was paralyzed from her breast down for 21 years of her life. She died the age of the year I was born, '61. I believe everything has a purpose under heaven…I believe that's the time that God wrote down she is going to die before she hit her 62nd birthday. She was going to die and be my guardian angel at 61 of the year I was born.

Notice this patient's unusual phrasing involving numbers as well as her reference to her mother being paralyzed from "the breast down." Other portions of this interview revealed that the patient expressed a great deal of sexualized ideation. Native English speakers might say that a person was paralyzed from the "neck" down, the "waist" down, etc., but not the "breast" down. The several odd references to numbers in this language sample are even more noticeable. The severity of language dysfluency is subtler than in the earlier language sample and does not impair understanding as severely. Yet, even these language anomalies are diagnostically relevant. Again, ignoring such language anomalies or "cleaning up" the language in one's translation would hide important diagnostic information from the clinician.

While encountering language dysfluency is one of the most challenging aspects of interpreting in mental health settings, it is also one of the most important – where the interpreter's response to this challenge typically holds diagnostic and/or treatment significance. Most interpreters who work in com-

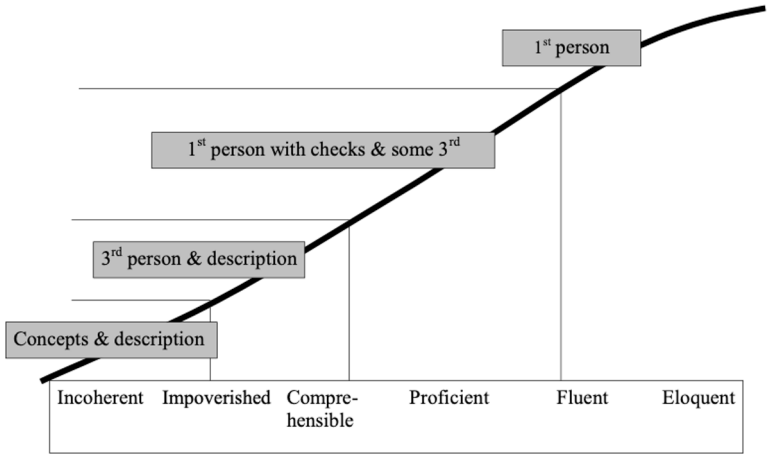
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munity settings have not encountered language dysfluency associated with psychiatric or neurological disorders, but it is not unusual to encounter in mental health settings. Despite the challenges involved, there are still helpful ways the interpreter can respond.

Again, the first rule is to not "clean up" dysfluent language or otherwise speculate what the patient "probably means" and then provide the clinician with a fluent, coherent (and misleading) target language translation. While a verbatim translation may not be possible when a patient's language is seriously dysfluent, interpreters still have options.

Figure 1 below portrays different options interpreters have when encountering dysfluent language. At the base of the figure is a scale of language dysfluency where fluent or even eloquent language is depicted on the right end of the scale. When language is of good quality, as depicted here, interpreters will normally translate in the first person and have little difficulty. Remember, here we are referring to the patient's preferred or best language. While most individuals are fluent in their preferred language some patients with psychiatric or neurological disorders are not. Thus, fluency (and logic) should never be presumed when interpreting in a mental health setting.

Figure 1. Translation options when confronted with language dysfluency



The middle portion of the scale is meant to depict language that is somewhat poorer in quality, such as proficient (but not fluent) language or language that is comprehensible (i.e., generally understandable, for the most part) but not even proficient in quality. Here, an interpreter will usually translate in the first person, when the language is good enough to allow this, but will often need to ask the patient to repeat or clarify what they said. Another option in this range of language dysfluency is to switch from first person translation to "third person" translation (e.g., "He was describing a physical fight he had with a friend, but it is not clear if this happened recently or long ago or which person punched which person first"). While a third person translation does not provide the clinician with the exact detail that the interpreter might desire, it still provides the "gist" of the language sample and further alerts the clinician that the interpreter is having difficulty translating the patient's language, therefore making the clinician aware that there is probably a degree of dysfluency being manifested by the patient. If the clinician truly cares about the unclear content, she/he can interrupt and ask the patient to clarify. But, more likely, the clini-

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cian may want to know (later) from the interpreter the nature of the translation difficulty she/he observed when the switch to third person took place. Such information may well reveal the type of dysfluency the patient was manifesting (Andreasen, 1980).

At the left end of the scale at the bottom of Figure 1, are the terms "MLS" (meaning "minimally language skilled"), where very little of the patient's language is clear and/or logical and "incoherent," where virtually none of what the patient is communicating is understandable. Again, this certainly can happen when patients have severe psychiatric or neurological impairment, but interpreters still can be tremendously helpful in such situations. As shown in Figure 1, while first person translation in such situations is likely impossible, there might be segments of the patient's language that are sufficiently understandable for a third person translation. But even when that is not possible, interpreters can still *describe* what they are observing in the patient's language. Such description can be extremely helpful to clinicians who are trained in identifying different forms of language dysfluency.

For example, there is a dysfluency symptom known as "clanging" in which patients are drawn to the structure of the language they are using and not the logic of what they are attempting to say. With hearing patients who "clang" they may put together a sentence with words that rhyme or begin with the same sound but, together, the sentence does not make sense. Deaf patients who clang also are drawn to the structure of sign language (and lose sight of the logic of their communication) by putting together a sentence that uses several signs involving the same handshape but, again, which do not make sense as a complete utterance. Since clinicians working with interpreters will not recognize rhyming, sign language handshapes, etc., the only way they might suspect that a patient might be clanging is for the interpreter to inform them that these types of phenomena are occurring.

While clanging is only one example of the many language dysfluency symptoms one might encounter, two key points remain – interpreters should always explain to the clinician (either in the moment or afterward, as the situation warrants) unusual language events that they observe and, second, never insert clarity or logic in a patient's language utterances when such clarity or logic is weak or absent. Failure in either regard "hides" potentially crucial diagnostic and/or treatment information from the clinician that may well impede or curtail the treatment that the dysfluent patient deserves.

Interpreter-Clinician Partnership in Mental Health Interpreting

When interpreters and clinicians work together in providing access to care for patients whose first language is not English, there are multiple benefits for all, especially patients. The following section offers considerations in developing a collaborative relationship and environment for the interpreting of MSEs, others psychiatric interviews, and medical appointments generally.

Like other venues of interdisciplinary teamwork, in medical contexts, preparation helps clinicians and interpreters work together most effectively. Interpreters should be recognized as fellow "practice professionals" (Dean & Pollard, 2013, 2018) on the service team. Familiarizing oneself with local interpreting agencies, national interpreter organizations and their codes of ethics or professional conduct, and specific guidelines for working with interpreters in medical and mental health settings can be very useful (Tribe & Morrissey, 2004). Written guidelines and contracts about interpreters in medical settings can include specifics regarding confidentiality, roles and responsibilities, and other professional and ethical issues (Sills, 1997). Introducing interpreters to key hospital or office staff, inviting their participation in continuing education lectures or courses and relevant meetings helps integrate interpreters with the broader

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medical team and environment (Tribe & Sanders, 2003). Clinicians could also provide a dictionary of medical terms available for interpreters to consult (Tribe & Morrissey, 2003).

Hiring qualified interpreters who have experience, training, and are comfortable in mental health and/or medical settings is valuable for many reasons, but is especially important when initial diagnostic (e.g., MSE) and treatment planning decisions are being made. Determining the client's preferred language, including dialect, and finding an appropriate interpreter with a background in both the patient's preferred language and mental health work is often a challenge that can be streamlined when interpreter referral agencies and clinicians work together. If possible, interpreters and patients should be matched for gender, age and religion, particularly if this is relevant to the meeting or consultation (e.g., in cases of sexual assault or intimate partner violence) (Patel, 2003; Nijad, 2003). If multiple appointments are anticipated and the patient and interpreters agree, then the same interpreter should be requested for ongoing appointments whenever possible. When that is not possible, interpreters should be encouraged to pass along key information about the assignment (e.g., key names and relationships that are discussed, important facts that have been established, etc.) to new interpreters who will be involved so that continuity of communication can be maximized between the clinician(s) and multiple interpreters.

Interpreted appointments almost always take more time than appointments where clinicians and patients speak the same language and schedules should be planned to accommodate that extra time. A 10-15 minute "pre-session" before the appointment begins, in order to explain the purpose of the meeting and clarify any technical concepts, vocabulary or jargon, cultural issues, and nonverbal communication norms that may arise should take place whenever possible. If using technical vocabulary or procedures other than discussion is anticipated, familiarizing the interpreter with these terms or procedures beforehand can allow for smoother communication during the appointment (Tribe & Morrissey, 2004). Even planning the physical arrangement of the environment, so that it is conducive to a three-way conversation is helpful (Tribe & Morrissey, 2004).

The value in taking the time to prepare in advance for interpreter-clinician collaborations cannot be overstated. Beyond the interpreters and clinicians themselves, interpreter service agencies, office managers, and human resources personnel also can be helpful in this preparatory stage.

If pre-appointment preparation is done well, this maximizes the likelihood that the clinician and interpreter can concentrate effectively on their respective duties during the appointment itself. Ultimately, when the appointment begins, the clinician, interpreter, and patient should all feel comfortable; it should be obvious to the patient that these fellow practice professionals "know what they're doing." Leading off with an open discussion, where all involved acknowledge that interpreted conversations present unique challenges is fundamental (Tribe & Morrissey, 2004). This can be achieved by first clarifying the interpreter's professional role and addressing confidentiality boundaries (Tribe & Sanders, 2003).

Being mindful of pacing and turn-taking is especially important when working with interpreters. They cannot interpret for more than one person speaking at a time and, as noted, words or concepts in one language do not always have exact equivalents in another language, sometimes requiring extra time for an effective bilingual, bicultural translation. Clinicians and interpreters should not discuss anything in front of the patient that is not intended for the patient to understand. That is, all communication conducted in the patient's presence should be translated. If issues arise which require private discussion between the interpreter and clinician, the interpreter can explain this to the patient and a break can be taken so that the interpreter and clinician can confer or, better yet, these things can be discussed in private before or after the meeting (Razban, 2003; Baylav, 2003). Particularly in mental health settings, it also is advised

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that interpreters not be alone with the patient/family without the clinician present (e.g., in a waiting room) to maximize confidentiality and professional boundary-keeping.

The collaboration between clinicians and interpreters should continue after the appointment as well. The appointment experience is often rich with communication dynamics, curiosities, and ideas for feedback that can be discussed during a short debriefing session. Any translation, cross-cultural or other challenges the interpreter noticed should be shared with the clinician. Debriefing on how well the clinician and interpreter worked together as a team is another important topic which may involve questions or even constructive criticism regarding their working partnership. Discussing arrangements for future communications and appointments also can occur at this point. This "post-session" is a wonderful opportunity for these practice professionals to share information and resources that may help one-another continue to develop their skills in bilingual, bicultural mental health work.

Continuing Education and Mental Health Interpreting

The lack of well-regulated training for interpreters is an issue in many countries (Dean & Pollard, 2001; Tribe & Sanders, 2003; Hwa-Froelich & Westby, 2003). Interpreter qualifications, training, and other professional and even legal requirements vary widely (Tribe & Morrissey, 2003). The effectiveness of interpreter preparedness and on-the-job judgement, whether regarding translation, behavioral, or ethical decisions depend a great deal on their familiarity with the setting in which they are working (Dean & Pollard, 2013). Unfortunately, interpreters often function or are trained as "generalists" – as if their bilingualism and cross-cultural knowledge prepares them to work with equal effectiveness in any setting. This is quite inaccurate. Medical and mental health settings, legal settings, and educational settings, especially post-secondary ones, present particular challenges regarding the requisite knowledge, vocabulary, and experience to perform competently as an interpreter (Pollard, 1998a, RID 2007a, 2007b, 2007c).

An interpreter's role is complex and demanding. Their work requires a variety of skills, including knowledge of specialist terminology, ability to reflect on meaning, memory skills and the ability to convey accurately the meaning of the content expressed (Tribe & Morrissey, 2003). Interpreters benefit greatly from continuing education, support, and supervision (Dean & Pollard, 2009, 2013). Interpreters who work in mental health settings also may need supervision and consultation resources around matters such as therapeutic boundaries, confidentiality, therapeutic practice, and the consequences of communicating traumatic material (e.g., vicarious trauma). Interpreter organizations should consider how to incorporate mentoring, consultation, and supervision into continuing education programs for all interpreters, especially those working in mental health and medical specialties.

Two organizations have created certification processes for medical interpreters: the Certification Commission for Healthcare Interpreters (CCHI) and the International Medical Interpreters Association (IMIA). The CCHI exam assesses healthcare terminology, interactions with other healthcare professionals, interpreting encounters, and cultural responsiveness and includes consecutive and simultaneous interpretation in addition to sight translations. The IMIA Certified Medical Interpreter status is available for Spanish and nearly 30 other languages and requires successful completion of written and oral exams (VanderWielen, 2014).

The United States presents a mix of state legislation and individual organization policies regarding medical interpreting. Even though the above two national organizations provide certification processes for medical interpreters, various state certification programs also exist. Pollard (1998a) developed a popular mental health interpreting training curriculum conducive to various interpreter training environments

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(e.g., small group, large group, individual, etc.) Other notable resources for mental health interpreter training include the Alabama Department of Mental Health's Mental Health Interpreter Training (MHIT) program, the CATIE Center's mental health interpreter training program at St. Catherine's University, Cambridge College's Mental Health Interpreter Certificate program, the Cross Cultural Communication Institute (CCCI) Mental Health Interpreter Certificate, the University of Minnesota's Interpreting in Refugee Mental Health Settings training, a program run by the National Latino Behavioral Health Association (NLBHA), and the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) Mental Health Interpreter Training Program (MHITP). In 1978, the U.S. Congress passed the Federal Court Interpreters Act, mandating that the U.S. courts establish a program to facilitate the use of certified and otherwise qualified interpreters in judicial proceedings instituted by the United States (VanderWielen, 2014).

CONCLUSION

The presence of qualified interpreters in mental health settings is gaining popularity. The benefits to patient access and satisfaction in healthcare, diagnosis, and treatment are many. The MSE is a central component of assessment in mental health settings that is used to examine and document various aspects of a patient's cognitive and emotional functioning. Some elements that impact interpreting for the MSE lie in the assessment techniques utilized by clinicians and some in the challenges that LEP patients may present (e.g., dysfluency, fund of information gaps). A collaborative and open relationship between clinicians and interpreters is the key to conducting a proficient MSE and bridging the gaps between the clinician, patient, and interpreter. Utilizing cooperative guidelines helps to organize interpreter and clinician roles and responsibilities before, during and after interpreter-mediated appointments. Supporting the progress of mental health interpreter training and certification programs is essential to promoting the vital role of interpreters in mental health care.

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ENDNOTE

[1] In the interpreting field, we denote that interpreters are receiving an utterance in one language (the "source language") and translating it into another language (the "target language")

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Chapter 33
Ageing and Mental Health:
A Psychological Aspect of Later Life

Neelam Verma
Talk to Cure, India

ABSTRACT

Estimated research findings suggest that almost two-thirds of adults with psychiatric conditions do not receive the required treatment services. This chapter enables readers to understand various aspects of ageing, how physical and mental health aspects are correlated, and which mental health conditions are most common in later life. The chapter also discusses major models of mental health in the context of ageing. Major psychiatric and psychological conditions that are most common in old age are outlined along with a major milestone of old age (i.e., retirement: a major lifestyle change that pushes older people towards psychological problems and adjustment issues with a new phase of life). A brief description is presented on the current status of psychiatric and psychological services for mental health issues of the elderly. The chapter concludes by summarizing the contents of discussed areas. Studies are presented throughout the chapter to accompany and enrich the discussion and validate the chapter content.

INTRODUCTION

When we talk about ageing and mental health it undoubtedly involves studying geriatrics. Geriatrics involves medical paradigms of old age such as clinical conditions and strategies to treat them. In psychology, a branch especially devoted to study ageing and provision of clinical services for older adults is *Geropsychology*. The field expands knowledge of normal ageing process and develop treatment modalities to address problems that occur when people age. Most individuals enjoy a good time in later life; however, American Psychological Association says that it is anticipated that the number of older adults with mental and behavioural health problems will almost quadruple from 4 million in 1970 to 15 million in 2030. Mental health conditions adversely affect the ability to function especially in later ages. World Health Organization (1948) defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Since the description of health includes mental health and wellbeing, it must be taken into account that psychological health is an important paradigm of

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one's overall health including older adults, and need to be recognized and treated with equal urgency as required for other physical illnesses. A conceptual definition given by Baltes and Baltes (1990a) explains normal ageing as" ageing without biological or mental pathology". It thus concerns the ageing process that is dominant within a society for persons who are not suffering from a manifest illness. Further in their conceptual framework optimal ageing has been referred as a kind of utopia; namely, "ageing under development-enhancing and age friendly environmental conditions" and pathological ageing characterizes an "ageing process determined by medical aetiology and syndromes of illness".

If we see the above definition of normal ageing which says that "normal ageing does not include manifestation of illness*"* it will be difficult to justify the fact presented by Centres for Disease Control and Prevention and the Merck Company Foundation [CDC & MCF](2007) which advocates that "chronic disease is typical of the experience of ageing". According to their database, in United States more than 80% older have at least one chronic medical illness and 65% older have at least two chronic medical illnesses. For example, Arthritis is considered to be an age-related illness but old age does not manifest its occurrence because every older does not suffer from this condition. Also, the functional ability or disability which is an important part of old age which affects the ageing process. Functional disability could be present physically (weakness, deterioration in physical health, inability to walk properly or slow walking etc.) or mentally (stress, irritability, and deterioration in cognitive skills). These functional manifestations of ageing are commonly seen in our own family members who are getting aged. Often, presence of physical illnesses leads to psychological issues or vice versa. According to Cohen (1992):

- Psychogenic stress (or stress that has psychogenic basis) may lead to health issues.
- Medical illnesses or other health problems may lead to emergence of psychiatric conditions.
- Interaction of coexisting mental and physical health problems may lead to occurrence of other psychological or physical health issues.
- Social and psychosocial resources may affect the course of psychological or physical health problems.

Plethora of literature talks about conceptual, statistical and functional aspects of ageing and mental health but there is lot more to explore. Further contents of the chapter will unfold other aspects of ageing and related mental health issues.

MAJOR MODELS OF MENTAL HEALTH IN CONTEXT OF AGEING

Psychodynamic Model

Psychodynamic model of psychological functioning is considered to be the oldest, yet most comprehensive model in context of psychological wellbeing and disorders. Its contribution as mental health model in later life was relatively late but the presented facts turned out to be as good as presented in the very first theory of this school proposed by Sigmund Freud; originally called psychoanalytic model. Journey from psychoanalytic model to psychodynamic model involved contribution of many legends of the field. Explanation of psychodynamic theory revolves around basic personality structure, developmental process and interpersonal relationships. This school of thought emphasizes on the complex interrelation among cognitive, emotional and motivational forces that work on formation of personality. As psychoanalytic

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explanation of personality development emphasizes a linkage between childhood experiences and development of adult personality, the theory in context of later life advocates strong correlation between adult personality and old age. Precisely, the theory says that elderly come to their latter part of lives extremely influenced not only by their childhood experiences, but also by their adult episodes and adaptations made during that phase of life. According to Newton and his colleagues (1986) the individual enters later life with a personality structure that reflects a long history of life experiences. In later life the adult confronts age correlated events (retirement, physical changes and illness, loss through death of friends and family) and the internal psychological changes can re-evoke unresolved conflicts. Despite of external events being important for adjustment with ageing process, individuals' basic personality has been found to be the mediator of adaptation in old age. Hildebrand (1982) explained that how difficulties in later life affect the mental health of elderly. these difficulties included fear of diminution/loss of sexual potency, threat of redundancy in work roles or being replaced by younger people, the need to reconsider and perhaps remake the marital relationship after children left, awareness of one's own ageing, illness and possible dependence, awareness that what one can achieve now is limited, the feeling of having failed as a parent, loss of partner and of intimacy, and the fact of one's own death in terms of narcissistic loss and pain. Mental health in later life demands overcoming all these fears and threats, and those who are able to negotiate them are said to have a good mental health. Cohler (1993); Schiff and Cohler (2001) emphasized the importance of '*deriving meaning'* as a major component of mental health in old age. According to their perspective, meaning must be worked out for the entire life cycle in the form of a coherent '*narrative'* that explains the continuity of an individual's life in the face of interruptions and adverse events, and those who fail to establish this integrity and unable to preserve or build a coherent narrative suffer from mental health issues in later life. Psychodynamic theory explains the nature of old age mental health issues with following assumptions or causal factors:

- **Childhood Losses Re-Enact as Losses in Old Age:** The model emphasizes importance of childhood trauma or loss and its impact on intra-psychic structures. Adaptive capacity is affected especially in cases of loss of attachment figure in childhood and grief caused by that evokes the anxiety of living in an unprotected world (due to loss of attachment figure). Wounds of childhood trauma or bad experiences definitely leave their scars that affect an individual for the whole life. Significant losses in old age evoke re-experience of negative feelings or grief experienced in childhood and increase vulnerability to get affected easily in similar situations.
- **Underdeveloped Self or Immature Defences Cause Insufficient Strength to Deal with Psychological Challenges of Later Life:** As discussed earlier about Erikson's developmental tasks in different ages, it is important to note that developmental tasks keep changing in every stage of development and those who have not mastered the earlier stage face difficulty while facing the current developmental task. It affects the ability to adapt in new situations. Gutman (1987) establishes a relationship between personality defences and loss using immune system analogy. He advocates that loss is dominated only when one's personality is vulnerable to the loss and those are affected most with losses of old age who adapted to early losses in immature ways. Precisely saying, an underdeveloped self, exaggerates the capacity of loss to induce or provoke pathology in later life.
- **Decline or Loss of Physical, Emotional and Cognitive Strengths Weakens the Functioning of Ego:** Self psychologists have pointed out the negative impact of physical and functional decline on self-esteem and balancing it by finding restitution for loss. If the surroundings of an older adult are

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not supportive enough or they fail to maintain the ego functioning they might use compensatory mechanisms (possibly pathological in nature) like putting the blame on others for their losses or remembering or recounting past achievements and glories.

- **Personal Narratives Cannot Integrate with Events and Transitions of Later Life:** Life constructs of earlier adulthood may be inadequate or insufficient to integrate experiences and expectations of old age into personal narratives requiring a developmental shift or transition and inability to make the transition may lead to develop vulnerability towards personal fragmentation.

Psychodynamic model focuses on the transitions of inner processes over the life span of an individual. It emphasizes the development of strategies to cope with the imbalance between inner life and outer world and how interpersonal dynamics in old age continue to have a great impact on quality of life.

Eriksonian Psychosocial Development Model

Erik Erikson's model is an epigenetic model of psychosocial development which describes human development across life. It comprises of a series of eight developmental challenges from infancy to old age where every stage is a foundation for the next stage. The theory emphasizes that not meeting the developmental challenges adequately in midlife results in stagnation and emotional despair in later life (Erikson, 1984; Erikson & Erikson, 1998). The eight stages of development comprise of two opposing statements representing the challenges faced by a person at a particular stage. Following description provides a glimpse of eight stages and their significance for later life and associated mental health aspects.

1. **Trust vs. Mistrust:** This stage belongs to infancy in which infants receive care from their primary care givers. If the care is consistent, predictable and reliable they develop a sense of trust and virtue of hope. Failure to meet the needs of this stage leads to mistrust in all other relationships made in future. This may also result in anxiety and insecurity in later life.
2. **Autonomy vs. Shame and Doubt:** This is the stage of discovering skills by learning to do self tasks such as walking, buttoning, putting on clothes etc. children allowed and encouraged to learn with trial and error are thought to be more confidant and develop the virtue of will. on the contrary, children who are not given ample opportunity to learn or consistently criticized for accidents made during this learning begin to feel inadequate in their skills and suffer from low self esteem and a sense of failure in later stages of life.
3. **Initiative vs. Guilt:** At this stage, individuals begin to plan and initiate activities with playmates. If given opportunity, they develop skills to lead others and make decisions. Conversely, if they are excessively controlled or criticised in their decisions or initiatives they develop a sense of guilt. This leads to control them always and they lack in self initiatives throughout their lives. If a healthy balance is maintained between initiative and guilt it leads to the virtue of purpose which helps them in retaining a good psychological health in later stages of life.
4. **Industry vs. Inferiority:** Teachers play an important role at this stage of development as the child learns to read, write, perform sums etc. Peer group has a greater significance at this stage and a major source of child's self esteem. Encouragement and reinforcement to take initiatives and perform tasks successfully develops a sense of pride in the children and they feel confident to achieve goals later in life. Conversely, if they are restricted to initiate tasks by teachers and parents they begin to feel inferior and start doubting their potentials. If a healthy balance is maintained between

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competence and modesty, it leads to the virtue of competence which is one of the major aspects of life satisfaction and sense of achievement. Subsequently, it helps in carrying out all tasks of personal and professional life confidently and developing a sense of fulfilment in late life.

5. **Identity vs. Role Confusion:** This stage belongs to the search of self and personal identity by exploring personal values, beliefs and goals. The person learns and explores about what role he or she will occupy as an adult. Also, it involves exploration of two identities i.e. sexual and occupational. Accepting the body image and understanding the physiological changes during adolescence leads to the virtue of fidelity which is important to accept others and maintain relationships in further stages or adulthood. Failure to establish an understanding of self may cause role confusion and identity crisis which results in rebellion tendencies, negative identity and feelings of unhappiness with self. Such feelings result in poor mental health in later life when a person goes to other physiological changes and loss of physiological and cognitive skills.
6. **Intimacy vs. Isolation:** This stage belongs to formation of relationships with others and commitments for long term with people other than family. Successful completion of this stage results in healthy relationships, fulfilment of commitments, a sense of security and safety and care in other relationships. On the contrary, avoiding intimacy, fear from committing to others and hesitation to form intimate relationships leads to isolation and loneliness. Successful completion of this stage leads to the virtue of love that helps in maintaining close and intimate relationships.
7. **Generativity vs. Stagnation:** This stage belongs to the establishment of career, settlement in personal and professional life, beginning and raising family/children and a sense of being responsible. Successful completion of this stage leads to the virtue of care; however, those who fail to succeed at this stage suffer from stagnation and feel unproductive.
8. **Ego Integrity vs. Despair:** In context of ageing, this is the most important stage of this model. Individuals are considered senior citizens at this stage as the productivity goes low and they explore life as a retired person. This is the time where an individual cherishes accomplishments of life and develops a sense of integrity through what has been achieved in life. Successful completion of this stage leads to the virtue of wisdom which provides a sense of completeness and develop acceptance of death as a natural process without fear and regrets. If an individual at this stage sees his or her life unproductive and regrets for the decisions made in earlier stages, it leads to dissatisfaction, despair and often depression characterized by hopelessness.

The theory advocates that if the challenges of one stage are not resolved they are likely to affect further stages and stay as a problem in later life. Each and every stage has a major contribution in an individual's life; however, Generativity may have particular significance in context of ageing as it is linked with emotional and cognitive capacities; an important functional aspect of later life (Mc. Adams, 2001; Slater, 2003). Erikson; 1950, proposed a series of developmental tasks in adult life such as forming intimate relationships, being productive and committing to guide younger generation (experiencing generativity), and coming to terms with past and future in the face of upcoming death with wisdom (experiencing ego integrity). According to him, those who failed to meet these developmental challenges successfully in their adulthood were thought to be more vulnerable to emotional distress as they aged. Other sources indicate that integrity versus despair and disgust are more often associated with later life as mature forms of psychological achievements in adulthood are integrated into a comprehensive sense of wisdom in old age (Erikson et al., 1986, pp. 55-56). Consistent with Erikson's model, a wide range of research findings suggests that relationships, work and identity formed in social contexts have

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important implication for healthy ageing (Cohen, 2004; Everard, Lach, Fisher, & Baum, 2000; Sato et al., 2008; Thomas, 2011). However, more researches are needed to establish links between Erikson's developmental model and cognitive and psychological functioning of people ageing.

Cognitive Behavioural Model

Cognitive behavioural model is an integration of two distinct approaches i.e. *cognitive* and *behavioural* which turned out great together. Cognitive model emphasizes the importance of thoughts and belief system to maladaptive behaviours and negative emotions. Dobson and Dozois(2001); Dozois, Frewen and Covin (2006)suggested that all cognitive theories share three fundamental hypotheses i.e. 1. Cognition affects emotion and behaviour 2. Cognition can be monitored and changed 3. Cognitive alteration can bring desired emotional and behavioural changes. The behavioural model focuses on behaviour rather than emotion, motives or biological factors. This model suggests that an individual's behaviour is the result of interaction between the person and environment and according to the principles of learning theory it supports the notion that environmental cues influence the acquisition, performance rate and termination of certain behaviours. The model supports primarily observable behaviours; however, some internal behaviour like feelings and thoughts are equally covered under the basic learning principles that are possible to modify through behavioural management techniques. In behavioural approach, the term "mentally healthy" has an alternative term called "adaptation" which denotes capacity to effectively meet one's own needs within the environment. Individuals unable to adapt to their environment are said to have mental health issues due to certain factors such as 1. Learning maladaptive behaviours or frameworks, 2. Inability to learn appropriate behaviours due to poor or unsupportive learning environment, and 3. Poor self-regulation or responding to wrong environmental contingencies. Cognitive behavioural paradigm of mental health for older adults (similar for other population as well) focuses on patterns of thoughts, values, belief system and behaviours leading to adaptation and adjustment in the current environment or impairment in one's functioning. Here, especially with elderly, the process of adjustment might be challenging because of some common challenges associated with age and decline in overall functioning. This limited functional ability restricts them to respond appropriately to environmental contingencies. Conversely, freedom from responsibilities (Looking after family, career, education of children etc.) makes them more responsive towards social situations or stimuli. Baltes and Baltes (1990b) advocate that older adults show high rates of adaptability or "behavioural plasticity" to modify their behaviour and adjust to the changing capacities and environment. This adaptation takes place through selective optimization and compensation for the lost skills. Some research findings suggest that the life in nursing homes is highly challenging for older adults in reference to their mental health as it limits the environmental stimulation (all work is done by the hospital staff), thus their responsiveness towards environmental changes fails to adapt and adjust (Molinary, 2000; Rosowsky, Casciani, & Arnold, 2008; Snowden, Sato, & Roy-Byrne, 2003).

The cognitive behavioural model enables to understand a framework in which problem behaviour is easily identified and treated. Knight and Satre (1999); Satre, Knight and David (2006) emphasized the significance of this model for cognitively intact elderly to treat conditions like depression, anxiety, insomnia etc. Some other treatments, especially more behaviourally focused (for example, incontinence program, improving activities of daily living, self-care etc.) have been found to be successful even on cognitively impaired older adults.

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Stress and Coping Model

This model presents a stress and coping perspective especially to work with elderly. Research work done by Aldwin (2007) suggested that it is useful to see stress and coping mechanisms as a process with three major elements i.e. 1. Strain an internal state of an individual, 2. Stressors; external events, and 3. Transactions: an experience derived from the interaction between an individual and his/her environment.

Strain encompasses physiological reactions of an individual such as sympathetic activation, parasympathetic suppression, neuroendocrine changes, and changes in immune functions, and emotional reactions such as positive or negative feelings, emotional numbness etc. Studies on mind body relationship are not new in the field but such researches have worked behind studying a relatively new field i.e. psychoneuroimmunology (PNI) that studies the interaction between physiological processes, nervous system and immune system of human body. Gruenewald and Kemeny (2007) studied and suggested substantial link between clinical depression and adverse immune response and geriatric population has been found to be most affected by this condition. Penedo and Dahn (2005) studied a similar line and established a correlation among stress caused by being diagnosed with cancer and its treatment, other stressors of life and subsequent health status. It thus clarifies that the stress does affect the immune system and there is an established link between the two.

Stressors are the events or conditions that cause stress or strain in an individual. Having problems in marriage, being victimized in a crime, death of a loved one are few examples of traumatic experiences that cause stress. Similarly, there could be other types of stressors like physical environment (weather), stress related to individual role (daughter to care for ageing parents, single parent to give healthy upbringing to children), and stress related to routine hazards such as traffic, conveyance etc. stress and stressors are distinct from each other in terms of their occurrence as stress is generally chronic but stressors are mostly acute. An individual faces stress in various contexts in a life span and when it comes to older adults it is even important. In cases of older adults social, historical and physical/non-normative contexts play a very important role in generating stress and it all concerns a series of events for them as being in a later age makes them see these things throughout their life span. An older would be a witness of all three contexts thus would be influenced by all three categories. Age graded influences cover entering school or passing out from college, history graded influences cover a particular historic period in which the individual has lived such as world war, terrorist attacks in country or a natural disaster. Non-normative influences are usually unexpected and may occur at any point of life such as loss of a loved one at a time when it is unlikely to happen or a big financial loss in business. Krause (1995a) suggested significant influence of financial strain on social and mental wellbeing of older adults. Its significance was found to be prominent for depressive symptoms and physical illness as well.

Transactions are the third important element as well as highlighting a cognitive dimension of the stress process. It summarizes the interaction between person and environment with a basic assumption that a person's perception of the stressor affects his or her coping response. Performance in final exams may have a different dimension for different students. Some may take it as a challenge for their intellectual skills; some may see it as a threat to their mental health and wellbeing, while others may take it as an opportunity to enhance their knowledge in the course topics. The perception of performance for final exams would influence the action of the students. In this process, appraisal of the intensity of stressor also plays an important role and it is said that stressors appraised with stronger intensity generate stronger emotional and physiological responses. Lazarus and colleagues explained coping based on perception of stress as problem focused and emotion focused coping. Problem focused coping focuses

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on altering the problem whereas emotion focused coping focuses on regulating the stress causing emotions. According to Lazarus and Folkman (1984) problem focused coping is implemented where there is an amenability to change the situation and emotion focused coping is used where nothing can be done to alter the situation. A person's style of coping depends on how a person perceives the stressful event and in many cases individual's use the combination of both styles to cope with a problem. Skaff (2007) presented perception in terms of 'Sense of control' over the event as a central element and a classic study done by Zautra, Reich and Newsome (1995) found links between sense of control, loss of autonomy and mental health amongst elderly. Their study focused on mental health of elderly in view of adapting to a phase of loss of autonomy caused by either decline in physical or mental abilities or due to loss or bereavement. Results showed high association between sense of personal control over events and positive mental health. Review of the results and literature by Skaff (2007) suggested that entering into old age with a strong sense of control is highly adaptive and promotes wellbeing of elderly.

Although the researches have been synthesized well in this field but the findings may not be implemented on every older adult. Thus, according to Gatz, Kasl-Godley, & Karel (1996) the approach needs to be more pragmatic as coping with stress involves an individual factor and said to be a function of three major elements i.e. 1. Level of vulnerability (includes genetic effect, acquired biological vulnerabilities and physiological factors affecting adaptation of the individual such as pessimistic tendency, poor problem solving and communication skills), 2. Stress being encountered (includes psychosocial and environmental elements and individual's way of perceiving the stress), and 3. Protective factors (include biological, social and psychological elements that help to moderate the stress by being physically active, having effective coping strategies or having a good social support network).

This model helps to understand that how the interaction between person and environment (i.e. individual capacities and environmental characteristics) affect the development and course of psychological disorder and influence the mental health and well-being of elderly. This area of work is highly progressive; however, caution needs to be taken while implementing this model in research work as we are still in process of learning about stress, coping and ageing altogether. Despite of limited knowledge this framework could be utilized while working with elderly and challenges of their life.

Family Systems Model

A family systems model focuses on interrelatedness of elderly with their families. It explores importance of considering ways in which their positive mental health is enhanced by supporting and smoothening the family functioning. Also, the model assesses the possibility of family dysfunctions that might be causing deterioration in mental health of elderly. In today's world where we have made communications limited to texting and phone calls, it is a positive fact that despite of isolation and abandonment of elderly from their families, they have been found to have regular contact with their children. In a research done by Troll & Bengtson (1993) it was found that even very old parents around the age of 85 years managed to have weekly face to face meetings and high frequency of phone calls/letters/greeting cards or gifts with at least one of their children. In this context, technology has been found to have a positive impact on parent- child relationship in old age when children are mostly far from their parents either for education or for occupation. According to Pruchno, Blow, and Smyer (1984) families are primary components of the "life event web" in which the ripple effects of major life changes are felt. Parent-child ties are very important yet crucial to understand. In early years parents provide care to their children and as ageing takes place the role reverses and children are expected to be the caregiver of their parents; however, the latter

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one is not guaranteed. Still, the care giving process from parents goes on for their children throughout their lives as they grow and need assistance from their parents for career, marriage, nurturance of their own children, marital conflicts, and divorce, physical or psychological illness and so on. According to Fingerman et al. (2009) an older adult being taken care by their children and great grandchildren is a common image in society and accurate as well because care giving and care receiving are important functions of families and later-life families. Indeed, families serve plenty of other functions for older adults other than just providing needed care such as providing mutual support in times of stress, help indecision making, sharing views on family tasks, celebrating individual developmental milestones etc. There are changes in the quality of relationship with family members and older adults that take place with time and as the person ages. Qualls (1995a) advocates that in a lifetime there are three major life transitions that cause restructuring of family relationships namely 1. Emptying and re-emptying of the nest, 2. Retirement, and 3. Onset of chronic physical illness. These life transitions affect various aspects of family relationships like time structure, individual roles, communication among family members, power balance, gap between generations and nurturance. Despite of such changes families often find an organization in new relationship patterns and familial structure.

The systems model also emphasizes on social context and conceptualizes family as a social unit. Thus, the problems are acknowledged to reside in the social unit (family) rather than an individual (family members facing the problem). Although the problems are particularly faced by one single individual, it is more distressing if the social unit is unable to manage it effectively. An elderly in the family suffering from Alzheimer's diseases would be a concern for everyone and if the problem is not being managed well by the family members it will worsen the wellbeing of the elderly and caregivers as well. Systems approach advocates that social units promoting fulfilment of family members needs are considered to be functional and those who are unable to do so or inhibit the process are considered problematic. Hence, mental health of elderly in systems model is not conceptualized on individual level, it is rather a mutual concept as everyone affects others and vice-versa. Families with poor functional structure are likely to face problems and unable to meet demands of family members throughout the life span including later life. However, many times even well-functioning families are stuck in problems and unable to adapt to the situation. Family with a demented family member would definitely face problems while taking care of the individual if they are unaware of basic issues related to that condition. Inability to provide appropriate care causes stress among family members and also affects the quality of relationship. The model also emphasizes on examining the interpersonal environment of family as mental health of older adults is highly influenced by the family characteristics and dynamics. The basis to demonstrate impact and utility of systems model for elderly's mental health is limited but the research works done by Qualls and Noecker (2009); Shields, King and Wynne (1995); Gaugler et al. (2008) and Mittelman et al.(1996) are promising. More empirical work is needed to establish the importance of systems model in context of elderly's mental health; however, available researches and their outcomes cannot be discarded.

MAJOR PSYCHIATRIC AND PSYCHOLOGICAL CONDITIONS OF LATER LIFE

As our loved ones grow old they are likely to have changes in their life that are common in old age such as normal forgetfulness, decreased attention, physical illnesses etc. According to National Institute of Mental Health, about 20% of individuals aged 55 years or older face mental health issues, but unfortunately around one in three of them do not receive required clinical attention. A major problem to detect

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psychiatric condition in older adults concerns physiological disorders that usually lead to secondary psychological or psychiatric disorders and overlap while diagnosing the problem. Many times even the common physical and emotional stressors in old age might be a cause of concern and put elderly at risk of developing major psychiatric conditions. The Geriatric Mental Health Foundation has proposed some conditions that may trigger the onset or development of psychiatric disorders in elderly such as physical disability, long term illness (like cancer or CVDs), Alzheimer's disease causing dementia, medical conditions affecting cognitive processing such as thyroid or adrenal disease, change of environment, illness and death of loved ones, interactions of medication, substance/alcohol abuse, and malnutrition or poor diet pattern. Gatz and her colleagues (1996) suggested three types of influential factors causing development of mental health conditions i.e. 1. Individual's level of vulnerability (biological and physiological factors affecting the risk of developing such conditions), 2. Stress (both kind of stressors like environmental and social stressors could cause development of psychiatric conditions in elderly), and 3. Protective factors (psychological, biological and social buffers for development of psychiatric conditions in old age). They suggest that risk factors and protective factors together make the individual susceptible to develop mental disorders.

There are some other demographic factors also that contribute to the psychiatric conditions among elderly. A study done by Singh, Kumar and Reddy (2012) suggested depression to be the most common problem amongst elderly. Other conditions included anxiety disorder, substance abuse, organic disorder and alcohol dependence respectively. Prevalence of psychiatric disorders was reported to be high in the illiterate population as compared to the literate population and females were reported to be more affected by psychiatric conditions as compared to males. Usually it is thought that older living in the old age homes have poor mental health, but results of this study turned out to be surprising as elderly living in community were found to have high rates of psychiatric disorders as compared to those living in old age homes. Based on empirical work following are some of the major psychiatric and psychological conditions seen in later life including conditions related to cognitive impairments:

Delirium

Delirium is a common condition causing cognitive impairment in older adults. Inouye et al. (2014b) defines Delirium as a state of acute and sudden change in attention and overall cognitive function is a serious medical problem for older persons which are often fatal. It is found to be the most frequent concern of older persons aged 65 years needing hospitalization. The condition is often unrecognized despite of its increased rate of incidence and prevalence, and poor prognosis put patients at risk of developing long term cognitive impairments (Pandharipande et al., 2013; Rudolph et al., 2010, Saczynski et al., 2012). Delirium is a potent risk factor for increased rate of mortality and illness among elderly along with long term care placement (Saxena & Lawley, 2009).

Dementia

According to American Psychiatric Association (2000) Dementias are a class of brain disorder characterized by irreversible declines in cognitive functioning that interfere with social and occupational functioning of an individual. It is most commonly seen in older adults because of its high prevalence in old age. It is estimated that approximately 35.6 million people had dementia worldwide in the year 2010. In this account, the population with dementia is expected to be 65.7 million in the year 2030 and 115.4

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million in the year 2050 (Prince et al. 2013). According to the Alzheimer's Association, approximately 5.2 million Americans have Alzheimer's disease (most common cause of dementia) and it is estimated as the sixth leading cause of death in United States (Theis et al., 2013). Major risk factor for dementia is ageing and gender has been identified as another risk factor for development of this condition as females being at higher side of the risk (Sheshadri et al., 2008).

Depression

Depressive disorder is believed to be normative with ageing; however, the rate of this condition is relatively lower in older adults as compared to younger adults. Despite of its lower rate among older adults many studies based on the epidemiological framework consistently report presence of clinically significant depression among around 15-25% elderly. Thus, the condition must be taken seriously especially if encountered in later life. Many times the symptoms might be so minor that they do not meet the diagnostic criteria of any of the category specified for depression in the classification system; however, the impact of even minor symptoms of depression on physical and mental health cannot be denied. A review study done by Fiske et al. (2009) indicated that institutionalization could be a risk factor for depression in later life as nursing home residents reported an increase in symptoms. Old age is a phase of life where people go through so many changes in their own life and their surroundings. Loss of a loved one, limited resources for enjoyment, and poor social and familial support along with poor coping mechanisms may contribute to the development of depressive symptoms (Zarit&Zarit, 2007). Another study highlighted Depression being a prevalent and disabling condition in elderly increasing the rate of mortality and negatively influencing quality of life (Sivertsen, Bjorklof, Engedal, Salbaek & Helvik, 2015).

Schizophrenia

Views on schizophrenia were first presented by Kraepelin (1971) as Dementia Praecox because the condition resulted in progressive deterioration in an individual's cognitive and functional ability. Initiation of this condition was believed to be in young adulthood; however, studies on schizophrenia and ageing possess strong challenge to this belief. Studies conducted by Reeves and Brister (2008) on older population have resulted in initiation of the disorder in middle and old age. Although the studies vary on the onset of schizophrenia but it's clear that it could be early-onset schizophrenia (occur in late life as lifelong disorder) or late-onset schizophrenia (first occur in old age). While some studies indicate worsening of the cognitive and functional decline symptoms of schizophrenia in old age, other indicate substantial improvement in the symptoms with growing age (Folsom et al., 2009 and Jeste et al., 2003) and rest show elderly struggling with the persistent symptoms throughout the life span (Palmer, Heaton, & Jeste, 1999). Schizophrenia in old age is a challenging situation even for the health practitioners as there are many comorbid situations that complicate the condition. Common factors include medical comorbidity such as hypertension, diabetes, cardio vascular diseases, obesity etc. other factors include substance abuse, cognitive decline and premature institutionalization for elderly (Andrews, Bartels, Xie, & Peacock, 2009; Bartels, 2004; Rystedt & Bartels, 2008). Many times negative symptoms of schizophrenia overlap with the neurological cases having traumatic brain injury (TBI) involving frontal lobe functioning (Jackson, 1984).

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Anxiety Disorders

Epidemiology for anxiety disorder suggests its occurrence in older adults more than the depressive disorder. Studies conducted in the United States (Kessler, Berglund, Demler, Jin, & Walters, 2005) and in Canada (Streiner, Cairney, &Veldhuizen, 2006) have signified elderly reporting symptoms sufficiently prominent to be diagnosed under the category of anxiety disorder. Among various categories of anxiety, phobias (Cairney, et.al., 2007) are most commonly reported. Since old age brings so many associated medical conditions it is difficult to establish a clear-cut diagnosis because the symptoms subjectively reported by elderly might be overlapping with symptoms of their medical conditions like heart diseases, hypertension etc. Also, there are various psychiatric disorders that overlap anxiety symptoms, and depression is commonest amongst them (Beekman et al., 2000; Mehta et al., 2003). Depression is also believed to have a neurological and psychological linkage to anxiety (Teachman, Siedlecki, & Magee, 2007). Apart from depression personality disorders (Coolidge, Segal, hook, & Stewart, 2000) and dementia (Twelftree & Qazi, 2006; Fisher & Noll, 1996) are also found to be comorbid with anxiety.

Sexual Disorders

It is believed that older adults are not interested neither capable of sexual activities; however, the recent pharmaceutical advances have made a remarkable impact on sexual functioning of men (Potts, Grace, Vares, &Gavey, 2006). Reduced rate of sexual activities in old age relates largely to the physiological changes among men and women and also it is normative in this age which may not necessarily be a sexual disorder. The rate of sexual activities dramatically drops in persons aged 75-85 years (Lindau et al., 2007). Reason for the same, apart from sexual disorder could be loss of partner, medical conditions and disabilities which affect the access as well as opportunity of sexual activities. Diagnostic criteria for sexual disorder remains same for individuals of all age group (including old age) and most common conditions are erectile dysfunction (genital erection during the sexual activity) and dyspareunia (pain during sexual activity) among men and women respectively and both men and women are vulnerable to sexual dysfunctions due to medical illnesses that interfere with sexual response. Attitude towards sexual activities and sexual response also influences the rate of being sexually active in old age and the findings vary across cultures as well as across gender. It is found that intensity of physical & emotional pleasure and satisfaction is reported to be low by women as compared to men, and western countries reporting higher satisfaction with sexual activities as compared to Asian countries (Laumann et al., 2005). Sexual functioning also has a linkage to cognitive impairments in old age and especially in cases where one partner is a victim and other is the caregiver. It is found that affection and sexual functioning, both declines in couples if any of the partners is diagnosed with dementia (Wright, 1998). Despite of changes in individual's sexual response many would report their sexual functioning satisfying as they are able to cope with the changes caused by ageing without identifying or may be without focusing on them. Another study pointed erectile dysfunction being most common among men and arousal disorder among women; in addition, the study also highlighted that biology plays an important role in male sexual dysfunction whereas psychology plays an important role in female sexual dysfunction (Sathyanarayana, Shajahan, Darshan & Abhinav, 2015).

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Sleep Disorders

Sleep disturbances are commoner among elderly than any other age group. Almost half of all older adults experience or reports sleep difficulties at some point of life. Insomnias are most commonly reported by elderly and the pattern of difficulties may involve difficulty initiating or falling asleep, difficulty falling back to sleep after awakening in night-time or early morning awakening. In a study, approximately 15-45% reported difficulty initiating sleep, 20-65% reported interrupted sleep, 15-54% reported terminal insomnia and 10% reported non-restorative insomnia (Ohayon, 2002). Bio-psychosocial model is best to describe the sleep disorders amongst elderly as their condition may be caused by physiological (medication induced insomnia), psychological (due to depression), and social factors (interference due to house hold responsibilities). Chronic illnesses and their treatment drugs have adverse effect on sleep and they may significantly contribute to sleep disorders in old age (Ancoli-Israel & Ayalon, 2006). Psychological causes of sleep disturbances usually involve anxiety, depression, loneliness, worrying etc. (Quan et al., 2005). Social causes behind sleep disturbances may include looking after a cognitively impaired partner who has the tendency to roam around the house during night or due to institutionalization because most day time is spent in bed which decreases or disrupts the sleep during night.

Substance Use/Abuse

Substance use and abuse among elderly is a complicated issue as it is difficult to understand the presentation of effect of substances due to their medical illnesses and drugs being taken for treatment of the same. Also, the misuse of prescribed drugs or medication by elderly is another issue and its use among elderly is common and higher than marijuana. In figures it would lay approximately 0.8% vs. 0.4% (as found in National Survey on Drug Use and Health, 2007). Apart from alcohol, use of prescribed benzodiazepine and opioids has been found to be in frequent use in later age. It is estimated that approximately 20-25% elderly (aged between 50-65 years) have substance abuse problems and consumption of alcohol by them is more than the standard set by National Institute of Health (NIH); however, only 3-5% have diagnosable substance use disorder (Behavioural Health News 2015). It is estimated that by the year 2030 the number of elderly with substance use issues would double especially for prescribed and illegal drugs. A systematic review done by National Survey on Drug and Health (NSDUH) in the United States suggested that more than 2/3rd men and half of women (aged 50 years and above) consume alcohol. Amongst them, the percentage of heavy drinkers was noted as 12.2% and binge drinkers as 3.2%. Approximately 6.7% elderly aged 65 years and above were found as heavy or binge drinkers (Blazer et al., 2009). It is found that women drinkers under 65 years of age are at higher risk of social isolation and economic deprivation (Choi & Dinitto, 2011). Use of other illicit drugs among elderly is rare and there is scarcity in the researches and literature. Initial epidemiological researches reported 11.3% prevalence of alcohol misuse among Indian population aged 55-64 years and 16.8% population aged 65-74 years (Sethi & Trivedi, 1979). One community based study reported 10% prevalence of alcohol use in the population aged below 60 years of age (Gupta et al., 1995). Prevalence of alcohol use disorders is found to be high in urban elderly population as compared to the rural elderly population of India (Nadkarni, Murthy, Crome& Rao, 2013 and Srinivasan, Vaz, & Thomas, 2010).

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Personality Disorders

There is little known about the Personality Disorders (PDs) in later life probably because of the difficulty to carry out long term researches with elderly. Reason for the same could be medical conditions of elderly, high dropout rate, and unwillingness to participate in studies. DSM-V (Diagnostic and Statistical Manual of Mental Disorders) defines a personality disorder (PD) as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (p. 646). This definition implies that maladaptive personality traits occurred during the adolescence or early adulthood may persist in later life; thus have a chronic course of illness. Despite of this assumed chronicity of PDs in later age there are limited resources of knowledge available focusing on PDs in adults aged 65 years or older. An integrative literature review suggested 3-13% of prevalence rate of PDs among elderly (Van Alphen, Derksen, Sadavoy & Rosowsky, 2012). A study conducted by National Epidemiological Survey on Alcohol and Related Conditions (NESARC), which is the largest study on prevalence of PDs in later life suggested that the prevalence of at least one PD in old age was 8% and among various categories of PDs, Obsessive Compulsive PDs covered most of the sample. Along with this, disability, medical and mental conditions of elderly were found to be highly associated with PDs in old age (Schuster, Hoertel, Le Start, Manetti & Limoson, 2013). Despite of limited literature at least recent findings indicate towards an optimistic future of researches to know more about PDs in old age. Having more knowledge about this area would definitely help in developing better assessment tools and treatment plan for elderly with PDs.

Elderly Abuse

Elderly abuse is a community based problem instead of an individual concern. Abuse might be physical, psychological, sexual, verbal, financial, intentional or unintentional. Definition of elderly abuse developed by Action on Elder Abuse in the United States (Action on Elder Abuse Bulletin, 1995) and further adopted by the International Network for Prevention of Elder Abuse says that "Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person." This definition holds a greater impact of outcomes of researches conducted in various countries like Canada, the United States, China, Finland, India, Greece, Ireland, Norway, Israel, Poland and South Africa (Koseberg & Garcia, 1995). Research works focusing on identification of factors for elderly abuse have identified several factors contributing to abusive and neglecting behaviour of family members towards the elderly living in home. Some studies identified cognitive impairment as one of the reason for such abuse (Pillermer, 1988), whereas others denied the fact (Paveza, 1992, and Cooney & Mortimer, 1995). Female elderly have been identified to be at greater risk for abuse due to economical disadvantages (Aitken & Griffin, 1996), on the contrary, male elderly in community based studies were identified to be abused more by their spouses, children and other relatives (Pillermer & Finkelhor, 1988 and Podnieks, 1992). As result of such neglectful and abusive behaviour elderly suffer from depression and psychological distress as compared to their non-abused peers (Bristowe & Collins, 1989; Phillips, 1983). Not only depression, but alienation, guilt, shame, fear, anxiety, denial and post-traumatic stress are also found to have a link with elderly abuse (Booth, Bruno & Marin, 1996 and Goldstein, 1996). Elderly abuse is a sensitive issue and must be taken care of. There is a need for awareness about human rights and prevention of abuse of older people. People working in institutional and community settings must receive a basic training

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for detection of elderly abuse and offering primary help to them. There is a wide literature available on psychiatric and psychological conditions among elderly; however, only the most common conditions are presented here in this chapter. Apart from the above mentioned conditions there is one paradigm of old age that every employed person faces at a particular time in life. With a time which technically says goodbye to one's career and profession i.e. "Retirement". We will discuss here, how this phase of life affects one's life and how it connects to one's psychological wellbeing.

RETIREMENT: A PHASE OF TRANSITION

Retirement is one of the biggest transition phases of an individual's life as it brings a drastic change in regular life style; however, for some, retirement may be stressing; for others, it may be a relaxing moment. In the literature of psychology retirement has been found to be a potentially stressful factor for retirees (Salami & Samuel, 2010) and researchers have been able to find out causal relationship between retirement and stress caused by that (Hammen & Constance, 2005). Since retirement leads to decrease in financial status it has been found to be linked with decreased subjective wellbeing and lower life satisfaction (Diener et al., 1993). Retirement may also cause decreased social networking which leads to social isolation and further leads to psychological distress (Sugisawa et al., 1997). Many research findings suggest mixed results on retirement and its impact on one's wellbeing. Dave et al. (2006) suggested that retirement causes 6-9% decline in mental health. Another study was conducted by Bonsang, Erik and Klein(2012) on two different samples including people with voluntary and involuntary retirement which indicated that there is no significant effect of voluntary retirement on one's wellbeing, however, the impact was found to be significant in case of involuntary retirement. Although there is less availability of literature on gender differences related to this concern of retirement and mental health as most research work has been done including the male sample. Some available researches suggest that men are found to be more affected by the retirement as compared to women as men report a greater degree of loss of social status after retirement (Barnes, Helen & Parry, 2004). No doubt retirement could be a great source of stress but it could be seen as a reward after long years of consistent work. Many people live even better life after retirement by being physically active and involving themselves in activities they could not participate during their career. They see this phase as exploration of themselves and devote time to their young age passions and hobbies. Staying physically active, being connected to social groups, spending time with spouse, volunteering for social services are some very good examples of healthy retirement.

CURRENT SCENARIO OF ELDERLY MENTAL HEALTH: THE FACT SHEET

It is well recognized that mental health of elderly is a globally neglected issue; however, it has been able to draw attention of mental health care providers in recent times. Required concern and appropriate actions in this direction have made the situation far better and commendable for elderly mental health as elderly are expected to be more active in family and community activities. Concerns of mental health professionals have been able to identify several issues important in elderly mental health such as abuse and maltreatment in old age, stereotypes against active ageing called ageism, poverty in later life, institutionalization etc. Involvement of civil societies, non-government and non-profitable organizations, and mutual efforts of community and mental health care providers are expected to gain good results

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for promotion of mental health of older persons. In the year 2015, WHO organized the first ministerial conference on global action against dementia that focused on public health and economic challenges posed by Dementia that has been identified as a public health challenge and need action at national and international levels. Dementia and depression have been included in the WHO mental health gap action programme (mhGAP) which aims at improving concerns and care for mental, neurological and substance use disorders by providing guidance and health care services to the elderly. The Institute of Medicine (IOM, 2012) and The Substance Abuse and Mental Health Services Administration (SAMHSA) reported lack of trained professionals working in the field of elderly mental health care and this shortage is likely to increase as the older population grows year by year. It has been confirmed by the researchers that older adults are less likely to receive mental health care services as compared to young adults and even if they receive some amount of care it is least likely to be delivered by a trained geropsychologist (Karel, Gatz & Smyer, 2012). Due to coexisting physical symptoms they are most likely to receive treatment in primary health care centres rather than particular mental health care centres (IOM, 2012). Also, medications are the first line treatment offered to elderly; however, they are rarely offered counselling and psychotherapy as an alternative treatment modality (Koh et al., 2010; Arean et al., 2002).

Mental health care issues of elderly are crucial and need prompt response of mental health care providers. Not only professionals, even family members and social network can modify current scenario of old age problems. They may work as a dignity booster for older adults and play a protective role in treatment outcomes of elderly's mental health and related interventions. Mental health in later age can be tackled well by promoting healthy ageing. Encouraging older people to participate more in meaningful and fruitful activities, bonding with family and peers and being physically active are very good sources of maintaining a good later life. Promoting healthy lifestyle among older adults can bring drastic changes in the current scenario of elderly mental health which requires contribution of mental health care professionals, authorities behind making provisions and policies about elderly mental health care, community and most importantly care givers.

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KEY TERMS AND DEFINITIONS

Elderly Mental Health: Elderly mental health refers to conditions affecting mental health aspects of individuals who are ageing.

Geropsychology: A branch of psychology that deals with the process of ageing and related mental health issues. It is also known as geriatric psychology or gerontology.

Mental Healthcare Services: A group or government, private or lay organizations operating at a community/state/national/international level to aid in the prevention and treatment of mental disorders.

Old Age: Old age refers to ages nearing or surpassing the expectancy of human beings, and is thus the end of human life cycle.

Psychological Conditions: A state of mind of an individual with emotional and behavioural problems that need intervention by a mental health professional.

Psychological Wellbeing: It refers to overall satisfaction with one's life characterized by self-acceptance, sense of autonomy, establishment of quality ties to others, pursuit of meaningful goals, continued growth, and ability to manage complex environment to meet personal needs and values.

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Chapter 34
The Social Mandate to Deal With Mental Health:
A Comparison Between Interventions in a Mental Health Center, a School, and a Psychoanalytic Office

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ABSTRACT

The chapter aims to explore the construct of mental health in a psychoanalytic perspective with a psychosocial approach. In particular, the chapter studies mental health by analysing traces to detect social mandate characterizing different mental health agencies. The highlighted hypothesis could be interpreted as that social mandate is a clue of local cultures about mental health, which determine fantasies about mental health issues, grounding on symbolizations shared by professionals, users, and community. The chapter introduces three clinical experiences of interventions, carried out in different contexts: a public mental health service, a public middle school, a psychoanalytic private office. All the presented experiences concern mental health field, even though they are characterized by different features in terms of subjects, methods, professionals, users, and organizations involved. The chapter explores those differences in order to focus on transversal issues.

INTRODUCTION

The wide concept of Mental Health could be considered deeply related to the concept of Well-being, which is even more wider than the first one. For instance, Merriam-Webster dictionary (n.d.) indicates Well-being as *the state of being happy, healthy, or prosperous* and the Cambridge dictionary's definition is (n.d.): *the state of feeling healthy and happy.* All the previous definitions about Well-being include the concept of Health. But what is Health, and in particular, what is Mental Health? Not a question with a

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simple or unambiguous answer. This chapter aims to focus on the concept of Mental Health, to explore it by studying different points of view about this topic.

It will be proposed, in particular, to consider Mental Health as a complex topic, historically and locally characterized, a culturally determined object. Getting to the heart of the epistemological matter, this chapter is not going to study Mental Health as a natural object, but as a cultural one. It is not going to take Mental Health as an object passible of being measured with examinations that could be replicated in any time and space, regardless the analyser's involvement. Whereas the chapter is going to explore the concept of Mental Health as a cultural construction, based on symbolizations which are shared in a particular social context, historically and territorially determined, which means characterized by local cultures. In this epistemological perspective, the analyser's point of view it's not something irrelevant or something which should be controlled to clean examination field. Contrariwise researcher's evolvement could be considered as a clue. For instance researcher's fantasies and feelings could be treated as a trace to explore issues' symbolizations in shared local cultures.

In this chapter's perspective, Mental Health is founded on local culture. Namely local cultures found different symbolization about Mental Health in Rome, in Tonga, or in Bangkok.

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According with the previously introduced epistemological framework, the initial question can be rearranged as: how could the concept of mental Health be defined?

On 30 March 2018, on its official website, World Health Organization (WHO) describes Mental Health as:

Mental health is an integral and essential component of health. The WHO constitution states: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (World Health Organization, 2018).

WHO's definition of Mental Health implies multiple elements which compose a complex concept:

- Mental Health does not coincide with the *absence of mental illness* but it's something more (and it's not exactly defined);
- Mental Health concerns the individual (*realizing his or her own abilities*) and the relations with his/her coexistence contests (*to make a contribution to his or her community*).

WHO identifies a multifactorial concept, composed by individual and relational factors. In accordance with that, this chapter will provide a Psychosocial perspective.

Both in Literature and in internet it is possible to find several interesting works about interventions based on a psychosocial approach. Those psychosocial interventions combine a psychological perspective, mainly concerning an individual target, and social perspective, generally aiming to determine actions on a community level. Whereas, the theoretical and methodological perspective here provided it's something different from that. We assume a Psychosocial perspective not only for interventions but also

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for analysing phenomena. We aim to explore phenomena concerning the relation between the individual and the social context.

In this perspective, Mental Health is not considered as an individual feature, as an object existing in nature but as a social construction, based on symbolizations that are shared in a particular cultural context. Common symbolizations ground people's fantasies and actions in those contexts they share. Let's think, for instance, to Mental Health agencies' users and professionals, they share symbolizations about what Mental Health agencies are and what they do.

This chapter aims to analyse the concept of Mental Health by studying the social mandate characterizing agencies supposed to deal with it.

In particular, this chapter intends to contribute to the debate on Mental Health, focusing on a question: how is Mental Health perceived by professionals working in different agencies with the mission of deal with it and by their users? The highlighted hypothesis is that users' demand could be considered as a trace of socially shared symbolizations about Mental Health, on which fantasies about agencies' and professionals' utility and social mandate are built on.

The chapter will introduce three experiences of psychological intervention within different organizational contexts in Rome. The first one is a psychoanalytic work with a young woman who turns to the professional because of her anxiety problems.

The second experience refers to a psychosocial project pursuing school inclusion, carried out by a non-profit organization, with middle school classrooms, through walks to explore street art in surrounding urban suburbs. The last one is a psychotherapeutic work with a woman, demanded by a psychiatrist to test her supposed dissociative disorders.

What do these interventions have in common? Experiences so different from each other by subject, method, professionals, users and organizations involved, can all fall into the category of interventions to support Mental Health. The chapter aims to explore those differences in order to identify transversal issues. The highlighted hypothesis is that what seems to characterize Mental Health is precisely the complexity of concept itself that includes a heterogeneity of professional practices and social meanings. This could sound obvious but it is not if you consider diffused cultural trends in sciences, which are globally widespread, such as Evidence-based medicine. Evidence-based medicine refers to an epistemological approach which treats phenomena as objectivable, looking for invariants, supposed to be always valid regardless geographical or historical conditions, namely regardless of local cultures (Bower & Gilbody, 2005).

Evidence-based approach is pervasive in Mental Health field too, determining professional practices grounded on a medicalization process of psychic and relational phenomena, looking for individual invariants. Often, this perspective lead to identify Mental Health with the absence of diagnosis of mental disorders.

Whereas in this chapter's perspective, Mental Health could not be detected by identifying solely individuals as unit of analysis. Contrariwise it is crucial to re-inscribe individuals into relational dynamics and social coexistence system they belong to. In accordance with this unit of analysis's definition, we need to settle specific methodologies that allow to study relationships between individuals and changing social contexts of coexistence.

Hence, this chapter intends to explore heterogeneity by referring to different cultures evoking professional practices and shared meanings in Mental Health field.

It seems necessary to focus cultural premises concerning Mental Health professional practices as a clue to detect how local cultures ground specific object of intervention. Therefore the chapter intends to

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focus on users' and professionals' interpretations about Mental Health and about social mandate to deal with it. These interpretations can be considered as a trace of shared symbolizations which determine common representations of agencies' function, influencing users' demands and provided services.

Furthermore, the chapter intends to analyse social mandate turned to Italian Mental Health agencies by studying institutional documents and also by providing an historical perspective on Italian Mental Health system's development.

BACKGROUND: A LEAD THROUGH COMPLEXITY

This paragraph aims to presents theoretical categories useful to analyse Mental Health construct, as a lead through complexity.

Throughout the chapter, the analysis will proceed basing on an Evidential Paradigm (Ginzburg, 1986). When we refer to the concept of "paradigm", we are implying a connection with an overall conceptual construction (Kuhn, 1970), determining a particular epistemology, grounding a specific research tradition.

We refer to qualitative research perspective, aiming to detect social, individual and situational phenomena by analysing details, inconspicuous aspects, small clues, revealing something bigger and submerged (Demetrio, 1992). Qualitative research's aim is idiographic, focusing on the particular, pursuing to deepen knowledge about the specific case study, instead of looking for general laws (Coggi & Ricchiardi, 2005). The goal is not to reach an "absolute truth", but to get closer to a deeper understanding of investigated phenomena (Caronia, 1997), by studying clues and detecting traces.

In a methodological perspective, we could assert that this chapter practices inductive investigation procedures, namely knowledge originates from the observation of specific collected data. This way to proceed is highlighted in *Myths, emblems and clues* (1986), where Carlo Ginzburg analyses three examples to study their conjectural methods: Giovanni Morelli, an Italian art critic; Sigmund Freud, father of psychoanalysis; Conan Doyle's fictional character, Sherlock Holmes. All the three cases proceed by detecting infinitesimal traces, which lead to the comprehension of a deeper and otherwise unattainable reality. Pictorial marks (for Morelli), clues (for Sherlock Holmes) or symptoms (for Freud) are treated as traces revealing wider phenomena.

Furthermore, the chapter is based on psychoanalytic approach, psychosocially oriented. In accordance with this theoretical framework, the chapter aims to explore Mental Health not through an individualistic perspective but through a relational point of view.

As we previously said, the chapter proposes to consider Mental Health as a complex topic, historically and locally characterized. Mental Health is treated as a culturally issue, not as an object existing in nature by itself. We are not going to take Mental Health as an object passible of being measured with examinations replicable in any time and space, regardless the analyser involvement. Whereas we are going to analyse the concept of Mental Health as a cultural construction, based on symbolizations which are shared in specific social contexts, determined by history and territory, which means determined by local cultures.

Furthermore the chapter proposes to consider Mental Health issues, not as a characteristic of the individual but as the precipitate of collusive systems' failure. Individuals could take decision to react to pain related to collusive systems' failure, turning a demand to agencies symbolized as competent with specific issues.

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The concept of collusive systems' failures refers to social systems of coexistence grounding on collusive assets, which fail. This perspective is based on the Theory of Collusion, a psychological psychoanalytic oriented model about emotional dynamic determining social relationships, conceived by Renzo Carli and Rosa Maria Paniccia (2003). In accordance with this model, social construction of reality begins by setting emotional meaning to different aspects of social experience, creating emotional symbolizations shared with people who participate to the same context. Colluding, from the Latin "cum-ludere", properly refers to this process of shared emotional symbolization (Carli & Paniccia, 2003).

In accordance with a psychoanalytic perspective, it's possible to assert that we proceed by constructing events through emotional symbolization of specific aspects of reality. In other words, we can identify reality through emotions concerning our way to symbolize reality's aspects. Furthermore this way to emotionally symbolize events is related to specific local cultures we participate to. Hence we should not presume events evoke emotions, whereas we assert emotions found events' construction. Otherwise, if this highlighted hypothesis is wrong, we wouldn't detect the complex common sense construction, that we could define as a collusive process, functioning in prescribing and protecting emotional system shared in a specific social context.

Individuals could experience a discrepancy between subjective feelings and common sense prescribed emotions. Such kind of experience could entail complex emotional reactions, often felt as painful, and could imply feelings like guilt, shame, social isolation or adaptation inadequacy.

Furthermore, reconsidering Mental Health within this perspective, it is possible to reinterpret individual's requests for psychological support and psychological distress as the precipitate of collusive systems' failure, which concerns the individual experience of a discrepancy between subjective emotions founding reality and common sense prescribed feelings. In accordance with this perspective, collusive process indeed work to socially share emotions grounding experienced events (Carli & Paniccia, 2012).

Hence we could reckon how can psychoanalytic psychotherapy specifically contribute to the debate on Mental Health? A psychoanalytic psychosocially oriented approach could provide criteria to clinically analyse contexts where Mental Health interventions are set, by detecting their peculiar local cultures grounding on collusive systems. In particular, we refer to interventions based on the Analysis of Demand model, whose objective and method concern the development of competence to detect emotions experienced in relations, using them as a trace, as a resource to explore problems encountered within those relations founding on specific collusive systems (Carli & Paniccia, 2003).

Moreover, we propose to focus how the individual, with his subjective decision, defines his state or experience as normal or pathological. Indeed Mental Health professional intervenes only if individual subjectivity comes to the decision to consult him. Therefore medical diagnosis is secondary to a sort of important subjective diagnosis acted by an individual who decides to define himself as diseased (Canguilhem, 1998). Absence of absence of pain is transformed in presence of illness, which could be object of diagnostic procedures. This symbolic process deeply marks the relationship between citizens and Mental Health system. Indeed this symbolic process founds on local culture based on a collusive system which requires an act of "proclaiming himself" as diseased, as a reaction to pain. Through this symbolic and emotional process the individual become "a user". Indeed becoming a user is requirement to establish a relation with Mental Health system. In a collusive dynamic, individual and coexistence context, share symbolic dimension setting the relationship with Mental Health agencies.

Coexistence context's social mandate entail mental diseased person identification, as an individual who because of his "different" behaviour contributes to the failure of conformist social systems.

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Social mandate requires diversity isolation and institutionalization, to protect collusive system holding social relations founded on common sense emotions.

Social system protect common sense establishment, by requiring that "non-compliant" individuals are assigned to specialized professional organizations. As far as possible, Mental Health agencies are required to seek the *restitutio ad integrum* of those deviating from common sense people (Carli, Paniccia, Caputo, Dolcetti, Finore, & Giovagnoli, 2016). Individual affected by *mental disorders*, as defined as a result of a diagnostic process, they are not "aware" of emotions violating common sense. Otherwise if this awareness is active, then we are faced with "common emotional disorders", therefore with a request for *psychological distress*. In Mental Health assistance system, this difference grounds a distinction between psychiatric and psychological intervention (Carli & Paniccia, 2012).

Finally, we want to highlight possible developments regarding Mental Health system: agencies required with the social mandate of take care of Mental Health, could focus problems in social coexistence, besides diseases by working on demand, local cultures and coexistence issues. Analysing users' demand means dealing with recurrent critical social events and problems, some of which are indications of social emerging emergencies (Vari, 2014).

THREE EXPERIENCES OF INTERVENTION IN THREE DIFFERENT AGENCY DEALING WITH MENTAL HEALTH

This paragraph introduces three clinical experiences in Mental Health field, aiming to explore differences in order to identify transversal issues. In particular, the analysis focus on social mandate which characterize different agencies dealing with Mental Health. Indeed the analysis will consider institutional documents and users' demand, as traces to explore local culture about Mental Health and about organizations dealing with it.

The clinical experiences we are going to present, are carried out by the author, with the role of psychologist, in collaboration with different teams. All the interventions we are going to introduce take place in Rome in 2017-18. They are set in different context: a public Mental Health Service, a psychoanalytic private office, a non-profit organization actualizing a project with a public middle school in the territory of a roman suburb. The data we are going to present are collected by analysing literature and reported clinical experiences, in accordance with a psychoanalytic approach, psychosocially oriented, based on the Analysis of Demand model (Carli & Paniccia, 2003).

A Psychosocial Perspective On A Public Mental Health Service Intervention

To present first intervention, which takes place in a public Mental Health Center, it is necessary to introduce Italian public Mental Health services' current organization, besides providing an historical perspective of its development.

Mental Health Center (for brevity, we will call it CSM, using the Italian acronym) is the organism that on behalf of the Department of Mental Health (for brevity, we will call it DSM) and the Local Institution for Healthcare, up to the Ministry of Healthcare, has the mandate to accept and to filter citizens' requests. The purpose of CSM is to *promote and protect health, both on an individual and a collective level*, for resident population and people standing in its own territory, to allow the best quality of life as possible, by providing services for *prevention, therapy, rehabilitation* (Ministero della Salute, 2006).

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On its official website, Local Institution for Healthcare defines Mental Health as a fundamental area of intervention, aiming to combine actions addressed to *support social inclusion* and actions addressed to *take care of psychic distress, psychiatric disorders and disabilities* (ASL Roma1, n.d.).

In the previous lines, it's possible to spot traces (in italics) of Local Institution for Healthcare's purposes. In particular:

- promote and protect Health, both on an individual and a collective level;
- support social inclusion;
- take care of psychic distress, psychiatric disorders and disabilities.

These definitions show differences about the object of intervention: "individual and collective Health" should not be considered the same concept of "psychiatric disorder", they are different constructs. The concept of "psychiatric disorders" evokes a purely *individual* issue, whereas the concept of "individual and collective Health" refers to a social dimension, evoking *relations* and *coexistence contests*.

"Psychiatric disorders" and "individual and collective Health" could be considered as traces of different shared symbolizations about Mental Health Services' scope.

Organization determines specific goals, which could be considered as traces of organizational social mandate, since social mandate founds on symbolizations about organization's function shared by professionals, users and community it lies in.

Specific symbolizations about organization's social mandate and purposes lead to determine specific goals and to define specific strategies and devices to reach those goals, according with the organization's scopes.

Different symbolizations lead differences in term of paradigms, methodologies and tools for interventions. In a wider perspective, they lead differences in term of representations about professionals' work and relationship with organizations' users (Mazzola, 2018).

It is possible to highlight once again how the notion of Mental Health is wide, complex and composite. It includes several and different constructs, coexisting in a heterogeneous category. In depth, mental disorder and individual or social distress represent two of the objects included in Mental Health category, despite the differences characterizing them.

Mental disorders evoke an individual perspective, with a focus on a person's idiosyncratic patterns and traits. Psychiatry provides theories and tools appropriated to deal with this topic.

On the other hand, the construct of individual and social distress evokes a relational perspective, with a focus on local context of coexistence. Psychology and Psychoanalytic Psychotherapy provide dedicated methodologies to deal with this issue.

What does this difference could be considered as a trace of? To inquire this question we propose to analyse agencies assigned to deal with Mental Health in an historical perspective, from asylum's existence to actual Mental Health services assets' development.

In Italy in 1978, Law No. 180 is approved, promoting a complete reform of psychiatric assistance, determining the progressive replacement of psychiatric asylum with a radically new model of territorial Mental Health service system.

Law's approval takes place under the pressure of deinstitutionalization movements diffused in Trieste and in other areas of Italy. At the time of the promulgation of the law, turnover of patients is minimal.

Law No. 180 aims to promote a cultural change, by asserting that even in psychiatric field Mental Health system must found its bases on person's rights to healthcare, contrariwise the assessment of so-

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cial dangerousness. In accordance with Law's issued values' asset, treatments turn to a voluntary basis. Law No. 180 establishes that no one can be hospitalized in psychiatric hospitals. Despite, in case of hospitalization needed, since Psychiatric asylum are removed, the Psychiatric Diagnosis and Treatment Services of general hospitals carry out clinical treatments.

A law, which dates back to 1904, previously ruled mental Health system in Italy, focusing on a specific social need, which is "protect society from mental disorders".

Process of hospitalizations started after a psychiatric certification and a commissioner's order to alienate civil rights to diagnosed person. Mental Health care was administered by local districts, each of them refers to their own asylum. Law No. 180 starts a process leading to asylums removal, on a national scale. By the end of the '90s, with all asylums' closure, new Mental Health services are introduced, with the aim to ensure mentally diseased people shall conduct their lives in an inclusive social context.

After Law 180's approval, it begins a long lasting process of wide Mental Health system's reorganization, involving administrative and institutional levels. New provisions are introduces on a national and regional basis, new regulatory frameworks are established to progressively determine Mental Health Departments' responsibilities, provided services, settled goals and procedures, involved professionals, determined targets and intervention standards.

In March 1999, Italian Ministry of Health announces the successful final closure of all public asylums. This event could be considered as the ending stage of a poignant cycle, more than two decades lasting. Italian Mental Health system reform represents a long and complex course, with a high historical and symbolical impact on Italian society on different levels, since it evokes heated debates among professionals, family members, administrators, politicians, involving Italian public opinion in a broad sense.

In 1981, Local Departments of Mental Health are established, as institutes entitled to rule territorial district on a technical, administrative and managerial level, programming and providing services, projects and activities.

Residential and housing groups are enhanced to provide accommodation addressed not only to previously hospitalized users but also to new users, never hospitalized before, turning Mental Health services because of precarious living conditions or involved in family conflicts. Mental Health agencies' aim includes rehabilitation, training and socialization, actualized through recreational and leisure activities such as expressive workshops, literacy courses and schooling.

In the mid of the '80s the number of cooperatives involved in Mental Health work placement grow and their range of competences and activities is gradually extended. In the following years, cooperatives increasingly focus on interventions aiming to promote empowerment for people with handicaps and disabilities or affected by addiction problems or social marginalization. Cooperatives work develop in a social entrepreneurship perspective. Cooperatives' social purposes meet Mental Health Departments' ones. Thus in the '90s Departments run a significant work to support Mental Health services' users to fully exercise their citizenship rights, namely as workers. Mental Health Departments and cooperatives' scope connection leads to enlarge cooperatives' business, providing new services and activities addressed to Mental Health services' users. Cooperatives' offer extends to rehabilitation and empowerment programs, with different specific focuses, such as accommodation, work, education and training, social inclusion, network building, self-help groups.

In 1975-1976 the first CSM was established with the purpose of supporting previously hospitalized patients and dealing with new users' crisis. CSMs run as day centers and work to reduce hospitalized patients' number and to shorten hospitalization's duration. It is interesting to highlight that CSMs are

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introduced before the national reform (Law 180), when asylums are still working. Hence for a while two different organizational and cultural assistance models operate at the same time (IDeaSS Italy, n.d.).

Law No. 180 is considered a worldwide example as a symbol of culture revolution in its field, since it radically changes Mental Health care and assistance methods. It is indicated as the first law in the world which bans asylums, representing a symbolic victory for people who worked for it, determining a huge cultural heritage, entailing nowadays living trains.

In accordance with Carli and Paniccia's work, we propose a psychosocial interpretation of Italian Mental Health system development.

In the '60s, '70s and in the beginning of the '80s italian asylum system collapses. At the same time, an emerging culture spreads. Growing values of equality and minorities protection condemn every act of diversities institutionalizing or marginalization. Meanwhile in that historical period Psychiatry attempts to actualize Mental disorder affected people's reintegration to social and familiar context. A new category it is introduced: "the psychiatric operator", which transversally includes psychiatrists, psychologists, nurses and all mental health professional workers, all together involved in pursuing users' social reintegration. Hence analysing Mental Health services development it is possible to remark that ideological base grounds social reintegration process, determined as attempted outcome. Social reintegration process was based on values rather than dedicated methodologies and differentiated contributions of various professional perspectives, entailing the lack of formalized techniques grounded on specific theories. Hence ideological tension replaces professional technicality.

In the mid of the '80s until the end of the '90s, social reintegration is at first juxtaposed and then replaced by psychotherapies, addressed to new users (as common emotional disorders affected users) and, when it is possible, addressed to traditional psychiatric users. Psychotherapy shows an increasingly clear and specific attempt to take care of mental disorders defined by using DSM psychiatric nosography categories. A pervasive return of technicality occurs, concerning not psychiatric movement but Psychotherapy. Both in Mental Health agencies and in professionals' orientation we see behavioural techniques gradually prevailing over psychoanalytic and systemic approach. Contrariwise the highlighted hypothesis is that a complex phenomenon, as social reintegration is, could not be chased by applying techniques pursuing interventions addressed to specific and limited objects, such as behaviours. Indeed psychoanalytic perspective with a psychosocial approach proposes categories to reinterpret social reintegration phenomenon as a psychosocial intervention within users' relation with coexistence context, where problems defined as mental distress emerge (Carli & Paniccia, 2011).

Furthermore this chapter aims to study Mental Health in a relational and psychosocial perspective grounded on psychoanalytic models, by focusing the area of Mental Health agencies. As we said, the highlighted hypothesis is that users' requests could be considered as traces of social mandate founded on symbolizations shared in local cultures. According with this focus we could inquire: what kind of requests users turn to Mental Health agencies?

Let's introduce a case study, set in a public Mental Health service: a CSM sited in Rome.

A woman turns to CSM because she got episodes of amnesia and disorientation. She asks for neurological examination, to check for the presence of dementia. A CSM psychiatrist visits her and, after excluding dementia, demands her for a psychological visit to verify the presence of dissociation disorder. When the CSM psychologist meets her for the first time and asks about her request, the woman starts crying and telling about her sentiments of anxiety and sadness. The psychologist, who is the author of this chapter, treats the woman's request with the Analysis of Demand approach. The woman reports problems within relations with her coexistence contests. Throughout a psychotherapeutic work, it was

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possible to reinterpret woman's demand. In this case, the woman emotionally denied her desire in relations, in which she acted with a sacrificial approach. At one point her relational pattern seems not to work anymore for her and she feels disoriented, both in a figurative way (emotionally) and in a proper one (with episodes of amnesia). She feels powerless facing problems with her family and at work and she feels assailed by sentiments of anxiety and sadness. The woman's demand to take care of her relations in crisis is turned to a CSM through a request to check a medical problem (amnesia). We could say the woman *medicalize* her issue, since she transform an emotionally complex relational problem in a request treatable through a medical approach.

Analysing CSM users' requests, it's possible to highlight recurring events like the clinical situation just introduced: in several other encountered cases, CSM receives demands to deal with relational problems, through requests of checking medicalized symptoms.

Not only the woman treats her issue as a symptom, but also CSM psychiatrist does (checking for dementia), properly according with his area of competence and in accordance with the determined goal of dealing with Mental Health, interpreted as mental disorders.

CSM users and professionals seem to share fantasies about CSM as an agency dealing with medical problems. Regarding medical problems, we intend to refer to individual related issues, which are liable of diagnosis and treatments, better if it's a pharmacological one not concerning emotional users' and professionals' subjectivity involvement.

It's worth to report a difference among *individual* and *subjective* level.

Merriam-Webster (n.d.) defines individual as "being an individual or existing as an indivisible whole", where individual is defined as *a particular being or thing as distinguished from a class, species, or collection: such as a single human being as contrasted with a social group or institution*. Instead *subjective* is defined as *relating to the essential being of that which has substance, qualities, attributes, or relations; characteristic of or belonging to reality as perceived rather than as independent of mind*.

It's possible to underline differences among two different constructs: on the one hand, individual as a whole, isolated from a species; on the other hand subjective with relations and perceptions, we could say with emotionally involvement.

According with the highlighted hypothesis about professionals' and users' symbolizations as a trace of social mandate, we could identify CSM as Mental Health agency dealing with individual problems treatable by medicalized approach, in accordance with the purpose of taking care of mental disorders. Whereas, CSM also got the scope of dealing with individual and social distress, which evokes social mandate to deal with users' request as result of relationships and coexisting contexts in crisis, with a focus on users' emotional distress about it.

Furthermore we could say that person who choose to turn Mental Health agency a request for psychological distress is the one who decide to take charge of a problem shared by coexisting system participants (Carli, 2015). As we previously said, we propose to define Mental Health issues not as a characteristic of individual but as precipitate of collusive systems' failure. Individuals could take decision to react to pain concerning coexistence collusive systems' failure, turning a demand to agencies symbolized as competent with specific issues.

We outline a possible development of CSM social function: it could be useful to work on a cross analysis about individual requests reported in a determined territory, to provide a social interpretation about local emerging issues, in order to plan interventions not only for individual treatment but for collective prevention too.

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A PSYCHOSOCIAL PERSPECTIVE ON A PSYCHOANALYTIC PRIVATE OFFICE INTERVENTION

Moving to another context, what kind of requests are turned to a psychoanalytic psychotherapist working in a private office?

Let's introduce a case study, set in a psychoanalytic psychotherapeutic private office, located in Rome.

A woman turns psychotherapist because of her feelings of anxiety. She says she is worried about her academic career, since she is afraid not to take last university exams. Throughout a psychotherapeutic work based on Analysis of Demand approach, it is possible to re-interpret the client's demand, who presents issues with her familiar and university contexts. She wondered about her life according with what she expected others would consider the right way for her, but at one point this strategy doesn't work anymore, since she feels a growing anxiety approaching her graduation. She is afraid for her future and feels paralyzed by the idea of taking a choice, facing her resources and her limits to identify desires and chase them.

As for CSM, analysing psychotherapeutic private office clients' demand, it is possible to trace recurring events. Psychoanalytic private office clients' demands often concern emotions perceived as wrong, unacceptable or problematic. These requests found on symbolizations of emotions as something dangerous and to be treated in private, in a confidential and discreet treatment context. Comparing with CSM users' demands, the psychotherapeutic requests are not symbolized as grave because medicalized symptoms, but because idiosyncratic.

In a different way comparing with CSM, the request are often at individual level, too. While, as we said, in CSM the unit of analysis is individual with his own medicalized symptoms, in psychotherapeutic private office social context seems to disappear and everything is an intimate place where to bring personal sentiments. Furthermore emotions could be disconnected by relational context which they are related to. Hence psychotherapeutic private office could be symbolized as a place out of time and space, as a metaphor for inner space, where to fix problems with personal feelings and emotions. These symbolizations could be shared in collusion by professionals and clients, evoking for both of them different related fantasies, such as some of the more widespread: fantasies about a place where to face limitless client's inner world ruled by frightening feelings; fantasies about professional's emotional neutrality (all the field is dedicated to customer's inner word); fantasies about not reportable or analysable professional's procedures because of an emotional nature of the work (perceived in opposition to a rational way to proceed); and so on. Moreover, we may consider psychotherapeutic literature, where there are many contents analysing psychotherapeutic setting of interventions, on the contrary it's hard to find professional contributes on social impact. The topic doesn't seem to provoke a particularly heated debate within the scientific community, if compared to other themes, such as the psychoanalytic setting and its variations. The unit of analysis is one again focused inside the office, detached by the context it lies in.

Document analysis provides other traces about psychotherapeutic private office's social mandate. Searching for Italian laws ruling psychotherapeutic private office's activity, it's possible to discover there are not many documents but the Article No. 41 of the Constitution of the Italian Republic:

Private economic enterprise shall be free. It may not be carried out against the common good or in such a manner that could damage safety, liberty and human dignity. The law shall provide for appropriate programmes and controls so that public and private-sector economic activity may be oriented and coordinated for social purposes (Senato della Repubblica, 1948).

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Therefore, psychotherapeutic private office, as private economic enterprise, should be *oriented for social purposes* and *shall provide for appropriate programmes and controls.*

What kind of programmes and controls are determined for psychotherapeutic private office's activity?

It is possible to refer to the Art. No. 2229 of the Italian Civil Code (1942) declaring that intellectual professions' exercise requires registration in dedicated registers or lists. Verification of registration requirements, list maintenance and disciplinary power over register's members are delegated to professional associations, under State supervision.

Hence the Constitution of the Italian Republic determines psychotherapeutic private office's activity must aim at social purposes and its activity must be ruled and controlled, switching level, by professional's behaviour.

Also on a legal level, norms concerning contexts (office and its social purposes) are juxtaposed with individual (professional and his behaviour).

Furthermore according with the highlighted hypothesis about professionals' and clients' symbolizations of Mental Health agencies as a trace of social mandate, we could identify psychotherapeutic private office as an agency deputed to deal with individual issues, too. Psychoanalytic psychotherapeutic office is symbolized as an intimate place taking cover from the social context. A place where to fix troubles with personal feeling and emotions, symbolized as idiosyncratic and problematic for the person who turns the request. We suppose psychotherapeutic private office professionals' social mandate is properly to deal with private individual issues.

Whereas, focusing on a psychosocial perspective, it's possible to propose an implied psychotherapeutic private office's social function in developing clients' relationships in coexisting context by working with the person who turns a psychotherapeutic request.

A PSYCHOSOCIAL PERSPECTIVE ON A NON-PROFIT ORGANIZATION INTERVENTION AT SCHOOL

Introducing the third case study, we propose a shift in terms of intervention's target, moving from individual to context. If in the previous two clinical situations, psychological interventions were carried out after an individual's request, in this case a clinical intervention is developed as psychosocial project addressed to a roman public middle school and its classrooms.

Regional district administration wanted to finance projects facing schools' dropout problems.

A non-profit organization composed of psychologists proposes a project whose aim is to develop relation between school and the area in which it is located. The project is based on a reinterpretation of dropout phenomenon, as a student's reaction to sentiments of isolation and uselessness felt within the relation with school coexistence context. The assumption is: if at school it's possible to get interesting activity, you want to get there. The project aim to work with school, at school and in school time, to explore students' interests related to a common object: territory, which school and students' family share. The territory we are talking about is a roman suburb, where most of the students live and where school is sited.

This intervention was carried by a team composed by the author and three colleagues, all of them psychologists. Every professional works with one classroom composed by 15-25 students aged 10-12. On a first stage, the project aims to explore students' interests and connections between interests and territory. Later, all the classrooms work to create a thematic map, linking emotional relevant places

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with point of interest to discover, planning territory exploratory walks that every classroom takes on its own. In the end, all the groups together plans a final event where the 4 classrooms meets and share their works. Teachers and families are invited to come to the final event to share their thoughts and stories about territory. As we said, every classroom choose a theme to elaborate. The chosen topic are: street art, history, trade and craft, classroom's story, in the surrounding suburb. Indeed the project's main aim is not to work on themes, but to intervene on students' relationship with classmates and the wider coexistence context at school, throughout working on themes.

The project's purpose is to develop relation between school and territory in order to develop the relation between students and school coexistence context, to contrast sentiments of isolation and uselessness, founding dropout phenomenon.

Hence it's possible to underline that this intervention lies in Mental Health field, by a reinterpretation of the construct. Indeed this project proposes a reinterpretation of Mental Health as an issue concerning coexistence system, rather than only related to problematic individuals. Dropout phenomenon is not solely a matter of students, it is actually a matter of sentiments connected to relations in coexistence contests, invoking schools, families and actors sharing a specific territory.

Dropout phenomenon is treated as a trace of risk of social isolation, which requires prevention interventions, according with WHO's definition of Mental Health, previously showed in this chapter: *Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community* (World Health Organization, 2018).

Within this intervention, psychologists assume a psychosocial perspective to propose a reinterpretation of Mental Health interventions as prevention of social isolations.

CONCLUSION

Throughout this chapter, we explored the construct of Mental Health in a psychoanalytic and psychological perspective with a psychosocial approach. In particular, the chapter analyses the construct of Mental Health by studying different organizations aiming to deal with it. The chapter introduces three clinical experiences of Mental Health interventions, actualized in different contexts. It's highlighted how the three proposed experiences represent different ways to regard to Mental Health, showing different users' and professionals' interpretations, defining different kind of interventions. Throughout the chapter we look for traces to detect social mandate characterizing different Mental Health agencies. The highlighted hypothesis is that social mandate is a trace of local culture about Mental Health, which defines fantasies about Mental Health issues, founding on symbolizations shared by professionals, users and community.

The chapter intended to explore differences between Mental Health agencies and their local cultures in order to identify transversal issues. The highlighted hypothesis is that what seems to characterize Mental Health is precisely the complexity of the concept itself which includes a heterogeneity of professional practices and social meaning.

After all, we could say Mental Health is actually a social mandate to intervene. With the purpose of planning interventions aimed to take care of Mental Health, it is important to focus on social mandate, which is locally, historically and culturally connoted.

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The first clinical experience introduces CSM local culture, whose social mandate identify a Mental Health agency dealing with individual problems treatable with a medicalized approach, according with the scope of taking care of mental disorders. Whereas CSM purpose of taking care of individual and social distress evokes social mandate to deal with users' request as a result of relationships and coexisting contexts in crisis, with a focus on users' emotional distress about it.

The second clinical experience is set in a psychoanalytic psychotherapeutic private office. It emerges symbolizations about a decontextualized context. In psychotherapeutic office's local culture, the social context seems to disappear and everything is an intimate place where to bring personal feelings detached by the relational context which they are connected to. Thus the office can be defined as a private economic initiative which, according to the Italian Constitution, must be addressed for social purposes. Social function of a psychoanalytic office may seem given for granted but it is not. We suppose psychotherapeutic private office professionals' social mandate is to take care of problems with personal feelings and emotions.

Comparing psychoanalytic psychotherapeutic private office and CSM, it's possible to remark that the requests are often at an individual level in both cases. While, as we said, in CSM the unit of analysis is individual with his own medicalized symptoms, in psychotherapeutic private office the focus is individual with his own idiosyncrasy.

In first and second case, we see interventions addressed to individuals, even though the unit of analysis is the relation between individual and social context. The third case introduces a new difference: the intervention is address on a social level. It's a psychosocial intervention carried out by a non-profit association and addressed to 4 classrooms in a public middle school. The project aims to develop relation between students and school coexistence contexts, to contrast sentiments of isolation and uselessness, founding dropout phenomenon. The association, composed by psychologist, work on the social mandate providing a new interpretation of it: facing dropout, means facing social isolation, as a preventive Mental Health intervention.

In conclusion, all the introduces experiences are based in Mental Health field although they show differences in terms of professionals and teams, targets, goals, tools and context of intervention. However it's possible to underline a transversal dimension: local cultures defines social mandates which determine users' requests and professional's goals of interventions.

Through the analysis of different Mental Health organizations' social mandate, it seems possible to draw a broad and heterogeneous scenario, including the diagnosis for individual to development of knowledge on problems of coexistence systems in crisis.

We could conclude highlighting that what seem to characterize crosswise Mental Health field is the amount of demands dealing with grave sentiments determining intervention's request addressed in first person or for another person.

Indeed Mental Health could be considered as a complex issue concerning local cultures which means concerning coexistence and social level although it relapses on an individual level. We remark that it is important for professionals and agencies dealing with Mental Health to analyse social mandate and users' requests, in order not to settle automatic procedures but to plan organizational developments oriented to social impact.

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Chapter 35
Mental Health Education and Literacy in Schools: The Australian Experience

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Mind Australia, Australia

ABSTRACT

This chapter will look at the current situation concerning youth mental health in Australia and provide information about youth mental health literacy, which was first coined by Jorm in 1997. A literature review of current Australian mental health promotion and education programs being offered in schools will be conducted as well as examples of some of the better-known ones that have been implemented internationally. The evolution of mental health education in Australian schools will be examined so as to provide a perspective of how some of the current programs came into being or existence. The main aim of this chapter will be to highlight the high prevalence of mental illness that exists amongst young people in Australia and how implementing mental health education in schools can be beneficial and helpful in improving their mental health and wellbeing. Mental health education in schools can help in breaking down the stigma surrounding mental illness. Another benefit is that young people will be able to identify mental health problems earlier amongst their peers and in themselves, which can lead to early help seeking, especially due to young people gaining a higher level of mental health literacy through mental health education programs.

INTRODUCTION

Australia has been active during the past 20 years in the development and implementation of Mental Health Policy and Mental Health Promotion. In the Fourth National Mental Health Plan 2009 - 2014 (Commonwealth of Australia, 2009), the Australian government in its wisdom and foresight choose to make Prevention and Early Intervention as its Priority Area 2. In the Summary of Actions (Commonwealth of Australia, 2009) in point one it noted that it would "work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience" (p.32). Following on from

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that it included as a further action to "implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations" (p.32). One of the indicators for monitoring that this change had been made was to observe the "proportion of primary and secondary schools with mental health literacy components included in their curriculum" (p.32).

It is interesting to note that with all the best intentions of the Australian government to make Prevention and Early Intervention a mental health priority in the Fourth National Mental Health Plan that this was inexplicably missing from the Fifth National Mental Health Plan of 2017 - 2022. The Black Dog Institute in its *'Submission in response to the Draft 5th National Mental Health Plan'* (Back Dog, 2016) said that the plan was "silent on prevention and yet it is potentially a powerful solution to chronic mental illness and should be included as a key strategy" (p.10). It went on to add that "prevention programs are most effective when implemented early" and that they "strongly believed that school-based prevention is critical to reducing the overall burden of mental illness on the community" (p.10).

This chapter will look at the current situation that exists in Australian schools concerning youth mental health and the seriousness of this health problem. It will explore why mental health education in schools is so important and the benefits for implementing it into curriculum. It will also investigate why being mental health literate is significant in improving both peers and a young person's own mental health.

Before examining the various mental health promotion and education programs that currently exist in Australian schools, it will look at what has happened in Australian schools from a historical perspective, including initiatives such as MindMatters and KidsMatter. The Australian experience of mental health education in schools will also be compared to the international experience by examining what exists as well as what has worked and not been so successful overseas.

The chapter will also reflect on what are some of the problems and barriers that exist in implementing mental health education in Australian schools as well as the benefits of introducing it into the school curriculum and the future of mental health education in Australian schools.

YOUTH MENTAL HEALTH IN AUSTRALIA

There has been considerable research and study carried out about the onset of mental illnesses and mental health problems in people, not only in Australia but around the world. The evidence suggests that three in four mental health disorders emerge by the age of 24 and half by the age of 14 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Sawyer, Arney, Baghurst, Clark, Graetz, & Kosky, 2000; McGorry, Purcell, Hickie, & Jorm, 2007). In 2013 - 2014, around a quarter of all young people aged 16-24 years in Australia had a mental disorder (approximately 26% or 671,000 young people). One in seven children and adolescents aged 4 - 17 years experienced a mental disorder in 2013 - 2014, which is equivalent to 14% or 560,00 young people. Depression impacts on the lives of 1 in 35 or 2.8% of young Australians aged 4-17. The statistics for anxiety are even greater where 1 in 10 adolescents aged 18 - 25 and 1 in 25 children aged 13 - 17 experience the condition. (Orygen Youth Health, 2008). Of concern was the fact that there was an increase of probable serious mental illness in the age group 15 - 19 from 18.7% in 2012 to 22.8% in 2016 (Mission Australia, 2016). Lawrence and colleagues (2015) commented that mental disorders were the leading cause of illness and disability for young people aged 10 to 19 years, ahead of any physical disease.

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There is evidence to support that only about one-third of young people and adolescents with a mental disorder will actually seek help. Of that one-third only about 30% of young people will seek referrals for psychological therapy (McGorry, Purcell, Hickie, & Jorm, 2007; Rickwood, Deane, Wilson, & Ciarrochi, 2005). As can be seen from the previous statistics about youth mental health and mental illness, it is a serious health problem in Australia which something needs to be done about soon. Young people and adults responsible for looking after young people need to improve their mental health literacy so that young people who are presenting with early mental health problems can seek appropriate mental health treatment. Early intervention and prevention is crucial and mental health promotion and education programs in schools, as long as they are implemented properly, will go a long way to addressing some of these problems and concerns.

WHY IMPLEMENT MENTAL HEALTH EDUCATION IN SCHOOLS?

The importance and significance of implementing mental health education in schools, both locally here in Australia as well as overseas cannot be underestimated. Later in this chapter there will be a discussion about the benefits of doing so as well as some of the challenges and implications that present themselves to schools in trying to introduce mental health promotion to the curriculum. Within schools you are able to assemble a captive audience where they can be educated about important mental health and wellbeing information. This can be delivered and rolled out to large numbers of young people at the same time. In Australia, as in most countries, it is compulsory to attend school up until a certain age. In the state of Victoria it is currently 17. Barry and Jenkins (2007) highlighted just how important the emotional and social development of young people is during the time that they attend school and that it provides an excellent opportunity to create a positive environment where they can thrive.

Schools are able to create a sense of community and belonging which will help some young people who are either socially isolated or more at risk of developing mental illness than other students, to be able to maintain good mental health. The onset of mental illness is high in childhood and adolescence. It is well known from the evidence that 75% of all mental illnesses develop before the age of 24 so it makes sense to target this age group with effective, evidence-based mental health education programs so as to be more preventative than reactive, when a young person becomes unwell. By introducing Mental Health Education into schools, it will help to improve mental health outcomes for Australians by reducing the incidence or impact of risk factors while building up people's protective factors and thus help children and adolescents to access support early if difficulties do arise. Well-planned and thought out Mental Health Education programs can also have an impact on improving the mental health literacy of young people and students which in turn can lead to building stronger resilience during adverse times and help in breaking down the stigma that exists in relation to mental illness. The positive outcome of all of this would see young people accessing mental health services earlier. Good mental health in childhood also provides a solid foundation for managing the transition to adolescence and adulthood, engaging successfully in education and making a meaningful contribution to society (KidsMatter, Primary 2017). Working with children and young people is one potentially cost-effective way to address the impact of mental health difficulties in the community, both today and into the future. (Response Ability, 2012).

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HISTORICAL CONTEXT OF MENTAL HEALTH EDUCATION IN AUSTRALIAN SCHOOLS

In 1996 the Australian government commissioned an audit to be conducted to look at Mental Health Education in Australian Secondary Schools. It was funded under the National Mental Health Community Awareness Program which was a National Mental Health Strategy initiative designed to reduce the stigma and discrimination experienced by people with a mental illness, their families and carers (Youth Research Centre and Centre for Social Health, 1996). A number of interesting findings from this audit helped guide the Australian government in the future direction of mental health education in Australian schools. It examined the National Curriculum at the time with regard to the school context of welfare while exploring the feasibility of implementing the World Health Organisation's 'Health Promoting Schools' policy.

The audit data focused on such things as what current policies on mental health and mental health education that there were, the perceptions and attitudes towards mental health in schools, particular classroom curriculum approaches, what welfare approaches were being used in schools and the involvement of community and other external agencies in school mental health education as well as what mental health education were available.

An important part of the audit report was to look at what current issues surrounded mental health education in schools as well as what the future direction of it might look like in Australian schools and what current education programs were already in operation. Issues included what actual coverage of mental health education was there in schools?; what professional development was being provided to teaching staff at schools in regards to mental health education?; how much involvement and support were external community and non-government agencies providing to schools?; where does mental health and mental illness education fit into the curriculum?; where can mental illness education be incorporated into existing programs and what medical interventions and suicide prevention programs are being conducted in secondary schools? Out of this audit the Australian government set up a mental health promotion initiative for secondary schools called MindMatters. The success of this would later produce the KidsMatter initiative for primary school students.

MindMatters

The original MindMatters pilot project began in November 1997 and lasted for about 18 months. The role out was delivered in 24 schools which included government and non-government schools. The pilot came about after an audit was completed in 1996, which examined what Mental Health Education there was in Australian secondary schools and if it was an appropriate setting for the promotion of mental health among young people. Upon completion of the evaluation of the MindMatters pilot it was decided to mass produce the resources and to disseminate these to schools with a secondary enrolment across Australia. This was carried out by Australian Principals Associations Professional Development Council and the Curriculum Corporation (Principals Australia Institute, 2017).

KidsMatter Primary

The Australian government saw the benefit of implementing a mental health education initiative such as MindMatters in secondary schools and realised that it might be even more important and beneficial

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to introduce a program that provided intervention for primary school aged children to deal with mental health problems earlier. Hence, KidsMatter Primary was introduced in 2006 and piloted in 101 schools over three years (2006 - 2009). This involved the Australian Psychological Society, the Australian Principals Associations Professional Development Council, beyondblue and the Australian Government Department of Health and Ageing (Principals Australia Institute, 2017).

The Gatehouse Project

The Gatehouse Project was a research project conducted in Victorian secondary schools between 1996 and 2001. Its aim was to promote the health and emotional wellbeing of young people by increasing connectedness and providing skills for managing life's ups and downs. Bond and colleagues (2002) referred to the Gatehouse Project as a school-based primary prevention program that offers a framework for building the capacity of school communities to address the emotional and mental health needs of students. A systematic process was used to create a whole school of change in regard to policies, programs, practices and structures. It was evaluated by using a randomised controlled trial. Findings found a reduction in the health risk behaviours of young people as well as system level changes within schools. The work of the Gatehouse Project is being further developed through the Adolescent Health and Social Environments Program (AHSEP), as well as there being national and international adaptations (Centre for Adolescent Health, 2017). An aim of the Gatehouse Project was to embed mental health promotion within the core business of school; that is to have connectedness to school and engagement with learning. The project used a variety of universal and targeted strategies at multiple levels to promote the emotional wellbeing of students combined with a whole school approach which would enhance and improve the social climate. It recognized that intervention was required for students who were more at risk due to the social environment that they came from (Bond, Butler, Glover, & Patton, 2002). The project identified three key priority areas for action; building a sense of security and trust; enhancing skills and opportunities for good communication; and building a sense of positive regard through valued participation in aspects of school life. The project emphasized the importance of healthy attachments or a sense of positive connection with teachers and peers (Bond, Butler, Glover, & Patton, 2002). The Gatehouse Project provided schools with a process of which to build on and develop new policies, programs and practices from an evidence-based platform. This included the establishment of an adolescent health team, reviews of programs, policies and practices, strategic planning to address risk and protective factors, training and implementation as well as monitoring and evaluation.

CURRENT MENTAL HEALTH EDUCATION PROGRAMS IN AUSTRALIAN SCHOOLS

MindMatters

MindMatters was originally developed by a team of academic researchers and health educational professionals. The 'whole of school' and holistic approach used by MindMatters was informed by the Health Promoting School concept and the Comprehensive School Mental Health Model, both of which were developed by the World Health Organisation (World Health Organisation Regional Office for Europe, 1994). Currently in Australia over 1,400 secondary schools are using MindMatters in some shape or form.

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Also, over 10,000 school staff and significant others have attended professional development sessions and in excess of 76,000 modules have been completed. Over 33,000 people are signed up to MindMatters. As can be seen from these figures its use is quite widespread. MindMatters is currently the key national mental health initiative for secondary schools in Australia (Principals Australia Institute, 2017). Principals Australia Institute (2017) defined it on it's website as the following, "It promotes mental health and wellbeing of students in secondary schools through a flexible framework that provides useful professional learning, resources and support. The resources enable staff to work with the school community to implement four components." The initiative is funded by the Australian Government Department of Health with beyondblue being designated as the lead contract for it while Principals Australia Institute staff help to deliver the program in each of the states. The MindMatters mental health framework is built around four key components. These include:

Component 1: Positive school community
Component 2: Student skills for resilience
Component 3: Parents and families
Component 4: Support for students experiencing mental health difficulties

Together these components provide a holistic and comprehensive view of student mental health and wellbeing within the wider school community. Each component is explored through a number of standalone online modules covering different topics. These modules include animation, video, interactive tools and downloadable resources and take around one hour to complete. Each module has a facilitator guide and can be explored individually or in a group. Special face-to-face events and experienced support from Principals Australia Institute project officers complement the online resources and help schools to implement what they have learnt (MindMatters, 2017). Central to the MindMatters philosophy is that of promotion, prevention and early intervention. It is about preventing the onset of early mental health problems through promoting positive mental health through a whole of school community approach and by providing students with the skills to improve relationships and build resilience. Staff are provided with professional guidance to help identify students who may be struggling with their mental health and knowledge on how to best support and help these students (MindMatters, 2017).

The attraction and advantage of MindMatters is that it is flexible in being to implement it into a school's curriculum so as to suit their own strategy / strategies and unique circumstances. Also the mental health resources has benefits not only for students but also staff and students' families. Sheehan and colleagues (2002) highlighted that "MindMatters can be distinguished from previous single-topic health education projects because it places mental health within the core educational business of schools rather than identifying it as a 'health topic'" (p. 113). They go on to say that "the professional development of teachers is fundamental to the success of the innovation". The main focus of MindMatters is on organisational structures, the social environment and the individual within this context.

KidsMatter and KidsMatter Early Childhood

After MindMatters was evaluated and the findings were disseminated, the Australian government saw the value and importance of developing a mental health education program for children of primary school age. It recognised that providing early intervention and prevention at an even earlier age than secondary school could make a difference in the mental health and wellbeing of children. KidsMatter is a

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national collaboration between the education and health sectors. It was jointly developed by beyondblue, Principals Australia Institute (PAI), Early Childhood Australia (ECA) and the Australian Psychological Society (APS), with funding from the Australian Government Department of Health and Ageing and beyondblue. (beyondblue 2016) KidsMatter Primary is a flexible, whole-school approach to improving children's mental health and wellbeing for primary schools. It can be tailored to schools' local needs.

Through KidsMatter Primary, schools undertake a two-to three-year cyclical process in which they plan and take action to be a positive community; one that is founded on respectful relationships and a sense of belonging and inclusion, and that promotes:

- Social and emotional learning (including evidence-based social and emotional learning programs);
- Working authentically with parents, carers and families;
- Support for students who may be experiencing mental health difficulties.

When schools take on KidsMatter, they build on the work that they are already doing in these areas (KidsMatter Primary, 2017). There are three parts that make up the KidsMatter framework. They are:

1. **Guiding Principles:** The beliefs that underpin KidsMatter;
2. **The Core Components:** The areas in which schools can most effectively concentrate their learning, planning and action;
3. **The Whole School Approach:** The essential elements for working together as a school community.

The four components that make up the KidsMatter / KidsMatter Early Childhood Framework are:

Component 1: Creating a sense of community.
Target Areas: A school community that promotes mental health and wellbeing and respectful relationships, belonging and inclusion.
Component 2: Developing children's social and emotional skills.
Target Areas: Effective social and emotional learning curriculum for all students and opportunities for students to practice and transfer their social and emotional skills.
Component 3: Working with parents and carers.
Target Areas: Collaborative working relationships with parents and carers, support for parenting and parent and carer support networks.
Component 4: Helping children who are experiencing mental health difficulties.
Target Areas: Understanding mental health difficulties and improving help-seeking and responding to students experiencing mental health difficulties (KidsMatter Primary, 2017).

KidsMatter recommended that schools should follow a 7-step implementation process related to focusing attention on the four components, as follows:

Step 1: Define the issues by writing a summary statement to describe the school's current situation related to each component.
Step 2: Set goals based on each summary statement.
Step 3: Identify any concerns in achieving the goals.
Step 4: Develop a broad range of options/strategies to address concerns and achieve goals.

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Step 5: Evaluate the feasibility of each option/strategy.
Step 6: Formalise the component plan.
Step 7: Implement the plan and review (Askell-Williams, Lawson, & Slee, 2013).

beyondblue Mental Health Education Programs for Australian Schools

Australia's well known and respected depression and anxiety initiative, beyondblue, has produced several mental health education programs for primary and secondary schools as well as resources for universities and pre-schools. The better-known programs are KidsMatter and MindMatters which have already been previously spoken about. Other school mental health education programs include the following.

SenseAbility

The SenseAbility program has been designed and developed for secondary school students aged 12 - 18. SenseAbility is a strengths-based resilience program designed for those working with young Australians aged 12-18 years. It consists of a suite of modules developed to enhance and maintain emotional and psychological resilience. It was created with classroom delivery in mind, but the modules can easily be adapted to benefit young people in other structured environments such as TAFEs and youth organisations. The program is based on cognitive-behavioural principles, the evidence-based approach which says that our thoughts play a critical role in influencing feelings and consequent behaviour. SenseAbility consists of seven modules, a DVD and a CD with downloadable curriculum materials and resources. The seven modules include:

1. Essential skills
2. Sense of self-worth
3. Sense of control
4. Sense of belonging
5. Sense of purpose
6. Sense of future
7. Sense of humour (beyondblue, 2016)

The SenseAbility package has been designed to be delivered by teachers in the classroom and lesson plans have already been developed for teachers to use. It has been designed to fit in with the Australian curriculum framework which will make it easier for school leaders and staff to deliver and assess the SenseAbility program.

Secondary Schools Program (Years 8-10)

The Secondary Schools Program (beyondblue 2016) was developed specifically for the middle secondary years 8 - 10 which is a critical time both emotionally and socially in the lives of young people. It is a 30 session program that is intended to be delivered over three years, with students participating each year in 10 weekly classroom sessions of 30 - 45 minutes duration. The sequentially developed sessions are based on cognitive behavioural theories. The program is built around the development of six senses that act as protective factors against mental health problems:

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1. Sense of self-worth
2. Sense of control
3. Sense of belonging
4. Sense of purpose
5. Sense of future
6. Sense of humour

Program delivery is based on principles of best-practice in effective teaching using a range of interactive methods including small-group exercises and discussions, role-plays, deep-learning tasks and quizzes. Each year level is built around different themes and there are downloadable teacher manuals as well as student workbooks. This program was developed collaboratively by the University of Queensland, the Victorian Centre for Adolescent Health, the South Australian Department of Education and Children's Services, and beyondblue. It draws on national and international research and the groundbreaking work conducted with schools in Australia in the past decade (beyondblue, 2016).

thedesk (University / TAFE Mental Health Education Program)

thedesk is a free online program aimed at providing Australian tertiary students with strategies and skills for success and wellbeing during their time at university or TAFE. *thedesk* includes modules to develop problem-solving and self-management skills. Topics include getting things done, staying calm, staying connected and feeling good. It also has tools to help with everyday issues such as relaxation, challenging unhelpful thoughts, using feedback constructively and problem solving. There are quizzes about different areas of life such as relationships, physical health and mental wellbeing and an online Coffee House for students to connect with other students, share experiences, music, art, recipes and more. Links are provided to information and support services to help deal with a range of common issue. All components of *thedesk* are informed by research on the prevention and treatment of mental health problems, web-based interventions and engagement. *thedesk* toolkit provides free information about *thedesk*, including the research behind it, what's involved and how schools and teachers can help promote it among their students (beyondblue, 2016).

Black Dog Institute: HeadStrong 2.0

HeadStrong 2.0 was developed by the Black Dog Institute to make it easier for teachers educating high school students about the tough topic of mental illness. The program has been linked to the Health and Physical Education curriculum for Years 9 - 10 and links directly to curriculum learning outcomes. The HeadStrong 2.0 curriculum resource is free to download and can help students better understand mental health, and how to build wellbeing and resilience. It is a unique program that equips teachers to better understand and help young people with mental health problems. HeadStrong 2.0 includes 5 modules that are split into a series of ready-to-use classroom activities and teacher development notes. Topics include depression and bipolar disorder, seeking help, helping others, and building wellbeing and resilience. It is complemented by MindStrength, a free online learning course to help young people build resilience.

Headstrong 2.0 has undergone a comprehensive research trial and is evidence based. Research has found that the program has helped improve the mental health literacy of young people which is crucial in young people seeking early help and support for a mental health problem (Black Dog Institute, 2017).

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Response Ability

The Response Ability initiative was launched in 2000 by the Australian Government Department of Health and Ageing. The aim of the program was to provide free multimedia resources and practical support to universities and teacher educators, while addressing pre-service education for secondary teachers. The main target group was secondary school students with the focus being on their mental health and well-being. The Response Ability Project was initiated in 1997 under the Australian Federal Government's National Suicide Prevention Strategy. Its aim was to influence the pre-employment education of professional groups, so graduates could play a constructive role in addressing youth suicidal behaviour. The project represents an effective collaboration between health professionals and tertiary educators, with the team comprising staff from the Hunter Institute of Mental Health and educators from the University of Newcastle (Allen & Vincent, 2005). In 2006 the government engaged the Response Ability project team to see how this program and resources could also be implemented and rolled out in both primary and early childhood education. The main idea of the initiative was to use the resources to "encourage pre-service teachers to engage with and promote social and emotional health in their teaching practices."

Inspire "ReachOut Schools" and "ReachOut Teachers Network"

The Inspire Foundation provides a couple of different resources that can be utilised by schools for mental health education purposes. ReachOut Teachers Network provides mental health and wellbeing teaching resources and online training activities as part of an initiative of the Inspire Foundation (beyondblue, 2016).

ReachOut Schools provides free educational resources, digital tools and practical tips to encourage the development of positive mental health and wellbeing across schools and extend the impact of existing programs. The service features easy-to-understand information on a full range of mental health and wellbeing issues. The school resources include innovative digital apps and online games to help students learn to take control of their mental health. Staff and parents can use ReachOut Schools to better understand the issues young people face and as a safe place they can recommend and refer students to. School professionals can also access a range of professional development webinars and information, with resources added throughout the year. School professionals are able to register for updates (ReachOut Australia, 2017).

MIEACT (Mental Illness Education ACT)

MIEACT was founded in 1993 to deliver education sessions in schools in the Australian Capital Territory (ACT) about mental illness and was formally incorporated in 1998. MIEACT secured recurring funding from the ACT Government in 2000, and since then has expanded to deliver additional programs that reduce stigma surrounding mental illness. Whilst continuing and further developing the original Schools Education Program, MIEACT has also developed education programs for the broader community, media programs, and resources for young people (MIEACT, 2016). The School Education Program (SEP) is based on the original core program that MIEACT was founded on 25 years ago. It is best designed for students or young people in Years 9 - 12. This program is delivered by pairs of MIEACT Volunteer Educators, who are people with lived experience either themselves or as a carer of someone with a mental illness. Volunteers are trained and supported to deliver the program into schools and other youth environments. The program provides students and teachers with evidenced-based information used to

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broaden the student's knowledge about mental illness. Each student is provided with a resource *Hang On To This* (HOTT magazine) which contains contact information for services which can assist young people and other stories and activities aimed at engaging young people (MIEACT, 2016).

Peer Support Australia

Peer Support Australia is a peer led, evidence based mental health education program that is offered to Australian school communities. It aims to enhance the mental, social and emotional wellbeing of young people. It does this through integrating the program into the school curriculum and sustaining it by running all year groups. By doing this it looks to support a positive cultural change across the school. The program is operated in both primary and secondary schools. The Peer Support Australia program provides:

- Training and professional development for teachers and parents;
- Student leadership training and resources;
- Peer led, skills based, experiential learning modules focusing on orientation, relationships, optimism, resilience, anti-bullying and values;
- Consultancy to assist Member schools in raising awareness of the program and planning for implementation.

There are several benefits to the program. It provides students with a supportive learning environment in which to develop the skills, understandings, attitudes and strategies to improve mental wellbeing. It also helps students to develop key skills in resilience, assertiveness, decision making, problem solving and leadership and empowers young people to support each other and contribute positively to society (Peer Support Australia, 2014).

Teen Mental Health First Aid

Since 2001 there has been several variations of the original Mental Health First Aid program delivered to members of the community not only in Australia but overseas as well. The first courses however were specific in providing Mental Health First Aid by an adult to another adult. Eventually a Youth Mental Health First Aid was developed for adults who work with young people as well as for parents so that they would be equipped with the skills necessary to help out young people who might be struggling with their mental health or presenting with early mental health problems. Over the years through research conducted by Mental Health First Aid International, it became apparent that there was a need for there to be a course to be developed for young people to be trained up in having the skills and knowledge to help and support their peers who may have mental health problems or be in a mental health crisis. Thus teen Mental Health First Aid was born. teen Mental Health First Aid is a 3.5 hour mental health education program specifically designed for students in years 10 - 12 on how to provide mental health first aid to their friends.

Research and evidence found that young people have a preference for sharing their problems with peers rather than adults, be it parents, teachers, sports coaches or other significant adults in their lives. The course curriculum is based on research that was conducted on how best a young person can support their peers who might have a mental health problem. Students learn how to develop a Mental Health First Aid (MHFA) Action Plan on how to keep their peers safe, as well as information about different

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types of mental health problems and mental health crisis situations in young people, and the relationship between thoughts, feelings and behaviours (Mental Health First Aid Australia, 2017). Hart and colleagues (2016) said that the program would:

Focus on developing knowledge and skills in recognising warning signs that a peer is developing a mental health problem, understanding how to talk to a peer about mental health and seeking help, when and how to tell a responsible adult, where to find appropriate and helpful resources about mental illness and professional help, and how to respond in a crisis situation… teen MHFA program aims to increase mental health literacy, decrease stigmatising attitudes towards individuals with mental illness, and improve MHFA behaviours. (p.3)

MENTAL HEALTH LITERACY IN AUSTRALIAN SCHOOLS AND YOUNG AUSTRALIANS

Anthony Jorm introduced the term, 'mental health literacy' back in 1997. He defined it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Jorm added that Mental Health Literacy consisted of several components including:

1. The ability to recognise specific disorders or different types of psychological distress;
2. Knowledge and beliefs about risk factors and causes;
3. Knowledge and beliefs about self-help interventions;
4. Knowledge and beliefs about professional help available;
5. Attitudes which facilitate recognition and appropriate help-seeking; (and)
6. Knowledge of how to seek mental health information (Jorm, 2000).

Jorm (1997; 2007; 2011; 2012) has written much on the topic of Mental Health Literacy. He has examined it from a whole population perspective in Australia and explained the importance and need to be mental health literate in order to stay emotionally and mentally well. Some of his research in collaboration with others has focussed on Mental Health Literacy around young people of school age. He found that the lack of mental health literacy in young people is similar to that of adults. His main concern was the inability of young people to recognise mental illnesses and their failure to know what appropriate professional help and pharmacological treatment that was available. Young people have a slightly more positive attitude of receiving help from a health professional than adults but that was not necessarily reflective in their own self-help seeking preferences. Young people would still prefer to speak to a friend or family member if they have a mental health problem. Many young people also do not have positive attitudes towards the taking of psychiatric medication. His research has also found that young people are ill-equipped to provide help to peers suffering from mental illness (Jorm, & Wright, 2007). From the 2006 National Survey of Mental Health Literacy and Stigma, Jorm and Reavley (2001) in conjunction with Melbourne University uncovered some key findings about youth mental health literacy in Australia. These included:

- Only a small percentage of young people saw doctors as a source of intended help;

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- There was widespread awareness among young people that the use of substances is harmful for mental health;
- When a peer had a mental health problem, it was not often recognised by a young person to encourage professional help seeking;
- Young people viewed general and informal sources of help as interventions that would be helpful rather than specialist mental health services;
- Stigma was lower in young people who had experience of mental health problems in self or others, who had been exposed to mental health campaigns, and whose parents had less stigmatising attitudes.

Following consideration of two international studies (Skre, Friborg, Breivik, Johnsen, Arnesen, & Wang, 2013; Mcluckie, Kutcher, Wei, & Weaver, 2014) it was found that after introducing mental health education and promotion programs into the curriculum that there were definite improvements in the mental health literacy of both students and staff. More research and education is needed in order to improve youth mental health literacy which in turn will improve early intervention outcomes of young people whom are developing signs of mental health problems and mental illness.

INTERNATIONAL EXPERIENCE OF MENTAL HEALTH EDUCATION IN SCHOOLS

Around the world there are literally hundreds of mental health interventions and education programs being run (Weare & Nind, 2011). From the evidence these are most popular in Western countries such as the USA, Canada, the United Kingdom, Scandinavia and parts of Europe. Most of these appear to be quite fragmented without there being one national integrated program per country. These vary in size, coverage and the amount of mental health resources that they produce and make available. Some are privately run while others have the backing of respective federal or state government money. Askell-Williams and colleagues (2009) identified several school-based mental health education programs based on the World Health Organisation (WHO) 'Health Promoting Schools' framework. These included Social and Emotional Aspects of Learning (SEAL) from the United Kingdom, the Collaborative for Academic, Social and Emotional Learning (CASEL) initiatives in the United States of America and the European Network for Socio-Emotional Competence in Children (ENSEC). Askell-Williams and colleagues (2009) noted that "each of these seeks to develop students' social, emotional and behavioural capabilities, as well as the capabilities of schools and families to support children's wellbeing". These examples show a whole-school approach not unlike MindMatters and KidsMatter in Australia.

In 2007, a secondary school mental health curriculum, the Mental Health and High School Curriculum Guide was developed in Canada in a collaboration between the Canadian Mental Health Association and mental health experts from several different organisations and universities. This has proven to be quite successful so far.

The United Kingdom have also been proactive in implementing a number of mental health education programs. These include YoungMinds, OpenMinds and Place2Be. Place2Be is the UK's leading children's mental health charity providing in-school support and expert training to improve the emotional wellbeing of pupils, families, teachers and school staff. OpenMinds is a student-led intervention, providing mental health education to school students by training medical students to deliver workshops in local schools.

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The United States has an abundance of mental health education programs. Examples of these included FRIENDS, which focuses on reducing anxiety and teaching skills for managing emotions and coping with stress among students, parents and teachers. It addresses six core topic areas, including identifying feelings, understanding one's physical responses, learning to relax, linking thoughts and feelings, developing plans for coping and practicing emotion management. Other ones were Positive Action (PA), Promoting Alternative Thinking Strategies (PATHS), Cognitive-Behavioural Intervention for Trauma in Schools (CBITS) and the American Psychiatric Association Foundation's School Mental Health Program 'Typical or Troubled?'.

BARRIERS AND PROBLEMS TO IMPLEMENTING MENTAL HEALTH EDUCATION IN AUSTRALIAN SCHOOLS

Although there are many benefits for implementing Mental Health Education into school curriculum, that is not to say that it does not come with its fair share of problems, barriers and challenges. After the original audit into Mental Health Education in Australian Secondary Schools was completed in 1996 a number of barriers were discovered. These included:

- Teachers and other school staff lacked specific knowledge and skills, and thus confidence in teaching, on these issues; this lack of information was also reflected in the prejudices of staff and others in the school;
- The specified curriculum lacked a space for mental health education; there was a lack of time in an already 'packed' curriculum;
- There was a lack of relevant and reliable resources;
- Students' and parents' values;
- Within the curriculum, health generally and mental health in particular has a low status;
- There is sometimes no continuity or commitment from teachers from year to year, across and within departments, and between teachers and other staff;
- Mental health issues are often seen as crisis-driven and individual, and thus more relevant to welfare approaches than to curriculum (Youth Research Centre and Centre for Social Health, 1996).

With the introduction of MindMatters and the two variations of KidsMatter, some improvements could be seen concerning these barriers and problems. Professional development has definitely been enhanced and the resources available to schools now is much improved to what was on offer in the past. Some of these barriers however still exist today, with schools trying to fit so much into their curriculum for example. As can be seen from the findings above there are a number of challenges that present extra stresses and pressures for teachers and schools in trying to implement Mental Health Education. Additionally, some teachers and educators believe that it is not a part of their role to provide Mental Health Education or to be a role model or provide guidance around it. Another point of contention for some schools that have even been successful at embedding Mental Health Education into their curriculum is the matter of sustainability. Some schools believe that this is not possible with their many pressing demands, changes in curriculum and changes in staff. Lastly, another possible barrier is that of the attitudes and values of some teachers and educators in regard to mental health and mental illness and their willingness to pick up delivering mental health resources.

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BENEFITS OF MENTAL HEALTH EDUCATION IN AUSTRALIAN SCHOOLS

There are a number of benefits and advantages for young people as well as teachers, families and the broader community with the introduction of mental health education into schools. With the high prevalence of mental illnesses such as depression and anxiety, young people are able to be provided with the skills, knowledge and understanding on how to manage these conditions as well as knowing what they can do to stay mentally and emotionally well in the first instance. Through having a greater understanding, insight and knowledge of mental illness and it's early warning signs, young people will be able to assist their peers in accessing important early help from mental health professionals and hopefully avoid a crisis situation. Education and knowledge will also help to break down the appalling stigma that still surrounds mental illness in the community and amongst young people, therefore enabling people not to feel judged and feeling comfortable to accept help for their mental health problems. Through the process of early intervention and prevention, young people will be able to learn to become more resilient and mental health conscious, which will help them to become more productive people who are better able to deal with stress and difficult and challenging life situations.

Introducing and exposing young people to mental health education at an early age will set a good precedent in raising children who are less judgmental towards people who have mental illness in the community as well as helping people to recognize the importance of maintaining their own mental health as much as their physical health. This would help in decreasing the amount of serious mental illness that exists in the community due to the fact that young people and future generations of adults would be more inclined to seek early help for either existing or emerging mental health problems or mental illness. Early identification of mental illness would help in decreasing the amount of admissions to emergency or psychiatric wards in hospitals, which is already under pressure and costs the Australian government millions of dollars each year.

Mental health education will also give young people a better understanding about the impact that drugs and alcohol can have on their mental health and recognizing that they may be self-medicating which may be masking what is an underlying mental health condition. A reduction in the use of drugs and alcohol will see an improvement in the mental health of young people which will also save the health system money and more importantly young people's lives.

Through mental health education young people will be raised to be more resilient and be able to better manage their stress from an earlier age which will prepare them better for adolescence and adulthood. This will lead to a more productive economy and save millions of dollars in tax payers money due to people taking less sick leave or filing claims for stress leave.

THE FUTURE OF MENTAL HEALTH EDUCATION IN AUSTRALIAN SCHOOLS

The future of Mental Health Education in Australian schools is looking bright after the announcement in June, 2017 by the Australian government of a new initiative to be rolled out in 2018. This new program will hopefully make it even more accessible and easier for schools to use than what is currently in place. The beyondblue Chairman at the time, Jeff Kennett, described the program as "a game-changer that would replace the current fragmented approach with a wholly integrated one" (beyondblue, 2017). From August 2018, beyondblue will lead a new National Mental Health in Education program with support from headspace and Early Childhood Australia, with funding from the Australian Government

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Department of Health, (beyondblue, 2016). This new initiative will transform Australia's approach to child and youth mental health care by providing a single end-to-end school-based mental health program. Covering the continuum from early childhood to secondary school, it will support mental health promotion and suicide prevention activity. The program will integrate and build on the strengths and evidence-based principles of key existing Commonwealth Government mental health initiatives being delivered in education settings.

These initiatives are:

- Response Ability
- KidsMatter Early Childhood
- KidsMatter Primary
- MindMatters
- Headspace School Support

In the meantime KidsMatter Early Childhood, KidsMatter Primary and Mind Matters will continue as normal in their current form until the new program launches in August 2018. From January 2018, headspace facilitators will deliver KidsMatter and MindMatters to primary and secondary schools, while Early Childhood Australia facilitators will deliver KidsMatter Early Childhood (beyondblue, 2016). beyondblue will continue to provide Response Ability resources to university lecturers and course facilitators who provide pre-service training to future educators, through to mid-2018. The Response Ability website will continue to be the primary information source for the pre-service training sector. In a media release from beyondblue, who were the successful bidder in a competitive tender process for the new Mental Health in Education program, their CEO, Georgie Harman affirmed that:

We will bring together the best minds from across the mental health and education sectors to build a contemporary national child and youth mental health program with the aim of helping everyone reach their full potential academically, emotionally, socially and in later life. (beyondblue, 2017)

CONCLUSION

Ever since the Australian government undertook an audit in 1996 into Mental Health Education in Australian Secondary schools, there has been a strong focus put on mental health education in schools. This is evident from the MindMatters (secondary schools) and KidsMatter (primary schools) initiatives that were successfully introduced and implemented in many schools around Australia. These initiatives also saw the introduction of other mental health education programs in Australia that have been discussed earlier. These initiatives and programs have seen Australia become one of the world leaders in school / youth mental health education as well as mental health promotion. Australia is well resourced for mental health education resources and professional development and the future is looking bright with the announcement by the government in June, 2017 of the Mental Health in Education initiative, which rolls out from 2018. This program will improve on what is already in existence by providing a seamless single end-to-end school-based mental health program from early childhood to secondary school that is wholly integrated as opposed to having separate programs in operation. From looking at the evidence that the mental health literacy of young people and students in Australia is still lacking, suggests that more

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needs to be done about this. Hopefully the current lack of knowledge about mental illness, mental health and seeking psychological treatment amongst young people in Australia will be improved through the new Mental Health in Education initiative and that more young people will seek out and utilize mental health services earlier. It is crucial that young people learn to recognize early presenting mental health problems and know what help and treatment options are available to both themselves and to their peers. The introduction of compulsory mental health education in Australian schools as well as forming part of the curriculum would see visible improvements in the mental health and wellbeing of young people in Australia, which in return would provide many benefits and opportunities for the broader community. For compulsory mental health education to work well would require that teachers receive good professional training and support and that schools are provided with excellent resources. It may be that the Australian government employs specialist mental health education teachers for schools to deliver the content so that the regular teachers can concentrate and focus on the rest of the curriculum. Mental health education in schools will help in decreasing the likelihood of mental health problems presenting for people when they are adults or minimizing the impact for people who have a mental illness. It will help build resilience in young people and create a society where people are more accepting of mental illness, which will lead to early help seeking. Mental health literacy will improve which will only seek to benefit Australia as a community moving forward due to the fact that more Australians in the community will be more mentally healthy.

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Chapter 36
Campus-Wide Initiatives

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ABSTRACT

In this chapter, the authors situate mental health issues in the context of U.S. institutes of higher education. They provide a brief history of the provision of mental health services on campus and contends that postsecondary schools should shift to a campus-wide, preventive, proactive approach to promote student flourishing. Four specific areas for interventions are discussed. These include academic or curricular adjustments, increased awareness and knowledge, supportive environments, and appropriate policies and procedures. These initiatives (which are not only the responsibility of "experts") rely on the open communication and collaboration of all members of the campus community.

INTRODUCTION

The authors begin by providing a brief history of the provision of mental health services on campus. Then they discuss four areas in which campus-wide initiatives have been found effective in supporting the mental health of college students. These include curricular adjustments, community environments, mental health literacy, and campus policy. These focus areas have been selected as they are most applicable to this audience: college/university faculty and staff whose background are not necessarily in mental health. These are the professionals who will have regular contact with students, those with and without mental health issues. As such, the initiatives in this chapter can be understood and implemented by professionals without degrees in the mental health field.

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OVERVIEW

With the increasing prevalence of mental illness in institutes of higher education (IHE), research suggests that colleges and universities must adapt to better serve their students. Reactive approaches and individualized counseling alone are not sufficient. Moreover, compartmentalized service (where responsibility for college student mental health resides in counseling centers) has limited influence. It is recommended that IHE shift from a targeted focus to a campus-wide focus and direct their efforts toward preventive measures (Fink, 2014; Hartley, 2012; Swaner, 2007; Wood, 2012). In the past few decades several organizations have proposed ways to facilitate this transition.

The Jed Foundation (JED), though not the only organization aimed at promoting emotional and mental well-being, is a leader in this field. It offers support to schools, students, families, and communities to strengthen mental health. JED's 7-point Strategic Plan is comprehensive, attending to the following areas: developing life skills, promoting social connectedness, identifying students at risk, increasing help-seeking behavior, providing substance abuse and mental health services, following crisis management procedures, and restricting access to potentially lethal means (JED, 2016). Such an approach affects multiple levels of the campus community from college policy, to particular organizations like student mental health services, to faculty training and involvement, to curriculum design, to student enculturation.

Building on the recommendations of JED and other relevant literature, IHE can take multiple steps to improve the mental health of college students. Academic adjustments to face-to-face and online courses have been found to mediate the negative effects of stress in academic settings. Such curricular changes include engaged learning models and course offerings in mental well-being (DiPlacito-DeRango, 2016; Fink, 2014; Mitchell, Darrow, Haggerty, & Neill, 2012; Savini, 2016; Swaner, 2007). IHE that endorse social and academic inclusion via residential communities, campus activities, and learning communities are found to be more supportive and promote a sense of student belonging, which are favorable factors of mental health (Condra, Dineen, Gauthier, Gills, Jack-Davies, & Condra, 2015; Fink, 2014). Moreover, IHE at all levels (leadership, faculty, support staff, and students) must be fully aware and fully trained to promote resilience and identify signs of mental illness (Barr, 2014; Condra et al., 2015; Hartley, 2012, Wood, 2010) to create environments in which students can flourish. Additionally, campuses should have the necessary policies and procedures in place to promote well-being and intervene when students are in mental distress (Condra et al., 2015; DiPlacito-DeRango, 2016; Murphy & Baines, 2015; Silverman, 2008; Wood, 2012).

PROVISION OF MENTAL HEALTH SERVICES ON CAMPUS

In the United States, the provision of mental health services in IHE morphed considerably during the 20th century. Amherst College is credited with establishing the first student health services in 1861, yet the first mental health services was not established until 1910 by Princeton University (Kraft, 2009; Kraft, 2011). In the first half of the 20th century, college mental health services were developed and primarily provided by psychiatrists. As the field grew, clinical psychologists and psychiatric social workers began providing services as part of a multidisciplinary team approach (Kraft, 2009; Kraft, 2011). Yet, services were often split between two departments: psychiatric mental health and other counseling resources. This model was expanded mid-century when increasing numbers of students, funded by the GI bill, entered colleges and universities (Kraft, 2009; Kraft, 2011). Increased student enrollment necessitated increased

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health professionals on campus. It also meant providing a broader range of services to address the new needs of students. Similarly, it required a new service-delivery approach.

A shift occurred mid-century. Mental health services no longer focused solely on the "mental hygiene" of a few acute students receiving in-patient care (Kraft, 2009; Kraft, 2011). Mental health services began to have a broader purpose, serving a larger population and doing so through ambulatory care services (Kraft, 2009; Kraft, 2011). These services included career or vocational counseling, psychotherapy, medication assists, and consultation across campus. In the second half of the century, another shift occurred (Kraft, 2009; Kraft, 2011). Campus counseling centers had a growing and changing role in the provision of mental health services moving from that of "providing only direct counseling services to one that makes multiple contributions to a campus community" (Bishop, 2010, p. 249). Addressing the ever-changing needs of college students, mental health services expanded their scope to deal with drug and alcohol abuse (initiated in the '70s), public health issues (initiated in the '80s), and recently stress, anxiety, and depression. Additionally, prevention efforts and education campaigns are now a significant part of mental health services.

Today's mental health services on campus are geared toward a diverse population and intended to be proactive rather than reactive. Standards set forth by the International Association of Counseling Services (IACS) support a systemic and comprehensive campus initiative. It highlights four key functions of campus counseling services: "individual and group student counseling; prevention and outreach; consultation to faculty and staff; and contributions to campus safety" (Prince, 2015, p. 6). These standards suggest that campus counseling services are important, though not the sole factor influencing student mental health. Faculty and staff also play an essential role. Moreover, these standards indicate that mental health services do not reside in a single location on campus. This notion is echoed by Bishop (2010). In reviewing the literature, Bishop (2010) found a continued need for counseling centers to make clear their engagement in "outreach, programming, and consultation work" (p. 250), implying that mental health services in IHE are most effective when viewed as a shared responsibility.

The responsibility of college student mental health does not reside within a single department or office. It is the responsibility of the entire campus community. Many IHE have adopted a "public mental health model – a model that attempts to address environmental factors of the campus that influence students' mental health" (Prince, 2015, p. 7). Through such a paradigm, members of student affairs and student services, faculty, staff, and students themselves work together to improve well-being on campus. It has been argued that colleges and universities are well situated to have a positive effect on mental health. Postsecondary education is often the place where:

A single integrated setting encompasses their [students'] main activities – both career related and social – as well as health services and other support services. Campuses, by their scholarly nature, are also well positioned to develop, evaluate, and disseminate best practices. In short, colleges offer a unique opportunity to address one of the most significant public health problems among late adolescents and young adults. (Hunt & Eisenberg, 2010, p. 3)

Hence, the focus of this chapter: college-wide initiatives that can enhance student mental well-being.

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COMPREHENSIVE INTERVENTIONS

There are multiple ways in which IHE can support the mental health of college students. This section of the chapter focuses on building a sense of community, increasing awareness and knowledge, curriculum adjustments, and establishing campus-wide policy. Although psychotherapy and medications can be used to treat some students, they are not discussed here. Likewise, interventions for students with mental health illnesses requiring individual care from the Counseling Center and/or private mental health providers (e.g., psychologists, clinical social workers, certified counselors, licensed nurse psychotherapists, or psychiatrists) are not discussed here. As a teacher educator, such therapies fall outside of my purview. Moreover, my intent is to present strategies that can apply to many students, not simply those requiring intensive or prolonged care, and that can be used preventatively.

Building a Sense of Community to Promote Mental Health

Mental health, or flourishing, does not simply exist in the absence of mental illness. As Keyes (2005 & 2007) describes in his model of Mental Health as Flourishing, there are 13 factors associated with flourishing. These include positive affect and avowed quality of life (emotional well-being); self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, and positive relations with others (psychological well-being); and social acceptance, social actualization, social contribution, social coherence, and social integration (social well-being) (Keyes, 2007). In replicating Keyes' work, Fink (2014) obtained similar findings. His analysis revealed four significant predictors of college student mental health. These include a supportive college environment, a sense of belonging, professional confidence, and civic engagement (Fink, 2014). Fink (2014) concluded that "socially supportive climates, such as easy transitions into college and supportive residence halls, as well as intermediate outcomes such as sense of belonging" were particularly strong predictors (p. 386). Myriad other researchers have noted similar associations with college student mental health, focusing especially on the type of environment in which students live and learn.

Without oversimplifying IHE, I conceptualize campuses as on a continuum from "cool" to "warm" with various degrees in between. Cool campuses are those that lack a sense of community and promote a sense of isolation. These are the campuses that have a "non-accepting culture" (Tinklin, Riddell, & Wilson, 2005, p. 507). As such, differences are viewed as deficiencies rather than natural occurrences that warrant empathy, compassion, and accommodation. On cool campuses public and personal stigma are prevalent.

Public, or social, stigma "is characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given" (Davey, 2013, p. 1). In other words, it is the stigma of others (family members, friends, instructors, and the media) emanating from outside the individual with the mental health disorder. Public stigma can present as "prejudicial attitudes and discriminating behavior" (Davey, 2013, p. 2). Stereotypes of individuals with mental health disorders as dangerous or intellectually inferior can lead to social isolation and lowered expectations. Personal stigma is just as, if not more, detrimental.

Self-stigma, also known as perceived stigma, "is the internalizing by the mental health sufferer of their perceptions of discrimination" (Davey, 2013, p. 1). It occurs when the individual with mental illness believes the negative stereotypes ascribed to his/her psychiatric label. Self-stigma may result in feelings of fear and shame (Condra et al., 2015; Davey, 2013; Tucker, Hammer, Vogel, Bitman, Wade, & Maier,

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2013), exacerbate symptoms of the disability (Pedersen & Paves, 2014), and heighten social isolation (Pedersen & Paves, 2014; Tinklin et al., 2005; Tucker et al., 2013). Stigma is a chief concern as it has been identified as a barrier to college students seeking help for mental illness (DiPlacito-DeRango, 2016; Hunt & Eisenberg, 2010; Pedersen & Paves, 2014; Shatkin, Diamond, Zhao, DiMeglio, Chodaczek, & Bruzzese, 2016). It can affect students' self-concept and influence their perceived need for help or their likelihood to deal with mental illness on their own.

On the contrary, warm campuses are defined by their open and accepting nature. Here, differences are not considered flaws. Rather, diversity is anticipated and welcomed. Moreover, pro-social interactions are encourage and fostered so that students do not feel a sense of alienation. Such environments are known as "welcoming culture[s]" (Condra et al., 2015, p. 277) supported by a "web of caring" (Asidao & Sevig, 2014, p. 132) and "social networks that reinforce a sense of campus community" (Silverman, 2008). In this way the camps is ecological in nature, where human beings interact with each other and with their environment. Interactions on warm campuses are different from interactions on cool campuses. They are grounded in compassion and empathy for others. Summarizing Kuh, Swaner (2007) underscores the importance of:

Small, 'human-scale' environments [that] encourage responsible, health-enhancing behavior," and emphasizes that where faculty and student contact is frequent and classes are small, "a college or university encourages its members to know each other, a precursor to caring for one another. (p. 21)

I would go farther, suggesting that positive interactions are not limited to those between students or among students and faculty. Positive interactions include all members of the campus community. This highlights the value of positive, supportive relationships grounded in getting to know and understand others.

Such warm campuses can be fostered in academic and non-academic settings. In fact, many researchers suggest that a comprehensive focus best serves college students. Classrooms can be turned into learning communities where students are engaged in meaningful ways and where students work with one another to grow intellectually and empathically (Bertram, 2010; Fink, 2014; Wrench, Garrett, & King, 2013). Residence halls, where students live in close proximity to a great number of diverse peers, are prime places to develop inclusive spaces (Bertram, 2010; Fink, 2014). Social networks and friendships are a critical component of warm campuses (Bertram, 2010; Fink, 2014; Wrench et al., 2013). Such relationships may start in the residential communities and typically expand beyond the dorm. Events and activities (academic, social, athletic, club-related, Greek life-based) can support the development of peer relationships, which shape the campus community. In addition to peer relationships, student-faculty relationships can contribute to a welcoming environment. Positive student-faculty relationships occur both inside and outside the classroom. One way to enhance such openness is to schedule events where faculty and students interact informally (Quinn, Wilson, MacIntyre, & Tinklin, 2009). In each of these ways, members of the campus gather to get to know each other and begin to form a community.

By definition, a community includes myriad individuals unified by common interests. This can include persons and agencies off campus (e.g., families, medical providers, counselors, religious groups, non-profit organizations, etc.) and on campus. In IHE, the focus of this book, everyone, including faculty, staff, and students, plays a role in developing a warm campus. Such supportive communities exist when "members look out for one another, value the individual, promote a collective identity, and are not afraid to speak out when they recognize distress" (Bertram, 2010, pp. 31–32). This environment cannot exist if mental

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health disorders continue to be stigmatized. Anti-stigma, or stigma reduction, programs are essential as IHE move forward. Stigma reduction initiatives can include shifting to asset-oriented language use on campus, making mental health services accessible, and correcting stereotypes and misconceptions (Condra et al., 2015; Davey, 2013; Pedersen & Paves, 2014; Tucker et al., 2013; Wood, 2012).

Service provision must be actualized in ways that are humanizing and maintain students' privacy. This could include communicating clear policies (e.g., confidentiality commitments and release authorizations), locating offices in convenient and private settings, and creating supportive cultures. Supportive cultures can grow by improving and increasing mental health literacy (DiPlacito-DeRango, 2016; Murphy & Baines, 2015; Tucker et al., 2013). In these ways, campuses move to normalize mental health disorders and encourage students to access the services available to them. The following section addresses mental health awareness and knowledge of both students and faculty.

Promoting Awareness and Increasing Knowledge of Mental Health

Students With and Without Mental Health Disorders Lack Information

Research indicates that many college students with mental health disorders lack the knowledge to effectively manage their disability. One major barrier is being unaware of their rights and responsibilities as a college/university student with a disability (Condra et al., 2015). Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act or 1973 (Section 504) prohibit discrimination on the basis of disability. These laws protect all individuals with disabilities, including students in elementary, secondary, and postsecondary settings. In IHE, Section 504 entitles eligible students to appropriate academic adjustments. "Academic adjustments may include auxiliary aids and services, as well as modifications to academic requirements as necessary to ensure equal educational opportunity (USDOE, 2011). Such academic adjustments can be gained if the student with the disability reports (provides documentation) that he/she has a disability to the appropriate office on campus and requests services. It is the responsibility of the college student to self-disclose and obtain academic adjustments, if needed. Students who are unaware of their rights and responsibilities are not likely to secure the supports to which they are legally entitled.

Those who are aware of their rights and responsibilities must also know how to access services on campus. Unfortunately, many college students with disabilities are either unaware of the services available to them, do not know where to go for help, or do not know the process for accessing services (Condra et al., 2015; Oswalt & Riddock, 2007; Pedersen & Paves, 2014; Quinn et al., 2009). These barriers are exacerbated by offices of student support services that are located in areas of campus either not known to or not readily accessible to students with disabilities (DiPlacito-DeRango, 2016; Quinn et al., 2009; Silverman, 2008). IHE can do a better job of educating students with mental health disorders about available services on campus and make these services readily available. Additionally, IHE can help students become self-determined human beings. "Professionals can do much to advocate for and support students, but ultimately students must learn to advocate for themselves and support each other" (Bertram, 2010, p. 32).

Students currently without mental health disorders also lack mental health knowledge. As a result, social stigma may exist. In this space, stereotypes and misinformation can breed fear and discrimination, which is detrimental for students with mental illness. Lack of knowledge also impedes the ability of college students without mental illness to help peers in crisis. If one cannot spot indicators of mental distress

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or is unaware of the services available on campus, he/she cannot intervene in positive ways. Bystander training has recently been encouraged to address this (Bertram, 2010; Prince, 2015; Wood, 2012). As Bertram (2010) asserts, "distressed students are more likely to go to their peers with their problems. Thus, it is critical that students are offered this information in a format that will give them agency when a friend is in need" (p. 31). Moreover, lacking mental health literacy can be personally harmful. Just because a student is currently mentally healthy, that does not mean he/she will never experience mental distress. Enhancing mental health awareness and knowledge for all college students is beneficial.

Faculty and Staff Lack Information

Research also indicates that many college faculty and staff lack awareness and knowledge of mental health issues on campus. They may lack knowledge of students' rights (Condra, et al., 2015). Consequently, some faculty and staff do not realize their legal obligation to make academic adjustments. They may be uninformed about the services to which they could refer students or the process to do so (Condra et al., 2015; Mitchell et al., 2012; Storrie, Ahern, & Tuckett, 2012) and unaware of the importance of referring students for non-acute, non-crisis mental health matters (Mitchell et al., 2012). Therefore, they are not able to advise students properly. Also, they may lack awareness of particular mental health issues, early warning signs of mental illness, and how such disorders manifest for individual students (Storrie et al., 2012; Tinklin et al., 2005). As such, they are unable to identify and intervene in a timely manner for students who are at-risk.

Additionally, some faculty and staff may be unsure of how to make appropriate academic adjustments in their courses (Condra, et al., 2015; Tinklin et al., 2005). A lack of effective accommodations can negatively affect the learning environment. In some cases reluctance to make academic adjustments is related to faculty and staff holding negative attitudes about individuals with mental illness (questioning their capacity to succeed) or the concern that making accommodations will diminish academic standards and compromise the rigor of the program (Condra et al., 2015). Such misunderstandings or misperceptions can contribute to a "knowledge gap" (Storrie et al., 2012, p. 101) where faculty and staff are unsure of or ill-prepared to fulfill their role as a "first-line responder" (DiPlacito-DeRango, 2016, p. 7) and college/university students with mental health issues do not receive the academic or psychological support to which they are entitled. Training and awareness campaigns can mitigate this knowledge gap, not only for faculty and staff but also for college/university students.

Campus Training and Awareness Campaigns

Numerous researchers (Asidao & Sevig, 2014; Bertram, 2010; DiPlacito-DeRango, 2016; Hunt & Eisenberg, 2010; Mitchell et al., 2012) discuss the importance of "gatekeeper" training. As defined by the U.S. Surgeon General (USDHHS, 2012), gatekeepers are community members:

Who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify personas at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military. (p. 139)

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By extending this definition beyond the P-12 setting to the college/university environment, faculty and staff in IHE can be considered gatekeepers. Gatekeeper training aims to educate individuals on identifying and referring students who may benefit from mental health services. This model is preventive in nature. It attempts to provide faculty and staff with the knowledge and skills to make early referrals. In turn, this should increase the number of students attaining mental health services before their situations escalate to acute mental distress and reduce the number of students who commit suicide.

One example of gatekeeper training is Question, Persuade, and Refer (QPR). QPR is nationally recognized and empirically based. It involves teaching:

Front-line people (e.g., faculty, staff, friends) how to recognize the warning signs of suicide, including verbal, behaviors, and situational clues, and provides guidelines on how to question persons about suicidal thoughts, persuade them to get help and refer them for help. (Asidao & Sevig, 2014, p. 136)

It is based on the notion that early recognition and early intervention are critical. Like Cardiopulmonary Resuscitation (CPR), it is an intervention "designed to increase the chance of survival in the event of a crisis" (What is QPR?). Another example of gatekeeper training is Campus Connect. It is "experientially based and teaches constituents to recognize distress and mental health issues in students, use basic helping techniques, and refer others to resources that could provide help" (Bertram, 2010, p. 31). In addition to providing information, Campus Connect uses multiple exercises and role play activities to increase communication skills, particularly empathic listening skills, of trainees. This evidence-based model builds on connectedness and uses culturally appropriate approaches. Both trainings are similar in that they promote community engagement and comprehensive strategies to save college/university students' lives. For more information on QPR or Campus Connect, please visit their websites.

Though useful, trainings like QPR and Campus Connect are not the only options for increasing awareness of mental health disorders. Training can be targeted to particular members of the campus community, and it can be provided via multiple avenues. Training for faculty and staff, who interact with college/university students on a weekly, if not daily, basis should incorporate wide-ranging information. This includes information about prevalent mental health disorders (particularly, characteristics and evidence-based academic interventions), the process students use to obtain accommodations, supporting students by using existing campus resources, and complying with confidentiality policies (Condra et al., 2015). Academic advisors, in particular, may benefit from such training (Wood, 2012). They have an opportunity to get to know their advisees as a "whole person." Academically, advisors have access to mid-term grades, course schedules, and transcripts, which enable them to see how the student is doing across all courses. Typically, advisors also have designated advising times where they meet individually with advisees and check-in on their overall well-being and adjustment to college/university. That is not to say these conversations do not or cannot occur organically with course faculty. In many cases the time and space for such conversations is intentionally built in to the formal academic advising structure (though it may not always be capitalized on).

Training to increase mental health literacy can be provided in multiple ways. It can occur at orientation for new faculty and staff and through new or enhanced existing professional development for current faculty and staff (DiPlacito-DeRango, 2016). Though initial trainings are important, one-shot deals are not enough. Training should be ongoing (Barr, 2014). Campus Counseling Centers often play a role in such professional development but are not solely responsible. Web-based self-training modules exist and centers for teaching and learning can host workshops, professional learning communities, and

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conferences on mental health (DiPlacito-DeRango, 2016). Combined, these approaches provide faculty and staff myriad opportunities to engage in meaningful conversations about mental health. In this way, information is made accessible in multiple formats. That is not to say that mere exposure to information will positively affect dispositions and behaviors. Admittedly, some employees could simply comply, complete training sessions, then not examine and/or change their role in promoting mental well-being on campus. For any training to work, the learner must authentically want to gain new understandings and use this new knowledge to change something for the better. While training focuses more on the individual or particular groups, general awareness campaigns have the potential to reach the masses.

Public information campaigns can increase awareness and work to reduce the stigma of mental illness on campus. Such campaigns can share statistics about mental health issues and provide mental health resources (Pedersen & Paves, 2014; Price, 2015). They not only benefit faculty and staff but also students with and without mental health disorders, especially when intentionally planned and implemented. Publications, forums, and tabling events are typical approaches to advertising services (Asidao & Sevig, 2014; DiPlacito-DeRango, 2016; Murphy & Baines, 2015). Such strategies reach a limited pool of students. Attention needs to be paid to all members of the campus community, including graduate students, commuter students, and online students. Due to their specialized study located in an isolated part of campus or their primary residence off campus, these students may not see traditional marketing campaigns (Oswalt & Riddock, 2007). To reach the broadest audience, additional tools like websites, online modules, and mobile phone apps can be used to disseminate information and provide services to support mental health (DiPlacito-DeRango, 2016; Murphy & Baines, 2015).

Many members of the campus community (students, faculty, and staff) have poor mental health literacy. As a result, students are not likely to pursue services and faculty and staff are less prepared to make student referrals for services. If an overarching goal for IHE is to positively affect mental health, or flourishing, then campuses should create cultures that cultivate acceptance and awareness. Increased mental health literacy is an important part of the solution. Yet knowledge alone is not enough to reduce the number of acute mental health crises on campus. Knowledge should be accompanied by action.

Applying Newly Acquired Knowledge of Mental Health Issues

There are multiple ways IHE faculty and staff can apply what they have learned about mental health in small-group and large-group settings. Such interventions range on a continuum from low-intensity to high-intensity and can be implemented by a single faculty member or a group of specialized staff. In the following section, I will discuss curriculum adjustments, face-to-face interventions, and online interventions that are associated with college/university student mental health. These strategies can be applied by faculty and staff in all academic programs across campus.

Engaged Learning

Civic engagement, as mentioned previously, is a predictor of college student mental health (Fink, 2014). Higher levels of civic engagement are associated with flourishing. Across campus, such engagement can be promoted through Living-Learning Programs (LLPs). As defined in the *National Study of Living-Learning Programs* report, LLPs are "programs that involve undergraduate students who live together in a discrete portion of a residence hall (or the entire hall) and participate in academic and/or extracurricular programming designed especially for them" (Inkelas, Brower, Crawford, Hummel, Pope, &

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Zeller, 2004, p. I-1). In these settings, students have opportunities to regularly collaborate with peers, faculty, and community members on specialized projects. Each LLP is designed around a common theme and typically includes community engagement. In addition to campus-wide initiatives like LLPs, civic engagement can be fostered in individual courses.

In the college classroom, engaged learning has been associated with student mental health and well-being (Swaner, 2007). The concept of engaged learning is often used in two distinct, though not entirely separate, ways. First, it draws from experiential learning theory, where the individual interacts with the environment and actively co-constructs shared meaning. In this way, the individual is actively involved in or "engaged" in his/her learning (Swaner, 2007). Second, it is associated with civic engagement, where students participate or are "engaged" with communities. Such engagement occurs on multiple levels, including local, regional, national, international, and global spheres. It has mutual benefits for private life and public life, both preparing students for citizenship in a participatory democracy and enhancing the community (Swaner, 2007). Common models of engaged learning include service learning, community-based research, collaborative learning, and problem-based learning (Swaner, 2007). Internships and interdisciplinary co-teaching are other examples. That is not to say, however, that these approaches are prevalent in IHEs. Although research indicates that many of the aforementioned engaged learning pedagogies "enhance learning, increase content mastery, encourage critical thinking, and foster personal development," such learning opportunities are "offered only on a limited and elective basis on most campuses" (Swaner, 2007, p. 20). Engaged learning could be promoted by both departments within Student Affairs and throughout academic departments. At the instructor-level, additional curricular adjustments can be made to enhance and support student mental health.

Curriculum Infusion

In addition to adopting a particular pedagogical framework, faculty can promote college student well-being by infusing aspects of mental health into the curriculum. Here, I borrow Mitchell et al.'s (2012) definition of curriculum infusion: "developing class activities and assignments that introduce faculty and students to mental health topics such as depression, anxiety, eating disorders, or suicide while at the same time focusing on academic content" (p. 25). Major assignments can be scaffolded around mental health literacy and texts about mental health issues can be assigned as required readings (DiPlacito-DeRango, 2016; Savini, 2016). Not all faculty and staff are knowledgeable in this area, so collaboration with qualified personnel is important during all aspects of course design and delivery.

Such curriculum infusion can be thoughtfully merged within numerous relevant disciplines. One university, for example, established partnerships between its Mental Health Awareness Committee and faculty in various academic programs to embed mental health literacy into particular courses. Here, a Visual Studies program used art exhibits to raise awareness about emotional distress, emotional wellness, and resiliency. The Design for New Media class created posters and Public Service Announcements to increase awareness about mental health issues and related campus resources. The Applied Marking Techniques class developed a marketing campaign on behalf of Counseling Services (Mitchell et al., 2012). In each of these cases, topics related to mental health were incorporated to help students achieve course objectives. The study of mental health was not simply a course add-on. Rather, that topic served as a vehicle through which students learned course content and provided service to the campus community through such applied projects. As compared to traditional training programs, curriculum infu-

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sion produced more faculty interest and involvement in mental health promotion (Mitchell et al., 2012). Faculty awareness and action is essential in promoting well-being and in deterring mental health crises.

Faculty can take additional steps to increase mental health literacy in their own courses. They can build-in class time to announce mental health campus-wide events, distribute counseling center information, host speakers on mental health related topics, and include a statement about mental health in their syllabi (DiPlacito-DeRango, 2016; Mitchell et al., 2012; Savini, 2016). Referring to a previous point, faculty can create communities of learners. They can do this by lecturing less and integrating more collaborative projects. They can also promote forums where students talk with each other to reduce isolation, in a way creating support groups (Quinn et al., 2009; Savini, 2016). Such forums could exist in face-to-face courses, online courses, and go beyond the classroom. One university even has a "buddying system" where second-year and first-year students are paired; the returning student offering support to the new student until he/she is acclimated to college life (Quinn et al., 2009). Additionally, faculty can intervene early. Surveying the class, checking-in with individual students, and referring students appropriately are effective strategies to address mental distress (Mitchell et al., 2012; Savini, 2016). Early intervention is more likely to occur when faculty have received training and taken the time to get to know their students. All of these examples demonstrate ways faculty can make adjustments in the classroom to better support student well-being. Beyond curriculum infusion, entire courses can be offered to address mental health issues.

General Course Offerings

Research indicates that general course offerings can be effective in promoting and facilitating mental health on campus. Such courses can disseminate information on campus mental health resources and help students better understand themselves as developing social and emotional beings (Conley, Durlak, & Dickson, 2013; Wood, 2012). Courses can also help students develop generalizable life skills that allow them to face the challenges and stress of college life and learning (Hartley, 2012; Silverman, 2008). These life skills can include, but are not limited to, time management, study skills and habits, self-care, and relaxation (Damer & Melendres, 2011; Hartley, 2012). Such skills can be connected to resilience, "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstance," and protective factors, "the qualities of persons or contexts that predict positive outcomes under high-risk conditions" (Hartley, 2012, p. 38). Resilience and protective factors are positively associated with mental health. Programs that focus on building resilience through skills-oriented approaches are associated with increased self-esteem, self-perception, self-confidence, self-leadership, and prosocial behaviors and related to decreased emotional distress, specifically depression, anxiety, and stress (Conley, Durlak, & Dickson, 2013; Hartley, 2012). Such courses enhance social and emotional development by teaching life skills that will help students be successful in academic and non-academic settings. To be constructive, programming should be both intentionally designed and delivered.

IHE have approached general course offerings to promote mental health in several ways. For instance, a medical school offers a one-semester course entitled "Mind–Body Medicine: an Experiential Elective." The 10-week course meets weekly for two-hour sessions. Students who volunteer to participate are first led through a didactic presentation, covering topics related to physiological responses to stress and ways to cope with stress. Small groups of students are then given the opportunity to practice specific skills related to the concept of the week. Additionally, students are expected to complete homework (physical activity and meditation). Results indicate that this mind-body course reduced participants' anxiety levels

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as students used newly developed skills "to cope more effectively with the stresses of medical school" (Finkelstein, Brownstein, Scott, & Lan, 2007, pp. 262-263).

As another example, a university offers a two-semester course to undergraduate students entitled "Risk and Resilience (R&R) in Urban Teens," which focuses on "mental health promotion, stress reduction, and resilience" (Shatkin et al., 2016, p. 205). Semester One, structured didactically, provides students with theories and practices about stress, stress reduction, and resilience. Semester Two, organized as a service-learning project, provides students the opportunity to apply their newly acquired knowledge by teaching skills and techniques intended to reduce stress to local high school students. Results indicate that, compared to controls, R&R students self-reported improvement in their mental health. "Specifically, they reported less perceived stress, better coping skills, and a reduction in dysfunctional attitudes" (Shatkin et al., 2016, p. 207).

At another IHE, a seminar on psychological wellness was offered to first-year undergraduate students. The seminar occurred weekly for 50 minutes during the fall and spring semesters. It covered a range of topics associated with psychosocial adjustment and stress management. Each seminar contained four elements: didactic instruction, journal writing about experiences and reactions, participation in class activities, and skills practice homework. Results indicate that students benefitted by an increased sense of well-being and by better managing college-related stress (Conley, Travers, & Bryant, 2013). Furthermore, the authors claim that such a course, "by taking a universal approach… can be applied to—or customized for—different campuses, contexts, and special populations" (Conley, Travers, & Bryant, 2013, p. 84). In other words, this model can be replicated throughout IHE and tailored to meet the needs of specific colleges/universities.

Admittedly, there are numerous ways to structure courses for mental health promotion. Such courses vary in size, interventions used, duration, audience, and format (Conley, Durlak, & Dickson, 2013). Taken together, the examples of skills-based courses presented here suggest that the explicit teaching of skills to enhance resilience and build protective factors are effective in enhancing mental health. Courses ranging from one semester to two semesters have been found to reduce stress and anxiety while increasing personal resources to successfully cope with college challenges. Common to the examples included here is an emphasis on both theory and practice. Students were provided conceptual schemes and evidence-based interventions and required to use their newly developed skills. Moreover, students were actively engaged in multiple settings–inside the classroom and outside the classroom (or as some students refer to it, "real life"). This suggests that one's mental status is not necessarily pre-determined or fixed. Students can learn factors that enhance mental health, hone coping skills, and implement effective practices. In this way, students act as agents to positively affect their own well-being.

Additionally, general course offerings could be tailored to two primary populations: new students and returning students. If early intervention is effective in mediating mental health crises, then it stands to reason that programming should be provided as soon as students first arrive on campus, even during orientation. But programming should not stop there. Although one- or two-semester courses have been found effective in helping students learn and apply stress coping interventions presently, some research indicates that they do not necessarily have long-term effects beyond the intervention period (Conley, Travers, & Bryant, 2013; Shatkin et al., 2016). This suggests that one-shot course offerings may need boosters, follow-up seminars, to have enduring usefulness. Furthermore, the models discussed here were offered to students on a volunteer basis. To reach a broader audience, IHE may include similar courses as part of the required coursework for all majors. In this way, such proactive and preventive interventions

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become "systemic in higher education" as they are "integrated into the routine structure and programming of higher education institutions" (Conley, Durlak, & Dickson, 2013, p. 297).

Mindfulness Training

In addition to skills-based interventions, mindfulness-based interventions have been found effective in promoting mental well-being. Here, I use mindfulness to mean "the awareness that emerges through purposefully paying nonjudgmental attention to present moment experiences" (Bergen-Cico, Possemato, & Cheon, 2013, p. 349). One example of such training is Mindfulness-Based Stress Reduction (MBSR). Students participate in discussions about meta-cognition and the mind–body–psychological connection; they also practice multiple types of meditation and guided body scan (Bergen-Cico et al., 2013). Upon completion of this training, students reported significant levels of improvement in mindfulness and self-compassion, two measures of psychological health. Likewise, a Mindfulness-Based Stress Management (MBSM/Mindful-Gym) program produced positive results regarding mental health. Training included didactic and experiential methods which were "designed for students to pay attention to the present moment, relaxing moments, and grateful moments in life" (Phang, Mukhtar, Ibrahim, Keng, & Sidik, 2015, p. 1118). Results indicate that students benefitted from reduced perceived stress and mental distress and increased mindfulness and self-efficacy. In a modified MBSR program, participants were provided information on coping strategies during group sessions and practiced new techniques on their own at home. Results reveal that students receiving MBSR training "increased their use of problem-focused coping," and those students with self-reported "high scores on neuroticism benefitted from the intervention in terms of reduced avoidance-focused coping and an increase in seeking social support" (Halland, deVibe, Solhaug, Friborg, Rosenvinge, Tyssen, Sorlie, & Bjorndal, 2015, p. 388). Each of these measures is associated with mental health.

Mindfulness training can be used in conjunction with general course offerings and/or embedded in courses to promote college/university student mental health. Both are similar in that they incorporate theory and practice, and they have relatively immediate results with positive outcomes reported within weeks or months of intervention initiation. They differ, though, in their duration. While courses can last a semester or two, mindfulness trainings typically last five to 10 weeks. Because mindfulness training is delivered in small groups, over short periods of time, without the expectation of students to disclose personal information, it can be "a relatively cost-, time- and labour-effective intervention" (Phang et al., 2015, p. 1128).

Online Interventions

Thus far, discussion has focused on campus-based interventions, as in those courses or seminars delivered by faculty and staff in a face-to-face format. This delivery method pertains to "traditional" college students and overlooks "online" students. As our society continues to embrace technology, the number of "distance learners" will likely grow. Students taking mostly online courses may benefit from a different approach to mental health promotion.

Technology has been found effective in promoting mental health awareness and as a vehicle for intervention (Asidao & Sevig, 2014; Barr, 2014; Hintz, Frazier, & Meredith, 2015; Koydemir & Sun-Selisik, 2016; Wood, 2012). IHE websites can serve as repositories of information on mental health education and available campus and electronic services. MiTalk is one such example. It is an "interactive, multimedia

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Web site" that provides students "with knowledge and skills to get help or to help friends who may be in distress because of depression, anxiety, social identity, trauma, stress management, or other mental health concerns" (Asidao & Sevig, 2014, p. 137). YouTube and Facebook can also be used for mental health outreach (Asidao & Sevig, 2014).

In addition, technology can support student development through online workshops. Though composition may differ slightly, web-based interventions "often contain psychoeducation delivered via text, video or audio, assignments, and personalized feedback" (Hintz et al., 2015, p. 138). One university offered a 4-module training via Google sites focused on common college stressors and past, present, future control theory. Each module consisted of a narrated presentation, student examples, and application exercises. Upon workshop completion, participants who practiced present control reported less perceived stress and reductions in anxiety and depression (Hintz et al., 2015). As another example, an 8-week online intervention focusing on strengths and goals, emotion regulation, pro-social skills, problem-solving and decision-making skills, and motivation was offered to first-year students at another university. Participants who completed the 5-module training (including both didactic and experiential components) reported improved well-being in several areas, "namely subjective happiness, life satisfaction, subjective happiness, ontological well-being and psychological well-being" (Koydemir & Sun-Selisik, 2016, p. 440). This suggests that "well-being promotion through technology can be effective in facilitating a flourishing life among students" (Koydemir & Sun-Selisik, 2016, p. 442). Though only two studies are presented here, these results support similar research in the field.

There are many benefits to online mental health resources. They have the potential to reach a large audience, regardless of students' proximity to the college/university, and can be sustained (Barr, 2014; Hintz et al., 2015; Koydemir & Sun-Selisik, 2016). Electronic resources may be more readily accessed by students due to their convenience as they can be used at times that fit students' schedules and allow for user anonymity (Hintz et al., 2015; Wood, 2012). Yet, given that some students are not digital natives or do not have access to adequate technology, digital approaches should not be the only way to enhance mental well-being. IHE should use a multifaceted approach that is inclusive of the diverse student body.

Campus Mental Health Policies

Without a common mission and cohesive procedures, mental health promotion initiatives will likely be sporadic and disjointed. If communicated superficially or to certain individuals (Student Affairs staff rather than Academic Affairs faculty, for example), then useful policy will not be systemic. Rather, it will be implemented in pockets across campus. Such random practices are potentially harmful as they allow students to slip through the cracks. Unfortunately, this is often the case. "Institutionalized, coordinated, and sustainable mental health policies have yet to emerge in post-secondary schools" (DiPlacito-DeRango, 2016, p. 3). Such underdeveloped policies are seen as a barrier to college/university student mental well-being, and as such, a place for reform (Condra et al., 2015; DiPlacito-DeRango, 2016; Murphy & Baines, 2015; Silverman, 2008; Wood, 2012). A unified and comprehensive approach to mental health is desired.

Campus-wide policies should be thorough and clear. They can include guidelines for promoting mental well-being in a preventive manner and specific procedures for responding during mental health crises. Such "student-friendly policies" are seen as proactive, not punitive (Murphy & Baines, 2015, p. 23). It should be clear how the campus will establish policy and review policy. Policy should be regularly evaluated for relevance to the overall mission of the college/university, current application, and usefulness (Condra et al., 2015; DiPlacito-DeRango, 2016; Murphy & Baines, 2015; Wood, 2012).

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Furthermore, policy should be shared with everyone who is responsible for implementing it. Both the "how to" (detailing steps) and the "why to" (garnering buy-in) should be communicated. A policy on paper and not enacted is ineffective. It is recommended that a multi-disciplinary committee convene to create such policy.

Many IHE now have committees of administrators, faculty, and staff who collaborate to establish and review mental health policy. Though common in IHE, these committees may differ organizationally and operationally. For example, such committees go by various names, including the Campus Assessment Team, the Student Behavior Consultation Team, the Assessment and Care Team, the Student of Concern Committee, and many others (Eells & Rockland-Miller, 2011; Prince, 2015). Their mission and purpose also vary. Committees can be divided into three categories: those that focus on student behavior assessment and intervention; those that primarily manage crises; and those that combine both approaches (Eells & Rockland-Miller, 2011). In addition to setting campus-wide policy, these teams can meet to evaluate individual student cases. Through early intervention, such teams review students "who demonstrate behaviors that are disruptive or worrisome," and provide support before problems escalate (Prince, 2015, p. 7). They also engage in a process of "threat assessment," where team members determine if a specific student poses foreseeable danger to him-/her-self or others and decide on steps to address the threat (Bishop, 2010; Eells & Rockland-Miller, 2011).

Committees are unique in other ways. Team responsibilities and composition differ. For example, teams may set policy, communicate policy, manage student cases, foster cross-campus collaborations with other groups promoting wellness, and/or train and support academic departments (Eells & Rockland-Miller, 2011; Murphy & Baines, 2015). Membership may include representatives from counseling services, student discipline office, campus safety, health services, academic affairs, student disabilities office, legal counsel, athletics, Greek life, and/or faculty (DiPlacito-DeRango, 2016; Eells & Rockland-Miller, 2011). Teams have case review procedures, documentation procedures, and referral sources, yet these factors may be actualized differently from IHE to IHE (Eells & Rockland-Miller, 2011). Regardless of these differences, all teams share the common goal of promoting mental health on their campus. This goal remains important as the prevalence of mental illness in college/university continues to rise. Policy-setting and -enforcing committees are important in addressing this issue as they "provide a venue for making caring, well-reasoned, and appropriate decisions about students" who may be in experiencing mental distress (Eells & Rockland-Miller, 2011, p. 22).

Yet campuses are not alone in this endeavor. Numerous mental health resources in the local and broader communities exist. IHE can work with these agencies to enhance mental health promotion on campus. National organizations and commercial services, such as the following, can be of use: The JED Foundation (Barr, 2014; Hoover, 2003; Silverman, 2008; Wood, 2012); Campusblues.com (Hoover, 2003); Active Minds on Campus (Hoover, 2003); Center for the Study of College Student Health (Wood, 2012); Mentality (Wood, 2012); The Mental Health and Wellness Association (Wood, 2012); The Suicide Prevention Resource Center (Silverman, 2008); The American Association of Suicidology (Silverman, 2008); The Garret Lee Smith Memorial Act (Silverman, 2008); and The Historically Black Colleges and Universities National Resource Center (Silverman, 2008). The aforementioned agencies serve as examples and do not constitute a comprehensive list. They are meant to be used as potential resources, starting points, for IHE looking to strengthen mental health policies on campus.

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CONCLUSION

If flourishing, as Keyes (2005 & 2007) presents it, leads to a good life, then IHE ultimately should provide students the knowledge, skills, and opportunities to flourish. This occurs not only in the absence of mental illness but with numerous factors associated with mental health, not the least of which are self-knowledge, a sense of belonging, and engagement. Today, the prevalence of mental illness on college/universities campuses is growing. Such mental health challenges prevent college/university students from flourishing. Wait-to-fail models where mental health services are provide after a serious event occurs are antiquated. They neither support the student in crisis nor the campus community. Current scholars in the field call for new initiatives, initiatives that promote mental well-being and prevent mental distress on a systemic level (Bertram, 2010; Conley, Durlak, & Dickson, 2013; Hartley, 2012; Hunt & Eisenberg, 2010; Murphy & Baines, 2015; Swaner, 2007; Wood, 2012). The responsibility for creating campuses where students can flourish is no longer the sole domain of counseling centers or student health services. This requires comprehensive, integrated policies and the collaboration of all stakeholders.

This chapter focused on strategies for college/university faculty and staff who do not have extensive knowledge or experience in fields related to mental health. It described several best practices, such as building community, gaining mental health literacy, and adjusting academic curriculum that are effective in promoting mental health. These initiatives can be instituted throughout and across departments with relative ease. Often, such initiatives do not require large amounts of money, time, or effort. They do, however, require support from all campus members. "Effective and creative intervention [is] imperative" (Bertram, 2010, p. 33). Students are best served by a "multidimensional approach that combines short-term therapeutic services with educational outreach, community support, and infrastructure for student empowerment" (Bertram, 2010, p. 33). In this way, "the campus is not made a treatment facility, but instead offers the tools for students to understand and negotiate the emotional, psychological, and intellectual components of these issues" (Bertram, 2010, p. 33). A concerted and effort and innovative approach to mental well-being is essential as IHE move forward.

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Chapter 37
Activism and College Student Mental Health: A Wellness Perspective

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ABSTRACT

Activism on college campuses in the United States is a long-standing phenomenon rooted in the counter-culture movements of the 1960s. Today, local, regional, and national issues and sociopolitical influences remain closely aligned with activism in higher education, with contemporary issues shaping student activism efforts on campus. College student activism ranges from organized marches and protests to more widespread social media campaigns, targeting issues ranging from inclusion and diversity to sexual assault and intimate partner violence. Involvement in activism can influence the mental health and overall wellness of college students who engage in these activities. This chapter focuses on contemporary activism in higher education, specifically as related to the potential impact of activism on the mental health and wellness of college student activists. Also discussed are implications for student affairs professionals, university-based mental health professionals, and higher education administrators.

ACTIVISM AND COLLEGE STUDENT MENTAL HEALTH: A WELLNESS PERSPECTIVE

In higher education, student activism has served as a driving force for boosting inclusivity and democracy on campus (Cabrera, Matias, & Montoya, 2017). The organization of students toward a common social goal is the backbone of activism (Barnhardt. 2014), with objectives typically reflecting the current sociopolitical climate (Lantz, Fix, Davis, Harrison, Oliver, Crowell, & Mitchell, 2016). Through power in numbers, students express a collective voice to influence positive changes on a campus (Rojas, 2006).

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Three primary objectives are associated with the current chapter: an overview of contemporary student activism in higher education will provide context to the complex nature of student involvement in activism, particularly as related to individual identity development and personal experiences with discrimination and oppression. Second, the relationship between involvement in activism and mental health will be discussed, with a focus on the application of an empirically-supported wellness model. Finally, suggestions will be provided to campus officials for fostering and supporting student activist efforts in higher education.

BACKGROUND OF THE DISCUSSION

Contemporary Student Activism in Higher Education

Path to Activism

In examining the trajectories of activism in higher education, it is clear that student involvement in activism often reflects their personal experiences with marginalization, oppression, and/or exclusion (Rhoads, 1997; Kimball, Moore, Vaccaro, Troiano, & Newman, 2016). Student activist causes have ranged from campus racial integration in the 1950's and 1960's (Caple, 1998) to inclusivity and safety for LGBT students in present day (Santos & VanDaalen, 2017). Scholars suggest that the socialization process for activism occurs early in life, and that many college students learn to become activists from parents, other early influencers, or possibly from painful personal experiences (Kimball et al., 2016). Students personally touched by issues such as racial discrimination, sexual assault, or potential deportation are often driven by their painful experiences toward collective action to address social and political inequalities, and to perhaps seek self-healing through their involvement.

Impact of Identity

The demographics of student activists have shifted with national trends in college student demographics. Compared with students half a century ago, the average contemporary college student is more likely to be a female, racial minority with a family to support, all of which can reflect novel stressors on student activists (Ruff, 2016). The historical notion of the typical college campus as an ivory tower for the elite is no longer accurate, and in fact, is imperative to abandon (Ruff, 2016). As college campuses in America become more reflective of societal demographics as a whole, it becomes critical to examine trends in college student activism through the lens of the multifaceted and intersecting identities held by the average contemporary college student.

One important objective in higher education entails facilitating students in developing an orientation toward activism (Gurin, Dey, Hurtado, & Gurin, 2002). Activism can serve as a developmental learning tool, providing students with the opportunity to engage in the democratic process on campus (Biddix, 2010). Student involvement on campus contributes to increased retention rates, as well as stronger academic performance and overall satisfaction with the college experience (Webber, Krylow, & Zhang, 2013). Activist causes can serve as a means of campus involvement that may be personally meaningful to the student. Scholars have expressed that activism is often driven by a greater sense of purpose, which develops in late adolescence. Purpose entails a drive to reach objectives that transcend the self, and may

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be of greater benefit to society as a whole (Damon, 2008). Some researchers have asserted that a sense of purpose, like activism, is an essential outcome of the college experience (Chickering & Reisser, 1993). In essence, utilizing activism as a change agent may also provide students with a sense of purpose and meaning (Kimball, Moore, Vaccaro, Troiano, & Newman, 2016), further contributing to their personal, and perhaps professional, identity development.

The literature is ripe with examples of activism affecting identity for students in higher education. For instance, many college students with disabilities grew up surrounded by the activist efforts of their parents/guardians in explaining their disability to others to initiate greater visibility and understanding, in addition to securing the appropriate accommodations at each educational level. Those with a more empowering approach to parenting likely also taught their children with disabilities how to self-advocate, which may shape the activist involvement of these students once they arrive on a college campus (Kimball et al., 2016). To cite another example, many students identifying as DREAMers (Development, Relief, and Education for Alien Minors) become activists in the undocumented student movement, often resulting in a deeper sense of personal and political identity. "Creating and sustaining an empowered undocumented identity allowed DREAMers to project their sense of self beyond the bounds of their legal status and confirms the power of their activism" (DeAngelo, Schuster, & Stebleton 2016, p. 227). Similarly, the intersectionality of marginalized identities for many Black and Brown college students may serve to impact identity as an activist, with these students seeking involvement in movements that offer voice and visibility to issues directly affect sense of self, such as Black Lives Matter (Logan, Lightfoot, & Contreras, 2017). As an example of activism intersecting with identity beyond the undergraduate level, Graduate Students Talk (GST) is a collective of student leaders who are pursuing graduate study in psychology, with a strong focus on activism and social justice (Lantz et al., 2016). Members of GST largely endorse a sense of personal and professional identity as driving their decision to join this organization, with several students citing a broader connection between their clinical work, research, and involvement in activism (Lantz et al., 2016). Regardless of the particular cause or the educational level of the student, activists in higher education often experience the inextricably intertwined nature of the personal and political, often influencing overall identity development.

The Many Forms of Activism in Higher Education

Students seeking involvement in activism in higher education typically do not have to look far for opportunity. Activist activities on campus can range from organized protests and marches, (e.g., recent marches for Black Lives Matter; the Women's Marches after the 2016 presidential election) to online activism (e.g., sharing a link to a powerful video or article; promoting activist groups/activities on personal social media pages). Student involvement in activism can be peripheral or central to their day-to-day lives, and may depend upon individual views about how activism is defined.

Researchers in one qualitative study examined how Black and Brown students at a Primarily White Institution (PWI) defined activism on a continuum, ranging from activism in the form of simply being present on campus, to activism being all-consuming in the lives of students (Logan et al., 2017). These scholars outlined five forms of activism. First, *existence as resistance activism* simply entails minority student visibility at a PWI, particularly when the campus climate is perceived as hostile toward minority students. Second, *social media activism* capitalizes on modern technology in the form of Facebook, Twitter, individual blogs, and similar forms of electronic activism, and was described by students as a more accessible path to activism. Third, *intellectual/educational activism* involves facilitating others

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in becoming more aware of current issues, and developing others as critical consumers of information. Fourth, *front line activism* flies in the face of social media activism, and demands a physical and hands-on approach (e.g., protests and marches), including the personal discomfort and sacrifice that oftentimes accompany such approaches. Finally, *activism consumes life* is self-explanatory, and applies to students who define their identities and actions almost exclusively in the activism realm (Logan et al., 2017). Outside of this particular study, the primary categorization of student activist activities in the literature seems to be whether social media plays a role. In the sections that follow, the intersection of social media and student activism will be discussed in greater detail, as this issue predominated much of the current literature.

Champions of Social Media Activism

Social media touches most aspects of contemporary life in the United States, including student activism in higher education (Cabrera et al., 2017). Some scholars herald social media as a critical tool for many objectives of activism, including disrupting power dynamics, building communities, and raising awareness about issues on campus (Linder, Myers, Riggle, & Lacy, 2016). Social media platforms often serve as an organizing tool in contemporary student activism in higher education (Biddix, 2010), and as a result, an internet presence is typically a component of most student activism (Cabrera et al. 2017). "If social justice is the overall goal, then online activity can and needs to be one component of this strategy" (Cabrera et al., 2017, p. 411).

Social media activism (also referred to as digital activism or cyberactivism) has emerged as a tool of choice for many students to share their stories and to reach audiences that might otherwise be inaccessible (Linder et al., 2016, Lantz et al., 2016). For example, participants in a recent qualitative study discussed the bias of media outlets in covering college sexual assault cases. These students argued that media coverage typically focuses on attractive, White, middle-class women, and largely excludes victims who do not fit this prototype. Participants asserted that social media provides both visibility and an emotional outlet for the many diverse faces of sexual assault, and allows both victims and advocates to directly criticize the media for failing to address the intersection of privilege and identity with sexual assault (Linder et al., 2016). As an activist response to the pervasive nature of sexual assault among college students, the group *Know Your IX* (www.knowyourIX.org) was founded in 2013 with the objective of empowering students to end sexual violence in schools. This political advocacy group allows like-minded activists and supporters to join forces digitally, and to experience the validation and strength in numbers that might otherwise be inaccessible without the use of online media platforms (Linder et al., 2016).

In addition to sexual assault, social media has provided widespread visibility to a variety of other student activist causes, such as the Occupy Movement and Black Lives Matter (Lantz et al., 2016). Interestingly, neither movement originated in higher education, but both quickly spread throughout a large number of college campuses via social media, ultimately resulting in a more open dialogue about income inequality and racial injustice (Cabrera et al., 2017). In sum, through challenging the idea that activism must entail a physical presence through protests or marches, both researchers and activists have opened the door to a variety of mechanisms through which students can make their voices heard. Some scholars have asserted that social media transcends the boundaries of power and privilege, providing visibility to students who may otherwise remain in the shadows due to lack of time or resources (Linder et al., 2016).

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Critics of Social Media Activism

Although scholars and students alike sing the praises of online platforms for increasing the visibility and accessibility of student activist activities, social media activism is not without critics who assert that activism exclusively through online mechanisms is akin to slacking, or taking the easy way out. The term *slacktivism*, coined less than a decade ago, is defined as "political activities that have no impact on real-life political outcomes, but only serve to increase the feel-good factor of the participants" (Christiansen, 2011, p. 1). As a more concrete example of this criticism, the number of activists donating money to support a given cause on social media is typically a very small fraction of the number of slacktivists heralding their "support" for the same cause in the form of likes or retweets (Morozov, 2009; Cabrera et al. 2017). Perhaps ironically, the more public the act of slacktivism, the lower the likelihood for more meaningful activism efforts to follow (Kristofferson, White, & Peloza, 2013). In this sense, the primary criticism entails slacktivists utilizing social media activism as a means of personal impression management (curating a particular online image) rather than authentic passion for social change.

In spite of some of the more scathing critiques of social media activism and its effects (or lack thereof), some scholars have noted that the line between activism and slacktivism is vague at best, and that mass slacktivism may now be an important component of activism (Cabrera et al., 2017). In other words, slacktivism and activism may frequently go hand-in-hand, with slacktivism serving as a launch pad for more traditional forms of activism (Jones, 2015). For every argument that slacktivism is synonymous with political ineffectiveness (Christiansen, 2011), and individual gratification (Kristofferson et al., 2013), there is a counterargument for the widespread visibility that social media activism provides (Vie, 2014). For example, Facebook users en masse have demonstrated their support for LGBTQ equality by applying a rainbow filter to their profile pictures, serving to highlight the widespread prominence of LGBTQ issues. Such awareness campaigns can lay the groundwork for future activism in the form of lobbying, raising money (Vie, 2014), or perhaps visibility as an ally at campus events such as Pride. Counter to the aforementioned argument regarding impression management, perhaps social media activism serves as an important tool for communicating the role of activism in individual identity.

In sum, the arguments for and against the use of social media activism are complex, but largely positive, particularly when the notion that online activism can spearhead in vivo activism. One additional arm of this topic entails the impact of social media on mental health, which bears mixed findings in the literature. In spite of criticisms that social media use contributes to mental health and self-esteem issues for young adults (Chen & Lee, 2013), other scholars have demonstrated the benefits of social media, noting higher levels of perceived social support, more favorable relationships with family, and overall greater wellness (Asbury & Hall, 2013). Social support and wellness, in addition to visibility and fighting for social reform, seem to be influential factors for college students who seek involvement in activism on campus. In the section that follows, the impact of activism on college student mental health is discussed in greater depth.

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MENTAL HEALTH CONSIDERATIONS

Activism and Student Mental Health

Mental health issues among college students are certainly not a new concern. According to a large annual survey of staff at university counseling centers, students struggle with disorders related to anxiety and depression most frequently (Center for Collegiate Mental Health, 2016). At PWIs, both Black and Latinx students report greater social isolation and depression than do White students (Ancis, Sedlacek, & Mohr, 2000). Coupled with a lower likelihood of seeking mental health treatment due to cultural stigma, many minority students are at a heightened risk of incurring negative mental health consequences (Gonzalez et al., 2005). Activism by definition is a quest for social change, and often focuses on groups historically silenced by society. Many students are compelled to become activists due to the climate on their campus (Logan, Lightfoot, & Contreras, 2017). Student experience of oppression or discrimination in some capacity often correlates with involvement in activism (Breslow et al. 2015; Logan et al., 2017).

THE PERSONAL IS POLITICAL

College students often find themselves drawn toward activism and protest as a result of feeling marginalized (Ruff, 2016; Logan et al., 2017). For example, two recent movements that have predominated student activism in higher education are Black Lives Matter (BLM) and Deferred Action for Childhood Arrivals (DACA). Researchers examined Black and Latinx involvement in both movements, and found that Latinx students were more likely to become involved in both causes when they had previously been the target of racial microaggressions. Prior political involvement predicted activism in BLM for Black students and in DACA for Latinx students. Additionally, both Black and Latinx students exhibited greater involvement in BLM than in DACA, presumably due to the larger social media presence of BLM (Hope et al., 2016). Researchers concluded that particularly for Latinx students, involvement in political activism serves as a positive coping strategy against experiences of discrimination (Hope et al., 2016).

Similarly, there has been a rapid influx of activism by undocumented college students in recent years for a variety of reasons, including negative mental health outcomes (Teranishi et al., 2014), discrimination and microaggressions (Kim & Diaz, 2013), and lack of resources to facilitate access and success in higher education (Nora & Crisp, 2009). Activism allowed undocumented students to band together to work toward equal rights in higher education, and achieve a strong collective identity in the process, serving as a protective factor for mental health (D'Angelo, Schuster, & Stebleton, 2016).

In a related example, members of the aforementioned activist group for psychology graduate students, Graduate Students Talk (GST), noted that part of their reason for becoming involved in this organization was to process difficult emotions arising from ongoing incidents of police brutality against black men (Lantz et al., 2016). The opportunity to converge with other like-minded graduate students to create a safe space for processing anger, disappointment, and hopelessness, as well as a commitment toward action for change, motivated many students to join GST (Lantz et al., 2016). To reiterate, activism may serve as one means of rallying against oppression, and is therefore a means of coping with the negative effects of discrimination (Santos & VanDaalen, 2017).

The degree to which activism fulfills the role of coping strategy seems to be dependent on the type of activism (low versus high risk) with the latter more strongly associated with physical, social, legal, and

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potentially financial consequences (Santos & VanDaalen, 2017). Given that the purpose of activism often entails challenging status quo power structures, risk serves as one of the primary distinguishing factors between student slacktivism (likely low risk) and student activism (potentially high risk) (Cabrera et al. 2017). Any kind of activism entails some degree of civil disobedience (Rojas, 2006), which exposes college students to varying degrees of personal risk. When personal risk becomes a chronic stressor, anxiety, as well as depression and hopelessness, can be an outcome for student activists.

MISPERCEPTIONS OF STUDENT ACTIVISTS

Complicating the matter of risk associated with activism involvement is the recent mischaracterization of many student activists (e.g., those standing against racial inequality) as attempting to restrict free speech (Halewood, 2016). Researchers have posited that some of the language associated with contemporary activism (e.g., microaggressions, safe spaces, trigger warnings) causes others to perceive that they are being told to what to say and what not to say, often resulting in mocking or trivializing activists and their efforts as a form of backlash (Halewood, 2016). Critics of progressive student activism in higher education often fail to grasp the reality that targets of microaggressions often experience perpetual exhaustion from a daily onslaught of ignorant comments, which can impede not only their experience in college and academic performance, but also their mental health and wellness (Halewood, 2016). We often struggle to respect what we do not understand, or that we misunderstand.

Student activists often become the target of criticism from anonymous voices online, labeling their advocacy for necessities such as safe spaces and access to mental health services as unnecessary grumbling (Ruff, 2016). The irony is that such criticism emphasizes the initial motivation to engage in activism: raising social consciousness and striving toward change. Activism cannot exist without the dichotomy of both hope and agitation (Cabrera et al., 2017). Sparking agitation in others often drives the unpopularity of many activists (Bashir et al., 2013). Even if they are able to dodge critique from others in their immediate surroundings, college student activists may experience emotional wear-and-tear from the necessity of chronically explaining their efforts and attempting to educate those who may not understand their motivations and objectives (Ruff, 2016). Additionally, balancing traditional academic demands with engagement in student protest groups can be a challenge for many. Researchers have outlined several detrimental physical impact of activism on college students, such as decreased appetite, decreased sleep, and overall exhaustion (Ruff, 2016). In light of the toll that activist involvement can take on contemporary college students, examining their means of support becomes critical.

SUPPORTING STUDENT ACTIVISTS ON CAMPUS

Researchers have called into question the role of universities in providing support to students engaged in activism, particularly given the chronic stress that often accompanies student protest (Ruff, 2016). Student activists, often from underrepresented groups, have asserted that university officials remain largely unaware of the time commitment and emotional reserves required to engage in activism outside of the classroom (Ruff, 2016). Although counseling services exist on most college campuses, minority students commonly seek counseling and support from professors or student organization sponsors with similar backgrounds under the assumption that staff at campus counseling will not understand their

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motivations and experiences in campus activism causes (Ruff, 2016). Additionally, students engaged in campus protests and other forms of activism have heralded the importance of social support and encouragement from fellow activists as a primary avenue for self-care (Ruff, 2016). Fellow student activists not only carry a deep understanding of one another, but also offer camaraderie and support in the ongoing fight for social change.

STUDENT ACTIVISM THROUGH A WELLNESS LENS

To reiterate, depression, anxiety, and other forms of emotional and psychological distress are common among college students (American College Health Association [ACHA], 2013; Castillo & Schwartz, 2013) and negatively correlated with academic performance and retention (Eisenberg et al., 2009). Campus counseling centers serve only a small minority of students who could benefit from professional mental health services (Castillo & Schwartz, 2013; Zivin, et al., 2009). These realities indicate the necessity for preventative mental health initiatives on campus, particularly for more vulnerable populations such as student activists. A holistic approach is essential to fostering the wellness and sense of balance for student activists in light of the variety of roles they fulfill as a student, an activist, and more broadly, as a productive member of society.

As individuals, each activist draws from and applies their own unique set of strengths to their work, while the collective strengths of the group merge to add depth and structure in the battle for societal change. As such, it is imperative for student activists to have self-awareness of the unique strengths and assets they bring to the table to help the greater group. This holistic, strength-based perspective is the essence of the counseling-based wellness approach. Wellness is "a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully" (Myers, Sweeney, & Witmer, 2000, p. 252). Although attending to student wellness is a noted goal of higher education institutions (LaFountatain, Neisen, & Parson, 2006), early efforts centered almost exclusively on academic and retention concerns (Isaak, Graves, & Mayers, 2006; Hermon, 2005). In more recent years, scholars have begun investigating the wellness of specific college student populations (Watson & Kissinger, 2007; Gieck & Olsen, 2007; Young, Turnage-Butterbaugh, Degges-White, & Mossing, 2015). Although the wellness of college student activists remains unexplored, many of the principles of the evidence-based Indivisible Self Model of Wellness (IS-WEL; Myers & Sweeney, 2005) apply to student activists (see *Figure 1*). A brief overview of this model is outlined in the section that follows.

Indivisible Self Model of Wellness

The IS-WEL is a holistic, strengths-based model with a higher order factor defined as *Total Wellness*. This factor underscores the importance of considering the totality of the activist's individual strengths. *Total Wellness* is divided into five second-order factors: *Creative Self, Coping Self, Physical Self, Social Self, and Essential Self.* Within the second-order factors are seventeen distinct third order factors that align with Adler's (1954) basic life tasks of work, friendship, love, self, and spirituality (Myers & Sweeney, 2005). This strengths-based, multidimensional view of wellness holds promise for measuring the overall wellbeing of student activists, as well as individual strengths (through the lower order factors) they bring to the activist stage.

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Student activists may seek activism due to strong traits within the *Essential Self*, which encompasses "our essential meaning making processes in relation to life, self, and others (Myers and Sweeney, 2008, p. 86). Within the second-order *Essential self* are several third order strengths relating to comfort with spiritual beliefs, cultural identity, and orientation toward self-care (see *Figure 1*). These factors may drive the initial choice to become involved in activism, and may determine the level of activist involvement. For example, a student activist possessing the strength of *control* may choose to use their strengths behind-the-scenes as an event organizer. Alternately, a student activist with a strength in *friendship* may use their abilities to connect in a meaningful way with members of their community, and/or to work directly with campus administrators and student affairs professionals in gaining the necessary permits for an activist-related event on campus. Another student with a strength in *thinking* might design event posters and other social media marketing strategies. These examples are consistent with *intellectual/educational*, *front line*, and, to a limited degree, *social media activism* (Logan et al., 2017), and illustrate how personal strengths (alone or in combination with the strength of others) may be instrumental in a student's perception their role in activism, as well as their degree of engagement in activism.

The IS-WEL's strengths-based approach holds that student activists may possess strengths across multiple wellness dimensions. The wellness model posits that everyone possesses strengths, some of which may be unrealized, under-utilized, or under-developed. Overall, the holistic wellness paradigm as framed by the IS-WEL can provide an evidence-based, detailed profile of subjective sense of wellbeing. Implementing this model in higher education may allow researchers to gain insight about how activism could influence a student activist's perceived wellness, while uncovering potential links between specific wellness traits and college student activists (e.g., the specific activist roles best suited for each individual activist). This shift in perspective honors and promotes college student involvement in activism, as opposed to criticizing or quieting student efforts for social change, meeting the aforementioned higher education objective of fostering an orientation toward activism (Gurin et al., 2002). Several recommendations for working toward this objective are outlined in the section that follows.

SOLUTIONS AND RECOMMENDATIONS

Recommendations for Designing Curricular and Co-Curricular Experiences

Mission statements for most institutions of higher education include some level of commitment to both diversity/inclusion, as well as service to others (Hope et al., 2016). As such, increasing the availability of service-learning courses that infuse social justice into the general education curriculum could serve as a powerful intervention for indirectly supporting college student activists. Similarly, living learning communities can provide a meaningful opportunity for students to be surrounded by a diverse group of their peers who share common academic interests. Powerful experiences such as these, which intentionally expose students to issues that are impactful for segments of the student body (Hope et al., 2016), facilitate not only visibility of many activist issues, but also transparent and corrective dialogue around more difficult topics.

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Recommendations for Diversity-Related Campus Programming

For many college students, particularly those from more homogenous and/or rural areas, their first exposure to diversity comes with their first steps onto their college campus. Many students may have a vocabulary peppered with words or phrases they may not realize to be offensive; others may lack basic skills in respectful communication and academic discourse; even students identifying as activists may approach their work in ineffective ways that lead to administrative penalties. As such, student affairs professionals in counseling or diversity offices may do well to offer best practices workshops (which could perhaps also be integrated into required coursework) on respectful communication, as well as appropriate mechanisms for engaging in activism to avoid sanctions from university administration (Hope et al., 2016). Making such information readily available may serve to circumvent much of the tension between student activists and campus officials.

Recommendations for Campus Officials

Many college student activists are quite young, with some not yet reaching adulthood. The courage and determination exhibited by young activists in asserting themselves with upper level administrators, and/or in the face of a hostile campus environment, is commendable (Hoffman & Mitchell, 2016). When examined through the lens of exposing novel methods for pursuing social change, and giving a voice to those who are silenced, it becomes quite clear that university officials (including faculty, staff, and upper administration) can learn a great deal from new wave young activists on campus (Halewood, 2016; Hoffman, & Mitchell, 2016). As such, campus officials are encouraged to maintain an attitude of curiosity and openness toward student activists. Existing literature highlights that it is imperative for "…faculty, staff, and administrators to create an activist friendly environment, and engage in advocacy work themselves for purposes of modeling, education, and to signal support and safety to students" (Lantz et al., 2016, p. 303). Taking this one step further, it is important for faculty to invite and embrace diverse student perspectives in the classroom, creating a safe environment for academic discourse that may challenge both students and faculty to adopt novel perspectives (Martin, 2014). Faculty who work more directly with students may also fill the role of facilitating access to upper administration, as students are often unfamiliar with the proper channels and hierarchy of communication (Linder et al., 2016). Moreover, campus officials would do well to maintain an awareness of current events on social media in order to anticipate and reduce potential harm to students (Linder et al., 2016). Administrators can keep abreast of student issues "…by observing public social media spaces where minoritized students are sharing their concerns" (Linder et al., 2016, p. 241).

Recommendations for Improving the Activist-Administrator Relationship

Student activism requires that higher administrators and student affairs professionals attend to a host of interpersonal, logistical, financial, legal, and media concerns (Harrison & Mather, 2017). The increased numbers of activist-related events on campus, coupled with and the uncertain and omnipresent role of social media (Brazelton, Magolda, & Renn, 2012) serve to complicate this task for many campus officials. In order for administrators to initiate and maintain favorable relationships with student activists, they must cognizant of the many diverse student communities on any given campus; inclusion must be a primary administrative objective. Student activists and administrators may interpret one another's actions

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in negative ways, which may be detrimental to the administrator-student alliance. For example, student activists identifying as minorities perceived administrators as detached from the emotional challenges related to their activism (Ruff, 2016). In the current climate, administrators are advised to resist the urge to use bureaucracy as a shield from conflict or honest engagement with displeased student activists (Clover, 2012). Failure to engage in honest discourse with student activists may only serve to create a further sense of disempowerment, causing each side to become more steadfast in their positions (Biddix, Somers, & Polman, 2009; Hoffman & Mitchell, 2016). Communication and collaboration between administrators and student activists are crucial elements to facilitating positive campus activism outcomes, and administrators are becoming more sensitive to the emotional dimensions of the student experience of activism (Harrison & Mather, 2017). In contrast to recent examples in the media, (Flaherty, 2017, Ruff, 2016) students broadly tend to perceive administrators as capable of effectively communicating with them, while maintaining openness to systemic change (Broadhurst & Martin, 2014).

FUTURE RESEARCH DIRECTIONS

Early trends are emerging that engagement in activism has an impact on the mental health of college students. However, this research appears to be in its infancy, and there are many opportunities for scholars passionate about this topic. In light of the paucity of research on the mental health and wellness of student activists, it is recommended that future investigations focus on the mental health impact of specific types of activism (e.g., social media vs. in vivo) for college students. Intervention studies are indicated to explore the impact of wellness-based programming on the mental health of student activists. In particular, the IS-WEL model may provide a viable framework for higher education professionals in counseling and student affairs through which individual strengths might be isolated and nurtured to boost effectiveness in specific activist roles. This model can also draw on areas for growth in student activists, as many individuals may engage in activism at the expense of other important areas of wellness. Wellness deficiencies are imperative to address for all college students, and perhaps for student activists in particular given the additional stressors that precede and follow their engagement in activism.

CONCLUSION

Student activism in higher education is anything but a new phenomenon. Activists tend to strive toward social change due to the impact of their own experiences, often integrating their activist work into their personal and professional sense of identity. Activism can take many shapes and forms; contemporary student activists often make use of social media to boost visibility of various causes, and to provide a voice to those who are silenced. Involvement in activism can take a toll on the mental health of student activists, and it may be critical to conceptualize the holistic functioning of activists across roles from a wellness perspective. The multifaceted nature of higher education environments requires that all campus stakeholders reflect on their attitudes and potential biases toward both activism and student activists. Such changes can serve as a catalyst for facilitating stronger and more meaningful campus relationships, and can facilitate a deeper understanding of the role student activism in boosting the overall health and wellness of all campus stakeholders.

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KEY TERMS AND DEFINITIONS

Activism: Individual or collective action to effect widespread change in social and/or political realms.
Holistic: Interconnection between parts of the self (e.g., emotional, spiritual, physical, etc.).
Identity: Self-concept related to how one views self and how one is viewed by others.
Inclusion: Opposite of exclusion; refraining from discrimination based on differences.
Slacktivism: Offering support to a social or political cause through primarily digital means.
Social Media: Mechanisms of communication that occur digitally, and with widespread reach.
Wellness: Holistic health and balance in all aspects of the self.

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Chapter 38
Interagency Collaboration to Improve School Outcomes for Students With Mental Health Challenges

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ABSTRACT

Students with significant emotional-behavioral concerns and mental illness tend to experience poor educational and social outcomes. This chapter describes some of the challenges facing schools that are responsible for educating students with and at-risk for mental health challenges. Although some students encounter numerous risks, thereby increasing the chances of developing mental illness and failing school, there are also protective factors that can be identified and harnessed to counterbalance such risks and promote higher levels of resilience. By examining relationships among factors such as poverty, mental well-being, family engagement, resiliency, and school performance, a school-focused, community-based framework is suggested for responding to and overcoming these challenges. This chapter provides practical guidelines for schools, community agencies, and families to work together to support and engage young people who are at-risk for school failure due to emotional-behavioral concerns and mental health challenges.

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INTRODUCTION

Partnerships among families, schools, and communities can be created and harnessed to support academic achievement for students with mental health needs (e.g. Adelman, & Taylor, 2006a; Adelman & Taylor, 2006b; Anderson, 2002; Conwill, 2003). Practitioners and researchers alike are now calling for a broader focus on collaborative efforts in schools and children's social services that include prevention, in addition to targeted early and intense interventions, across child-serving systems (e.g., education, health, child welfare, etc.) (Anderson & Cornell, 2015). The significance of this chapter is that it provides a practical orientation for schools and community agencies to work together, along with families, to successfully engage students, particularly young people who are at-risk for school failure due to emotional-behavioral concerns and mental health challenges. First, the chapter describes some of the challenges facing primary and secondary schools that are responsible for educating students with mental health challenges by examining the interconnected relationships among poverty, mental health, and school performance. The authors then argue that in this field, much of the research base examining academic failure has been limited by focusing on risk factors, often to the exclusion of critically important individual variation within subgroups of children with and at-risk for mental health challenges. While such research has uncovered important risks that correlate with school failure, our narrow attention on risks has reduced our ability to understand how resiliency influences academic and social development.

Once a better understanding of risk and resiliency has been established, the second goal of this chapter is to provide a practical guide for developing interagency prevention and intervention approaches, designed to bring together the entire community resource pool to reduce the number of students who fail in school due to unmet mental health needs. Interagency collaboration has been defined as "the process of agencies joining together for the purpose of interdependent problem-solving which focuses on improving services to children and families…" (Hodges, Hernandez, & Nesman, 2003, p. 292). Current policy implications supporting school-based interagency collaboration also are presented. It is further argued that by using resiliency within a collaborative model consisting of individual, family, community, and school assets, effective pedagogical and social approaches can be applied that allow young people with and at-risk for mental illness to succeed in and out of school. A number of well-known preventative and early intervention models are described. Finally, some specific steps for creating models of interagency collaboration are discussed.

BACKGROUND

Although the relationships between school functioning and mental health challenges are not fully understood (Epstein, Nelson, Trout, & Mooney, 2005), scholars have suggested wide-ranging interactions among school and non-school factors may be at fault, which can include clinical, familial, and environmental variables (Anderson, 2011). Explanations for the poor academic achievement for students with emotional challenges have included (1) poor grades leading to aggression; (2) aggression leading to poor grades; (3) a reciprocal relationship between poor grades and emotional challenges; and (4) other underlying factors that cause both poor grades and emotional challenges (Epstein et al., 2005; Barriga, Dorans, Newell, Morrison, Barbetti, & Robbins, 2002). Adelman and Taylor (2006a; b) described a continuum with causes from environmental factors, causes coming from within the person, and a transactional view caused by an interaction between the environment and the individual.

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STUDENTS WITH MENTAL HEALTH RISKS

In the United States (U.S.), students with mental illness often have been labelled by the mental health community as having *serious emotional disturbances* and/or by schools as having *emotional disabilities*[1] (e.g., Anderson & Mohr, 2003). These terms can encompass numerous other labels and diagnoses such as conduct disorders and emotional-behavioral disabilities. Furthermore, this chapter expands the focus beyond young people with the most significant mental health challenges to also include students who may not be formally labelled but nonetheless are at great risk for school failure due to mental health challenges. While the percentage of young people identified as having significant mental health challenges has been estimated in the 3-6% range, when students who are at-risk are included, this figure increases significantly (e.g., Anderson, 2016). The purpose of taking the more expansive position of including youth who are at-risk is to promote capacity building for models in schools and communities for earlier intervention and prevention of mental illness (Anderson & Cornell & Cornell, 2015).

Overall, the population of students who have or are at-risk for mental health challenges has been documented as failing or risking failure across a wide range of domains, including home, school, and community (see e.g., Bradley, Henderson, & Monfore, 2004). Although researchers have indicated that as much as one-fifth of children in the United States has been diagnosed with a mental health disorder, only a small percentage of them will receive treatment (Rones & Hoagwood, 2000). It is estimated further that more than 40% of the young people experiencing these kinds of challenges will exhibit externalising behaviours aggressive enough to result in school suspensions. It is doubtful that students with serious behavioural challenges are effectively serviced by their schools (e.g., Walker, Ramsey, & Gresham, 2004); thus, the authors argue, schools need additional supports to assist this population of students in succeeding in school.

In fact, poor progress and outcomes for this population of young people has been documented in every school domain, including attendance, achievement, school behavior, social skills such as friendships with peers or relationships with teachers, involvement in extra-curricular activities, secondary graduation, and successful progression to post-high school work or training (Bub, McCartney, & Willet, 2007; Lopes, 2007; Reinke, Herman, Petras, & Ialongo, 2008; U.S. Department of Education, 1998; 2001; Vitaro, Brendgen, Larose, & Trembaly, 2005). Although researchers who study risks and resiliency for youth with mental health challenges advocate for increased focus on modifying negative trends (Edgeland, Carlson, & Stroufe, 1993; Wong, & Donahue, 2002), the continued reliance on using methods that emphasize risks to the exclusion of identifying protective factors may be limiting the growth and development of the field (Anderson, Howland, & McCoach, 2015).

Risk and Resiliency

Risk factors for mental illness can include internal influences, such as biological and psychological risks, as well as external influences like family and community risks (Trussell, 2008). Biological risks include those that can impact the central nervous system and development of the child and can increase the potential that students will have difficult dispositions and poor social and problem-solving skills (Garmezy, 1993; Trussell, 2008). Such difficulties can stem from prenatal damage such as exposure to alcohol, drugs, and/or malnutrition during pregnancy (Trussell, 2008). Psychological factors are described as "individual personality characteristics that are associated with poor future outcomes" (Trussell, 2008, p. 150). Depression, substance abuse, other mental health issues, and ineffective parental role models

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are some examples of psychological risk factors (Reid & Eddy, 1997). These kinds of psychological concerns also appear to be more prevalent in people who experience socioeconomic disadvantages and the consequential environmental stresses (Webster-Stratton, 1990; Webster-Stratton & Hammond, 1998).

The relationships children form with their families and the people around them help develop their personalities and their ability to connect with others (e.g., Anderson & Mohr, 2003). Children who grow up in abusive or neglectful homes may have difficulty forming healthy, loving relationships with others and struggle to regulate their own emotions (Toth & Cicchetti, 2004; Trussell, 2008; Barnett, 1997). Research has shown that those who have difficulty developing healthy relationships are at greater risk for depression and substance abuse (Toth & Cicchetti, 2004). Children who have grown up in abusive environments also may avoid intimacy or displaying emotions and may have higher rates of aggressive behaviour or harming others (Trussell, 2008). Children with these risk factors are almost twice as likely to be arrested during adolescence (Toth & Cicchetti, 2004).

Family difficulties, stressful life events, and community risks such as crime and high levels of poverty, are examples of external influences that can negatively impact students with mental health challenges. Family risks are considered to include those characteristics of a family that can be detrimental to a child's development such as "severe parental conflict, overcrowding within the home, and a parental history of criminal behaviour or psychopathology" (Trussell, 2008, p. 150; Toth & Cicchetti, 2004). Families experiencing significant poverty or economic difficulties may experience higher levels of stress, increasing risks for abuse or neglect due to lack of parental engagement (Baydar, Reid, & Webster-Stratton, 2003). Stressful life events, which cause undue hardship on a family, such as the death of a parent, parental divorce, and surviving a life-threatening experience (Trussell, 2008), can also increase the risks for school challenges. Living in situations of significant poverty can increase exposure to parental stress during infancy. This can lead to emotional dysregulation, which in turn increases children's risks for developing more negative symptoms in elementary school (Essex, Kraemer, Armstrong, Boyce, Goldsmith, Klein, Woodward, & Kuper, 2006).

Risk factors, experienced in isolation or cumulatively, can increase the likelihood of negative or undesirable outcomes in school and other life domains. However, the presence of risk alone does not lead to poor outcomes for all children (Oldfield, Hebron, & Humphrey, 2016). Although greater risk is associated with the likelihood of experiencing negative outcomes, such as school failure (Garmezy & Marsten, 1986; Rutter, 1985; Werner & Smith, 2001), not everyone in a given risk group will fail; nor will all of the members of a specific group experience similar levels of risk. Indeed, when data are aggregated, risk status is not equal for all students with mental health challenges (Anderson, Howland, & McCoach, 2014). Students who are resilient to various risks tend to possess protective factors. For example, Werner and Smith (1992), described five factors or attributes that may reduce the negative influences of risks: 1) having an even temperament; 2) having a positive and meaningful relationship with an adult; 3) having an outside support system to help develop self-confidence; 4) having an interest in one's own future by setting goals and making decisions; and 5) being of average intelligence. Researchers have noted that students who are more resilient may possess certain protective skills, know their self-worth, and/or have had effective parenting (Masten, 2006).

Resiliency also appears better developed when students have parents who are caring, nurturing, and communicate openly with their children (Trussell, 2008). Likewise, scholars have pointed out that schools need to be considered among the most potentially powerful protective factors. Through instructional practices, curriculum, teacher perceptions, social support, and community building, schools can encourage and support resiliency in children (Masten, 2006; Trussell, 2008). Young people come to school with

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a variety of academic, behavioural, and social strengths and needs. In spite of the levels of individual need, attending an effective school correlates with how successful a student will be in school (Masten, 2006). On the other hand, attending under-resourced or ineffective schools can present another set of risks to students' learning and social development (e.g., Chen, Anderson, & Watkins, 2016). The literature examining what it means to be an ineffective school has identified common themes, including a) lack of materials and supplies, b) overcrowded classrooms, c) teachers who are inadequately trained, d) staff turnover, e) high absence rates by students and staff, and f) a highly mobile student population (Trussell, 2008). Therefore, researchers have demonstrated that learning best occurs when healthy, reciprocal relationships exist among families, schools, and communities (Kim, Sheridan, Kwon, & Koziol, 2013).

Legal Support for School-Based Interagency Collaboration

Unfortunately, under-resourced schools tend to have a harder time building and sustaining resiliency in their students (Chen et al., 2016). In the U.S., during the years following the passage of the Federal No Child Left Behind (NCLB) legislation in 2001, it became increasingly clear that the patterns of poor academic outcomes observed in many under-resourced schools were going to be difficult to reverse (Blank, Melville, & Shah, 2003; Dryfoos, 2005; Tagle, 2005). During this time period, advocates called for more and better involvement of families in schools and more support from community social service agencies, especially in schools serving poor and disadvantaged neighbourhoods and populations (Dryfoos, 2000; Harris & Wilkes, 2013). With the U.S.'s recent passage of Every Student Succeeds Act (ESSA), which replaced NCLB in late 2015, some of those same advocates are expressing hope because the new law emphasises authentic family engagement in schools, as well substantive community involvement. According to the National Center for Mental Health in Schools (NCMHS, 2016), ESSA is intended to "(1) significantly improve the academic and developmental outcomes of children living in the most distressed communities of the United States, including ensuring school readiness, high school graduation, and access to a community-based continuum of high-quality services; and (2) provide support for the planning, implementation, and operation of full-service community schools that improve the coordination and integration, accessibility, and effectiveness of services for children and families, particularly for children attending high-poverty schools, including high-poverty rural schools." Moreover, the authors stated that ESSA clearly acknowledges that the coordination and integration of community support services in schools is necessary for overcoming barriers to learning and teaching (NCMHS, 2016). This follows efforts by the U.S. Department of Education (2000) to set expectations for schools to deliver practices that foster mental health well-being. Schools are the ideal environment for students to learn the academic, behaviour, and social skills necessary for developing into healthy young adults (e.g., Anderson, 2016; Anderson, 2016; Powers, 2002).

Supporting Under-Resourced Schools

Scholars have argued that service coordination and integration can help under-resourced schools increase their effectiveness (Anderson & Cornell, 2015; Dryfoos, 1994; 2005). By strengthening family social support networks, interagency collaboration can help to expand opportunities for parents, schools, and agencies to work together. Interagency collaboration also can help increase the interconnectedness of schools and their neighbourhoods (e.g., Coleman, 1988). For example, support for finding stable housing and employment counselling can be offered to parents and caregivers within their children's schools by

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community agencies (Anderson, 2000). Mental health screenings can be provided in schools by clinicians from nearby community mental health centres. Moreover, by providing the organizational framework for schools, communities, and families to work together in creating multi-tiered systems of supports, school-based approaches can provide the kinds of supports necessary to help children and youth with or at-risk for emotional-behavioral challenges succeed in school, while simultaneously supporting youths' families and teachers (Anderson & Cornell, 2015).

Drawing from *community schools* approaches (Dryfoos, 2005) in education and systems of care initiatives in the children's mental health field (Stroul & Friedman, 1986; Stroul & Blau, 2010), contemporary interagency frameworks in schools provide children and their families, as well as teachers and administrators, access to a variety of community supports (e.g., caregiver support groups, behavioral training for adults who work with students) and services (e.g., family case management, therapeutic services, residential treatment facilities) to address the wide range of possible physical, emotional, academic, and social needs students may be experiencing that can interfere with learning (Rones & Hoagwood, 2000). In such a framework, each system, agency, and school commit to operating under a community-wide tiered network or system of support. Partners, including families, collaborate with the goal of supporting individuals, schools, and families, to improve the overall functioning of students with and at-risk for mental health challenges and school failure (e.g., Chen et al., 2016).

As the focus of these collaborative efforts has shifted from children with mental illness and their families to the entire population of young people within a community, broader, more comprehensive approaches to interagency collaboration that include prevention are being created (Anderson, 2016). Services and supports are not only being offered in schools, but agencies and schools are starting to collaborate in new and innovative ways (Anderson & Cornell, 2015). For example, in one interagency model called the Full Purpose Partnership (FPP), located in Indianapolis, Indiana, *care coordinators* who act as case managers for the school and community are housed within participating schools (Anderson et al., 2010). These care coordinators are responsible for implementing four components core to the FPP model: (a) effective curricula and instruction; (b) inquiry driven, data-based decision-making; (c) systems of care and wraparound principles (including authentic family involvement; strengths-based practice; cultural competence; and interagency collaboration); and (d) school-wide positive behavior supports. Each of these components is conceptualised through a three-tiered system of school-wide supports (Sugai & Horner, 22002), focusing on prevention, early intervention, and comprehensive intervention. Borrowing heavily from positive behavior interventions and supports, which in turn was adopted from the field of public health (Walker, Ramsey, & Gresham, 2004), the multi-tiered system simultaneously coordinates prevention (what schools do to ensure that all students are successful); early intervention (what schools do to intervene quickly and effectively when students experience challenges); and comprehensive intervention (what happens when students are experiencing chronic levels of school challenges).

Community-school collaborations like the FPP make it easier to identify gaps in community service networks, thus allowing for the creation of new services and supports to fill those gaps. The ultimate goal is that each child serving system or agency, including schools, will collaborate to offer prevention efforts at the base level and more intensive targeted services to smaller numbers of individuals as needed (Anderson et al., 2010). Another goal is to move away from children's social services systems that historically were expert-driven, overly restrictive, fragmented and uncoordinated, costly, absent, or separated from the natural settings where children's challenges occur (Johnson, Zorn, Yung Tam, Lamontagne, &

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Johnson, 2003; Stroul & Blau, 2010). By offering services and supports that are family-driven, youth-guided, and grounded in strengths orientations, caregivers are empowered to become decision-making partners in the planning of such services (e.g., Anderson, Wright, Smith, & Kooreman, 2007; Atkins, Hoagwood, Kutash, & Seidman, 2010).

Educating Students At-Risk for School Failure

With the passage of ESSA in the U.S., schools now have a clear legislative mandate to connect school and community supports through collaborations among educators, families, and communities. A beginning framework for the systematic integration will require schools and their communities to "(1) coalesce existing student and learning supports into a cohesive component and (2) over a period of several years, develop the component into a comprehensive intervention system that is fully interwoven into instructional efforts. Such a component is key to enabling all students to have an equal opportunity to learn at school and all teachers to teach effectively. This type of systematic approach is especially important where large numbers of students are not succeeding" (NCMHS, 2016; p. 15). It is clear that students need to experience success to increase their resiliency and that schools are ideal places for success to occur (e.g., Keogh, 2000). Thus, a critical area of importance for schools is the use of effective classroom methods (Wang, Haertel, & Walberg, 1998). For example, teachers can use evidenced-based practices for instruction to improve opportunities for students to succeed. This is particularly important for students who are at-risk for various types of school failure. Researchers have shown that teachers improve learning by creating safe and caring environments where students feel comfortable taking risks and by using positive behavioural techniques such as verbal praise and positive reinforcement to enhance student learning and classroom management (e.g., Jones & Jones, 2015). Most teachers understand that their own teaching styles can create increased risks for students (Trussell, 2008). It is well understood that teachers should avoid yelling or using negative verbal remarks, which may potentially cause students to be disruptive or disengaged (e.g., Anderson & Mohr 2003). Educators should also realise that some students have deficits in prerequisite skills that may interfere with their ability to meet the grade level requirements. Likewise, curricular content should be interesting and flexible enough to address the individual strengths and needs of students (e.g., Adelman, & Taylor, 2006a; b). When developing school curriculum, educators should not only incorporate student interests into the curriculum, they should plan for the necessary attention and instructional remediation, to ensure that their students who are at-risk for failure have necessary opportunities to succeed (Trussell, 2008; Brooks, 2006).

Teacher perceptions and expectations of their students also influence how successful students are in school (Anderson, Howland, & McCoach, 2014). Both teachers and students view antisocial peers in negative ways (Walker et al., 2004); therefore, teachers need to be trained in classroom management skills such as posting rules and consequences, setting behavior goals for classrooms and individuals, and following through with the management plan for the class (Jones & Jones, 2013). Educators who spend time with and learn to understand both the challenges and strengths of their students who are at higher risk for school failure can serve as an important protective factor for this population of students (Brooks, 2006; Trussell, 2008). At-risk students who have a positive relationship with an adult tend to be more successful in dealing with challenging situations and are more likely to succeed (Werner & Smith, 1992; Trussell, 2008). Another protective factor for students at-risk is social support. Friendships with peers and adults provide an important source of social support, which can act as a buffer for students who have experienced a stressful life event (Werner & Smith, 1992; Brooks, 2006; Trussell, 2008). Resilient

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students are more likely to turn to their friends during times of crises (Werner, 1989). Thus, schools should provide opportunities for students who are at risk for failure to develop relationships with peers and adults. In fact, an important goal of schools should be to help students develop social competence (Consortium on the School-Based Promotion of Social Competence [CRPSC], 1994). Social competence involves students working on their citizenship skills, which include: problem-solving, assertive decision-making, communicating clearly, regulating emotions, managing and resolving conflict, resisting pressure from peers, and developing positive personal relationships (CRPSC, 1994; Farrell, Meyer, & White, 2001; Griffin, Botvin, Nichols, & Doyle, 2003).

Schools can work to improve and ensure positive outcomes for all students, including students at higher risks for failure, and promote resiliency by building a strong sense of community both in classrooms and throughout the entire school (Battistich, Schaps, Watson, & Solomon, 1996). By creating warm and caring environments where students feel safe and valued and by teachers providing effective instruction, educators are helping students succeed (Battistich et al., 1996). At the school level, a governance body is established, directly involving parents and caregivers as decision-making partners, designed to eliminate territorial issues among partnering community agencies. Support for teachers to use the best, evidenced-based instructional and classroom management practices is provided, as is assistance for teachers to connect and stay connected with the families of their students. Incentives, benchmarks and expectations for interagency collaboration are developed, implemented, and monitored. The governance group systematically builds linkages among schools, families, systems, and agencies to support broader goals of community wellness and improved overall functioning for students, their families, as well as teachers and administrators (see, e.g., Anderson & Cornell, 2015).

Examples of School-Based Approaches

School-based interagency programs should incorporate universal preventative interventions that focus on students' social and problem-solving skills (Anderson et al., 2010). Preventative interventions need to target all students, with a specific focus on young people who are at a higher risk for developing emotional-behavioral difficulties. This is especially important for youth who may "fall through the cracks"; which is when students exhibit symptoms and signs but do not qualify for services (Chen et al., 2016). Many different preventative programs have been developed for schools. Such approaches can vary but they typically assist students in developing and using appropriate social and emotional skills. For example, Promoting Alternative Thinking Strategies (PATHS) is a school-based prevention program that "aims to increase children's ability to discuss and understand emotions, facilitate the development of self-control, promote a positive peer climate, and enhance interpersonal problem-solving skills" (Rones & Hoagwood, 2000, p. 229). Another prevention program, Linking the Interests of Families and Teachers (LIFT), is designed to prevent or reduce aggressive and antisocial behaviour for elementary students who live in neighbourhoods with high crime rates (Rones & Hoagwood, 2000). The Family and Schools Together (FAST) Track program targets kindergarten students who are oppositional and aggressive. Researchers have noted that students who completed FAST were less likely to be referred to special education and exhibited less aggressive and oppositional behaviour than those who did not receive these services (Rones & Hoagwood, 2000). The Life Skills Training (LST) Program is a skills-based substance abuse program, which teaches students skills on how to manage anxiety, build self-esteem and relationships, communicate effectively, be assertive, and resist peer pressure (Rones & Hoagwood, 2000).

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In addition, the Kaleidoscope program is a rapid response program designed by the Indianapolis Public School system in Indiana to provide supports for students who are experiencing difficulties with their behaviour in the school setting, as well as for their teachers and families (Wang, Cornell, & Anderson, 2016). In brief, the program theory is that students who start exhibiting behaviour problems in school can be assisted through intensive, comprehensive interventions before challenges escalate. While the purpose is to intervene early to prevent the need for more intensive interventions and placements, when necessary, the program also guides the process for students who require more intensive support (e.g., special education services). Kaleidoscope uses a team-based approach, pairing a behaviour specialist and social worker who provide coordinated services and supports across home, school, and community. An example of team efforts can include: 1) designing intervention plans, which include interventions at home and school; 2) relationship building among caregivers and school personnel; 3) educating parents about how to communicate with professionals in their community; 4) educating teachers and other school professionals about classroom management; 5) educating families, teachers, and other school professionals about how mental health related issues can affect learning; 6) conducting environmental assessment and modifications to increase opportunities for learning; and 7) easing frustrations among the adults living and working with youth experiencing mental health challenges. Kaleidoscope staff members are also trained to navigate the organisational culture already in place in the schools in which they work and then assist educators in building healthy engagement with the parents of students in those schools.

School-based interagency programs tend to have similar components, such as flexibility and individualization (e.g., Chen et al., 2016). Programs often include opportunities for teaching parents and teachers to use effective behaviour management skills. These preventative programs can be integrated into the general education curriculum and, of course, need to be developmentally appropriate for the students (Rones & Hoagwood, 2000). To be successful, Rones and Hoagwood (2009) stated that clear, specific guidelines are needed clarifying how the program should be implemented. Teachers, caregivers, and others actually implementing the program should receive feedback about their efforts and school leaders need to support teachers by funding both the training and maintenance sessions as well as monitor program fidelity (e.g., Anderson et al., 2010).

Guidance for Developing Interagency Frameworks

Interagency collaboration can reduce fragmentation and redundancy and allow service gaps to be identified and filled. However, to have effective interagency collaboration, schools and community agencies must have dedicated staff, be willing to understand and respond to philosophical differences, and have appropriate funding and time for such engagement (Anderson-Butcher & Ashton, 2004; Gonsoulin & Read, 2011). While most child-serving agencies have their own funding and management systems, these functions may conflict with the ability of the agencies to work together (Anderson, 2000; Anderson, 2000; Tapper, Kleinman, & Nakashian, 1997; Johnson et al., 2003). Thus, systems, schools, and agencies have to be willing to share relevant information to coordinate the most effective configurations of services and supports for each participating child and her or his family (Johnson et al., 2003; Gonsoulin & Read, 2011).

Arguably the key component of effective interagency collaboration is sustaining clear and open communication and cooperation with the other agencies (e.g., Chen et al., 2016). When students are involved with two or more agencies, someone will need to coordinate meetings and facilitate shared decision-making. Scheduling these meetings is not easy and takes time and resources (Tapper et al.,

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1997; Gonsoulin & Read, 2011). One straightforward task to develop frameworks and infrastructure for interagency collaboration is the creation of memoranda of understanding (MOU). The MOU can serve many purposes but at a minimum, it can clearly outline how participating agencies and schools will share information regarding the needs of specific students, such as demographic information, information about strengths and challenges and data related from student records (Gonsoulin & Read, 2011). For example, if a goal is improved school attendance, information about current and future performance will be needed. Developing MOUs allows all partners to delineate both how and what information will be shared, which can include medical records, information about the family, and educational records (Gonsoulin & Read, 2011). MOUs should also clearly address confidentiality and specific procedures in terms of what information can be shared, how it can be shared, with whom the information can be shared, and who from each agency will grant permission for the sharing of information (Tapper et al., 1997; Gonsoulin & Read, 2011). By outlining the information and goals shared, this establishes trust among the partners. Leaders from all partnering agencies and schools, along with legal staff, can help navigate the MOU, ensuring compliance with national, state, and local laws (Gonsoulin & Read, 2011). Further, by sharing fiscal responsibility and staff, the interagency team can benefit from the expertise of multiple disciplines (e.g., health, education, social work), while working to eliminate duplication of services and fill in service gaps (Tapper et al., 1997; Gonsoulin & Read, 2011). However, the sharing of funds can be a complicated process, which often requires changes in existing policy and law. Many public and private agencies have to provide evidence regarding their collaboration efforts in order to receive funding (Gonsoulin & Read, 2011).

These partnerships continue to benefit all stakeholders in the community (Anderson-Butcher, 2004). The benefits include teachers, families, and counsellors understanding the many issues students may be facing; increased support among school professionals and the families; and more effective psychoeducational programs for youth with mental challenges (Tourse & Sulick, 1999). Research has shown that students have increased academic achievement and reduced behaviour issues due to interagency collaboration (Smith, Armijo, & Stowitschek, 1997). Collaboration among agencies has helped improve school attendance for students in addition to the quality of the students' learning experiences (Hatch, 1998). Anderson (2011) found that school functioning significantly improved between the time students enrolled in a local community-based interagency system of care and up to 36 months, post-enrollment. Moreover, these longitudinal improvements also were found to be significantly associated with improved clinical functioning over time. In an earlier study, Manteuffel, Stephens, and Santiago (2002) also reported that school performance and attendance improved from enrollment in a system of care to two years post enrollment for a national sample of young people served by interagency systems of care.

CONCLUSION

Emphasising a strengths orientation to service provision and authentically partnering with families have dramatically changed how society works with young people with mental illness, and their families (Anderson, 2011). Indeed, best practices now require that children's mental health and social services be *family-driven* and *youth-guided* (Stroul & Blau, 2010). Perhaps the most challenging aspect of such interagency initiatives is building and then sustaining trusting relationships not only among service providers but with the child and family. Personnel from schools and child-serving agencies must first acknowledge that children and their families are experts about their own circumstances. Thus, students

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and families will be considered as full partners in all teaming, treatment, and decision-making processes. Gonsoulin and Read (2011) provided a number of practical suggestions for working with families: 1) schedule meetings when it is convenient for the family; 2) ask the family to define their basic interests and needs; 3) define roles of family and participating professionals; 4) find local support groups for the family; 5) provide child care for the family to facilitate meeting attendance; 6) arrange for transportation for families to attend the meetings; 7) provide food, snacks, and beverages when meetings occur during mealtimes; 8) use technology (email, phone conferences, and web conferences) to eliminate unnecessary face-to-face meetings; 9) ensure that children and family are empowered not only to share their own stories but to take leadership roles in these processes; and 10) eliminate the use of professional jargon. The authors recommend that professionals start by adopting and adhering to these simple suggestions.

Viewed as a way to overcome intractable patterns of educational failure occurring in many seriously under-resourced communities, interagency collaborative initiatives are emerging in schools and children's social services across the U.S and elsewhere. Combined with other recent innovations such as multi-tiered student supports (MTSS), Response-to-Intervention (RtI), and trauma-informed service provision, these kinds of partnerships offer multiple pathways for schools to better achieve their primary goal of academic growth for all students, including young people at higher risks of school failure. Moreover, the recent ESSA legislation in the U.S. highlights the importance of supporting learning through organised networking and collaboration among educators, families, and community social services agencies. However, it is critical that school-community partnerships and authentic family involvement in schools do not become just another educational "fad" that comes along, consumes a lot of time and resources, and then fades away. With appropriate development and support for communication, coordination and wide-ranging community backing, schools and community agencies can begin to think and act in new ways.

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KEY TERMS AND DEFINITIONS

Family-Driven: Families are the primary decision-makers in the care of their own children and authentically contribute to all policymaking and procedures governing care for all children in their community.

Interagency Collaboration: Systematic communication and cooperation among child-serving agencies (school systems, mental health services, welfare services).

Mental Health: The field of study and practice that focuses on the psychological and emotional well-being of an individual.

Prevention: Stopping something before it happens.

Protective Factors: Qualities that people possess or interactions with others that predict better outcomes for people who face adversity.

Resiliency: The ability to recover from risks or difficult life experiences.

Risk Factors: External and internal influences that can lead to poor outcomes for people.

School-based Interventions: Strategies or techniques used by the school to help students improve their academics, behavior, and/or social skills.

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Systems of Care: Clusters of organizational strategies that are focused on improving outcomes and grounded in a set of principles, including cultural competence, strengths-focused, family-centered, and least restrictive/community-based.

Youth-Guided: Young people are fully involved in all decision-making role related to their own lives and authentically contribute to all policymaking and procedures governing care for all children in their community.

ENDNOTE

[1] In 1997, the Individuals with Disabilities Education Act was reauthorized and the term SED was shortened from 'Serious Emotional Disturbance' to 'Emotional Disturbance' (ED) (Anderson and Mohr (2003) and Anderson (2000) discuss labels and diagnoses in education and mental health).

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Chapter 39
Providing Primary Prevention and School Mental Health Services to LGBTQ+ Children and Youth:
A Resiliency-Based Approach

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ABSTRACT

This chapter provides an overview of the difficulties facing LGBTQ+ youth in schools and their barriers to healthy psychosocial development. The risk and resiliency model is applied to these challenges, and specific risk factors and resiliency factors are explored. The focus is on means to foster healthy growth and development in sexual minority students through developing school-based programs and practices that have been proven to increase resiliency. The chapter provides specific strategies for school-based mental health professionals to use to increase resiliency in sexual minority youth through the application of school-wide policies and practices. Strategies for making such systemic changes and garnering support are also presented.

INTRODUCTION

School-based mental health professionals such as school counselors, school psychologists and social workers use their skills on a daily basis to promote healthy overall development for all students. In order to prevent the development or worsening of emotional, behavioral or academic problems, prevention and early intervention services are vital tools to accomplish this goal. Application of the risk and resiliency model can identify strategies to address areas of concern and help students to succeed despite adversity. This chapter applies this model to the experience of LGBTQ+ youth in schools and suggests

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how school mental health professionals can make schools safer and more nurturing environments for sexual minority youth.

BACKGROUND

Public schools have often struggled in their attempts to meet the needs of diverse groups of learners. Issues of racial and economic segregation and means of providing appropriate services to meet the needs of students with disabilities created controversy and enormous challenges. Schools' efforts to meet the needs of sexual minority youth have followed a similar path and the difficult journey continues. The National Education Association's (NEA) status report on GLBT issues in education notes that, "Hostility and apprehension toward homosexuality and gender nonconformity—reinforced over many decades by law, medicine, religion, and other cultural and societal institutions and conventions—continue to plague GLBT youth and adults in schools in every region of the nation, even as signs of greater inclusion and acceptance appear in some areas" (Kim, Sheridan, & Holcomb, 2008, p. vii).

Healthy social and emotional development in LGBTQ+ children and youth is a relatively new concept. Only in 1973 did the American Psychiatric Association (APA) remove homosexuality as diagnostic category of mental disorder (Baughey-Gill, 2011). Gender identity disorder was not removed until 2012, although gender dysphoria remains a controversial and related diagnosis. These identities were defined as manifestations of psychological disorders until relatively recently and public opinion and understanding of sexual minority individuals is still evolving. As society's primary public institution responsible for teaching social norms and guiding the development of children and youth, schools' understanding and skills in meeting the needs of LGBTQ+ individuals continue to evolve.

School mental health professionals are in a unique position to provide both individual and systemic support for sexual minority students. The role of school support personnel (counselors, social workers, and school psychologists) in meeting the developmental and mental health needs of LGBTQ+ children and youth (setting the tone, needs assessment, developmental guidance activities, using the positive behavioral interventions and supports (PBIS) process to meet the needs of LGBTQ+ children & youth, working with parents, administrators & school personnel, training issues, providing consultation) is ideal for developing school-wide policies and practices to support these children and youth. In addition, school mental health professionals can use their clinical skills to meet the individual mental health and emotional needs of sexual minority youth. Not surprisingly, these students say they would be more comfortable discussing LGBTQ+ issues with a school-based mental health professional such as a school psychologist, counselor or social worker (52.8%) than a teacher (42.3%), school nurse (30.1%), school administrator (25.9%) or coach (18.4%) (Kosciw, Greytak, Zongrone, Clark, & Truong, 2018).

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SUPPORTING HEALTHY DEVELOPMENT IN LGBTQ+ CHIDREN AND YOUTH

Healthy LGBTQ+ Youth

Definition of Healthy LGBTQ+ Youth

As stated previously, the concept of healthy LGBTQ+ individuals is a relatively new concept to many. Like other healthy individuals, healthy sexual minority individuals are able to learn and grow, meet developmental and social challenges, develop and maintain rich and rewarding relationships, and move towards their potential despite occasional adversity.

A Note on Self-Definition

While the majority of LGBTQ+ youth define themselves in those terms and see themselves as members of a sexual minority, this is not the case for all. LGBTQ+ children and youth are a large and richly diverse group of individuals with a variety of perspectives and views. Ritch Savin-Williams (2005, 2006) reports that many adolescents currently do not define themselves in the same way as previous generations who engaged in same-sex activity. Despite being open in their romantic and sexual relationships, they often reject the word "gay." They may want to avoid the political label or frightening life course many associate with being gay. These teens do not see their life as all that different from their straight peers. They do not reject their actual attractions or report deep emotional difficulties. In sum, they "don't want their sexuality to define them" (Savin-Williams, 2006, p. 16). While internalized homophobia or safety concerns may play a role for some of these youth, others feel a greater fluidity in their sexual expression or do not perceive themselves as fitting the gay stereotype. In their view, they may be best understood through understanding adolescent development generally.

A Note on Intersectionalities

LGBTQ+ individuals are also vulnerable to all of the social stigma, marginalization and discrimination that occur within the larger society. Issues of race, gender, religion, social class, and other factors impact each individual's experience. While a discussion of all of these factors is beyond the scope of this chapter, it is clear that they have a major impact on the LGBTQ+ individual's lived experience.

LGBTQ+ Youth Vulnerabilities

Russell and Fish (2016) provided a review of the current knowledge of mental health issues in LGBT youth. LGBT individuals in adulthood clearly have higher levels of substance use and abuse, depression, anxiety, post-traumatic stress disorder and suicidality. Research indicates that LGBT youth have elevated risk for emotional distress, depression, anxiety, and suicidality (Fish & Pasley, 2015; Needham, 2012; Marshall, Dietz, Friedman, Stall, & Smith, 2011). Of all of these concerns, suicide risk is the most pressing.

Adams, Hitomi & Moody (2017) conducted a meta-synthesis of research on suicide within the adult transgender community. Their review of 42 Canadian and U.S. studies found that 55% of the participants had considered suicide at some point and 29% had made one or more suicide attempts. Kuper, Adams

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and Mustanski (2018) found even higher rates of suicide ideation in their sample of young transgender and gender nonconforming individuals recruited for an online survey. The vast majority (83.7%) reported suicidal ideation in the last year with most of them screening positive for suicide risk (81.3%). However, a much smaller proportion of the larger group (10.9%), said they had made a suicide attempt in the last year. An even higher percentage (95.5%) reported suicidal ideation at any point in their life and 32.3% reported having made a suicide attempt at any point. Gender-related victimization, negative self-concept, and depressive symptoms were related with negative outcomes.

Rivers, Gonzalez, Nodin, Peel, and Tyler (2018) conducted a qualitative study of LGBTQ+ individuals in England who had attempted suicide during their adolescent years. Issues of isolation, religious conflict, stresses associated with coming out, concurrent mental health issues, and grief all played a major role in these individuals' youthful suicide attempts.

The Risk and Resiliency Model

Early research into the development of LGBTQ+ youth, like early studies with most marginalized groups, came from a student-at-risk model. From this viewpoint, researchers enumerated the many negative experiences of discrimination and harassment faced by sexual minority youth and the correlation of such experiences to numerous negative developmental outcomes. This was a valuable exercise and helped to lay the foundation for understanding the day-to-day challenges many LGBTQ+ youth face. A shift in thinking towards the resiliency approach, however, can provide mental health professionals and schools with information that can be used to develop policies and practices that can actually help students to negotiate healthy overall development despite adversity. Resilience can be defined as the ability of the individual to adapt and function in a relatively healthy matter despite adverse experiences. In the words of Olsson, Bond, Burns, Vella-Brodrick, and Sawyer (2003), "Resilience does not so much imply an invulnerability to stress, but rather an ability to recover from negative events" (p. 2).

While most individuals have a clear understanding of the term "risk factors," or factors that are correlated with negative outcomes or developmental problems, fewer may be aware of resiliency factors. The resiliency framework focuses on key variables known as "resiliency factors" that help buffer the individual against negative experiences and assist continuing positive development. These factors include individual characteristics such as intelligence and a positive temperament, key individual skills such as effective oral communication and social skills, personal attributes such as flexibility and self-esteem, family variables such as parental warmth and cohesion, community variables such as resources and programs to assist, and school variables such as supportive peers and positive relationships with teachers (Olsson, et al., 2003). The current chapter will focus on those resiliency factors which can be developed or supported by schools and school personnel.

Key Risk Factors and Outcomes

A Lack of Safety

Maslow's pivotal 1943 work postulated that individuals have a hierarchy of needs and that lower level needs must be met for the individual to be able to focus their energy and attention on meeting higher level goals and challenges. The need for safety is essential, falling just above physiological needs such as air and water on Maslow's scale. Unfortunately, many sexual minority youths do not feel safe at school.

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Fears and safety concerns are paramount for many LGBTQ+ youths in their schools. In the Gay, Lesbian and Straight Education Network's (GLSEN) 2017 school climate survey, "59.5% of LGBTQ+ students felt unsafe at school because of their sexual orientation, 44.6% because of their gender expression, and 35.0% because of their gender" (Kosciw, et al., 2018, p. xviii). These concerns led to frightened students starting to withdraw from the larger school community. They often refused to come to school at all (34.8% missing a day in the last month and 10.5% missing four days or more), avoided locations like bathrooms (42.7%) and locker rooms (40.6%), refused to attend school functions (75.4%) or join in after-school clubs and activities (70.5%). Nearly 1 in 5 had actually changed schools for these reasons and others planned on leaving school altogether. According to GLSEN, "of the LGBTQ students who indicated that they were considering dropping out of school, a sizable portion (42.2%) indicated that they were doing so because of the harassment they faced at school" (Kosciw, et al., 2018, p. xx).

Gender Non-Conformity as the Root

It is the appearance of gender non-conformity that is the root of most acts of homophobic harassment. According to Kim (2008),

Bullying of GLBT students stems largely from discomfort with students who do not conform to traditional gender roles in their appearance or behavior, i.e., who are gender-nonconforming. A student's actual sexual orientation may be far less relevant to his or her social victimization than his or her gender identity or gender expression." (p. vii)

Both LGBTQ+ youth and their heterosexual peers are the victims of homophobic harassment with resulting damage to their academic, emotional and physical functioning (D'Augelli, Pilkington, & Hershberger, 2002).

Physical Assault

Fears for physical safety are often well-founded. LGBTQ+ students report frequent harassment, bullying and assault at school. Of the LGBTQ+ youth responding to GLSEN's 2017 school climate survey, 70.1% reported homophobic harassment with 59.1% reporting harassment based on gender expression. Physical acts of aggression against this population were common. LGBTQ+ students were frequently physically intimidated, as in being pushed (reported by 28.9% for sexual orientation issues and 11.2% for gender expression) or physically assaulted such as being hit with a fist or a weapon (reported by 12.4% for sexual orientation issues and 24.4% for gender expression). Sexual harassment was also very common with 57.3% having been the recipients of unwanted touching or sexualized remarks at school in the last year. Cyberbullying was also reported by 48.7% of these LGBTQ+ students (Kosciw, et al., 2018).

Slurs & Homophobic Language

Nearly all of the respondents to GLSEN's 2017 school climate survey reported hearing homophobic language and slurs at school and being hurt by them. For example, 98.5% heard the word "gay" used in a pejorative way, 70% of them heard this frequently, and 91.8% said this caused them distress. Other homophobic slurs were reported by 95.3% of respondents with 60.3% hearing them often. The vast

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majority (94%) of these LGBTQ+ students heard distressing statements about gender expression with 62.2% hearing them regularly. Hearing targeted slurs against transgender individuals were reported by 87.4% of the respondents and 62.2% heard these regularly. Even more distressing was the fact that 56.6% heard members of the faculty making homophobic remarks and 71.0% had heard school staff making pejorative remarks about gender expression (Kosciw, et al., 2018). Accroding to Kosciw, et al. (2018),

hearing biased or derogatory language at school, especially sexist remarks, homophobic remarks, and negative remarks about gender expression, was a common occurrence. However, teachers and other school authorities did not often intervene when anti-LGBTQ+ remarks were made in their presence, and students' use of such language remained largely unchallenged. (p. 132)

Most Harassment is Never Reported

Most of these incidents never come to the attention of school staff. According to GLSEN's 2017 school climate survey, "55.3% of LGBTQ+ students who were harassed or assaulted in school did not report the incident to school staff, most commonly because they doubted that effective intervention would occur or feared the situation could become worse if reported," and "60.4% of the students who did report an incident said that school staff did nothing in response or told the student to ignore it" (Kosciw, et al., 2018, p. xix).

Discriminatory School Policies and Practices

Many schools engage in discriminatory practices that further erode LGBTQ+ students' sense of acceptance and belonging at school. A 2017 survey of LGBTQ+ students found that 62.2% reported having experienced these at their school. Discriminatory experiences included the refusal to allow the development of a Gay-Straight Alliance (GSA) (14.8%), refusal to allow same-gender dates at school functions (11.7%), punishment for displays of affection that are allowed for other students (31.3%), and not allowing clothing considered inappropriate for their legal gender (22.6%). LGBTQ+ students reported having been banned or discouraged from school sports (11.3%). Many students even reported school practices that prevented them from fully engaging with the school curriculum such as prohibitions against writing about or discussing LGBTQ+ issues for school assignments (18.2%) or engaging in free speech activities such as wearing t-shirts or other items that espouse LGBTQ+ causes (13%) or discussing such issues in school clubs or other extracurricular activities (17.6%) (Kosciw, et al., 2018).

Heteronormativity in not Safety

Short (2017) found in his qualitative study of Canadian schools that many LGBTQ+ students saw school safety as more than freedom from physical violence and bullying. They saw equity as a factor and addressing heteronormativity in general, and in the curriculum in particular, as essential to the safety of their identities. In the words of one of his interviewees,

Safety for queer kids is about changing things, not protecting things. I mean, of course, that you have to protect kids, but that's a given, isn't it? But it's not just about bullying, I mean, in a physical way. We're bullied by just the culture we're in. (p.14)

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In their 2017 survey of LGBTQ+ students, GLSEN found that only a minority (19.7%) "were taught positive representations about LGBTQ+ people, history, or events in their schools; 18.4% had been taught negative content about LGBTQ+ topics" (Kosciw, et al., 2018, p. xxii). Less than half (41.0%) said their school library had sources for information on LGBTQ+ issues. A survey of high school students found that only 20.8% said LGBTQ+ topics were taught in their school building (Greytak, Kosciw, Villenas, & Giga, 2016). One barrier to an inclusive curriculum may be the feelings and comfort of the school faculty. Less than a third of teachers surveyed (33.1%) expressed comfort in including LGBTQ+ related content in their lessons (Greytak, et al., 2016).

Sex Education is Particularly Problematic

Only a fraction of LGBTQ+ students surveyed (6.7%) reported that their school's sex education curriculum included LGBTQ+ content (Kosciw, et al., 2018). According to GLSEN, quoted by Greytak, et al. (2016),

there is evidence that much of the sexuality education in U.S. schools is not inclusive of LGBTQ+ people and issues, and, that even when LGBTQ+ issues are acknowledged, they may be presented in ways that stigmatize or marginalize LGBTQ+ people. (p. 40)

Under 5.0% of LGBTQ+ middle and high school students said they experienced an affirming message on LGBTQ+ issues in their health curriculum. Not surprisingly, sexual minority youth were more likely to rate their sex education classes as unhelpful in comparison to other youth (46.5% vs. 29.9%) (Greytak, et al., 2016).

School Discipline

There is evidence that school discipline may also be a factor in the alienation of LGBTQ+ students from their schools. The majority of sexual minority youth surveyed by GLSEN said they had been disciplined at school (62.8%), far more than their non-LGBTQ+ peers reported (45.8%). This trend continued for high school students who did not conform to gender norms with 55.2% having received discipline in school in comparison to 45.9% of students displaying gender normative behavior. LGBTQ+ students in the GLSEN survey were more likely to have been suspended than their non-LGBTQ+ peers (24.9% vs. 14.5%). Even more concerning is the fact that LGBTQ+ students may be disciplined in a discriminatory manner. Greytak et al. (2016) note that

Research from GLSEN's National School Climate Survey and others suggests that LGBTQ+ students may be disciplined for being open about their identity or breaking rules that are not enforced for their non-LGBTQ+ peers. LGBTQ+ youth who are gender nonconforming may also be more likely to face school discipline due to school rules that prohibit some types of nonconforming gender expression, such as gendered dress codes. (pp. 30-31)

For example, a transgender student who identifies as female may be suspended for wearing a skirt which is in defiance of the school dress code for a male student, the gender assignment he was given at birth. LQBTQ+ students are also likely to be disciplined in relation to incidents of their own victimiza-

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tion. Students who reported receiving higher levels of LGBTQ+-targeted victimization were also more likely to have been disciplined in school than their peers without such victimization (54.7% vs. 43.9%) (Greytak, et al., 2016). Students who have been victims of homophobic bullying have been reprimanded for "bringing on the bullying" themselves due to their status as being out members of a sexual minority.

Impact

Experiencing harassment, bullying, and discrimination at school is directly related to negative school outcomes for LGBTQ+ youth. Kosciw and colleagues (2013) found "in-school victimization predicted decreased self-esteem and worse educational outcomes (lower GPA and more missed days of school)" (p. 54). A 2017 survey of LGBTQ+ youth found that those who experienced more homophobic victimization were more likely to miss school days (63.3% vs. 23.1%), had poorer academic performance (GPA of 3.0 vs. 3.3), were more likely to have been the recipients of school discipline (54.1% vs. 30.3%) and were much less likely to pursue higher education after high school than those who had experienced less victimization at school. Similarly, students in the same survey who reported more victimization based upon their gender expression were much more likely to have missed school (61.6% vs. 23.2%), had poorer academic performance (GPA of 2.9 vs. 3.3), were more likely to have been the recipients of school discipline (52.1% vs. 30.8%), and were half as likely to pursue higher education after high school than those who had experienced less such victimization. Students who experienced higher levels of victimization were also more depressed and had poorer self-esteem (Kosciw, et al., 2018).

Experiencing bullying at school can lead to academic difficulties, erosion of feelings of connection to the school and emotional difficulties in LGBT youth (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). One study found that victims of homophobic victimization were even more likely than those with victimization without homophobic overtones to consider suicide, 5.8 times vs. 2.86, as likely as peers who were not victimized (Russell, Sinclair, Poteat, & Koenig, 2012).

Students who reported LGBTQ+ discrimination showed similar negative outcomes. Those who experienced such treatment were more likely to miss school (44.6% vs. 15.7%), had poorer academic performance (GPA of 3.1 vs. 3.4), were more likely to have been the recipients of discipline at school (44.0% vs. 26.5%). Students who experienced discrimination were more depressed and had poorer self-esteem (Kosciw, et al., 2018).

Minority Stress Theory

Minority stress theory has been used to explain the numerous negative outcomes related to the victimization of LGBT youth. Given the disproportionate discrimination, harassment, and stressors these individuals face, physical, emotional and academic difficulties are likely to follow. Hall (2018) stated, "LGBQ-specific stressors can be categorized into four domains: prejudice events (e.g., harassment, violence, discrimination, rejection), expectations of prejudice events, concealment of identity, and the internalization of negative societal attitudes and beliefs (e.g., internalized homophobia)" (p. 265). All of these impact sexual minority youth. Studies indicate many long-term emotional problems which are correlated with homophobic victimization including depression, anxiety, trauma-related stress, and suicidal behavior. In addition to these emotional concerns, youth have experienced such harassment also tend to have more risky sexual behaviors, poorer school attendance, and report they are more likely

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to drop out (D'Augelli, et al., 2002; Poteat, Mereish, DiGiovanni, & Koenig, 2011; Almeida, Johnson, Corliss, Molnar, & Azrael, 2009).

Limited Educational Aspirations

LGBTQ+ students have frequently been found to have more limited educational aspirations. GLSEN's study of LGBTQ+ high school students were more likely to say they planned to leave high school before graduation than their non-LGBTQ+ peers (2.7% vs. 0.8%). Accordingly, they were also less likely to plan to continue their studies after high school (9.6% vs. 5.7%). The same was true for student who did not conform to gender norms in comparison to those who were gender normative. They were more likely to state their intent to leave high school early (3.1% vs. 0.5%) and were more likely to have no plans for college (12.6% vs. 4.2%) or graduate school (Greytak, et al., 2016).

Key Resiliency Factors

Johns, Beltran, Armstrong, Jayne & Barrios (2018) conducted a comprehensive review of English and Spanish language articles in peer reviewed journals spanning the years from 1999 to 2014. Their review yielded 27 protective factors for positive outcomes in transgender and gender atypical youth. Four of these protective factors strongly emerged across multiple studies – individual self-esteem, positive relationships with parents, positive peer relationships, and gay straight alliances – and are discussed in the following sub-sections.

School Belonging

Wallace, Ye, and Chhuon (2012) examined high school students' sense of belonging within their schools. Their analyses identified four key experiences that were related to feeling of belonging including a general connection to faculty, a connection to a specific faculty member in the school, actively participating in a school-based extracurricular activity and a perception that one fits in with their peer group. In addition, they identified a factor previously unidentified in research, the adolescent's feeling of being known by a teacher, having his or her true identity recognized. Adolescents bereft of connection and belonging either at home or at school feel emotional pain (Cohn & Leake, 2012). Students who experience higher levels of victimization or discrimination report less school belonging (Kosciw, et al., 2018).

Social Support

Youth with more positive peer relationships have better mental health overall and are less likely to report depression or loneliness (Johns, et al., 2018). Strong and supportive friends also helped provide an anchor when parents were rejecting. McConnell, Birkett, and Mustanski (2015) studied various types of social support and mental health outcomes across a sample of LGBTQ+ youth. Youth with less social support had higher levels of loneliness, depression, anxiety and suicidality. Higher SES youth had significantly higher levels of overall social support while poorer youth reported less social support. Males also tended to have lower levels of social support than females. Adams, Hitomi & Moody (2017) found that friend and family support were correlated with better mental health outcomes.

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Family Support

LGBTQ+ youth who feel affirmed and accepted by their families report lower depression and fewer suicidal thoughts (Eisenberg & Resnick, 2006; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Johns and colleagues (2018) found that positive relationships with parents and family support was associated with higher self-esteem and later initiation of sexual intercourse. Youth who perceived their parents as more supportive were less depressed and felt more life satisfaction. Rivers, et al. (2018) found that around three fifths of their sample reported little family support and those with higher levels of family support also tended to have higher support from other sources. Many sexual minority youths, however, feel they do not have this option. Many LGBTQ+ youths are not out to their parents although they may be open to their friends. Therefore, these students are unlikely to share their victimization experiences with their parents and lack their support when dealing with these experiences.

Positive Relationships with Supportive School Staff

Supportive school staff are vital to the success of LGBTQ+ students. Youth who had a positive relationship with a supportive member of their school staff had better attendance and were less fearful at school (Johns, et al., 2018). In their comprehensive review of the role of school supports in mitigating the roles of victimization and harassment in LGBT youth, Kosciw, et al. (2013) found that,

Perhaps the strongest positive influence for LGBT students, as shown from our results, was having supportive adults at school. The number of supportive educators was one of the stronger predictors of a less hostile school climate and of greater self-esteem for LGBT students. Not surprisingly, the number of supportive educators was associated with positive educational outcomes; specifically, students who reported having more supportive educators were likelier to report higher GPAs and less likely to have missed school. Further, supportive staff might be especially helpful for students who are highly victimized, given the significant interaction between victimization and educators for missing school. Our findings related to supportive educators might reflect the myriad ways that these individuals can influence the school climate for LGBT students. Supportive staff might provide the personal connection needed to help keep students in school and buffer against severe victimization. Staff also might make the environment safer and more affirming directly for these students by intervening when homophobic remarks are made and anti-LGBT victimization occurs, providing support for individual students and perhaps advocating for school-wide efforts, such as affirming and protective policies and practices among staff and administration. (p. 58)

While almost all LGBTQ+ students (96.7%) surveyed could name at least a single supportive staff member in their school building, only 61% could name more than 6 adults in the building who were supportive of LGBTQ students with just 38.8% identifying 11 or more such staff members. A sizable minority (39.8%) said their school administration was at least somewhat supportive of LGBTQ+ students (Kosciw, et al., 2018). Having a significant number of school staff who they recognized as supportive of LGBTQ+ students made a difference. Students who were in schools where they could name at least 11 supportive adults reported feeling less afraid because of their sexual orientation (43.4% vs. 79.2%) or gender expression (34.8% vs. 51.0%) and said they were less likely to miss school due to such fears (20.1% vs. 48.8%) when compared to students without supportive adults. They performed better academically

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(GPAs of 3.3 vs. 3.0) and were less likely to consider dropping out and more likely to say they planned to continue their education after high school. They had a greater sense of school belonging (Kosciw, et al., 2018). Students who perceived their teachers as insisting upon respectful and safe spaces in their classrooms, reported less homophobic bullying (Poteat, DiGiovanni, & Scheer, 2013).

Barriers to Support from School Staff

While teachers regularly have to intervene in student behaviors such as bullying and name-calling, their comfort with doing so varies with the type of harassment observed. Techers surveyed reported feeling least comfortable in addressing disparaging remarks made about gender expression (49.3%) and transgender individuals (50%) (Greytak, et al., 2016). Many teachers may have had little training on how to provide specific support to LGBTQ+ students. In a GLSEN survey, the majority of teachers reported that they had received preservice or other professional development on general issues of bullying (85.1%) and diversity (76.4%). Yet fewer had received any specific training on support for LGB (32.9%) or transgender (23.6%) youth and topics (Greytak, et al., 2016). Training in these areas was directly related to more supportive practices with LGBTQ+ students. Of teachers who had received specific training in dealing with LGBTQ+ issues, 70% said they were providing active support to these students. Of those who had not had such training, less than 40% provided such support (Greytak, et al., 2016).

GLSEN surveyed high school teachers and found that over one in four (26.4%) said they had worked to support LGBTQ+ students. The majority of teachers who had not shown such support were further questioned as to their reasons or barriers from doing so. Teachers' own personal and religious beliefs were a major factor with

over half (51.7%) of teachers indicating that they believed addressing LGBT issues was not necessary or appropriate, or believed that because these issues had not come up in their classes, there was no need to address them. Over a quarter of teachers (26.2%) identified external pressures as barriers to engaging in LGBT efforts, such as lack of administrative support, or backlash from parents or community. Just about one in five (19.0%) teachers noted that they faced logistical barriers, such as not having enough time to include these issues in their teaching or not knowing how to include them. (Greytak, et al., 2016, p. 67)

GLSEN asked teachers what actions might be most useful in helping making schools safer for LGBTQ+ youth. The greatest majority (91.3%) said that establishing "anti-bullying and/or anti-discrimination policies that explicitly protect LGBTQ+ students" would be helpful (Greytak, et al., 2016, p. 75). Such policies provide guidance to teachers on when to take action and give them the permission (and obligation!) to do so even when they may be uncomfortable. The vast majority of teachers (89.2%) also said administrative support would be helpful. Guidance from the school's administration and the feeling that administrators would be supportive if parents or community members questioned the teacher's actions can help them feel safer to address LGBTQ+ issues directly. The vast majority of teachers (88.8%) also felt further training would be helpful as would establishing a GSA in the school (85.6%) (Greytak, et al., 2016).

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Gay-Straight Alliances

Gay-straight alliances (GSAs) are school clubs or organizations that serve a support and advocacy function for LGBTQ+ youth. Consisting of LGBTQ+ youth themselves as well as peer allies, these groups started in the 1980s as research about the stress and accompanying psychological toll on LGBTQ+ youth became widely known (Mayberry, 2013). Some school administrators used this data as a way to "justify to higher-level administrators, school boards, and community members the presence of GSAs on their campuses" (Mayberry, 2013, p. 36). Since that time, these groups have spread widely and now number in the thousands across the U.S. Their mission has also evolved from that of merely providing support to LGBTQ+ students to the broader purpose of challenging the "heteronormalizing institutional practices that exclude and stigmatize nonheterosexual identities" (Mayberry, 2013, p. 36). According to GLSEN's 2017 school climate survey,

GSA student clubs continue to serve as a potent force for positive change, and the LGBTQ+ students that lead them are changing their schools and their world for the better. Progress in the growth of GSAs continues, bucking the concerning trends, and more than 50% of LGBTQ+ students are in schools that now have one. (Kosciw, et al., 2018, p. xiii)

The presence of a GSA improves student attendance and participation in the school's GSA leads to improved school climate and improved self-advocacy (Johns, et al., 2018). Research shows that GSAs help students develop and improve positive social support networks (Hecht, 1998; Lee, 2002). In addition, the presence of such groups in schools leads to other positive psychosocial outcomes for LGBTQ+ students, including decreases in suicidality (Goodenow, Szalacha, & Westheimer, 2006; Walls, Freedenthal, & Wineski, 2008). Lee's (2002) qualitative study of high school student GSA members reported that their participation had led to academic improvements, better attendance, and better relationships with school administrators, teachers, family and peers. These students were less anxious about being "out" with their peers and felt safer, reporting less harassment and actually feeling more belonging and connection to their school. Kosciw and Diaz (2006) reported that the presence of a GSA in a school was associated with better attendance and greater feelings of safety and school belonging in LGBTQ+ students. A study of Massachusetts schools with GSAs found that LGBTQ+ students attending schools with such organizations were "half as likely as those in schools without a GSA to report experiencing dating violence, being threatened or injured at school, or missing school because they were afraid to go" (GLSEN, 2007, pg. 1). Poteat, Sinclair, DiGiovanni, Koenig, and Russell (2013) found that LGBTQ+ students in schools with a GSA reported less frequent sexual behavior while under the influence of alcohol or other drugs and students generally (both LGBTQ+ and not) reported less suicidality than those attending schools lacking such a support group. A prospective study found that having a GSA predicted decreasing LGBT-related harassment from year to year (Ioverno, Belser, Baiocco, Grossman & Russell, 2016).

A 2017 survey of LGBTQ+ students found that attending a school with a GSA made a noticeable difference in school climate. The presence of a GSA was associated with fewer LGBTQ+ students frequently hearing the word *gay* in a homophobic manner (62.7% vs. 78.5%), hearing homophobic slurs (53.4% vs. 68.1%), or hearing ugly remarks about gender expression (53.4% vs. 68.1%). Students in schools with a GSA said school staff were more likely to intervene when hearing such remarks (18.2% vs. 11.3%). School staff in schools with GSAs were reported to be more supportive and fellow students

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more accepting. This difference in school climate appears to lead to greater feelings of safety and better attendance as well as an increased sense of belonging (Kosciw, et al., 2018).

GSAs can help students in many ways. The club's advisor(s) can provide a visible and supportive adult within the school building. The group can increase staff awareness of LGBTQ+ issues and make it more likely that staff will intervene in situations of bullying and harassment. Since LGBTQ+ students frequently avoid extracurricular activities and school events, membership in the GSA can help these students develop a greater sense of school connection and belonging. Relationships with both LGBTQ+ peers and straight allies can blossom and increase students' sense of social support as well as increase the social norms of LGBTQ+ acceptance throughout the school. When GSAs support and nurture student activism, this may further increase students' self-esteem and feelings of efficacy. Through social and political action, students can be exposed to the larger world in a positive and supported way, make new relationships, and gain a sense of their own power.

Inclusive Curricula

Inclusive curricula can help increase student engagement, thereby improving student academic achievement, graduation rates, and post-secondary educational goals. Attending a school that intentionally includes LGBTQ+ content within the curriculum is related to greater feelings of safety among LGBTQ+ youth (Russell, Kostroski, McGuire, Laub, & Manke, 2006). According to Kosciw and colleagues (2018), having an LGBTQ+-inclusive curriculum was related to many positive outcomes for these students. Students surveyed in schools with such curricula reported fewer homophobic slurs (42.9% vs. 64.6%) or hurtful comments about gender expression (51.1% vs. 65.1%). LGBTQ+ students in these schools felt safer and reported lower levels of LGBTQ+-related victimization. Their grades were higher (3.3 vs. 3.2 GPAs) and more of them had plans for continuing education after high school. They reported that peers were more accepting (67.6% vs. 36.0%) and they had a greater sense of school belonging than those in schools without LGBTQ+-inclusive curriculum (Kosciw, et al., 2018). Another student noted that an LGBTQ+-inclusive curriculum was a key component in moving school culture in the direction of inclusivity and equity. She saw her school's gay and lesbian studies course as important: "I think courses like this make that possible. It just sends a message, you know. Oh, I just love my school" (Short, 2017, p. 19).

Anti-Harassment Policies that Specifically Mention LGBTQ+

While most of the LGBTQ+ students surveyed say their school has a specified anti-bullying policy (79.3%), few of them had a policy that specifically included sexual orientation and gender expression (12.6%), with even fewer reporting that their school district had specific policies to protect gender nonconforming individuals (10.6%) (Kosciw, et al., 2018). Youth who reside in communities with anti-bullying policies that specifically state the protection of LGBTQ+ individuals have less self-reported suicidality (Hatzenbuehler & Keyes, 2013). LGBTQ+ students attending schools with inclusive anti-bullying policies were less likely to hear homophobic slurs (46.6% vs. 62.5%) or hurtful remarks about gender expression (51.0% vs. 63.7%) than those in schools with a more generic policy. Students in these schools reported less homophobic LGBTQ+-related victimization and were more likely to tell school staff when such incidents occurred, feeling the adults' responses were more effective (Kosciw, et al., 2018).

Schools with specific policies for dealing with gender nonconforming and transgender students had such students report much less discrimination during the school day in terms of refusal to use their chosen

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name and preferred pronouns (22.5% vs. 47.5%), using their preferred restroom (23.5% vs. 51.9%) or locker room (26.1% vs. 48.1%), or being prohibited from wearing clothing not considered appropriate for their gender (9.0% vs. 28.3%). Fewer transgender or gender nonconforming in schools with such policies reported missing school because of fear for their safety (54.7% vs. 67.0%), and they reported greater feelings of school belonging (Kosciw, et al., 2018).

Middle School Is Tough

The middle school years may be a particularly difficult time for sexual minority youth both in terms of increased harassment and fewer resources. According to GLSEN's 2017 school climate survey,

LGBTQ+ students in middle school had more hostile school experiences than LGBTQ+ students in high school, including experiencing higher rates of biased language, victimization, and anti-LGBTQ+ discriminatory school policies and practices. LGBTQ+ middle school students were less likely than high school students to have access to LGBT-related school resources, including GSAs, supportive educators, LGBTQ+-inclusive curricular resources, and inclusive policies. (Kosciw, et al., 2018, p. xxvii)

RECOMMENDED STRATEGIES FOR SCHOOL-BASED MENTAL HEALTH PROFESSIONALS TO FOSTER RESILIENCY IN LGBTQ+ CHILDREN AND YOUTH

1. **Become an Ally:** According to Cooper (2016), "A key role of a school-based ally is to use the power and influence they have as an educator to advocate for the rights of LGBTQ+ students and ensure safe schools for all" (Communiqué, p. 32). Make a commitment to fulfill this role through as many of the activities listed below as possible.
2. **Work to Gain Administrative Support:** Use clinical, consultation, and collaboration skills to garner support from school administration. Nearly all of the resiliency strategies presented in the current chapter require or would greatly benefit from the active engagement and clear support of school and system administrators. Cooper (Communiqué, 2016) provides suggestions for gaining administrative support. She suggests using data-based approaches, illustrating the need for change with statistics or observed behaviors within the school. Emphasizing that change will improve the safety of the school and benefit all students is likely to resonate with administrators, particularly if a clear and specific action is proposed.
3. **Develop a GSA or Support an Existing GSA:** Serving as faculty advisor or supporter of a GSA helps to identify a staff member as a supportive adult on campus. The existence of a GSA has enormous benefits for school climate and LGBTQ+ youth resiliency.
4. **Support and Enforce Title IX Provisions:** Current interpretation of existing school law provides some guarantee of protection. Failure to apply protections has led to lengthy and expensive court cases for school districts. According to GLSEN (2016), the "U.S. Departments of Justice and Education jointly released specific guidance to schools and districts clearly stating that discrimination based on transgender status is in violation of Title IX and detailing school's specific responsibilities to ensure transgender students' rights are protected" (p. 38).

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5. **Review Discipline Policy & Practices:** Becoming a member of the school's Positive Behavior Support (PBS or PBIS) team can be an effective way to help make changes in the school's discipline practices and the larger school climate. Look at school data to determine if LGBTQ+ students are receiving a disproportionate amount of discipline. Investigate to see if these students are being disciplined for behaviors that are not cause for penalization for their non-LGBTQ+ peers. Once data have been collected and analyzed, make appropriate policy and practice changes. This might include changes such as developing a gender neutral dress code. Help to institute more positive behavior supports to all students who display behavior difficulties. This might include social skills training, conflict mediation, or "cool down" spaces within the school.
6. **Support Non-Exclusionary Discipline Practices:** A focus on restorative practices as opposed to exclusionary discipline can be a powerful tool in transforming the school culture for both bullies and the victimized.
7. **Provide Professional Development & Training to School Staff:** Most school administrators (69%) say that training is needed in order to help their school staff intervene to effectively address LGBTQ+-related harassment and bullying and most (75%) think their staff would be receptive to efforts to increase support and safety for LGBTQ+ students (GLSEN & Harris Interactive, 2008). Teachers agree and the vast majority have reported that staff development would help makes schools safer for LGBTQ+ youth (Greytak, et al., 2016).
8. **Help to facilitate a school atmosphere in which LGBTQ+ staff, families, and students feel safe and encouraged to be out:** Greater numbers of individuals within the school community who are open and authentic will help to lessen stigma and bias overall as non-LGBTQ+ individuals within the school community develop positive relationships with their LGBTQ+ colleagues. This will also allow LGBTQ+ students see appropriate role models, and feel a greater sense of belonging within the school community. Contact with LGBTQ+ peers leads to intergroup friendships and fewer self-reported homophobic acts (Poteat et al., 2013). Being open about their sexual identity is linked with stronger academic achievement, higher self-esteem, and fewer difficulties with anxiety and depression in sexual minority students (D'Augelli, Grossman, & Starks, 2005; Kosciw, Palmer, & Kull, 2014).
9. **Provide support to teachers in developing a more inclusive curriculum:** Assist faculty with resources to positively include LGBTQ+ individuals, issues, and history within their discipline. Two sources of outstanding resources on these topics are GLSEN's Educational Resources page ("Educational Resources," glsen.org/educate/resources) and Teaching Tolerance's Classroom Resources page ("Classroom Resources," tolerance.org/classroom-resources). Suggest ways to embed such content within existing curriculum standards.
10. **Help to make extracurricular activities safe and affirming for LGBTQ+ students:** This might include providing training and support to athletic staff and coaches as well as those who serve as advisors to other clubs and activities.

FUTURE RESEARCH DIRECTIONS

While research has supported a handful of school-wide practices (e.g., GSAs, inclusive curricula) that provide a resiliency function for LGBTQ+ youth, there is still a need to investigate other policies and practices that may be helpful. Moreover, there is a need for research to establish more individual

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and small group supports and mental health services that may promote healthy development in sexual minority youth. While adolescents have been the focus of most existing research, a deeper look at the developmental experiences and needs of younger LGBTQ+ individuals is crucial. Early intervention is key to halting the development of long-term problems in most populations. Promoting the resiliency of younger individuals is an important goal. Finally, research on the most effective means for educating and supporting school-based mental health professionals, school and district administrators, and teachers as they do this work is recommended.

CONCLUSION

Supporting the healthy growth and development of all students within schools is the goal of school staff generally and school-based mental health professionals in particular. Understanding the challenges faced by LGBTQ+ youth is essential in meeting their needs. Using a resiliency-based approach, mental health professionals can help support and guide their schools towards practices that have been proven to nurture the development of sexual minority youth and increase their resiliency. The rewards of such work will benefit society, families, schools, and the students they serve.

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KEY TERMS AND DEFINITIONS

Ally: An individual who uses their power and energies to help support LGBTQ+ individuals.

Gay, Lesbian, and Straight Education Network (GLSEN): An organization founded by teachers dedicated to making schools safe, affirming and inclusive places for LGBT youth.

Gay-Straight Alliances (GSAs): School clubs or organizations consisting of LGBTQ+ youth and peer allies that serve a support and advocacy function for LGBT youth.

Minority Stress Theory: An explanation for the numerous negative outcomes related to the victimization of LGBT youth. Given the disproportionate discrimination, harassment, and stressors these individuals face, physical, emotional and academic difficulties are likely to follow.

Resilience: The ability of the individual to adapt and function in a relatively healthy matter despite adverse experiences.

Resiliency Factors: Variables that help the individual buffer against negative experiences and move forward.

Sexual Minority Youth: Young people who do not identify as heterosexual and/or gender typical.

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Chapter 40
Inherent Requirements and Social Work Education:
Issues of Access and Equity

Steve Boucher
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ABSTRACT

The aim of this chapter is to contribute to addressing issues of access and equity in social work education for people with mental health disabilities. The objective is to carefully consider the introduction of inherent requirements in universities, and particularly in relation to social work education, in Australia. A targeted review of relevant literature including legislation, policy, and practice standards frameworks identifies the parameters of inherent requirements and possible areas of discrimination. Consideration of the use of inherent requirements in social work education is from a human rights social justice perspective that acknowledges the strength and resources of people and communities and actively advocates for the protection of disability rights.

INTRODUCTION

The generation of knowledge through research is not a neutral activity. What is investigated, how and by whom is intrinsically political and invites the question, what is the purpose of this inquiry? This is particularly true when it comes to studies which serve to delineate the terms on which historically oppressed groups are to be granted access to mainstream activities. As I consider literature relating to the participation of "mad" students in tertiary education I believe that it is essential for me to clearly state my own experience, position and purposes.

I am a person whose life and perspectives have been fundamentally shaped by the experience of disability, both physical and psychological. Furthermore, I have worked as an advocate within the tertiary sector and in an organisation which has encouraged me to dedicate myself to actively fighting against discrimination alongside students with disability. My approach to research comes from an originally Marxist understanding of how experience is shaped through social processes of class based oppression,

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deepened by the application of critical disability studies to understand how the material experience of living within a 'disabled' body/mind is mediated by discourses, physical and social structures which serve to limit and marginalise the participation (and perspective) of those who deviate from a medicalised 'norm'. For me, the purpose of scholarship is to take a side and consciously work to develop tools for change.

The management of disability within the western tertiary sector is a complex and contested space (Bessant, 2012). Despite the rights of students with disabilities being protected by legislation, critical authors have noted that university practices focus on short term individualised accommodation, within existing educational practices, at the expense of change towards a more truly inclusive system (Jung, 2003; Meacham, Tandy, Giddings, Vodde, Curington, Morris, & Holliman, 2004). From a disability rights perspective, disability is tolerated on the proviso that individual students comply with institutionalised rituals and norms within a system which often considers 'it' to pose a threat to underlying academic and professional standards (Poole, Jivraj, Arslanian, Bellows, Chiasson, Hakimy, Pasini, & Reid, 2012; Price, 2011; Quinn, Wilson, MacIntyre, & Tinklin, 2009).

A growing trend with Australian universities has been to articulate statements of 'inherent requirements' in order to help programs define their standards in relation to disability (Brett, Harvey, Funston, Spicer, & Wood, 2016). To date these statements have received little critical scrutiny despite their apparently pivotal significance in drawing boundaries to inclusion (McNaught, 2013). Whether these statements will act as a platform for more inclusive practice or create further rationales for limiting the participation of students with disabilities remains to be determined.

The literature review in this chapter provides a background for an investigation into the potential impact of the statements in social work, a discipline with both a long history of managing 'unsuitable' behaviour and an active commitment to inclusive and empowering practice (Meacham, Tandy, Giddings, Vodde, Curington, Morris, & Holliman, 2004). It provides an overview of disability accommodation within the Australian university sector with a particular focus on the experience of students with depression and anxiety, amongst the most prevalent disabilities on campus, which are also often unaccommodated by disability support systems due to low disclosure rates and structural barriers to support (Markoulakis, 2014; Martin, 2010). The review concludes by examining social work's literature on professional suitability and critiques of its practices regarding mental health.

BACKGROUND

The Australian Tertiary Education Sector

The preceding three decades have been a time of significant structural change in Australian higher education (Watts, 2016). Reforms have caused an expansion in student enrolments and the number of public universities (Harvey, Burnheim, & Brett, 2016). Public providers now face direct competition from private colleges and within a globalised marketplace, for fee paying international student enrolments necessary to maintain institutional budgets in the face of reductions in government funding (Marginson, 2006). A key reform has been to link tertiary education to labour market outcomes and universities have refocused teaching away from disciplines such as liberal arts into vocational and professionally focused programs (Watts, 2016). This can add another level of regulatory complexity as programs also have to teach towards accreditation standards set by professional qualifying bodies (Harvey, Burnheim, & Brett, 2016; McNaught, 2013).

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Universities are heavily regulated (Probert, 2015). Public universities' primary source of government funding are commonwealth grants through the Higher Education Support Act which are linked to enrolled student load and which require compliance with external quality frameworks, particularly the *Threshold Standards for Higher Education Providers* and the *Australian Quality Framework* which respectively set mandatory standards for facilities, staffing and administration and the educational levels of qualifications (DIISRTE, 2011; Watts, 2016).

Universities are required to meet equitable performance targets. First elaborated by the Commonwealth in *A Fair Chance for All* (1990), targeting focuses on recruitment of students with characteristics which have traditionally been underrepresented in higher education, including people with disability (Harvey, Burnheim, & Brett, 2016). This regime has succeeded in increasing both participation and completion rates for students with disability (Brett, 2014). The increased participation of these students adds another significant regulatory overlay to higher education, anti-discrimination law (Varnham & Kamvounias, 2009).

DISABILITY RIGHTS IN UNIVERSITIES

Although universities are covered by state equal opportunity legislation (Varnham & Kamvounias, 2009), government funding and service agreements stipulate compliance with the Disability Discrimination Act, 1992, (Cth) (DDA) (Urbis, 2015). Section 22 of the DDA prohibits discrimination in education, including by refusing to accept or placing unreasonable conditions on admission, denying access to benefits or services, expelling a student and/or by developing or accrediting criteria which will have these effects (DDA, 1992). The Act also applies to bodies which regulate professional qualifications (s19). The definition of 'disability' in the Act is broad and is explicitly based on a social model of disability (Howe & Duffy, 1992). Similar to disability rights legislation in other English-speaking countries, such as Britain, Canada and the United States (Harvey, Burnheim, & Brett, 2016), the foundational assumption is that discrimination occurs as the product of an interaction between an individual's impairment and social conditions ranging from policies and standardised expectations through to aspects of the built environment (Howe & Duffy, 1992). Section 6 of the DDA has the effect of requiring adjustments to be made to requirements placed on people with disability where reasonable alternatives can be identified (Australian Human Rights Commission, 2011).

A legislative instrument, the *Disability Standards for Education*, *2005*, (DSE) provides detailed guidance on how the Act is to be implemented across schools, vocational education providers and universities. Standard 3 establishes processes for making adjustments and is generally considered to be the most critical standard in higher education (AHRC, 2011). There is not an automatic right for the impact of a disability to be accommodated (AHRC, 2011). Education providers must balance a number of factors, including the nature of a disability's impacts on particular requirements, the views of the affected party and the broader impact of making an adjustment including costs and benefits (DSE, 2005, Part 3). An additional significant proviso is that:

In assessing whether an adjustment to the course or program in which the student is enrolled, or proposes to be enrolled, is reasonable, the provider is entitled to maintain the academic requirements of the course or program, and other requirements or components that are inherent in or essential to its nature (DSE, 2005, 3.4(3)).

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In universities, reasonable adjustments are typically recommended by specialised units located outside of academic programs (Jung, 2003; Timmerman & Mulvihill, 2015). The system requires students to provide medical documentation to verify their status as disabled and only captures students who are prepared to disclose their condition (Jung, 2003). Although common adjustments to assessment have been demonstrated to have high validity (Konur, 2002), their implementation is at the discretion of academic staff who sometimes refuse to make accommodations (Fuller, Healey, Bradley, & Hall, 2004). Studies of the system of seeking accommodations have documented that students find it time consuming and difficult to navigate (Markoulakis, 2014).

INHERENT REQUIREMENTS IN HIGHER EDUCATION

Despite a significant early judgement, W v Flinders University, which considered inherent requirements in relation to a teaching practicum (Dickson, 2012), inherent requirements in education have received very little attention in academic publications until recently (McNaught, 2013). Borrowing from principles established for considering claims of discrimination in employment, Watts and colleagues at Curtin University first enunciated a framework for Australian university programs to define inherent requirements in the year 2000. Although the term still has no universally accepted definition it is commonly understood that inherent requirements should be explicitly based on fundamental requirements for learning and practice as distinct, for instance, from the methodologies used situationally to teach or assess these requirements (Bialocerkowski, Johnson, Allan, & Phillips, 2013; Dickson, 2012).

Watts and colleagues' (2000) central arguments were that universities need to define inherent requirements in order to assist prospective students to make informed choices before enrolment and to facilitate determining which adjustments were reasonable. This position was strongly advocated by a number of universities during the 2010 and 2015 reviews of the DSE (DSERT, 2012; Urbis, 2015). The reviews found that greater clarification of the relationship between inherent requirement statements and the Standards was required with the 2015 review concluding that the application of inherent requirements in the vocational education context was inconsistent and contested (Urbis, 2015). Brett and colleagues (2016) identified the University of Melbourne as the first to publish statements across all programs but noted that these were typically brief and generic. Despite notes of concern, universities have begun to publish increasing numbers of statements (Bialocerkowski, Johnson, Allan, & Phillips, 2013). More significant to the process of developing statements was the introduction of Western Sydney University's Inherent Requirements of Nursing Education (IRONE) project in 2010-11 (McNaught, 2013). IRONE set out a detailed framework of domains for requirements which is now being applied to other health disciplines across Australia (Bialocerkowski, Johnson, Allan, & Phillips, 2013).

Brett's (2016) study is the first large scale attempt to map statements in Australian tertiary education. Conducted in 2015 its targeted search located a total of 78 unique statements. The authors noted that methodological difficulties with the search, which focussed primarily on fields of education where it was known that statements existed together with its time limited rather than longitudinal nature, meant that this figure underestimates the likely true number of statements. Statements themselves vary considerably in detail, 17 are of less than 500 words and 30 are 2000+ (p. 21). There are differing frequencies with which statements are encountered by university grouping and field of education (pp. 22-3) with the greatest prevalence being in health, where 59% of programs surveyed had a statement. In social work and community welfare the figure was 9 out of 31 or 29% of sampled programs (p. 24).

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While the statements show a degree of borrowing from other institutions they do not all cover the same categories. Brett provides a Table (p. 24), reproduced below, of the general categories employed to group requirements together with their frequency.

These broader categories are split into sub-domains which contain specific statements of requirements. Exemplars given by Brett (pp. 30-2) include:

Table 1. Frequency of common domains in inherent requirement statements (reproduced from Brett, 2016)

Category	Number of inherent requirement statement including category	Percentage of inherent requirement statement including category
Verbal and non-verbal	73	93.6
Behavioural stability	66	84.6
Cognition	65	83.3
Written	52	66.7
Motor skills	51	65.4
Ethical behaviour	48	61.5
Literacy	44	56.4

Verbal and Non-Verbal Communication: "*Effective and efficient verbal communication, in English, is an essential requirement to provide safe delivery of care*."

Behavioural Stability: "*Students will be exposed to highly complex human situations and will be required to have behavioural stability to manage these events competently and professionally.*"

Cognition: "*Consistent and effective knowledge and cognitive skills must be demonstrated*."

Motor Skills: "T*asks that include fine motor skills include being able to grasp, press, push, turn, squeeze and manipulate various objects and individuals*."

Brett found that only nine statements provided information about their legal basis. None included explanatory case studies or reference to complaint processes and the rights individuals could rely on to seek accommodations (p. 25).

The lack of contextual information accompanying the individual requirements suggest that the statements will be problematic for both people with disabilities and the universities. The DSE requires that adjustments be made to requirements to avoid discrimination with universities currently providing students with adjustments such as Auslan interpreters, rest and recovery breaks in assessments and participation aids to assist with motor tasks (Konur, 2002). Performance requirements such as the manipulation of equipment falls into an additional legal dimension of adjustment; whether an institution (or future employer) has an obligation to provide modified equipment (AHRC, 2011). Such decisions require consideration of whether modifications will result in 'unreasonable hardship' by placing a strain on overall resources (Waldeck & Guthrie, 2004). That a university can undertake a greater level of expense than a small employer is uncontroversial but raises the question of how universities should manage the boundary between education and preparation for future employment (Brett, 2014; Harvey, Burnheim, & Brett, 2016).

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There has been little analytical scholarship on the potential impacts of statements. In the context of a case study regarding a visually impaired physiotherapy student's participation in professional placement, the authors noted that statements of inherent requirements may have a discriminatory effect by not taking adequate account of personal factors such as a student's adaptability and resilience (Johnston, Mackintosh, Alcock, Conlon-Leard, & Manson, 2016). Noting that several of the common domains of requirements will potentially impact on the participation of students with mental health issues, McNaught (2013) questions whether the statements, in potential combination with requirements for mandatory reporting of impaired health, will deter students from disclosing these conditions to their universities.

PARTICIPATION OF STUDENTS WITH DEPRESSION AND ANXIETY

Students with mental health problems are participating in tertiary studies in increasing numbers. College counselling services in the United States have reported increases both in the number of students seeking help and the severity of their symptoms (Wyden, 2007); a trend which has been reported across English speaking countries. Although higher levels of distress in students are often reported (Larcombe, Finch, Sore, Murray, Kentish, Mulder, & Williams, 2016), these increases have been found to be reflective of broader societal trends which include the common age of onset of disorders, more widespread awareness and diagnosis and improved treatment regimens (Cvetkovski, Jorm, & Reavley, 2012; Hunt & Eisenberg, 2010; Stallman, 2010). Retrospectively analysing files from an English university counselling centre, Schwartz (2006) found that the underlying prevalence and degree of student distress was relatively stable over the period from 1992 to 2002. Exactly identifying the prevalence of mental health problems amongst students has been complicated by different studies employing different methodologies and cut off points for identifying serious levels of distress (Buchanan, 2012). If, it is accepted that the mental health of the Australian student body is reflective of that of the broader community, the yearly prevalence rate of depression alone is 11% (APS, 2012). This makes the accommodation of mood disorders is a serious issue for universities. Large scale studies of the impact of disease by the Australian Institute of Health and Welfare (2016, pp. 38-9) have estimated that mood and substance abuse disorders contribute 24% of the non-fatal burden of disease, and that the contribution of depression and anxiety is greater within the age groups traditionally entering university:

Table 2. Contribution of depression and anxiety to non-fatal burden of disease by age and gender

		Depression	Anxiety
15-24 year olds	Males	8.3%	7.1%
	Females	11%	14%
25-44 year olds	Males	8.5%	7.5%
	Females	10%	12%

Study can be a stressful experience and students have been shown to be at heightened risk of developing depression and anxiety while at university (Hunt & Eisenberg, 2010). Students experience greater stress during first year (Cooke, Bewick, Barkham, Bradley, & Audin, 2006) and distress across their degrees

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with one Australian study of over 6000 students finding that 19.2% of students demonstrated clinical symptoms of anxiety and depression (Stallman, 2010). Compounding these issues are low disclosure rates and significant delays between the onset of mental health problems and treatment (El Ansari & Stock, 2011; Kessler, Olfson, & Berglund, 1998; Laidlaw, McLellan, & Ozakinci, 2015; Olfson, Kessler, Berglund, & Lin, 1998; Thompson, Hunt, & Issakidis, 2004; Wang, Berglund, Olfson, & Kessler, 2004). Although there is a generally decreasing trend over time in help-seeking delays these remain significant (Christiana, Gilman, Guardino, Mickelson, Morselli, Olfson, & Kessler, 2000).

Many students do not seek assistance from campus services (Hunt & Eisenberg, 2010; Julal, 2015; Kerns, 2013; Rosenthal & Wilson, 2008). A large-scale study of six colleges in Pennsylvania found that 73% of student in distress were not seeking help (Popple, 2013). Reasons for not seeking assistance have been linked to a lack of awareness of services and the existence of stigmas around mental illness (Laidlaw, McLellan, & Ozakinci, 2015; Lustig, Madon, Hyun, & Quinn, 2006; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Thompson, Hunt, & Issakidis, 2004). Studies which spanned students and graduate practitioners in law and medicine students have confirmed the existence of high levels of perceived public stigma together with reluctance to seek help (Chew-Graham, Rogers, & Yassin, 2003; Di Stefano, 2010). More recent general scholarship has found that attitudinal factors are the primary barriers to seeking assistance (Hunt & Eisenberg, 2010). Psychological research into mental health stigma with students has tended to explore the difference between internalised feelings of shame and perceived public stigma towards the condition. Although heightened levels of concern about public stigma are reported (Eisenberg, Downs, Golberstein, & Zivin, 2009), it is commonly found that internal factors more critically influence disclosure and help-seeking decisions (Golberstein, Eisenberg, & Gollust, 2009; Hunt & Eisenberg, 2010).

Qualitative studies provide a rich insight into the lived experiences of students with mental health conditions illustrating reasons for not disclosing and experiences following disclosure. While most participants report positive experiences these are not universal (Martin, 2010; Timmerman & Mulvihill, 2015). In a meta-synthesis of existing studies of students who had disclosed Ennals, Fossey and Howie (2015) found that a common theme was of encountering difficulties negotiating appropriate support. Negotiating adjustments can be complex and time consuming for students with mental health problems (Markoulakis, 2014) and students with disability employ scripts in order to downplay their needs and avoid potential negative judgements (Barnard-Brak, Lechtenberger, & Lan, 2010; McCarthy, 2007). Participants interviewed by Andrade (2015) described frequent experiences with mental health stigma from other students, and prior to commencing study, with one respondent likening their experience to being "subjected to a hate crime" (p. 82).

These student experiences point to the ongoing presence of negative attitudes towards mental illness in the academy. Lack of exposure to students with disability has been found to be associated with negative attitudes amongst graduate students, who are frequently employed as tutors (McAllister, Wynaden, Happell, Flynn, Walters, Duggan, Byrne, Heslop, & Gaskin, 2014). Negative faculty attitudes about the participation of students with mental health problems have been reported by Thomas (2015) who found that:

- 31.5% of staff felt uncomfortable dealing with a student exhibiting mental health symptoms in the classroom;
- 12.4% did not feel secure in these circumstances, and;
- 10.9% felt that these students were dangerous.

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Thomas' study was conducted in the United States of America, where portrayals of violence on campus have been reported to reinforce stereotypes by focussing on perpetrators' mental health status (Price, 2011). While Australia has lower levels of lethal violence on campus, incidents at Monash and Latrobe did lead to similar coverage and to Victorian universities adopting tribunal style processes for managing students with challenging mental health issues (Preiss, 2013).

Issues, Controversies, Problems: Social Work Students With Mental Health Problems

Social work students have been found to show elevated levels of depressive symptoms, with over 50% of students surveyed by Ting (2011) being over the cut off point for clinical levels of depression. Commenting on similar findings in social work and other caregiving professions, authors have posited that occupying such a role places professionals at higher risk for untreated distress (Pooler, 2008; Sherman, 1996; Strozier & Evans, 1998). A similar survey to Ting's in the United States by Horton, Diaz and Green (2009), found evidence of depression in 34% of respondents. Ting (2011) found that a mix of concerns about stigma, together with resource implications and a distrust of the mental health system, were contributing to low disclosure and treatment rates.

As a profession, social work influences and is influenced by mental health issues (Meacham, Tandy, Giddings, Vodde, Curington, Morris, & Holliman, 2004). Social workers play a pivotal role in mental health treatment systems and community support for underprivileged groups, including those with or at risk of mental health diagnoses (Scheyett, 2005). The profession's emphasis on the critical application of self as part of its signature process creates a situation where workers' unresolved personal difficulties can negatively affect clients (Collins, 2006; Gillis & Lewis, 2004; Watkinson & Chalmers, 2008).

In Australia, the profession employs three main devices to regulate professional conduct and the standard of graduating students; a code of conduct, accreditation standards for education programs and practice standards (AASW, 2010; AASW, 2012a; AASW, 2013). The Code of Ethics requires constructive and reflective practice and for students and professionals to seek adequate support when their performance may be impacted by personal factors, matters which may be impacted by mood disorders (AASW 2010). A search of the Education Standards and supporting documents reveals that the Association does not specify a direct requirement for programs to make adjustments for students with disability, except in the Guideline for Field Education Programs, where disability is treated an as 'extenuating circumstance' which may justify waiving the requirement for continuous five-day blocks of placement (AASW, 2012b, pp. 3-4). The lack of information about legal requirements to provide adjustments is extraordinary, given that bodies which accredit programs fall under the ambit of the DDA and DSE (Brett, 2014; DDA, 1992, S19; DSE s1.5(g)ii-iii). Social work must balance the imperative to ensure safe and effective practitioners with its historical commitments to social justice and inclusive practice without specific guidance from the professional accrediting body, the Australian Association of Social Workers (AASW), creating tensions for academics charged with responsibility for judging professional suitability (Adams, 2011; Sowbel, 2012).

The establishment of academic standards alone does not guarantee suitable graduates and significant attention has been devoted to how educators should manage issues of students' professional suitability. While some authors suggest that the primary site for gatekeeping should be within the application process (Collins, 2006; Tam & Coleman, 2009), application statements do not reliably predict future problems (Regehr, Stalker, Jacobs, & Pelech, 2001). These difficulties are illustrated by legal action in Canada

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which resulted in damages against social work educators for an admission decision made on grounds of perceived suitability (Redmond & Bright, 2007). Once a student is admitted, social work programs tend to have low failure rates making the primary sites for screening out unsuitable students informal counselling and field practicums (Adams, 2011; Barlow & Coleman, 2003; Urwin, Soest, & Kretzschmar, 2006). It is logical to expect that statements of inherent requirements will be used within these processes to guide students and educators on the expected standards of the program with anecdotal reports suggesting this is happening (Adams, 2011; Elpers & FitzGerald, 2013; Mazza, 2015; McNaught, 2013).

While management of students with mental health problems is a common theme in social work's gatekeeping literature, discussion tends to be under-developed and problematic (Meacham, Tandy, Giddings, Vodde, Curington, Morris, & Holliman, 2004). It is common for articles to refer to errors with managing the impact of a student's mental health problem as a starting point for a discussion of gatekeeping issues, without providing any analysis of how shortcomings could have been addressed (Collins, 2006; Watkinson & Chalmers, 2008). When referring to legal issues, authors often devote considerable space to explaining the courts' traditional deference in matters of academic judgement without informing readers of rights and processes for making reasonable adjustments (Currer & Atherton, 2008; Wayne, 2004). Other articles report the development of gatekeeping policies without any specific discussion of disability rights (Barlow & Coleman, 2003; Urwin, Soest, & Kretzschmar, 2006). One notable exception is Valdosta State University whose social work program took the lack of clarity in the literature as a prompt for a sweeping review of their practice with students with disability (Meacham, Tandy, Giddings, Vodde, Curington, Morris, & Holliman, 2004).

Meacham commented that management of disability in practicum courses can be made more difficult by lack of knowledge and discriminatory attitudes amongst field supervisors and agencies (2004). This reflects a critique of social work by critical disability scholars and some faculty who contend that the profession has paid insufficient attention to disability rights (Dupre, 2013; Poole, Jivraj, Arslanian, Bellows, Chiasson, Hakimy, Pasini,& Reid, 2012). Acrey (2004) has documented social work scholarship's focus on medicalised models of mental health at the expense of empowerment and Scheyett (2005) notes that social work has made little contribution to the discussion of mental health stigma. Drawing these themes together, authors have begun to call for the discipline to thoroughly review its approach to mental health (Meekosha & Dowse, 2007; Poole, Jivraj, Arslanian, Bellows, Chiasson, Hakimy, Pasini,& Reid, 2012; Reid & Poole, 2013).

Social work has a significant role in mental health services and its current students have been demonstrated to have heightened risk of experiencing these problems. It has been the subject of justifiable criticism for its uncritical approach to the education and inclusion of students with mental health conditions. While professional standards apply these do not specifically address students with disability's rights. The discipline has a strong interest in screening out potentially unsuitable students and its approach to articulating inherent requirements will directly shape this practice. How social work programs frame their statements in regard to common hidden disabilities is therefore a critical issue for its currently enrolled students and requires further investigation.

SOLUTIONS AND RECOMMENDATIONS

Social work academy and professional accreditation bodies need to focus on the personal and political aspects related to inherent requirements. Disability rights are inherent in social work mission statements

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on social justice and human rights and this includes the disability rights of prospective and current social work students. Prejudicial, often covert, attitudes and practices of academic staff regarding 'personal views on suitability for social work practice' need to be openly named – for discriminatory practices to be addressed so that students feel safe in the knowledge they will be provided with appropriate adjustments in a supportive and non-judgmental environment. Open discussion is required amongst social workers on what is a very contentious topic with strong views on either side. However, a sign of a truly mature profession is in its ability to engage with and openly discuss controversial topics particularly where issues of human rights and discrimination are involved. Education is a main facilitator of life opportunities leading to increased employment opportunities, affordable housing options and socialisation. If inherent requirements are to be adopted by universities and social work programs, it is imperative that these do not become another vehicle for discriminatory practice by social work academics and practitioners who believe that people with certain disabilities are more suited to client and not worker roles. Recent developments in the consumer movement with the co-design and co-production of mental health services, and the rapid growth of the peer mental health workforce, suggest that a focus needs to be on student's strengths and capabilities and not a narrow and limited view of disability from a deficits perspective.

FUTURE RESEARCH DIRECTIONS

Further research is required on the implementation and impacts of inherent requirements, particularly in relation to the health and human services disciplines. This includes impacts on student disclosure and help-seeking for initial entry into a degree program as well as when problems develop post enrolment. This is in relation to different mental health issues as stigma and discrimination vary according to diagnosis. Further research is required on discriminatory attitudes amongst staff and students toward students with disabilities and issues of social inclusion and exclusion in the university environment. Research that considers roles and responsibilities of universities, professional accreditation and registration bodies and practitioner communities in determining suitability for practice would be useful.

CONCLUSION

The introduction of inherent requirements in social work education requires careful consideration of the mission of social work and the personal and political aspects of the profession. Universities need to carefully consider whose responsibility it is to determine a person's suitability for enrolment to study in a particular discipline. The limits of such decisions need careful consideration. For instance, does a university simply decide on a person's capacity to effectively engage in and complete a program of study, or does this extend to deciding on a person's suitability to practice in a particular profession? Universities take a different view on this and in disciplines and countries, such as Australian social work, that do not have a professional registration body, pressure is placed on universities to be the gatekeepers for the profession. Any actions taken by universities need to uphold disability rights and to acknowledge the strengths and capabilities of students with mental health issues. Prejudicial attitudes and discriminatory practices need to be eliminated and staff held to account if students are to feel truly safe and supported and to have their rights upheld at university and in practice during field practicum.

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Chapter 41
Healing Together:
The Lid Project

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ABSTRACT

This chapter emphasizes several key concepts concerning mental illness in today's society. The author strongly believes that mental health recovery is possible and that it is an individualized journey. People struggling with mental health issues can find hope and healing through the use of artistic expression. This chapter is designed to encourage and inspire others to use everyday items and turn them into art. The author describes how collaboration can be a key ingredient to the success of the healing that takes place while doing art together.

INTRODUCTION

While trauma disorders are currently receiving significant attention, countless other mental health disorders often remain undiagnosed, ignored, and stigmatized. Statistically, 1 in 4 adults struggle with a mental illness in a year (Johns Hopkins Medicine). That is 1 out of every 4 people in a family, 1 out of every 4 coworkers, students, friends and neighbors. In other words, a quarter of the population is struggling with a mental illness at any given moment. Mental illness is non-discriminatory and crosses all cultural lines, age brackets, and economical statuses. So while communities and schools rush to become trauma-informed, it may be more poignant to acknowledge, educate, and respond to the extremely high percentage of people living with mental illnesses beyond those associated with trauma.

Fortunately, the benefits of art making do not discriminate either. Regardless of diagnosis, the arts have repeatedly demonstrated an ability to heal. Engaging in music correlated to a form of relaxation, a decrease of tension and anxiety, and control of chronic pain. Making art led to a reduction of the stress producing hormone cortisol, and also gave participants a sense of identity. The findings of movement expression and expressive writing are similar, but added findings of a boost in immune functioning, significant improvement in physical health, and an overall improvement in quality of life (Stuckey and Nobel, 2010).

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Collaborative art projects seek to intertwine people traveling similar paths; building trust and connections in an effort to simultaneously decrease feelings of isolation while providing movement towards coping and healing. This chapter shares the story of The Lid Project, a collaborative art project set at Transitions, a psychiatric rehabilitation program. While the story may offer the reader a project to replicate, the more substantial takeaway is the richness of metaphor for the healing journey found within the story and the process of creating art together.

Collaborative Art Making

Strategically planned arts based experiences can play a very valuable role in healing for those living with mental illness. The arts have been shown to improve focus, mood, brain function, communication, and social skills, all of which are necessary for working toward healthy living and thinking (Nurrie-Stearns, 2013). The arts offer choice and opportunities to take control. For those who have experienced trauma or live with a mental health diagnosis, art making can promote skills to help regulate emotions, build confidence and self-esteem, and foster therapeutic communities and relationships through collaboration.

The shared experience of group art making in particular has many benefits. First it provides safety, which aids in building trust and stronger relationships among members of a group. The art maker is able to be vulnerable and understood by the group, without having to verbalize his experience, making it a safe form of communication and expression (Moon, 2010). Secondly, collaborative work lessens the pressure for one person to achieve an end goal successfully on their own. Both the individual and the community around him are empowered as they work together to achieve their goals (Moon, 2010). Finally, according to art therapist Dr. Bruce L. Moon (2010), "Making art in the presence of others is an expression of hope" (p. 8). When an individual is free to express and be understood by others through his artwork, he can begin to trust in something outside of, or greater than, himself. Ultimately, working collaboratively can move the participant away from feelings of isolation towards being part of a community (Rossetto, 2012).

Feelings of isolation are common among people who are in the midst of mental illness, addiction, grief and other traumatic experiences. These experiences may be difficult to talk about, which is why art making can be a valuable and effective method of therapy for many. Moon says, "In art-based group therapy we often witness creative expressions of feelings that are beyond the communicative abilities of conventional speech" (2010, p. 29). Making art within a group context allows people to share their stories without having to verbally articulate their experiences. This helps to establish an atmosphere of safety and trust, which is key to successful group therapies.

Artwork in any form (dance, music, painting, writing, etc.) can be considered a "partial self-portrait that metaphorically represents that artist's life" (Moon, 2010, p. 67). This makes one very vulnerable to the group when they share their work. However, when other group members are able to see and relate to the experience of the art maker, organic relationships begin to form, and the power of understanding that one is not alone in the world begins to establish feelings of hope. Moon says, "Acts of creating are invitations to relate. By making things, artists take images from within and give them visible form in the world" (2010, p. 4). Art making offers an alternative way for one to reconnect not only with himself, but with the world beyond.

When in a group, an individual is part of a collective whole working to achieve a common goal. This can set a participant at ease because he/she is not solely responsible for a final outcome of a project. The potential for creativity magnifies as ideas from one participant are able to expand off of ideas of

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the other group members. Working through ideas with others changes isolation into connection (Moon, 2010), and gives group members choices about how they work together, and what they want to achieve as a collective whole. After that achievement is met, a sense of pride and ownership becomes evident, and group members find the confidence to continue trying new things and working together.

Description of Facility Program and Population

Psychiatric Rehabilitation (Psych Rehab) programs are designed to promote recovery, community integration, and an overall improvement in life for those diagnosed with a mental illness (Psychiatric Rehabilitation Association, n.d.). Transitions, located in Chester County, Pennsylvania, is a group-based model that utilizes evidence-based practices within a rotating twelve-week schedule. These groups vary based on the needs of the current membership and the goals they have set for themselves. Transitions serves adults who live with severe and persistent mental illness.

Upon arrival, new members are assigned a Primary Coach. These Psych Rehab workers are not therapists, but are there to support the client and assist them in achieving goals they set for themselves in areas such as living, learning, working, and socialization. The Primary Coach also helps to navigate the mental health system, which is vast and can be intimidating.

Participants

According to the Mayo Clinic's website, the definition of mental illness is, "disorders that affect your mood, thinking and behavior." Among the different diagnoses, the symptoms of mental illness are vast. Those who are accepted into the Transitions program exhibit characteristics associated with mental illness that can be nuanced or overt. Symptoms of schizophrenia, bipolar disorder and major depression disorder tend to be more widely recognized. However, symptoms associated with personality disorders, anxiety disorders, and trauma related disorders may not be so obvious.

Any and all mental health symptoms may cause those experiencing the symptoms to feel disconnected to friends and family or just as likely, have friends and family reject or turn away from them. Symptoms demonstrated by individuals with schizophrenia and bipolar disorder include depression and anxiety, hopelessness and thoughts of suicide, lack of social skills, and cognitive impairment. Those with bipolar disorder may also experience rapid mood swings, mania, or insomnia (Rodseth, 2011). Individuals diagnosed with major depressive disorders may demonstrate a lack of interest in activities, lack of energy and appetite, have trouble sleeping and may have suicidal thoughts or behaviors. Symptoms of anxiety disorders manifest as excessive worry, restlessness, irritability, and sleep disturbance (Smith, 2018). Trauma symptoms are similar to those of anxiety and depression and may include fear and anxiety, sleep disturbance, hypervigilance, difficulty concentrating, and problems controlling anger. Trauma survivors also struggle with feelings of safety and the ability to trust others (Setti & Argentero, 2014).

Many people facing mental illness find it very challenging to make friends, obtain jobs, and even complete simple tasks if these symptoms are not managed (NIMH, 2016). There are many reasons why adults struggling with mental health issues would come to Transitions: some are looking for people to whom they can relate; some need support going back to school, getting their driver's license and/or finding a job; others are there to learn a new skill set based on the impact of their mental illness symptoms.

From the inception of the Transitions program, there are a handful of groups that remain consistent in the different twelve-week schedules. Within these groups, participants develop coping skills for mental

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health issues, relationship skills, job development skills, and artistic expression. The groups themselves have several goals including but not limited to building on skills, increasing natural supports, connection to community services, and building self-esteem. Through the use of art, it is possible to accomplish all of these.

Primary Coaches and Specialists

Psych Rehab workers or Primary Coaches along with Psych Rehab Specialists believe in the philosophy of mental health recovery. The term recovery has been historically linked to drugs and alcohol rehabilitation. However, the term recovery is also associated with mental illness. In 2005, the Pennsylvania Department of Mental Health and Substance Abuse Services released a publication titled, *A Call For Change: Toward A Recovery-Oriented Mental Health Service System for Adults.* This document was a proclamation of the Department's dedication to the Recovery Movement.

Certified Psychiatric Rehabilitation Specialists (CPRP) are professionals who have worked at least two years in the mental health field and have completed a minimum of 45 hours of training specific to "the treatment and/or rehabilitation of adults with serious mental illness" (PRA & PRF). After that time they are eligible to take the exam to become certified. CPRPs believe that people living with mental illness are first and foremost individuals. They believe that they have skills and talents unique to them, and recovery pulls on these strengths. Recovery is an individualized journey and different for everyone. They also work through the belief that recovery means people living with mental illness can find meaningful employment, stable housing, a supportive network and live a fulfilling life (PRA & PRF). It is this philosophical stance that guided the Lid Project.

The Creation of the Lid Project

The Transitions program is part of Human Services. Inc., which is a non-profit agency. As many staff of non-profits would attest, money for art can be tight or non-existent. When approaching this project the staff at Transitions began by working with the supplies they already had available to them: paints, paint brushes, and a large canvas they found tucked away in a closet. They also reached out to people in their network. During the daily morning meetings the Primary Coaches asked all of the Transitions' members to bring in lids of various shapes and sizes. They then approached other staff in the agency and local stakeholders to ask them to save lids as well. Rather quickly bags of lids started showing up. Peanut butter jar lids, soda lids, pickle jar lids, jam lids and so forth. No lid was too big or too small!

After the lids were gathered the project was officially started. Members were told that this was a group project and asked to decorate the lids. Staff presented the theme of mental health recovery and expressed that the lids were to represent what that means to them. Members asked about what the finished project would look like and the facilitator at the time was honest in saying that she wasn't sure what the end result would be. This actually excited the members! There was anticipation about what the lids would turn into.

During that first art group, some of the lids were painted. Members and staff worked side-by-side, each painting a lid or two. Some members were nervous because they hadn't really painted before. Yet, the staff watched as other members encouraged them, saying things like, "That's ok, just put some dots on them, or squiggly lines." This set the members who were nervous at ease and they joined in.

A few weeks went by and more people became involved in the lid project. There were times when the art room was buzzing with laughter and chatter. Other times music was heard up the halls. On some

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lids words started to appear: hope, discovery, journey, etc. Other lids were painted in solid colors with a few accents. The colors ranged from loud primary colors to pastel tones. Each one was unique and symbolized a different artist.

As weeks passed something magical started to happen. The first was that as the members and staff painted, conversations unfolded about past experiences, the realities of mental illness, past traumas as well as fears mixed in with conversations of everyday life. Bonds started to form that didn't previously exist. Relationships between both staff and members became stronger. The members who participated were set at ease and went more in depth with sharing their stories. Around the program there was a genuine camaraderie that developed. Through spending time painting together the members found other members who had gone through similar experiences. They realized that others dealt with comparable mental health symptoms, and they began to share coping skills that had worked for them.

The second was that members started to become even more creative. The art room was a place that had a wall of storage closets. In these storage closets were unused art supplies of projects past. Members and staff alike started rummaging for items that could be glued to the lids. This was a surprising yet welcomed development!

At this point lids started taking on personalities all their own. Some had faces others had entire scenes painted on them, birds flying over grass and fish swimming in the ocean just to name a few. Then there were the more abstract pieces that were left to interpretation. Suddenly lids started appearing with feathers and beads on them and even mini dream catchers were attached for decoration. The creativity was contagious and this brought even more participation.

Approximately 100 lids later, the staff and members of Transitions thought it was time to look at the canvas and try to envision the final outcome.

What to do with the lids? At first the staff thought that they would just glue all of the lids on the canvas until the canvas was full. The canvas turned out to be bigger than they thought, and it was decided by the group that there might be too many lids. This is where members and staff started discussing some alternative options.

To get started they took some of the lids and arranged them on the canvas to see what it would look like with lid next to lid. It looked good, but it was observed during this process that pressing the lids up next to each other left gaps due to the different sizes of the lids. What to do with the gaps?

Again as a team they went back to the storage closets and, as luck would have it, found a bag of clear decorative glass gems. They fit perfectly in between the caps. This was the inspiration needed and a group went for exploration purposes to the dollar store. There they picked up more glass gems and some small round mirrors, which seemed like great options to glue onto the canvas as well.

It took a bit of dreaming, some more conversation between members and staff, and the vision finally emerged: "Journey of Recovery, River of Hope." Over the next few weeks staff and members jointly painted the canvas, and glued finished lids as well as glass gems and mirrors onto the canvas. The lids and gems became the bank of a river. Then a river was painted with lids lazily floating down it. Above that was a night sky with an artistic moon leaving a shadow reflecting off the river. Finally the mirrors were artistically positioned within the sky to reflect the onlooker. After a few months, good conversations, much laughter and some tears, the masterpiece was complete!

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Healing Effects Observed

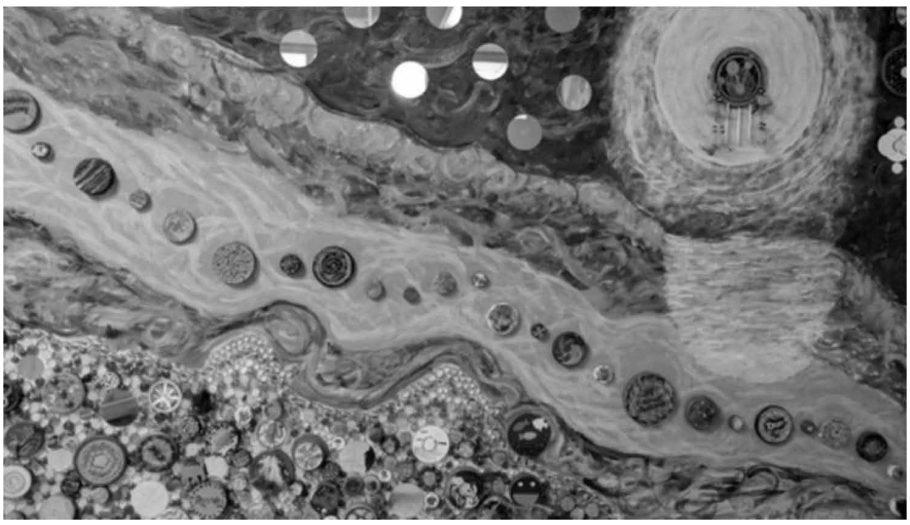
In the mental health field of today, employees at every level are being trained in trauma informed care. It is more commonly accepted that mental health issues can be connected with past traumas and vice versa. As facilitators, when approaching a group art project, it is important to remember that we do not know what traumatic experiences have impacted our participants, and it is impossible to know what might trigger the individuals we are working with. With that in mind, the Transitions Psych Rehab staff found that providing an activity with no specific end goal was more welcoming and safe than a more specific project. This allowed the project to focus on working collaboratively, providing choice and helping to set the participants at ease with making art. Even though no formal therapy was done during these sessions, healing effects were noticeable.

Members who participated felt pride in the finished project, and their confidence seemed to rise when they saw their painted cap(s) put into a collective project. When individuals who did not think that they could make art became involved, their self-esteem improved by being included.

Working on the same project as a group encouraged the development of meaningful relationships and natural supports within the group. New friendships developed through conversations that took place during the art groups. The Psych Rehab workers developed bonds with the participating members, leading to deeper therapeutic conversations that helped with breakthroughs and healing. Many of those participating in the project shared that the process was very therapeutic for them, and they began making art at home with everyday items. The shared experience helped build a sense of camaraderie among community members, and the continued openness with which they shared their experiences after the project was completed demonstrated the establishment of hope.

As the project progressed, more and more members took part in the art sessions. After The Lid Project was completed, more individuals participated in future art projects, and the walls of the Psych Rehab center are now covered with artistic expression. When visitors and new members arrive at Transitions, they stop at the mural and read the words associated with the journey of recovery. This has created an atmosphere of hope.

Figure 1. The completed lid mural



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Metaphors Discovered in the Process

The destination is not always known at the onset of a journey

The Lid Project began as a way for the Primary Coaches to make art with their members as inexpensively as possible, but ended up being a very valuable journey. Through this process, participants learned to focus not on working towards something, but to trust in the process and be present in the moment. In recovery, this is a valuable lesson to learn. By focusing on neither the past or the future, participants can truly engage in the present moment, the present treatment method, and the present environment and community.

We can always reach deeper within to find new tools and resources.

As confidence and trust in the creative process and the project grew, participants began searching for more materials to use. They had become comfortable using the tools already on hand and were both prepared and excited to try new things. The supply closet became a treasure trove; providing creative materials once passed over or discarded as being useless. It was not until later in the process that the participants were able to recognize the value of what was on hand and how it could be incorporated into the artwork. In a similar fashion, as the healing process unfolds, with guidance and support participants are able to reach deeper into themselves to find more tools, untapped strength and energy, and deepened commitment to support further healing.

The small steps we take at the beginning still move us down the path.

The first few lids created were simple and unadorned. Yet, each simple, first lid moved the project forward towards the final 100 lids decorated and collected. The beginning of a treatment method or the beginning of a new program or even the beginning of a new relationship can feel overwhelming. It may seem at the start that every step must be completed simultaneously or that the first steps are so insignificant that they can not possibly be going anywhere. Those first lids helped to demonstrate the very opposite. Every small step, in any direction, is part of the journey and a valuable step towards healing.

CONCLUSION

Admittedly, at the start of this project, the Psych Rehab workers did not recognize the value of the journey they were about to embark on with their clients. They simply sought to build relationships using art in its most therapeutic form; to work through past traumas, build self-worth, and bring hope. A collaborative art project seemed like the best way to bridge the gap between someone who struggles with a mental illness and someone who wants to connect with him/her. The Lid Project accomplished all of these things and more.

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Chapter 42
Healing Alex's Wound:
Application of MSJCC in Adlerian Play Therapy

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EXECUTIVE SUMMARY

Multicultural and Social Justice Counseling Competencies (MSJCC) has emphasized the need to consider multicultural and social justice factors into all aspects of the counseling profession. Consistent with the MSJCC guideline, it is essential that counselors provide developmentally and culturally responsive interventions when working with children from diverse backgrounds. Adlerian play therapy is a unique approach in which counselors incorporate basic tenets of individual psychology and premise of play therapy to help children work through different types of emotional or behavioral issues. This chapter provides an overview of the effects of adverse childhood experiences (ACEs) on children's mental health, particularly the multitude of effects on Hispanic children. The author then illustrates the application of Adlerian play therapy from MSJCC's perspective to work with a Hispanic boy exposed to a high level of ACEs.

INTRODUCTION TO THE CASE

In this case study, to protect the child and his families' confidentiality and anonymity, pseudonyms are used. Alex was a 6-year-old Hispanic boy living with his grandparents, Mr. and Mrs. Garcia, two uncles, and a younger sister, Abby. Mr. and Mrs. Garcia were first generation immigrants in the United States and their children and grandchildren were born and raised in the United States. Mr. and Mrs. Garcia brought Alex to play therapy services because of Alex's increasingly aggressive behavior. Mr. and Mrs. Garcia reported that Alex's biological mother left the family when Alex was three years old due to the abusive relationship with Alex's father. Before living with Mr. and Mrs. Garcia, Alex and Abby had moved a lot with the father and his girlfriend, and Alex was asked to call the father's girlfriend "Mom".

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Mr. and Mrs. Garcia reported that they called Child Protective Service (CPS) after finding out their grandchildren were victims of domestic violence by the father. They shared it was a hard decision for them to contact CPS because he was their son and they felt shame to reveal this incident to everyone. However, they wanted to protect their grandchildren and they think it was better for their grandchildren to leave their father. They noted that Alex's father was physically and emotionally abusive toward Alex and Abby when the father was angry or drunk. After CPS had been involved, they had removed Alex and Abby from the father's house. Alex and Abby had lived with their grandparents for about a half year since the removal. Although the father would visit the children once a week, Mr. and Mrs. Garcia reported that Alex would feel confused about why his father would come and go every week. They further reported that the father recently gave up the guardianship, so they had become legal guardian of their grandchildren. However, recently, the children's biological mother re-entered their lives and wanted guardianship of her children. Mr. and Mrs. Garcia were worried about losing their grandchildren. They shared the mother was not likely to get the guardianship back because she had not contacted the family since she left. Yet, it would be an ongoing issue in the family.

Mr. and Mrs. Garcia described that Alex would behave like his father when he got angry. For example, Alex would show anger outbursts, such as kicking, hitting, yelling, and threatening towards his grandparents and sister. However, his behavioral issues seemed to only occur at home. Alex's kindergarten teacher reported that Alex did not show any behavioral problems in the classroom and described Alex as a cooperative and polite child in the school setting. He seemed to get along with his peers well. However, the teacher commented that when Alex felt sad, he tended to hold his tears back from teachers and peers.

The grandparents reported feeling stressed and helpless about Alex's behavioral issues because they have tried different ways to discipline him, such as telling him not to hit people when angry, using timeout, or taking his toys or TV time away. However, their parenting methods did not seem to work. They were worried about Alex's aggressive behavior and their families' safety. They shared their hopes to decrease Alex's aggression and improve his relationships with his families.

ADVERSE CHILDHOOD EXPERIENCES IN HISPANIC CHILDREN

Adverse childhood experiences (ACEs) are chronic and traumatic experiences and events, ranging from abuse and neglect to parental separation or divorce, and may have negative, lasting effects on well-being in childhood or later in life (Sacks, Murphey, & Moore, 2014). A growing body of research has shown that ACEs are becoming a critical mental health issue (Sacks & Murphey, 2018). Adverse childhood experiences study was first conducted by Kaiser Permanente, a health insurance company in collaboration with the Center for Disease Control and Prevention (CDC) from 1995 to 1997. Over 17,000 middle-class adult participants completed the survey exploring their current physical health status, social functioning, and behavior along with questions related to their childhood maltreatment and family dysfunction. The questionnaire used in this study categorized ACEs into three groups: abuse, neglect, and family/household challenges. There are 10 ACE factors, including emotional, sexual, and physical abuse, emotional and physical neglect, substance abuse and mental illness within household, mother treated violently, parental separation or divorce, and incarcerated household member. Each factor weighs one point and the total score of the different categories of ACEs reported by participants was added up to assess cumulative childhood stress ranging from 0 to 10 points in which higher ACE scores indicate higher exposure to adversity events. The results indicated that almost two-thirds of study participants reported at least one

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ACE and more than one in five reported three or more ACEs (Centers for Disease Control and Prevention [CDC], 2016). The findings further revealed the greater exposure to ACEs is positively associated to the greater risk of behavioral and physical health across the lifespan (CDC, 2016). Numerous research studies have shown that children exposed to ACEs are more likely to develop physical, mental, behavioral, psychosocial, and/or cognitive issues into adolescence and adulthood, such as substance abuse, depression, poor academic and work performance, and risk for intimate partner and sexual violence (Burke, Hellman, Scott, Weems, & Carrion, 2011; Flaherty et al., 2013; Jimenez, Wade, Schwartz-Soicher, Lin, & Reichman, 2017; Kerker et al., 2015; Mersky, Topitzes, & Reynolds, 2013).

Hispanic children currently account for one-fourth of U.S. children and are projected to remain the largest ethnic minority group among children (Passel & Cohn, 2008). Hispanic children who are US-born or in the immigrant families (foreign-born children with at least one foreign-born parent, or US-born children with at least one foreign-born parent) are at high risk for mental health disorders stemming from poverty, exposure to trauma, acculturative stressors, and discrimination (Caballero et al., 2017). Sacks and Murphey (2018) examined the prevalence of ACEs among children using nationally representative data from the 2016 National Survey of Children's Health (NSCH). They found that 51 percent of Hispanic children have experienced at least one ACE, compared with 40 percent of white non-Hispanic children. Caballero, Johnson, Muñoz Buchanan, and DeCamp (2017) surveyed adverse childhood experiences among more than 12,000 Hispanic children from immigrant and U.S.-native families. The results indicated that about 30 percent of Hispanic children in U.S.-native families and 16 percent of children in immigrant families are in high ACE exposures (≥2 ACEs), including poverty, abuse, neglect, household dysfunction (e.g., parents' divorce, violence, and substance abuse, etc.). Specifically, economic hardship, the divorce or separation of a parent or guardian, living with an adult with a substance use problem, and parental incarceration are the most common ACEs reported for Hispanic children (Sacks & Murphey, 2018).

Childhood trauma exposure have been linked to an array of mental health issues, including externalizing and internalizing problems (Martinez, Gudiño, & Lau, 2013). Thus, children who have experienced ACEs often need mental health counseling services. Martinez et al. (2013) investigated the use of mental health services by children (N=1,600; 19.3% Hispanic) who had experienced some form of maltreatment and found that neither internalizing nor externalizing problems predicted the use of mental health service for the Hispanic children population. However, they indicated that cultural and family issues might discourage Hispanic parents to seek mental health services after their child's exposure to maltreatment. As a result, many mental health professionals have addressed a need to identify the predictors of mental health services among Hispanic children and enhance competencies to work with children using developmentally appropriate and culturally responsive interventions due to an increased concern about mental health for at-risk Hispanic children.

Play therapy has been identified as a developmentally appropriate approach to counseling children from age 3 to 10 because play is children's natural way to communicate and express their feelings and thoughts (Landreth, 2012; Ray, 2011). In play therapy, counselors utilize selected toys, art materials, and other play media, and build a safe and trusting relationship in which children can explore their world and express themselves more fully through the form of symbolic play (Landreth, 2012; Kottman & Meany-Walen, 2016). Meta-analytic results for play therapy outcome research have shown play therapy to be an effective intervention for children with a variety of presenting problems (LeBlanc & Ritchie, 1999; Bratton, Ray, Rhine, & Jones, 2005). There are different theoretical approaches to play therapy resulting in unique ways of counseling children and conceptualizing children's presenting issues.

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Adlerian play therapy developed by Terry Kottman (1995) is a play therapy model based on the theoretical constructs of individual psychology (Adler, 1964) and is adapted to meet children's development level. Kottman and Meany-Walen (2016) indicated that therapists use Adlerian play therapy in clinics and school setting and the interventions are effective when working with children who exhibit a variety of presenting concerns. This approach has shown especially appropriate with children who have issues related to power and control, poor self-concepts, inadequate social skills, strained families relationships, and traumatic experiences (e.g., Kottman, 1999; Kottman, 2001; Kottman & Warlick, 1989; Meany-Walen, Bratton, & Kottman, 2014; Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015; Morrison, 2009; Rotter, Horak Jr., & Heidt, 1999; Snow, Buckley, & Williams, 1999).

To work effectively with diverse populations, the Multicultural Counseling Competencies Revisions Committee (2015) has developed the Multicultural and Social Justice Counseling Competencies (MSJCC) that serve as a conceptual framework for competent multicultural counseling practice. This framework signifies the need to focus on multiculturalism and social justice as the center of all aspects of the counseling profession. The core belief of MSJCC is that counselors and clients both bring to the therapeutic relationship various cultural values, beliefs, biases, and complex identities consisting of different race, ethnicity, gender, sexual orientation, socioeconomic status, religious/spirituality, and disability. Counselors, therefore, need to address how the interactions of power, privilege, and oppression influence the counseling relationship. Adlerians focus on an individual's subjective perspective and interpretation of an individual's world. By understanding an individual's experience, counselors can begin to understand the impact of culture may have on clients' values and perceptions. Thus, Adlerian play therapy may also work well with children from diverse cultures and ethnic groups (Kottman, Bryant, Alexander, & Kroger, 2009). In this chapter, the author shares her cultural identity and approach to counseling children. The author further illustrates the application of the MSJCC in Adlerian play therapy process with Alex and his families.

COUNSELOR BACKGROUND

Counselor's Cultural Background

I was born and raised in Taipei, Taiwan and immigrated to the United States approximately 12 years ago to pursue higher educations and trainings in clinical mental health counseling and play therapy and now being a counselor educator in a university setting. When I lived in Taiwan, I was aware of my power and privilege status, as I was raised in an upper-middle class family and in a capital city. I was able to receive many resources, such as education opportunities and financial supports to achieve my personal and professional goals and development. However, moving to the states, I become part of an ethnic minority for the first time in my life and have to think about my identity in a new way. In the U.S., I identity myself as an East Asian immigrant. Specifically, I am a heterosexual female counselor and counselor educator of color. I became aware of my transition to the marginalized group and the impact of my social status on my worldview, values, beliefs, and biases.

I have experienced various challenges during this acculturative process, including culture shocks, immigration status, acculturative stress, language barriers, limited support system, low self-efficacy, career concerns, discriminations, and oppression. Among these challenges, I reflected how my cultural values

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have interfaced with the western culture and how my cultural background and acculturative process have impacted my identity as a counselor and a counselor educator.

Confucianism, Buddhism, and Taoism are the main cultural values that have profoundly influenced my view of myself, others, the world, and counseling relationships with clients. Confucianism defines family and society as hierarchical and authoritative where relationships are based upon moral principles, which reflect love, integrity, loyalty, sincerity, and benevolence (Jung, 1998). Buddhism indicates human beings are leading their own lives with guiding rules, refraining from evil and purifying own mind (Jung, 1998). Discovering harmony with the natural order of things as well as stressing themes of passivity, asceticism, and the search for immortality are the major tenets in Taoism (Jung, 1998). I believe that these philosophies, including collectivism, hierarchical structure in the family and society, well-defined social roles and norms, repression of the expression of emotions and problems, harmony, and indirect forms of communication (Sheu & Fukuyama, 2007) and my upbringing have shaped my worldview, interpersonal relationships, expectations of self and others, and communication styles.

Counselor's Counseling Approach

My counseling approach is based on Alfred Adler's individual psychology. Adlerian theory serves as my guiding theory because its underpinning philosophy is the most congruent with my beliefs about people and their personalities. I believe that people are socially embedded and striving for a sense of belonging and significance. I believe that people's behavior and beliefs are purposeful and they have the capacity and power to pursue a successful life. I also believe that people's family history and life experiences have influenced their personality and perception of the world. It is my fundamental belief that our experiences are not the cause of who we become but, rather, it is our personal understanding of our experiences that gives meaning to our lives. This personal understanding is essential to the way in which we develop relationships, pursue our life goals, and how we respond to adversity and challenges. Therefore, I endeavor to understand each client as a whole and unique individual with distinct attributes, personal values and strengths, and life purpose.

I view the therapeutic relationship as an imperative factor for growth and positive change to occur in the counseling process. Hence, I work with clients to identify their goals of counseling and I help clients recognize thoughts and behaviors that keep them from reaching their goals. Moreover, I support clients in recognizing solutions to their concerns. I expect through our collaborative effort that clients will grow and find new ways of seeing the world around them and create a more meaningful way of being in the world.

MSJCC IN ADLERIAN PLAY THERAPY

Historically, Adlerians have worked with children in the context of family and school in the form of family therapy, parent education and teacher consultation (Dreikurs, 1967). In Adler's view, children's play provides rich information about children's present situation as well as their future (Dreikurs). Adler considered children's play as an opportunity for counselors to view children's characteristic ways of behaving; hence, counselors may confirm their hypotheses of children's lifestyle by observing children's play behavior (Dreikurs). One of Adler's major assumptions was that an individual is guided by one's lifestyle that can be presented in every expression of the personality. Thus, counselors may observe

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and interpret children's lifestyle through their verbal and nonverbal behavior (Adler, 1956). Adler also believed people are socially embedded and considered social interest as a criterion for mental health (Mosak, 1989). Thus, Adler indicated that therapists could determine children's social feelings by observing children's group play and further provide an opportunity for children to develop their social interest as needed. It is obvious that play can give counselors clues to understand children's lifestyle, goals of behaviors, private logic, and interpersonal relationships.

Based on Adler's view of children, Terry Kottman (1995) integrated Adlerian theory with play therapy and developed Adlerian play therapy for working with children, parents, and teachers from a systematic approach. Kottman and Warlick (1989) posited that the concepts of individual psychology and various Adlerian therapy techniques could be incorporated with the premise of play therapy to create a model for helping children who exhibit various types of emotional or behavioral problems.

Theoretical Foundation of Adlerian Play Therapy

Adlerian play therapy exemplifies the tenets of individual psychology and applies them within a framework of how children view themselves, others, and the world. Adlerian play therapy may foster collaboration and purposeful movement, and help children master life tasks (Even & Armstrong, 2011; Kottman, 2003; Kottman & Warlick, 1989). Kottman (2003) defined play therapy as "an approach to communicating therapeutically with clients using toys, art materials, games, and other play media, giving clients a safe and nurturing relationship in which they can explore and express feelings, gain insight into their own motivation and into their interaction with others, and learn and practice socially appropriate behaviors" (p.1). Some primary theoretical tenets and constructs that Adlerian play therapy rests on are described below.

People are Socially Embedded

Adlerian play therapists work with children based on the beliefs that people are socially embedded, goal-directed, subjective, and creative human beings (Ansbacher & Ansbacher, 1956; Carlson & Slavik, 1997). One of the basic tenets of individual psychology is social interest and this is considered a criteria for mental health. Adler believed that people are born with an innate desire to develop social interests and connections with others, and strive for belongings and significance in their families, classrooms, communities, and other social groups (Ansbacher & Ansbacher, 1956; Carlson, Watts, & Maniacci, 2006).

As part of the development, children must form a secure attachment with their primary caretakers who are able to help them flourish their connections to the community at large (Kottman & Meany-Walen, 2016). Hence, Adlerian play therapists must investigate and understand how children build relationships and make connections with others. They accomplish this by observing their play in the playroom and discussing with parents and teachers the child's ways of interacting with others and seeking significance and belonging outside the playroom, such as schools and neighbors (Kottman & Meany-Walen). In addition, Adlerian play therapists want to assess children's level of social interest and try to increase children's social interest by modeling healthy ways to connect with others and maintain relationships, and fostering these abilities in children through encouragement (Kottman & Meany-Walen).

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People Behavior is Goal-Directed

Another tenet in Adlerian play therapy is that children's behavior is purposeful and goal-directed. As children interpret their environment, they make early decisions regarding the predictable way that they will behave to achieve that goal (Ansbacher & Ansbacher, 1956; Carlson et al., 2006). Kottman and Meany-Walen (2016) stated that Adlerian play therapists must help children recognize their goals of behavior and support them to strive toward constructive goals. Play therapists particularly focus on children's goals of misbehavior (Dreikurs & Soltz, 1964) and four crucial Cs: count, connect, capable, and courage (Bettner & Lew, 2005).

Lew and Bettner (1996) postulated that children strive toward these four crucial Cs and believed that children needed to perceive themselves as possessing attributes of the crucial Cs in order to grow and mature successfully in society. Adlerian play therapists make hypotheses about children's assets and limitations and the ways in which they approach life by assessing the crucial Cs (Kottman & Meany-Walen, 2016). Adlerian play therapists consider the crucial Cs on a continuum to observe how children connect with others, believe they are significant, believe they are capable of success, and they demonstrate courage to be imperfect and try new tasks (Kottman & Meany-Walen).

Dreikurs and Soltz (1964) posited four goals of children's misbehavior: attention, power, revenge, and proving inadequacy, and believed that children use these behaviors to meet their needs. Adlerians believe that when children feel discouraged and lack feelings of belonging and connecting with others, they may unconsciously use goals of misbehavior to meet their needs (Dreikurs, 1964). Hence, Adlerian play therapists aim to understand how children behave to meet their goals by observing children's play, consulting parents and teachers about children's behavior that upset them, examining reactions of adults, and observing children's reactions to corrections (Kottman & Meany-Walen, 2016). Once play therapists understand children's goals of misbehavior, they can help children strive for more positive goals, such as the crucial Cs.

In order to gain a better understanding of children and their dynamics, play therapists can use goals of misbehavior and crucial Cs as tools to conceptualize children's lifestyle and potential personality priorities, including superiority, control, pleasing, and comfort. Play therapists assess children's lifestyle by looking for patterns of behaviors, thoughts, attitudes, and relationships that help children navigate their life. Moreover, play therapists can apply these concepts to enhance their understanding of children's parents and teachers as well (Kottman & Meany-Walen).

Play therapists use play techniques to investigate children's lifestyle, help children examine their faulty assumptions, and help them draw more positive perceptions about self, others, and the world. When observing children exhibiting more socially appropriate goals, play therapists can encourage children's behavior to help them move toward the positive goals of behavior (Kottman & Meany-Walen).

People's Perspective is Subjective

Another central construct in individual psychology is that people view their life subjectively. They filter the reality through their subjective interpretation of facts based on their convictions in their lifestyle and perception of how they believe about self, others, and the world (Ansbacher & Ansbacher, 1956; Carlson et al., 2006). Children usually develop their lifestyle and perceptions about self, others, and the world before the age of eight by observing interactions and reactions, examining self-worth, and exploring best ways to gain belonging and significance (Kottman & Meany-Walen, 2016).

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Some of these perceptions and conclusions about life and relationships are not accurate because children lack experiences and perception to accurately evaluate and interpret the situations and relationships, leading them to develop mistaken beliefs and private logic. Hence, Adlerian play therapists must be aware of each child's subjective interpretation of various issues. When play therapists gather information from parents or teachers, they also need to remind themselves that parents and teachers may have different views of the relationships and situations.

Striving for Superiority

Adlerians believe that children are born inferior and not yet having a place of belonging and significance in their social environment; thus, they are motivated to move from feelings of inferior to superiority in which they feel competent and significant (Ansbacher & Ansbacher, 1956; Carlson et al., 2006). A sense of inferior can result in discouragement. Adlerian play therapists believe that children who feel discouraged may feel overwhelmed and worthless, and thereby may experience maladjustment because of their mistaken beliefs about self, others, and the world (Kottman & Meany-Walen, 2016).

Encouragement is a distinguish feature of Adlerian play therapy and is a significant intervention strategy throughout the play therapy process (Kottman, 2003). Encouragement is essential for children to learn and feel significant in their social environment. Encouragement also fosters a sense of significance and responsibility for children (Kottman). Adlerian play therapists focus on children's assets, effort, and improvement of children, parents, and teachers to enhance everyone's self-efficacy and encouraged feelings. Therefore, play therapists encourage children, parents, and teachers by providing unconditional acceptance, showing faiths in their abilities, recognizing their efforts, focusing on their strengths and assets, focusing on the positive, modeling the courage to be imperfect, helping them learn from mistakes, and developing positive ways to gain a sense of belonging (Kottman).

ADLERIAN PLAY THERAPY PROCESS

Adlerian play therapists work with the children and primary caregivers through four phases: (a) building an egalitarian relationship, (b) exploring the child's lifestyle, (c) helping the child gain insight, and (d) reorienting and reeducating the child (Kottman & Meany-Walen, 2016). In the first stage, Adlerian play therapists establish an egalitarian relationship with the children through tracking children's play behavior, reflection of feelings and content, questioning strategies, encouragement, active interaction with the children, cleaning playroom collaboratively, and limit settings (Kottman & Meany-Walen).

During the phase of exploring the child's lifestyle, play therapists not only observe children's play behavior and actively interact with children, but also use other strategies, such as questioning techniques and art assessments to gather information about children's goals of behavior, the Crucial Cs, personality priorities, the family constellation, family atmosphere, early recollections, assets, and private logic (Kottman & Meany-Walen, 2016). Play therapists conceptualize children based on the information obtained from the play sessions and parent consultations and further develop treatment plans, including goals and strategies for children and parents (Kottman & Meany-Walen).

In the third stage of Adlerian play therapy, play therapists' goal is to help the children better understand the goals of their behavior, their convictions about self, others, and the world, and the behavior they uses to get a sense of significance and belonging. Play therapists make interpretations of the children's play

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in the form of hypothesis about the goals of their behavior and lifestyles, and use role playing, metaphor, art techniques, confrontation, immediacy, and humor to help the children reexamine their thoughts, feelings, perceptions, attitudes, and behavior (Kottman & Meany-Walen, 2016). When children gain insight into their lifestyles and clarify about the purposes of their behavior, they may decide which of these behaviors or attitudes they want to continue or they want to make some changes in their life (Kottman & Meany-Walen).

In the reorientation/reeducation phase, play therapists help children learn and practice new ways of viewing self, others, and the world, behaving in different situations, and connecting to others. Play therapists use brainstorming and problem-solving strategies to help children learn new constructive manners and interactional patterns while helping parents enhance their parenting skills (Kottman & Meany-Walen, 2016). Importantly, Kottman and Meany-Walen noted that these phases are not discrete. It is essential that play therapists continue to build relationships with children throughout the process. Play therapists also can flexibly combine the techniques to help the children gain insights into their private logic or mistaken beliefs during the investigation phase or choose to teach some new skills during the insight phase. In order to have effective outcomes, it is crucial to go through the four phases.

ROLE OF ADLERIAN PLAY THERAPIST

In Adlerian play therapy, counselors conceptualize children and their social environment from an Adlerian perspective (Kottman, 2003). Traditionally, Adlerian counselors are more active and directive to facilitate client's insight and encourage client's reorientation and growth. Adlerian play therapists generally follow the four phases of Adlerian therapy; however, the role of the therapist is rather fluid throughout the course of play therapy (Kottman, 2003).

Kottman and Meany-Walen (2016) indicated that in the first phase, Adlerian play therapists use a relatively non-directive approach to allow children to explore the playroom freely. In the second phase, play therapists tend to be more active and directive to gather children's and parents' lifestyle information, including attitude, perceptions, thoughts, feelings, and interpersonal relationships (Kottman & Meany-Walen). During the third phase, play therapists play a partner role to communicate essential information, including children's lifestyle, goals of misbehavior, and mistaken beliefs to children and parents (Kottman & Meany-Walen). Play therapists may challenge children's mistaken beliefs about self, others, and the world, support their decision making to changes and crucial Cs, and encourage increased social interest. In the final phase, play therapists actively educate and encourage children and their parents and possibly teachers to make necessary changes in attitudes, behaviors, and beliefs with the goal of reorienting the insight gained in the therapy. Play therapists provide opportunities to allow children and parents to practice various skills, such as communication skills, social skills, and parenting skills to enhance interactions and cope with situations (Kottman & Meany-Walen).

CONSULTING PRIMARY CAREGIVERS AND TEACHERS

Watts (2006) stated that effective counselors needed to be capable of providing consultation and educational services. Kottman (2003) indicated that consulting with children's primary caregivers and teachers is a critical component in Adlerian play therapy because these adults play significant roles in children's

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life and bring important impact on children's lifestyle. In addition, primary caregivers and teachers can provide valuable information about children's developmental history, learning style, or interactional patterns. Importantly, they can provide support and encouragement for children's change throughout the therapy process. As children learn new ways to view themselves, others, and the world and develop new skills to practice socially appropriate behavior, primary caregivers and teachers can help children apply their new learning outside the playroom (Kottman).

Usually, primary caregivers and teachers also need play therapists' education to help them move in positive ways to interact with children (Kottman, 2003). Hence, having primary caregivers and teachers involvement is an imperative component of Adlerian play therapy. Alderian play therapists use basic counseling skills and teaching strategies to engage primary caregivers and teachers and tailor the consultations to meet individual needs of families and teachers (Kottman).

Caregiver Consultation

Caregiver consultations follow the same phases as Adlerian play therapy with a focus on investigating lifestyles of primary caregivers and children. The goals for consultations depend on the phase of play therapy (Kottman, 2003). During the first phase, play therapists work to build egalitarian relationships with parents. In the parent consultation, play therapists aim to explore parents' views about themselves as parents, their parenting styles, marital issues, and personal issues that may inhibit their ability to interact in a healthy manner with children. In the second phase, play therapists discuss the treatment plans with parents and outline strategies for working with parents based on their understanding of their children's needs (Kottman). In the third phase, play therapists simultaneously work with parents on helping them gain an understanding of lifestyles of parents and children with a goal of helping parents change their views and attitudes toward themselves and children (Kottman). In the reorientation/ reeducation phase, play therapists facilitate various strategies, such as modeling, brainstorming, problem solving, and teaching to help parents practice new strategies in their interactions with children (Kottman). Additionally, it is recommended that play therapists conduct a parenting training based on Adlerian principals, such as *Systematic Training for Effective Parenting (STEP)* program (Dinkmeyer & McKay, 1989) and *Positive Discipline* (Nelsen, 2006). Play therapists can also use a filial therapy model (Guerney, 1997) to train parents as therapeutic agents to enhance their relationships with children.

Teacher Consultation

Dinkmeyer (1987) indicated that during the therapeutic process, counselors needed to focus on their relationships with teachers as well. Kottman (2003) recommended that play therapists build relationships with teachers with a professional and collaborative manner. In order to get a holistic view of children's lifestyle, it is important for play therapists to gather information about children's interpersonal relationships at schools and children's view of self, others, and schools (Kottman, 2003). It is also helpful to investigate teachers' lifestyles, teaching styles, and their views toward children. Play therapists are encouraged to observe children at schools if permitted because play therapists can observe children's interactions with others and feel the atmosphere in the classrooms (Kottman, 2003). Some goals for teacher consultation are to share play therapists' information and insights about children's interactions with teachers and to help teachers gain a better understanding of the children's goals of behaviors and attitudes (Kottman, 2003). During the teacher consultation, play therapists provide some important information on Adlerian

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principals, including crucial Cs, goals of misbehavior, logical consequences, encouragement, and techniques that are applicable in the classrooms (Dinkmeyer, Dinkmeyer, & Sperry, 1987; Kottman, 2003). Similarly, several resources are available for teachers to incorporate Adlerian principals in the classrooms, including *Positive Discipline in the Classroom: Developing Mutual Respect, Cooperation, and Responsibility in Your Classroom* (Nelson, Lott, & Glenn, 2013), and *Systematic Training for Effective Teaching (STET)* (Dinkmeyer, McKay, & Dinkmeyer, 1980). Kinder Training (White, Flynt, & Draper, 1997) is another teacher training model that can be helpful for teachers to apply basic play therapy skills and Adlerian constructs in the classrooms.

APPLICATION OF THE MSJCC IN ADLERIAN PLAY THERAPY PROCESS

The Adlerian play therapy process is consistent with the MSJCC's emphasis of seeing clients' issues from a culturally contextual framework and its recommendations for working with clients from individual and systems levels. The MSJCC expect counselors to understand the sociocultural system that influences clients' well-being and to address corresponding issues appropriately through counseling and advocacy interventions. Specifically, counselors are suggested to provide interventions and strategies at the interpersonal, intrapersonal, institutional, community, policy, and global levels (Ratts, Singh, Butler, Nassar-McMillan, & McCullough, 2015). Adlerians believe that people must be understood within their cultural or social experiences. Adler postulated that an individual's culture, climate in which an individual live, and perception of his or her community and society at large play a role in an individual's creation of lifestyle and beliefs of self, others, and the world (Oberst & Stewart, 2003).

The MSJCC note privileged and marginalized counselors must develop self-awareness by exploring their attitudes and beliefs, develop knowledge, skills, and action relative to their self-awareness and worldview. Kottman and Meany-Walen (2016) stressed the importance of examining one's beliefs and held biases about other cultures when working with diverse children and their families. For example, Adlerian play therapists are recommended to ask self "What are your beliefs about the work ethic or intelligence of low-income families?", "What are your beliefs about parenting and discipline styles of different ethnic families?", "What is your internal reaction when you learn that a child is being raised by grandparents, same-sex parents, or single parent?", and "What resources do you provide to families who speak different language than yours?" (Kottman & Meany-Walen, p.32).

Multicultural and social justice competent counselors take initiative to explore clients' relationships with families, friends, and their communities so that counselors are able to identify clients' obstacles to progress and help them develop their support systems (Ratts et al., 2015). Adlerian play therapists observe children's interactions with families inside and outside of the therapy, attend to children's play behavior in the playroom to explore children's subjective view of self, others, and the world, and conduct classroom observations to identify children's classroom behavior and relationships with peers and teachers.

Counselors are also recommended to facilitate open and genuine conversations with clients to discuss their own cultures and identities, gather information about their clients' experiences with microaggression, discrimination, and oppression, and explore how privileged and marginalized identities might enhance or impede the counseling relationship (Ratts et al., 2015). Counselors also want to explore clients' issues through societal lenses by considering the impact of cultural norms and values on clients' well-being. In the Adlerian play therapy process, it is important that counselors bring this discussion into parent and teacher consultations by exploring how cultural backgrounds and experiences affect their relationships

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with child clients and counselors. Counselors also focus on discussing if children and their families think that society holds negative stereotypes or attitudes about their membership in a privileged or marginalized group. Counselors may utilize toys, art materials, games, and other play media to establish a trusting and working relationship so that children can explore and express their feelings and thoughts about their world. By using play media, children are able to gain awareness of their experiences and interaction with families and communities resulting in their interpersonal relationships and lifestyle.

In addition to focusing on individual changes, multicultural and social justice competent counselors also make efforts into community and institutional change (Ratts et al., 2015). Adlerian play therapists advocate for children by collaborating with children's families and school personnel to improve home and school environments that might inhibit children's well-being and growth. For example, Adlerian play therapists might advocate for children's emotional and behavioral needs by attending a school meeting to discuss inequity issues that are affecting children's learning environment. Counselors also provide teacher consultations and professional development trainings to help teachers gain a better understanding of children's needs and learn new ways of interacting with children.

CASE CONCEPTUALIZATION AND TREATMENT PROCESS

Lifestyle Conceptualization

From an Adlerian perspective, counselors can develop a picture of how children's lifestyles are reflected in their patterns of misbehaviors, thoughts, attitudes and relationships by considering the crucial Cs, the goals of misbehavior, and personality priorities (Kottman, 2003). Kottman indicated that in order to survive and flourish, children must master each of the crucial Cs, which are courage, connect, capable, and count. Based on my observation of Alex's play behavior and his report, Alex seemed to struggle with connect and count. Children who do not have the skills necessary to connect will feel isolated and insecure, where those who do not feel as though they count will feel insignificant (Kottman). In the playroom, Alex showed a play theme of relationship building as evidenced by his frequently saying "look, I did it" or "look what I got" and bringing all the toys in front of me and inviting me to join his play, indicating his desire to get attention from me. Alex also shared the need to protect his sister from bad people and he would play out wishing to have his own bedroom in the family dollhouse, indicating Alex's challenge of feeling counted in the family.

Given that Alex had been exposed to various ACEs, he appeared to seek connections with his family and me in order to feel that he has a sense of belonging in the playroom and with his family. Alex also seemed to possess low self-esteem and caution to answer the questions about his family when I explored his family atmosphere and relationships. He would look down or change play behavior when I reflected his emotions and thoughts about the family issues. Additionally, Alex seemed to feel no power or control in his life and to believe that he only counts if he protects his sister and takes care of his family.

In terms of personality priority, Dinkmeyer and Sperry (2000) described it is a pattern of behaviors and reactions that are based on a person's convictions about how he or she acquires belonging, significance, and a sense of mastery. Alex seemed to have developed control as his personality priority as evidenced by his attempt to control my reflections and behavior in the playroom. He was eager to get more attention from his grandparents and uncles through goals of misbehavior.

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Alex's family atmosphere appears to be chaotic-conflictual, hopelessness, and inharmonious. Parents in this type of family atmosphere often discipline their children in an inconsistent manner and structure, depending on their mood and status of their marital conflict (Kottman & Meany-Walen, 2016). Having witnessed verbal or physical abuse between their parents, children from chaotic-conflictual families often develop an idea that having power and control is the only way interacting with others (Kottman & Meany-Walen). Therefore, Alex seemed to develop mistaken beliefs that by acting angry, he can control others, connect with them, and receive more attention. He also seemed to believe the need to protect his family, which is a typical characteristic of a first-born child in the family constellation. Mr. Garcia further shared that he told Alex to be brave and to protect his family because in Latino culture men are supposed to be strong and protect their families. Consequently, Alex's lifestyle is a method of expressing anger, frustration, and power in order to obtain a sense of significance, belonging, and to engage with others.

Due to the childhood trauma of abuse, domestic violence, and mother's absence, Alex had experienced fear, worry, insecurity, and sadness in his life. Impacted by his father, Alex seemed to tend to express his anger with physical aggressions toward his family and he often had bad dreams about monster's coming at night. Alex seemed to strive for a sense of belonging in the family as evidenced by his report that he did not have a room in grandparent's house and grandparent's report that Alex had moved from one house to another house with his father.

Treatment Goals and Therapy Process

Over the course of Adlerian play therapy, I conducted 22 weekly individual play therapy sessions with Alex and five caregiver consultation sessions to support Mr. and Mrs. Garcia. My overall treatment goals included (a) increasing Alex's positive goals of behavior and self-regulation skills, (b) helping Alex substitute positive convictions from mistaken beliefs, (c) enhancing Alex's grandparent's compassion toward Alex's behavior and needs by teaching Alex's grandparents basic play therapy skills and language, and (d) improving caregiver-child attachment. The following illustrates how I worked with Alex and his grandparents through Adlerian play therapy four phases using the MSJCC framework.

Prior to the first play session, I conducted a caregiver consultation session with Mr. and Mrs. Garcia and one of Alex's uncle to gather more information about Alex's background, presenting issues, and his family's goals of counseling. I was aware that Mr. and Mrs. Garcia's preferred language is Spanish, but they tried their best to communicate with me in English given that I am not a Spanish-speaking counselor. Alex's uncle would sometimes translate his parents' disclosure in the session. I observed Mr. and Mrs. Garcia's uncertainty of the counseling process and their tendency to see me as an expert. Therefore, I made efforts to foster an egalitarian relationship with them by sharing my professional background, clinical experiences, explaining my role in the play therapy process, and my expectations for their involvement in the treatment. I also shared how my cultural background may be very different from their values and beliefs and thus, I appreciate their sharing to help me gain a better understanding of Alex's and their needs. They all seemed appreciative of my genuineness and care about Alex's situation.

In the first play session, I observed Alex's interactions with his sister and grandparents in the waiting area. Alex looked cautious and nervous about going to the playroom when I met him in the waiting area. Being aware of his young age and his history of ACEs, I began the play therapy process by building a collaborative and egalitarian relationship with Alex. I communicated respect, unconditional acceptance, and trust in Alex's abilities in the playroom by means of tracking his play, reflecting feeling and content, consistent limits setting, and encouragement. After the first session, Alex seemed happier and less anxious

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walking to the playroom. During the first several sessions, Alex looked hesitant to initiate the play and he did more exploratory play by looking around the room and playing briefly with different categories of toys. Gradually, Alex appeared to play more freely and had more interactions with me as evidenced by his increased verbal communication and invitation to his play after four play therapy sessions.

In the phase of exploring the child's life, I made efforts to gain a deeper understanding of Alex's lifestyle, personality priority, goals of behavior, and crucial Cs through his verbalization and play behavior in the playroom as well as consultation with Mr. and Mrs. Garcia. During one self-directed puppet show, Alex created a scene where an alligator puppet was fighting for a rabbit puppet. I observed that Alex was not completely comfortable sharing his feelings yet; therefore, I used metaphoric techniques to reflect my observation of the puppet's goals and emotions. Alex then reported that the rabbit is his sister and he had to protect his sister because he is always her brother and he had to protect grandparents, too. After the session of the puppet show, Alex's play themes of dominance, control, and need to take care of others became apparent. Alex had shown control as his personality priority as evidenced by his attempt to control my reflections and behavior. For example, he frequently told me what to do and say. He was also eager to show me his power through some aggressive play behavior and would feel upset or frustrated when things did not go the way he wanted to in the playroom. I reflected his need to correct my responses, feel powerful by maintaining a sense of control, and seek attention from me through metacommunications.

Based on my observation of Alex's play behavior and reports, he seemed to feel challenged with the crucial C's of connect and count causing Alex feelings of isolation, insecurity, and insignificance. Alex had developed a mistaken belief that he only counts if he shows others his power to protect his sister and taking care of his grandparents. Alex also constantly sought attention from his family and me in order to feel that he belongs in the playroom and to his family. In addition, Alex's exposure to adverse events caused his perception of the family atmosphere as a skewed dynamic of chaos and powerless. Consequently, Alex had also developed a conviction that only by acting out angrily and aggressively, he could build relationships with others and receive attentions from others. I concluded that Alex's lifestyle is a method of expressing anger and frustration in order to obtain power, control, and attachment. Due to the trauma of physical and emotional abuse and abandonment, Alex had experienced fear, worry, insecurity, and sadness in his life. Lacking a secure attachment and role model, Alex tended to express his emotions with aggressions toward his family as well.

In the insight phase, in order to help Alex gain awareness of his lifestyle and mistaken beliefs, I elected to use puppets, mutual storytelling, and other creative arts to communicate the value of building relationships, empathize Alex's feelings and beliefs about connecting, and teach him new ways of connecting with others. I conveyed my tentative hypothesis about his mistaken beliefs about himself, others, and the world. I also facilitated encouragement to help him know that he is significant and counts. Moreover, I reflected the purpose of his attention seeking behavior to facilitate his insight into his goal of misbehavior and to help him understand that he does not need to be the center of attention to gain a sense of belonging. Furthermore, I continuously provided a safe environment where he can be a child and enjoy playing and having fun. I aimed to convey the idea that he can feel safe without showing aggression and even when he cannot control situations.

Alex's play behavior in the final phase was considerably different from his play at the beginning of our counseling relationship. His play became more spontaneous and relaxed with a sense of pleasure. He no longer exhibited a need to control my behavior or responses and did not seek attention from me to approve his abilities or significance. Instead, he connected with me in positive ways and showed play

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themes of mastery and resiliency. For example, during one session, he created a challenging situation where toy soldiers were in a battle. He was able to use different strategies to end the war and he was proud that no one was injured. In the earlier stage of therapy, I would sense his frustration and disturbance whenever he was in a chaotic and deconstructive play. This change indicated that Alex made improvements in increasing his self-regulation skills, healing his traumatic experiences, and overcoming his faulty assumptions of his perceived world. Mr. and Mrs. Garcia also reported observing significant improvements in Alex's aggressive behavior at home. He interacted and communicated better with his family.

Throughout the course of play therapy, I regularly conducted caregiver consultations. I began with assessing Mr. and Mrs. Garcia's lifestyle and supported their parenting roles in Alex's transition. I helped them understand Alex's lifestyle, mistaken beliefs, and goals of misbehavior. I discussed Alex's need for gaining a sense of control and belonging. I showed my respect toward their cultural value of patriarchal structure. However, I shared with them that Alex's childhood trauma influenced his sense of value and potentially affected Alex's perception of himself, others, and the world. They seemed to get a better understanding of Alex's underlying purpose of behavior. I collaborated with them to come up some ideas to help Alex feel safe, decrease his fear of abandonment, and seek healthy ways to seek power. Additionally, I taught them some basic play therapy skills, such as reflection of feelings, encouragement, limits setting, and choice giving to help them develop better relationships with Alex, feel capable of parenting, and help Alex feel significant and count. Mr. and Mrs. Garcia were very cooperative and willing to adapt new ways to interact with Alex. Alex's uncles were also supportive and understanding of Alex's situation. His uncles would take turns to attend the caregiver consultations with Mr. and Mrs. Garcia as well. Knowing that Alex missed a father figure in his life, the two uncles both wanted to show him a good role model.

In addition to conducting caregiver consultation, with caregivers' permission, I contacted Alex's schoolteacher over the phone to address the teacher's concerns. Although Alex's behavioral issues mostly were presented at home, I aimed to advocate for Alex's needs systematically. Thus, I encouraged the teacher to be aware of Alex's withdrawing behavior in the classroom and showed the teacher ways, such as active listening, to reflect Alex's behavioral and emotional needs. I also helped the teacher find creative ways to help Alex feel significant in the classroom, such as assigning him a special task to help peers so that he would increase his self-esteem and feel counted. The teacher shared her appreciation for me reaching out and helping her feel more prepared to address Alex's needs if necessary.

CONCLUSION

Research has indicated that adverse childhood experiences (ACEs) can cause negative outcomes on physical and mental health issues, including asthma, obesity, attention-deficit hyperactivity disorder, depression, and substance use over the lifespan (Caballero et al., 2017; Loria & Caughy, 2017). Hispanic immigrant children are the fastest-growing child population in the U.S. (Passel & Cohn, 2008). Hispanic children, including US-born and foreign-born children have shown a higher prevalence of ACEs exposures in the U.S. (Loria & Caughy, 2018). Children who have experienced ACEs are more likely to have emotional and behavioral challenges (Sacks & Murphey, 2018). Consequently, they may benefit from counseling services.

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Adlerian play therapy developed by Terry Kottman (1995) is a play therapy model based on the theoretical constructs of individual psychology (Adler, 1964). It is a developmentally appropriate approach where counselors use play as a modality to work with children exhibiting a wide spectrum of social-emotional and behavioral issues (Kottman & Meany-Walen, 2016). Adlerian play therapy is also a culturally responsive intervention. It has shown its effectiveness to work with children from diverse cultures and ethnic groups (Kottman & Meany-Walen). Moreover, given Adlerian's focus on clients' subjective perception of self, others, and the world, counselors are able to understand how clients' views lead to their responses to ethnic values and perceptions.

Multicultural and social justice competencies have been considered as core values to work effectively with clients from diverse backgrounds. The Multicultural and Social Justice Counseling Competencies (MSJCC) developed by Ratts et al. (2015) has served as a conceptual framework for competent multicultural counseling practice. The central concern of MSJCC is that counselors and clients both bring to the counseling relationship a constellation of identities, social locations, cultural values, beliefs, and biases. It is important that counselors address how the interactions of power, privilege, and oppression influence the client in all aspects of the counseling profession.

The process of Adlerian play therapy is congruent with MSJCC framework. It addresses the complex of identities that counselors and clients bring to the therapeutic relationship. The ultimate goal in Adlerian play therapy is for counselors to use the therapeutic relationship with children and their families to help the family enhance their understanding of interpersonal and intrapersonal dynamics and to allow the family to use these insights to make necessary changes in their thoughts, feelings, behavior, and attitude (Kottman & Meany-Walen, 2016). To accomplish this goal, it is crucial that Adlerian play therapists develop self-awareness, knowledge, skills, and action related to their self-awareness and worldview. Adlerian play therapists are recommended to examine their beliefs and biases or prejudice about other cultures when working with diverse children and their families. Adlerian play therapists conceptualize children's presenting issues from a cultural and social context and work with them from individual and systems levels (Oberst & Stewart, 2003). Adlerian play therapists discuss children's experiences with power, privilege, and oppression during parent and teacher consultations by exploring how cultural backgrounds and experiences affect their relationships with child clients and counselors. During play therapy sessions, counselors utilize toys, art materials, games, and other play media to establish a trusting and working relationship with children and allow children to explore and express their feelings and thoughts about their world.

To help children develop their support system, Adlerian play therapists take initiative to observe children's interactions with families both inside and outside of the therapy, attend to children's play behavior in the playroom to explore children's subjective view of self, others, and the world, and conduct classroom observations to better understand children's school behavior and interpersonal relationships. Notably, Adlerian play therapists advocate for children's mental health by collaborating with children's families and school personnel to improve the social environment that might impede children's well-being and growth. The presented case example of Alex and his families illustrates how I, a marginalized counselor, worked with a marginalized child who has experienced ACEs. Utilizing MSJCC as a framework, I was aware of my power and privilege that may bring in our counseling relationship. Thus, I was mindful of my approach to involving Alex and his families in the therapy by understanding their needs in a cultural context. I was able to address barriers and create opportunities for advocacy when helping Alex heal his wound.

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Chapter 43
Culturally Responsive Practices:
African American Youth and Mental Health

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ABSTRACT

Achieving positive mental health is a worthy desire as positive mental health leads to better success in all aspects of life. Unfortunately, for some youth, achieving positive mental health is a struggle. African Americans demonstrate mental health difficulties approximately 20% more than their White counterparts. To address mental health concerns, schools have increasingly implemented multi-tiered supports to better identify and support students. Unfortunately, interventions implemented in schools have largely ignored the impact that race, culture, and behavioral expectations have on the mental health of African American youth. African American youth exhibit symptoms and behaviors of mental health similar to youth of other cultures and races, yet they experience lower levels of mental health services. To help African American youth experiencing mental health difficulties, stakeholders must implement culturally responsive, evidence-based interventions.

INTRODUCTION

What is mental health? Mental health is the bases for interaction between the individual and their community, family and friends. It is directly related to an individual's ability to be resilient and how she or he views their worth (Parekh, 2018). Mental health can affect how an individual acts, thinks, and feels, in addition to one's ability to cope with life stressors (mentalhealth.gov) which include emotional, behavioral, and cognitive functioning. Mental health difficulties can affect individuals in all life stages, from all races, cultures, ethnicities, SES, and religious affiliations. Mental health difficulties can also manifest as the result of trauma, life stressors, genetics, and a family history (mentalhealth.gov). Often the behavioral manifestations of mental health do not look the same across individuals, even if individuals

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have the same diagnosis (NAMI.org). The National Institute of Mental Health (NIMH) estimates that millions of people are affected by mental health difficulties each year.

In 2004, the World Health Organization (WHO) defined mental health as an individual's well-being where the individual understands their own abilities, is able to cope with stressors in life, is able to be productive, and contributes to their community (WHO, 2004 as cited in Galderisi, Heinz, Kastrup, Beehold, & Satorius, 2015). This definition resulted in progress towards a more inclusive definition of mental health. For example, Bhugra, Till, and Sartorius (2013) state that mental health is an integral part of one's overall health and does not exist in isolation. They further note that the individual is able to maintain positive relationships and engage in social and cultural roles according to Bhugra et al., (2013).

The state of mental health implies that the individual has the ability to form and maintain affectionate relationships with others, to perform in the social roles usually played in their culture and to manage change, recognize, acknowledge and communicate positive actions and thoughts as well as to manage emotions such as sadness. Mental health gives an individual the feeling of worth, control and understanding of internal and external functioning. (p. 3).

Despite the definitional progression of mental health, Galderisi et. al., (2015) recognize that there may continue to be misunderstandings regarding "positive feelings and positive functioning as key factors for mental health" (p. 231). They note that individuals with positive mental health with a fully lived life can experience a variety of emotions including sadness, unhappiness, and anger. Moreover, these authors note that a focus on positive emotions as a determining factor for mental health "risks excluding most adolescents, many of whom are somewhat shy, those who fight against perceived injustice and inequalities or are discouraged from doing so after years of useless efforts, as well as migrants and minorities experiencing rejection and discrimination" (p. 231). It is this definition of mental health, that notes varied emotions as a part of life's experiences coupled with the inclusion of cultural factors that will be used for this chapter.

According to Bailey (nd), there are approximately 40 million people who identify as African American. This chapter will address mental health in relation to African American youth. Topics in this chapter will include prevalence, barriers, stigmas/perceptions, cultural expectations, culturally responsive evidence-based interventions, and school-based mental health practices. The terms adolescent and youth will be used interchangeably as both are being used to describe individuals ranging in age from 12 to 17.

Mental Health and African Americans

Historically, African American individuals have experienced significant challenges accessing mental health supports and services (mhanational.org.nd) that date back many years where the African American community was denied or treated differently by the mental health community. In order to address the lack of mental health services utilized by African Americans, one must look at the historical abuses experienced by African Americans in the mental health system. Briggs, et al., (2014) note that historically, the use of proper treatment for African American's experiencing mental health difficulties "was virtually nonexistent" (p.2). African American's suffering from mental health difficulties suffered abuses such as whippings, as a justified cure, and placement in poor houses or jail houses. Additionally, the authors note that debilitating labels, such as "negritude, a condition that was analogous to leprosy" (p. 2) continued to perpetuate the inhumane treatment African American's with mental health difficul-

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ties suffered. African American's experiencing mental health difficulties continue to suffer from the historical perceptions of mental health in the African American community. Because of the historical abuses, there continues to be a level of skepticism and cultural mistrust "toward institutions, systems, and individuals that have exhibited harm in the past and the potential for future harm" (Breland-Noble, 2004, p. 536), thus affecting participation with mental health supports and services.. These perceptions also affect African American youth. According to Breland-Noble (2004),

...black adolescents and their families do not use a systematic method for identifying the disorder; that black adolescents and their parents consult different entities for help, and that blacks perceive mental health clinical care as a majority culture phenomenon for people with severe psychopathology, thereby making these services irrelevant for them (p. 537)

While mental health and depression can affect African American families from across the socioeconomic status (SES) spectrum, the literature regarding mental health and African American youth has focused on youth from lower SES backgrounds with limited mental health resources (Breland-Noble, 2013) thus leaving a void in research examining mental health difficulties with all youth who identify as African American.

Adolescents

For many, adolescent years can be a difficult time. There are issues related to educational transitions, phenotypical changes, and instability regarding self-esteem. Adolescents dealing with mental health difficulties can experience this developmental period with a heightened sense of negativity. Mental health difficulties can affect an adolescent's interpersonal relationships, daily behaviors, and productivity at work, home, and school. During this time, there is an increased desire for autonomy regarding their behavior, cognition, and emotions in relation to their social environment (Compas, Jaser, & Benson, 2009). Research has shown that African American youth experience mental health difficulties at rates higher than their White counterparts, and that adolescents experiencing mental health difficulties have a greater chance of experiencing severe mental health difficulties later in life (Hurd, Stoddard, and Zimmerman, 2013). During adolescence there are many behavioral, psychological, and emotional changes that take place, which can make it difficult to know which behaviors are normal typical developmental changes, and which behaviors are symptoms of mental health difficulties. While it is normal for young people to experience feelings of anxiety, fear, sadness, loss, and depression, when these feelings persist for long periods of time, there can be cause for concern. For most adolescents, "…mental health distress is episodic, not permanent…" (Youth.gov, nd). There are warning signs for individuals experiencing mental health difficulties, therefore, it is important to note these changes in behavior as they can last for weeks or months. Often, these behavior changes interfere with the adolescent's daily interactions with family, friends, and/or their school performance (NAMI, nd). Some symptoms are observable such as changes in sleeping patterns (sleeping more or sleeping less), changes in eating patterns (eating more or eating less), experiencing mood swings (including anger, sadness, crying), weight fluctuations, low energy level, changes in school performance and poor grades, and a lack of desire to spend time with friends. At the same time, there are internal signs that can include thoughts of wanting to harm her/himself, and

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thoughts of suicide (Youth.gov, nd; NAMI, nd). Some adolescents struggling with mental health concerns experience psychosomatic symptoms such as body pain and headaches. When adolescents express or display these behaviors, it is important to obtain mental health supports.

Prevalence

The National Institute of Mental Health (NIMH) estimates that mental health difficulties affect millions of people each year. Unfortunately, only approximately half of those affected by mental health difficulties receive treatment (nimh.gov). Approximately one out of five youth experience mental health concerns, yet a majority of youth affected by mental health difficulties do not receive the required supports and services (Kataoka, Zhang, & Wells, 2002). Mental health does not manifest the same for everyone. There are variations in severity and topography. The National Alliance of Mental Illness (NAMI, nd), notes that African Americans experience higher levels of disadvantages regarding access to mental health supports and services. The NAMI also notes that African Americans are more likely to receive incorrect mental health diagnoses.

While approximately 20% of youth suffer from mental health difficulties, the survey by the Substance Abuse and Mental Health Services Administration (SAMSHA, 2018) examined the number of youth under the age of 18 who received mental health supports. This survey disaggregated the data to demonstrate the prevalence of service at each age level. According to the survey 13.8% of 12-13-year old's, 15.1% of 14-15-year old's, and 15.6% of 16-17-year old's received mental health supports. This resulted in an overall total of 28.4% of 12-17-year old's experiencing mental health difficulties. Of the youth who received supports and services for mental health concerns, 58.9% percent reported feeling depressed, 33.5% had thoughts of killing oneself or had attempted to kill oneself, 33.2% reported feelings of anxiety, 23.5% noted problems at home or with family, and 19.7% reported problems at school. In general, the SAMSHA (2018) data showed that the mental health concerns noted most often by adolescents included depression, anxiety, and suicidal ideation. As such, this chapter will focus on these three areas- depression, anxiety, and suicidal ideation.

Depression

Depression is defined as a common mood disorder that is marked by difficulty concentrating, changes in sleeping and eating patterns, feelings of hopelessness and sadness, chronic pain, and a general loss of feeling joy or happiness. Individuals diagnosed with depression must exhibit these symptoms for a minimum of 2-weeks (American Psychiatric Association, nd). Depression is "…one of the most prevalent and incapacitating mental disorders…" (Kalibatseva & Leong, 2014, p. 433) and is the leading cause for youth to seek out and receive mental health services. The SAMSHA 2018 report notes that 59.7% of youth age 12 through 17 received mental health services due to depression. Historically, research regarding mental health, specifically for depression stemmed from a medical model, thus negating the expressed symptomatology of people from racially and ethnically diverse backgrounds (Ofonedu, Percy, Harris-Britt, & Belcher, 2013). The medical model consists of a systematic process of identifying internal struggles based on external manifestations in which a diagnosis is given without the inclusion of ecological variables. These external behaviors are tied to societal norms of how one would express

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emotion or thought. The behavioral demonstration of African American youth suffering from depression can display behavior of sadness and low energy but also anger and irritability (Ofonedu et. al., 2013). It is these demonstrated behaviors of African American youth that can, and have, led to the misdiagnosis and underdiagnosis of mental health concerns.

Anxiety

Anxiety is the second leading reason for youth to receive mental health services. While feelings of anxiety are normal, according to the Mayo Clinic, individuals with anxiety disorders can experience frequent fears and worries regarding everyday situations. Common characteristics of anxiety include, rapid breathing, feelings of nervousness, trouble sleeping, feeling tired, trembling or shaking, and an inability to control the anxiety provoking thought (Mayo Clinic, nd). The SAMSHA (2018) report states that 33.2% of youth age 12 through 17 received supports for anxiety.

Suicidal Ideation

Suicidal ideation or attempts is the third leading cause for youth to receive supports and services for mental health difficulties. The SAMSHA (2018) report indicates that overall 32 percent of adolescents aged 12 to 17 had thoughts of or attempted to kill oneself. It is important to note that the percentage of youth receiving mental health services for suicide attempts or ideation increased 3.4 percent from 2016 to 2017. African American youth report feeling sad and helpless at rates higher than their white counterparts, but African American are less likely to die from suicide, though they have higher attempt rates (Bailey, nd).

PROTECTIVE AND RISK FACTORS

There are various factors that can contribute to adolescents experiencing mental health difficulties. These factors are called risk and protective factors. Risk and protective factors can emanate from the same entity, such as family, friends, and community.

Protective Factors

O'Connell, Boat, and Warner (2009) note the developmental progression of an individual is intertwined with various life interactions. Life interactions can help or hinder the mental health development of adolescents. Protective factors are typically associated with desirable behaviors and can include a high self-esteem, positive academic development, good problem-solving skills, and the engagement of social interactions through sports, peers, and/or religious affiliations (O'Connell et. al., 2009). Facilitators are also considered protective factors. Facilitators are events or individuals who assist in the receipt of information, services, and treatment (Planey et al, 2019). Mental health facilitators for African American youth include people who identify behavior changes and help the youth proactively seek help, provide assistance to the youth by accompanying the youth to an appointment, and having a positive and trusting relationship with the mental health service provider (Planey et al., 2019).

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Risk Factors

The ability to identify risk factors can help match the evidence-based intervention and prevention strategies to support the adolescent appropriately. Risk factors are typically associated with negative or problematic behaviors, and can include being shy, having low self-esteem, experiencing symptoms of depression, poor social skills, and an increased need for external validation (O'Connell et. al., 2009). In general, African Americans experience increased risk factors such as poverty and classism which can affect their mental health. African American adolescents increased exposure to life stressors such as poverty, stereotypes, involvement in social service program - like foster care, racism, and violence can contribute to increased rates of risk factors associated with negative behavior and mental health concerns (Breland-Noble, 2004).

BIAS, STIGMAS, AND IDENTIFICATION

Access to mental health for African American youth is also mitigated based on perceptions and stigmas. Perceptions of care givers and friends, access to supports and services, and knowledge of how to obtain supports and services (Planey et. al., 2019; Lindsey, Barksdale, Lambert, Ialongo, & Lindsey, 2010) can impact stigmas associated with help seeking behaviors. African American youth are less likely to receive mental health service due to stigmas and negative perceptions (Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013). Moreover, studies show that African American youth feel that they will be perceived negatively by friends and family if they disclose mental health concerns.

Barriers are obstacles that inhibit someone from accessing information obtaining supports, and receiving treatment (Planey et al., 2019). These barriers also result in African American youth suffering from mental health needs at rates higher than their White counterparts (Breland-Noble, 2004). Barriers for African American youth include access to mental health service providers, transportation, refusal to obtain help, prior negative mental health service experiences, a perception that mental health difficulties do not exist, lack of trust for the mental health service provider, and cultural aspects of self-reliance (Planey, et al., 2019). Another barrier that impacts African American mental health supports and services center around bias and identification.

Barriers such as negative perceptions, biases, and stigmas result in a decrease in African American youth seeking mental health services (Barksdale, Azur, & Leaf, 2010). "Overall, African American students and males are the most likely to be overrepresented as a result of teacher referral for mental health services" (Stiffler & Dever, 2015, p.32). Some of the issues regarding African American youth and mental health has stemmed from bias regarding assessment and intervention. Previous research has noted that African American youth are often misdiagnosed or underdiagnosed when dealing with mental health concerns (Breland-Noble, 2013). Much of the misdiagnosis and under-diagnosis can be attributed to the fact that depression symptoms and mental health topographies are typically defined by and based on the behavior of mainstream (White) youth (Castro-Olivio, 2017; Cokley et. al., 2014; Ofonedu, Percy, Harris, Britt, & Belcher, 2013).

As stated earlier in the chapter, African American youth depressive behaviors can consist of low energy and sadness, but they can also display behaviors of anger and irritability (Ofonedu et. al., 2013) whuch contributes to African American youth being identified as a behavior concern versus in need of mental health supports. While African American youth demonstrate mental health needs at an increase

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rate compared to White youth, the behaviors of African American youth are overidentified for behavioral issues and under identified for mental health difficulties. The misdiagnosis and under-diagnosis of African American youth as can lead to increased mental health concerns due to a lack of supports and treatment. The lack of treatment and supports can manifest into an increase in mental health symptoms, behavioral concerns, academic difficulties, and violence which can lead to an "increased risk of juvenile justice" (Lindsey, et al., 2010, p. 367) encounters.

Issues regarding proper diagnosis can affect self-help behaviors. While there is a vast amount of information regarding mental health topics, identification, and access to mental health services, African American youth seek out mental health supports at lower rates than their White counterparts (Barksdale et. al., 2010). Data from the SAMSHA 2018 study showed that African American youth identified as receiving mental health supports was 11.7 percent compared to 16.9 percent for White youth. Approximately 14.7 percent of the adolescents received supports and services from school-based mental health providers (SAMSHA, 2018). At the same time, African American youth received .7 percent of their mental health supports from the juvenile justice system, while .1 percent of White youth received mental health supports from the juvenile justice system (SAMSHA, 2018). A 2019 study by SAMSHA conducting a National Mental Health Services Survey (N-MHSS), examined who was receiving mental health services and the types of facilities providing mental health services. This report states that youth age 17 or younger accounted for 26 percent of outpatient mental health services with 15 percent African American and 40 percent White (SAMSHA, 2019, figure 16 and 17). Additionally, youth under the age of 17 receiving mental health services through community mental health centers equated to 28 percent, with 16 percent African American and 55 percent White. While jail and prisons are not included in the SAMSHA (2019) report, many African American youth receive support for mental health and social-emotional disorders through entrance into the juvenile justice system or though involuntary methods via law enforcement (Breland-Noble, 2004; Cauce et al., 2002).

According to Snowden (2003), "One possible reason for disparities is that practitioners and mental health administrators make unwarranted judgements about people on the basis of race or ethnicity. Their inappropriate expectations lead to inappropriate decisions and actions" (p. 239). Cokley et al., (2014) examined the disproportionate rates of African American male youth being identified as emotionally and behaviorally disturbed at rates higher than their White counterparts noting that the"…pervasive negative stereotyping of blacks can bias teachers toward addressing externalizing symptoms (e.g., delinquent and aggressive behavior) rather than being sensitive to their underlying internalizing causes (e.g., depression and anxiety)" (p. 41). Because of disparities with mental health assessment/intervention, response, and support, African American youth have been systematically denied proper mental health supports due to exclusionary practices such as suspension and special education placement. It is vital that educators and service providers, "…work to understand what underlies the student's behavior rather than using [the students] misconduct to harshly judge students" (Cokley et. al., 2014, p.42).

CULTURAL RESPONSIVENESS

Cultural responsiveness incorporates the clients and mental health providers age, race, gender, sexual identity and language (Cabassa & Baumann, 2013). Though there are several barriers for African American youth to receive mental health supports, research has shown an increase of African American youth seeking out, and participating in, mental health services (Lindsey et. al., 2013). Increasing the mental

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health participation of African American youth would require an increase in services being provided for families that have historically been under served. This would require the use of school-based mental health screenings and treatments in addition to culturally responsive practices. Evidence based practices have largely ignored the socioeconomic status, race, and culture of the individual (Castro-Olivo, 2017). This is problematic as Castro-Olivo (2017) notes that culture matters in the development of an adolescent.

Responding to the mental health needs of youth from diverse backgrounds has led to the increase of positive academic and behavioral performances (Schellengerg and Grothaus, 2011). To date, there are still issues around trust and stigma in the African American community. This is further exacerbated by the lack of culturally responsive mental health practices. Studies and researchers alike have stated that the lack of mental health service providers who are of color leads to a disconnect between the mental health provider and the individual (Briggs, Banks, and Briggs, 2014; Breland-Noble, 2004).

CULTURALLY RESPONSIVE EVIDENCE-BASED PRACTICES

Cognitive Behavioral Therapy

One type of evidence-based practice used to support adolescents dealing with mental health difficulties is Cognitive behavioral therapy (CBT). As noted earlier in this chapter, there is an increased number of individuals identifying as being culturally diverse. With the majority of school-based mental health service providers being primarily heterosexual, middle-class Caucasian women, this demographic disparity can and has led to issues regarding assessment, diagnosis, and appropriate interventions/services for people of color (Jones, Lee, Zigarelli & Nakagawa, (2017). The implementation of evidence-based therapies focuses, "… on the importance of implementation fidelity and efficacy of contextual aspects to mental health care… (Zigarelli, Mones, Palomino, & Kawamaura, 2016, p. 458). Ensuring that evidence-based interventions are culturally responsive is important.

The use of CBT was originated to help individuals with emotional difficulties such as anxiety and depression (Zigarelli, et. al., 2016,). Cognitive behavioral therapy is action-based psychotherapy that focuses both on the cognitive thoughts and demonstrated behaviors. Cognitive behavioral therapy does not address the origins of the thoughts or behaviors of concern, but rather focuses on changing the thought patterns, which would in turn change the exhibited behaviors (Ford-Martin, 2018). This form of therapy combines the cognitive therapy with behavior modification; thus, the individual is an active participant in the process. Additionally, CBT is conducted within a specified timeframe (Ford-Martin, 2018) with an established goal that is being worked toward. There are several CBT techniques that can be utilized. These techniques include conditioning, journaling, modeling, behavioral homework assignments, and systematic desensitization (Ford-Martin, 2018). The implementation of culturally responsive CBT takes into account ethnic and culture factors and fosters the interventions specifically for that individual (Zigarelli, et. al., 2016). Further, research has shown that including ethic and cultural variables into therapy sessions results in an increase in students' academic performance (Zigarelli, et. al., 2016).

Interpersonal Therapy

Interpersonal therapy is another culturally responsive evidence-based intervention that is typically used with individuals demonstrating depressive symptoms. Interpersonal therapy is a short-term therapy

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that examines the adolescent's mental health concerns (i.e., depression) in relation to the adolescent's relationships with people in their social network (Spurling, 2012). More specifically, individuals are assisted in understanding how their relationship with others are linked to their depressive symptoms, how to deal with those feelings, and how to "…improve the quality of their relationships" (Spurling, 2012 p. 233). This form of therapy can be adapted to incorporate the adolescent's depressive symptoms in relation to external cultural relationships. The symptomatology and stigma associated with depression, "…may be grounded within a cultural context…" that can be carefully explored through interpersonal therapy (Kalibatseva & Leong, 2014, p. 447). The implementation of "culturally adapted treatments for depression appear effective in symptom reduction…" as studies have shown that interpersonal therapy is effective for African Americans (Kalibatseva & Leong, 2014, p. 447).

MULTICULTURAL COUNSELING

Another evidence-based intervention is multicultural counseling. In multicultural counseling, the mental health support provider is aware of his/her own bias and works with the individual from their cultural perspective or lens (Zigarelli, et. al., 2016). Multicultural counseling has been found to be effective with individuals from various backgrounds as well as individuals with diverse sexual identities. According to Lee, Blondo, Mizelle, and Orzco (2010), when working through a multicultural lens the mental health provider should understand that adolescent's culture and what is considered aceptable within that cultural group. Additionally, the adolescent's behavior can be evaluated in relation to the cultural norms. "Behavior that is abnormal in one culture may be adaptive in another" (Lee, et. al., 2010, p. 2). The impact of the individual being able to express concerns and receive supports from a mental health service provider that is of the same culture, or at least someone who has cultural awareness, increases the effectiveness of the counseling. African American adolescents "…may be more likely to seek and stay in treatment if they consider the issues discussed in therapy relevant to their culture" (Kalibatseva & Leong, 2014, p. 447).

School-Based Mental Health Supports

Schools can be a vital component for the provision of supports and services for students experiencing mental health difficulties (Lindsey, et al., 2010). Schools are primed to provide early screening, identification, referral, and support. There is an increase of schools implementing "…multi-tiered levels of support [that] can help them better identify and treat children and adolescents in need of mental health" (Castro-Olivo, 2017, p. 177). Stiffler and Dever, (2015) note that "Schools are an optimal setting for service delivery" (p. 33). Utilizing school-aged mental health services can assist in facilitating mental health care for youth (Husky, Kanter, McGuire, and Olfson, 2012). According to SAMSHA (2018) of the 59.7 percent of the youth who received supports for depression, 45.3 percent of those youth received supports in a school-based setting. At the same time, of the 32.2 percent of youth who received supports for anxiety, 23 percent of those youth received supports in a school-based setting. Additionally, of the 32 percent of students who received supports for suicidal thoughts or attempts, 18.4 percent of those students received services in a school-based setting.

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For many African American youth, school based mental health services provide most of the received supports (Lindsey, et al., 2013). Mental health screenings are conducted in schools to more readily provide and improve the identification in students (Husky, et al., 2012). In a study conducted by Husky, et al., (2012) approximately 40 percent of African American students who were screened for mental health scored in the range of needing mental health supports. Additionally, the African American youth voluntarily participated in mental health services at rates higher than their white peers.

While school-based mental health services allow for quicker identification and consistency of supports and services, there is little diversity among mental health service providers. This can cause African American youth to have feelings of mistrust and fear of potential judgement from the service provider. These feelings of mistrust and judgement can reduce the number of African American youth who receive school-based mental health services. At the same time there is a difference between the prevalence of African American youth exhibiting mental health difficulties overall in comparison to African American students identified in the school setting. This indicates that African American youth are being underdiagnosed in schools. Unfortunately, African American youth demonstrating aggressive or deviant behaviors as a manifestation of their mental health difficulties receive harsh discipline consequences instead of appropriate mental health supports to address the specific needs of the youth (Hess, Pejic, and Castejon, 2014).

One way of being proactive with mental health identification is through the implementation of the problem-solving model which includes the response-to-intervention/multi-tiered systems of supports (RTI/MTSS) process. Many schools use the RTI/MTSS approach for the identification and treatment of students in need of mental health supports (Castro-Olivo, 2017). Though the use of RTI has not historically been implemented to assist students with mental health difficulties, this systematic process can be beneficial in determining the effectiveness of the intervention (Hess, et. al., 2014).

Problem-Solving Model

Froiland (2011), examined the possibility of addressing mental health issues through the problem-solving model. This research consisted of implementing mental health interventions. The use of RTI allows for the student to receive interventions that are monitored over a specified amount of time to determine the effectiveness of the intervention. The impetus of response-to-intervention is that the student receives evidence-based interventions in the general education setting, the teacher and the student receive supports upon the inception of RTI, and the potential identification of the student needing support for emotional or behavioral difficulties is not based on potential biased teacher referral, but rather based on the evaluation of the outcome data (Harris-Murri, King, & Rostenberg, 2006).

Response-to-intervention is a systematic method of solving problems. The use of the problem-solving model within the RTI framework allows for the "…application of the scientific method…" (Froiland, 2011, p. 36) through the four problem solving stages: problem identification, problem analysis, treatment implementation, and treatment analysis (Kratochwill & Bergan, 1990). The problem-solving model is based in behavioral consultation and is effective with both academic and behavioral difficulties.

The first stage in the problem-solving model is problem identification. This stage consists of obtaining a concrete definition of what the behavior is and what the behavior is not. The behavior is described in measurable observable terms that assist in determining if a problem exists. The potential existence of the problem is determined through observation and the students' performance. This step allows for the systematic process of collecting data regarding the student's difficulties demonstrated at school (Brown-

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Chidsey and Steege, 2010). The problem identification stage is completed when it is clearly established that, "…a discrepancy exists between the occurrence of the current and the desired levels…" of the behaviors of concern (Kratochwill and Bergan, 1990 p.35).

The second stage in the problem-solving model is problem analysis. Problem analysis consists of determining factors that may identify a solution to the concern and develop a plan to support the student and solve the problem (Kratochwill and Bergan, 1990). Emphasis is placed on environmental factors and social interactions of the adolescent (Kratochwill and Bergan, 1990). During the problem analysis phase a hypothesis is developed in an effort to determine why the student is demonstrating behaviors of concern. Through this information, student perceptions, as well as the perceptions of others, in addition to cultural variables are incorporated into the hypothesis. This information can be gathered through a Review, Interview, and Observe (RIO) process, or Instruction, Curriculum, Environment, and Learner (ICEL) process. Information from these processes analyze both the skill level of the student and also the ecological variables that may be contributing to the student's behaviors.

The third stage in the problem-solving process is treatment implementation. Treatment implementation consists of implementing an intervention or treatment to support the student in addition to monitoring the effectiveness of the intervention through progress monitoring (Brown-Chidsey and Steege, 2010; Kratochwill and Bergan, 1990). At the same time, this phase should incorporate the ecological variables as well as any cultural variables. It is vital that the intervention is implemented with fidelity to ensure that the intervention is carried out the way it was intended.

The fourth stage in the problem-solving model is treatment analysis. During this stage data is examined to determine the effectiveness of the intervention. With mental health concerns, the analysis would note changes in behavior and or thoughts in addition to the frequency of these behaviors or thoughts. If the intervention was not effective or the mental health concerns require a higher level of support and or treatment, multiple mental health providers may need to be brought in to help support the student and increase success (Brown-Chidsey & Steege, 2010). Essentially, treatment analysis consists of gathering the data from all three previous stages and determining the effectiveness of the intervention.

The utilization of the problem-solving model should take into consideration cultural responsiveness. This includes the students background, race/ethnicity, primary language, and potential bias for the initial referral (Harris-Murri, King, & Rostenberg, 2006). The number of students enrolled in public schools from diverse backgrounds are increasing (Kena, et. al., 2014). At the same time, the percentage of White students attending public schools has decreased from 28.7 million students to 25.6 million students, which results in an approximate 12 percent reduction of White students attending public schools. According to the U.S. Department of Education Schools and Staffing Survey, 82 percent of teachers in public schools identified as White in 2015, which is a 2 percent decrease from 84 percent of teachers in public school who identified as White in 2000 (U.S. DOE, 2016). Further, data from a national survey conducted in 2015 noted that 80 percent of teachers and principals in the public-school system identified as White (U.S. DOE, 2016).

There is a higher percentage of teachers who are White in relation to the percentage of students from non-white backgrounds in elementary and secondary schools (U.S. DOE, 2016). The racial discrepancy between teacher and student can create a cultural separation regarding academic and behavioral expectation (U.S. DOE, 2016). The cultural separation can be noted in expected academic performance, behavioral expectations, and discipline practices (Gregory & Roberts, 2017). When culturally responsive practices are not considered regarding discipline and instruction, the behavior and emotional well-being of students can be misinterpreted as a disorder (Harris-Murri, et al., 2006) instead of a skill-based or mental health

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need. Research has shown that teachers of color add to the culture of the campus by representing as positive role models for all students. Having diversity among teachers assists in robust conversations and actions around culturally responsive teaching practices (U.S. DOE, 2016) and can assist in eliminating negative stereotypes for racial and ethnic groups.

Response-to-Intervention

While RTI was originally used for academic assessments, research has shown that this method can be used to identify students demonstrating an emotional disturbance (Stiffle & Dever, 2015; Froiland, 2011). The use of RTI resulted in a change in the way students were assessed. Instead of the identification process stemming from a "with-in" child perspective, RTI encompasses more of an ecological perspective and incorporates variables in the student's life that may be attributing to the behavior of concern. Response-to-Intervention places emphasis on evidence-based interventions prior to a referral for special education (Harris-Murri, King, & Rostenberg, 2006; Brown-Chidsey & Steege, 2010 and 2005). Using RTI to address mental health needs is something that school psychologists can do (Froiland, 2011). "School psychologists can utilize RTI to further consult with schools and families to develop potent interventions that foster students' mental health, social success, and resilience" (Froiland, 2011, p. 41).

Response-to-intervention (RTI) is an alternative method for identifying students who need additional supports. With RTI, all students are screened and monitored through a systematic objective data-based system that determines the needs of the student based on the student's response to the intervention (Brown-Chidsey & Steege, 2010; 2005). "Essentially, RTI is an objective examination of the cause-effect relationships(s) between academic or behavioral *intervention* and the student's *response* to the intervention" (Brown-Chidsey & Steege, 2005, p. 2). It is also essential that the systematic process is culturally responsive and connects different aspects of the youth life such as school, community, and home (Harris-Murri, et al., 2016). Response-to-Intervention can consist of 3 or 4 tiers. "Tier 1 is comprehensive and universal" (Brown-Chidsey & Steege, 2010, p. 4).

Tier I

In Tier I all students are screened and provided with evidence-based academic interventions in a general education setting. Culturally responsive behavioral practices promote general positive interactions and supports for students across the school, while noting any underlying factors that are contributing to the behaviors of concern (Hess, et al., 2014). Data obtained during screening and monitoring in Tier I can assist in determining if there are behavior patterns that result in disproportionate consequences or responses with certain ethic, racial, and/or cultural varied students. Data should be examined and disaggregated to note if there are any differences regarding office referrals, types of behavioral consequences, or inconsistent supports and follow up that would affect one group of students over a different group of students (Hess, Pejic, & Castejon 2014).

Unfortunately, despite some systematic Tier I interventions designed to support all students, evidence shows that there are still disproportionate disciplinary actions and consequence (Hess, et. al., 2014). These cultural response practices can be ameliorated through systematic reviews of data examining the referral of the student, and the consequence received by the student while monitoring the frequency of the represented cultural groups to note which cultural group receives the most disciplinary consequences and the type of disciplinary consequences (Hess, et al., 2014). Through systematic behavioral monitoring, most

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students can be successful and receive the supports needed at Tier I through school-wide interventions. Students who demonstrate a need for additional supports after receiving Tier I supports, move to Tier II.

Tier II

Tier II consists of providing additional supports for the student while the student is still receiving Tier I interventions. Tier II adds on additional interventions versus replacing Tier I interventions with Tier II interventions. Approximately 20% of students will move from Tier I to Tier II. Interventions in Tier II include the implementation of small group supports that allow for additional learning and practice of the desired skill. Unfortunately, for students demonstrating mental health difficulties, the inclusion of small-group settings may not be appropriate as the inclusion of new students to the group can disrupt the current group (Hess, et al., 2014). Additionally, students may be more reluctant to share if the make-up of the group is not consistent. Intervention structures that are centered around the student being able to meet with or check-in with an adult mentor have proven successful. Students who continue to demonstrate a need for additional supports would receive intensive instruction, intervention, and possible assessment in Tier III (Brown-Chidsey & Steege, 2010 and 2005). "However, if culturally responsive academic and behavioral components are not integrated at each tier, these programs may not adequately address the needs of all students" (Hess, et al., 2014, p. 323). It is important that school staff who are from different cultural backgrounds, or who have knowledge of the various cultures on campus are a part of the problem-solving process when examining the behavioral concerns and developing the behavioral supports (Hess, et al., 2014).

Tier III

Tier III consists of providing small group instruction or supports to students who need additional supports at a level and frequency higher than Tier II. Approximately five percent of students within the RTI process will require supports and services at Tier III (Brown-Chidsey & Steege, 2010 and 2005). Typically, at Tier III, the student receives an in-depth evaluation consistent of a record review and data collected during Tier I and Tier II to determine needs and supports while receiving supports. During the evaluation, students continue to receive supports and services with increased frequency and duration (Hess, et al., 2014; Brown-Chidsey & Steege, 2010 and 2005).

CONCLUSION

With a culturally diverse population, mental health supports for adolescents must incorporate culturally responsive evidence-based interventions. African American adolescents experiencing mental health difficulties for depression, anxiety, and suicidal ideation should receive supports and services that are in conjunction with the cultural norms of behavior from a mental health provider who is aware of the cultural norms and can incorporate that information into a pro-active intervention strategy. Schools are a mecca of diversity, and the use of culturally responsive practices in schools is vital. Adolescents in need of supports and services for mental health concerns should be able to receive evidence-based interventions that are shown to be effective for a variation of cultures and backgrounds. African American adolescents should be free from bias and assumptions of symptomatology based on the behavioral expectations of the

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mainstream culture. Noting the various issues discussed in this chapter regarding stigmas, perceptions, and community supports, it is incumbent on the mental health system to ensure that African American youth are able to receive the mental health supports and services needed from a variety of mental health providers with demonstrated cultural awareness and responsiveness to the students symptomatology.

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KEY TERMS AND DEFINITIONS

Cognitive Behavioral Therapy: A solution-focused therapy that focuses on current concerns to modify emotional and behavioral concerns.

Culturally Responsive: Being knowledgeable of, relating to, and incorporating other cultures and backgrounds.

Evidence-Based Interventions: Strategies and practices proven to be effective through systematic evaluation.

Interpersonal Therapy: Evidence-based therapy that focuses relationships the individual has with others in relation to the areas of concern

Multicultural Therapy: A form of therapy that takes into consideration the individuals cultural background in addition to other diverse experiences in addressing areas of concern.

Response-to-Intervention: A multi-tiered approach for identifying and supporting students with academic and behavioral needs.

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Chapter 44
Mental Health Challenges in Children With Intellectual Disabilities

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ABSTRACT

There is limited evidence base regarding mental health issues in people with intellectual disability (ID), and hence, findings from the general population are often applied to ID groups. Available evidence suggests that individuals with ID experience higher rates of mental health disorders than the general population, although findings are mixed with regard to the determinants of this increased prevalence. Further, the consequences of this comorbidity for individuals, families, and the wider community are often overlooked including the multiple challenges in identifying and managing these concerns. Accurate diagnosis and effective intervention are currently hindered by factors including the applicability of standardized psychiatric classification systems, gaps in service delivery models and access to such services, as well as unmet training needs. It is critical that further research is carried out to examine the specific challenges facing individuals with ID along with facilitating appropriate mental health services to individuals with ID.

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INTRODUCTION

Despite increased recognition of the prevalence and impact of psychiatric disorders among individuals with Intellectual Disability (ID), the early assessment and treatment of these concurrent comorbidities remains a significant societal challenge and affect the functional skills and intensity of daily support needed for those living with ID. Limitations in current assessment and diagnostic systems prevent the equitable access to services for people with ID in line with Article 25 of the United Nation's Convention on the Rights of Persons with Disabilities which outlines 'the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability' (United Nations 2006; Stuart, 2012). Consequently it is critical to further develop and refine standardised diagnostic systems to achieve these aims. Furthermore, in order for intervention to be effective, it must address the multiple risk and resilience factors underlying ID and comorbid mental health problems. Therefore, from a public health perspective, rates of comorbid psychiatric disorders should be taken into account when planning for the equitable provision of services. Similarly, intervention research should consider the role of comorbidity in predicting outcomes and the nature of the barriers that prevent access to services, while basic science research would benefit from increasing understanding of these comorbidities by delineating possible heterogeneous aetiological and neurobiological determinants. This chapter will review and synthesise the literature on the prevalence, impact and determinants of the comorbidity of ID and psychiatric disorders, and discuss important considerations to improve accurate identification and effective management of these concerns.

Background

Intellectual Disability (ID) is characterised by deficits in both intellectual and adaptive functioning beginning during childhood or adolescence (APA, 2013). Adaptive behaviour includes conceptual skills (e.g., language, money and time concepts), social skills (e.g., interpersonal skills and social problem solving), and practical skills (e.g., activities of daily living and occupation) (Maulik, Mascarenhas, Mathers, Dua, & Saxena, 2011).

A comprehensive meta-analysis found that the overall global prevalence of ID was approximately 1%, with higher prevalence rates found in low- and middle-income countries, and among child and adolescent populations (Maulik et al., 2011). Social gradients and ethnic disparities have been reported in previous research on the prevalence of ID. Lower socio-economic status (SES) has been found to be associated with a marked increase in the prevalence of ID, particularly mild ID (Emerson, 2012; Leonard et al., 2005; Leonard & Wen, 2002; Roeleveld & Zielhuis, 1997; Stromme & Magnus, 2000), and higher rates of ID have been found among African-American and Indigenous Australian children (Croen, Grether, & Selvin, 2001; Leonard, Petterson, Bower, & Sanders, 2003; Leonard et al., 2005; Yeargin-Allsopp, Drews, Decouflé, & Murphy, 1995).In a recent epidemiological study it was estimated 5.9% of the Indigenous population lives with ID compared to 2.5% of the non-Indigenous Australian population(Statistics, 2015).

It has been proposed that socioeconomic disadvantage can contribute to both causation and severity of ID. (Durkin & Yeargin-Allsopp, 2018)For instance the etiology of some causes of intellectual disability, such as Down syndrome have been associated with environmental factors and stress that are linked to low SES. Additionally low SES families may not have the resources to provide the early socio-cognitive stimulation that is associated with improved outcomes in ID. Of particular concern is the evidence that an "inverse care law" applies, in that the greater number of risk factors a child may have for ID, the less

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access they have to preventative and comprehensive health care (Woolfenden et al., 2013). This creates a vicious cycle whereby the risk factors that may predispose a child to ID are also the same risk factors that may mean they are likely to miss out on timely and effective identification and intervention.

CHALLENGES IN THE ASSESSMENT AND MANAGEMENT OF PSYCHIATRIC DISORDERS AMONG INDIVIDUALS WITH INTELLECTUAL DISABILITY

Prevalence of Psychiatric Disorders among Individuals with Intellectual Disability

In a comprehensive systematic review, Einfeld, Ellis, and Emerson (2011) found that between 30 and 50% of children and adolescents with ID had a comorbid mental disorder, and that the relative risk of mental disorder associated with ID, when compared to children and adolescents without ID, ranged from 2.8 to 4.5. Consistent with these findings, a secondary analysis of the 1999 and 2004 Office for National Statistics surveys of the mental health of British children and adolescents estimated that the 3% of British children with ID accounted for 14% of total child and adolescent psychiatric morbidity (Emerson & Hatton, 2007b). Comparing 641 children with ID and 17 774 children without ID, this research found that the prevalence of psychiatric disorders was observed to be 36% among children with ID and 8% among children without (Odds Ratio/OR=6.5). Increased prevalence among children with ID was particularly marked for autism spectrum disorder (OR=33.4), hyperkinesis (OR=8.4) and conduct disorders (OR=5.7). Furthermore, a cumulative effect was observed, with research suggesting that the greater the number of social or environmental risk factors a child with ID is exposed to (e.g., low SES, stressful life events, poor parental mental health), the higher their risk of having mental health problems such as emotional or conduct disorders (Emerson & Hatton, 2007b).

Other studies have also noted an increased relative risk for psychiatric disorders among children and adolescents with ID, and this has been found across a range of diagnoses including anxiety and mood disorders, behaviour disorders and attention deficit hyperactivity disorder (Dekker & Koot, 2003a,b; Emerson, 2003; Emerson & Hatton, 2007b). A secondary analysis of the 1999 Office for National Statistics survey of the mental health of children and adolescents in Great Britain found that the prevalence of any diagnosed ICD-10 disorder, as well as specific disorders such as conduct disorder, anxiety disorder, hyperkinesis and pervasive developmental disorders, was significantly greater among children with ID than among their non-ID peers(Emerson, 2003). A more recent examination of the mental health of adolescents with ID found that they were significantly more likely to report symptoms of anxiety than their peers without ID (King et al., 2019).

Longitudinal studies suggest that comorbid psychiatric disorders among children with ID persist through to adolescence and adulthood (Chadwick, Kusel, Cuddy, & Taylor, 2005; Einfeld et al., 2006; Richardson & Koller, 1996; Tonge & Einfeld, 2000). For example, in a 14-year longitudinal study of children with ID in Australia, high initial levels of behavioural and emotional disturbance decreased only slowly over time, with 31% of participants continuing to meet criteria for a psychiatric disorder in young adulthood (Einfeld et al., 2006). Greater decreases in psychopathology were found among males rather than females, and in participants with mild ID compared to those with severe or profound ID.

Overall findings with regard to rates of mental disorder among adults with ID have been somewhat inconsistent, partially due to differing methods for assessing psychiatric comorbidity. In their meta-

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analysis, Maulik et al. (2011) found that studies based on diagnosing psychiatric comorbidity using psychological assessments or scales showed higher prevalence compared to those using standard diagnostic systems and disability instruments. When ICD-10 or DSM criteria have been applied, reported rates of psychiatric disorder among adults with ID have been comparable to those found in the general population (Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Deb, Thomas, & Bright, 2001); however, the utility of these criteria among individuals with ID has been questioned (Einfeld & Tonge, 1999; Sturmey, 1995). When psychiatric diagnoses were made by consultant psychiatrists on the basis of clinical interviews, Cooper et al. (2007) found that 41% of adults with ID met diagnostic criteria for at least one mental disorder. This is a significantly higher point prevalence rate than that observed in the general population, where rates have been estimated to be approximately 13.2% (Andrews, Henderson, & Hall, 2001). Indeed, reviews generally indicate a three to four-fold increased prevalence of psychiatric problems among individuals with ID compared to the general population (Harris, 2006; Munir, 2016). As for children and adolescents, a number of psychiatric disorders have been found to be more common among adults with ID than among the general population, including anxiety and affective disorders, psychotic disorders, and behavioural problems(S.-a. Cooper, 1997; Pallab K Maulik & Catherine K Harbour, 2010). Additionally recent cross sectional study of Scottish primary care practices found that people with ID were twice as likely to have one or more concurrent mental health conditions relative to people without ID (Cooper, 1997).

Impact of Psychiatric Disorders among Individuals with Intellectual Disability

Psychopathology associated with ID carries significant consequences for individuals with ID, their families and the wider community. For individuals themselves, for example, the dual disability of ID and psychiatric disorder is a major cause of failure of transition to school programs and community residential placements (Bruininks, Hill, & Morreau, 1988; Einfeld et al., 2006), leads to restricted participation in recreational and educational programs (Parmenter, Einfeld, Tonge, & Dempster, 1998), and is associated with reduced workplace opportunities following school (Anderson, Lakin, Hill, & Chen, 1992). Robust evidence indicates that a lack of early detection and intervention, including interventions directed at improving parental wellbeing, has significant implications for the future academic, behavioural and social functioning of children with ID (Bouras, 2011; Crnic, Neece, McIntyre, Blacher, & Baker, 2017).

Mental health challenges can also be exacerbated by the inaccessibility of services and resources to allow people with disabilities to achieve goals such as independence, to whatever extent possible, from the familial unit. For instance the lack of adequate support during the transition from school to adulthood including a lack of post-school opportunities, such as supported work placements and the inaccessibility of many workplaces for individuals with disabilities has also been identified as contributing to heightened(Young-Southward, Cooper, & Philo, 2017) anxiety and mental health difficulties among youth with ID and their parents. A lack of meaningful daytime activities in addition to negatively affecting mental health is also often associated with a loss of functional skills that had been previously gained and limited formation of socially supportive net words (Gauthier-Boudreault, Gallagher, & Couture, 2017).

Interactions between social environment, family, ID and mental health problems are complex and not unidirectional. It is known that families experiencing additional life stress prior to having children are more likely to have children with ID (Eapen, Al-Gazali, Bin-Othman, & Pramathan, 1998). This is particularly the case with respect to Indigenous families, those from culturally and linguistically diverse backgrounds, and those with a parent who has ID or a mental illness (Leonard et al., 2011; Leonard et

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al., 2005; To et al., 2004). Hence, a vicious cycle of the development of ID and mental health problems can be seen at an individual level or in population groups experiencing adversity (Whitehouse, Durkin, Jaquet, & Ziatas, 2009; Whitehouse, Watt, Line, & Bishop, 2009). This confluence of factors generates a significant health burden for individuals, families, and communities, as well as inequity in child health resulting in significant health and economic impacts.

The long-term support of individuals with ID places a considerable burden on families and carers (Bourke et al., 2008; Crnic et al., 2017; DeRigne & Porterfield, 2017; Miodrag & Hodapp, 2010), and mothers in particular are at increased risk of mental health problems (Abbeduto et al., 2004; Gilson et al., 2018). Several studies have found that parents of children and adolescents with ID have higher levels of child-related stress and depression than parents of typically developing children (Browne & Bramston, 1998; Dyson, 1997; Olsson & Hwang, 2001; White & Hastings, 2004), and key short- and long-term outcomes for families of individuals with ID may be mediated, at least in part, by mental health difficulties (Eapen, 2014). For example, the mental wellbeing of parents of children and young adults with ID has been shown to be more strongly influenced by the severity of their child's comorbid mental health disorders including emotional and behavioural problems than by the severity of their ID (McIntyre, Blacher, & Baker, 2002; Tonge & Einfeld, 2003). Mental health problems among children and young adults with ID have also been shown to significantly predict parents' feelings of dissatisfaction with the family situation (Maes, Broekman, Došen, & Nauts, 2003), mothers' perceived negative impact of their child on the family, and the family's decision to seek out-of-home placement (Maes et al., 2003; McIntyre et al., 2002). It is interesting to note that stress did not account for significant additional variance in this decision-making (McIntyre et al., 2002), suggesting that mental health problems can significantly impact on the family's ability to care for a young person with ID without requiring out-of-home care arrangements. This adds to the social and financial burden of ID on families and societies, in conjunction with the economic impact of caregiving with mothers of children with ID earning significantly less over the course of their lifetimes than their peers with typically developing children(Parish, Seltzer, Greenberg, & Floyd, 2004). Overall, the inequities relating to the mental health of people with ID and their families relative to the general population has significant implications for service provision and policy development.

A recent meta-analysis based on studies published between 2010 and 2015 (n = 17) found the range of prevalence estimate to be 0.05 to 1.55%.(McKenzie, Milton, Smith, & Ouellette-Kuntz, 2016 ; McKenzie et al 2016). ID is also associated with reduced life expectancy and poorer quality of life (Begg et al., 2007), and high economic costs for governments and families (Doran et al., 2012). It ranks within the top 20 sources of burden of disease (Begg et al., 2007) and is among the 20 most costly disorders (Polder, Meerding, Bonneux, & Van Der Maas, 2002). This burden is compounded when ID is associated with a comorbid mental health disorder, leading to greater economic burden for provision of health care and education, in addition to further reductions in capacity for employment and earning.

Determinants of Mental Health Problems in Intellectual Disability

Given the high prevalence of mental health disorders among individuals with ID, and the impact of this dual diagnosis on individuals, families and the community, there has also been interest in examining specific variables that may influence this comorbidity.

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Available evidence from the literature suggests that most variance in developmental vulnerability is associated with the social determinants of health and their interaction with an individual's innate biological susceptibility to adversity (Guralnick, 1997; Zeanah, Boris, & Larrieu, 1997). Cumulative exposure to risk factors over time in the absence of protective factor scan result in changes in neuronal circuitry with long-term consequences (Eapen, 2014).For example, there is evidence of altered brain architecture found in children exposed to abusive environments or who have a history of sensory deprivation, as well as an association between the impact of less extreme adverse environments on brain architecture linked with language and reading skills (Hackman, Farah, & Meaney, 2010; Marmot et al., 2010). Such risk and protective factors have their maximum effect during critical or sensitive periods, especially in the first five years of life (Maggi, Irwin, Siddiqi, & Hertzman, 2010; Siddiqi, Irwin, & Hertzman, 2007). While brain plasticity offers an opportunity for maximum gains with appropriate intervention during the early years, this becomes increasingly difficult the further we move away from childhood.

There is also emerging evidence of a transactional relationship between genes and the environment (A. E. Sameroff, 2009), suggesting that individuals with certain genetic profiles may be more sensitive to favourable and unfavourable environmental influences than those without such genetic makeups (Mitchell et al., 2013). In other instances the behavioural or mental health problem may be part of the behavioural phenotype of the underlying genetic condition as is the case with Lesch-Nyhan syndrome and self-injurious behaviours, Fragile X syndrome and disruptive behaviours, Williams syndrome and exceptional conversational verbal abilities and excessive empathy, Prader-Willi syndrome and temper tantrums and obsessive-compulsive features, and Angelman syndrome and happy affect and hyperactivity (Cassidy & Morris, 2001). Further, when the condition is associated with dysmorphic features or changes in physical appearance, such as short stature or excessive growth, or delayed sexual development or functioning, affected individuals can suffer from low self-esteem and this can, in turn, lead to secondary emotional or behavioural difficulties.

In a recent case-control study using data from the Intellectual Disability and Mental Health Assessing the Genomic Impact on Neurodevelopment (IMAGINE-ID) study, genotype to phenotype associations in children with copy number variants associated with a high risk of neurodevelopmental and psychiatric disorders (referred to as ND-CNVs) was examined. Among individuals with 13 ND-CNVs, a similar range of phenotypic expressions in neurodevelopmental adverse outcomes was observed although there were subtle quantitative and qualitative differences. The findings suggest that the genomic risk for neurodevelopmental and psychiatric disorders has pleiotropic effects involving varying processes and diverse neural circuitry involvement rather than specific or individual phenotypes (Chawner et al., 2019). Due to the transactional and inter-dependent relationship between these factors, developmental vulnerability should be understood, assessed and treated with consideration given to the cumulative impact of multiple factors, both risk and protective, including those related to the individual child, family, psychosocial status, neighbourhood, and service systems and policy (Eapen, 2014).The occurrence and nature of mental health comorbidity in children with ID is therefore influenced by the interaction between biological and environmental risk and protective factors, with the overall risk increasing as the number of risk factors increases (Eapen, 2014).

Exposure to a range of social and environmental risk factors such as poverty, living in a single-parent household, exposure to negative life events, low parental education, and poor maternal mental and physical health, has been found to be associated with increased prevalence of emotional and conduct disorders among children both with and without ID (Emerson & Hatton, 2007b). Importantly, however, exposure to these risk factors was found to be significantly higher among children with ID, with 46% of

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them having been exposed to three or more potential risk factors compared to 24% of children without ID. While there is limited evidence regarding the specific factors predicting the presence of mental health problems in individuals with ID (Costello & Bouras, 2006), these findings are consistent with the prevailing view that individuals with ID are more vulnerable to psychosocial stress than people without ID, and are therefore more likely to develop psychiatric symptomatology (Deb et al., 2001).

Similar findings were reported by Emerson (2003), who conducted a secondary analysis of data from 10 438 children aged between five and 15 years from the 1999 ONS survey of the Mental Health of Children and Adolescents in Great Britain (Meltzer, Gatward, Goodman, & Ford, 2000). Specific family characteristics were found to be associated with increased rates of particular psychiatric diagnoses, and children living in families belonging to lower social classes, and those from single-parent and lower-income households, were found to be at increased risk for a range of psychiatric disorders, including emotional disorders, anxiety disorders, depression and conduct disorders. A further study specifically examining the contribution of socioeconomic position to the health and mental health status of children and adolescents with ID, using the same sample, found that between-group differences in socioeconomic position and household composition accounted for 24% of the increased risk for poor health, 23% of the increased risk for conduct disorder and 37% of the increased risk for emotional disorder among children and adolescents with ID (Emerson & Hatton, 2007a). The authors concluded that socioeconomic disadvantage may account for a significant proportion of the increased risk for poorer physical and mental health among children and adolescents with ID. Another study, however, failed to find significant differences in the prevalence of psychiatric disorders between children classified as low SES and those classified as medium to high SES (Dekker & Koot, 2003a,b).

Factors related to parents, including parental mental health and parenting practices, have also been found to be an important determinant of mental health problems in children and adolescents with ID (Dekker & Koot, 2003a,b; Emerson, 2003). (Hazarika, Das, & Choudhury, 2017) in a study of parental attitude towards children and adolescents with ID found that while parents exhibited love and acceptance towards their children, there was also evidence of frustration, disappointment, and overprotection. This in turn had a negative impact on the children's adaptive functioning and independent skill development. Further, children whose primary carers reported more frequent use of punitive strategies and who had higher scores on the General Health Questionnaire (a measure assessing risk of developing psychiatric disorders) were more likely to have a range of psychiatric disorders, including an emotional disorder, an anxiety disorder, a conduct disorder and hyperkinesis (Emerson, 2003).

In a systematic review, Einfeld et al. (2011) discuss individual factors that have been associated with mental disorder in children and adolescents with ID. Factors that have been most commonly examined include age, gender and severity of ID, but findings have been largely inconsistent. With regard to age, some studies have found higher rates of psychiatric disorder in younger children when compared to teenagers(Molteno, Molteno, Finchilescu, & Dawes, 2001), but others studies have shown no significant relationships between age and overall rates of mental disorder (Einfeld & Tonge, 1996a, 1996b). Other studies have examined age effects for particular psychiatric disorders. Older children with ID (aged 11 – 16 years) have been found to be more likely to have an emotional disorder, including a depressive disorder, while younger children (aged 5 – 10 years) were more likely to have hyperactivity or a pervasive developmental disorder (Emerson, 2003; Emerson & Hatton, 2007b). Among adults with ID, increasing age has been found to be associated with a higher likelihood of psychiatric illness (S. A. Cooper, 1997; Deb et al., 2001).

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Mixed findings have also been noted with regard to the association between gender and risk of mental disorders among children and adolescents with ID. Some studies have found no effect of gender on overall rates of mental disorder (Einfeld & Tonge, 1996a, 1996b; Molteno et al., 2001), but other studies have reported significantly higher overall rates of mental health problems among male children and adolescents with ID (Emerson, 2003; Stromme & Diseth, 2000). Further, some studies of children and adolescents with ID have found that males are significantly more likely to have conduct disorder and hyperactivity than females with ID (Emerson, 2003; Emerson & Hatton, 2007b), while others have shown no gender effects for anxiety, mood or disruptive disorders (Dekker & Koot, 2003a,b). In a study of adults with ID, female gender was associated with increased prevalence of psychiatric disorder (Cooper et al., 2007). In a study of older adults with ID, women with ID were more likely to have been diagnosed with affective disorders or dementia than men with ID and less likely to have been diagnosed with substance use related disorders (Axmon, Sandberg, & Ahlström, 2017). This study also found no gender differences were found for anxiety disorders or psychotic disorders. The research to date has not however been able to elucidate whether these gender differences are due to differences in prevalence, identification or treatment of mental health disorders among adults with ID.

The literature is also unclear about how the severity of ID affects an individual's vulnerability to developing different psychiatric disorders (Costello & Bouras, 2006). Among children and adolescents, several studies have reported no statistically significant association between severity of ID and risk of psychiatric disorder (Einfeld & Tonge, 1996a, 1996b; Stromme & Diseth, 2000), but one study found higher rates of mental disorder in participants with more severe ID (Molteno et al., 2001). Findings are also mixed in adults. Some studies have shown higher rates of psychiatric illness among people with severe ID (Cooper et al., 2007; Gostason, 1985; Lund, 1985), others among individuals with mild ID (Borthwick-Duffy & Eyman, 1990; Iverson & Fox, 1989), and others have found no evidence either way (Corbett, 1979). Intellectual functioning has also been examined, with findings suggesting that depressive feelings, anxiety and antisocial behaviours are more common among those with higher IQs, while psychotic, self-absorbed and autistic behaviours are more likely to be found in children with lower IQs (Dekker & Koot, 2003a,b). The impact of physical disability on psychiatric illness is also unclear. Some studies have found that physical disability is associated with an increased prevalence of mental disorder (Deb et al., 2001), while others report that the absence of severe physical disability and immobility is associated with greater prevalence of psychiatric illness (Cooper et al., 2007).

Challenges in Identification of Psychiatric Disorders among Individuals with Intellectual Disability

There are a number of obstacles to the valid and reliable identification of mental health problems in people with ID (Hatton, 2002). Firstly, standardised psychiatric classification systems are often adopted in studies of mental health problems in people with ID (Costello & Bouras, 2006); however, the applicability of these to this population is questionable. Two factors have been posited to influence the applicability of standardised psychiatric assessment criteria to individuals with ID: linguistic abilities and the presentation of mental health problems (Costello & Bouras, 2006).

Current diagnostic systems such as ICD-10 and DSM-5 rely upon verbal accounts of an individual's symptoms. The utility of these systems is therefore limited by the linguistic skills of the individual being assessed. As Costello and Bouras (2006) note, some features of psychiatric illness are complex, requiring a high level of verbal fluency to describe and differentiate between symptoms. Therefore, the use of

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these existing diagnostic symptoms may not be appropriate among people with ID, particularly those with severe ID who frequently have limited or no language skills. When examining mental health among individuals with ID, it is therefore necessary to assess the individual's non-verbal behaviour, in addition to gathering historical information and observations from other people such as family members or carers. Importantly, the validity of this information is also dependent on the particular psychiatric condition in question, with informants likely to be more aware of disorders with clear behavioural manifestations rather than subjectively experienced phenomena such as thought disorder or anxiety (Costello & Bouras, 2006).

In addition to concerns with regard to linguistic abilities, the use of standardised classification systems among individuals with ID assumes that mental health problems present in the same way in this population as they do in the general population; however, this may not be the case and may also depend on the severity of ID. For example, in a review of mood disorders among patients with ID, Hurley (2006) reported that individuals with mild ID had a fairly typical presentation and could be assessed using standard practices with minor accommodations. An atypical presentation of mood disorders, however, including increased behavioural problems such as aggression, was more frequent in individuals with moderate to profound ID. Due to limitations in the use of standardised diagnostic symptoms, various instruments (including both self- and informant-report measures) have been either designed specifically or adapted for use with individuals with ID (for a review, see Hatton, 2002).

Differential diagnosis between symptoms that may be an expression of underlying brain damage and those that are related to a psychiatric disorder may also be particularly important when working with individuals with ID (Costello & Bouras, 2006). Disturbances of emotion, attention, activity and thought, and associated behavioural problems, may occur as part of the ID and it is often difficult to ascertain whether these additional difficulties are due to a comorbid psychiatric disorder. For example, it is important to distinguish between ID and the negative symptoms of schizophrenia such as slowness of thought and poverty of speech (Clarke, Littlejohns, Corbett, & Joseph, 1989).

It is likely that many individuals with ID have mental health problems that remain undetected and therefore untreated (Taylor, Hatton, Dixon, & Douglas, 2004). Einfeld et al. (2006), for example, found that only 10% of young adults with ID and definite psychiatric disorder had received specialist mental health intervention. Insufficient numbers of professionals with appropriate training and necessary expertise may impede accurate diagnosis and the adequate provision of mental health services to people with ID (P.K. Maulik & C.K. Harbour, 2010; McCarthy & Boyd, 2002). Diagnostic overshadowing, where a clinician regards the ID as a sufficient explanation for an individual's presenting symptoms rather than attributing them to a psychiatric disorder and making a dual diagnosis, may be partly responsible for the under-recognition of dual disability in clinical settings (Mason & Scior, 2004; Tonge & Einfeld, 2000). Recent linkage of disability services and ambulatory mental health services data in the Australian state of New South Wales further found that people with an ID were more than twice as likely to receive an "unknown" diagnosis as those without ID (Howlett, Florio, Xu, & Trollor, 2015).Recognition of comorbid psychopathology requires detailed interviews using sensitive assessment techniques by specialist staff (P.K. Maulik & C.K. Harbour, 2010). It has been theorized that the rates of mental health disorders in people with ID may be both higher and untreated for longer periods of time than among the general population however no research to date has formally examined this notion(Munir, 2016) .

Furthermore, in the general population, identification of a mental health problem is often prompted by the failure of an individual to maintain social roles such as employment and parenting. In contrast, individuals with ID generally have fewer societal role expectations and the severity of their symptoms therefore does not necessarily relate to the degree of impairment in daily life(Costello & Bouras, 2006).

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This reduces the chances that mental health problems will be recognised by carers, and means that conditions such as anxiety and depression may cause significant distress to an individual yet remain undiagnosed(Whittle, Fisher, Reppermund, Lenroot, & Trollor, 2018)

The prevalence, persistence and consequences of comorbid mental health problems in individuals with ID necessitate improvements in the availability of early assessment and diagnostic services for these individuals and their families, for whom there are currently significant gaps in service provision urgently necessitating extensive further research and evaluation (McCarthy & Boyd, 2002; Whittle et al., 2018).

Challenges in Management of Psychiatric Disorders among Individuals with Intellectual Disability

The significant comorbidity between ID and mental health disorders poses considerable challenges to individuals with ID and their families, and for service providers (Eapen & Jairam, 2009), including not only significant barriers in the detection of mental health problems among individuals with ID but also the unique challenges in the management of these concerns. Some of the specific challenges in this regard include the lack of an interdisciplinary service model; lack of dedicated 'space' within mainstream mental health services for individuals with ID; lack of a clear transition model from childhood to adult services; and lack of staff training and expertise. Such deficiencies in service provision, and the associated cognitive, emotional and behavioral problems, combine to increase rates of unemployment, social isolation and depression in individuals with ID and their families, and the consequent healthcare burden for communities and governments.

Additionally as highlighted by a recent systematic review there is a dearth of quality evidence regarding the effectiveness of treatments designed to address the mental health needs of children and adults with severe ID (Vereenooghe et al., 2018). While the scope of this review was broad, only 5 studies were found that examined the mental health related experiences of people with ID and the findings of these studies were largely inconclusive due to small sample sizes, there were a total of 16 participants across the 5 studies examined. Concerningly this review found that the most recent study in the field was published in 1999 with many of the others employing pharmacotherapies that are no longer routinely prescribed. While there is more evidence for treatments that may be promising for adults with mild to moderate ID, the heterogeneity of study designs and the presence of underpowered trials make it difficult for clinicians to make decisions regarding effectiveness of many existing mental health interventions for their patients with ID(Koslowski et al., 2016). Given the limited available evidence, the findings of studies examining the broader population are often applied to manage mental health issues among people with ID. Given that these interventions may not address the specific needs of people with ID, there is an urgent need for further research in the area to facilitate adequate mental health services to children and adults with ID.

Thus, one of the primary targets of intervention when working with children with ID and their families should be to reduce stress and increase wellbeing among parents. This is also important because it is likely that parents of children with ID who report high levels of stress may engage in parenting behaviour that may negatively affect outcomes both in the child with ID and his or her siblings (Hastings & Beck, 2004), thus maintaining a vicious cycle. Indeed, it is likely that complex and multidirectional relationships exist between parents' wellbeing, psychological coping styles, parenting practices, and their child's behavioural problems, and comprehensive and effective intervention should aim to target these various factors.

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Several factors have been found to explain stress among parents of children with ID. For example, research has suggested that child characteristics, such as the frequency or severity of behaviour problems, may lead to parental stress (Hassall, Rose, & McDonald, 2005; Hastings, 2002). For example, in a study of Australian children with a disability, the severity of children's behaviour was associated with parents' experience of greater stress in relation to their child, and their own personal wellbeing (Gavidia-Payne, Richdale, Francis, & Cotton, 1997). Thus, interventions that are successful at improving skills or reducing problem behaviours in children with ID also seem to benefit parental wellbeing (Gavidia-Payne & Hudson, 2002; Hastings & Beck, 2004). Other studies, however, have found that different factors are more important in predicting parental stress than child characteristics. For example, the way in which parents define their situation, and the resources available to them, have been found to predict significantly more variance in stress levels in mothers (29% and 42% respectively) and fathers (37% and 33% respectively) than any characteristics of the child, which accounted for only 2% of variance in maternal stress and 8% of variance in paternal stress (Saloviita, Itälinna, & Leinonen, 2003). Similarly, significant variance in mothers' parenting stress has been found to be explained by parental locus of control and parenting satisfaction (Hassall et al., 2005). These findings are encouraging, as changing parents' attitudes and perceptions may be an easier intervention target than ameliorating the child's disability and associated difficulties (Saloviita et al., 2003).

Recent reviews suggest that behavioural family interventions that train parents to respond contingently to child behaviour indicate positive results among both children with ID and their parents (Gavidia-Payne & Hudson, 2002; Hastings & Beck, 2004).For example, Stepping Stones Triple P (Sanders, Mazzecchelli, & Studman, 2003), an adaptation of the Triple P Positive Parenting Program for families of children with developmental disabilities, has been found to lead to fewer maternal-reported child behaviour problems, improved maternal and paternal parenting style, and decreased maternal stress, with gains maintained at the six-month follow-up(Roberts, Mazzucchelli, Studman, & Sanders, 2006). Similarly, parents of children with ID who have been trained in behavioural principles, such as limit setting and use of consequences and rewards, have been found to report increases in their self-efficacy in managing their child's behaviour, as well as lower levels of stress (Feldman & Werner, 2002). While parent training programs have been found to be beneficial, some research has suggested that families with additional psychosocial stressors such as lack of employment and poor marital adjustment may make the least gains (Baker, Landen, & Kashima, 1991). Additionally recent research has identified that parents of children with disabilities facing mental health problems also report greater difficulty in arranging appropriate childcare, financial difficulties and limited service provider availabilities as barriers to accessing treatment for their own psychiatric issues. (Osborn, Roberts, & Kneebone, 2019)

Hastings and Beck (2004) have also reviewed other interventions for stress reduction in parents of children with ID, including parent-to-parent interventions, and group interventions with parents. Although descriptions of various models have been published, strong evaluation data has rarely been reported for parent-to-parent interventions. One exception is a controlled trial of the Parent-to-Parent model (Singer et al., 1999), in which a parent who has experience caring for a child with a disability is paired with and provides emotional support and information to another parent of a child with ID. Although no measure of parental stress was used, the study found that parents' positive perceptions of their child and his or her impact on the family improved significantly in the treatment group, and parents' ratings of progress towards the resolution of their main need showed a clear improvement (Singer et al., 1999). Aside from the value of formal or informal networks of parents, research has also investigated the efficacy of group interventions for decreasing stress among parents of children with ID. Most group interventions have

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involved elements of cognitive-behavioural therapy (CBT), and suggest a reasonable evidence base for the use of CBT techniques in improving the wellbeing of parents of children with ID (for a review, see Hastings & Beck, 2004). For example, mothers assigned to a Life Skills Training group where sessions focused on CBT techniques including coping and communication skills, problem solving and decision making, and skills to manage and control social networks, had reduced depression and stress and improved social support compared to mothers who were assigned to a non-directive parent support group (Kirkham & Schilling, 1990). Further, mothers in the Life Skills Training group maintained lower depression scores and higher levels of social support at a two-year follow-up (Kirkham, 1993). Furthermore, there is increasing evidence of the buffering role of informal support in the management of young people with ID and mental health problems and their families. For example, parents of adolescents with ID who perceived greater helpfulness from informal supports (e.g., spouse, extended family, friends) reported lower stress, anxiety and depression, even after controlling for child characteristics (White & Hastings, 2004). Typical appropriate supports provided by services for children with ID and their families such as respite services, case management and provision of key workers are also likely to contribute to reductions in parental stress (Hastings & Beck, 2004). Further, the establishment of early family-school partnerships is important in promoting positive outcomes among children with developmental delays and should not be overlooked as children transition to school (McIntyre, Blacher, & Baker, 2006).The importance of school-based intervention programs for mental health difficulties, including among children and adolescents with ID, has been recognised (Christensen et al., 2011). School-based interventions, such as the NSW School-Link initiative in NSW, Australia (NSW Ministry of Health, 2015), and targeted policies, such as the No Child Left Behind Act ("No Child Left Behind Act of 2001," 2002) are vital in ensuring effective intervention is provided to children and adolescents with comorbid mental disorders and ID.

There is also an acute need to be aware of the impact of ID and associated mental health difficulties not only on the individual, but also on the wellbeing of his or her family. Several studies have found that parents of children with ID report higher levels of child-related stress than parents of typically developing children (Browne & Bramston, 1998; Dyson, 1997; Patton, Ware, McPherson, Emerson, & Lennox, 2018), however this heightened stress has not been found to be the case across all causes of intellectual disability (Dabrowska & Pisula, 2010). Parental stress may result from life events that may impact on any family such as marital breakdown, but also from family life-cycle transitions that may be especially relevant to families of children with disabilities, such as the diagnosis of the child's disability, starting school, transition from child to adult services, and increasing age and infirmity of parents (Hastings & Beck, 2004). It has been assumed that the extra stress of caring for a child with disabilities places parents at an increased risk for depression. Indeed, mothers of children with ID have been found to have higher depression scores than mothers of typically developing children. (Olsson & Hwang, 2001). While no differences were reported in the wellbeing of fathers of children with ID in early studies (Olsson & Hwang, 2001), more recent studies have found significantly higher levels of depression and stress than normative data (Giallo et al., 2015).Similarly, having a brother or sister with ID is a risk factor for sibling adjustment problems (Rossiter & Sharpe, 2001). Within their families, siblings may experience extra caregiver burden, differential treatment, and an imbalance of family resources (Lobato & Kao, 2002). Outside their families, siblings may experience limited access to information about the child's condition, negative peer reactions, and disruptions in age-appropriate peer and family activities (Lobato & Kao, 2002). Thus, siblings of children with ID may also require formal support. Studies have investigated the efficacy of combined group interventions for siblings and parents of children with ID that are designed to increase the siblings' understanding of and adjustment to ID. These studies have found

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significant improvements in siblings' knowledge of the child's disorder, siblings' self-competence, and sibling connectedness, and decreases in parent-reported behavioural problems among siblings (Lobato & Kao, 2002, 2005). Several of these improvements have been shown to be maintained at three-month follow-up (Lobato & Kao, 2002, 2005). Open communication and sharing age-appropriate information with siblings appears to be the best approach, as this reduces uncertainty and confusion, helps the development of family-centred problem solving skills, and allows siblings to support parents in the best way they can. If there are issues of risk to the sibling in terms of violent or aggressive behaviours, appropriate safety steps should also be taken.

Despite this range of interventions, there are significant challenges in providing a comprehensive and integrated service for those with ID and mental health problems. For example, studies from the UK have shown that young people with severe ID and mental health problems fall between a number of healthcare providers, including child and adolescent mental health services, specialist ID services and paediatricians (McCarthy & Boyd, 2002). Working with children with ID and their families likely necessitates a multidisciplinary approach, potentially involving physiotherapy for motor development and coordination, occupational therapy for proprioception and sensory integration, speech therapy for receptive, expressive and pragmatic communication, psychology for assistance with thoughts, feelings and behaviour including social interaction, and medical specialists for assistance with physical health difficulties, just to name a few. In this regard, it is worth noting that severity of ID is associated with an increase in associated medical conditions and complications, with the relationship being complex as they interact with one another and can result in secondary medical and behavioural complications (O'Brien, Barnard, Pearson, & Rippon, 2002). Collaboration and clear communication is also needed between families, health providers, and the various other agencies involved in the patient's care including education, housing and financial support services. Due to the multidisciplinary nature of services required for children with ID and their families, a model where one person works closely with the family and can mediate between the family and various services or professionals may lead to the most positive outcomes for parents (Hastings & Beck, 2004). However, there is often no collaboration or communication to enable a continuum of care. This is further compounded by the fact that different disciplines and agencies use different models of care ranging from patient-centred to those involving the family. Often there is no continuity between various services such as acute inpatient units, emergency departments, outpatient and community services, education services, vocational centres, the juvenile justice system and disability services. Families may be expected to go from one specialist to another, and navigating the complex health system is a significant challenge for both patients and their carers.

Hatton (2002)Reviewed the literature on psychosocial interventions for adults with ID and comorbid mental health problems. Individual and group intervention studies using modified CBT, including one small waiting list controlled trial (Rose, West, & Clifford, 2000), have found reductions in anger and aggressive behaviour among adults with ID. Adaptations of CBT have also shown reasonable outcomes in reducing depression and anxiety among adults with ID, but the reviewed research is limited to case studies and case series (Hatton, 2002). When implementing CBT with adults with ID, Hatton (2002) discusses the importance of assessing the individual's capacity to give informed consent. Wong, Clare, Holland, Watson, and Gunn (2000) found that people with ID and people with dementia were less able to make an informed consent decision than people with a chronic mental health problem or a comparison group. All participants benefited when the informed consent decision-making task was simplified by presenting information as separate elements and reducing the level of expressive verbal ability required to respond (Wong et al., 2000). These considerations may be particularly important when working with

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adults with comorbid ID and mental health problems. Further, consideration must be given to the person's suitability to engage in CBT, including assessment of communication skills, cognitive aptitude, ability to identify emotions, and capacity to understand the CBT model (Hatton, 2002). Enhancing skills including communication, emotion recognition, problem solving and social skills can lead to increased independence and self-determination, which in turn can improve overall quality of life among individuals with ID (Nota, Ferrari, Soresi, & Wehmeyer, 2007). Assistance with housing, employment, social networks and independent living skills also deserve attention.

As such it is critical to facilitate the development of clinical tools for use by people with ID including those who are non-verbal to allow for better communication with clinicians regarding the nature of concurrent mental health issues in ID. Given the heterogeneous range of functional, behavioral and cognitive features among people with ID, the lack of consensus with regards to the tools to measure functional outcomes presents a significant challenge to health service provision. Once mental health problems have been identified however gaps in the integration and sharing of information between service providers of disability and mental health services, lack of appropriately targeted services and deficits in clinician knowledge act as barriers to access to appropriate health care(Whittle et al., 2018). Risk management is also important when working with individuals with comorbid ID and mental health problems. One particular area that warrants attention is the issue of behavioural change associated with sexual development, which can lead to sexualised behaviours and offending. Social stories appropriate to the mental age of the person with ID and sexual health education are critical in these situations. CBT has also been found to be successful in changing attitudes in sex offenders with ID (Hatton, 2002). Planning for emergencies and crisis situations is an important consideration of treatment, and having a safety plan with contact numbers of case workers or members of the treating team in case a crisis happens can put the mind at ease for both the patient and the family.

While randomised controlled trials concerning the effectiveness of psychotropic medications for people with ID and comorbid mental health problems are virtually absent (Hatton, 2002), psychopharmacology is a treatment option although this is also associated with challenges. It is to be noted that individuals with ID are often more at risk of developing side effects. One example of the potential complexities when treating people with ID who also have mental health problems is evident when these individuals are treated with second generation antipsychotics (SGAs) which considerably decrease the lifespan due to increased risk of weight gain, cardiometabolic changes, metabolic syndrome and related side effects of SGAs. Concerns have also been raised about the inappropriate use of antipsychotics in individuals with ID especially for behavioral problems without a diagnosed mental health condition(O'Dwyer et al., 2019).In this regard, a recent study examining the antipsychotic use in people with ID found that, of the 305 participants, 45.1% received antipsychotics with only 25.9% having evidence of a psychotic disorder with the rest being treated for problem behaviors. This highlights the need for careful consideration of the indication and the justification for the use of antipsychotics in individuals with ID. In either case, attention should also be given to an integrated and comprehensive physical health care plan for people with ID and mental health problems. While such a plan would be a policy direction to aspire to, research is needed in order to understand gaps in attitudes, awareness, and training of staff, resources, and service delivery options.

While various interventions have been found to show efficacy, Dosen (2007) argues that a monodisciplinary treatment approach to behavioural and psychiatric problems in persons with ID, such as psychotropic medication or behaviour modification alone, has yielded limited success. He argues for an integrative diagnostic and treatment approach consisting of four dimensions – biological, psychologi-

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cal, social and developmental – for people with ID and mental health problems, where the focus should not be primarily directed towards the symptoms of the disorder but towards restoring a person's mental wellbeing. For individuals with an established dual diagnosis of both ID and a psychiatric disorder, treatment goals should include preventing further disability, restoring premorbid functioning, and improving quality of life through restoration of functionality, independent living and rehabilitation.

SOLUTIONS, RECOMMENDATIONS AND FUTURE RESEARCH DIRECTIONS

A developmental-bio-psycho-social-cultural model of service delivery and training and education of professionals involved in the care of people with ID is critical for early identification and appropriate management of comorbid mental health problems. People with ID and mental health problems are some of the most vulnerable people in society and they are often let down by the health care system, funding and service delivery models. Efforts to intervene in a more coordinated and integrated way can significantly improve their outcomes. Further, both the patient and the family or caregiver would need support, advocacy and case management. This would require coordination rather than separate services across types of difficulty, age groups, treatment modalities and disciplines. This should include a focus on the individual in a family context and using skill building models for developmental gains and appropriate management of maladaptive behaviours through an integrated multidisciplinary and multiagency collaborative service.

In order to plan effective and comprehensive prevention and intervention strategies for young people with ID and mental health disorders, it is important that there is a better understanding of the complex interplay of both risk and protective factors at different levels, including individual child factors, family, neighbourhood and society, as well as services, systems and policies. It is also important to consider the perspectives of the family members and support persons and work collaboratively together. Differentiating between behavioural challenges and mental health co-morbidity is also important and in doing so information from multiple sources needs consideration and interpretation (Weise, Fisher, & Trollor, 2018; Weise et al 2018).Given that no factor acts in isolation, and that there is an interaction of these factors at multiple bio-ecological levels, and at multiple time points along the life course, it is essential to have rigorous and relevant epidemiological and statistical techniques that can apply a bio-ecological model using a life course approach(Woolfenden et al., 2014). A cumulative risk index, being the sum of individual risk factors, is one way of conceptualising how risk factors interact over a life course(A. J. Sameroff & Seifer, 1983), but in this model all risk factors are given an equal weight which is a significant disadvantage when compared to a regression model. Structural Equation Modelling and Multilevel Modelling techniques, on the other hand, are based on a proposed hypothesis and, using regression techniques, variables including time are grouped into hierarchical levels(Diez Roux, 2004), and measured to see which model fits best. Future research exploring risk factors should where possible use composite theoretical models, longitudinal study designs and multilevel modelling in order to tease apart risk factors at different levels including individual, family and neighbourhood as well as society, services, systems and policy factors, which might increase vulnerability of people with ID to develop mental health problems. In this context, it is noteworthy that the occurrence of mental health comorbidity in children with ID, and the nature and type of such comorbidity, is shaped by the interplay of biological and environmental risk and resilience factors, mediated by the life course issues as to when these factors are in operation in the child's life.Eapen (2014) has described such a model of a

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Developmental Risk Index where appropriate weighted scoring is given to different microsystem (child's most immediate or proximal environment), mesosystem (reciprocal relationships and interconnections), exosystem (distal factors that indirectly impact on the child and their family) and macrosystem (societal, cultural and service or policy) factors. Future studies should also explore biological risk factors including genetic factors, perinatal events, trauma, toxins, infections and immunological factors. Research should also focus on early identification processes that accurately assess the nature and reasons behind behavioural and emotional problems encountered in the context of ID; for example challenging behaviours may be due to the underlying brain pathology, or due to speech and language difficulties resulting in communication problems, or due to lack of stimulation and opportunities resulting in poor quality of life. Such a comprehensive assessment would no doubt facilitate the development of an individualised multidisciplinary treatment model and better outcomes.

Regarding management of co-morbid ID and mental health disorders, a recent study examined a discrete choice experiment (DCE) for assessing care management preferences of parents for their children(N'Dri, Ross, Castillo, Reeves, & Butler, 2019; dos Reis et al 2019). Using mixed methods, this study tested six attributes of care management decisions by parents namely medication use, parental custody, time cost, social interactions, medication effects, and school placement. Among children with ID the common co-morbidities were autism spectrum disorder (55%) and attention-deficit/hyperactivity disorder (76%). The study found that the participants had a preference for using fewer medications and maintaining decision-making authority and that they considered medication effects on the child's mood to be more important than its effects on personality or body weight.

CONCLUSION

There are significant challenges in the detection and characterisation of comorbid mental health problems in the context of ID. For example, for those with limited language and cognitive abilities, can the same diagnostic criteria and measures be used? Identifying the nature and extent of mental health problems is further compounded by the lack of measures specific for ID. There are also difficulties in identifying the nature and extent of ID and the consequent impact on function (measurement of adaptive behavior), as there is considerable variability in the terms and definitions as well as the diagnostic criteria and assessments across settings and across the different parts of the globe. While some of these issues could be addressed through better training of professionals, there are also significant barriers in service delivery models and access to services. In this regard, there are significant gaps in the availability of evidence based intervention programs in general for children with ID and mental health problems. In particular, the needs of those with behavioural or mental health problems and chronic and complex health care problems are not met by mainstream services. There is an urgent need to have a consensus on a statement of minimum standards of care, with clear policy objectives, program outlines and comprehensive training of staff, followed by evaluation of its implementation. Family and support persons perspectives also need due consideration during the management planning and decision making process. Furthermore, improved longitudinal outcomes will only be possible for people with ID and psychiatric disorders if there are opportunities for access to integrated services including better identification and treatment models, and improved knowledge and awareness of health-related conditions for people with ID, enhanced parent or carer support, as well as changes within health and disability service systems to ensure universal coverage of quality services.

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KEY TERMS AND DEFINITIONS

Cognitive-Behavioral Therapy: A type of psychotherapy that helps individuals to identify and teaches skills to modify unhelpful thinking patterns, feelings, and behaviors.

Indigenous Australians: The original inhabitants of the Australian continent and nearby islands, including Aboriginal people and Torres Strait Islanders.

Intellectual Disability: A disability characterized by significantly impaired intellectual and adaptive functioning, formerly known as mental retardation.

Multidisciplinary: Drawing on expertise from multiple disciplines to accurately define and manage complex situations including health concerns.

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Chapter 45
Mental Health Issues, Wellbeing, and Related Issues Among Caregivers of Individuals With Intellectual Disability

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ABSTRACT

Caregivers are the important and integral part in the lives of people with intellectual disability. As caregiving is extensive and mostly lifelong for this population, the associated burden, stigma, and also wellbeing of the caregivers are also equally important as these are often very directly correlated with the wellbeing of the individuals with intellectual disability. The chapter focused on the issues and impacts of caregiving, mental health problems, wellbeing, and related issues of caregivers. The authors also discuss the various facets of stigma caregivers do face and ways to deal with the stigma.

INTRODUCTION

Care giving to individuals with disability is laborious and associated with many mental health issues and related problems. In a longitudinal study on the well-being of parents of individuals included in the Australian Rett Syndrome Database over the period from 2002 to 2011, Mori, Downs, Wong, & Leonard (2019) reported that poorer parental physical well-being was related with residential remoteness, the child being a teenager at baseline, having frequent sleep disturbances or behavioural problems, and being a single parent or on a low income was associated with later poorer physical well-being, while the child having enteral feeding was associated with later poorer emotional well-being. Laurvick, Msall, Silburn, Bower, de Klerk, & Leonard (2006) reported in a study on mothers (n = 135, age ranged from 21 to 60 years) of children with Rett syndrome (age between 3 and 27 years) that the most important predictors of maternal physical and emotional health are child behavior, caregiver demands, and family function. The scenario is not much different with caregivers of individual with intellectual disability.

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Many researches focused on the management of individuals with intellectual disability, the mental health issues, stress and burden of the care givers of intellectually disabled individuals are equally important as indicated by the recent researches. In some cases, family members neglect the disabled individuals. Enoch, Mprah, Isaac & Joseph (2018) have reported in a study from Ghana that most parents refuse to visit their children with intellectual disability in school. However, due to deinstitutionalization and perspective of inclusion in to society, most of the intellectually disabled children, adults and older adults are taken care at home and at least one of the family members to be the primary care taker. Such scenario gives importance for the needs and difficulties for the caregiver. The chapter focused on the issues and impacts of care giving, mental health problems, wellbeing and related issues of caregiver.

Care giving and Mental Health Issues

The negative impact of caregiving on the mental health of caregivers is well documented in the literature. In a population based study, Schofield et al., (1998) found less life satisfaction, less positive affect, and more negative affect among caregivers compared with non caregivers regardless of age or marital status. Caregivers experienced depression, anxiety and stress symptoms and these symptoms were found to be significantly higher among caregivers of individuals with intellectual disability than those with Psychiatric illness (Panicker & Ramesh, 2019). Similar findings were reported in other studies too. For example, in a study on family burden in people with intellectual disability with or without mental disorders, higher levels of family burden were related to higher functional disability in all the areas, lower intelligence quotient, diagnosis of ID with mental disorders and presence of organic, affective, psychotic and behavioral disorders. Stepwise multiple regression showed that behavioral problems, affective and psychotic disorder, disability in participation in society, disability in personal care and presence of ID-MD explained more than 61% of the variance in family burden (Irazábal, Marsà, García, Gutiérrez-Recacha, Martorell, Salvador-Carulla, & Ochoa, 2012). In another study, higher family impact was found between caregivers to people with mental health disorders - intellectual disability. The interaction of both conditions (ID and mental health problems) results in a higher degree of burden on families (Martorell, Gutiérrez-Recacha, Irazábal, Marsà, & García, 2011).

Maternal depression in families having a child with a disability has been the subject of considerable research over four decades. Bailey, Golden, Roberts, Ford (2007) reviewed 42 articles on maternal depression and found that only eight were clinically diagnosed depression; most of them used a scale rating depressive symptoms. Across the studies, mothers of children with disabilities generally exhibited a higher than average rate of depressive symptoms and are more at risk for clinical depression, but the incidence may be lower than reported in previous literature. Child behavior problems, maternal stress, coping style, and support were consistently associated with depressive symptoms. The distinction between clinical depression and depressive symptoms may be important in conceptualizing how a child with a disability can influence family members and the nature of support that may need to be provided.

Many studies on mental health issues of caregivers of intellectually disabled individuals in different cultural settings consistently reported increased maternal distress and burden. Australian Bureau of Statistics (ABS) (1998) reported that, approximately 30% of caregivers reported that their well-being had been affected by caregiving, and that they were often worried or depressed. McConkey, Truesdale-Kennedy, Chang, & Jarrah, Shukri (2008) have studied 206 mothers with intellectually disabled children in three different countries and reported that mothers experienced poor mental health, increased levels of child-related stress and poorer family functioning. Their child's behaviour problems were a major factor

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in this. The impacts on mothers' well-being were not alleviated by access to professional supports or use of coping strategies. John (2012) assessed stress among mothers of young children with intellectual disabilities in urban India and examined the extent to which child functioning and maternal coping predict maternal stress. Three-fourths of the sample obtained a clinically significant stress score, and maternal coping emerged as a robust predictor of stress for mothers of boys with intellectual disabilities. Qualitative analyses indicated positive and negative maternal experiences related to self, child, family and community. In a study involved secondary analysis of data from the 2011 Survey on the Actual Conditions of Individuals with Developmental Disabilities, conducted by the Ministry of Health and Welfare of Korea reported that all components of caregiving burden and depression (effects of caregivers' characteristics, caregiving time and cost, and perceptions of time and cost, on depression) were significantly higher in the 1st grade, designating the most severe disabilities. Overall, caregiving burden tended to be higher in female caregivers, the unemployed, parents, co-residents, and people with health problems. Caregivers' characteristics such as spouse relationship, having health problems, and perception of caregiving time and cost were associated with depression (Nam & Park, 2017). Studies across the world confirming the fact that caregivers experience stress, burden and various mental health issues.

Gardiner, Miller & Lach (2018) have tried to identify functional predictors of perceived impact of childhood disability among families of children with neurodevelopmental disorders and disabilities. They examined the relationship between sub-domains of adaptive and problematic behaviour and perceived family impact, and whether the same sub-domains would emerge as significant after controlling for the impact of child diagnosis, including autism spectrum disorder, cerebral palsy and intellectual disability. Caregivers of 216 children and adolescents with neurodevelopmental disorder and disability completed measures of children's practical, conceptual and social skills (i.e. adaptive behaviour), behaviour problems and positive and negative family impact. Indices of child adaptive and problematic behaviour were only significantly associated with perceived negative family impact. Children's practical and social skills, as well as emotional symptoms, emerged as significant predictors of perceived negative family impact, with emotional symptoms accounting for greatest variance. The study findings suggest that it is not children's most impaired domains of functioning that are perceived as significantly impactful by the family. The findings highlight the importance of devoting consideration to the ways in which the functional limitations experienced by children with chronic developmental health conditions similarly impact family life and well-being, regardless of disorder designation. Future studies are required on this direction.

Care Giving and Wellbeing

The impact associated with long term care giving has been indicated that care givers are burned out with poor subjective well being, life satisfaction and social support. Gebeyehu, Sahile, & Ayalew (2019) reported in a study on level of burden, social support, and life satisfaction of seventy four caregivers (parents, grandparents, and siblings of the child) of children with intellectual disability that caregivers are experiencing much level of burden with inadequate social support and have pitiable satisfaction in their life. Burden is negatively correlated with social support and life satisfaction, but social support is positively correlated with satisfaction in life. The authors emphasized the need of result social support for caregivers in order to reduce the level of burden and enhance their satisfaction in life.

The impact of care giving and compound caregiving (i.e. multiple caregiving roles) on caregivers are different in many ways. Compared with the non-compound caregivers, the compound caregivers of adult children with intellectual disabilities had increased desire to place their care recipient into residential

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care. They also spent an average of 12 additional hours per week undertaking the compound caregiving role. Overall findings indicated that caregivers reported giving more tangible and emotional support than they vii received, but considerable variability was evident. Relative disadvantage in tangible reciprocity was associated with increased depressive symptomatology, poorer mental health, and reduced desire for residential placement of the care recipient, but not with physical health or life satisfaction (Perkins, 2009).

In order to compensate for the disadvantages of caring, researches tried to identify factors associated to caregivers' subjective well-being (SWB). Hope is found to have significant impact on social self-care, mental health and conscientiousness of staff working with people with intellectual disabilities (Oliver, Revuelto, Fernández, Simó-Algado, & Galiana,2019).

Caregiver Impact on Management

Attitude and perception of the caregiver influence the service selection and outcome of management. The responsibility of choosing the kind of services to be provided to the disabled individuals is also related to the knowledge and attitude of the caregiver. Werner, Stern, Roth, & Tenenbaum (2019) have examined the roles of stigma and of enabling factors in help-seeking by parental caregivers of individuals with intellectual disabilities and dual diagnosis. Questionnaires were completed by 195 family caregivers. Lower family stigma was related to higher personal enabling factors (e.g. knowledge about services and previous experience in seeking help), which in turn was related to higher help-seeking behaviors. Higher professional enabling factors (e.g. attitude of the professional, services in the vicinity) were related to higher intentions to seek help, which were related to higher help-seeking behaviors. Professionals can help families achieve a greater sense of self-efficacy in their own help-seeking process by providing them with knowledge about services and facilitating a more positive experience in the process.

The involvement of caregiver in the intervention programs for intellectually disabled individuals could predict the success of the intervention. For example, many weight reduction programs fail to show positive and sustainable impacts due to not involving parents, who are usually unavailable to attend school-based health programs. The mHealth interactive interventions were carried out in September 2015-August 2016 by Lee, Brown, Leung, Chen, Louie, Chen, & Lee (2019), engaging carers to monitor and sustain their children's healthy lifestyle behaviours at home. Twenty family carers were recruited and four themes emerged such as improving family carer-child interactions and communications, gaining useful and practical health information from experts, supporting each other via an mHealth platform and appreciating the collaborative effort between school personnel and family carers. Family carers stressed the usefulness of the mHealth interactive interventions in monitoring and sustaining the children's healthy lifestyle behaviours at home. The mHealth interactive interventions for increasing family carers' involvement and monitoring were well received. The findings provide new insights into using mHealth interventions in future weight management programmes involving parental participation in the home environment.

Carer mental health literacy and help seeking are areas that are not well researched in the intellectual disability field. Man & Kangas (2019) aimed to explore the above including service utilization experiences of Australian parents with an offspring with an intellectual disabilityand a comorbid psychiatric disorder. Forty-one parents took part in an online survey assessing satisfaction and helpfulness ratings of received services. Twenty-six parents also completed items to assess mental health literacy and attitudinal barriers to help seeking. Parents showed good mental health literacy with depression and with challenging behaviour associated with autism and poorer literacy with mixed presentations. Parents

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reported varied helpfulness and satisfaction ratings with disability and mental health services and they are capable of recognizing the need to seek professional help for their offspring.

The relationship between ethnicity, service use and perceptions of service effectiveness is inconclusive. The study examined differences in service use and perceptions of service effectiveness between Israeli Jewish (Jewish) and Israeli Arab (Arab) parental caregivers of individuals with intellectual disabilities and dual diagnosis of psychopathology. Arab parental caregivers perceived health services to be more accessible than did Jewish caregivers, but there was no difference between the two groups in the use of the services. Overall, greater enabling factors and accessibility were associated with higher use of education and social services. No differences were found between the groups in their perceptions of service effectiveness.Arab family caregivers use education and social services less than do their Jewish peers, possibly because they have fewer enabling resources. The finding that both groups reported similar use of health services may be explained by a shared perception that informal help may not be suitable for dealing with situations of psychopathology. The similar perceptions of service effectiveness may be explained by extensive services available in Israel, to the satisfaction of both groups, or by the fact that participants perceived these services as their only alternative, and therefore fear losing them (Werner, 2019).

Stigma and Caregivers

Stigma, can be understood as mark of social disgrace, where discrimination happens based on variable factors like disability, mental health problems, ethnicity etc. Both the individuals with intellectual disability and their respective caregivers do face significant amount of stigma and prejudices, resulting in added disability and obstacles restricting their human rights. Stigma can be conceptualized as an attitude or belief which lead people to reject or avoid others who are 'percieved' to be different. The word is greek in origin which initially meant a cut or burn mark in skin used as identification mark for slaves or criminals.

Among the various type of stigmas described; family, courtesy or associative stigma has been described for the people or caregivers associated with targeted individuals, who are subjected to stigmatization by common people. Both associative and affiliate stigma has been researched in details and Mak et al (Mak WWS et. J Appl Res Intellect Disabil 2008) has mentioned about three components of family stigma; i.e. affect, cognitions and behavioral responses whereas Mak & Cheung's Affiliate Stigma Scale(MakWWS et al 2008)measures the extent of self stigmatization with good predictive value on subjective burden, even after controlling the factors like extent of caregiving involvement and caregiving stress.

Researches from India has shown direct correlation of lower parental education belongingness to low socio economic strata and low paying high labouring job of the parents with the prevalence of intellectual disability, all of which definitely increases the burden of caregiving leading to a further vicious circle. (Naskar S, et al . Int J Med Sci Public Health 2016. In a country like india, with 21 million people living with disability(as per census 2011), of which nearly 75% staying in rural background, without basic resources and minimum facilities, the burden of caregiving is immense. Stigma certainly make things even worse. The legislation related to intellectual disability(PWD Act 1995, National Trust Act 1999, UNCRPD 2007), simplified procedure of issuing disability certificates, multiple educational facilities(acceptance of 'Child with Special Needs', CWSN into regular school, The Right of Children to Free and Compulsory Education (RTE) Act, 2009, under Article 21-A) along with employment ben-

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efits might have changed the Indian scenario partially, but the social stigma alone hindering access to maximum benefit to this population.

Other than legislation and policy making at the government level, village gatherings and support from community or religious leaders can turn very useful to deal these stigmas of caregivers in a developing country like India (McConkey et al 2016) McConkey proposed four key strategies to challenege the negative perception about intellectual disability, which include nurturing the child's development, inclusion in the society and also in the peer group, information about myths, superstitions and advocacy about their needs and rights. (McConkey, R., Kahonde, C., & McKenzie, J. 2016). Cross et al mentions about matrix of intervention plans which could be explained at various levels, like intrapersonal, interpersonal, organisational or at community level. For the first three level the labelling, stereotyping, status loss and discrimination out of it need to be dealt specifically however government lead policy and favourable legislation can change the scenario over time.

Stigma by now, is more than a belief. It's a social, cultural and moral process, whose complex interaction within the socio cultural environment affects not only the stigmatised individuals but also their caregivers, in multiple domains. The anthropological researches on stigma has emphasised about the moral standing of an individual determined by their local social world, and local social obligations and norms further maintains one's morality.

CONCLUSION

Understanding the disability impact on parenting and caregiving is important for intervention. Despite variations in coping pattern, both positive and negative coping strategies were observed in caregivers and positive coping does not rule out negative coping strategies (Kishore, 2011). Use of appropriate coping styles can reduce the negative impact of care giving. The factors positively associated with better maternal physical health were the mother working full-time or part-time outside the home, having some high school education, having private health insurance, the child not having breathing problems in the last 2 years, the child not having home-based structured therapy, and high scores on the Family Resource Scale (indicating adequacy of time resources for basic and family needs). The factors positively associated with better maternal mental health: were the mother working full-time or part-time outside the home, the child not having a fracture in the last 2 years, lesser reporting of facial stereotypes and involuntary facial movements, being in a well-adjusted marriage, and having low stress scores (Panicker & Ramesh(2019); Laurvick, Msall, Silburn, Bower, de Klerk &, Leonard (2006). The amount and quality of social support available to caregivers is an important factor in moderating the impact of caregiving and social support can be provided both informally, by family, friends, neighbours, social groups and so on, and formally, by professionals and agencies (Dunst, Trivette & Deal, 1988).

Factors such as the type of disability of the care recipient and where the caregiver is in the caregiving process will affect the impact caring has on the caregiver's mental health, and thus the type of supports most appropriate for the caregiver. The important role of moderators of the impact of caring, such as the caregiver's financial situation and coping strategies used, should also be considered by service providers when planning how to assist caregivers. Greater consideration of some of these factors may assist in more efficient use of the resources available to support caregivers. Attention should be paid to the individual situation of each caregiver. Careful assessment of caregivers' needs should consider the factors associated with a negative impact of caregiving and of the various mediators of this impact.

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It is also important to acknowledge the positive aspects of the caring role to ensure that these are not obstructed by interventions to assist caregivers. Global responses to the needs of all caregivers will not provide the most benefit to individuals (Sally Savage & Susan Bailey (2004).

It is important to give attention to various issues of caretaking and negative impact of care giving and to implement appropriate intervention strategies and policies to deal with such issues.

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Chapter 46
Flying With Eddie:
Complicated Grief in the Military

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EXECUTIVE SUMMARY

Over 2.4 million American service men and women were deployed overseas between 2001 to 2011. Families of these service members include over one million spouses and two million children under the age of 18. There is a growing need for counselors to understand the mental health needs of military service men and woman, and the unique aspects of military culture. This chapter will demonstrate how to practically apply the Multicultural and Social Justice Counseling Competencies (MSJCC) to counseling work with the military population through a case study.

INTRODUCTION TO THE CASE

Case Description

Eddie calls my private practice office for counseling, stating that he recently lost a friend in an accident and people are urging him to talk with someone. He states he is in the military and does not want to see a counselor on base because he does not want anyone to find out he is in counseling. He is tearful on the phone and asks for the first available time slot. I previously served fourteen years in the military as an aviator before becoming a counselor. I schedule him for an intake the very next day.

Eddie arrives promptly at the office in jeans and a collared shirt. He is groomed, though his eyes are swollen and red. He appears nervous as I invite him into the counseling space. When asked what brings him into counseling today, Eddie tears up. Eventually, he blurts out that his best friend, who was in the same aviation squadron as him, died. A week ago his friend was completing an annual flight evaluation in marginal weather, and Air Traffic Control lost radar on the airplane. Three days later the plane was found in the ocean underneath the area where the plane had been operating. Both pilots died in the incident.

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Since that time Eddie reports difficulty sleeping and eating. He reports increased use of alcohol. He no longer drives his own car but instead drives his best friend's car around. He is in shock about the mishap and is angry the squadron has started to continue normal operations. Eddie states that he knows the squadron needs to continue workups before they leave on their six-month deployment in three weeks. He is not sure whether he can go on this deployment, whether it is safe for him to fly an aircraft under these circumstances. He is concerned that if he does not go on this deployment, it will impact his career. "I just can't get myself together!"

I utilize a biopsychosocial assessment during the intake session to assess the psychological, social, and cultural factors that impact Eddie. Eddie is from a middle-class background, in which his parents urged him to seek scholarship opportunities for college. Eddie is a white male who entered the Naval Academy after high school. Upon his graduation from the Naval Academy, he entered the pilot training program in the Navy and became a helicopter pilot. He has served as an active duty officer for five years and is currently on a tour of sea duty that is three years in duration. Eddie is 27 years old, identifies as Catholic, and is a Lieutenant (O-3) (Redmond et al., 2015) in the Navy. He is scheduled to leave for deployment onboard a ship in three weeks. He has been married for five years and has no children. He and his wife live off base. He states no family history of mental illness or substance use. Eddie reports this is the first time he has experienced a significant death in his life. Eddie reports that there are some negative aspects of the military, but overall, he enjoys his occupation and lifestyle.

Literature Review

The military as a social institution has a distinct culture, and within the larger culture, subcultures are based on an individual's affiliation with a specific branch of the military, such as the Navy, Air Force, or Army, etc. (Branson, 2017). In April 2019, the Navy reported a total force of 332, 507 active duty members and 101, 018 reserve members (www.navy.mil). Men and women who are part of the Navy are involved in various careers that include aviation, navy seals, search and rescue, medical, cryptology, meteorology, navigation, explosive ordinance disposal, etc. (www.navy.mil). A unique aspect of the Navy is the sailor's experience with "shipboard life" during their sea tour, which they rotate with a shore tour (Wilcove, Schwerin, & Kline, 2009, p. 446). During a sea tour a sailor typically leaves for a six-month deployment on board a US Fleet ship or submarine, and is forward deployed to strategic locations around the globe.

Redmond et al. (2015) summarized the structure and culture of the US military for those who may not have an understanding of that culture. Service members learn military cultural norms during their indoctrination training, which teaches military personnel how to think, communicate, and interact with each other. Individual thinking transforms from individualist to collectivist thinking that focuses on completing the mission. Service members learn a new communication style, which emphasizes professionalism in greetings (e.g., using *sir* or *ma'am*), and common military terms and acronyms (e.g., *galley* means *dining room*; *O-6* stands for *Captain*) (Redmond et al., 2015). Additionally, service members learn new ways of interacting, in which salutes replace handshakes. Rules of interaction focus on following a chain of command and maintaining professional relationships with coworkers.

Within the military culture, a member's social status depends on the subculture with which they identify. Subcultures include differences common to many groups of people such as gender, sexual orientation, social class, race, ethnicity, and age, but there are additional subcultures in the military (Branson, 2017). Each service branch has a distinct culture, and rivalries exist between services, as evidenced in

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the annual Army vs. Navy football game. An individual's rank identifies him or her as part of another subculture, comprised of officers or enlisted personnel (Gleeson & Hammer, 2014). Additional subcultures exist based on an individual's job duty assignment, for example, pilots, sailors, shipmates, and "grunts" (Redmond et al., 2015). Aspects of military culture common to most service members include a lack of control over assignments and deployment dates, exposure to combat or life-threatening situations, lack of sleep or rest during operations, and high expectations for performance (Branson, 2017).

An example of a specific subculture in the US Navy is the aviation component. Aviation service men and women deploy on the same ship as sailors, though identify as aviators and maintain a distinct identity from their shipboard peers. Movies such as *Top* Gun depict a culture of aviators with attitude who participate in dangerous operations (Simpson, Bruckheimer, & Scott, 1986). The risks inherent in the aviation duty assignment are discussed often. Aircraft mishaps are due to either mechanical or human error, with aircrew/human error explaining the majority of mishaps (Alkov & Gaynor, 1991). During deployment aviation missions occur primarily at night, causing fatigue and stress which can lead to degraded pilot performance (Neri & Sheppell, 1994). The Navy spends a considerable amount of time emphasizing aircrew coordination training in which pilots monitor each other for signs of work overload and stress, and readily admit the psychological or physical stressors that can impact an individual's ability to complete a mission (Alkov & Gaynor, 1991).

Military culture also impacts the families of service members. Often a military spouse hierarchy develops based on the rank of the active duty spouse (Redmond et al., 2015). The family might live in a certain geographic location based on the service member's current duty assignment (Russo & Fallon, 2015). Other cultural differences include whether the family lives on or off base, whether they utilize health care at a base or civilian medical facility, and what school the child attends (DeGraff, O'Neal, & Mancini, 2016). When they become adults, some military children refer to themselves as *military brats* to summarize their frequent relocation and inability to call one place home (Wertsch, 1991).

A unique aspect of military culture is the deployment cycle and how it impacts service members and their families (Redmond et al., 2015). The five stages of the deployment cycle include predeployment, deployment, sustainment, redeployment, and postdeployment (Pincus, House, Christenson, & Adler, 2007). Hicks, Lenard, and Brendle (2016) described each of these five stages of deployment in their research with military families. During predeployment, service members work long hours in preparation for leaving and experience tension and anxiety about leaving. The deployment phase occurs during the first month of separation and is characterized by feelings of anger, frustration, grief, and loneliness. During the deployment stage, the service member and family adjust to life without the service member present. The redeployment stage is filled with anticipation and expectations about the return home, and sometimes frustration due to high expectations of a positive return. In the last stage, postdeployment, emotional needs must be reconsidered as the service member reintegrates into civilian culture.

The values of military culture are summarized as a warrior mentality and extend into every aspect of a military member's life (Redomond et al., 2015). Military culture values physical and mental strength (O'Brien, Keith, & Shoemaker, 2015). Service members learn to adapt and overcome challenging situations and to think from a collectivist perspective that emphasizes group cohesion (Branson, 2017; Canfield & Weiss, 2015). "Obedience, discipline, self-sacrifice, trust, and courage" are key military values (Redmond et al., 2015, p. 14). Values such as mental toughness and self-reliance help service members tolerate difficulties and emotional distress. Individuals with problems are perceived as weak and may be rejected or viewed as a liability to completing the mission (Bryan, 2016).

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Castro, Kintzle, & Hassan (2015) compiled a list of common thoughts, emotions, and behaviors of combat veterans from discussions with veterans or counselors. Thoughts include being proud of one's service, and "people will think I am weak if I ask for help…showing emotions is a sign of weakness" (Castro et al., 2015, p. 301). Emotions include being angry, sad, happy to be alive, and lonely. Common behaviors include not being able to sleep, constantly feeling on edge, and not being able to calm down. The authors recommended increasing service members' self-awareness of their thoughts, emotions, and behaviors so they can recognize when they might need the assistance of a mental health practitioner.

Many of the cultural values listed above are protective factors, however, they can also be risk factors for a service member's mental health. Mental toughness and self-reliance can lead to avoiding problems, not asking for help when it is needed, and rejecting social support (Bryan, 2016). Service members who discuss problems instead of solutions may be seen as unmotivated or complaining, and subsequently may be rejected by peers. Additionally, a social dominance orientation exists within the military, in which members of the dominant group stigmatize members of the out-group if they do not conform to the dominant mentality (Johnson, Rosenstein, Buhrke, & Haldeman, 2013). Many service members will not voluntarily seek counseling and will only attend counseling if ordered by their command or given an ultimatum by a family member (Canfield & Weiss, 2015).

Additional barriers to seeking mental health treatment for soldiers are: shortcomings in a counselors' understanding of military culture, career concerns, mental health concerns, and evaluation of mental health issues (Eckart & Dufrene, 2015). Service members become frustrated at having to explain basic aspects of the culture to therapists who have little knowledge of military culture. Service members are concerned that seeking mental health treatment might negatively impact their careers, in terms of duty assignments, confidentiality, and promotions. Concerns about mental health include a stigma against receiving help. Finally, mental health issues are often assessed incorrectly or inaccurately, so that those who seek help do not receive the treatment they need (Zinzow et al., 2013).

To effectively help clients that are service members, counselors need to understand military culture, subcultures, social norms, and values. A therapist can better understand a client's worldview by considering military service as an extension of an individual's identity (Strom et al., 2012). Strom et al. pointed out that a counselor's direct experience serving in the military would enhance cultural competence with clients. In a study assessing 89 health care providers for military cultural competence, the authors found that participants with military exposure had increased knowledge of military culture compared to participants with no military exposure (Meyer, Hall-Clark, Hamaoka, & Peterson, 2015). However, the authors warned that a counselor may also make false assumptions about a client when a counselor's culture is similar to a client's culture.

Other considerations for counseling military members center on the member's schedule. Once a service member enters counseling, it is important to consider interventions the service member can use while on deployment or during extended periods away from the counselor. These interventions might include journaling, books, teleconferencing, email contact, and long-term homework (Eckart & Dufrene, 2015). Other counselors implement *smart books* (Bryan, 2016, p. 167), small notepads that allow a service member to write down coping statements or lessons from therapy and carry them discreetly in a uniform. A therapist should continually modify and adapt treatment approaches to meet the needs of each client.

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INTRODUCTION TO THE COUNSELOR

Cultural Background

My background includes growing up as a white female in U.S. culture and serving as an officer in the U.S. military. I am the middle child in a single-parent family raised in the Midwest. I received a Reserve Officer Training Corps (ROTC) scholarship to attend college and upon graduation was required to enter the military. Because I had a college degree, I entered the military as an officer, where I completed nine years of active duty service, four years of select reserve duty, and currently serve in an inactive reserve status. My husband is an active duty service member who currently resides in a separate geographic location from me and my daughter, because of his duty assignment and our future plans upon his retirement.

Being an aviator in the Navy opened my eyes widely to the privilege and oppression that exist in the United States of America and other parts of the world. In 2001, when I entered the military, restrictions placed on females precluded them from participating in combat operations, some job duty assignments (e.g., being assigned to a submarine), and some military occupational specialties (MOS). In January of 2013, the Department of Defense rescinded the direct combat exclusion rule that had been in place since 1994 (Segal, Smith, Segal, & Canuso, 2016). There were few females in the pilot training program, and an immense amount of pressure to meet the program's high expectations was both physically and mentally demanding.

I had the privilege of being an officer, but I also experienced oppressive acts such as sexual harassment and gender bias. During my first deployment in 2004, my assigned ship had recently become integrated, meaning females were allowed. At that time, females were only present in the officer ranks, and I was one of three females on the entire ship. On my second deployment, I was the only female in my helicopter detachment of 35 personnel, though there were other females present on that ship.

Visiting other countries while in the Navy, I realized the privilege that Americans have, even as one of a few females present. In Oman, American females were told they needed to have their heads and knees covered before going out in the town. In other countries, such as India, women sat backward on scooters, holding their babies while males zoomed down the street. I was shocked to see the sacrifice some individuals would make to find more privilege in life when we rescued boatloads of migrants trying to go to America with nothing but oranges and the clothes they were wearing. Most of them were women and children. Even as I conducted rescue operations during Hurricane Katrina, I saw the privilege and oppression that is present in US society.

Counseling Approach

My approach to counseling is first to form a therapeutic alliance with the client. Using a feminist approach, I form a therapeutic relationship that is egalitarian and addresses any imbalances, i.e., between the therapist as expert and the client (Otting & Prosek, 2016). Sessions start by asking the client, "how would you like to use your time today?" Intake sessions usually begin by asking clients if they can tell me a little bit about what brought them in. My theoretical orientation is solution-focused, so I focus on what the client is experiencing, how they are experiencing it, and what they would like the future to look like when the problem is no longer present (Froerer & Connie, 2016). During intake sessions, I will ask clients to "tell me more about that" if I need clarification. I want to know and understand clients' worldviews so I can empathize with them.

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My perspective that a session should be about the client's needs limits my level of self-disclosure with firm boundaries. I have received feedback that I can be very direct, yet still empathic. I believe some of these characteristics come from my military background. I learned a lot about boundaries through the division of officers and enlisted personnel. From my experience, it is easier to keep those boundaries if there is less self-disclosure. As a counselor and counselor educator, I begin a relationship with firm boundaries and limited self-disclosure, and those things can be relaxed at a later time if needed. Some clients ask about the military pictures in my office, and I answer by objectively telling them what I did in my previous career. The majority of clients who ask also have a military background or experience with someone in the military. In the case of Eddie, I feel it is important to disclose my military background as a way to let him know that I understand military culture, yet I also recognize that his worldview and experience in the military is different from mine.

CASE CONCEPTUALIZATION

The next section of this chapter focuses on case conceptualization of Eddie. Symptoms and presenting problems are used in case conceptualization to formulate a treatment plan. The symptoms the client describes and I observe are crying, trouble sleeping, trouble eating, and increased use of alcohol. The problems are grief and problems related to deployment. Thus, goals focus on decreasing symptoms and formulating solutions to the problems. At this time, Eddie appears to present with normal bereavement, though if his symptoms worsen, that may be changed to adjustment disorder (American Psychiatric Association, 2013).

Theory

When working with the military population, it is important for counselors to consider the amount of time they will have with a client to implement interventions and for clients to begin the process of change. Solution-focused therapy is a brief therapy with a concentration on client strengths, what the client would like to happen in the future, how things will be different when the problem no longer exists, and solution-oriented talk that does not focus on the problem (Seponski, 2016). Solution-focused brief therapy (SFBT) is collaborative, as the therapist believes the client has the solutions for his or her problem. Criticism of SFBT includes the theory being too simplistic and dismissive of client problems (Froerer & Connie, 2016).

In SFBT, interventions seek to increase client awareness and maintain a present and future focus. Solutions always come before the problems (De Shazer, 1988). For Eddie, the solution is to overcome his grief and join his squadron on deployment. If something is not working, the client is encouraged to try something different. Any time the client thinks about a past moment, it is to determine an exception when the problem was not present or when the client reacted differently (Cepeda & Davenport, 2006). The therapist focuses on what is working for the client. I want to ask about what is working, what has worked, and what might work. Acknowledging exceptions allows a client to recognize previous success in a given problem area and that solutions exist for a given problem. SFBT holds that small changes can lead to more significant changes. For Eddie, a small change in the impact of his grief will lead to more of his feelings changing related to the loss he recently experienced. As will be discussed later, Eddie acknowledges that not talking to his command about his grief is not helping him. Therapists emphasize

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that problems are caused by life transitions and do not indicate pathology. Considering the stigma against mental health treatment in the military (Eckart & Dufrene, 2015), it is important to normalize Eddie's experience of grief.

Therapists help clients achieve small changes by asking scaling questions (De Jong & Berg, 2013). When asking scaling questions Eddie can be asked how he rates his experience of grief (6 or 7), and what would need to happen for that to be a 5 instead. The *miracle question* is used to talk with clients about how things will be different when the problem no longer exists (Strong & Pyle, 2009). Conversation about the miracle question focuses on action and perceptions that help the client begin to create the solution to his or her problem, emphasizes behavioral descriptions of what that will look like (De Jong & Berg, 2013). I ask Eddie to describe how he will know he is no longer grieving his friend, what will be different, and how will he feel.

De Jong and Berg (2013) introduced a staged approach to forming solutions in SFBT. The stages are describing the problem, developing goals, finding exceptions, feedback, and evaluating client progress. These stages focus on the future and empower the client to resolve the problem. The language used in SFBT focuses on solution talk as opposed to problem talk. Thus, increased solution talk indicates progress in a client. Clients may shift their language from helplessness to taking control and becoming empowered to change things. Eddie can recognize areas in his life where he does have control in his life and can be empowered to make different choices, such as choosing to cope with alcohol or not. Compliments are given to the client on his or her progress toward a goal (De Jong & Berg, 2013). When a client is asked a scaling question, a change in number is another indication of progress. The stages of SFBT serve as a framework for the counseling session.

Multicultural and Social Justice Counseling Competencies (MSJCC)

Counselor/Client Intersectionality

Ratts et al. (2016) depicted a framework that indicates the privileged and oppressive statuses of counselor and client. When counseling Eddie, the quadrant that summarizes the therapeutic relationship is that of marginalized counselor–privileged client, given a male client receiving counseling from a female counselor. However, this interaction represents a snapshot in time, and it is possible for the counselor and client to consider themselves in more than one quadrant throughout the counseling session. For example, when discussing the military, both myself and Eddie experience privileged status due to our identities as officers, although a gender difference remains.

Developmental Domains and Competencies

The developmental domains in the MSJCC are: counselor self-awareness, client worldview, the therapeutic relationship, and counseling and advocacy interventions. Competencies within these domains are: attitudes and beliefs, knowledge, skills, and action (Ratts et al., 2016). By applying these domains and competencies, counselors are committing to a multicultural practice that includes the action of social justice when considering interventions for clients.

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Counselor Self-Awareness

When working with Eddie, I must first consider my own attitudes, beliefs, and biases. I can examine my beliefs about being an individual who previously served in the military and the privilege of being an officer. I can also examine my beliefs about the oppression that occurred in the military due to my status as a female. When counseling Eddie, it is important for me to be aware of any feelings I have about the privilege white male officers experience. I can then explore how these beliefs impact my worldview. I acknowledge that other members of the military will have a different perspective than my own. In regard to action, I have spent a considerable amount of time immersed in military culture. I can be aware of how my military experience impacts my communication and how I talk with Eddie about his experience. *Counseling Military Families: What Mental Health Professionals Need to Know* (Hall, 2008) is a book I use a resource to separate my experiences in the military from the experience of my clients, and to review approaches to working with military members.

Client Worldview

To understand the client's worldview, I can understand the privilege and oppression the client experiences and how those experiences shape the client's attitudes and beliefs. Eddie is experiencing oppression for several reasons related to military culture. First, senior individuals in command make decisions that impact Eddie without his input, such as the decision to resume normal operations. Second, he is experiencing concerns about his career if he does not go on deployment. He has a loss of control over when he can leave on deployment and how that will impact his career, thus feels oppression. Additionally, he does not want anyone in the military to know that he is going to counseling, suggesting a stigma against mental health issues oppressing individuals who experience them.

To gain knowledge about Eddie's worldview, I can review research on mental health stigma in the military, and how career and confidentiality concerns may impact a client's decision to seek counseling (Eckart & Dufrene, 2015). I can use critical thinking and analysis to understand the oppressive force of power in the military and those senior to Eddie, and how that power impacts the client. The oppression this client feels contributes to his problems in several ways. First, the client is not reaching out to his military community for support but is coping by self-medicating with alcohol instead. Additionally, Eddie is not discussing his problems and loss with his command, so they are not aware of how much these events have impacted him. They are also not aware of his career concerns. If he discusses these concerns with them, there may be more solutions to choose from that will still allow him to meet his goals.

To better understand Eddie's worldview, I can stay current with the literature on counseling the military population. Prosek et al. (2018) developed competencies for counseling military populations that "offer a framework and foundational principles and practice for working with military-connected clients" (p. 88). These competencies are based on research and are considerations for counselors working with military clients.

Counseling Relationship

Counselor self-awareness and knowledge of the client's worldview can help me determine how the privileged and marginalized statuses of both Eddie and myself impact the therapeutic relationship. Thus, I ask the client things such as "tell me what being in the squadron is like for you" or "tell me what it would

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be like to tell a senior officer your concerns about leaving for deployment." For example, one way in which the marginalized status of myself in the military could impact the counseling relationship is in a situation where I use therapeutic confrontation. I might not use therapeutic confrontation because of my experiences with males in the military. In order to manage this I can be aware of my attitudes and beliefs about confronting a client in the military and rely on the knowledge and skills I have used when working with other clients. Ratts et al. (2016) suggest counselors know when it is appropriate to discuss topics such as power and stereotypes. In the case of Eddie, one way to manage the privilege and oppression present in the therapeutic alliance is to acknowledge that Eddie and I had similar experiences in the military yet that differences also exist.

In terms of action, I can participate in continuing education that focuses on being accepting of clients. When working with Eddie, this means accepting his wish to maintain confidentiality due to the stigma about mental health. I can also collaborate with colleagues when I feel I am not remaining objective or accepting of the client's choices (Sheperis & Sheperis, 2015).

Counseling and Advocacy Interventions

Once I gain self-awareness about working with Eddie, acknowledge Eddie's worldview, and discuss power, privilege, and oppression as they impact the therapeutic relationship, I can suggest appropriate interventions that promote social justice. In this case, Eddie has three weeks before leaving on deployment. SFBT is an appropriate counseling theory to use, as well as interventions that can be completed during deployment, such as books, email contact, journaling, and teleconferences (Eckart & Dufrene, 2015). Advocacy interventions for Eddie focus on the oppression Eddie is experiencing and how that is impacting his ability to formulate realistic solutions. I might try to help Eddie reflect on his thoughts about leaving for deployment and what is hindering him from telling his senior officers about his concerns. I can also discuss how military culture might support Eddie during this time and influence his well-being, as the military family takes care of its members. It is appropriate for myself and Eddie to discuss goals in terms of how he can advocate for himself so that the military can give him some of the support he needs.

Competencies for Counseling Military Populations

In 2016, the Military and Government Counseling Association appointed a task force to develop the Competencies for Counseling Military Populations (CCMP). "The intention of the CCMP is to provide a research-based set of guidelines that represent military considerations through the lens of a counselor professional identity" (Prosek et al., 2018, p. 88). Seven core competencies serve as the framework for the CCMP: military culture, ethics, system features, assessment of presenting concerns, identity development, treatment, and advocacy. These fall within the MSJCC competencies as seen in Table 1.

Military Culture

"Military culture represents general information about the functioning and worldview of military service members and their families" (Prosek et al., 2018, p. 88). Specifically, in this component counselors are "aware that differences in experiences may exist between Veterans who previously served and Service members/Veterans who currently serve, as well as Veterans who served in different areas" (p. 88). In

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Eddie's case, it is important for me to recognize that my military experiences occurred almost ten years before counseling Eddie and may have been very different from his experiences. Additionally, counselors should be aware of differing worldviews between civilians and military members. I am currently in civilian employment outside the military, so I will naturally have a different current worldview than my client.

Table 1. Alignment of CCMP competencies within the MSJCC competencies (Prosek et al., 2018; Ratts et al., 2016)

Attitudes and Beliefs	Knowledge	Skills	Action
Ethics	Military Culture	Assessment of Presenting Concerns	Advocacy
	Identity Development	Treatment	
	Systems		

Identity Development

The identity development component "represents the whole person concept of military life including one's personal identity as a Service member and connection to mission and core values of working as a military Service member across the lifespan" (Prosek et al., 2018, p. 89). In counseling Eddie, I start to understand how Eddie's sense of self relates to his occupational role and how his military rank influences his sense of self. Additionally, he may tie his career progression to his identity. Therefore, concerns about his mental health status impacting his career might ultimately affect his sense of self.

Systems

The systems component "represents general information about how Service members' families, spouses, and children experience the nature and structure of the military lifestyle" (Prosek et al., 2018, p. 90). It includes deployment, long periods of separation, and consequences of injury. When counseling Eddie, I want to acknowledge the stress of leaving for deployment and how it impacts the client. I also consider the emotional demands of the military and the impact of a high-risk occupation on the individual and family members. I consider Eddie's sources of support, such as marital and family support. Additionally, with Eddie's concerns about leaving for deployment, it is important to consider how his absence will impact his family system. From an SFBT perspective, the client discusses how the family system has handled past deployments and what solutions the family will implement while he is away.

Assessment of Presenting Concerns

The next component lists common clinical concerns of military members seeking counseling services. The list includes military stigma against seeking mental health treatment, as well as TBIs, PTSD, secondary and vicarious trauma, substance use, suicidality, and military sexual trauma (Prosek et al., 2018). Since Eddie expresses concern about stigma against mental health, making it difficult for him to talk with his command about his recent loss, I can advocate for him by discussing how important it is for him to seek

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mental health treatment and work toward addressing that stigma. Eddie also admits to increased alcohol use. Heavy drinking is often normalized within the military, therefore an individual might not recognize a substance use problem (Fuehrlein et al., 2016).

Treatment

The treatment component addresses unique concerns when treating military members, as well as research-based approaches to treatment and best practices. I understand how military care systems work and what services they may offer its members (Prosek et al., 2018), such as adjunctive services including talking with a chaplain, utilizing peer support, or incorporating physical therapy. I can help Eddie develop coping skills and continually assess social support and substance use. I determine Eddie's social support, including support from his command, and discuss his increased alcohol use and develop alternative coping strategies as well.

Ethics

The ethics component describes ethical considerations for counselors working with military members as well as counselors reflecting on their motivation to work with this population (Prosek et al., 2018). The task force recommends that counselors receive experiential training in working with military clients and learn the legal requirements for documentation and disclosure of records. Additionally, counselors who also identify as military members should assess for countertransference. I decide to seek additional supervision/peer consultation while working with Eddie, due to the possibility of countertransference. This section also discusses considering a community referral for military members if needed. In this case, Eddie felt more comfortable with a community counselor, so it is important that I maintain the confidentiality Eddie is requesting.

Advocacy

Finally, the advocacy component addresses "counselors' ability to understand and influence individual, system, and public policy efforts to increase access to mental health resources for military-connected clients and promote the role of counseling professionals working with military populations" (Prosek et al., 2018, p. 93). Counselors can advocate for approaches that use a wellness model and are strengths-based. Counselors support decreasing mental health stigma within the military and actively assist service members in self-advocacy strategies. Eddie feels self-advocacy is best in consideration of whether he is able to leave for deployment or not. Once Eddie has made this decision, I can help him advocate for himself to his command.

TREATMENT

Goals

In SFBT the counselor and client collaborate on treatment goals so the client can determine the best solutions for the problem. When formulating goals with Eddie, it is important to remember that he only

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has three weeks before leaving on deployment. Therefore, goals need to be short-term. I ask what the future will be like when the problem is no longer present, and Eddie expects that he will no longer be so reactive to the tragic death of his friend. Therefore, the first goal is to process the feelings of grief and loss that are present. The second goal is to address Eddie's feelings about the upcoming deployment and advocate for the best solution with one member in his command in the next two weeks. The third goal is for Eddie to recognize how military culture affects how he is experiencing his problems and to list more effective coping skills. I use solution-talk and a future focus when communicating with Eddie about meeting these goals (Froerer & Connie, 2016).

Goal 1: Processing Grief

I choose to use psychoeducation to help Eddie process his feelings of grief and loss. Kubler-Ross proposed a grief model with five stages: denial, anger, bargaining, depression, and acceptance (Sheperis & Sheperis, 2015). Sharing this model with Eddie can help normalize some of the feelings he is currently experiencing and give him hope about the future stage of acceptance.

Worden (2008) emphasized that the space provided in counseling for processing bereavement is more important than an intervention. In many other areas of life, the client may be trying to hold it together to avoid being too emotional, trying to act a certain way, or trying to hide feelings. Eddie states that he has tried to do his best at work, but often when he gets into his car for lunch, he is overwhelmed and begins sobbing at the loss of his friend. He recognizes that by not talking to others in his command about how he is feeling, he is trying to hide his feelings. He wants to maintain the perception that he can handle this and still go on deployment so it will not impact his career. Eddie and I talk about the stages of grief, and Eddie views himself as currently being in the denial stage and at times the anger stages. I recommend that Eddie read *On Death and Dying* (Kubler-Ross, 1970) while he is on deployment and journal about his feelings to continue processing his grief while he is not attending bi-weekly counseling sessions.

Goal 2: Individual Advocacy

The stated goal is for Eddie to decide what is best for him in terms of leaving for deployment and then advocate for himself by discussing this with a senior member of his command. Scaling questions can be very insightful while discussing this goal. When asked how ready he feels to leave for deployment on a scale of one to ten, with one being not ready and ten being ready to leave tomorrow, Eddie states he is currently at a five. When asked what would need to happen to change that number to five and a half, Eddie states he wishes he had more time and is afraid that if he does not leave on time, it might impact his career.

I then ask Eddie for exceptions: "Does everyone always make the whole deployment?" and, "Are there any penalties for those that do not?" Eddie remembers that two pilots split a previous deployment and were still able to accrue enough flight hours to qualify as an aircraft commander or otherwise avoid impacting their careers. Eddie states that he has been planning for this deployment and would like to be a part of it, but he feels that he needs more time to prepare since this tragedy happened. He states that he feels the best solution would be to meet his squadron on deployment two to four weeks later than the scheduled date.

After identifying this solution, the next step is to discuss is how Eddie can advocate for himself. I ask Eddie if he has ever felt comfortable talking with anyone in the command about something like this.

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Eddie identifies his department head as such a person and decides to ask his department head if he can join the squadron two to four weeks into the deployment because he is having some difficulty dealing with the mishap and needs a little more time to "get his head on straight" before he flies an aircraft overseas. Eddie and I also discuss how it is important for Eddie to discuss his career concerns and ask his department head how leaving late for deployment might impact his career. Eddie decides that he will do this before his next session.

Goal 3: Awareness of Military Culture

In this goal, I help Eddie explore how military culture might be hurting or helping with his current problem, including military cultural norms related to confidentiality and mental health stigma. He describes an environment in which service members handle their own problems and are mocked if they do not meet standards or act tough. He wishes he could be more courageous in managing his feelings about the mishap and that he could talk to others, but he does not want others to view him as too weak. The inability to do a job is a sign of weakness; asking for more time could be interpreted as not being part of the team.

I also discuss how military culture is helping Eddie with this problem and focus on his strengths. We discuss how other military members might be supportive of Eddie and help him get through this time as a team, despite his fears of being seen as weak. One of Eddie's strengths is the courage to seek help and to speak with his department head about leaving later for deployment. It also takes courage to recognize that it might not be safe to perform his job and to admit he fears retribution on his career. In many ways, Eddie is adapting to the situation and managing it. We also discuss self-reliance and how there are times in the military when one does need to talk with someone else.

Finally, I discuss Eddie's increase in alcohol use. Eddie states that he usually drinks at the end of the day when he is alone. I am aware that military culture promotes drinking, and alcohol misuse can be problematic (Ijamanta & Lasebikan, 2016). Alcohol use in military aviators is associated with an increased risk for safety (Gates, Duffy, Moore, Howell, & McDonald, 2007). For this reason, I decide to use the Alcohol Use Disorders Identification Test (AUDIT), to gather information on the quantity and frequency of alcohol consumption (Stevens & Smith, 2018). Eddie reports drinking every day since the mishap, and usually has three to four drinks, although occasionally he consumes more than that. Stevens and Smith (2018) recommend counselors utilize psychoeducation on the effects of alcohol which includes poor judgement, endangering self or others, and negative effects on cognitive functioning. Eddie and I identify some people that Eddie can reach out to for support during these times. We also talk about journaling and reminding himself about good times he shared with his friend. Eddie is able to identify that feeling alone is a trigger for his drinking, so we discuss alternative activities for his leisure time. Eddie mentions that he could also go running or watch a movie to keep his mind off being left alone without his friend. He also recognizes that it is important to spend time with his wife prior to leaving for deployment. I also talk with Eddie about the possibility of attending an Alcoholics Anonymous (AA) meeting. He does not wish to pursue an AA meeting at this time, but I do provide him a list of meeting times and locations.

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Progress

Goal 1: Processing Grief

One measure of Eddie's progress is to look at his symptoms. During the intake session, Eddie reported having trouble sleeping and eating and also feelings of anger toward his squadron. As therapy continues, Eddie's physiological responses will hopefully subside so that he will be able to sleep and eat better and therefore will be able to meet some of his basic needs. Maslow (1954) proposed a hierarchy in which basic physiological needs (e.g., shelter, food) must be met before one can move up the hierarchy to safety and security, belongingness, esteem, and self-actualization. An individual is at a higher level of mental health when the basic needs are met.

Another measure of progress is forward movement through the stages of grief. However, this may be a long-term process, and it is common for clients to move forward and then revert to a previous stage (Sheperis & Sheperis, 2015). Journaling is an effective way to track the stages of grief.

Goal 2: Individual Advocacy

Progress on this goal depends on Eddie following through with his decision to talk with his department head about the possibility of leaving for deployment at a later time. Improved responses to the scaling question of how ready Eddie feels to leave on deployment also indicate progress. Eddie stated he is currently at a five. As the deployment approaches, I would expect this number to go up. If it does not, Eddie and I can discuss what is stopping him from being ready for deployment. We may need to reconsider the solution and try an alternative. In SFBT, if something is not working, it is time to try something else (Froerer & Connie, 2016).

Goal 3: Awareness of Military Culture

Progress in this goal is indicated by Eddie's awareness of how he is feeling and where those thoughts and values originate. Keeping a feelings journal should be very effective, in which Eddie writes down his feelings, reflects on the events that precipitated those feelings, and reflects on any cultural values that might influence how he is feeling. In this way, Eddie can separate his feelings from cultural factors that might be influencing them. He can learn to honor his feelings and recognize when he might be placing judgment on those feelings. Eddie can understand that military culture has some excellent values but also has some values and behaviors that are maladaptive. In this way, Eddie can begin to advocate for himself, allow for his feelings, and realize mental health issues need not be stigmatized. Progress on this goal would also be indicated by a decrease in the frequency and amount of alcohol consumed, and utilizing the alternative coping strategies that were discussed.

CONCLUSION

Ratts et al. (2016) discussed the importance for counselors to reflect on the intersecting identities of the counselor and client and how that impacts the process of therapy. This chapter specifically focuses on the intersecting identities of current and former members of the military. Military culture can serve

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as a protective factor for military members, but it may also be a risk factor in terms of mental health (Bryan, 2016). The Competencies for Counseling Military Populations (CCMP) serve as a framework for counseling military clients (Prosek et al., 2018), and these competencies fall within the MSJCC and can help counselors reflect on the intersecting identities of counselor and client (Ratts et al., 2016). A case study illustrates the practical application of the CCMP and MSJCC.

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Chapter 47
Organizational Prevention and Intervention Services:
Beyond the Early Intervention System

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ABSTRACT

Improving the opportunities for enhanced health and wellness in first responders has gained national attention in recent years. Employers and other stakeholders striving to improve employee utilization of available resources will need to increase transparency in the process and improve understanding between first responders and clinicians. One potential process, early warning systems (EWS) are primarily designed to alert management to an at-risk employee. However, the continuing goal of any effort should be to identify and remedy any employee issue before the employee exhibits the predetermined number of events that trigger an early warning alert. Although many organizations are adopting an EWS by either choice or mandate, they are largely separate and distinct from the agency's health and wellness programming. Administrators are not only unsure of what data to consider, but also what to do when an alert is activated. Ideally, agencies move toward early intervention systems that themselves are conceptualized within the larger framework of wellness programming.

ORGANIZATIONAL MENTAL HEALTH SERVICES

First responder organizations vary across disciplines, occupations, and jurisdictions in their handling of the health and wellness of employees. Prevention and response approaches may vary, even among different subdivisions or teams in the same organization. Standardizing prevention and intervention strategies for all first responders would be difficult, given differences in organizational cultures, geography, and individual experiences; however, basic elements of prevention and intervention programming

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can remain consistent. For example, as a minimum, each organization's preventive measures should include resilience-building training for employees and their families, beginning before a first responder is deployed in the field, and training on improving mental and physical health in response to adversity and stress (Kelly & Hoban, 2016). Recent initiatives such as the President's Task Force on 21st Century Policing (COPS Office, 2015) and the Law Enforcement Mental Health and Wellness Act of 2017, have placed national attention on the need to make mental health a priority. As such, first responders require (a) continuing education, (b) stress management training including adaptive coping strategies throughout their careers, (c) early intervention systems (EISs) that focus on the whole employee (i.e., not just the behavior triggering an alert), (d) responses to early behavioral alerts that promote well-being, and (e) general intervention options to address mental health emergencies. Employee health and wellness and early warning/intervention systems should be designed with the employee, families, the organization, and the service population in mind.

Training and interventions developed to enhance the health and wellness of public safety employees should be evidence-based or at least integrate research findings. Those involved in the research, development, implementation, and assessment of employee health and wellness programs must be properly trained and vetted to ensure they will benefit employee and organizational health. They must also be able to deal with the sensitive nature and confidentiality requirements of this work. Attention must be paid to ensuring that intervention strategies listed in policies are operational, following the agency's plan, prior to any program rollout.

This chapter provides policy makers, researchers, administration and supervisory staff, and clinicians a framework to create policy that fosters prevention and intervention for mental health difficulties in first responders. It demonstrates the need for transparency and collaboration among stakeholders regarding prevention and intervention, discusses benefits of early alert systems, and presents examples of programming for first responders, not only as they begin their careers, but when they have experienced risk factors for impairment and for those exhibiting mental health difficulties.

EARLY WARNING SYSTEMS

Early Warning Systems (EWS) were originally created to detect and address problematic police officer conduct and enable intervention to correct it (Walker, Alpert, & Kenney, 2001). This concept was born out of the 1981 U.S. Commission of Civil Rights recommendation that police agencies create systems to identify "problem officers" that are frequently the subject of citizen complaints (DeCrescenzo, 2005). The original EWSs were designed primarily to alert management about at-risk employees (DeCrescenzo, 2005; Bertoia, 2008). EWSs are widely used in first responder organizations and are mandated in some locations (e.g., the authors' home state of New Jersey). Despite this, many stakeholders, both on the frontlines and in administrations, are still unsure what data to collect or how to respond appropriately.

Arguably, the original concept of an EWS should be reframed and redesigned more broadly to maintain healthy first responders and organizations, with indirect consequences that benefit their organizations and the communities they serve (Amendola & Davis, 2019). Collaboration with all stakeholders, including labor unions, administration, frontline personnel, and mental health professionals, would help to ensure EWSs are used as intended, to both prevent and address alerts, and not as a disciplinary tool. Union leaderships acknowledging the nonpunitive value of a properly administered EWS would promote

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frontline personnel buy-in (DeCrescenzo, 2005). Any effort should continuously identify and remedy any employee issue before it triggers an early warning alert.

In 1999, at least 39 percent of county and local law enforcement organizations with service populations greater than 50,000 were using or working toward implementing an EWS (Walker et al., 2001). With increasing mandates to adopt such programs, it is safe to assume the agencies are increasing in number and more varied in size. EWS research has typically only measured the number of complaints against employees. It has been suggested that enhanced employee scrutiny could lead to reduced proactivity, which obviously could skew research (Macintyre, Prenzler, & Chapman, 2008). Formal exploration of the EWS' impact on the health and wellness of employees and the overall agency is needed. An EWS can serve as an additional layer of strategy to maintain a healthy and sound workforce. Little research addresses EWSs in public safety.

Weaknesses in the EWS

In the standard EWS, public safety agencies compile data and then wait until the number of events in a given period triggers an early warning alert for a supervisor to address a potential issue with an employee. Some EWSs are designed to treat the symptom and not the whole person, by offering limited interventions or lacking preventative strategies for employees. Underlying causes of symptoms that trigger EWS alerts are typically not explored or addressed, although doing so would help develop intervention strategies. A more proactive approach would benefit the organization as a whole by preventing, mitigating, or reducing the need to react to an early warning trigger.

Improving the EWS

Fortunately, public safety agency leaders and employees are increasingly acknowledging the need to help first responders cope with trauma and stress. The second author was personally affected by the suicides of two friends who were police officers in 2009 and has seen a quarter of his academy class leave police work since graduating from the police academy in 2004, due to injury, domestic violence, felony arrests, and drunk driving, while one member died of a heroin overdose (after being terminated). According to Chae and Boyle (2013), "at least five prominent themes emerged as content domains that were positively associated with police suicide: organizational stress, critical incident trauma, shift work and atypical work hours, relationship problems, and alcohol use and abuse" (p. 92). Along with bolstering support systems, a holistic approach to officer wellness will address, educate, and mitigate these factors. An EWS can help protect employees, since these stressors often present identifiable symptoms and patterns of conduct.

In addition to helping employees, public safety organizations must seek to prevent civil litigation, civil-rights violations, excessive force, accidents, workplace injury, negligence, suicides, substance use disorders, domestic violence, family crises, divorce, public relations crises, and employee turnover through resignations or terminations. An effective system must include education for employees, supervisors, and their families. So, the warning system concept evolved to offer interventions before more serious issues develop (Walker, 2003). A more holistic Early Intervention System (as opposed to an EWS) with comprehensive health and wellness programming embedded may reduce reliance upon formalized warning systems. According to Walker, Milligan, and Berke (2006), an employee's supervisor is the key to successful early interventions. The way the program is framed, and even its title, can positively

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impact employee views toward it. Walker et al. (2006) elaborate upon the importance of using the proper terminology, along with the logic behind it:

It is important to get the terminology of EIS right. Supervisors must set the right tone from the beginning. When EISs first appeared about 25 years ago, they were usually called early warning systems. Many agencies still use that term, although it does not convey the right message. The word warning has a punitive, negative tone, implying that it is a precursor to discipline. The PERF (Police Executive Research Forum) study revealed that the best EIS emphasize assisting officers, not punishing them. These systems typically include a range of programs designed to help officers recognize and deal with their performance problems because, time and again, it was discovered that performance problems are rooted in stress and personal and family problems. As a result, the more positive term early intervention system is preferred. (Walker et al., 2006, p. 13)

CASE EXAMPLE: EWS MANDATE IN NEW JERSEY

New Jersey mandates EWSs in every law enforcement agency in the state. Although the directive is titled "Early Warning Systems," the explanation recommends that the EWS "assist officers through early intervention" (New Jersey Office of the Attorney General, 2018a). EWSs hold agencies accountable for their officers' ethical behavior and their wellness and ability to protect and serve their respective communities. The New Jersey Attorney General's Office provided the following explanation on the intention of the EWS in New Jersey:

Early warning systems are designed to monitor officer conduct using objective measures that indicate a potentially escalating risk of harm to the public, the agency, and/or the officer. They are intended to increase public safety and public confidence, while assisting officers through early intervention. . . .

Under Directive 2018-2, the following performance indicators are required to be included in all early warning systems:

1. *Internal affairs complaints against the officer, whether initiated by another officer or by a member of the public;*
2. *Civil actions filed against the officer;*
3. *Criminal investigations of or criminal complaints against the officer;*
4. *Any use of force by the officer that is formally determined or adjudicated (for example, by internal affairs or a grand jury) to have been excessive, unjustified, or unreasonable;*
5. *Domestic violence investigations in which the officer is an alleged subject;*
6. *An arrest of the officer, including on a driving under the influence charge;*
7. *Sexual harassment claims against the officer;*
8. *Vehicular collisions involving the officer that are formally determined to have been the fault of the officer;*
9. *A positive drug test by the officer;*
10. *Cases or arrests by the officer that are rejected or dismissed by a court;*
11. *Cases in which evidence obtained by an officer is suppressed by a court;*
12. *Insubordination by the officer;*
13. *Neglect of duty by the officer;*

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14. *Unexcused absences by the officer; and*
15. *Any other indicators, as determined by the agency's chief executive.*

(New Jersey Office of the Attorney General, 2018a)

New Jersey Attorney General Directive 2018-3 (2018b) offers more examples than most policies of potential remedial actions in response to an EWS alert. The list provided includes:

1. *Training or re-training*;
2. *Counseling*;
3. *Intensive supervision*;
4. *Fitness-for-duty examination*;
5. *Employee Assistance Program referral*; and
6. *Any other appropriate remedial or corrective action*.

(New Jersey Office of the Attorney General, 2018a, pp. 3–4)

In New Jersey, if an early warning alert is triggered based on the data maintained in the EWS, the officer's agency must notify the county prosecutor's office and provide all the data for review, including the intervention used in response to the alert. This mandate is designed for oversight, to ensure appropriate data collection and interventions in the agencies. In an investigation, the data could lead to adverse consequences for the organization or the employee, including remedial training, a change in employment status, and even an administrative or criminal investigation; agencies may face sanctions, audits, or increased oversight.

EIS BEST PRACTICES

Amedola and Davis (2019) offer an aspirational definition of EIS, which would provide employees with "resources and tools in order to prevent disciplinary action, and to promote officer safety, satisfaction and wellness." They also suggest going beyond the traditional data collection and evaluation followed by intervention, to include monitoring employees and supervisors. As they note, the EIS is designed to be "pre-disciplinary," which shows the primary objective must shift toward officer wellness, not reprimands.

According to Amedola and Davis (2019), this focus on pre-disciplinary interventions means a system should consider indicators beyond those that directly lead to discipline, such as excessive force complaints. An EIS that considers an employees' need for additional knowledge or training, life changes, personal problems, and mental health difficulties, might include indicators such as tardiness, risk-taking behavior, damage to vehicles, complaints by peers, and excessive overtime (indicating potential family or financial difficulties), etc. Best practices warrant thresholds relevant to each employee's position with potential variations depending on the unit, shift, etc. Absolute and comparative approaches to defining thresholds may more accurately reflect an individual employee's difficulties than a simple threshold of occurrences. This may include officers who are subthreshold across several categories of alert or ones who are approaching an alert threshold (Jackson et al., 2016). Reviewing the context of each alert to potentially rule out concern based on prior knowledge about the officer or unit could reduce false positive results. An EIS policy needs clear performance standards and thresholds in order to determine what training is necessary. Responses to alerts should be recorded, including detailed descriptions of the

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interventions taken and their outcomes. Maintaining historical data is likely to prove useful, not only for quality assurance of the system, but to monitor the success of the intervention as well as the performance of supervisors (Amendola & Davis, 2019).

Perceptions, Misconceptions, and the Need for Transparency

Some government organizations have taken the increased call for transparency in government to heart by publishing online their rules and regulations, reports on use-of-force data, and even body-worn-camera footage. However, government leaders tend to miss the importance of transparency within the organization, particularly in mental health.

Too much mystery and paranoia still surround mental health professionals and their role with first responders in our culture. The only interaction some first responders may have with a mental health professional is during their pre-employment psychological screening. They then spend roughly 25 years of their career trying to avoid being "on the couch" again. The reason? The only thing they know about coworkers going to see "the shrink" is that it never ends well for the employee, which is often a misconception. The first responder community sees fitness-for-duty examinations as career-ending events (Schlosser & Kudrick, Jr., 2019). The perception is that even if the person is cleared to return to duty, they are not promotable, nor will they be considered for any special assignments. Sadly, the same perception holds true for first responders who realize on their own, without an organizational intervention that they should talk with a mental health professional. The employees who do seek help will often do so by paying cash out of pocket and will proceed to their appointments with a cloak-and-dagger approach. Employees do not want the stigma of perceived weakness for speaking with a mental health professional or a diagnosis to follow them around for the rest of their careers.

Public safety personnel experience uncertainty, anxiety, or even fear of mental health professionals and the potential for a diagnosis due to health care coding requirements mandated for mental health clinicians. In consultation with mental health and human resource professionals, leaders of public safety organizations must work together to demystify the preconceived notions prevalent in the first responder community. This attention to internal transparency could send a positive message to agency members regarding the importance of employee health and wellness.

Bridging the Gap Between Employees and Wellness Services

More open dialogue and opportunities to embed the clinician in public safety activities can bridge the gap between first responders, administrations, and mental health clinicians. Some examples include mental health clinicians speaking at in-service training sessions, multidisciplinary police mental health working groups, and mental health professionals participating in ride-along programs with frontline and supervisory personnel. Integrating the mental health professional in this manner will provide an understanding of the culture of the organization the clinician is servicing, common sources of distress and anxiety among employees and their families, and perhaps ways the organization can reduce distress for their employees, all while taking care not to breach confidentiality. Once a person perceives a betrayal of trust, regaining that trust is typically difficult. Opportunities such as the examples listed above would enable first responders to get to know mental health professionals and perhaps break preconceived notions regarding those who choose to serve others through the practice of counseling and psychotherapy.

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Standardized Training

In the absence of a closer relationship between first responder agencies and certified mental health clinicians, other (often well-meaning) people or organizations will fill that void. Problems arise when they do not have the appropriate education and experience or become complacent about evaluating new evidence or continuing their education.

Wellness is becoming a popular topic in both the public and the private sectors, with an increase in attention to wellness initiatives, grant availability, and expanding budgets may receive additional funding for health and wellness programs. Demand requires a supply of organizations and instructors offering their services in return for payment. Public safety administrators must use caution when vetting psychoeducational training curricula and instructors. It is wonderful that health and wellness, especially mental health, are finally getting the attention they demand.

However, public safety organizations must make sure not to cause harm in their well-intentioned attempts to address the issues facing our first responder populations. Establishing a standard for certification to provide instruction to first responder communities is something public safety leaders and mental health professionals can work on together, to ensure that what is taught helps first responders, rather than hurting them. This collaborative approach to reviewing and approving programs will further bridge the gap between the agency and trainer/clinician. A peer-reviewed and evidence-based training curriculum for each discipline could be standardized with input from police, corrections, fire, emergency medical services, and emergency-communications communities. At a minimum, the agency should consult with a licensed mental health professional to vet the qualifications of any instructors and the validity of their training programs.

Transparency in Early Interventions

Organizational responses to mental health emergencies should not be a surprise to employees or supervisors. If an employee comes to a supervisor and indicates thinking about suicide, a substance use disorder, or domestic issues, the supervisor should not have to dig out the policy manual. These revelations could even surface during a meeting between the supervisor and employee in response to an EIS alert. Everyone should know before the employee's personal or professional crisis arises how the organization responds and helps.

Internal transparency and collaborative relationships are both components of this topic. For example, the authors' experience in law enforcement is that employees often fear that the organization will take custody of the officer's firearm if the employee relays experiencing a mental health emergency. The likelihood of that scenario should be made clear to all. Effective resilience-building strategies made available to employees and accepted in the employee's life prior to the crisis should work to end the over-identification with title and foster more identification as a human being, so that the loss of symbols of authority does not increase psychological trauma to the already suffering employee. Public safety employees need to know that symbols of their authority are not symbols of their personal identity or humanity.

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Common Interventions for Early Alerts

The typical response to an early intervention alert is one of two options: remedial training or counseling (DeCrescenzo, 2005; Walker et al., 2001; Bertoia, 2008). The supervisor or training staff of the agency often orchestrates remedial training and presents it in-house. This response may fail in the absence of formal lesson plans and learning objectives, because of the time constraints of the supervisor, employee, or both, or because an underlying catalyst to the behavior is left unexplored. The training may also take place by sending the employee to an external training course, with the potential drawback being the lack of feedback to the sending organization regarding the employee's reception and retention of the information provided. The focus could be on how to avoid unwanted attention at work, rather than on how to return things to their normal balance in the employee's life.

Counseling sounds like a huge step forward for the public safety community. Traditionally, public safety organizations have resisted mental health counseling or even involvement of mental health professionals with employees following pre-employment psychological screenings. Counseling in first responder jargon is not what it seems to readers coming from the psychological disciplines. The term *counseling* in the public safety realm deals with correcting a specific behavior through discussion and a plan to improve, diminish, or eradicate the flagged employee behavior. In a counseling session that a supervisor organizes, the employee is presented with the problematic behavior and research the supervisor has conducted into that employee's history. The supervisor seeks the employee's acknowledgment of the behavior and the adverse impact it has had or could have on the service population, the organization and its mission, and the employee. Together they try to formulate a performance improvement plan, establish benchmarks to measure improvements, and adopt a timeline for the changes (Walker et al., 2001; Walker et al., 2006). The present authors propose a clearer focus on the underlying difficulty, within both the alert mechanism and intervention, so that employees' mental health is best served.

An agency contemplating developing an EIS should consider consulting its employees and mental health professionals to see if they feel it would be beneficial to share these alerts with a departmentally sanctioned mental health professional. An oversight mechanism like this would help ensure the agency is responding with appropriate intervention strategies based upon the needs of both the organization and the individual employee. In essence, it is consulting with the agency's mental health professional to obtain feedback on potential avenues to best address underlying mental health issues.

The other standard intervention option in an EIS is the referral to an employee assistance program (EAP), whether in-house or contracted to an external provider. A noteworthy concern in this process relates to the level of training and experience the EAP staff have in assisting public safety personnel with their unique stressors and the impact of their careers on family members and support systems. A variation of the existing EIS referral to EAP would be a yet different type of psychological visit from pre-employment screening, annual wellness visit, or fitness-for-duty examination: An automatic EIS alert visit with a mental health professional who specializes in public safety treatment. Akin to the EAP referral, the latter may be much more effective if it precedes the two common traditional responses of remedial training and supervisory counseling in that it will potentially lead to the treatment of the underlying cause(s) of any behavior that triggers early alerts.

When behaviors leading to an early alert or other complaints are too severe or disruptive for the effective and safe provision of services to the community, the fitness-for-duty examination may be the most appropriate intervention. Although a fitness-for-duty examination is listed as a potential interven-

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tion strategy in the New Jersey Attorney General's Directive 2018-3 (2018b), it may not always be an appropriate response by a mental health professional. The following list includes potential clinically relevant intervention options once an employee has been identified by the EIS:

- Voluntary referral EAP
- Automatic referral to the department psychologist
- Peer support referral
- Occupational health referral
- Referral to rehabilitation facility
- Sleep specialist referral
- Anger management referral
- Fitness-for-duty examination

Family as an Early Intervention System

Taking the term *Early Intervention System* most literally, a first responder's family and personal support system is where changes and difficulties are first noticed, and training and participation in any meaningful program must not neglect that fact. In most instances, close family members or friends are more likely than a coworker or a supervisor to observe changes in mood, behavior, energy levels, optimism, faith, and happiness.

The first vital step to empowering the employee's family to act as an additional layer of protection involves a trained mental health professional conducting a seminar to educate first responder family members and support systems. There they could learn to recognize warning signs their loved ones may display, realize those signs could correlate with distress from work, and identify ways they can assist their loved one and/or find the resources available to them, should they need more assistance.

Both authors have conducted family education courses for police agencies and academies and have received overwhelmingly positive feedback and expressions of gratitude from those who have attended. Feedback often includes reports of a better understanding of their police officer family member's calling and the unique stressors that come with a career in service, including being under the constant microscope of the media and the general public. Employees must also take personal responsibility for realizing when they need help, seeking it themselves when they are able to do so, and accepting the help. Believing this before it becomes needed is the key. A major factor in ensuring that employees will trust the agency and the process is their knowledge of the steps involved in assisting them prior to their crisis surfacing.

Achieving Greater Buy-In

Public safety leaders must always be mindful of all stakeholders. If an organization has an employee-oversight system to detect potentially problematic behaviors or patterns of behaviors, that organization could be sending a message that it is only interested in sifting out the negative, unless the oversight system is complemented with an awards and recognition program, a health and wellness program, and the ability to offer valid interventions for employees when they are going through a crisis or triggering a confirmed early warning alert. If the organization offers proactive and preventative interventions in addition to a transparent EIS it may prove to be a more accepted management tool.

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Transparency and *health and wellness* have recently become popular buzzwords in the public safety leadership community, although rarely, if ever, are these two terms used in the same conversation. Could separating them result in missing a vital link for sustainable health and wellness efforts? In the experience of the authors, the fear and mystery surrounding the mental health profession is real for most first responders. The authors are personally aware of first responders who have experienced substance use disorders or mental health, personal, or family crises and have paid out-of-pocket to see a mental health clinician due to an intense fear of a real or perceived stigma that comes with a diagnosis required to utilize one's health-insurance plan.

Achieving buy-in through education is the key to success in the implementation of effective and meaningful organizational strategies. An early intervention system could be a component of a more comprehensive plan to help the first responder community.

Critical Incident Interventions

While the EIS is meant to look at data sets over a period of time and alert supervisors to potential issues, a critical incident is a triggering event in its own category. A common intervention public safety agencies use is critical-incident stress debriefings that administrators and/or peers typically conduct. In some of the more traumatic cases, a one-on-one appointment would be made for the affected personnel with a licensed mental health clinician who specializes in treating public safety personnel. The lack of standardization and training on which resources to utilize and who decides what defines a true critical incident for a particular employee or group of employees would be an area worthy of further research and collaboration between public safety leaders, researchers, and the mental health community. Organizations must have an open dialogue when considering criteria that would gauge which incidents are traumatic enough to require a one-on-one consultation with a licensed mental health professional, with the possibility that this would best be done on a case-by-case basis. Subjectivity in these decisions and the selection process and decision-maker training or lack thereof are extremely problematic.

Wellness Options for Employees

A multidisciplinary approach to serving the needs of employees and their support systems requires working across paradigms. Integration could include all or some of the following: peer support, critical-incident stress-management teams, EAP staff, chaplains, and mental health clinicians. Each of these groups of professionals can work within the discipline or in concert with others to assist the first responder community in preparation for shiftwork, the disturbing situations and scenes they will encounter, moral injuries, potential shifts in their faith and idealism, dehumanization, gallows humor, and personal family disruptions. Those agencies would achieve this most effectively through resilience training, psychoeducation, early intervention systems, intervention options, and the inclusion of families and support systems in these initiatives. Agency leaders must be aware that individual employees may have different preferences regarding who makes them feel most comfortable in these dialogues. For some employees, a peer support team member may be preferable, others may choose to confide in a chaplain, and some may wish to speak only with a licensed mental health professional. The employee's preference may also vary according to his or her needs or stage in life. Ideally, policies and programs would be designed to allow the employee to control selections for personal counsel and support while ensuring that employees are

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educated on the services and unique perspectives each discipline may provide. Employees must also be made aware of the confidentiality protections or lack thereof in working with each of these disciplines.

Employees may not always have the level of self-awareness or the ability to overcome obstacles, real or perceived, to seek help during a time of personal and/or professional crisis. Agencies may rely on supervisor or peer observations of changes in an employee's attitude, demeanor, behavior, or personal situation. EISs are one solution being utilized by public safety agencies to aid the organization in identifying employees who may need assistance through interventions.

Pre-Existing EWS Flags

Those in public safety circles commonly know that exposure to trauma, moral distress, moral injury (Papazoglou & Chopko, 2017), substance use disorder (Sack, 2017), post-traumatic stress disorder or injury, cardiac issues, digestive issues, hypertension, and sleep disorders are all prevalent dangers in first responder communities (Violanti, 2014) and should serve as a pre-existing flag for first responders. Action should focus on reducing the dangers associated with what is already known to be hurting or killing our first responders, in addition to causes such as felonious assaults, accidents, disease, and fires. Preventative strategies should be designed with input from mental health professionals, frontline personnel, labor union representatives, supervisors and administrators, and members of first responder families.

The responsibility for the health and wellness of our first responders should not rest solely upon the shoulders of the leaders of public safety organizations. Ideally, labor unions incorporate health and wellness when negotiating for their represented employees. There is a tendency for collective bargaining units to place emphasis on gaining increased salary for employees toward the end of their careers in public safety, in order to increase the take-home amount of their pension, to the exclusion of more present-focused concerns. Health and wellness bargaining items, such as fitness center memberships and/or incentives, more affordable health care plans, education incentives or tuition reimbursement, psychotherapy, maternity/paternity leave, and bereavement leave are often not typical concerns. Public safety leaders and union leaders are in a unique position to guide these conversations so that employees value thriving in the present equally to monthly pension payout calculations that are 30 years or more in the future. This shift in mindset could improve the quality of life for first responders and their families and support systems in the present.

Comfort With the Clinician

In order to ensure a comfortable relationship in which the public safety employee is open to sharing thoughts and feelings with a mental health professional, agencies may want to consider instituting a wellness check-up program with a licensed mental health clinician who specializes in treating the first responder community. Post-critical-incident visits may be the first time employees meet a mental health professional. Perhaps it is the second time, the first being a pre-employment screening, also an uncomfortable situation for a job candidate. The first author has partnered with several police departments in Burlington County, New Jersey, to facilitate annual wellness visits for agency employees. The officers meet to discuss anything they wish or simply to receive psychoeducation. Benefits to this approach include an opportunity for the employee to discuss with a professional in a secure environment the operational and organizational stressors, family difficulties, coping skills, critical-incident and cumulative stress, and any other topics that benefit their overall wellness. Other advantages include the opportunity for

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individual education on resilience, coping skills, and self-care. One of the most beneficial aspects of this program is the familiarity between the officer and the clinician. The building of trust and rapport can be achieved early, which could greatly assist if the officer automatically attends a counseling session in response to a critical incident or an EIS alert.

Agency leaders, along with their respective organizations, would benefit greatly from familiarizing themselves with some of the resources currently being used, such as resource phone numbers, training programs, and critical-incident stress debriefings, and the research available on such programs. Critical-incident stress debriefings have contradictory or little evidence gleaned from studies. The studies that evaluated critical-incident stress debriefings did not specifically address a sample that was exclusively public safety personnel to prove efficacy in that population (Mitchell & Dorian, 2017). The selection of a critical-incident stress management (CISM) team to service the organization should be vetted with a mental health professional. There are numerous resource phone numbers available in the first responder community for employees to make a cold call for help. These services can be evaluated by offering anonymous surveys to first responders to determine how effective or detrimental the sources whose services they attempted to use were to their health and wellness.

FUTURE DIRECTIONS

Policies dictating responses to the needs of first responders' mental health would best be written with the counsel of mental health professionals to ensure the correct message is being sent to public safety personnel. A commonly discussed nuance in the language is the use of the word *mandatory* versus *automatic* intervention. The two terms may seem synonymous to a policy writer, but something as simple as word choice could make or break buy-in of a well-intentioned organizational intervention strategy. This example is just one of many that could be listed to illustrate the importance of multidisciplinary collaboration in policy and procedure development.

Organizational interventions for public safety agencies must be carefully planned with the assistance and counsel of mental health professionals, buy-in from the rank and file and administration, and support of the community served. The interventions should cover all phases and facets of the public safety employee's career and ensure support for their personal lives as well. An organization's opportunity to show the priority placed on health and wellness begins in the hiring process. Training programs in academies for both new employees and their family regarding critical-incident and cumulative stress, organizational stress, sleep disorders, resilience-building techniques, nutrition, physical fitness, financial wellness, spiritual wellness, and resources available to help the employee and the family in times of crisis are critical. These training sessions and face-to-face visits should not be a "checkbox" completed one time in a career of 30 years or more; rather, they should continue as an ongoing open dialogue between the employees and mental health professionals throughout an employee's entire career.

EIS conceptualization can be broadened to capture a greater variety of potentially problematic behaviors. In New Jersey, while the list of circumstances requiring documentation is extensive, it is focused on behavior suggestive of illegal or at the very least overly aggressive behavior. However, other circumstances could aid in monitoring the well-being of public safety personnel, such as a noticeable increase in overtime and secondary employment shifts, avoidance of going home after work or arriving for work extremely early, isolation from coworkers, complaints of pain, increased sick time usage, complaints of changes in sleeping habits or lack of sleep, unexplained weight gain or loss, changes in eating habits, or

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changes in marital or family residence status. These suggested factors that a supervisor could monitor may not necessarily be part of a formal EIS; nonetheless, they could provide an early alert to trigger a supervisor's probing questions. They are likely not dissimilar from the facts that down the road would trigger an alert or employee assistance program referral. The best case scenario would result in helping an employee before a formal EIS alert mandates an intervention; the worst case scenario would be that nothing is wrong, and the employee perceives their supervisor's care for his or her welfare (given the conversation is framed appropriately)—obviously, a win-win situation. As such, the EIS needs to remain flexible and continually reviewed to ensure any policy changes are reflected.

In addition to training supervisors on the goal of the EIS and the manner in which to assess employees close to alert status or already flagged, organizational staff in other fields may also play a role. The agency's human resource professionals can further enlighten personnel about their available insurance and relevant health care plans, including any employee assistance programs available to them and their support systems. The human resources representative could also have conversations with employees regarding logistical issues, such as sick time, administrative leave, the Family and Medical Leave Act, temporary disability, and worker's compensation, to name a few.

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Chapter 48
Application and Integration of Psychological First Aid in First Responder Organizations

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ABSTRACT

First responders are exposed to many potentially traumatic events throughout their careers. Given the risk of adverse mental and physical health outcomes secondary to frequent trauma exposure, access to culturally-sensitive, evidence-informed early intervention is paramount. Critical Incident Stress Management (CISM) and components therein (e.g., Critical Incident Stress Debriefing, peer support) represent the most commonly utilized early interventions within first responder organizations. Limited research has evaluated these models, and evaluation of early interventions presents many challenges due to characteristics of first responder cultures and organizational demands and constraints. Psychological First Aid (PFA) is a widely endorsed and promising evidence-informed early intervention model grounded in research on trauma recovery and resilience. This chapter examines the theoretical underpinnings and core actions of PFA and describes the potentially diverse applications of PFA within first responder organizations and concludes by discussing recommendations and future directions.

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INTRODUCTION

First responders are exposed to many critical incidents (e.g., Carlier, Voerman, & Gersons, 2000; Malcolm, Seaton, Perera, Sheehan, & Van Hasselt, 2005) or potentially traumatic events that "may cause a given individual's emotional resources to become over-taxed, resulting in a spectrum of reactions from exhaustion to increased and unrelenting mental health symptomology" (Maguen et al., 2009, p. 754). For example, research suggests police officers are exposed to an average of 166 – 188 critical incidents during their careers (Chopko, Palmieri, & Adams, 2015; Weiss et al., 2010). Not surprisingly, first responders are at elevated risk for PTSD, depression, and alcohol use disorders (Berger et al., 2012; Kleim & Westphal, 2011).

Given the potential for adverse mental health outcomes secondary to frequent trauma exposure, access to culturally-sensitive, evidence-informed early intervention is paramount. While definitions of early intervention vary, it has been viewed as secondary prevention efforts occurring in the immediate (0-48 hours) or acute (a few weeks later) phases following a potentially traumatic event (Litz, 2008). Current early interventions within first responder organizations often include elements of the multi-component Critical Incident Stress Management (CISM) model (Everly, Flannery, & Mitchell, 2000; Mitchell & Everly, 2001). However, CISM has not been rigorously evaluated, has not specifically been studied with first responders, and includes components (e.g., Critical Incident Stress Debriefing) that have been called into question (Bisson, McFarlane, Rose, Ruzek, Watson, 2009; Brucia, Cordova, & Ruzek, 2017; Bryant, 2007; Fox et al., 2012; Rose, Bisson, Churchill, & Wessely, 2002; Ruzek et al., 2007; Tuckey, 2007; Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Thus, evidence-based early interventions for first responders have not been established and there are realistic challenges to implementing standardized approaches in first responder organizations.

Psychological First Aid (PFA, Forbes et al., 2011) is a specified set of early post-trauma helping behaviors derived from research-based principles (Hobfoll et al., 2007). While multiple models exist, this chapter will focus on a PFA approach collaboratively developed by the Child Stress Traumatic Network and National Center for PTSD (Brymer et al., 2006). Although this model has great potential, it has yet to be empirically validated for use in first responder populations.

This chapter will initially discuss critical incident exposure and mental health sequelae in first responders and highlight first responder cultures as an important context in which support programs must be designed. Current critical incident and early intervention models will then be reviewed, followed by examination of the theoretical underpinnings and actions of PFA (Forbes et al., 2011) and descriptions of the potential diverse applications with first responders. The chapter will conclude by identifying methodological and organizational challenges in the development, implementation, and evaluation of PFA, and discuss future directions. While first responders (e.g., emergency medical services, fire, dispatch, law enforcement) at large will be considered there will be an emphasis on law enforcement personnel and organizations given the state of the literature.

TRAUMA EXPOSURE AND MENTAL HEALTH OUTCOMES

In the United States (U.S.), civilians' lifetime risk of trauma exposure ranges from 37-92% and the prevalence rate of PTSD is 6.8% (Kearns, Ressler, Zatzick, & Rothbaum, 2012; Litz, Gray, Bryant, & Adler, 2002). While psychological distress following trauma exposure will resolve naturally for most

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individuals, those who continue to experience symptoms beyond 3 months are at increased risk for chronic conditions (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Litz et al., 2002). Identified risk factors for PTSD include perceived life threat during the traumatic event, peri-traumatic responses, previous trauma exposure, self and family psychiatric history, insecure attachment style, and limited social support (e.g., DiGangi et al., 2013; Kearns et al., 2012; Ogle, Rubin, & Siegler, 2015; Renaud, 2008; Woodhouse, Ayers, & Field, 2015). Female gender, younger age, and certain personality traits (e.g., neuroticism, hostility, trait anger, anxiety, and dissociation) are also associated with increased risk of PTSD (e.g., Brewin, Andrew, & Valentine, 2000; DiGangi et al., 2013; Litz et al., 2002; Maguen et al., 2009).

First responders are significantly more likely than the general public to be exposed to critical incidents. For example, research suggests the average 30-year police officer is exposed to between 166 – 188 critical incidents (Chopko et al., 2015; Weiss et al., 2010), and Marin (2012) posited that number may be as high as 250 critical incidents. Berger and colleagues' (2012) meta-analysis suggested that 10% of emergency service workers (e.g., police officers, firefighters, paramedics) worldwide have PTSD, with approximately 400,000 cases in the U.S. alone (Haugen et al., 2012). Prevalence rates of PTSD in police officers range from 4.7% to 19%, suggesting approximately 135,000 U.S. police officers have the condition; many more may experience subthreshold PTSD (Berger et al., 2012; Carlier, Lamberts, & Gersons, 1997; Komarovskaya et al., 2011; Marin, 2012; O'Hara, 2012). Risk factors for PTSD in first responders include cumulative trauma exposure, environmental and work stress, avoidant coping and difficulties problem solving, and poor social support (Beaton & Murphy, 1993; Brondolo, Wellington, Brady, Libby, & Brondolo, 2008; Evans, Pistrang, & Billings, 2013; Haugen et al., 2012; Kleim & Westphal, 2011; Maguen et al., 2009; Marchand, Nadeau, Beaulieu-Prevost, Boyer, & Martin, 2015; Marmar et al., 2006; Meyer, Zimering, Daly, Knight, Kamholz, & Gulliver, 2012; Phillips, LeardMann, Gumbs, & Smith, 2010; Royle, Keenan, & Farrell, 2009).

Beyond PTSD, the most commonly diagnosed psychiatric conditions in first responders are Alcohol Use Disorders and Major Depressive Disorder (MDD) (Kleim & Westphal, 2011). Sterud, Hem, Ekeberg, and Lau (2007) found that 17.7% of male and 9.1% of female Norwegian police officers ($N = 2{,}372$) endorsed hazardous alcohol use. Compared to the general American population (5.2%), rates of depressive symptoms are higher in female (12.5%) and male (6.1%) police officers (Violanti & Drylie, 2008). Stanley, Hom, and Joiner's (2016) systematic review of 63 studies on suicide in police, firefighters, and EMTs/paramedics identified elevated risk of suicidal thoughts and behaviors. Between 2008 – 2012, police officers were twice as likely to die by suicide than be killed in the line of duty (Marin, 2012).

FIRST RESPONDER CULTURES

While there are many first responder sub-cultures, police, fire, and emergency medical services personnel share common characteristics including unique indoctrination procedures, a strong sense of duty, discipline and compliance with rules and authority, and strong allegiance to their organizations, which have hierarchical command structures and long-standing traditions (Brauer, 2016; Cassan, 2010; Liedenbaum, 2011). Norms include working unusual schedules, exposure to inordinate amounts of danger, special privileges (e.g., arrest power), and the ability of superiors to cancel leave due to work demands (Brauer, 2016). Further cross-cutting first responder values and behaviors include communalism, separateness from civilians ("the thin blue line") and isolation from society, keeping work-related concerns in-house,

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caring for others before self ("mission-first," self-sacrifice), exhibition of physical and emotional strength, and compartmentalization and suppression of emotion (Kirschman, 2007).

Importantly, first responder cultures and beliefs about self, other, and the world may pose real and perceived barriers to seeking informal support and/or formal mental health treatment. Mental health issues are often stigmatized, particularly given that many community calls involve responding to mental health crises, and disclosure of emotional distress or mental health concerns may be viewed as weakness. (Kirschman, Kamena, & Fay, 2014). While these attitudes and coping strategies may be viewed as resilient and foster effective first responder work in the short-term, they may inhibit expression, detection, and treatment of mental health problems in this population (Haugen, McCrillis, Smid, & Nijdam, 2017; Kirschman et al., 2014; Wester, Arndt, Sedivy, & Arndt, 2010).

COMMON INTERVENTIONS FOR FIRST RESPONDERS

Given characteristics of first responder cultures and organizational demands and constraints, the development, implementation, and evaluation of critical incident interventions presents many challenges. In the 1990s, Mitchell and Everly (2001; Everly et al., 2000a) developed the multi-component Critical Incident Stress Management (CISM) model. CISM is a comprehensive stress management model utilized by some first responder organizations, with the primary aim to provide various types of mental health support to first responders, their families, and their organizations at various time points before and after a critical incident (Everly & Mitchell, 1999; Everly et al., 2000a; Everly, Lating, & Mitchell, 2000b). CISM includes pre-critical incident psychoeducation about stress reactions and stress management, and assessment of the needs of first responders during or immediately following a critical incident. The model further calls for a group defusing intervention to assess current needs within 12-hours post-critical incident, followed by a Critical Incident Stress Debriefing (CISD) in the subsequent days or weeks. CISM also includes peer support and chaplaincy services, consultation with organization and community administrators to tailor the model as appropriate for the setting, referrals for ongoing psychological distress, and debrief-the-debriefer sessions (Sheehan, Everly, & Langlieb, 2004).

Some meta-analytic studies have reviewed the effectiveness of CISM interventions. Everly, Flannery, and Eyler (2002) conducted a meta-analysis investigating the effectiveness of eight CISM interventions on outcomes, including PTSD symptoms. Results demonstrated large mean effect sizes, suggesting delivery of CISM interventions may mitigate adverse psychological outcomes of trauma. However, these naturalistic studies were not conducted with first responders, and contained many methodological limitations that limited generalizability and the ability to draw definite conclusions.

Within many first responder organizations, isolated CISM components are utilized as stand-alone interventions that are not embedded within the multi-component stress management model. Psychological debriefings are the longest-standing and most common critical incident intervention for first responders, though debriefing structures and content can vary dramatically between organizations and there is confusion in the literature about the definition of debriefings (Bisson et al., 2009; Brucia et al., 2017; Litz et al., 2002; Tuckey, 2007). First developed in the early 1980s, Critical Incident Stress Debriefing (CISD) is the most frequently utilized group critical incident intervention for first responders and is comprised of seven phases: Introduction, Fact, Thought, Reaction, Symptom, Teaching, and Re-entry (Malcolm et al., 2005; Mitchell, 1983). While very limited research has evaluated CISD delivered to first responders (e.g., Bohl, 1995; Carlier, Lamberts, Van Uchelen, & Gersons, 1998; Carlier et al., 2000), multiple meta-

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analytic studies concluded that both CISD and non-CISD stand-alone group psychological debriefings do not reduce psychological distress or prevent PTSD and may even exacerbate symptoms (Bisson, Jenkins, Alexander, & Bannister, 1997; Bisson et al., 2009; Brucia et al., 2017; Bryant, 2007; Carlier et al., 1998; Carlier et al., 2000; Fox et al., 2012; NIMH, 2002; Gene-Cos, 2006; Rose et al., 2002; Ruzek et al., 2007; Tuckey, 2007; Van Emmerik et al., 2002). Notably, the CISM manual explicitly states that CISD is not intended to be delivered as a stand-alone intervention.

In the U.S., Canada, and globally, there is a proliferation of peer support programs in emergency medical services, fire, and law enforcement organizations (Papazoglou & Tuttle, 2018). Although informal peer support has been an integrated part of police culture for decades, some police departments offer formal peer support programs as a way to support the psychological health of officers (Benner, 1982; Graf, 1986; Kamena, Gentz, Hays, Bohl-Penrod, & Greene, 2011; Waters & Ussery, 2007). To this end, the International Association of Chiefs of Police (IACP, 2016) developed Peer Support Guidelines, which provide guidance and flexible recommendations for creating and maintaining a formal peer support program within an organization. Peer support members are specially trained co-workers who serve to normalize and validate the range of decisions (e.g., tactical, emotional) made by officers (IACP, 2016; Kirschman et al., 2014). Peer support members may be particularly well-suited to identify officers in increased distress, and because of the peer relationship, distressed officers may be more amenable to sharing (M. Bloesch, 2018, personal communication; Kirschman et al., 2014). Peer support programs have numerous intended effects, including providing emotional, social, and practical support to those in distress due to personal and work-related issues, and helping officers navigate the challenges of policing (IACP, 2016). Peer support programs may protect against the adverse outcomes of trauma exposure, may reduce feelings of shame, embarrassment, abandonment, and rejection, and may increase help seeking behavior (Graf, 1986; Flannery, 2015; Kirschman et al., 2014).

Limited research has evaluated the effectiveness of peer support programs in reducing psychiatric morbidity (Brucia et al., 2017; Grauwiler, Barocas, & Mills, 2008). Berg, Hem, Lau, Haseth, and Ekeberg (2005) found greater work injuries and perceived job pressures in a nationwide sample of Norwegian police ($N = 3272$) who worked in districts lacking peer support programs and whose populations were greater than 50,000 people. These findings highlight the importance of peer involvement in early intervention programs.

Several support structures for first responders have emerged outside of the workplace. National peer-to-peer organizations have developed (e.g., The Badge of Life, 2018; Concerns of Police Survivors (C.O.P.S.), 2018; COPLINE) in an effort to increase awareness of mental health, support bereaved survivors of duty-related deaths, and prevent suicide (Samuels, 2018). Other innovative models of care include residential treatment programs (e.g., First Responder Support Network) for first responders with post-traumatic stress reactions (e.g., Brucia, 2018; Dunnigan, 2012; Fay, Kamena, Benner, & Buscho, 2006).

In some fashion, CISM model, CISD, and peer support all incorporate information about coping and fostering social connectedness in the immediate aftermath of a traumatic event. However, these interventions have limited empirical support, particularly with first responders. Given the complex organizational demands, diverse roles, and multiple critical incident exposures of first responders, flexible, empirically-informed, principle-based approaches to early intervention are needed.

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CORE PRINCIPLES AND ACTIONS OF PSYCHOLOGICAL FIRST AID

Developed to be utilized in the immediate aftermath of a traumatic event and delivered by mental health and/or disaster response workers, Psychological First Aid (PFA) (Forbes et al., 2011) is an early intervention with primary goals of reducing acute distress and facilitating individual and community short- and long-term resilience, adaptive coping, and functioning (Brymer et al., 2006). The basic standards of PFA are consistent with research on trauma-related risk and resilience, practical for field settings (e.g., emergency departments, staging areas, feeding locations), appropriate for use in individuals across the developmental lifespan (e.g., children, adolescents, adults), and designed to be delivered in flexible and culturally sensitive ways (Forbes et al., 2011). PFA has multiple basic objectives identified as eight core actions: 1) contact and engagement, 2) safety and comfort, 3) stabilization, 4) information gathering regarding current needs and concerns, 5) practical assistance, 6) connection with social support, 7) information on coping, and 8) connection with appropriate services (Brymer et al., 2006; Ruzek et al., 2007; Uhernik & Husson, 2009). Importantly, PFA acknowledges that trauma survivors will experience a range of reactions, that not all survivors will experience chronic symptoms, and that natural recovery is common.

PFA emerged from five core theory-based principles that are rooted in empirical support and that highlight mechanisms of trauma recovery (Hobfoll et al., 2007). The five central intervention principles are promotion of safety, calming, self- and collective efficacy, connectedness, and hope. These principles can guide organizational responses to work-related trauma exposures at the individual, group, organizational, and community levels, including workforce education, peer support, specialist counseling, media communications, and organizational ceremonies and practices (Hobfoll et al., 2007). Further, the underlying principles of PFA are generative tenets that can be creatively applied in culturally appropriate, flexible ways. The following text will describe the five core theory-based principles underlying PFA and the core actions of PFA that map onto these principles; it will also discuss the particular relevance and application of these principles and actions for first responders. These broad principles and core actions are potentially applicable at multiple levels; mental health providers may provide PFA to first responders, and first responders may deliver PFA to each other and to those in the public they serve. Given that many PFA components are nested within multiple underlying principles and core actions, those most salient to each will be discussed.

Safety

Traumatic events threaten self and other physical and psychological safety. In the face of real or perceived on-going danger, the human body is hardwired to make biological and survival driven behavioral and cognitive adaptations (van der Kolk & Saporta, 1993). Bryant and colleagues (2007) posited that promotion of safety in both humans and animals is associated with regulating biological responses, such as the fight-flight-freeze response, that maintain anxiety and fear. Traumatic events also impact safety-related cognitions and threat appraisal such that the ability to realistically appraise threats can be compromised, increasing the likelihood that ambiguous and neutral stimuli will be experienced as real threats (Ehlers & Clark, 2000; Foa & Rothbaum, 1998). As such, beliefs about self- and other- safety and the dangerousness of community environments have important implications for trauma-related mental health sequelae.

Self and other safety concerns map onto two core actions of PFA. Contact and engagement, PFA's first core action, encourages those in response roles to develop non-intrusive and compassionate human

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connections with trauma survivors (Forbes et al., 2011). Specifically, PFA recommends introducing oneself, explaining one's role, and inquiring about immediate needs while respecting confidentiality and upholding relevant ethical and legal standards. The second core action of PFA is focused on the promotion of immediate and ongoing physical and psychological safety and comfort (Forbes et al., 2011; Hobfoll et al., 2007). Re-establishing safety at multiple levels (i.e., individual, group, organization, and community) is emphasized, and ensuring immediate and ongoing physical safety is paramount. Depending on environmental circumstances and personal needs, this may include basic actions like removing sharp objects (e.g., broken glass), asking about the need for medications, eyeglasses, wheelchairs, or other mobility devices, or provision of blankets. It is also critical to assess for ongoing threats to self or others and to identify individuals who may be in shock and in need of immediate medical and/or psychiatric attention.

Given unique cultural factors and the significant risk of work-related trauma exposure in first responder populations, re-establishing physical and emotional safety in the immediate aftermath of a traumatic event may be challenging. Re-establishing physical and emotional safety is likely best delivered via bottom-up and top-down approaches. Immediate bottom-up approaches may include providing first responders with information about tactical response activities and available services, giving them the opportunity to ask questions about what may happen next, and providing support for acute stress and/or grief reactions. Top-down approaches may include dissemination of accurate, organized, and timely information by first responder administrators and other leaders (Shalev & Freedman, 2005). To create a more comfortable physical environment and promote social interactions with colleagues who are coping adequately, organizational leaders may designate a separate staging/recovery area in a safe area for respite, attention to practical needs (e.g., hunger, thirst), and social connection.

Safety-related beliefs are particularly salient for first responders and may present unique challenges to immediate and ongoing post-trauma interventions. First responder training and experiences may alter and/or reinforce prior beliefs and contribute to the development of new self, other, and world safety-related beliefs (Brucia, 2018; Kirschman, 2007; Kirschman et al., 2014; Terpstra & Schapp, 2013). Beginning in the academy, police officers are trained to be suspicious and skeptical of others and to view civilians as "suspects" and potential sources of danger. Research examining risk factors of PTSD in male firefighter cadets ($N = 82$) found that those with fewer negative and catastrophic beliefs prior to work-related trauma exposure were at decreased risk of PTSD one year later (Bryant & Guthrie, 2005). Later in their careers, self and other safety concerns may generalize to broader distrust of non-police individuals, politicians, command staff, and administrators, who may be perceived as unable to understand policing demands, experiences, and culture (Terpstra & Schapp, 2013). Many negative safety-related beliefs held by first responders may prove functionally adaptive in some aspects of the job, but may contribute to psychological distress and dysfunction in other work and non-work contexts. Providing psychoeducation (see below) about trauma reactions and coping on an ongoing basis, including at the onset of first responders' careers as well as in the immediate aftermath of traumatic events, may be one particularly useful way to protect against development of problematic beliefs about personal and community safety.

In the immediate aftermath of a traumatic event, individuals delivering PFA to first responders may encounter individuals whose self and other safety and trust-related beliefs inhibit engagement with mental health providers, and this may be compounded by self- and other-stigma as well as label avoidance (Corrigan, Watson, & Barr, 2006; Goldstein, 2005). Importantly, practical (e.g., duty-related responsibilities) and systemic barriers (e.g., organizational policies that prohibit interactions with others prior to evidence collection and formal statements) may further impede contact and engagement with first responders in need, and compound safety-related beliefs and stigma that contribute to reluctance to

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utilize social support and mental health services. A clear understanding of organizational policies and procedures as well as depth and breadth of knowledge of first responder culture is critical for otherwise well-intentioned mental health providers.

Calming

The second underlying principle of PFA is promotion of calming (Hobfoll et al., 2007). Increased emotionality, anxiety, and hypervigilance and/or affective detachment and numbing are common responses to traumatic events. However, if these symptoms are maintained over time they can interfere with basic needs, such as eating, sleeping, or hydration, and contribute to impairment in concentration, completion of routine tasks, and social connectedness (Goenjian, Karayan, Pynoos, Minassian, Najarian, Steinberg, et al., 1997; Goenjian, Walling, Steinberg, Karavan, Najarian, & Pynoos, 2005; Hobfoll et al., 2007). There is also a well-demonstrated relationship between stress and trauma and adverse physical health outcomes (e.g., cardiovascular, autoimmune disease, chronic pain, GI conditions), as well as increased utilization of healthcare services (Engelhard, van den Hout, Weerts, Hox, & van Doormen, 2009; Hoge, Terhakopian, Castro, Messer, & Engel 2007). Physical and emotional calming may be promoted via psychoeducation that identifies and normalizes early trauma responses, formal relaxation training methods (e.g., breathing, mindfulness, meditation), and relaxing activities that enable teams and individuals to find calm across their daily routines. Indeed, most evidence-based psychosocial post-trauma interventions include promotion of calming as a critical component (e.g., Bryant, Harvey, Dang, Sackville, & Basten, 1998; Foa & Rothbaum, 1998; Foa, Hembree, & Rothbaum, 2007), and an indicator of successful treatment completion is attainment of mastery and calming over the traumatic memory (Forbes et al., 2011).

Promotion of calming relates to the third and fourth core actions of PFA. Stabilization, the third core action, aims to calm and orient overwhelmed survivors who may be numb, unresponsive, confused, or incapacitated by anxiety and worry by engaging individuals in calming strategies. The fourth core action of PFA focuses on identification of current needs and concerns and gathering additional information (Forbes et al., 2011). While multiple factors in the field may limit what and how much information is gathered, PFA suggests asking questions in an effort to clarify the following: nature and severity of experiences during that trauma, death of and/or separation from colleagues and if relevant, family and loved ones, concerns about immediate or ongoing danger, history of exposure to trauma, physical illness and psychiatric conditions and need for medications, losses (e.g., home, neighborhood, property, business), strong feelings of guilt or shame, suicidality and homicidality, access to social support, and/or historical or current substance use. PFA also recommends enlisting nearby family members or friends to comfort the individual, engaging the individual in conversation about their current concerns, remaining calm and quiet, and providing orienting information (e.g., next steps) (Forbes et al., 2011).

Promotion of calming in first responders is vital given research demonstrating first responders are more frequently diagnosed with stress-related physical illnesses than the general population, though it may be challenging (Alkus & Padesky, 1983; Centre for Occupational and Environmental Health, 2000; Marin, 2012). Their training to suppress outward signs of physical and emotional stress enables effective action in response to victims but may reduce awareness and self-regulation of heightened internal states. That said, helping first responders learn to recognize their own distress and arousal and re-establish calm may be accomplished through a variety of strategies. Psychoeducation specific to common psychological, emotional, and physiological reactions during the stabilization phase may also serve to normalize and validate first responders' reactions and challenge negative safety-, doubt-, and

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stigma-related beliefs (e.g., "I'm losing it; I'm not safe because my reactions") and emotional distress, which may in turn foster increased coping self-efficacy. Referrals for professional mental health services may likely utilize cognitive-behavioral and exposure strategies to increase self-awareness of antecedents of anxious distress, gently challenge beliefs, and increase coping self-efficacy (see below). For example, in the immediate aftermath of a traumatic event, anxiety management techniques might include physical, mental, emotional, and self-soothing grounding strategies, such as diaphragmatic breathing and progressive muscle relaxation, which have been found to reduce anxiety and counter intense emotionality (Foa & Rothbaum, 1998; Somer et al., 2005).

Calming interventions for first responders are being implemented. Some police departments in the U.S. and Canada are creating "quiet" rooms for rest, relaxation, or meditation, furnished with comfortable recliners and televisions (McHugh, 2019; PoliceOne, 2017). Christopher and colleagues (2015) evaluated an 8-week Mindfulness-Based Resilience Training (MBRT) program for police officers ($N = 43$) and found significant improvements in self-reported mindfulness, physical and emotional health, perceived stress, burnout, emotion regulation (e.g., anger), resilience, sleep difficulties, and fatigue. These approaches reflect proactive, early organizational-level interventions that may foster calming coping strategies and restoration of homeostasis following critical incidents. In contrast, interventions such as CISD, which involve emotional processing and ventilation, may exacerbate disequilibrium at precisely the time when recently traumatized individuals are attempting to restore calmness (Bisson et al., 2009).

Gathering information about current concerns may guide tailored responses to first responders. For example, emotionally flooded first responders may benefit from immediate and ongoing use of grounding and calming strategies. Alternatively, individuals expressing intense negative self, other, and/or worldviews may benefit from immediate and ongoing use of cognitive interventions (e.g., reframing, gentle thought challenging, crafting more realistic/flexible beliefs). First responders may also present with culturally-unique concerns. For example, specific types of critical incidents (e.g., officer involved shootings) may initiate organizational policies that require an officer's duty weapon be removed from their possession. Approaching the function of firearms from a self-psychology perspective, Feldmann and Johnson (1992) suggested that weapons serve to combat feelings of powerlessness and vulnerability and maintain self-cohesion. As such, police officers who have their duty weapon removed from their possession following a critical incident may feel particularly uneasy and unsafe. To ease such concerns some departments ensure that a replacement weapon is available and provided to officers as appropriate (M. Bloesch, 2019, personal communication).

Self and Collective Efficacy

Promotion of self- and collective efficacy is the third principle underpinning PFA. Trauma can overwhelm one's coping resources and contribute to feelings of powerlessness and helplessness (Hobfoll et al., 2007). The concept of self-efficacy emerged from social cognitive theory (Bandura, 1997) and may be defined as beliefs that one can successfully implement a particular behavior and that one's "actions are likely to lead to generally positive outcomes, principally through self-regulation of thoughts, emotions, and behavior" (Hobfoll et al., 2007, p. 293). Most individuals draw from a broad array of learned adaptive and maladaptive coping strategies in an effort to self-regulate following trauma exposure. Research suggests that the development of trauma-specific adaptive coping self-efficacy is particularly beneficial for trauma recovery and resilience (Benight & Harper, 2002), and that those with greater coping self-

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efficacy may naturally select more adaptive, action-oriented strategies compared to those with lower self-efficacy (Luszcynska, Benight, & Cieslak, 2009).

Bandura (1997, p. 477) defined collective efficacy as "a group's shared belief in its conjoint capability to organize and execute the course of action required to produce given levels of attainment." Given the action-oriented nature of first responder careers, the development and maintenance of collective efficacy vital as it promotes action (Cicognani, Pietrantoni, Palestini, & Prati, 2009). Importantly, self-efficacy and collective efficacy are often interwoven; solving large-scale problems requires the collaboration of multiple people and systems.

Self- and collective efficacy are associated with the fifth core action of PFA, which consists of offering practical assistance, identifying and clarifying the most pertinent need(s), and discussing the action plan (Forbes et al., 2011). Accessing and retaining resources is associated with post-trauma recovery and may foster self- and collective efficacy (Forbes et al., 2011). For first responders, practical assistance may include organizational and peer support, religious activities, briefings, meetings, mourning rituals, and dissemination of information and resources (Benight, 2004; Cicognani et al., 2009; de Jong, 2002; Sampson, Raudenbush, & Earls, 1997). Providing and helping first responders maintain access to these resources may improve self-efficacy, contribute to restoration of dignity and empowerment, buffer against a loss of hope, and promote optimism, a sense of predictability, positive beliefs, and for some religious faith.

To cope with their complex job duties, responsibilities, and exposures, first responders need to be familiar with and confident in their ability to use a broad range of strategies. Learning and rehearsing strategies for problem-focused coping, sleep hygiene, managing media exposure, relaxation, and engagement in pleasurable activities that foster positive emotions such as joy, curiosity, humor, and love, may result in more effective coping (Hobfoll et al., 1991, 2007).

Some cultural norms underlie maladaptive coping. For example, first responder culture condones drinking as a coping strategy. High rates of problematic alcohol use in police officers have been documented and may have the unintended long-term effect of decreasing self-efficacy (Kirschman, 2007; Larson, Eyerman, Foster, & Grfoerer, 2007; Richmond, Wodak, Kehoe, & Heather, 1998).

Given the collaborative and interdependent nature of their work in high risk, stressful situations, first responders are likely to develop collective efficacy beliefs about situations they can master as a group (Cicognani et al., 2009). However, discrepancies may exist between their beliefs about the abilities of their frontline colleagues versus the abilities of command staff and organizational leadership. Further, positive outcome expectations may depend on a just world view (i.e., good things happen to good people, bad things happen to bad people). First responders may be at risk of lower collective efficacy due to past work-related stressors and trauma, organizational demands, childhood and civilian trauma exposure, and minority stress/trauma. Formal assessment and education about the impact of past learning experiences on individual and group beliefs, and training to identify and evaluate maladaptive beliefs and formulate more helpful thoughts may foster greater self- and collective efficacy.

Connectedness

The fourth principle of PFA is connectedness. Trauma can be isolating and alienating, and social support is one of the strongest post-trauma protective factors against PTSD and suicide (Bernert, Kim, Iwata, & Perlis, 2015; DiGangi et al., 2013; Ozer, Best, Lipsey, & Weiss, 2008; Vallieres, Azaiez, Moreau, LeBlanc, & Morin, 2014; Van Orden et al., 2010). Survivors often yearn for immediate connection to

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those with whom they have a strong relationship (e.g., family, close friends, clergy, colleagues), and social support immediately after a traumatic event serves multiple functions, including normalization and validation of emotional reactions and facilitation of problem-solving (Hobfoll et al., 2007). Talking with supportive others can help individuals process emotions and develop a coherent and realistic understanding of traumatic experiences (Lepore, 2001). In contrast, social constraints related to talking about trauma, whether objectively imposed by others' behavior or subjectively experienced due to one's expectations or perceptions, can inhibit trauma processing and pose obstacles to natural recovery (Lepore & Revenson, 2007; Belsher, Ruzek, Bongar & Cordova, 2012).

Establishing and connecting survivors with social support is the sixth core action of PFA. Social support may include emotional support, physical and material assistance, social connection, feeling valued and needed, reassurance of self-worth and that others are reliable, and advice and information. PFA advocates guiding those who are reluctant to seek social support to consider what type of support might be helpful and who they may feel comfortable approaching.

Social support is associated with reduced distress in a range of first responder populations. Specifically, among police officers, social support has been found to protect against mental health disorders, hopelessness, and suicide, and to increase recovery rates from PTSD, even in the absence of a formal treatment intervention (De Terte, Stephens, & Huddleston, 2014; Klimley, Van Hasselt, & Stripling, 2018; Marchand et al., 2015; Violanti et al., 2016). Stanley et al. (2018) found that among firefighters social support received from coworkers, supervisors, family, and friends buffered against the development of PTSD. Dispatchers displayed higher rates of burnout, stress, and anxiety when they perceived a lack of social support (Klimley et al., 2018; Burke, 1995; Kirmeyer & Dougherty, 1988). Regehr, Goldberg, Glancy, and Knott (2002) found that current social support was associated with paramedics' tendency to use mental health stress leave.

While families are often the primary source of support following a traumatic event, it is common for first responders, particularly police officers, to experience a decrease in social support from non-law enforcement family and friends as they progress through their careers (Gilmartin, 2002; Violanti & Drylie, 2008). This decline in support may be influenced by beliefs that "others can't understand me and my job," a desire to not burden family and friends with the stress of first responder work, substance use, emotional numbing and distancing, and feelings of isolation.

First responder peer support programs provide social support in a variety of situations and can be designed to integrate PFA principles and core actions. Although some organizational peer support programs incorporate chaplains as part of the CISM model, these programs tend to emphasize collegial peer support (Gillespie, 2017). In addition to work-related peer and spiritual support, encouraging connection with multiple sources of social support, including connecting first responders with their family members, non-first responder friends, and other community-based social, religious/spiritual, and recreational groups, is especially important. Further, departmental peer support programs may also implement programming specific to first responders' significant others, partners, children, and extended family.

Hope

Instilling hope is of central importance following a traumatic event. Trauma can shatter world-views and contribute to feelings of despair and hopelessness (Janoff-Bulman, 1992). Hope is commonly defined as a "positive, action-oriented expectation that a positive future goal or outcome is possible" (Haase, Britt, Coward, & Leidy, 1992). Hobfoll, Briggs- Phillips, and Stines (2003) note that this view of hope

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may be more consistent with Western, upper-class, and white majority culture, and based on a notion of "rugged individualism" that overlooks realities of those who experience racism, poverty, and/or mass trauma. More inclusively, hope may be viewed as a sense of strength and optimism for recovery. Maintenance of hope is a resilience factor; optimism following a traumatic event is associated with a favorable outcome (Hobfoll et al., 2007).

The seventh core action consists of providing psychoeducation about common stress reactions and coping strategies, which may foster hopefulness about trauma recovery and resilience. As previously discussed, trauma survivors may be alarmed by their stress reactions and their baseline coping tools may be ineffective following trauma exposure. Providing reassurance about trauma responses and teaching a range of adaptive coping strategies may enhance a sense of self-efficacy and foster goal-oriented coping. These coping strategies may include seeking social support, accessing information and resources, engaging in distracting, enjoyable activities and physical exercise, maintaining a normal schedule to the extent possible, utilizing relaxation methods such as calming self-talk, journaling, and grounding. PFA also recommends identifying and modifying maladaptive coping strategies (e.g., substance use, overworking, excessive self/other blame, lack of self-care).

Referring survivors to additional services is the eighth core action of PFA. Providing information about professional support services may instill hope, contribute to calming, and foster a plan for action. Recommended referrals might include mental health care, medical treatment, social support services, and drug and alcohol support groups. When possible, PFA recommends warm hand-offs (i.e., provider-to-provider communication about survivors), which can ease the transition for survivors, increase sense of being cared for, and decrease the burden survivors may feel to "re-tell" their story to multiple providers.

Psychoeducation and referrals for first responders should be couched in terms that are consistent with first responder culture. Ideally, this would include education, during training/academy and then on an ongoing basis, about common trauma responses, the trajectory of and obstacles to natural recovery, the strengths and potential liabilities of first responder culture with regard to emotional and physical well-being (e.g., "it is not a sign of weakness to experience distress, even when it persists"), and adaptive and maladaptive coping. Education should also be provided regarding formal empirically-supported treatment options for post-trauma distress and their efficacy. Organizations should maintain a network of mental health professionals that have the cultural competence and evidence-based training to work effectively with first responders and should take steps to reduce stigma and barriers to initiating treatment (e.g., confidentiality of referrals, warm hand-offs when feasible, assurance that seeking treatment will not negatively influence job status or promotion).

In sum, promotion of safety, calming, connectedness, self- and collective efficacy, and hope are the core evidence-informed elements that guided the design of PFA and are integral components of many evidence-based treatments (Hobfoll et al., 2007). The underlying principles of PFA are interrelated; feeling physically and psychologically safe and calm may increase one's sense of coping self-efficacy and hope for recovery, which may increase likeliness of social connectedness, and positive outcomes of social support likely enhance a sense of individual and collective efficacy (de Jong, 1995; Hobfoll et al., 2007).

METHODOLOGICAL AND ORGANIZATIONAL CHALLENGES

Significant methodological and organizational challenges to evaluating and implementing PFA in first responder organizations exist. In general, conducting evaluations of PFA is difficult. Most broadly, PFA

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is not a structured, one-size-fits-all approach. It is not surprising that there are no published RCTs of PFA given practical and ethical challenges of assessing pre-trauma functioning, randomizing trauma survivors to treatment modalities, delivering replicable interventions in the field, monitoring what is actually happening during those helping encounters (i.e., fidelity, replicability), retaining participants, and obtaining consistent follow-up data.

Evaluation of PFA will be especially challenging in first responder populations, particularly police officers. First, it is likely that PFA would be integrated as one of many components of a peer support program and would not exist as a stand-alone model. Second, although law enforcement peer support program guidelines exist (e.g., IACP, 2011), departments vary in their application of these guidelines. Third, the intended effects of peer support programs are conceptually unclear and may include outcomes both for those whom the first responder helps and interacts with and for first responder themselves. These might be as wide-ranging as detection of symptoms/impairment, prevention of chronic and impairing psychiatric conditions, receipt of professional support/treatment, maintenance of on-the-job functioning, prevention of adverse events, reduction of needed stress leave or workman's compensation cases, and improved employee retention. Fourth, it is ethically and functionally challenging to conduct RCTs, resulting in the self-selection of officers who choose and are selected to participate in peer-support programs. Fifth, it would be rare to obtain a true baseline level of functioning prior to a given critical incident and few psychological assessments have been normed and validated for police officers (Robinson & Mitchell, 1993; Malcolm et al., 2005). Thus, it is acknowledged that rigorous research evaluation of PFA outcomes faces complex obstacles.

Challenges in implementing PFA in first responder organizations are also anticipated. Strong leadership support is needed, and must be sustained across changes in personnel and organizational change. Effective training methods are required to ensure mastery of PFA skills and routine ongoing use in day-to-day practice. Optimal training in PFA would likely entail didactics, observed role-plays with feedback, and ongoing supervision and case consultation. Such continuing support is needed to help trainees continue to apply their skills and reach a level of familiarity and confidence that will lead to continued use. Should they be mastered, the new ways of helping included in PFA will need to negotiate cultural barriers, including previous ways of doing business and countervailing norms of behavior. It remains challenging to encourage openness and sharing of thoughts and feelings in organizations characterized by a commitment to placing others before self and norms of "emotional strength" (Kirschman, 2007). Finally, it may be necessary to alter staffing patterns, shift rotations, use of organizational space, and allocation of resources in order to make it possible for newly trained helpers to successfully deploy their skills. All these considerations mean that leaders intent on building effective PFA programs will need to think beyond simply adding training workshops to include planning for sustained use in the context of local factors and challenges of encouraging busy people to do things differently in busy organizations, where the focus on community service under emergency conditions may push to the side considerations of staff wellbeing. Additionally, ensuring the confidentiality of peer-to-peer supports and referrals for professional services is paramount given internalized stigma about mental health concerns among first responders.

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RECOMMENDATIONS AND FUTURE DIRECTIONS

As demonstrated above, developing, implementing, and evaluating evidence-based or evidence-informed early interventions for first responders following trauma exposure poses many practical, methodological, and organizational challenges. There is an alarming paucity of research demonstrating that the historically implemented early intervention models (e.g., CISD/CISM, peer support programs) are effective at ameliorating acute psychological distress, preventing trauma- and stressor-related disorders, and promoting a natural recovery (Everly et al., 2000a; Everly et al., 2000b; Tuckey, 2007). Clearly, there is a need for innovative, integrative early intervention work-related stress management models that expand on the traditional CISM model or offer novel ideas; this would facilitate assessment of the centrality of critical incident exposure and its interaction with other stressors (e.g., poor relationship with supervisor, overall workplace functioning, family stressors). With high-stress, physically and emotionally taxing jobs, frequent exposure to potentially traumatic events, and higher rates of stress-related physical illnesses, depression, PTSD, alcohol use disorder, and suicide compared to the general population, there is an urgent need for flexible, adaptable, and evidence-based early interventions for first responders. PFA is a promising and widely endorsed evidence-informed model grounded in theories of trauma recovery and resilience. PFA may be particularly well-matched for first responders because it 1) expands on currently culturally accepted interventions (e.g., peer support programs), 2) can be delivered on both mental health provider to first responder and peer-to-peer bases, and 3) may enhance first responders' skill-sets when caring for those they serve. As such, PFA may be diversely utilized and integrated within first responder organizations for an array of purposes. More specifically, multi-component PFA interventions could include staff education and preparation for stressful aspects of the job, response to critical incidents, team-building/morale, peer response programs, specialized crisis counseling and/or treatment, and family programs.

Detailed below are several evidence-informed recommendations. First, the beginning of a first responder career should include comprehensive psychoeducation about common mental health issues, coping strategies, self-care, peer/social support, and resources, and this should be reinforced throughout their careers via continued training. Second, it is recommended that first responders be trained in PFA (Forbes et al., 2011), and that these interventions be utilized in the immediate aftermath of a critical incident and integrated into peer support programs. Such training would likely enhance first responders' knowledge and skill-set in supporting their colleagues and have the added benefit of enhancing their skill-sets when serving their constituents. For example, first responders are exposed to mass disaster and hostage situations, distressed survivors and family members, suicidal and homicidal suspects who may be armed and dangerous, and deaths of adults and children secondary to suicide, homicide, accidents, and natural causes (Golden, Jones, & Donlon, 2014; Kleim & Westphal, 2011). First responders additionally provide emergency medical care and engage in handling of human remains (Golden, Jones, & Donlon, 2014; Kleim & Westphal, 2011). As such, PFA training may facilitate their ability and self-efficacy to provide psychological and practical support to victims and may protect against the experience of a loss of coping ability. More specifically, PFA may provide a clear, organized mental template that first responders can use when tasked with providing psychological and practical support to trauma survivors in the immediate aftermath of a traumatic event. PFA also provides recommendations for death notifications and body identification, which may be particularly relevant for first responders tasked with this challenging role.

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Third, it is recommended that first responder organizations develop peer support programs, particularly in light of research demonstrating social support as a primary protective factor of PTSD and related mental health sequelae. With regard to peer support, it is recommended that peer support programs follow the IACP Peer Support Guidelines (2016) and are confidential, provide ongoing monitoring and support as indicated, and utilize targeted and appropriate interventions for specific problems. For the field to advance, and to ensure that services are actually helping, there will be a need for conceptual clarity about the intended effects of peer support programs. Fourth, it is recommended that intentional efforts be undertaken to assimilate peer support programs as a culturally-normed component of first responder organizations.

Beyond PFA, there is also a need to develop evidence-based teaching interventions to train those who provide peer support, and to tailor these trainings to the variety of existing first responder subcultures. It is now well established that, by themselves, simple training workshops are unlikely to effectively add to staff skills and change routine practice. Instead, they need to be followed by a period of supervision and consultation as trainees try out the new skills and make them their own. A few preliminary yet promising interventions have emerged, including Marks and colleagues (2017) peer support training program titled Recognize, Evaluate, Advocate, Coordinate, and Track (REACT). This four-module training program was designed to promote psychological health and prevent stress injuries in first responders.

Internet and mobile technologies offer significant opportunities to innovation. Given recent technological advances and the potential value of integrating mobile-health into early intervention responses, PFA Mobile was developed and is available for download on iOS and Android operating systems. The mobile app is provides a broad and comprehensive overview of PFA, including the five evidence-informed principles and basic objectives, information about who should deliver PFA and where it should be used, PFA guidelines (e.g., how to engage survivors, recommended behaviors to avoid), and considerations for cultural/diversity factors and supporting at-risk populations. The mobile app contains sections about PFA in practice, the eight core actions, and common reactions across the lifespan (e.g., infants/toddlers, preschool-age, school-age, adolescents, adults). There is also a section within the app that allows for providers to create a survivor needs form as a quick and practical way to keep track of individuals with whom providers come into contact. Provider self-care is another component of the PFA mobile application, including a provider self-assessment and information about self-care before, during, and after relief work. Lastly, the PFA mobile app includes a resource section with direct links to SAMHSA's Disaster Distress Helpful, the National Suicide Prevention Hotline, FEMA, and National Center for PTSD and National Child Traumatic Stress Networks.

At present there is no published research evaluating PFA. While RCTs may not be tenable due to aforementioned methodological and organizational challenges, there is a need for program evaluation research of PFA that is generalizable to first responder cultures, although there are still many obstacles (e.g., funding, organizational support) to conducting this type of research. At present, little is known about whether programs (e.g., CISD/CISM) accomplish their intended objectives, so managers cannot adequately evaluate the cost-effectiveness of their initiatives and, most important, it remains unclear if these programs are effectively reducing individual distress. There is a need to evaluate PFA peer support programs on multiple outcomes such as PTSD, depression, substance/alcohol use, suicide, and social and occupational functioning, and quality of life (e.g., Wessely & Deahl, 2003), and to consider the role of stigma of mental health and broader organizational context in which peer support programs are developed, implemented, and evaluated.

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Perhaps most importantly, in order for leadership to manage effectively and for peer support and other procedures to benefit staff members, it is important that organizations conduct periodic assessments of staff well-being and areas for concern. This information can be gathered anonymously, to evaluate PFA programs and inform their improvement and redesign. Further, first responder organizations are likely to benefit from collaboration with academic partners in order to evaluate current models of support and to develop and investigate innovative and potentially more effective proactive, preventative interventions as well as posttraumatic early intervention models for first responders, who fulfill vital and complex roles in society.

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Chapter 49
Media, Social Media, and the Securitization of Mental Health Problems in Nepal: Yama Buddha's Case Study

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ABSTRACT

This chapter attempts to unfold the trend and nature of mainstream and social media coverage on mental health issues in Nepal through suicide case of Yama Buddha, a popular musician. Using the securitization theory and concepts of threat construction and threat neutralization, major findings through content analysis and key informant interviews reveal reputed mainstream media following cautious route towards threat neutralization and therefore, maintaining a level of journalistic professionalism. However, especially in the other online media, blogs, and other social media, there were sensationalist words and tone used to attract the audience, triggering various sorts of emotional responses, thereby fulfilling the act of securitization. Major recommendations from this chapter include more awareness and understanding about the nature and type of mental health problems; capacity building of journalists and media professionals to better understand and report on mental health problems; development and proper implementation of media guidelines on reporting mental health issues.

INTRODUCTION

Anil Adhikari, popularly known as Yama Buddha, a celebrated Nepali rapper reportedly died of suicide at his residence in Ruislip, United Kingdom on January 14, 2017, leaving scores of his fans and followers in shock. This tragic incident triggered a wide attention about celebrity suicides, especially linking

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to the dreaded late twenty's club of global celebrities such as Jimi Hendrix, Janis Joplin, Jim Morrison and Amy Winehouse. Extensive mainstream and social media coverage of Yama Buddha's suicide also led to the ongoing debates and thereby public discourses on rising cases of suicides and mental health problems in Nepal.

About 90 percent people living in Nepal are suffering from psychiatric problems and there is 'insignificant attention' given to this sector (Uprety & Lamichhane, 2016). Furthermore, the lack of proper knowledge and understanding about the subject matter, lack of mental health specialists; poor implementation of policies and guidelines and lack of adequate resource allocation for mental health sector has aggravated the stigma surrounding mental health in Nepal (Luitel, et al., 2015). This stigmatization has led to under-reporting of many mental health cases and lack of proper care and attention towards the issue.

This chapter attempts to unfold the trend and the nature of stories reported in mainstream and social media on mental health and suicides in Nepal, meticulously unfolding the media reporting about Yama Buddha's case and how different discourses on mental health, suicides and stigma have been developed as a result of the attention the celebrity's death gathered.

Events occurred in this world including suicides are a 'shared reality' held not only by individuals, but also institutionalized in everyday practices and public artifacts such as media coverage (Uchida et al, 2015). While communicating a certain message through media, stories present socio-cultural attitudes and values apart from presenting objective facts, consequently generating a collective perception. However, the story teller or the journalist brings in his/her individuality making stories more interesting. In that sense, media coverage is not just a collective or macro phenomenon, but also comprises of individual psychological facts.

Social media has added a new dimension in the era of communication. Social media sites such as Facebook and Twitter provide that space of inter-linkage where 'weak links' or connections could be established with another person or group without having any previous interaction or good understanding about such people and groups. The power of digital media is as such today that a celebrity suicide case could go viral in no time that such news can have both effects – positive in terms of building a discourse and bringing mental health issues into the mainstream of national health debates on one hand while on the other hand, the lack of understanding about mental health and suicide, in the lure for 'dying to be famous' thus promoting more number of suicides. The fact that the number of Facebook users in Nepal rose from 0.85 million to 4 million in the space of 4 years (2011 to 2014) goes to show the escalating figures of social media usage amongst Nepalese and the impact as well as vulnerabilities it brings along with growing number of users (Anil, 2014).

In that regard, the authors would like to analyze in depth about the type and nature of media reporting on mental health/suicide issues and whether and how the Nepalese media is 'securitizing' such issues. Furthermore, with the social media analysis, it would also be useful in drawing the nature of discourses on mental health issues carried out at the public level and how that is contributing to the construction or deconstruction of stigma surrounding mental health issues in Nepal.

For the purpose of this chapter, the authors collected primary data about Yama Buddha death stories from various mainstream electronic and print media published from January 14, 2017 until end of April, 2017. Ten Key Informant Interviews (KIIs) were also taken with mental health professionals, mainstream media and social media researchers to understand the broader context. Furthermore, relevant literature reviews were undertaken to gather more global and local evidence to gain an in-depth insight and understanding on the issue.

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BACKGROUND

Some studies have attempted to analyze the media reports on suicide – in terms of sensationalizing them in a way to solve problems.

Instances of Securitization by Media

A fact sheet by Media Frame (Pirkis & Blood, 2010) illustrates how media reporting and framing leads to imitation or 'copycat' suicide: when there is repeated and prominent coverage (across multiple media sources and on front page); when the reader or viewer identifies with the person as either someone that is similar to themselves or someone they look up to such as a celebrity; when certain subgroups in the population (e.g. young people; people experiencing a mental illness) may be more vulnerable; and when there are explicit descriptions of the method or location.

Interestingly, there are evidences to illustrate that celebrity suicides had more of imitation/copycat effect than non-celebrity suicides. A comprehensive study covering meta-analysis of 419 findings from 55 studies revealed that studies based on celebrity suicides were 5.27 times more likely to report a copycat effect than studies based on non-celebrity suicides (Stack, 2005).

Of 13 studies of television news reports of suicides on at least two of three national TV networks in the USA, an increase in suicide rates was found after the reports in 10 of the studies. Five of these 'positive' studies were of teenage suicide rates and one was of suicide rates in elderly people. Of 10 further studies of news coverage of suicides in more than one news medium, an increase in suicide rates was found in six (Programme, 2003). In some there was clear evidence of the direct impact of the reports on subsequent suicides (e.g. following the suicide of a very popular Japanese pop singer and of Miss Hungary).

Celebrity suicides are clearly newsworthy, and reporting them is often regarded as being in the public interest. Reports of suicides by famous entertainers and political figures are particularly likely to influence the behavior of vulnerable individuals, because they are revered by the community. Glorifying a celebrity's death may suggest that society honors suicidal behavior (WHO, 2008).

A particular incidence of securitization of a celebrity suicide case using Twitter can be understood from a tweet by the Academy of Motion Pictures and Arts (Dewey, 2014) which tweeted an image of Robin William's death with the phrase, 'Genie, you are free'. The impact of this tweet was as such that almost 340,000 retweets were made, violating the ethical norms of talking about suicide using social media.

Likewise, a review about media reporting on mental health issues (Ma, How the media cover mental illnesses: a review, 2017) of more than four decades of published studies revealed that media portrayals of mental illness were consistently inaccurate and unfavorable; people with mental illness were labeled as inadequate, unlikable, and dangerous. The review further indicated that media portrayals of mental illness influenced people's knowledge and attitudes toward mental illness and that negative depictions could have an unfavorable impact on people's attitudes toward people with mental illness.

Similarly, some of the studies provided evidence that reporting of the graphic and disturbing details of suicides might act as a deterrent, putting people off suicide as a solution to their problems, and that in fact 'sanitizing' the reporting of suicides might encourage suicidal behavior. Although there is evidence to suggest that features which include graphic or disturbing images of suicide methods may inform the majority of the audience about the dangers of a particular method, those individuals who are most at risk may actually be attracted to or encouraged by the same graphic details (Programme, 2003).

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Furthermore, there have been numerous other empirical studies showing media's influence in negative portrayal of mental health problems. A study in 2005 found almost 40 percent of newspaper stories portrayed mental illness as dangerous and violent, and the stories often appeared in the front section. Likewise, reviews of the US media found rates of dangerousness of 85 percent in representations and particularly controversial reporting of schizophrenia. Similar trends have been identified in New Zealand and Australian studies, where identified dangerousness in 62 percent of 600 articles drawn from a four-week timeframe. In a particular review of representations in various media over a one-month period, using content analysis, themes of violence and dangerousness were identified in more than 60 percent of the 562 articles. Likewise, another study found significant negative reporting in 1035 articles over a one-year period, and 50 percent of reports depicting danger (Knifton & Quinn, 2008).

Instances of Desecuritization by Media

Although majority of media stories tend towards sensationalizing the mental health issues, especially celebrity suicide cases owing to various socio-political and economic context, there have also been some instances of media encouraging desecuritization or normalizing such suicide cases.

There have been instances of desecuritization through media to discourage such acts such as an Australian study of reporting of Kurt Cobain's suicide in a range of media found that rates of suicide among 15-24 year olds fell during the month following the reporting of Cobain's death as the media was highly critical of the musician's act (Pirkis & Blood, 2010).

A review of 41 empirical studies conducted in 12 years shows that although negative portrayals of mental illness still account for a large portion of the research findings, researchers also found the number of such stories is decreasing (Ma, 2017). In that review, a study revealed recovery about mental illness and advocacy action was beginning to be discussed in the media, and more stories focused on biological or environmental causes instead of personal or parental blame. The researchers claimed that this finding was good news because previous research suggested people tended to view people with mental illness as more responsible for their condition than those with other health disorders. Likewise, another study found a large proportion of articles on autism sampled from The New York Times and The Washington Post provided more solutions for autism than causes and more often used medical experts as the news sources, which could help normalize this disorder.

There have also been efforts to desecuritize mental health issues using various social platforms. One such is PatientsLikeMe.com where people suffering from an illness exchange information with others with the same condition, e.g. to find alternative treatment opportunities. Forums such as these promote a patient centered approach to discuss and share problems, experiences in disease control initiatives – including mental health.

Due to the greater influence of media to influence policies, there have also been some instances of mental health policy influence through media with the help of strong evidence. In Australia (Meurk, Whiteford, & Head, 2015), media have contributed to making mental health a national issue. This has been possible with the global attention towards mental health with the combined with the global reach of media to promote inter-cultural dialogue and bringing stakeholders together for required policy uptake.

The 'shock' and 'celebrity' factor appears to count higher in rating the newsworthiness of a suicidal event than broader issues (debt, depression, despair) that may have a greater resonance with readers/audiences lives (Trust, 2007). At the same time it is evident that media coverage of suicide and suicidal

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behavior can and does highlight important social and societal issues, especially where time and space is given to examining context and considering policy implications.

Media Ethics on Reporting Mental Health Issues

BBC Editorial Guidelines (BBC, 2017) also provides various tips for journalists in reporting suicide cases such as: avoiding language which sensationalizes or normalizes suicide, or presents it as a solution to problems; avoiding prominent placement and undue repetition of stories about suicide; avoiding explicit description of the method used in a completed or attempted suicide; avoiding detailed information about the site of a completed or attempted suicide; wording headlines carefully; exercising caution in using photographs or video footage; taking particular care in reporting celebrity suicides; showing due consideration for people bereaved by suicide; providing information about where to seek help and recognizing that media professionals themselves may be affected by stories about suicide.

In specific country contexts, Media Guidelines prepared by Ministry of Health of New South Wales, Australia (Health, 2014) suggests the following considerations for reporting suicide:

1. **Volume and Prominence:** Positioning the story on the inside pages of a paper or magazines, or further down in the order of reports in TV and radio news
2. **Context:** Reporting the underlying causes of suicide (e.g. mental illness, drug-related illness or other familial or social risk factors) can help dispel myths and increase community understanding
3. **Method and Location:** Detailed descriptions of suicide methods can prompt some vulnerable people to copy the act. If it is important to the story, discuss the method in general terms only. Particular care should be taken not to promote locations as 'suicide spots' or 'hotspots'.
4. **Add Crisis Support Contacts:** Including phone numbers for 24 hour crisis support services to provide immediate support to those who may have been distressed, or prompted to act, by the story
5. **Language:** If the story is about a death, use the term 'suicide' sparingly and check the language you're using does not glamourize, sensationalize, or present suicide as a solution to problems.
6. **Celebrity Suicide:** Celebrity suicide is often reported where it is considered to be in the public interest. To minimize risk, ensure the story does not glamourize suicide or provide specific details about method or location of death.
7. **Interviewing the Bereaved:** The bereaved are often at risk of suicide themselves. Follow media codes of practice on privacy, grief and trauma when reporting personal tragedy.

Likewise, in early 2009 the Canadian Psychiatric Association issued a position paper on safe media reporting (Medicine P., 2009). The paper urges reporters to avoid the following: giving details of the suicide method; using the term 'suicide' in the headline; including photos or admiration of the deceased; repetitive, excessive, or front page coverage; 'exciting' reporting; romanticized or simplistic reasons for the suicide; the idea that suicide is unexplainable; and approval of the suicide.

Theoretical Framework

Authors, through this chapter have used the Theory of Securitization (Buzan, Waever, & Wilde, 1997) first conceptualized in the mid-1990s. The basic notion of securitization is the positioning through speech acts of a particular issue as a threat to survival, which in turn enables emergency measures and

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the suspension of 'normal politics' in dealing with that issue. The notion of securitization has also been closely linked with linguistics through scholars like Jacques Derrida. Derrida's theory of deconstruction, where his famous quote that "a text matters more for what it does than for what it says".

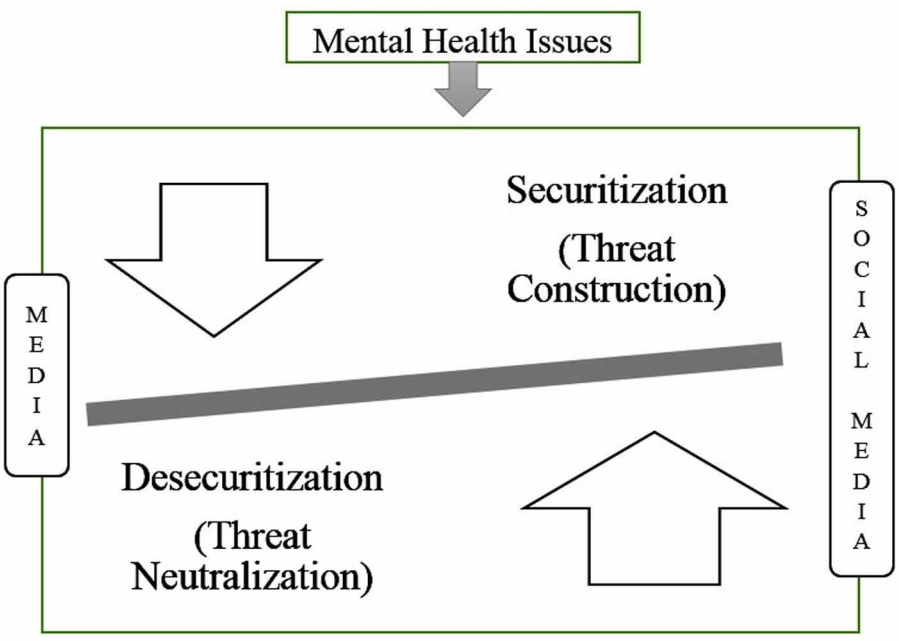
Authors have also aligned their analysis of the stories covered in mainstream and social media through the lens of Copenhagen School of Security Studies (Sulovic, 2010), conceptualizing security as a process of social construction of threats which includes securitizing actor, who declares certain matter as urgent and a posing threat for the survival of the referent object, that, once accepted with the audience, legitimizes the use of extraordinary measures for neutralization of the threat.

This sort of analysis is very important in the current context of the use of social media for developing and spreading fake news about suicides of certain celebrities that create a lot of fear, shock, anxiety and confusion among the public, thus contributing to the stigma surrounding mental health/suicide issues.

Therefore, for the sake of analysis of this case study, the term securitization has been defined as the process of sensationalizing the celebrity's death and his act of killing with the deliberate use of certain words and terminologies – thereby contributing to threat building with regards to suicidal tendencies. Likewise, the process of desecuritization has been linked with efforts by media to normalize the act of suicide and rather promote better education and awareness of mental health problems.

In a figurative presentation, the theoretical analysis of this chapter rests on analyzing the elements of securitization and desecuritization prevalent in reporting mental health issues by Nepalese mainstream and social media (see Figure 1).

Figure 1. Securitization and Desecuritization of Mental Health Issues



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FINDINGS

Mainstream and Online Media Coverage

Republica (Sharma, 2017), covered this event of Yama Buddha's death with the title, 'Famous rapper Yama Buddha no more'. The choice of words in the title is mild with no negative connotations hinting at suicide or any mental health problem, therefore no direct association of securitization can be drawn directly from the title. The phrase 'no more' just suggest the rapper's death and the readers need to read through the content to get more details of the content.

As in the title, the content of the news also avoids any terminologies that securitizes the mental health issues or suicide incidents. The news agency attempts to put forward its event based reporting. Excerpts from the media story:

In an apparent suicide, famous Nepali rapper Anil Adhikari, widely known as Yama Buddha, has been found dead here on Saturday morning.

Quoting the family sources, journalist Bhagirath Yogi of BBC reported that the singer committed suicide in his residence in northern London.

Marhatta added that the cause for the death will be known only after the postmortem is conducted.

With lack of detailed information, the news agency does not give any suggestion or indication about the cause of his death. Professional ethics also seems to be maintained while the source of the death has been quoted (BBC) as well as mentioning the death of the rapper ('in an apparent suicide').

Some of the interesting reactions to the online version of the story are:

It is more important to not lose hope than winning. I am having a nightmare before sleep.

Damn, goose bumps as I read this!

My soul is dead hearing this.

These reactions suggest that shocking news that too of a suicide of a celebrated rapper could trigger grave responses from their fans and the reactions could be very pessimistic such as the ones mentioned above ('having a nightmare before sleep' and 'my soul is dead hearing this').

Daily Mail (Summers, 2017) chose a very long and provoking title: 'Nepal mourns its 'voice of a generation' after the mysterious death of the country's most famous rapper who was found hanged at his wife's parents' home in a west London suburb' of the event. The choice of words used by the news agency definitely has a securitization angle with description of the cause of death (found hanged at his wife's parents' home). Likewise, the phrase 'Nepal mourns its 'voice of a generation' also an attempt to trigger an overwhelming response especially from youth and music fraternity. The story is mentioned as 'exclusive' news in block letters, specifically highlighting that Yama Buddha had hanged himself in the bathroom.

The major content of the story provides a detailed description of the event such as:

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When his father-in-law went to use the bathroom at 6am he found he was unable to open the door and could not get an answer.

Eventually he forced his way in and found his son-in-law hanging from his belt in the bathroom.

The rapper had not left a note and friends and relatives are mystified why he would want to end his life.

Providing as detailed information as possible to the readers could be the motive behind publishing such content by the media agencies. However, these sorts of explicit descriptions may also lead to securitization and result in negative connotation of the news agency.

Some of the interesting reactions to the online version of the story are:

The disillusionment of many people in this world is reaching epidemic proportions. So sad to see this happen.

I am a Nepali and I am baffled by his suicide. He could get any sort of help from his fans if he had appealed or gave some signals. It feels so bad. Why?

Nepal is one of the poorest countries in the world and has spent several decades in severe political turmoil. After what they've been through I very much doubt if the country has been "thrown into mourning" by the death of a rapper.

Why would he kill himself when he got the world? There is more to it.

There have been mixed reactions to this story. While the fans of Yama Buddha were in despair, there was also desire to know more about the cause of his death. Likewise, the reactions also suggest the worry about the increasing trend of mental health problems. One of the interesting comment was also related to the title of the story – with the inclusion of the term 'thrown into mourning', clearly having the securitization element to gather attention to the readers while the situation might not have been so extreme.

The Himalayan Times (Times, 2017), a mainstream English news daily chooses a shorter self-explanatory title, 'Yama Buddha commits suicide' to cover the event. The title provides an enough detail for the readers regarding the cause of the rapper's death and moreover as debated by various mental health experts, deems the act as an offense with the term 'commits suicide'.

The Himalayan Times presents an event based reporting of the incident as per the available information, also quoting the source of information:

Famous rapper Yama Buddha has reportedly committed suicide. Anil Adhikari, popular as Yama Buddha, reportedly took his life at his residence in northern London on January 14, according to BBC Nepali Service. He was 29 years old. Quoting his family sources, BBC Nepali Service confirmed that his dead body was found in the bathroom.

There were no apparent reactions to this coverage by the news agency in the comments section.

A popular online website among non-resident Nepalese, Canada Nepal (Baral, 2017) also chooses a similar shorter self-explanatory title, 'Rapper Yama Buddha committed suicide'. Similar to the choice

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of words for the title by The Himalayan Times, Canada Nepal opts for usage of the term 'committed suicide' linking it as an act of offense.

Canada Nepal chooses to provide a rather detailed account of the event – not just informing about the death of the rapper but also additional detail of his death, stating that he was found dead in his bathroom. However, the tone of the story does not have an explicit securitization angle as it obtains its information from trusted sources (such as BBC and family members) and mentions that additional details about the cause of the death would be revealed after the post mortem report.

In an apparent suicide, famous Nepali rapper Anil Adhikari, widely known as Yama Buddha, has been found dead here on Saturday morning. Adhikari's brother-in-law Resh Marhatta confirmed the death talking to Republica Online. BBC Nepali Service said that the rapper is no more. Quoting the family sources, journalist Bhagirath Yogi of BBC reported that the singer committed suicide in his residence in northern London.

According to family sources, the singer was found dead in his bathroom at around 3 am. Adhikari, 29, had been living in London with his wife. The dead body has been kept at Northwick Park Hospital, Harrow. Source added that police have told the family members to contact them only on Monday. It is learnt that the postmortem will be conducted on Wednesday. Marhatta added that the cause for the death will be known only after the postmortem is conducted.

Another online Nepali portal XNepali.net (2017) does have a securitization component in its coverage. The title itself is attracting the audience when it says, 'Why Yama Buddha committed suicide?' for the audience to be interested to know the cause of its death.

The news agency put forward its arguments to its readers questioning the official report of the rapper's death that it was a suicide case.

This story also has many horrific pictures about the dead body of the rapper further securitizing the act of suicide.

An online portal, Habamoment.com (2017) explicitly mentions about the cause of the rapper's death and also associated with other celebrity suicides with the title, 'Yama Buddha and Three Other Nepali Celebrities Who Committed Suicide'.

The online portal discusses about how Yama Buddha's death 'has made all Nepali think about all high-profile suicides in Nepal'. The article has a negative tone filled with shock with the choice of words such as: "he had name, fame, money, and most importantly the love from his family, wife, and fans but who knew that he too had the courage to kill himself!"

The title of the story by another online portal Update Medicine (2017) attracts the audience in terms of asking the audience one pertinent question: 'The Case of Death: Suicide or Murder?' Through this title, the story gathers attention of the readers to unfold the mystery surrounding the rapper's death.

The story follows a negative tone, inclined towards a fan/follower's reaction towards his death. The story provides additional detail about the death of the rapper and some of the suspicions surrounding Yama Buddha's death:

His near ones say he had not been under any ongoing personal conflict with anybody. After hearing the news, some people in Nepal had some kind of suspicion (correlating to Rap & Hip Hop Culture) that Rapper abused some form of drug before it all had happened but it is said the post mortem examination

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did not find evidence of drugs over his body. Rather it's been said that they found some traces of alcohol regarding which it said that he had drunk few sips of wine with his wife after returning from his work at Royal Mail that night.

The Guardian published an article the next day stating that rapper's father in law found him after his second attempt to open bathroom door with the next set of keys they had inside the house. On the other hand, other media sources state that it was another person living in the next floor of the same house who on an attempt to enter into bathroom that morning found the door locked from inside. He then opened the door with the next keys and found him hanging dead. The same question gives rise to next suspicion that how can a door be opened with the next key from outside when it was locked with the original set of key from inside.

It has also been reported that torn pieces of passport was found on the scene but the reason behind and its relation with his death still remains a mystery. There seems no other way to assume why Yama Buddha had done so. The absence of any reports regarding the footprints investigation has also become the matter of suspicion. Another mystery regarding this case is relevance of fractured lower molars (some sources report lower jaw) with hanging. It is still unclear if those got fractured before it all took place (due to some other incident) or the knot simply broke off after his death leading to that fracture.

The story had plenty of securitization elements especially with the big bold sub-headings such as 'Who saw the dead body first?' and 'The torn pieces of passport and the torn pieces of molars/jaw'.

Barun Ghimire, a Nepali blogger pays an emotional tribute through his blog (Ghimire, 2017) to the rapper as reflected in the title, 'Rest in Beats Yama Buddha'. Ghimire attempts to desecuritize the event with suggestions on more awareness about suicide and mental health issues.

We need to connect, communicate and care if we are to combat suicide. Let us work together towards suicide prevention and let people know them that they matter more than they think they do. We need to talk about suicide and create awareness in the underlying cause or at least we need to explain to everyone that suicide is not the ANSWER.

To those who want to express respect and tribute to Yama Buddha, I urge them to work towards suicide awareness and suicide prevention so we'd deal with actual killer. Let's talk about suicide and spread awareness. It is high time we do something about it.

Ghimire also expresses a strong message that 'suicide doesn't end the chances of life getting worse, it eliminates the possibility of it ever getting any better'.

Another attempt of desecuritization to this story was made by a blogger Shiva Neupane from Melbourne in his letter to The Himalayan Times (Neupane, 2017) emphasizing on more diffusion of academic knowledge and awareness on psychological studies especially to the younger generation as he writes:

We all have different level of capacities to resist suicidal tendencies. The capacities come from our deeper understanding of life, and the way we look at what it means to live. As long as we are mindful in what it takes to know the internal locus of control, then nothing would happen to us. However, it is

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our independent mindset to contemplate the entwined fabric of our likes and dislikes about our own boundary of our personal life.

Surprisingly enough, we can see the national and international examples that even the celebrities who have name, fame and money commit suicide just because of their pseudo-views that may be logical for what they do in the first place. The society is the sole- reason why they commit suicide. Directly or indirectly society is culpable for blanketing the individual's framework of understanding about how they view life in which they are encapsulated.

What I personally perceive is the material gains may not fulfill our life. The singer lived in the sophisticated city of London. However, he committed suicide. This reflects the fact that it is not a conscientious decision to readily accept the fact that the people's class and status may not be the only yardstick to measure that they are living in harmony with peace of mind. When there is no peace of mind it doesn't matter how rich you are or how popular you are, death will steal you away in a matter of few minutes. We need psychological studies about mitigating and finding the root causes of this kind of incident.

Social Media Coverage

YouTube

A YouTube video by a channel, Efact TV (2017) has uploaded a video on January 15, 2017 explaining the reason why Yama Buddha committed suicide. The video as of April 11, 2017, 6 am Nepal time has reached 267,573 views with 1220 likes and 145 dislikes.

The title itself has a lot of securitization element with the choice of words, 'Why Yama Buddha hanged himself using belt?' drawing curiosity among readers in terms of not just the cause of the suicide but also the method used by the rapper to kill himself.

The video mentions that the rapper killed himself by hanging in his bathroom. The video also provides details of his hanging mentioning why he chose belt as the rod to hang clothes was located at some height and using belt was easier. The video also mentions that the reason behind his act of killing himself mainly was the gradual erosion of his popularity which sore in 2002/03 and then there was downfall which led him to prolonged depression.

Some of the viewers of the video have commented suspecting the details provided by the media that the rapper woke up from his bed at around 3:30 am and was inside the bathroom for more than 3 hours without his wife even noticing that while she was just sleeping beside him.

Another YouTube video by Thuloparda TV channel (2017) uploaded on January 28, 2017 shows the pathetic emotional condition of a father while his son's corpse was brought for cremation to Kathmandu. This video with images of his corpse surrounded by his family members and relatives along with scores of his fans and other commoners interested to take his photograph triggered a lot of rage amongst its readers. Some of the readers' comments were:

How insensitive people have become? In such a tragic moment, some people are finding it interesting to take photographs using mobiles while the poor parents are in such a shock.

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So sad to see that most people are concerned taking pictures only instead of offering prayers and condolences.

Likewise, this video also triggered some of the extreme reactions from the rapper's fans, thus fulfilling the securitization motive of the media agency:

Why is media all the time trying to prove that Yama Buddha committed suicide by assuming that he went into depression after being revealed publicly that the celebrated rapper was earning money by being a postman in the UK?

This life is such a waste! All the time we are worried about what we don't have and what others have. Ultimately, we all will be worthless one day!

Another YouTube channel NK TV goes further extreme in terms of choosing its title for covering the Yama Buddha story. The chosen title is 'True story behind Yama Buddha's death now revealed: the reason you hear will shake your heart'. The choice of words used in the title such as 'true story now revealed' and 'shake your heart' has securitization move. Consequently, this video had a high viewership (422, 307 views with 2161 likes and 243 dislikes as of April 11, 2017, 6:30 am Nepal Time).

This video without citing any source provides an elaborate description on why Yama Buddha killed himself mentioning that the rapper was in a state of worry with him residing in his in-law's house in the UK. Furthermore, the media states that he went into a state of depression having lost all his pride as a celebrated rapper in Nepal and having to work as a postman, delivering letters in the UK. He went into contemplating how could he earn his living just by singing rap songs? According to this channel, one incident really triggered Yama Buddha in killing himself. Once while he was delivering letter in one of the residences in UK, he met one of his fans. She was so excited to meet him. She called all her friends and took photographs with him. This incident went viral on social media and everybody came to know that a celebrated Nepali rapper was doing the 'menial job' of a postman in UK. Furthermore, sympathizing his condition, those people who knew him used to give him tips while delivering letters, which made him feel very uncomfortable. The media concluded that the rapper being fed up with his life, ultimately, committed suicide.

Another YouTube channel Nepal Reviews chooses the title, 'Yama Buddha suicide letter' with the strategic attempt to securitize the story and attract more viewership (Reviews, 2017). There is no mentioning of the suicide letter. Instead the video runs through some of the photographs of the rapper and the audio narration in the background explaining the reason (all based on assumptions and no quoting of the source) why the rapper killed himself. The channel claims that he had already had a fame but deep down he was frustrated. He was not able to make money and was also into drugs occasionally. He was struggling financially to keep up to his name.

With the choice of emotional words, the channel makes an attempt to securitize this story to his followers:

It might be true that good persons go to heaven earlier. He used to rock at live performances. The Almighty might also be interested in his live performances – so the God also might have been interested in his live performance.

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Naya Naya News Nepal – another YouTube channel chooses to desecuritize the Yama Buddha case (2017). Published on January 30, 2017 (with 102, 069 views – 367 likes and 66 dislikes as of April 7, 2017 6:30 am Nepali time), with the title, 'Who is this Person who is revealing death secret of Yama Buddha?'

Rather than providing any first-hand detailed account of the rapper and its audience, this video is more of a commentary about the social, psychological and economic factors leading to the rapper's death:

Why competent youth go abroad? This trend needs to stop. This death teaches us a lesson how to manage our life effectively. There is a trend of Burger nationalism where competent youth go abroad and preach about how Nepal should develop. Yama Buddha wasted his time and competence by engaging in menial jobs such as that of a postman. Some people assumed that he was embarrassed and depressed after it was revealed in social media that he was working as a postman. Yama Buddha's weakness is not to feel proud about the work that he was doing. We should not do activities that embarrass us. Recently, another youngster committed suicide after his piracy scandal of Chakka Panja movie was revealed. Life is not synonymous to sadness and failures. Life should be spent with joy and happiness. He/She should do justice to the talent/skills he/she bears. There is an increasing trend of going abroad to earn money. Student visa has been misutilized not to study abroad but to work as laborers. Greater attention needs to be paid in terms of stopping from going abroad in the lure of earning dollars, getting depressed and committing suicide. There is no point of toiling hard in the abroad. Rather than that, it would have been worthwhile to work hard in own homeland and do something for the country.

Furthermore, the video also talks of various pertinent questions raised in the social media about his suicide such as:

In Britain, there wouldn't be appropriate place to hang oneself inside the bathroom.

Yama Buddha's wife who had slept with him – how could she not notice that her husband was in the bathroom for over 3 and half hours and the dead body was noticed by another member in the family only in the morning?

Yama Buddha's jaw was also broken. How did that happen?

How was the door of the bathroom unlocked?

Overall, the video makes a good effort to desecuritize the story and give a positive message to its viewers with these closing remarks:

These [assumptions made in the media] are all just unproven doubts and until they are proven, we should not be highlighting these issues in the media. We should not be assuming that this could have happened and that could have happened.

Rather we should support the family of the deceased at this time of need.

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A talented Yama Buddha – how he spent his life was a wrong message. Nepali youth should take a lesson from this tragic event.

Twitter

There has also been mixed reactions from Yama Buddha's fans and other general public reacting to his death. Some of the interesting tweets collected by the authors are as follows:

I feel ashamed to see the fake cheap videos on YouTube regarding Yama Buddha' death and people accusing his wife who isn't in right state of mind

And the irony is that it took the death of a celebrity for many Nepalese to understand that depression is deadly.

Let the poor soul, loved by everyone rest in peace. Dammit, don't use his death as earning source. Truth will find its way.

Please, stop putting up Yama Buddha's picture as you DP, it's unpleasant, the reminder of his mode of death.

We can't judge anyone as a coward unless we dun know the pain behind the suicide as their last way out.

With curiosity searched about Yama Buddha, ended up with Kurt Cobain's' suicide note

Couldn't tear out a single page of life, so decided to throw the whole book into the fire.

I wish all my books to do suicide like Yama Buddha

The demise of Anil Adhikari (Yama Buddha) Yama Buddha resembles Swiss cheese, lots and lots of holes. Does not sounds suicide to me.

I wish I could actively get involved in case of Yama Buddha's death/suicide conspiracy. I had few question to ask to his acquaintances.

Yama Buddha, you had the guts to commit suicide. There are several people who have no desire to live longer but are not able to kill themselves. You are great.

Yama Buddha is a legend in his own right. His death (reportedly suicide) bursts the bubble our newsrooms & society in general dwells in.

I also have an excuse to kill myself, but I these days I also seek to find excuses to live every day and defeat the death.

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People say that suicide is a permanent answer to a temporary problem, but sometimes that problem isn't so temporary.

If Yama Buddha had really committed suicide, then he must be a coward.

Thus, these reactions are filled with extreme love and support and at the same time hatred for the rapper as well as disappointment in his act. Some of the tweets do have desecuritization elements – with appeals to leave this case aside and not to blow this story out of proportion but rather analyze the contexts that lead to such acts and hopefully control such incidents in the future.

Facebook

Similar reactions were received on Facebook and with no word limitations as in Twitter, there have been elaborate discussions about the causes of his death and in general why people, especially celebrities end up killing themselves.

Anil Adhikari's (Yama Buddha) death by suicide is a sad news indeed as is hundreds of Nepalese who commit suicide every year. Mental illness is still such a stigmatized subject. It's about time we speak out about it and encourage people in need to seek support!

Am I the only one who wants to find out the actual reason behind the so called 'suicide' of Yama Buddha? What is written in Nepali news sites is so unclear. Hope to find out the reason soon. I still can't believe that he did suicide and he is with us no more) I am so confused.

I read somewhere, suicide is a temporary solution of a permanent problem. I don't know if you ever read that, but I'm sad to let you know that the problem that you thought you got rid of just got amplified by a larger scale. You thought that you had a valid reason to decide for yourself, but, do we really get to decide for ourselves?

If he had committed suicide there's no space for him on heaven.

Yama Buddha did not commit suicide because he was weak or out of options or in pain. He was just too fed up with these human structured unemotional machines. He only tried to escape them.

As illustrated above, some were in total shock and disbelief about the incident and blamed Nepali media for not providing clear information about his suicide. On the other hand, there were also attempts made to understand the real context that led him to such circumstances as well as appeals to discourage such acts by being sensible and attempting to address our problems rather than taking an escapist route.

Findings From Key Informant Interviews (KIIs)

Few mental health and media experts were also consulted through Key Informant Interviews to gather their perception and opinion about the media coverage of mental health issues in Nepal, particularly linking with celebrity suicides.

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Limited Understanding of Mental Health Issues

Both mental health and media experts have pointed towards limited understanding of mental health issues in Nepal.

Mental health as a discipline is very broad subject in itself. However, due to very less proportion of mental health experts, wide misconceptions regarding mental health exists. It is therefore imperative that wider awareness, knowledge and understanding regarding mental health needs to be spread to the public. – Consultant Clinical Psychiatrist

As a mental health researcher, sometimes I am surprised that even the 'educated' and 'informed' citizens have very limited understanding of mental health. Major reasons for this could be limited academic orientation on the subject; lack of resources easily accessible about mental health through the media and social media; more focus on urban settlements – linking mental health issues more towards work related stress management, anger management, depression, among others. – Mental health researcher working in an NGO

As a journalist reporting for the past 9 years on health and social sector, as an honest confession, I admit that I have limited understanding of mental health issues. We have very few journalists (equal to none), who have academic background on health reporting in Nepal. – Journalist of a national daily

Capacity of Journalists to Report on Mental Health Issues

It is striking to notice that the media sector itself was skeptical of its capacity to understand and report mental health issues in a proper way.

The reality of media reporting needs to be taken into consideration. Media professionals are educated mostly on the theories and practical approaches to journalism and mass communication. Yes, we do have some academic training on development journalism, but in terms of mainstream media coverage, the principles of development journalism are not applied to a larger extent. Nowadays, as a positive sign, development agencies have started engaging media professionals on different issues such as health and education. Therefore, there are some opportunities for journalists through fellowships to learn and understand more about the health – including mental health sector. However, these efforts and initiatives are miniscule considering the wider network of commercial media and journalism sector. – Sub editor of a national daily

I have been reporting on health issues for the past seven years now and the basis of my reporting is self-exploration and consultation with mental health experts. The problem with us is that with various constraints for us to report on a regular basis – including time and resource factor for an investigative reporting, it should be admitted that our understanding on mental health issues is not adequate. Furthermore, we are not provided with adequate training and orientation on mental health issues for us to report better unless we take the initiative ourselves through self-learning. In simple terms, there is no institutionalized practice for capacity development of the journalists. – Journalist of a national daily

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Media's Role in Securitization on Mental Health Issues

There have been mixed reactions by the key informants when it comes to media's role in securitization of mental health issues.

A section of the key informants believed that at least in the Nepalese context, mental health issues have not been securitized to that extent through media, unless there was a major celebrity suicide or mental health disorder incident.

Frankly speaking, Nepali media sector has not matured enough to that extent where there is institutionalized practice or intention to securitize on 'soft issues' such as health and education. Yes, there have been some instances where there has been some 'over-reporting' or 'sensationalism' created over media reporting of celebrity suicides but, still to a great deal as securitization principle envisages of an existential threat. – Media researcher

As a nation, we are still yet to experience that kind of celebrity 'mania' or 'paparazzi' as experienced in the West or even in India. Nepali celebrities are found accessible to the commoners. In a way, this is a good thing as it limits general public to be idolizing or patronizing acts or deeds of celebrities. In real life incidents elsewhere, there have been many instances of 'copy-cat suicides' which hasn't been 'viral' yet in Nepal. – Clinical Psychiatrist

Whereas, some of the key informants also believed that there is increasing trend of securitizing acts on mental health issues in Nepal.

Yes, to some extent, we are heading towards it [securitization of mental health issues] and moreover, with the increasing growth of media agencies and social media use, the tendency to be interested in celebrity incidents such as suicide cases will increase. – Psychologist

As a media researcher and enthusiast, though I am excited about the staggering growth of media outlets and social media platforms, I am also equally cautious about the consequences of growth of this nature. This ultimately brings us to an interesting debate on media freedom and ethical reporting. It is not a hidden thing that the growth of social media has led to securitization of mental health problems, particularly celebrity suicides and Nepal is no exception. – Media researcher

On Securitization of Yama Buddha Suicide Case

As a reader, I was also confused initially with the nature of stories reported in the media about Yama Buddha's suicide story. The act of securitization really began when there were numerous story links posted in online and social media about horrific pictures of the rapper's dead body and his parents crying in shock, symbolic photographs about the rapper's act of hanging using belt, and various assumptions based coverage about why the rapper could have killed himself. This definitely had a negative impact upon the minds of his young followers. – Psychiatrist

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As a close observer of the digital media activities in Nepal, I was well aware of the patterns and intentions of the media agencies in reporting Yama Buddha stories. During informal chats with the media agency owners, they have also revealed about the need for the 'masala' or 'spicy' content to increase their views and shares of their stories. Yama Buddha was a big name and an inspiration for the youth, with his followership growing. His most recent tweet, four days before his death declaring that his latest album was soon to be released had also contributed to his greater fan following. In other words, this is click bait journalism in simple sense. – Media researcher

On developing an interface between media and mental health professionals to improve reporting on mental health issues

Both media and mental health professionals appreciate that there has been a positive response towards improving the practice of media reporting on mental health issues in Nepal. However, they admit that it is more of a 'reactive' rather than a 'proactive' response:

Yes, there has been greater realization that mental health issues are sensitive to have a significant impact upon wider public due to media reporting and we have had discussions at the policy level to address this issue. However, no substantial steps have been taken to institutionalize this practice. – Mental health professional

What strikes me, at this point of time, as media professionals, is that, we do realize that an intermediary is required to strike a balance between a 'journalistic reporting' and policy uptake, may be more in the line of principles of development journalism. This realization has been there at all levels from a novice journalist to a seasoned editor. However, we haven't taken this to the next level, which I suppose is a strategic policy engagement by a civil society organization, a critical media group or similar structures.

Overall, the key informants have shared that the current journalistic practice and lack of adequate information and underlying misconceptions about mental health in Nepal definitely leads to securitization of mental health issues in the long run if the concerned agencies working in the field of media ethics and media education are not cautious enough at an early stage.

CONCLUSION AND RECOMMENDATIONS

This study attempted to understand the nature of media reporting on mental health issues in Nepal, particularly investigating the Yama Buddha suicide case and the extent of securitization applied by the mainstream and social media channels, while covering the story.

Though the Yama Buddha case might not be entirely sufficient to make a comprehensive conclusion, given the high mainstream media and social media attention the story gathered, certain conclusions can certainly be drawn.

Reputed mainstream media outlets in general have chosen a cautious route towards threat neutralization. From the choice of words used for the title to the content, there was an attempt made to ensure that the followers/fans of the celebrity do not follow the path of 'copycat suicide'. In this regard, it can be deduced that a level of understanding and journalistic professionalism is maintained at least by mainstream media outlets.

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However, especially in the other online media, blogs and other social media, there were sensationalist words and tone used to attract the audience. This definitely drew the audiences towards such stories and triggered various sorts of emotional responses – thereby fulfilling the act of securitization. The suicide case of Yama Buddha, as a famous celebrity and his songs being widely popular, became a perfect story for click bait journalism for Nepali online media sites. This nature of click bait journalism, knowingly or unknowingly has resulted in mental health issues being 'over-reported' in the media as compared to, previously, even though through an individual case like that of Yama Buddha. Particularly, in the Youtube videos, the securitization element was prominent with titles suggesting explicit details of the rapper's suicide including the cause as well as method of killing himself while the content of such videos barely described such minute details. Some of those videos receiving almost half million views shows the extent of reach among his fans/followers.

Through the key information interviews, it was also revealed that the mushrooming of online and social media globally and in Nepal with increased competition and trend of click bait journalism, the securitization on sensitive issues such as celebrity suicides have also been justified in some occasions. However, this doesn't negate the fact that the capacity of journalists to report on mental health issues, especially suicide cases sensibly needs to be improved to a great extent. The context of story production – the tight deadlines, limited resources and the interest of media houses to capitalize on the celebrity coverage could also have triggered on the nature and extent of media reporting on such issues. Furthermore, with some level of realization and advocacy for the need for an 'intermediary' to take the initiative forward for evidence informed policy development exercise following the media reporting, some efforts have already been made such as a collaboration between Primary Health Care Revitalization Division (PHCRD) under the Ministry of Health and Health Research and Social Development Forum (HERD), a non-government organization to improve media reporting on urban health issues in Nepal (Uprety, McGrath, McNerney, Ghimire, & Baral, 2016).

More often, the triggers resulting in a response become more important than the response itself. When the mental health issues in Nepal are over-reported and in most cases, without substantial details or readers/viewers being misled, three major recommendations can be drawn from this study:

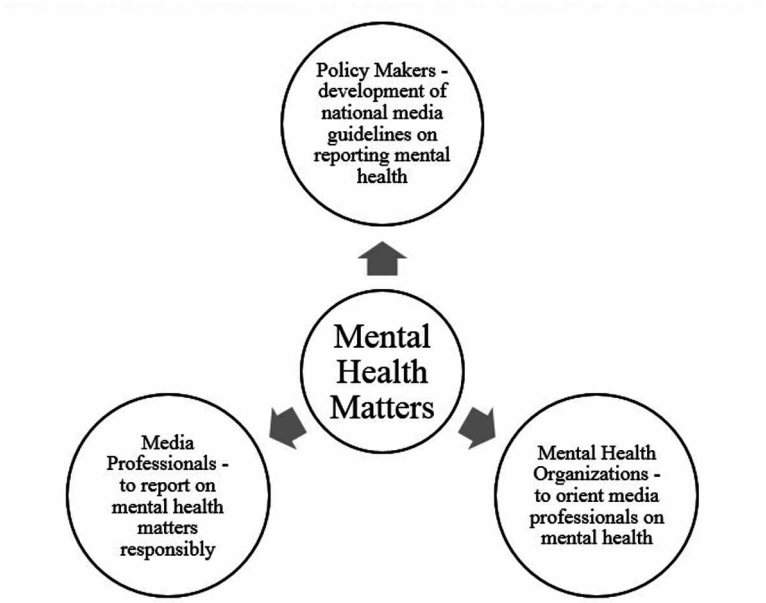
1. More awareness and understanding about the nature and type of mental health problems as well as the existing myths and misconceptions at the public level.
2. Capacity building of journalists and media professionals to better understand and report on mental health problems and consequences of securitization at the public level with over-reporting on suicide cases. This could be done in collaboration with organizations working on mental health.
3. Development and proper implementation of media guidelines on reporting suicide and other mental health issues.

Thus, these recommendations form a multi-sectoral coordination between policy makers, media agencies and mental health organizations promoting better reporting on mental health matters, as presented in Figure 2.

The authors, through this chapter, thus, advocate for the desecuritization of mental health issues in order to deconstruct the stigma and myth surrounding mental health in Nepal.

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Figure 2. Multi-sectoral coordination between policy makers, media agencies and mental health organizations



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Section 5

Organizational and Social Implications

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Chapter 50
Barriers to Practitioners' Endorsement of a Recovery Perspective:
Considering Attitudes Through a Schema Lens

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ABSTRACT

This chapter is concerned with the impact of practitioner biases on the experience of a meaningful life for individuals who live with serious mental illness (SMI). Professional biases, systemic biases that originate in societal fear and lack of knowledge, and internalized stigma taken on by the consumer affect life decisions. Following a history of treatment initiatives experienced by consumers as abusive, it is important to understand how a system envisioned to protect and treat was often experienced as harmful. In the 1980s a movement emerged to transform the nature of mental health treatment to a client-centered, recovery-oriented model. In 1999, the Surgeon General proclaimed that all agencies serving this population should be recovery oriented. Yet, the shift to this approach to understanding people with SMI has not been complete. While there are many explanations why practitioners may not fully embrace this perspective, this chapter introduces the concept of "schemas" from cognitive behavioral theory as a way of examining professional biases in the field of SMI.

INTRODUCTION

This chapter concerns the impact of professional biases on the ability of individuals with Serious Mental Illness (SMI) to experience a life of meaning and purpose in the same way as those who do not live with SMI. Due to the inherent power differential between patient and therapist, client and coach, or consumer and guide, professional biases can devastate the dreams of individuals who turn to the

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mental-health system, voluntarily or involuntarily, for the purpose of learning strategies to manage life with SMI. Most studied is the impact on help-seeking behaviors of people with SMI due to public and professional stigmas (Hailamariam et al., 2017; Henderson et al., 2013). When professionals are not able to reflect on their own schemas, there is potential for a cyclical and damaging dynamic. This dynamic is one based on personal biases of the professional, systemic biases originating in societal fear and lack of knowledge, and subsequently the internalized stigma taken on by the consumer, can prevail (Beretta et al., 2005; Orbell & Henderson, 2016). In the face of obvious reservations on the part of their treating professional, rare is the individual who will have the courage to move forward in pursuit of a life course of their choosing (Mead & Copeland, 2000; Deegan, 1996).

The mental health system has a long history of offering interventions that were ineffective and sometimes barbaric. However, when professionals act on the science and data of the time, interventions are usually reasonable and calculated risks. Bloodletting, ice baths, and even frontal lobotomies most likely emerged in a genuine effort to effect healing. Yet, these treatments often continue long past the acquisition of evidence that they are ineffective and in fact harmful, and the realization of their effects. One explanation of how this happens might be the impact of professional stigma. At what point does the practitioner embrace an "us and them" attitude toward his or her charges? At what point is it easy to detach from empathizing with the other because the other has become somehow less human?

In 1999, the Surgeon General proclaimed that all agencies serving this population should be recovery oriented; yet, the shift to this more client-centered approach to helping people with SMI has not been seamless or complete. Many reasons impede greater embrace of this directive, including but not limited to lack of consistent and widely disseminated data that a Recovery Perspective is more effective; lack of understanding of the practices that make an agency recovery oriented; and misconceptions that suggest this orientation is cost-prohibitive. Thinking critically about the recovery perspective reveals that this "perspective" or "paradigm" is not an evidence-based practice. In fact, it is not so much a "practice" as it is a way of working with people—an ethical focus on an individual's right to self-determination, dignity, and respect. Therefore, failure to fully embrace these principles remains somewhat curious. This chapter will define the cognitive behavioral concept of schemas, and consider how a greater understanding of this psychological mechanism may be a way of examining professional biases and their impact on consumers in the field of SMI.

By the end of this chapter, readers should have a basic understanding of the Recovery Perspective in mental health, and areas of common ground as well as conflict when compared with the more traditional Medical Perspective. We discuss how this perspective offers a client/consumer-centered approach to services for people with SMI, and how attention to professional schemas may be a vehicle for understanding the perpetuation of stigma against the people with SMI by professionals in the field of mental health. In closing, the chapter will offer some possible directions for mitigating the inherent harm that can occur from unchecked schemas among mental-health professionals.

TYPES OF STIGMA AND THE PERSPECTIVES THAT MAY HELP DRIVE THEM

Understanding a number of key concepts can assist the reader in fully appreciating the impact that stigma and bias have had on the lives of adults with SMI. First, this chapter refers to individuals who utilize mental-health services as "consumers." The nomenclatures for this population and the terms by which they are identified have morphed with the emergence of new scholarly and political developments. The

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term "patient" gave way to "client" as many recognized that the original term promoted a sense of illness and a role or position of dependence upon a person with a title suggesting "expert" status. "Client" gave way to the term "consumer" in the 1990s. This coincided with the emergence of the recovery movement that quickly became a formidable component of the mental-health landscape. The title "consumer" emphasizes a shift in the understanding of the relationship between a person in need of services and a service provider. Rather than a person with a disability being acted upon, "consumer" connotes a sense of the system working for the person in need of service. The battle for adoption of this change has been hard-fought and the term remains in inconsistent usage. Other important concepts include the notion of personal biases among professionals, social and systemic bias among others in the society, and bias that consumers of mental-health services often internalize.

Personal bias among helping professionals is one type of stigma. Numerous factors influence the development of individual perspectives on SMI, and like lay people, professionals are not immune to these factors. Lessons learned from family of origin, school and community experiences, religious organizations and affiliations, the political climate, and everyday experiences impact expectations and assumptions about human beings with SMI. The inclination toward science and/or religion can have an impact on how people understand the world around them, and the influence of the media cannot be overstated. Images of SMI in popular culture, such as sound bites on television or radio news broadcasts, movies, sitcoms, miniseries, and even social media, can have a profound influence on a person's understanding of causes, prognoses, appropriate treatment alternatives, and implications for public safety.

Haller (2010) makes the argument many representations of disability in the media show a tendency toward distortion that betrays the "ableist" values so dear to society. "Ableist" values essentially promote the worth of physical and mental, and intimate that their lack may even be a reasonable excuse for suicide. Haller uses the notion of assisted suicide to make this argument. If it is understandable that under the circumstance of losing a physical or sensory ability, one should have a right to end one's own life, what message does this convey to a person who never had that sense or ability? In her content analysis of media images of disability, although she observes shifts in public consciousness that were promising, the theme of disability represented as weakness remains prevalent. In addition, the theme of disability deserving derision or ridicule continues to be a problem.

Science in and of itself can exhibit bias. While greater learning and science can challenge misconceptions and fallacies, the history of the treatment of people with SMI is plagued by interventions founded in science that ultimately proved ineffective, dangerous, or sometimes even downright barbaric. Azar, Benjet, Fuhrmann, and Cavallero (1995) emphasize that "scientific facts" are laden with personal values.

Personal values of professionals informed by beliefs and perceptions that stigmatize can be profoundly detrimental to life outcomes for individuals with SMI. A professional making a decision based on an unsubstantiated fear can exert tremendous and unfair power over the life choices of a consumer. Not all mental-health professionals are experts on the scholarly literature of mental illness and societal risk; however, all mental-health professionals influence decisions over the lives of others, which their unchecked personal views may govern.

History has played a role in professional bias—perhaps small, but nonetheless a definitive role in the perpetuation of personal biases held by many mental-health professionals and lay people. For instance, Emil Kraepelin was the first to distinguish a separate set of symptoms that could be associated with what is now called schizophrenia. Kraepelin (1919, cited in Warner, 2004) named this separate disorder Dementia Praecox, which translates in essence to an illness that begins in adolescence (praecox) and results in a dementia-like state. He proclaimed that what differentiated dementia praecox from other

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forms of mental illness was its incurability. Thus, over a hundred years later and in spite of evidence to the contrary, diagnosis of a SMI, particularly a psychotic disorder such as schizophrenia, is often thought incurable. In fact, Kraepelin himself conducted numerous studies and found that a small percentage recovered from SMI (Kraepelin, as cited in Warner, 2004). Even today, many professionals believe recovery is hopeless with a diagnosis of schizophrenia.

A further historical blow came later in early 1900s when one of the greatest minds in psychiatric and psychological history, considering the diagnosis of schizophrenia, declared that psychotic illness falls on a continuum separate from the mental health of the average person. In his contemplations about varying types and levels of neurosis, Sigmund Freud (1911) in his work on dream interpretation expressed concerns about the ability of a person with damaged ego strength to delve into this material without exacerbating psychotic symptoms. Regardless of Freud's personal reckoning of the implications of that assertion, the message suggests that people with SMI were somehow less than capable of psychological growth and change.

Another factor in professional bias might be the influence of a theoretical framework to which a given professional subscribes. Freud was the father of psychoanalysis, and psychoanalytically oriented mental-health professionals understand the cause of mental-health issues to be rooted in unconscious conflicts, usually traceable from childhood. In other words, symptoms or behaviors for which a consumer might seek help from a professional are a result of these unconscious conflicts. Recovery is thus a cessation of symptoms that results from working through past traumas by putting them into words with affect. Particularly in classical psychoanalytic theory, the roles of analyst and patient were clearly delineated and hierarchical. The treatment was usually quite long term, with a belief in recovery. However, whether this type of treatment is appropriate for people with more serious disorders is still a question, suggesting that there is actually no strong belief in recovery from SMI. Even today, some professionals see psychodynamic treatment of serious mental illness such as schizophrenia as akin to malpractice (Fuller Torrey, 2006). The value in this theory is the idea that motivations and drives made conscious free the consumer to make choices of his or her own free will. Recovery is ultimately the moment when through complex psychodynamic processes, the consumer "internalizes" the therapist and is able to do this kind of detective work on his or her own.

Alternatively, cognitive behavioral theory (CBT) was a bold and radical shift that emerged at a time when the "unconscious" was a household word. Albert Ellis (1994) proposed the idea that perhaps rather than an unconscious that would require long-term detective work with an expert professional, the locus of why people behave and feel as they do lies in how they interpret cues from their environment. In other words, the thoughts that go through a person's head in a given situation will determine how they feel and then act, and then perhaps think, feel, and act again. Thoughts, feelings, and behaviors are cyclically related. However, with just a few sessions with a cognitive behavioral therapist, a person can learn to identify thought distortions and thus interrupt the unhelpful patterns. CBT is an active therapy, particularly for the consumer. While both theories require hard work, CBT requires specific homework assignments and activities. Therapist and consumer roles are more level, and the therapist is more of a coach. Therefore, after just a few sessions, the consumer will have the tools to coach him- or herself. There is once again an expectation that with this work, recovery is a possible outcome.

Sociocultural theory minimizes the impact of internal dialogue and unconscious conflicts on the functioning of an individual or group. On the contrary, this theory suggests that if we resolved societal inequities and injustices, people would not behave in symptomatic ways. This theory sees causality as related to social injustice, and therefore the cure lies in social change. The role of a helping professional

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might be to stand side by side with a consumer at a march, painting a mural, lobbying legislators, and fighting together for social change.

Dividing theories into separate categories—biological, psychodynamic, cognitive, behavioral, family or systems, and sociocultural theories—is neat and organized. But in practice, varying degrees of each theory have an impact on the individual's emotional health in different and unique ways. Societal biases and systemic bias are crucial issues, and different consumers respond well to different approaches fueled by different theories. In sum, professional bias can be attributed to personal life experiences of the practitioner, to historical inaccuracies perpetuated over a century, and even to the theory that most resonates for the individual helping professional.

Internalized stigma is another level of presupposition that negatively affects the lives of consumers. People with SMI are members of the same social system as everyone else. The images they see of SMI are the same as the rest of the population sees. In addition, many have experienced a medical-model culture where calling an individual "a schizophrenic," "a borderline," or "a depressive" was standard nomenclature. This can be very demoralizing. The problem with this language is that once an identity becomes a label that entails lesser social and professional expectations for a meaningful life, only an extraordinary human being could overcome such expectations and thrive.

Expectations expressed by the professional community have a tremendous impact on people with SMI and greatly affect their expectations for themselves. In an editorial piece in *Schizophrenia Bulletin*, a family member explains that when the disease affects the brain, it is difficult to see where the disease ends and the person begins (Sundstrom, 2004). This difficulty is compounded when professionals in the field cannot make this distinction either.

The Recovery Perspective

Harry Stack Sullivan (1962), a renowned psychoanalytic theorist and practitioner in his own right, was a disciple of Sigmund Freud. Their paths diverged due to professional disagreements. One important difference in their understanding of mental health was that while Freud saw psychosis on a continuum separate from that of the rest of humanity, Sullivan saw humanity in SMI. On many points, he presaged innovations of the late 20th and early 21st centuries. Long before evidence-based practices were a celebrated initiative in mental health, Sullivan made the claim that any treatment offered to a person with a SMI requires study. He also understood that when a person with a SMI believes that the treatment provider considers the illness degenerative, the patient is at great risk of losing hope for the future. He also believed that an illness that affects the life of people as young as adolescents must be curable. Although his contributions were made before the onset of the recovery movement (and subsequently the recovery perspective), crossovers between his humanistic theory and the recovery perspective are noteworthy.

Although a large number of studies throughout the 20th century document recovery from the most serious mental disorders (see Warner, 2004; Calabrese & Corrigan, 2005), in 1987 Courtney Harding published an article on a study that she conducted, which also presaged aspects of the recovery movement. Not too distant history conjures up an image of SMI housed in a mental institution from which many people never were discharged. Images included restraints, screaming, electric-shock treatments, and lack of care such that human adults sat for interminable periods of time in soiled clothing. Harding (1987) wondered what the impact might be of a twofold intervention, the first being inpatient skills training, and the second a coordinated plan for support, from the same team that taught the inpatient skills, for patients reintegrating into the world-at-large. She led a team that provided this intervention,

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and conducted a longitudinal analysis. Her findings were quite positive and became a turning point in the scholarly discourse around the notion of recovery from SMI. This skills-building and environmental-support model presaged the Psychiatric Rehabilitation Model that, in addition to sharing office space with proponents of the Recovery Perspective, is in many ways the operationalization of the Recovery Perspective.

While standing up for the dignity and appropriate treatment of people with SMI is not a late 20th-century phenomenon, (e.g., Dorothea Dix, Philipe Pinel), in the 1980s this movement developed leadership among consumers, their families, and professionals, which turned it into quite a formidable movement. Some leaders and advocates of this movement include individuals who identify with attributes of both scholars and consumers, including Patricia Deegan, Ph.D. (1988; 1996), Mead & Copeland, (2000), and Anthony (2000), to name a few.

In the 1980s, the recovery movement was born, and it would change the face of mental-health treatment. Two divergent forces were the impetus for this transformation. First, people with SMI began writing in large numbers, not only about their experiences with recovery, but also of abuse that they experienced in the mental-health system. Second was the development of the Psychiatric Rehabilitation Model, dovetails with the Recovery Perspective in that both are strengths-based models of care that recognize the value of peer support, encourage integration into the community-at-large, and maintain core values in understanding recovery from SMI.

Today's scholarly discourse about the definition of recovery from SMI considers what recovery means to those with serious mental illness. Up until the 1980s, recovery was essentially synonymous with cure, and thus meant a cessation of symptoms, cessation of hospitalizations, and the achievement of a "normal" level of functioning (Warner, 2004). This provided a measurable definition that would satisfy medical practitioners and quantitative researchers alike. This Medical Model perspective sees recovery from SMI as an endpoint that does allow for measuring recovery in a consistent and unbiased manner. On the other hand, recovery-oriented clinicians and consumers tend to view recovery as a non-linear process. Although from a Recovery Perspective there is variation in the way in which recovery is defined, certain key elements are present in most definitions, including the restoring of a sense of hope, a sense of meaning, and a sense of purpose in life (Noordsy et al., 2002). Other important elements of this newer definition include creating and/or maintaining a peer-support network outside the mental-health system (Davidson, 2006), taking responsibility for one's own recovery journey, and considering one's own understanding of spirituality (Anthony, 2000; Davidson, 2006 Noordsy et al., 2002). Measuring recovery by this definition is a greater challenge than examining the number of hospitalizations, symptoms, and defined levels of functioning, but there is tremendous value in the endeavor. This method of measuring recovery recognizes the identity of a person as more than an illness and a number, and instead as a multidimensional human being.

Mental illness is rarely an event from which recovery is linear. While measures and numbers are clear and concise, mental health is a grey and murky concept best envisioned as multilayered and inexact. All human beings are learning, growing, and changing in different aspects of their lives at any given time. Thus, envisioning recovery from serious mental illness as a process that evolves in stages rather than as an endpoint is compelling (Lieberman & Kopelowicz, 2002). Proponents of the recovery movement invest their energy in changing the way we provide services. Rather than being acted upon by a system of experts, recovery-oriented consumers strive to be equal partners in determining their course of treatment.

Although this philosophy resonates with the social work code of ethics, a code that specifically emphasizes a need to respect client self-determination and the dignity of a person (NASW, 2017), like

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any organizational change, this paradigmatic transition has experienced some obstacles. In fact, the vast majority of agencies serving those with SMI may not be fully compliant with the Surgeon General's directive.

There is a real and critical need to address myths and assumptions on the part of professional helpers. In general, stigma creates an "us and them" environment that enables people to behave in inhumane ways towards others. This can become routine and acceptable. Germaine to the experience of people with SMI are numerous concrete examples of how stigma against people with SMI has resulted in harmful and inhumane treatment of this population. A right to participate in one's own treatment-plan development is a recent addition to consumer rights. Prior to this, once a person bore the label of SMI, the norm became being acted-upon with little if any of their input. Protections to ensure that people with SMI would be free to live in the least restrictive environment that could allow for both their personal safety and society's is also a new phenomenon. Providers are attempting to review the use of restraints, and further, to recognize the element of retraumatization inherent in many of these routine practices. Only recently have programs begun to examine the risks of abuse of power within programs for people with SMI, and to implement strategies to mitigate this potential. Although the notion of internalized stigma and the knowledge of how institutional care can foster this situation has been documented as far back as 1961 when Erving Goffman published *Asylums*, rigorous efforts to address internalized stigma are still in their infancy.

In many ways, the greatest and perhaps the most critical negative impact of stigma, for people with SMI in particular, has been the impact on the psychological concept of hope (Davidson, 2006). Having lost hope, a person has lost a sense of controlling his or her destiny. Without enabling a sense of hope for the possibility of change, for the possibility of something better, we greatly diminish a person's motivation to find any meaning or purpose in life. Consumers have documented numerous examples of mental-health services that demonstrate how the mental-health system perpetuates this state of hopelessness, due to stigmatization based on lack of understanding, experience, and knowledge about SMI. This undermining of hope for a positive future robs many of years of their lives.

Frequently when treatment does not appear to be yielding positive outcomes, clinicians blame the consumer. Linehan (1994) has argued that if the treatment is not working, it is the treatment at fault, not the person. This perspective can promote compassion and recognition that SMI is not a willful attempt to sabotage treatment interventions.

"Schemas" are semifixed and long-held beliefs that individuals often develop from childhood experiences, which drive how they organize data in their world and make decisions, and how they relate to one another. This concept of schemas may offer a way of looking at professional attitudes influenced by stigma, and an understanding of how providers maintain errant views.

SCHEMAS

A Manner of Understanding Professional Biases From the Cognitive Behavioral Theoreticians

Many initiatives have been geared toward helping people with mental illness find strategies to cope and even fully recover. The historian Gerald Grob (1994) has separated periods in the history of treatment for

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the mentally ill into four discrete eras. Each period represents a shift in the understanding of the cause of mental-health issues and a new direction for providing treatment.

The first of these periods he called the Asylum Period, which occurred from approximately the mid-1800s through the early 20th century. While members of society with mental illness and without economic privilege found themselves in asylums, others found themselves in "sanctuaries," removed from the stresses of everyday society. These patients received "moral treatment" offered in some of the state hospitals. The rationale was that disorders of the mind were a by-product of the chaos, greed, and sense of meaninglessness in society, and thus the cure was to remove the afflicted person from these social stressors. Providing a sanctuary promotes a peaceful environment designed around a routine of purposeful and structured activities, and healing occurs. In fact, this type of treatment did prove successful. The industrial revolution led to overcrowding in an overwhelmed system that provided custodial care at best, and at worst neglect and abuse.

The Mental Health Hygiene period began in the 1890s with the notion that cure of SMI could be an outcome of proper scientific approaches to treatment. The shift was to small hospitals that were associated with medical schools. The emphases were on early diagnosis and reenvisioning mental-health care as equivalent to medical care, and thus moving into the mainstream. However, this model also met its demise with a loss of funding and an increase in demand for services, which overwhelmed the system.

The shift in the mid-20th century to Community Mental Health Care grew out of a few important developments. First was the discovery in the 1950s of psychotropic medications that could be combined with other medications, resulting in a calming affect that made community reintegration a real possibility. In addition, societal awareness of the conditions in mental hospitals put pressure on government officials to take action. President Kennedy, with a personal interest in human beings with mental disabilities of varying kinds, both emotional and intellectual, was persuaded to sign into legislation the Mental Health Centers Act of 1963 (Community Mental Health Centers Construction Act, public law 88-164) (Clark, 1993). Deinstitutionalization was the outcome of this bill, but the results were not as anticipated. Moneys earmarked for community treatment centers that were unaccustomed to meeting the needs of this challenging population were used to provide treatment to higher-functioning clients, and mass numbers of people discharged from the psychiatric institutions became homeless and in danger.

The Community Support period began around 1975 and continues today. This period represents a shift in the understanding of causes of mental illness, and recognition of the importance of addressing the stigma of SMI. One shift was the emergence of the recovery movement, wherein consumers began disseminating anecdotal data about recovery from SMI. The understanding of what causes SMI shifted from faulty parenting to a neuroscientific perspective. The development of new technology that allowed for neuro-imaging of the brain greatly supported this shift. The shift from bad parents to neuroscience promoted two ideas: that recovery is possible, and that the biggest challenges to societal reintegration for people with SMI were attributable to social stigma, not the illness itself. Social stigma was used to block appropriate housing for people with SMI (ex. group homes, scattered site homes) from receiving permits in safe neighborhoods, as well as funding that could help to integrate people with SMI into the competitive workforce. Social stigma interacts with personal stigmas imposed by professionals, and stigmas internalized by those with SMI.

Studying cognitive behavioral theory requires that a thought, feeling, or behavior that seems intractable or impermeable to change be questioned as to what mechanisms are perpetuating the problem. Similar to the difficulty many people experience when attempting to break a habit or develop a new behavior,

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professionals and lay people who determine the care that will be provided to people with serious mental illness may be vulnerable to acting on schemas that might be outside of their completely conscious control.

The intractability of stigmatized thinking may be a by-product of the cognitive behavioral concept called "schema." Schemas are a fact of development; human beings develop schemas throughout life in order to help them to make sense of the world around them (Azar et al., 1995). Schemas emerge as children collect a repertoire of life experiences, and familial as well as social relationships and interactions can impact them. They are also developed as we observe images of popular culture including television, movies, books, games, and all sorts of social media. Schemas respond to social norms, cultural beliefs, and experiences from infancy to the present, with families, schools, community centers, religious affiliations, and more. Further, human beings develop role schemas (Azar et al., 1995), which allow them to conceive of expectations or definitions for mental fitness, competence, and essentially mental health. The experiences that enable people to develop these schemas also determine their understanding of how human beings should act when confronted with various social relationships. This can elicit preconceived ideas of how consumers should act in the presence of a mental-health professional. This has crucial implications for professional decision-making. There is an inherent power differential between a provider and a consumer. Providers can determine what services and opportunities are available to a consumer. Thus, providers have an ethical responsibility to make decisions not driven by stigma and bias.

Schemas are not necessarily a negative construct. Like any personal characteristic, schemas can be rigid or flexible, closed or permeable to new data. They can encompass a negative assessment or evaluation, or a positive one. Professionals making decisions guided by fixed and negative schemas have the capacity to detract from client self-determination in a powerful and negative way. For example, how a provider writes a biopsychosocial report for an application for independent housing can be the deciding factor as to whether or not a consumer obtains the housing he or she desires. Like unchecked biases, unchecked schemas can result in professionals taking full responsibility for the life situations of their charges. Every professional possesses his or her own set of schemas, and thus can positively or negatively affect the basic right to self-determination of consumers of mental-health services. Schemas can determine the roles and expectations that practitioners hold for their charges.

Azar et al. (1995) have used the concept of schemas to offer a compelling way of examining bias in child-welfare decisions about termination of parental rights. Likewise, this chapter uses the concept of schemas as a manner of examining bias in decision-making on the part of professionals in the field of mental health. One way of examining schema is to look at expectations of people within role relationships. Often without realizing it, we have predetermined expectations of how individuals should behave in their role as consumers, toward others in the role of practitioners. One dyadic role that might be somewhat commonplace is that of the compliant client. What is a compliant client, and what happens when that role is not satisfied?

The Compliant Client

Although most professionals today would probably agree that the hallmark of a successful treatment is not fostering compliance and dependence, but rather fostering critical thinking, self-advocacy, problem solving, and a wide repertoire of safe coping mechanisms, adherence to this philosophy can be complicated in practice. Reasons for this conundrum may be the history of mental-health professions, and the context of the world in which people today practice.

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From an historical perspective on the field of mental health, direct-service providers have struggled to enjoy respect as both professionals and scientists when their area of specialization is studies of the mind and behavior. Although psychiatrists were devalued by other medical doctors, many social workers made the choice to associate with both the medical and the psychiatric professions in an effort to enhance their professional status. This social work profession carries a past haunted by functioning as "friendly visitors" who, while largely pure of heart, practiced by imparting knowledge about what was moral, as keepers of the social order. Therefore, it is not surprising that when the profession arrives at the 1980s, working from a position of more or less "equal" status with patients could be perceived as a threat to the psychiatrist's or social worker's public image of professional and scientist.

In addition, there is no denying that society has become increasingly litigious and blaming. There are very real professional consequences at risk when promoting consumers' right to self-determination and the kind of risk-taking that promotes growth and learning that other citizens can take for granted. Should a consumer voice a desire for independent housing, and a professional assist in exploring wants and desires before making a global assessment of the consumer's overall functioning; and should that housing situation result in a loss of the apartment, and emotional stress and suffering, who would be held accountable? On the other hand, what percentage of the population without a diagnosis of SMI learns in the absence of experience? Is there really another way to learn the skills of living independently?

These tensions trouble a field that values strengths-based and client-centered approaches to treatment, and that honors the right to self-determination for all people and aim to empower all charges.

The Mentally Deranged

Another expectation of the role imposed on persons diagnosed with SMI is that they are a threat and dangerous to society. Until quite recently, film and television stories of individuals with mental illness have consistently portrayed people with mental illness as regressed, dangerous, and irrational. When struggling, stressed, and symptomatic, lack of a clear sense of reality can be a symptom of many with these afflictions, which can be frightening to observe. On the other hand, frightened people are not sufficient to support an assessment of dangerousness. In fact, studies support the idea that the vast majority of people with SMI are at much greater risk of victimization than of ever committing a violent crime.

When a news story begins with a report of a terrifying, distressing, and unconscionable mass shooting, immediately followed by reporting that indicates belief that SMI was a factor, it creates a specific social response. That the gunman unsuccessfully sought treatment twice in the week before the incident due to a shortage of staff would create a different story and result in a different public sentiment. It would be a story less about the danger of the SMI, but rather about the need to provide adequate supports to all citizens to enable them to participate in the world safely and successfully. A story beginning with: "The shooter had never been known by the mental-health system . . . " would communicate a different message. If there were a weekly segment on every news broadcast that showcased the contributions of a different people living in the world with SMI, fully contributing and functioning as valuable members of society, again we would have a different story.

Diagnosis, Stigma and Schema

Diagnosis is a wonderful tool for identifying a set of symptoms that respond well to certain interventions, and for securing funding to help consumers obtain the supports required for growth and development.

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Diagnoses simply allow consumers access to various programs. Other than these uses, it is always a potentially dangerous practice to put a label on a human that can have far-reaching consequences with respect to how they view themselves, how they are seen by society, and even how the community of helping professionals sees them. Diagnoses result in expectations that can be a detriment to growth and change.

Cognitive behavioral theorists are interested not only in the schemas that drive our actions, but also in the conditions that maintain and perpetuate these thoughts, feelings, and actions. In other words, it is not enough simply to strive to change a behavior; one must understand what maintains that behavior. When individuals look for confirmations of their expectations, they can very often find them. There is an abundance of societal expectations for how someone with SMI will behave in a given situation. Retroactively, people can often find ways to interpret what they see in a manner that supports their expectations. When looking through the lens of one's own schemas, we interpret multiple layers of a situation accordingly. Thus to be mental health professionals who promote recovery rather than stand in its way, the field will need to identify improved methods of helping professionals to better identify, understand, and resist acting on their existing schemas about people with SMI.

There are numerous schemas held by lay people, people with SMI, and professionals in the field of mental health, which are based on feelings rather than facts. These schemas have a tremendous impact on consumers' rights to self- determination, a life of dignity, and living in the least restrictive environment that allows for their care and safety and the safety of others. Identifying ways to ensure that professionals make decisions and recommendations they base on accurate information, and not long-held schemas, is a necessary priority in deconstructing stigma around mental illness.

SOLUTIONS AND RECOMMENDATIONS

Failing to address professional schemas is unethical, and it causes genuine harm in a number of ways. One issue is the notion of a self-fulfilling prophecy. Orbell and Henderson (2016) discuss the findings of a study that suggest that we activate subliminally based on a schematic representation of illness. In other words, the messages that consumers receive might be automatically activating behaviors that we then document as symptoms.

Studies around the word also suggest that social expectations about SMI drive beliefs that this group needs or deserves fewer social comforts to survive. One study (Rayan & Obiadate, 2017) examined the impact of stigma and poverty on people with SMI in Arab countries, and found that they experienced significant differences in overall quality of life.

One consequence that receives considerable attention is the impact due to stigma on help-seeking behavior in people with SMI (Corrigan, Druss, & Perlick, 2014; Clement et al., 2015; and Natan, Drori, & Hochman, 2017). In examining how specifically professional stigma acts as a barrier to help-seeking behavior, Clement et al. (2015) identify fear of disclosure—i.e., of being revealed as a "mental patient"—as a strong factor that keeps people from seeking treatment. Corrigan et al. (2014) concur and note as a deterrent the lack of accurate information possessed by not only the consumer, but also families and communities.

A concerning finding is that consumers in a 2017 study identified power relations in mental-health care as a primary locus of stigmatized behaviors. Sercu & Bracke (2017) found that one in four experiences of stigma occur at mental-health facilities. Professionals communicate these attitudes to consumers when they infantilize consumers and take no interest in aspects of their humanity outside of the diagnosis. The

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presence of other power attributes such as class and social inequalities compound these effects. Another study found that poor quality of life for people with SMI in India was significantly greater due to poverty. People with SMI were unable to pay for treatment and received unreliable medications, particularly those that could reduce side effects of the primary medications. There was a lack of understanding about the potential long-term nature of the illness, and that made sustaining support and connections a challenge. There was also a lack of education, and therefore a lack of flexibility in methods of engagement when someone was actively delusional, or unwilling or unable to enter treatment options (Hailamariam, Fecadu, Prince, & Hanlon, 2017).

Disclosure of mental illness has been correlated with better outcomes for people in recovery who are reintegrating into society (Pahwah, Brekke, Rice, & Fulginiti, 2017). However, stigma from professionals and people in the society-at-large is a factor in dissuading people from disclosure. The issue here is that many of the professionals who should be providing community education and advocating against stigma are unaware of their own discomfort and tendency to stigmatize consumers. Other studies support this idea and state that the mistrust of mental-health professionals might not be unfounded (Zieger et al., 2017). Many studies are showing that there is little success in most of our initiatives to reduce stigma and its harmful effects (Clark et al., 2013).

Some studies demonstrate that anti stigma campaigns help. Musyimi, et al. (2017) reviewed a study that analyzed results of campaigns at numerous levels. The study looked at how anti stigma efforts affected the attitudes of children, social media, adults, social marketing, and community initiatives. Indications appeared that initial help-seeking among people with SMI increased, and stigma from friends, family, and even community members decreased. Unfortunately, there was no indication that stigma perceived by health professionals decreased, and it is unclear as to why that occurred. This may identify long-held schemas about mental health and mental illness. How do we work to change stigmatizing behaviors, bias, and schema that we are unaware we carry?

Unexpected Consequences

Interesting studies have found that negative cognitive self-schemas increase self-stigma (Shimotsu et al., 2014). Pedersen and Paves (2014) addressed a perplexing question: Since we know that perceived public stigma is a barrier to young adults seeking treatment, how does this relate to personal stigma? In other words, they wondered how people with SMI would view and treat others, and how would this compare with perceived public stigma? Interestingly, the majority of responders would not have thought less of someone who had SMI or sought help; yet they believed others would think less of them. Also perplexing is that for so many people around the world, having a quality life is less important than avoiding the pain of a stigmatizing label. Stigma diminishes self-esteem and robs people of opportunities (Corrigan, Druss & Perlick, 2014).

In the United States and Western European countries, Sontag & Sontag (1990) observes a relationship between campaigns to overcome illness and other psychosocial stressors. As we call for a war on poverty, on homelessness, on AIDS, we communicate that to have an illness or any psychosocial concern is weak, vulnerable, and unacceptable. We communicate this in such a manner that often the person is lost in the war against their illness.

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What Is Important to Successful Treatment?

Engagement and ability to connect with a benevolent other is an important element in successful treatment. Beretta et al., 2005 suggest that the therapeutic alliance is associated with the patient's wish to be close, to perceive others as trustworthy and helpful. However, they found that people with low alliance, relates not to a wish to avoid, but to a patient's wish to be close impeded by perceptions of others' responses as negative, with diminished capacity for affiliation. This is further complicated by the reality that many professionals unwittingly communicate the same fears, low expectations, and stigmas to consumers as people in the general population.

For instance, another study found that while most medical doctors, primary-care nurses, psychiatrists, psychiatric nurses, and psychologists self-report respect for the dignity of their patients, follow-up exploration of a vignette reveals that most would not want to hire or be neighbors or friends of people with SMI (Smith, Mittal, Chekuri, Han, & Sullivan, 2017). Likewise, in Sweden a study explored whether professionals would hire, date, or let a person with SMI take care of young people. Responses were quite negative. Like public perceptions of SMI, professionals on some level fear that people with SMI are dangerous, unpredictable, and difficult in relationships. This stigmatizing view does not seem to change in spite of global efforts to challenge stigma (Hansson, Jormfeldt, Svedberg, & Swensson, 2011).

Schemas drive decision-making. If reading an article exposing facts could change practitioner behavior, this would be a simple solution and likely would have been accomplished long ago, eliminating decisions based on negative schemas. Mechanisms that retrigger long-held beliefs make challenging schemas difficult. A practitioner may be privy to reliable, trustworthy data indicating that the majority of people with SMI are not a danger to other people. Nonetheless, this may not be enough to change the deeply wired mindset that drives how the practitioner makes decisions related to his or her work with consumers.

In order to address unconscious schemas that may drive treatment decisions, new and innovative training to identify negative schemas must be sought. Finding ways not only to identify schemas held by mental-health professionals, but also to examine the myths upon which they are built, where they originated, and how they are perpetuated, and to challenge them in a safe environment in which the professionals can do this personal work, will be a challenge. Research utilizing structured conversations to assist mental-health professionals in examining the schemas they may have about individuals with SMI may be a place to begin. Small-group dialogue that surfaces schemas in a safe environment can help identify those that are negative and biased, and find adequate ways of challenging those beliefs in a rigorous, yet safe manner as a means of practitioner training.

What Reduces Stigma and Professional Stigma?

O'Reilly, Bell, and Chen (2012) suggest that fostering empathy is a major factor in decreasing stigma. Others have recommended a need to recognize the culture within which one hopes to campaign against the stigma of SMI (Pawluk & Zolezzi, 2017). For instance, in Qatar, health professionals shared that they supported efforts to decrease stigma but thought efforts should target school-age children to provide education about SMI and appropriate pathways to treatment. Others concur, stating that mental-health literacy may be more effective than challenging stigma once it is entrenched (Greenwood et al., 2016). In another study, strategies such as role-play were not found to be as effective as direct contact with a

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person with SMI, and indirect contact (e.g., through film). Even educational emails showed short-term positive impact on decreasing stigma (Stubbs, 2014).

There are four accepted paths to changing perceptions. First, people learn from training (Bedregal, O'Connell, & Davidson, 2006). Numerous studies have found that specifically training on the Recovery Perspective and its operational model, Psychiatric Rehabilitation, opens professionals to growth and learning. Second, people learn from meeting and having meaningful connections with real human beings who have SMI (Eack & Newhill, 2008). The implication of this path to change is that as trainings are re-envisioned to improve professionals' ability to monitor their own schemas, it is logical that consumer participation in structured discussions be included. Third, people learn from self-reflection and genuine openness to challenging their own misperceptions (Kadushin & Harkness, 2014). Fourth, people learn from open dialogue (Brown & Isaacs, 2005). A tenet of group therapy is trusting that a group of people can come together to support one another. People can come together for the purpose of solving social problems, particularly when all acknowledge that they do not have the single answer that needs to be imposed on others. When people can demonstrate a willingness to share and contemplate their own thoughts and ideas and those of others, a willingness to work towards learning, growth and consensus building, there is hope for finding ways to end stigma. People come together willing to ask deeper questions and trust that together they may be able to identify innovative and positive solutions to stigma within the field of mental health, even those notions of stigma held by professionals.

CONCLUSION

When reviewing moments and shifts in the history of treatment of people with SMI, one can come away with a sense that people who cared about and empathized with the plight of people with mental illness often initiated efforts to heal, which ultimately went awry. One can look at the role of stigma—in particular stigma emanating from mental-health professionals—and see harmful interventions that required Herculean efforts to eradicate. Cognitive behavioral theory, when a thought, feeling, or behavior is recurrent or difficult to change, may aid in attending to the schemas that drive that behavior, and provide a place to begin. Thoughts, feelings, behaviors, and attitudes can be difficult to change because environmental factors retrigger them. This chapter argues for understanding the concept of schemas and considering training alternatives to help mitigate the harm resulting from stigma on the part of mental-health professionals.

Social workers provide the majority of services to adults with SMI (Kirk, 2005). The Social Work Code of Ethics posits ideas about service provision that are very much in sync with the Recovery Perspective. Therefore, it is curious that this would not be a smooth, timely, and easy transition. Yet there have been barriers to professionals embracing this client-centered perspective.

Recovery-oriented care represents a paradigm shift that not only has implications for clients but also involves a rather formidable shift in the role of the professional and how services are provided. In the litigious and blame-oriented environment that surrounds current practice, social workers who may wish to fully embrace a Recovery Perspective would have considerable concerns. This perspective supports people with SMI taking risks—the same risks that people who are not diagnosed with SMI are able to take for granted. This perspective honors a consumer's expressed desire for an independent apartment, and seeks it without a global assessment of functioning. While this does not mean abdicating responsibility for assessing consumer safety and problem solving around potential skills deficits that can be

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addressed, its premise is that in the absence of data suggesting the person is not competent, we can assume the ability to budget and/or learn from mistakes, as a person without a diagnosis would. To work from an assumption that people with SMI can learn these lessons, in the same way as their non-SMI counterparts can, is a shift that can be threatening to a professional who may be held accountable by families and/or systems when a worthwhile risk does not work out.

Another challenge is failure to accurately understand definitions of the Recovery Perspective and the Medical Perspective. Some professionals see the Recovery Perspective as an anti-medication movement. While many consumers and professionals do question whether medication is overprescribed, this is not a Recovery Perspective agenda. Similarly, some believe a Medical Perspective is solely about medication. This again is inaccurate, as evidenced by a longstanding and ongoing history of Medical Perspective practitioners diligently working to identify new and progressive methods of helping consumers, which go far beyond medication.

One key difference between the two models can be articulated in terms of the shifting role of the professional. Recovery-oriented professionals see their role more as a coach or guide on the journey of recovery, while the medical model assumes more of an expert stance. Another key difference is the very definition of what it means to recover. In practice, however, this is not always the case. Greater attention to the role of schema in professional decision-making is one recommendation.

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KEY TERMS AND DEFINITIONS

Cognitive Behavioral Theory: A theory of cause of emotional or behavioral issues based on the once revelatory idea that rather than being driven by unconscious factors, we behave as we do due to how we interpret stimuli around us.

Cognitive Distortions: Types of distortions that most people have experienced at one time or another, which can be challenged and reframed. For instance, a person states, "I am going to fail this exam." When this thought, which often leads to anxiety, is based on data to the contrary, it can be challenged

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by identifying the type of distortion—in this case, "predicting the future"—and then challenged with a more realistic statement/thought.

Consumer: Terms such as patient, client, consumer, and survivor have all been used to describe the role of the person receiving mental-health services. "Consumer" is the term associated with the recovery perspective.

Hope: A reason to continue to try to find purpose and meaning in life.

Internalized Stigma: Feelings of unworthiness and self-directed rage internalized from societal assumptions; essentially seeing oneself in the role of "an illness" as learned from experiences in society.

Medical Perspective: A traditional medical perspective in the field of mental health looks at decrease in symptoms, decrease in hospitalizations, and increase in functional behaviors as end points in achieving mental health. From this perspective the role of the professional is elevated and hierarchical in relation to the consumer.

Recovery Perspective: A recovery perspective in mental health understands a definition of recovery to encompass a reawakening of a sense of hope, meaning, and life purpose. It suggests a more equal or level playing field in the relationship between a mental health provider and a consumer of mental health services.

Schema: Strongly and long-held beliefs based on early experiences that are often experienced as facts, and consistently influence our behaviors. For example, "I must adhere to directives of people in authority."

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Chapter 51
Fighting Stigma in the Community:
Bridging Ties Through Social Innovation Interventions

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ABSTRACT

This chapter will discuss action research conducted in Tuscany to fight stigma surrounding mental illness. Public mental health services (PMHS) in Italy are perceived as ascribing a mentally ill label to individuals who utilize these programs. Local associations, especially sports associations, can be used to fight this stigma. This chapter will present key aspects and results of a community social innovation intervention jointly performed by a PMHS and the University of Florence. The research will explore perceptions surrounding the role and value of the community sports association, participants' perceived improvements, effects of sports participation, and the role of the sports association as an instrument to promote mental health. Results will show that the sports association is perceived as an agent of social capital to reduce social barriers emerging from mental illness. In addition, stigma is deconstructed through improvements to individual and social wellbeing.

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INTRODUCTION

This chapter will describe the role of the *La Rugiada* sports association as a powerful instrument to deconstruct stigma in mental health. First, the chapter will summarize the theoretical background. Next, the context of the intervention and its main features will be presented. The chapter will share study results related to a local community's strategies to prevent stigma surrounding mental illness.

Stigma consists of a social dimension (or public stigma) and an individual dimension (or self-stigma). Both dimensions are capable of affecting an individual's recovery from mental illness and isolation (Andrews, Issakidis, & Carter, 2001). Through individual participation, sports and teams can create a sense of community (Soundy et al., 2015).

By exploring a sports association's role in well-being, services can be identified to fight the effects of stigma and promote community mental health. This chapter will describe the role of *La Rugiada* in rural Tuscany, Italy. It will consider interventions realized through a sports association's role as a social innovation strategy.

THEORETICAL FRAMEWORK

Stigma: Threat to Others and to Self

Although it has been 50 years since Goffman's opera (1963), its contributions continue to be widely used (Bos, Pryor, Reeder, & Stutterheim, 2013). "Stigma" identifies negative characteristics attributed to others. In addition, it devalues stigmatized people. The rise of social problems causes limited citizenship and social segregation, including disqualification from daily community life (Montero, 2010). Participation in community life increases emotional connections in the community. However, a lack of participation, which is associated with disadvantaged social groups, can cause disempowerment (Christens, Speer, & Peterson, 2011; Gaebel et al., 2014; Bosco et al., 2016).

Stigma is a relational process because it is realized in social groups (Hebl, Tickle, & Heatherton, 2000). Through an individual's aversions and discredit toward others, it induces dehumanization and depersonalization for the out-group member (Dovidio, Major, & Crocker, 2000; Tajfel, 1981).

Negative social stereotypes surrounding a social group can be associated with both positive and negative value responses, which can cause different responses of power. As reported by Link and Phelan (2001), the interconnectedness of stigma and power is due to stigma's allowance of the balance of a prevarication relationship. In a psychosocial perspective, stigma's prevarication function is recognized between people who are and who are not stigmatized (Phelan, Link, & Dovidio, 2008). This function favors an imbalance between the powerful and the powerless groups (Major & O'Brien, 2005; Lukes, 2005).

Negative impacts of stigma generate several consequences in people who are stigmatized, including social discrimination and a system of low expectations (Crandall & Eshleman, 2003; Kurzban & Leary, 2001). Moreover, membership in a low-status group can negatively affect the individual level because it can lead to the perception that one's social identity may be threatened (Steele & Aronson, 1995).

The social identity theory (SIT) recognizes cognitive, social, and emotional aspects related to a sense of belonging to a social group as identified by society (Tajfel, 1981). This process involves both individual and social levels (Anderson & Lowen, 2010; Walton & Cohen, 2003). Belonging to a social group establishes significant emotional bonds and impacts positive self-image (Haslam, Jetten, Postmes,

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& Haslam, 2009). On the contrary, belonging to a low-status group causes a negative self-categorization (Sellers & Shelton, 2003). According to Major and O'Brien (2005), when the social identity is stigmatized, people can perceived themselves as at major risk of discrimination.

Coping strategies are tools to handle stigma's effects. The first strategy focuses on the attribution of negative events to discriminatory behaviors in a social system. Using this strategy, individuals can defend their self-esteem and self-identity (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). The second strategy is strictly associated with social identity, in which being a part of a labeled group can lead to evaluate self-identity independent from the in-group or to defend the social group from the society. However, the sense of belonging to a social group, even if stigmatized, allows an individual to obtain social support. The last strategy is associated with social groups (Major & O'Brien, 2005). People suffering from mental illness cope with pathology and stigmatized status. As reported by Link, Mirotznik, and Cullen (1991) people may adopt three specific coping strategies to avoid social rejection:

- Maintaining secrecy about their unhealthy conditions
- Limiting social interaction to those who know their psychological problems
- Using *"preventing telling"* to obviate negative attitude from others

When people are stigmatized, they use both functional and dysfunctional strategies, which may affect the self-evaluation (Link et al., 1991).

PUBLIC STIGMA AND SELF-STIGMA: NEGATIVE IMPACTS ON MENTAL HEALTH

Stigma grows in individual, interpersonal, and societal levels. According to Corrigan and Matthews (2003), public stigma is defined in a social system and self-stigma is a redefinition of the self, based on negative characteristics recognized by society.

Public stigma is a loss of status that produces discriminatory behavior toward people with mental illness (Corrigan & Boyle, 2003). According to Parcesepe and Cabassa (2013), public stigma is based on beliefs and negative attitudes shared by the social system. It may generate fear and social exclusion toward people with mental illness.

Self-stigma is the harmful impact that results from internalizing prejudice leading to diminished self-esteem, lower self-efficacy, and a sense of 'why try' self-deprecation" (Corrigan et al., 2012, p. 65). Moreover, self-stigma can lead stigmatized people to be aware of their social devaluation because of their unhealthy condition (Bos et al., 2013).

Both public stigma and self-stigma have cognitive (stereotypes), emotional (prejudice), and behavioral (discrimination) components. In mental illness, cognitive components are associated with a lack of expertise attributed to others or to one's self (Brohan, Elgie, Sartorius, & Thornicroft, 2010). This is also the case for emotional reactions. For example, that statement that "all people with mental illness are violent" causes the reactive statement that "everybody scares me" (Link & Phelan, 2001). Finally, the discrimination component can be defined as a barrier in the achievement of personal goals (Pingani et al., 2012). This affects opportunities to benefit from life experiences and can lead to a negative redefinition of social status (Corrigan, Larson, & Rüsch, 2009). The interiorization of attributes affects psychological resources and leads to social isolation (Feldman & Crandall, 2007).

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Corrigan and Watson (2002) defined "three As" of self-stigma: (1) agreement; (2) awareness; and (3) application. As reported by Watson, Corrigan, Larson and Sells (2007), group identification, awareness of negative stereotypes, agreement, and application to the self allows self-stigma to impact individual self-esteem and self-efficacy.

Self-stigma may generate an individual's powerless response (or "the why try effect") (Watson, Corrigan, Larson, & Sells 2007). Disempowered people may be affected by a lack of self-efficacy, express a negative personal evaluation, and use an internal locus of control in case of failure (Huang & Lin, 2015). Thus, self-stigma may reduce an individual's quality of life and coping strategies (Vogel, Wade, & Haake, 2006).

From a clinical perspective, self-stigma appears to be associated with a serious increase of positive and negative symptoms, depressive symptoms, and reduced social functioning in people with schizophrenia (Yanos, Roe, Markus, & Lysaker, 2008). Self-stigma causes negative feelings, particularly shame, and embarrassment for the unhealthy condition and the discredited attitude by the social system. Self-stigma leads to negative feelings about the self, which causes an individual to perceive themselves as inferior to other community members (Huang & Lin, 2015; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

The deconstruction of stigma must consider individual and social dimensions (i.e., health professionals, formal and informal associations, users as citizens, and the community). In doing so, community-based interventions and resources will be identified to promote empowerment, improved mental health, and social change.

SOCIAL CAPITAL TO PROMOTE MENTAL HEALTH

Mental health recovery through social engagement increases social capital (Tew et al., 2012). Promotion of social capital may result in greater integration in society and more access to opportunities for people with mental illness (Zoppei et al., 2014).

Social capital is a complex and debated concept with multiple definitions (Morgan et al., 2007). Its core can be summarized with the idea that networks and social relationships are valuable community resources (Field, 2003). Social capital studies refer to various aspects of social life, including social networks, mutuality, and social participation (Zoppei et al., 2014). In a more theoretical definition, social capital was defined as an "investment in social relations with expected returns" (Lin, 1999, p. 30). More specifically, *A Dictionary of epidemiology* (Porta, 2014), identified the concept's twofold nature with characteristics linked to both individual and group dimensions. Social capital is also described as a resource available to members of social groups (e.g., trust, norms) and a resource embedded in an individuals' social networks (e.g., social support, social credentials; Forsman et al., 2013).

Therefore, social capital is conceptualized as both an individual and community attribute. There has been considerable interest as to whether social capital is a feature of individuals, groups, or both. However, the notion has been at the center of a significant academic and policy debate on how socioeconomic disadvantages impact mental health (Bertotti et al., 2013).

A definition of its dimensions is needed to better understand the practical implications of social capital. Studies have discussed several types of social capital, such as structural and cognitive social capital (McKenzie, Whitley, & Weich, 2002). According to Ehsan and De Silva (2015, p. 1021):

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…structural (participatory) social capital refers to relationships, networks, membership, organisations, associations, and institutions that may link groups or individuals together. Cognitive (perceived) social capital refers to values, norms, attitudes, beliefs, civic responsibility, altruism, and reciprocity within a community.

In other words, the structural component could be considered the quantity of social capital. It examines the extent and intensity of links between individuals, their behaviour, and their participation in group activities (Bertotti et al., 2013). On the other hand, the cognitive component could be regarded as the quality of social capital as it focuses on the types of social interaction between individuals (Harpham, Grant, & Thomas, 2002).

The structural and cognitive components influence health in different ways. The cognitive component, including perceived social support, trust, and a sense of belonging, has been strongly associated with a range of mental health outcome measures across several countries at individual and ecological levels (Phongsavan et al., 2006; Tomita & Burns, 2013). The structural component, which derives from social contacts and social participation, appears to have a more complex relation with health.

Systematic reviews using cross-sectional or experimental data found that social capital may act as a protective factor in mental health problems (De Silva, McKenzie, Harpham, & Huttly, 2005). The most recent systematic review from Ehsan and De Silva (2015) confirmed that both individual and ecological cognitive social capital reduce risks of common mental disorders. This means that these forms of social capital protect against mental illness.

At the same time, weaker associations emerge surrounding the positive influence of structural social capital on mental health. According to studies, low-resource settings (and selectively in these conditions) can impact an individual's participation in civic activities. This can be associated with an unexpected increase to the risk of mental disorders (Forsman, Nordmyr, & Wahbeck, 2011). Similar results emerged from Bertotti et al. (2013). In this work, the effects of social networks and perception of neighbourhood quality, which are components of structural social capital, change the sense of the relations to mental health depending on the socioeconomic characteristics of the environment (ibidem). Clayton et al. (2013) found similar unexpected results in their longitudinal randomized controlled study focusing on citizenship to prevent mental illness and criminal justice involvement.

Evidence reported in this work highlights the importance of innovative interventions based on the ecological community approach, the use of creative instruments to improve social capital and prevent mental illness, and caring for relationships among patients and the community (Bosco, Petrini, Giaccherini, & Meringolo, 2014). Social innovation interventions can be useful because they are based on solidarity and reciprocity among citizens and the social system.

SPORTS TO FIGHT STIGMA

An increasing amount of research shows that sports intervention improves physical health in people with severe mental illness (Firth et al., 2015; Rosenbaum et al., 2014). People with serious mental disorders experience a premature mortality, approximately 15 to 20 years earlier with respect to the general population. This differential mortality gap has grown in recent decades (Saha, Chant, & McGrat, 2007). Two-thirds of these deaths are due to physical health risk factors from limited access to medical care,

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poor diet, reduced levels of physical exercise, and medication-induced weight gain. This risk particularly affects people with mental illness due to greater amounts of sedentary behavior (Stubbs et al., 2016).

Many of the physical health issues, which are related to modifiable risk factors, can be attenuated through lifestyle changes, including exercise (Curtis et al., 2016; McNamee, Mead, MacGillivrey, & Lawrie, 2013). Physical exercise programs are valuable to people with serious mental illness. Recent meta-analysis of randomized controlled trials demonstrated that physical exercise has a moderate to large effect size for individuals with depression disorders as compared to control groups (Krogh, Nordentolf, Sterne, & Lawlor, 2011; Retrhost, Wipfli, & Landers, 2009).

Research in adults with schizophrenia shows that exercise interventions reduce negative symptoms and cognitive deficit (Firth et al., 2016; Kimby et al., 2015). This also includes secondary symptoms like depression, low self-esteem, and social withdrawal (Faulkner & Biddle, 1999).

In the treatment of mental disorders, exercise may complement other interventions. It can be used as a stress management strategy to prevent recurrences and improve functional recovery, lifestyle practices, and overall health (Morgan, Parker, Alvarez-Jimenez, & Jorm, 2013).

Firth et al. (2015) found that the most prominent exercise barriers for people with mental illness is the lack of support. This was reported by 50% of those analyzed in the systematic review.

Within physical activities, sports are considered a type of leisure time (Howley, 2001). Thus, sports participation can be viewed as a pleasant way for people with mental illness to achieve physical activity recommendations (Bulut, Eren, & Halac, 2013; Howley, 2001; Vancampfort et al., 2012). Based on literature, sports participation has psychological and social benefits. As reported by Langle, Siemssen, and Hornberger (2000), sports participation can have positive psychological effects on an individual's mental health, including self-esteem, body awareness, social interactions, and time management.

Regarding individuals with schizophrenia, a recent study by Soundy et al. (2014) identified broader, more direct psychosocial benefits of sports participation. They highlighted self-initiated positive changes in behavior, increased confidence, pride in other settings, and a sense of purpose, meaning, and achievement. A sense of belonging, cohesion, and support are identified by Soundy et al. (2014) as benefits of sports participation.

In a meta-synthesis review on qualitative data, Soundy et al. (2015) emphasized the following themes associated with sports participation for individuals with mental illness:

1. Social Meaning of Sports in the Lives of Patients
    a. Positive social experiences to look forward to and be a part of
    b. Feelings of community and positive identity
    c. Activities to promote autonomous behavior and social engagement
2. Direct Benefits of Sports
    a. Places to go and things to do
    b. Normalized activities and opportunities to be in a positive group
    c. Distractions from typical worries, anxieties, or symptoms of mental health
3. Organization, Process, and Challenges of Sports
    a. Progression of tasks' difficulties and use of supported competitions
    b. Importance of environment and use of sports to foster a sense of belonging, identity, and interaction

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4. Functional Social Support
    a. Esteem support, encouragement, and positive feedback
    b. Emotional support from staff and peers

Thus, sports can offer positive opportunities for social engagement to people with mental disorders. Participation in sports-related activities is a social learning experience. It can be an opportunity to feel "normal" in front of others. Moreover, sports can provide access to new social levels, as well as create a distance from institutionalized settings and identities (Soundy et al., 2014).

Voluntary sports organizations represent the largest voluntary sector in the western countries. According to literature, volunteering and active participation in society are considered crucial elements to social capital (Baum & Ziersch, 2003; Hartmann; 2003). Sports and exercise interventions can be used by mental health services as instruments to fight stigma and social isolation. Moreover, sports and exercise interventions can promote social interaction and a sense of community and connectivity (Coaffee, 2008; Hartmann, 2003). Thus, social interventions based on sports activities can promote community mental health and social capital by engaging diverse audiences and providing avenues for social inclusion in communities (Sherry & O'May, 2013).

PMHS IN ITALY: INNOVATIVE INTERVENTIONS WITHIN THE COMMUNITY

Research reported in this work took place in Tuscany, Italy.

The Italian system of mental health is founded on the Law n.180, Basaglia Law, from the name of its promoter. Realized in 1978, this psychiatric reform signified the closing of all insane asylums within the national borders. It also introduced diagnosis and care psychiatric services into general hospitals.

Psychiatric reform generated an enormous cultural change for communities and people living with mental illness. Prior to the Basaglia Law, the psychiatric system was addressed to the custody and social control of the deviance. After its approval, people with mental illness received the civil right to be cured and cared for in their community.

In 1998, a new organization of PMHS was settled following the first national mental health project. In accordance with the project, small services were founded in local communities and territorial areas, aimed to care for people with mental illness. To meet this goal, they used therapeutic and rehabilitative interventions, promoted empowerment, and increased healthy communities by means of preventive strategies.

The connection between PMHS and communities allows for planned interventions to prevent the worsening of mental illness, establishes networks of people suffering with mental illness, and improves social capital. This process can be achieved by starting from resources in the territory, promoting empowered communities, and generating well-being and mental health. Civic participation and civic engagement are key features to this perspective (Arcidiacono, Gelli, & Putton, 1999; Ehsan & De Silva, 2015).

The Italian system of mental health is based on participation. Bridging health professionals, families, and patients of PMHS promotes a proactive attitude toward health (Bentall, 2003). On the other hand, it is possible to obtain positive effects on the quality of PMHS due to the added value derived from the participatory process (Crawford et al., 2002; Simpson & House, 2003). Social innovation interventions generated a new model of organizations based on collaborative relationship between social actors, including nonprofit organizations, users, and citizens.

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It is important to recognize interventions based on ecological approaches in the current Italian debate on mental health community care (Agnetti, 2007; Bosco et al., 2014; Re, 2005). The realization of social innovation interventions is required to achieve this recognition.

As reported by Stiglitz (2009,) social innovation can be defined as new responses to social problems, and as an instrument to improve individual and social well-being.

More specifically, the Bureau of European Policy Advisers (BEPA, 2011) defined social innovations as new ideas able to meet social needs, create new social relationships, and enhance society's capacity to act.

Considering the ecological community approach, social innovations can be a powerful strategy to promote positive effects on societies at both macro- and micro-levels. This empowers people by engaging them through participation as a model of intervention.

The sports associations for social integration was founded within this process. The group brings together PMHS and third sector organizations with mental illness users, their families, and their communities. Using sports to build social integration, they involve citizens in the management of activities to promote community wellness. Their purpose, which is based on the principles of welfare community and welfare mix, is to redefine the reciprocal relationship between individuals and communities as they bridge ties within the social system.

LA RUGIADA SPORTS ASSOCIATION FOR SOCIAL INTEGRATION

La Rugiada, a sports association, was founded in 1996 in partnership with a PMHS of Florence. It is situated in a rural area of 110,000 habitants. *La Rugiada* has 120 members, including people with mental illness, PMHS professionals, and volunteers. Football, volleyball, hiking, canoeing, and sailing are the main activities. The association promotes social integration for people suffering with mental illness. It maintains links between PMHS and the community.

La Rugiada was officially recognized in 1998 as a sports association for social integration. It earned formal autonomy in the improvement of sports activities, social projects, and management processes. An important evolutionary step of *La Rugiada* was the foundation of its sailing club in 2008. This represented true innovation. Figure 1 illustrates the principal steps of *La Rugiada*.

Figure 1. Steps of La Rugiada's evolution



The sailing activities are carried out in a small lake near the town. Community activities included families, children, youth, high schools, and citizens in the community and nearby territories. In 2016, 100 children participated in the summer activities. Three hundred young people were enrolled in sporting activities.

Members of the sailing club included individuals with mental illness, PMHS professionals, and volunteers who worked in the community. The principal innovative aspects were to:

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1. Create a sailing club in Tuscany's hilly landscape (far from the sea or basins) as an attractive community resource
2. Establish recognize social roles for people with mental illness (e.g., patients are sailing activity instructors)
3. Consider the sailing club as an instrument to fight stigma in mental illness, promote participation, and enrich community wellness

These new activities generated an important cultural change in the territory. Prior to the sailing club's foundation, activities promoted by PMHS and *La Rugiada* focused on people with mental illness and their social reintegration. After its foundation, as comanaged by users of PMHS, activities refocused on the community to address of social well-being. In this process, PMHS users became community resources.

The present work explores *La Rugiada*'s potential as an agent of social capital to fight stigma. It studies *La Rugiada* as an instrument to promote sports' impact on mental health in the community.

RESEARCH

The present contribution describes action research carried out by the University of Florence and a PMHS in Tuscany. The studies discussed planned effective community strategies to prevent mental illness considering the role of stigma.

The increased number of young patients led PMHS to identify new instruments and methods to care for young people with mental illness and meet their psychological needs. When faced with psychological problems or mental health episodes, young people may be reluctant to seek PMHS help due to stigma. This reluctance, which is associated with an increase of mental health problems, may generate negative consequences to future health. Moreover, it can cause drop outs, social isolation, and marginalization. This study reviews *La Rugiada*'s experience using sports participation in PMHS and the community.

The first and second studies used qualitative methods to explore sports association in the community and the effects of sport participation on people with mental illness. The third study was action research in local high schools. It investigated the role of the sports association as an instrument to prevent and promote mental health in the youth population.

The exploratory investigation used both qualitative and quantitative methods. Qualitative studies explored the perceived role of *La Rugiada* in the community. It considered the points of view of professionals and patients of PMHS. The quantitative study detected changes in the high school prior to and after the sports intervention.

Study 1: *La Rugiada* as a Change Agent in the Community

Aims

The exploratory qualitative research analyzed:

1. The perception of the role and value of the sports association in the community
2. Participants' perceived improvement from participation in the sports association

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Methods

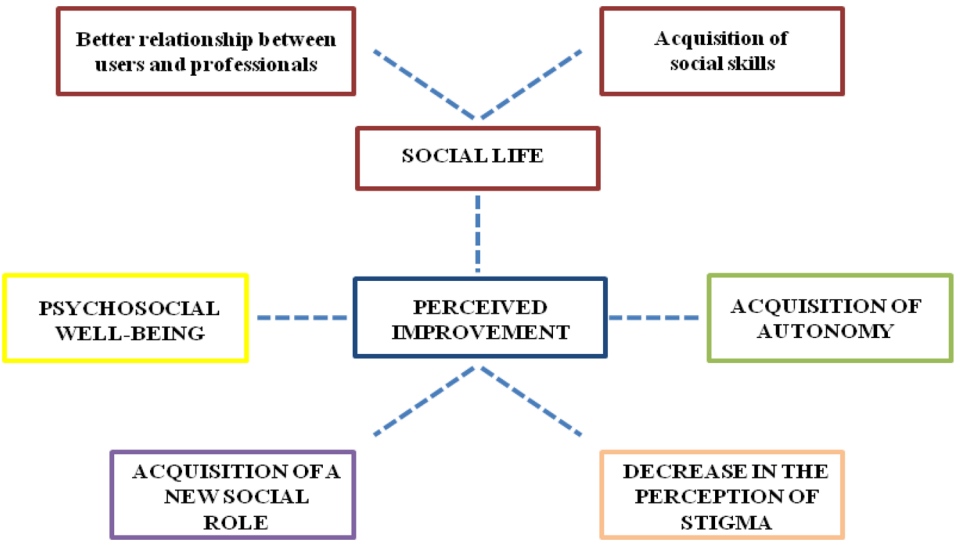
- **Participants:** Twenty-three members of *La Rugiada* (users and professionals)
- **Instruments:** Semi-structured interviews.

Qualitative content analysis was inspired by Grounded Theory approach (Glaser & Strauss, 1967) and was performed using the qualitative data analysis software Atlas.ti.

Findings

Qualitative analysis shows that user-members who participated in sports activities experienced personal change (see Figure 2).

Figure2. Perceived improvement



Growth in personal and social knowledge by people with mental illness was perceived. In members' perceptions, sports participation by *La Rugiada* generated social responsibility, which positively impacted self-esteem:

I am starting to be more independent. Now I am more confidence. (user, male)

An increase of social networking and support between members was reported, which generates "weak ties" (Granovetter, 1983) between them:

Now I have friends. Before I was alone! We can meet also outside La Rugiada. (user, male)

Before [La Rugiada] I was very shy […] now I have another idea to stay with other people. (user, male)

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Sports participation promoted by *La Rugiada* offers socialization opportunities to people with mental illness.

It brings new social opportunities like participating at national events or on summer holiday. (user, male)

According to participants, *La Rugiada* promoted specific changes in the "autonomy area of life" for people with mental illness. In particular, *La Rugiada* acquired daily organizational skills and self-care tools. Through sports participation, members could:

learn with others and apply the game's rules in the social context. (user, male)

Being a part of *La Rugiada* was perceived as a protective element in case of stressor events.

The main change reported by PMHS professionals was members' peer relationships, including those with mental illness. Being a part of *La Rugiada* meant:

they were a part of the same group … members of the same association … with the same rights. (professional, female)

Social and professional roles were reduced in this setting. Sports activities allowed for more spontaneous and close relationships between professionals and users. Experiencing *La Rugiada* as PMHS professionals and members reduced biases related to mental illness.

Before this experience, I used to categorize 'us' and 'them.' I used social barriers as a form of psychological defense in the professional setting. After this experience I understand that there are not differences between us. (professional, male)

Sports participation appears to reduce prejudice and barriers caused by illness. Participation also generates *"a sense of sharing and belonging":*

Through participation in sports activities, it is possible to share memories, emotions, time, and difficulties. (professional, female)

Moreover, in the participants' perception, *La Rugiada* played a valuable role in the community as a *"central instrument to promote community mental health."* As was reported by one research participant, "*it was possible to connect PMHS and the local community."*

Finally, *La Rugiada* was perceived as a powerful instrument within the social system for people with mental illness. This was due to *"the strength of the weakness ties."*

Through the participation, everyone connected with each other … it generated the opportunity to interact with other social groups in the local community. (user, female)

La Rugiada is a possibility to interact with others in a context where the social barriers are reduced … to create a new culture on mental health. (professional, female)

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Study 2: Exploring Individual Perceptions on the Sailing Club as a Community Resource

The sailing club represents the most innovative activity promoted by *La Rugiada*. Members of the sailing club are people with mental illness, professionals of PMHS, and a great number of volunteers working together spreading their work into the community. The sports activities, sailing and canoeing, are addressed to all citizens (family, children, schools, et.)

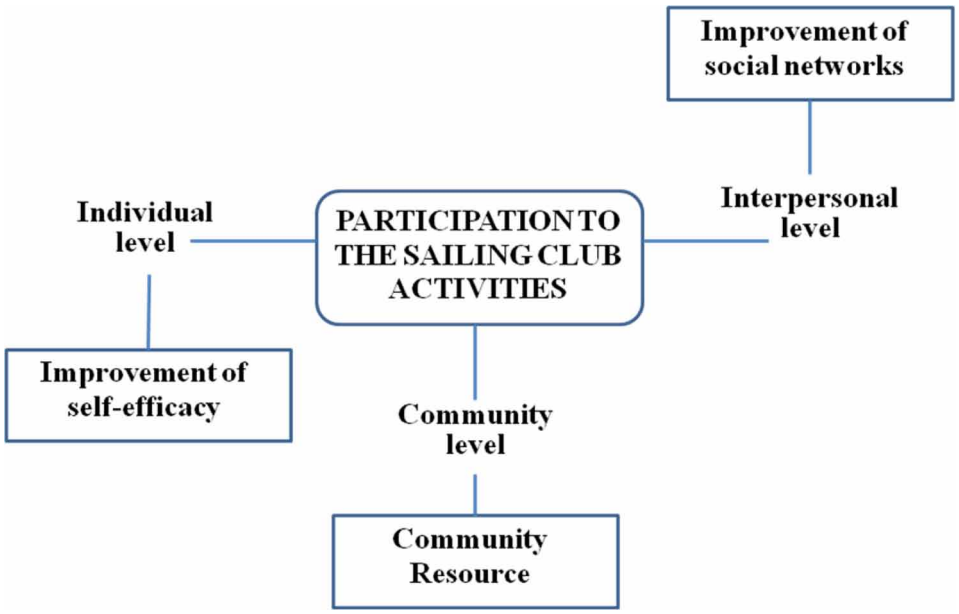
While the first study focused on individual perceptions about the role and value of the *La Rugiada* sports association, a second study was carried out to investigate perceptions surrounding the sailing club and its peculiar function in bridging ties with the community.

- **Aims:** This study explored the effects of sports and association participation on individual well-being, as well as the value of the sailing club as a community resource.

Methods

- **Participants:** Seventeen stakeholders (directly and indirectly involved in sailing club activities)
- **Instruments:** Semi-structured interviews were analyzed using the Grounded Theory approach (Glaser & Strauss, 1967). Qualitative content analysis was performed using Atlas.ti.
- **Findings:** Data analysis showed a shared and coherent perception among stakeholders about objectives, health benefits, and community interests promoted by participation in the sailing club activities (see Figure 3).

Figure 3. Main effects of participation in the sailing club



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Reduced social isolation and improved social networks appear to be an expected outcome for all stakeholders.

Before this experience, I was in a [therapeutic] community. I was just released and I did not know even where to go. My parents suggested the sailing club. (user, male)

Relationships require time. Here [in the sailing club], sports, dinners, and holidays are realized with others ... they are elements that can help to maintain contacts. People can discover positive aspects to stay with others. It is important to be part of a group. Here, I meet new people and I can spend time with people that I already know. (user, male)

According to professionals, sports participation fosters patient autonomy, improves self-efficacy, and assists in time management.

What I see is that they [user-members] are more responsible because the club also gives them responsibilities [...] there are timetables and they learn to manage the time themselves … they learn to do things they had never done. (professional, male)

The mutual help is a crucial dimension of the sailing club. This is recognized by all participants; they feel it reduces stigma surrounding mental illness:

When you join the club, there are no social differences. We are all equal; we are the same as a person! So, you cannot tell another 'you're problematic' or 'I have problems' and 'stay away.' On the contrary, 'I stay closer to you.' (volunteer, female)

Data suggests that the lack of competitiveness in this kind of sport could represent an added value for the recovery of people with mental illness:

This reality is special: it is not a football team or a volleyball team in which you are always with the sport team … where you train every week, do the weekly match, and you are sharing the aim of winning more than staying together […]. Sailing is an activity that you can do by yourself. (user, male)

The sailing club is perceived as an innovative community resource as underlined by all participants:

Sailing is an innovative activity in the community. La Rugiada promotes different sports activities, such as football and volleyball. But if you want to do sailing, you'll need to travel 90-100 km from the community. Thus, sailing is able to meet and respond to the needs of the territory. (volunteer, female)

Sailing generated a great curiosity between citizens. It generated the desire to perform sailing. There is a great interest about sailing in the community. (user, male)

The sailing activity is a very attractive sport activity, and it is perceived by participants as a *"shared dynamic movement between citizens."*

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The sailing club is a place for everyone! We tried to create a place within the community. It is a sports association realized with people. So, the sailing club is an instrument and a resource for the community. (professional, female)

According to participants, another added value of the sailing club is its ability to generate relationships between members and citizens who are not involved in *La Rugiada* sports.

The sailing activity is performed by all the citizens - not only by members. This is an extraordinary wealth. (volunteer, male)

The sailing club is the spearhead of La Rugiada. It connects the community and PMHS. (professional, male)

Other institutions also perceive the sailing club as *"a resource for the community."* The social inclusion process for people with mental illness involves the community as a resource. Through interventions promoted by the sailing club, patients become resources for the territory. As reported by participants, *"this reverse of position has a strong value for the community."*

The sailing club is also perceived as a place to meet young people and an instrument to prevent mental disease:

the leisure time is important for young people. We have to take into account their needs considering that they use their extracurricular time at home or using the Internet. (user, male)

We have to include young people in the sailing club in order to realize activities able to reach their psychological needs. (professional, male)

Another important finding is the interest to spread knowledge about the sailing club. This enhances the social and solidarity dimensions, as well as characterizes the setting:

We have to stay in the community! We also have to organize meetings in the local schools. Then, students will talk with their parents, and so on. When people meet us [the sailing club], they discover a safe environment where people get involved thanks to their altruism. It's a wonderful thing that the sailing club is taken care of by all we meet. (volunteer, male)

Participants highlight their interest to work with young people. Their opinions are crucial when promoting a cultural change in the field of mental health.

We have to bring the sailing club into high schools because we need to educate youth on a culture founded on social inclusion and to change their beliefs about mental health. (professional, male)

Study 3: Preventing Mental Illness to Deconstruct Stigma

Findings from the qualitative research in the previous studies led to specific actions to prevent mental illness and promote mental health in the community. In addition, it focused on a specific setting and

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young people. To deconstruct stigma toward mental illness, action research was realized through *La Rugiada*'s sports activities involving Grade 12 high school students.

As reported, young people with psychological problems may avoid professional help due to prejudices toward PMHS. They may also fear receiving society's "mentally ill" label.

After considering the principal findings of the previous studies in this chapter, the third work aimed to increase knowledge about mental health. It studied how PMHS can use *La Rugiada* as an instrument of change.

- **Aims:** Action Research investigated beliefs surrounding mental illness, social and professional resources for youth with psychological problems, and the role of the sports association in promoting mental health. Moreover, the research aimed to verify if attending participatory sports activities can modify perceptions about mental illness.

Methods

- **Participants:** Three-hundred and fifty Grade 12 high school students (mean age = 17.46 years, SD = 0.66).
- **Instruments:** for each participant demographical information and data about the perception of seeking help have been collected. An ad hoc questionnaire was administered in order to explore their attitudes about mental illness and to assess perceived social support in case of psychological problems. The questionnaire had a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Moreover, perceptions about the role of the sports association were collected and analyzed after the action.
- The Statistical Package for the Social Science (SPSS) was used to performed data analysis.
- **Descriptive Analysis:** One-hundred and sixty-three males (51.7%) and 152 females (48.3%).
- Almost all participants (96.8%) stated that their family had a mother and father. Participants reported that:
    - 40% of fathers held a high school diploma
    - 7.8% of fathers held a college degree
    - 45% of mothers held a high school diploma
    - 12.3% of mothers held a college degree

One-fifth of the participants (20.6%) stated that they repeated at least one school year. Of the participants, 41.5% experienced less severe educational difficulties.

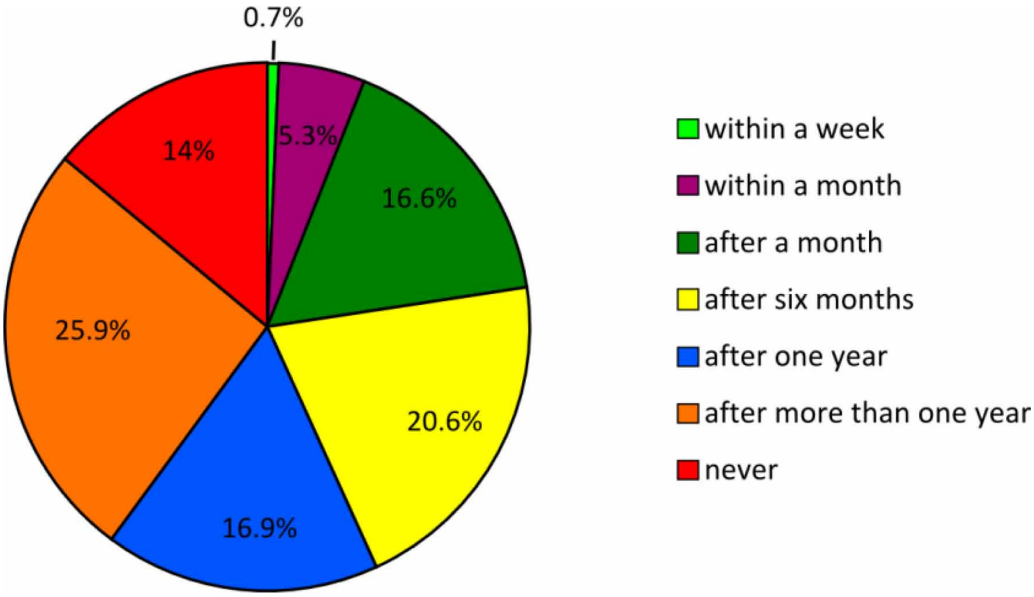
Seventy-seven percent of the study participants had a friend with psychological problems. More than 53% suffered personal psychological problems. The most frequently reported issues were affective problems with partners or friends (36.4%), depression (32.6%), and anxiety (25.3%).

Among the participants, 57.6% sought help by speaking with friends for emotional support. Within the social system, participants used the social network to seek out health professionals (20.9%), peers (10.8%), and family (8.9%). Family doctors (4.1%) and teachers (2.8%) were perceived as potential helpers. The Internet was considered an instrument to seek help for 8.5% of participants. In fact, only 0.9% used social network forums for useful information.

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Participants were asked to identify the time between the arising of the first symptoms and the actions to seek help. More than a quarter of participants (25.9%) consider that young people seek help after more than one year; 16.9% seek help after one year; 20.6% seek help after six months; and 5.3% seek help in one month. A low percentage (0.7%) of participants report that youth seek help in one week; 14% will not seek help (see Figure 4).

Figure 4. Time before seeking help



Participants believe that response time before help can be received: one week (21.8%); one month (24.8%); after one month (21.8%); and after six months (9.4%). For 12.1% and 5.7% of participants, the response time can arrive after one year or several years (see Figure 5).

Some social beliefs are associated with mental illness. Of the participants, 42.4% believed that 1 out of 10 people will suffer mental illness during their life. Lazy or weak people are perceived to be at a greater risk for mental illness (75.9%). According to the study, 83.2% of participants believed that people with mental illness do not seek professional help. Only 3.8% of participants believed that it was impossible to help someone with mental illness.

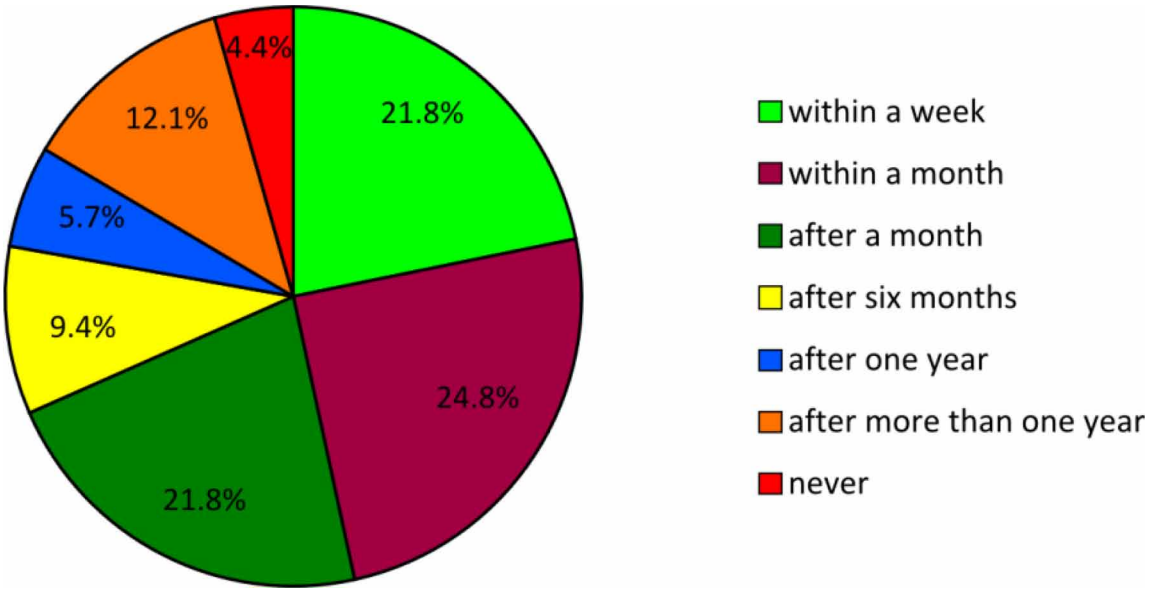
During the study, 8.2% of participants felt that *"it is not possible to get better from mental illness.",* which was recognized as a cause of absenteeism (34.2%) and crime (45.6%).

Difficulties to seeking help with PMHS included prejudice (M=3.54; SD=1.23), lack of knowledge about services (M=3.37; SD=1.08), and low confidence in PMHS (M=2.85; SD=1.17). Participants reported poor motivation to seek help by young people (M=2.92; SD=1.03).

Despite difficulties perceived for young people, participants considered that seeking help through PMHS would solve psychological problems (M=3.36; SD=0.80). PMHS was perceived as a social resource in the community in which family members affected by psychological distress could seek help through professional services (M=3.24; SD=1.1).

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Figure 5. Time before receiving help



However, seeking help through PMHS was regarded as a cause of a negative social response in the peer network (M=2.96; SD=1.18). Due to this reason, young people preferred to cope with the problem by relying on their own resources (M=2.85; SD=1.32).

Psychological problems led to feelings of shame (M=3.74; SD=0.82) and self-isolation (M=3.50; SD=0.88). Participants noted youngs with psychological problems received negative responses from peers (M=3.39; SD=0.95) and may be emarginated by them (M=3.20; SD=0.89). Hence, in the participants' opinion, young people can use social resources (M=2.85; SD=0.89) to receive useful help (M=2.55; SD=0.85).

Private professionals were perceived as more competent (M=3.75; SD=1.05). Peer networks (M=3.58; SD=0.92) and family (M=3.52; SD=1.01) were the principal sources of help related to psychological distress. Participants, in fact, reported that they sought help through friends (M=3.61; SD=1.16) and family members (M=3.36; SD=1.18).

Partners were also perceived as helpful (M=3.03; SD=1.02). Significant adults (M=2.77; SD=1.04), family doctors (M=2.49; SD=1.06), and teachers were perceived as less able to provide helpful actions (M=2.41; SD=1.0). In fact, in participants' personal experiences, teachers (M=1.75; SD=0.95), family doctors (M=1.51; SD=0.87), and PMHS (M=1.51; SD=1.03) were considered less able to give support to their own psychological problems.

- **Actions in High Schools:** High school students participated in a reflection process on mental health issues. This action was realized using sports activities as an instrument to promote mental health for the community and social inclusion for people with mental illness.

A volley match (see Figure 6) and a sailing boat tour (see Figure 7) promoted the interaction and connection between students and members of the *La Rugiada* sports association.

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- **Analysis of the Intervention's Outcomes:** This study aimed to explore if participation promoted changes in participants. A paired sample t-test compared the mean scores for the same group of participants in two time frames (T1 = before the intervention; T2 = after the intervention).

Figure 6. Volley match with high school students

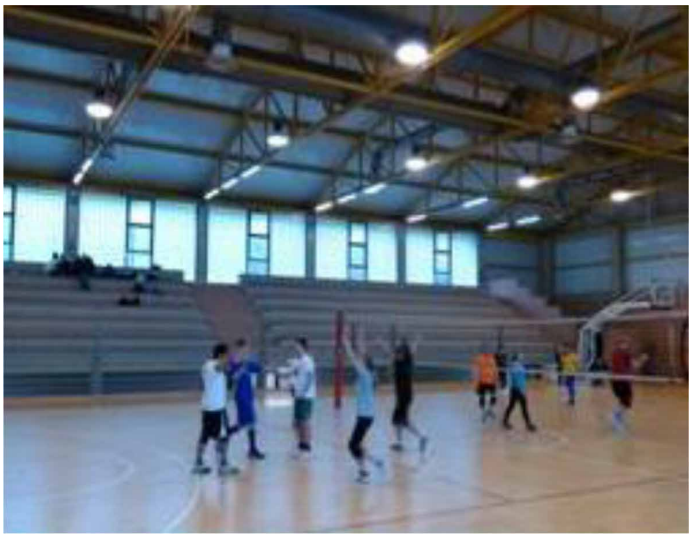


Figure 7. Sailing boat tour



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Table 1. Source of support before and after intervention

Source of Support	T1		T2		*t***
	M	SD	M	SD	
Parents	2.92	1.61	3.35	1.25	-3.42**
Partner	2.81	1.34	2.72	1.32	0.77
Friends	3.73	1.10	3.63	1.06	1.11
Teachers	1.79	0.94	1.94	0.95	-1.99*
Family Doctor	1.50	0.86	1.39	1.12	1.14
Significant Adults	1.95	1.08	2.08	1.13	-1.1
Private Professionals	1.94	1.36	2.22	1.43	-2.2*
PMHS	1.47	0.91	1.94	1.28	-3.3**

*: $p.< 0.05$, **: $p.< 0.01$

Table 1 shows that the intervention impacted student scores on the source of support. After the action, youth perceived parents (T1: M=2.92, SD=1.61; T2: M=3.35, SD=1.25; t=-3.41, p<.01) and teachers (T1: M=1.79, SD= 0.94; T2:M=1.94, SD=0.95; t=-1.99, p<.05) as more helpful in the case of psychological problems. Statistical differences were detected in the role of private professionals (T1: M=1.94, SD=1.36; T2: M= 2.22, SD=1.43; t=-2.20, p<.05) and PMHS (T1: M= 1.47, SD=0.90; T2: M=1.94, SD=1.28; t=-3.30, p<.01) as more effective in psychological distress after interventions.

A statistically significant change emerged in terms of difficulties perceived in a psychological problem. After the intervention, students had an increased awareness to negative attitudes and behaviors by the social system (T1: M=2.59, SD=0.96; T2:M=2.73, SD=0.94; t=-2.18, p<.05). After the intervention, students could identify adequately formal sources of support in the case of psychological problems (T1: M=2.13, SD=0.83; T2: M=2.25, SD=0.78; t=-1.94, p=0.054). They could also receive adequate help from these sources (T1: M=2.52, SD=0.84; T2: M=2.74, SD=0.89; t=-3.24, p<.01).

Reflections related to these experiences were collected. Many participants defined the association as an important *"source of help"*. A young male noted that he *"finally knew who and how to seek help in the future in my community."* Moreover, a young female defined the sports association as *"able to take care of the community and cure people with mental illness."* Another student (female) felt that the relationship built by the sports association was based on *"non-judging attitudes … this can really help people with an illness condition."*

Some participants found it difficult to seek help through PMHS because young people strongly recognize it as a place *"where crazy people go"*. However, the sports association is perceived as *"able to demolish prejudice that disease poses."(female)*

DISCUSSION AND CONCLUSION

La Rugiada experience is an innovative activity developed through the collaborative efforts of public organizations (a local PHMS and the University of Florence), a third sector association, users, and the community. These social actors strongly promoted a new culture of mental health founded on social inclusion for people with mental illness, and community wellness.

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This contribution shows an innovative social intervention to fight stigma in mental health, as well as prevent mental illness through sports participation. Two qualitative studies explored perceptions surrounding *La Rugiada* sports association. They looked at the effects of sports participation, specifically sailing. The third study by means of an action research investigated the role of sports as an instrument to prevent mental illness and promote mental health in youth.

One of the most interesting aspects of the experience was the capacity of the intervention in linking fundamental elements in the work of mental health.

Several actions have been realized through *La Rugiada* and the sailing club: fought stigma and implemented rehabilitation pathways for people with mental illness; prevented mental illness in young people; promoted well-being in the community.

Another important outcome of this intervention was the awareness that *La Rugiada* may be a community resource, and users became active members in this process.

Fighting Stigma and Implementing Rehabilitation

Sports participation as a rehabilitative program was a powerful strategy to improve people's mental health. Consistent with the literature, findings suggest that social interventions by sports participation improved both physical health and social responsibility in people with mental illness (Firth et al., 2015). It reduced isolation and social barriers between members, as well as improved social support (Morgan et al., 2007). Both professionals and patients considered sports participation as an instrument to promote socialization for people with mental illness (Rosenbaum et al., 2014; Sherry & O'May, 2013). Active roles and perceived skills positively affected self-esteem and self-efficacy. Participation generated a sense of reciprocity between PMHS, users (considered by the community as "citizens able to"), and the community. Sports participation reduced prejudice and barriers caused by mental illness. It created of a sense of belonging.

Preventing Mental Illness in Young People

Data emerging from the third study confirmed that stigma has a central role in the decisional process of seeking help. Among young people, reluctance to seek professional help may be explained by the lack of knowledge and prejudice surrounding local mental health services. These aspects were confirmed as relevant barriers by participants (Gaebel et al., 2014; Bosco et al., 2016).

Seeking help through PMHS was considered by young people as a cause of negative social reactions in the peer network. In their opinion, people with psychological problems are stigmatized by others in the society. This process may negatively affect the Self-evaluation (Corrigan et al., 2012; Parcesepe & Cabassa, 2013).

The negative attribution derived by the society (public stigma), may categorize them as members of a powerless and stigmatized group because of their unhealthy condition. Thus, in case of psychological problems, young people do not seek professional help to avoid the social rejection, and to protect themselves by feelings of shame, self-isolation (self-stigma), and discriminatory behavior acted by the peer group.

In the case of psychological problems suffered by a friend, emotional support was the principal action realized by participants. Young people would not seek help from formal resources event when the resources were perceived as more adequate (Rickwood et al., 2005).

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Actions in local high schools fostered reflections on consequences experienced by people with mental health problems. Significant changes (before and after the intervention) have been detected, particularly related to increased awareness on the consequences of stigma (public stigma and self-stigma) in social life (Vogel et al., 2006). Following the sports participation intervention, significant differences were found about the source of the support. Participants perceived formal help seekers more adequate than informal help seekers (Anderson & Lowen, 2010). Moreover, significant adults, parents, and mental health professionals were perceived as more helpful than friends in the case of psychological problems.

The reluctance of young people to seek professional help, as well as their self-reliant attitude as preferred coping strategies, required a closer connection between PMHS and young people. The example of *La Rugiada* can be effective in connecting people and institutions through sport.

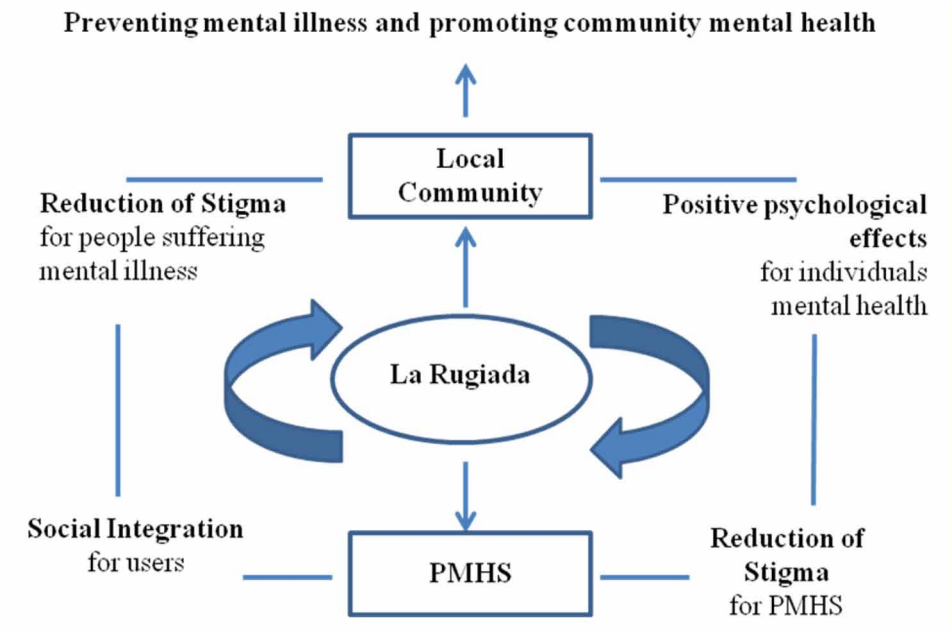
Sports participation generates a sense of belonging and creates significant relationships, which may include adults. We know that stigma negatively affects PMHS: therefore, mental health services must connect with the youth population through social innovation interventions for psychological needs. *La Rugiada* can be a significant resource to promote positive attitudes toward seeking help.

Promoting Community Well-Being

La Rugiada can be an innovative intervention. It generates mutual help, creates a sense of belonging to a sports team, and boosts members' confidence. These are crucial elements to meeting a community's psychological needs.

Results suggested relevant aspects to deconstruct stigma. *La Rugiada*, particularly its sailing club, may modify beliefs about mental illness. This activity allows people, including those with mental illness, to meet and connect. The community is considered a setting for everyone. People are assigned a new social role recognized by society.

Figure 8. Social role of La Rugiada



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Promising findings suggest that *La Rugiada* developed a powerful setting to link PMHS and the community. According to participants, the sports association functioned as an *"open workshop addressed to the whole community,* and *La Rugiada* is defined as a *"place of care"* for citizens. Thus, the intervention based on community setting and sports participation seem to be able to reduce stigma surrounding PMHS and mental illness (Soundy et al., 2015).

The social role and impact of *La Rugiada*, as suggested by results, are summarized in Figure 8.

La Rugiada may be an innovative experience to generate community participation. The capacity to promote positive change in various aspects of social life, including social networks, mutuality, and social participation (Zoppei et al., 2014), is the added value of the sailing club. It leads to consider this sports activity and *La Rugiada* as a bridging element of social capital.

As suggested by the results, *La Rugiada* connected citizens, formal and informal community networks, and the community. Thus, it can be viewed as a powerful instrument to promote healthy communities through destigmatizing strategies.

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KEY TERMS AND DEFINITIONS

Basaglia Law: A legislative reform about psychiatric services that resulted in the closing down of all insane asylums in Italy.

La Rugiada: A sports association for social integration which promote well-being and mental health through sport.

PMHS: Public mental health service aimed to care and cure people with mental illness through therapeutic and rehabilitative interventions, and to promote community mental health.

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Social Capital: A social and/or individual dimension in which social networks, mutuality, and social participation are valuable resources.

Social Inclusion: A process to improve participation in the society for disadvantaged people.

Social Innovation Intervention: New strategies and/or services able to meet social needs and enhance individual and social wellbeing.

Stigma: A label attributed to others based on undesirable social characteristics.

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Chapter 52
Reducing Stigma in Mental Health Through Digital Storytelling

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ABSTRACT

The authors present the use of digital storytelling with two populations that have been consistently shown to be at increased risk for developing mental health disorders: veterans and firefighters. Despite efforts to increase access to evidence-based mental health programs, stigma remains a major barrier to care. AboutFace and Firefighters Helping Firefighters are two DST resources designed to help recognize the symptoms of posttraumatic stress disorder (PTSD) and related mental health symptoms, and to encourage help-seeking. These web-based video galleries introduce the viewer to 70+ peers who have experienced PTSD and have received formal treatment. These sites use the shared bonds of service to educate and help normalize common reactions that they may have due to the stressful nature of their occupations. Visitors to the site can "meet" peers and hear how mental illness has affected them through unscripted, authentic personal stories and can learn about common symptoms, struggles regarding decisions to seek care, and detailed descriptions of what treatment was like.

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DIGITAL STORYTELLING: A PROMISING, SCALABLE APPROACH TO REDUCE MENTAL HEALTH STIGMA

Approximately 1 in 5 adults in the U.S. (43.8 million) will experience a mental health disorder in their lifetime, yet despite the availability of efficacious mental health interventions, fewer than half (45%) of individuals with a mental health problem seek treatment (Han et al., 2015; Hedden et al., 2015). Rates of treatment seeking for Posttraumatic Stress Disorder (PTSD) are similarly low. Several barriers to care have been examined, including financial, knowledge-related, logistical (e.g., transportation, scheduling), and attitudinal-barriers. Stigma consistently has been identified as a key barrier to mental health care (Corrigan, 2004). Feelings of weakness, shame, and fear of discrimination by others are reported reasons for not seeking or engaging in mental health treatment (Corrigan, 2004; Hoge et al., 2004; Kessler et al., 2001). Widely used strategies designed to reduce mental health stigma include training interventions and educational programs that address a range of audiences (e.g., health professionals, first responders, general public) and mass media campaigns (Bahora et al., 2008; Beltran et al., 2007; Corrigan, 2004, 2011). Whereas these have been found to be successful in improving attitudes toward mental health, most of these effects are short-lived (Corrigan and Gelb, 2006). In this chapter, we will provide an overview of how digital storytelling has been used to address mental health stigma and will present two digital-storytelling resources that can serve as a model for researchers seeking to develop and/or improve other web/smartphone-based DST resources to improve relevance, interest, and effectiveness in decreasing stigma.

Research consistently demonstrates that people are most responsive to advice or education when it comes from someone they consider similar to themselves (peer education). Indeed, mental illness stigma reduction has been found most effective when targeted toward specific populations, credible (using people from the targeted population to deliver the message), and when it involves contact with peers who have experienced mental health problems (Corrigan, 2011). More specifically, peers, especially those with the same psychiatric disorder or presentation of symptoms, can provide patients with accurate information (i.e., education) as well as personal contact with a similar peer that, in turn, can challenge perceptions about mental illness. A growing body of evidence supports the effectiveness of peer educators in reducing stigma and improving treatment seeking. For example, peer educators have been shown to improve knowledge, self-efficacy, and behavioral outcomes in people with HIV (Mahat et al., 2011; Medley et al., 2009), reduce drinking in college students (White et al., 2009), and reduce stigma in depressed older adults (Conner et al., 2015). However, this is a growing area of research and there is still much to be learned about the value of peer education in addressing mental health stigma. The National Alliance of Mental Illness program, *In our Own Voice (IOOV)*, is one such program that has shown success in reducing stigmatizing attitudes (Pinto-Foltz, Logsdon, and Myers, 2011). This program involves a 90-minute group interaction led by two facilitators who have successfully managed their mental illness. The group interaction consists of watching education videos, sharing of personal experiences by group facilitators, and open discussion. A major limitation of this, and other existing programs, is that they are delivered in-person, which does not address a number of noted barriers to service use, including transportation, time-commitments, scheduling difficulties, and worries about confidentiality. Moreover, costs associated with training peers and supporting their interactions with the target population limit the scalability of these approaches.

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Web-based systems have effectively used this peer education approach to relay health related information to high-risk groups. Rapid growth in the use of smartphones (now used by roughly 80% of the adult US population) has strengthened the reach of these approaches and made them even more accessible and much more user-friendly. Peer education has been used effectively in online formats to address topics ranging from healthy lifestyles to severe medical illness. More recently, Naslund and colleagues (2016) proposed that online peer networks can improve access to treatment. These authors view online peer support networks as a mechanism to challenge stigma, increase consumer activation, and ultimately increase access to mental healthcare. This low-cost, highly sustainable and scalable approach to peer education may have particular value for populations with stigmatized conditions. Naslund and colleagues further suggest that people with PTSD may be motivated to access online peer interventions because they are struggling to deal with their PTSD symptoms, feel socially isolated and tend to avoid in-person interactions, and/or are afraid to reach out for traditional face-to-face help due to concerns about how others will perceive them or concerns about social or occupational repercussions to seeking help. These factors may encourage a person with PTSD to seek out online support, which is anonymous and less anxiety provoking. The decision to visit an online peer network provides opportunities to challenge stigma or other misperceptions that are preventing an individual from accessing needed mental healthcare. Additionally, peers may help people feel less isolated and alone in their illness, more empowered, and more hopeful. These interactions can motivate interest in learning more about PTSD and demystify the treatment process resulting in an increased likelihood that evidence-based care for PTSD will be accessed.

Overview of Digital Story-Telling Approaches to Address Mental Health Stigma

Peer education through digital storytelling (DST) is a particularly efficient way for everyday people to connect with others similar to themselves in a low-burdensome and sustainable way. DST features videos of individuals sharing aspects of their own personal stories (i.e., testimonials) through the use of recorded audio, video, graphics, and text that are disseminated electronically (e.g., via the Internet or DVDs) to a target population for a particular purpose (e.g., to train, instruct, educate, and motivate). This is accomplished through several storytelling modalities, including re-telling of historical events, informational or instructional videos, and/or personal narratives. DST has been used in a number of contexts and has traditionally been used in educational settings. For example, instruction-based and student-driven digital storytelling methods have led to positive learning effects in educational settings (Robin, 2008) and, when compared to basic technology-integrated instruction, DST leads to better achievement, critical thinking, and learning motivation (Yang & Wu, 2012). DST has been used with promising results in a number of mental health settings, such as development of trauma narratives in exposure therapy for PTSD (Anderson & Wallace, 2015), promoting stress reduction in female adolescents (Goodman & Newman, 2014), and encouraging positive health practices in patients with HIV (Medley et al., 2009). Despite positive findings for the role of DST as an educational and therapeutic tool, little is known about its value in decreasing mental health stigma and increasing treatment-seeking behavior. Because DST is a low-cost, scalable peer education approach, it may have tremendous value, particularly for individuals with stigmatized conditions such as PTSD, depression, alcohol and drug use, and other chronic diseases.

In the remaining sections of this chapter, we will present the use of digital storytelling with two populations that have high risk for developing mental health disorders, Veterans and firefighters. These individuals are frequently involved in life-threatening duties and occupational impacts with respect to posttraumatic stress disorder (PTSD), depression, substance abuse, and marital discord (Hoge et al.,

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2006; Wagner et al., 2010). Yet, despite tremendous efforts from their respective organizations to develop and increase access to evidence-based mental health programs, misconceptions about mental health and treatment continue to be pervasive, and stigma remains a major barrier to care. *AboutFace* (http://www.ptsd.va.gov/apps/AboutFace/) and *Firefighters Helping Firefighters* (http://pocketpeer.org) are two DST resources designed to help visitors recognize the symptoms of PTSD and related mental health symptoms, and to motivate visitors to seek evidence-based assessment and treatment. These web-based video galleries introduce the viewer to a community of 100+ peers who have experienced symptoms of PTSD, depression, and/or other mental health and behavioral conditions and have received both formal treatment and other support mechanisms. These sites use the shared bonds of service to educate the user and to help normalize common reactions that they may have due to the stressful nature of their occupations. Consistent with this, visitors to the sites can "meet" peers and hear how mental illness has affected them through unscripted, authentic personal stories. Moreover, they can learn about common symptoms of PTSD and other behavioral problems, treatment opinions, struggles regarding decisions to seek care, and detailed descriptions of what treatment was like. Additional features include receiving advice from expert clinicians, hearing how PTSD can affect family members, and hearing from supervisors and other leadership the importance of seeking help.

AboutFace: A Veteran-to-Veteran Digital Storytelling Resource

Military operations frequently involve life-threatening duties, such as patrols and direct fire, witnessed violence and human suffering, and hostile responses from civilians (Hoge, Auchterlonie, & Milliken, 2006). Although the majority of Veterans are resilient and/or recover quickly, PTSD occurs in around 17% of Vietnam Veterans (Dohrenwend et al., 2006) and 13% of Veterans from Iraq and Afghanistan (Kok et al., 2012). PTSD is associated with other mental health problems such as depression and alcohol abuse (Blow et al., 2013; Cohen et al., 2010; Hoge et al., 2006; Hoge et al., 2004; Kim et al., 2010), and all of these disorders are in turn associated with high levels of distress, functional impairment, and morbidity and mortality. However, mental health treatment seeking among Veterans remains strikingly low; most Veterans with mental health problems do not seek mental health services (Han et al., 2015; Hoge et al., 2014). Stigma is frequently reported as a barrier to seeking treatment (see Clement et al., 2015; Gulliver et al., 2010 for two reviews). Stigma may be even more problematic among service members who perceive that disclosing a mental illness could negatively impact their military career. In one survey of four US combat infantry units, among those who met screening criteria for a psychiatric disorder, 65% were concerned that others would see them as weak, 63% were concerned that leadership would treat them differently, and 59% were concerned that members of their unit might have less confidence in them. Importantly, those most in need of care were also the ones most concerned about stigma (Hoge et al., 2004).

Developed by the National Center for PTSD, *AboutFace* is a web-based video gallery that introduces viewers to a community of 77 veterans, diverse with regard to military experience, age, gender, and race/ethnicity. The veterans have experienced PTSD and received treatment through the Veterans Health Administration (VHA). The site also contains testimonials from 23 family members and 22 clinicians. As such, it serves as an online peer network where Veterans can meet similar others and learn from them. *AboutFace* aims to use the shared bonds of military service to educate veterans and their families and help normalize common reactions that veterans may experience due to their military service or deployment experiences. Consistent with this, visitors to the site can "meet" veterans and hear how

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PTSD has affected them through unscripted, authentic personal stories. Veterans are filmed in natural settings looking directly at the camera. *AboutFace* visitors to the site can challenge their stigmatizing beliefs by choosing to engage with the Veterans on the site with whom they most closely identify. They can view the clips that are most relevant to them and learn from others how they have handled similar situations. Veterans who access *AboutFace* can learn about other veterans' military histories, the common symptoms of PTSD, treatment options, and the struggles of other veterans regarding decisions to seek care. They can get detailed descriptions about what treatment was like for other Veterans. Real life examples provide corrective information to challenge misperceptions about PTSD or the treatment process for PTSD. There is even a section where Veterans give advice on what they think fellow Veterans with PTSD should know about seeking help. Thus, through honest and open testimonials, the Veterans of *AboutFace* serve as encouraging peer supports to other Veterans as they consider their own need for mental healthcare, what the process of PTSD treatment will look like, and how they can obtain and initiate needed services through the Veterans' Health Administration. This use of a peer-to-peer approach is innovative, relevant to a wide range of healthcare conditions, and has the potential to increase access to care through trusted narratives that promote hope in recovery. *AboutFace* has an open format that allows visitors to navigate the site freely based on their own user preferences (Bunnell et al., 2017). Visitors can learn about one Veteran's experience at a time by selecting that Veteran's image and then choosing from a series of statements that represent topics addressed by the Veteran (e.g., What is PTSD?, Am I ready for help?, What is treatment like?). Alternatively, the visitor can choose a specific topic and review video clips of all Veterans, who have addressed that topic. Veterans also can receive advice from expert clinicians and hear how PTSD can affect family members, via a separate component of the *AboutFace* site. Topics addressed in the brief (~1 minute) clips are included in Table 1. We recently conducted a two-stage evaluation of *AboutFace,* which included (1) a usability testing phase and (2) a pilot randomized controlled trial phase to explore the feasibility of incorporating *AboutFace* into a specialized outpatient clinic for PTSD (Hamblen et al., 2018). Twenty veterans participated in the usability testing phase in which they answered moderator posed questions regarding *About Face* while actively exploring the website. Sixty veterans participated in the pilot study after completing a PTSD clinic evaluation and were randomized to receive an educational booklet about PTSD treatment or to *AboutFace* prior to starting treatment. Stigma and attitudes about treatment seeking were assessed at baseline and two weeks later. Our results indicated that Veterans had positive attitudes about *AboutFace* and gave suggestions for improvement. Veterans in both conditions reported improved attitudes towards mental illness from baseline to the two-week follow-up. Future directions will include a large-scale randomized controlled trial to evaluate the efficacy and preliminary effectiveness of *AboutFace.*

Firefighters Helping Firefighters: A Digital Storytelling Resource for Firefighters

Based on the context of their job duties, firefighters are often faced with multiple and repeated life-threatening duties including direct fire, witnessed violence and human suffering, and sometimes death, which have significant impact on their physical and psychological well-being (Berninger et al., 2010; de Borros, Martins, Saitiz, Batos, & Ronzani, 2013; Mitani, Fujita, Nakata, & Shirakawa, 2006; Norwood & Rascati, 2012). Thus, firefighters are at elevated risk for trauma-related consequences such as PTSD, sleep disorders, suicide, depression and alcohol abuse (de Barros et al., 2013; Laposa & Alden, 2003; Stanley, Hom, Hagan, & Joiner, 2015); all of these disorders are in turn associated with high levels of

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distress, functional impairment, and morbidity and mortality. However, mental health treatment seeking among firefighters remains strikingly low; most firefighters with mental health problems do not seek mental health services (Gist et al., 2011). A primary hypothesis for this is stigma, which is frequently reported as a barrier to seeking treatment (see Clement et al., 2015; Gulliver et al., 2010 for two reviews), especially among firefighters (Del Ben et al., 2006). Specifically, firefighters report significant reluctance to discuss stress and mental health problems with coworkers, peers, and family members (Antonellis & Thompson, 2012; Norwood & Rascati, 2012), as they may be seen as a sign of weakness, vulnerability, and failure (Henderson, Van Hasselt, LeDuc, & Couwels, 2016). Further, stigma may be even more problematic among firefighters and other emergency response professionals who perceive that disclosing mental illness could negatively impact their fire service career.

Table 1. AboutFace video clips

CLIPS OF VETERANS	CLIPS OF CLINICIANS	CLIPS OF FAMILY MEMBERS
WHO I AM *Example: A.J., US Army (1978-1998), Germany/Korea/US*	**WHO I AM** *Example: Dr. Peter Tuerk, Clinical Psychologist, Director of PCT Clinic, Ralph H. Johnson VA Medical Center, Charleston, SC*	**WHO I AM** *Example: O.J., daughter of A.J.*
HOW I KNEW I HAD PTSD *I was waking up, sweating, [and I] couldn't go back to sleep…*	**WHAT PTSD IS** *A very, very lonely experience… People have thoughts and nightmares they experience alone. They want to isolate…*	**LIVING WITH SOMEONE WITH PTSD** *I didn't experience a childhood… I would give up going to a friend's house in case Dad needed me.*
HOW PTSD AFFECTS THE PEOPLE YOU LOVE *My daughter would ask, 'Mommy, why is Daddy crying?'*	**HOW TO KNOW YOU'RE READY FOR HELP** *Have the worst time sleeping, they isolate the most, have no relationships, extremely on edge all the time…*	**THE SIGNS THAT I SAW** *He wouldn't converse with me as much, he was a little distant, his temper…*
WHY I DIDN'T ASK FOR HELP RIGHT AWAY *I didn't think she [my therapist] could relate to what I had been exposed to…*	**WHAT TREATMENT IS LIKE** *People are asked to sort of get used to the things that are bothering them the most…*	**HOW PTSD AFFECTS A FAMILY** *When I got older, he would start isolating himself… I would talk "at him" without him saying anything.*
WHEN I KNEW I NEEDED HELP *I heard about Gulf War Vets not being able to sleep, etc. I thought "Wow, that's some of the symptoms I have."*	**WHAT TREATMENT CAN DO FOR YOU** *Set goals and target treatment to those goals. If Veteran wants to get rid of nightmares, use exposure…*	**THE HARDEST PART** *PTSD made him shelter me a lot…I couldn't go to the movies on the weekend or house parties*
WHAT TREATMENT WAS LIKE FOR ME *My homework was to go into the Walmart or crowded mall for 30-45 minutes.*	**QUESTIONS WE'VE BEEN ASKED** *Does my family have to be involved?*	**HOW TREATMENT CHANGED THINGS** *We don't argue as much. He's a different person, and I like it. He's happier and taking care of himself.*
HOW TREATMENT HELPS ME *I still have PTSD, but I'm in control of it now… I'm at peace with it, and I can talk about it [the trauma].*		
MY ADVICE TO YOU *They [the therapists] are waiting for Veterans like you and I. Try it. You won't regret it.*	**MY ADVICE TO YOU** *You really want a treatment that involves some type of exposure…*	**MY ADVICE TO YOU** *Support them [the family member] and let them know you're there for them. Most importantly - listen.*

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Firefighters Helping Firefighters (FHF), is a video-storytelling resource that provides peer education through a video library of over 250 personal stories from firefighters and support personnel intended to reduce stigma and improve readiness to seek behavioral health care when needed. It was developed by the Technology Applications Center for Healthful Lifestyles and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, in partnership with the National Fallen Firefighters Foundation. *FHF* is committed to improving the lives of fire service members who are experiencing common behavioral health problems associated with occupational stress, such as symptoms of PTSD, depression, or anxiety. On this site, members of the fire service can learn about common behavioral health problems, discover treatment options, and hear firsthand from other fire service members as well as fire service supervisors. More specifically, *FHF* visitors have access to real life examples from fellow firefighters about the effects of stress on themselves as well as their families, various ways they tried to cope with this stress, how they knew it was time to ask for help and the types of help they considered, what getting help was like for them, and what advice and recommendations they have for other firefighters who are struggling, yet are reluctant to seek help. Similar to *AboutFace*, *FHF* has an open format that allows visitors to navigate the site freely by selecting what discussion topic they would like to hear and from which firefighter or support personnel. Topics addressed in the brief (~1 minute) clips are included in Table 2.

Table 2. Firefighters Helping Firefighters clips

CLIPS OF FIREFIGHTERS	CLIPS OF SUPERVISORS
WHAT IS THE MOST STRESSFUL PART OF YOUR JOB? *"You get comfortable in your job and then …something happens…Everything you see in the movies… flashbacks… it's all true"*	**WHAT UNIQUE STRESSORS DO FIREFIGHTERS FACE?** *"…having a lot of different calls. We call it the Big Four: any call involving children, a mass casualty, and threat of death or injury to themselves or another firefighter"*
ARE THERE ANY PARTICULAR STRESSFUL EXPERIENCES THAT STAND OUT TO YOU? *"I was trapped in a fire and I had to be pulled out. In that 5 minutes and 18 seconds, you know, you thought you were going to die"*	**HAVE FAMILIES OF FIREFIGHTER EVER REACHED OUT TO YOU IN REGARD TO SYMPTOMS?** *"I've had some family members reach out to me, especially after they know the symptoms of stress…we encourage firefighters to talk with their families..."*
HOW DO YOU KNOW WHEN YOU ARE STRESSED? *"When I lose sleep, I love to sleep, but when I know I'm waking up at night, my body lets me know through that …"*	**WHAT ARE SOME COMMON THINGS YOU HAVE SEEN FIREFIGHTERS DO WHEN THEY ARE STRESSED?** *"… A lot of times Firefighters withdraw from their families and fellow firefighters… become isolated and unfortunately go into depression sometimes…"*
HOW DOES STRESS AFFECT YOUR FRIENDS AND FAMILY? *"I would distance myself from my wife and kids… because I didn't want them to see me in that type of stress"*	**HOW DOES STRESS AFFECT THEIR FAMILY OR FRIENDS?** *"… .they feel left out, sometimes they feel anxious like they've done something wrong to affect the firefighter"*
HOW DID YOU KNOW YOU NEEDED HELP? *"After probably the third night without sleep, with all the flashbacks… I was taking it out on my wife and kids"*	**HOW DOES A FIREFIGHTER KNOW THAT THEY NEED HELP?** *"A lot of times the firefighter don't necessarily know … talking to someone is the best way to get help."*
WHAT TYPE OF HELP DID YOU CONSIDER GETTING? *"I went to a chief who was trapped in a fire one time and got burnt also … if it wasn't for him, I probably wouldn't be sitting here in front of you. He took me to [a program called] SAVE"*	**WHAT STEPS WOULD A FIREFIGHTER TAKE TO GET HELP?** *"Like a chain of command… go to that person that you trust… we have a support group we go to… have that person know not to be afraid to ask for help"*
WAS HELP WHAT YOU EXPECTED? *"It took time, but after a few sessions, it took that burden right off my shoulders"*	**WHAT CHANGES HAVE YOU SEEN AFTER PEOPLE SEEK HELP?** *"I've seen firefighters be reunited with their families in a whole sense… and see them grow back together as a family"*
WHAT WOULD YOU TELL OTHERS WHO ARE IN A SIMILAR SITUATION? *"I would tell them my story. Let them know that it's okay…we'll get help. It helped me and it will help you"*	**WHAT WOULD YOU RECOMMEND TO FIREFIGHTERS WHO ARE THINKING ABOUT SEEKING HELP?** *"To do it. Talk to somebody, reach out to peer, a family member, someone in your department that you trust, and talk."*

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CONCLUSION

Individual and societal costs of stigmatized mental health disorders, such as PTSD, anxiety depression, suicidality, and alcohol abuse are enormous, and evidence based treatments are available to address these behavioral health problems. Benefits from career preservation, enhanced productivity, and improved quality of life are immeasurable if treatment can be accepted earlier and seen through to completion. Education may assist in addressing stigma (Dickstein et al., 2010; Finkelstein, Lapshin, & Wasserman, 2008), as well as knowledge, attitudes toward seeking mental health treatment, and service utilization (Corrigan, 2004; Pinfold et al., 2003). Education that is delivered by peers who give first-hand accounts of their experiences may be particularly effective in accomplishing these goals. Uniquely, peer education delivered via DST is a low-cost, scalable, and sustainable aid to such efforts. In this chapter, we presented two digital-storytelling resources that can serve as a model for researchers seeking to develop and/or improve other web/smartphone-based DST resources to improve relevance, interest, and effectiveness in decreasing stigma. Promisingly, this can be accomplished on both the disease (e.g., HIV, diabetes, obesity, and eating disorders) and demographic (e.g., Veterans, civilians, and first responders) level. The use of a peer-to-peer approach through digital storytelling is innovative, relevant to a wide range of healthcare conditions, and has the potential to increase access to care through trusted narratives that promote hope in recovery. Further research is needed to measure that short and long-term value of digital storytelling approaches toward addressing stigma and increasing motivation to initiate and follow-through with mental health treatment. If found valuable, DST is a scalable and sustainable approach for that can used with a wide range of traumatic stress populations (e.g., disaster victims, traumatic injury patients, first responders) to reduce attitudinal barriers and increase access to care.

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Chapter 53
Health Literacy in School

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ABSTRACT

Health literacy is a core element of patient-centered healthcare. Poor health literacy is a silent epidemic across the globe as it affects every aspect of health. Schools bear an important role in increasing health literacy. Improving health literacy in adolescence is supposed to improve the later life as adolescents are used to carry their modified behavior lifelong. Various school-based interventions covering physical and mental health have been studied and found to be effective. International bodies recommend incorporation of health-related tasks into school lessons and considered that teaching the young people will be a good investment for future. Multisectoral collaborations and locally proved effective strategies are the practical challenges. This chapter aims to focus on health literacy, global scenario of health literacy, measurement tools, role of school, interventions, limitations, and challenges of health literacy.

INTRODUCTION

In this contemporary and consumer driven world, education is considered as an important tool to increase income, reduce poverty, employ equality and justice, ensure sustainable growth and improve quality of health (United Nations General Assembly, 2015). Since 2000, preprimary education enrollment increased almost two third globally (UNESCO, 2015). According to UNESCO institute for statistics (2015), the youth literacy is 91% and adult rate is 85% around the globe (UNESCO, 2014). Health literacy is a domain which is directly connected to education. As a term "Health literacy" was mentioned first in 1974 in an article titled "Health Education as Social Policy" (Mancuso, 2008; Peerson & Saunders, 2009). In

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past 30 years, more attention has been given to health literacy and it has gained popularity in most parts of the world (Berkman, Davis, & McCormack, 2010). But, still the definition of health literacy is yet to be unified and different authors, organizations, institutions, such as American Medical Association (AMA), WHO and Institute of Medicine (IOM) (Palumbo, 2015; Serper et al., 2014; Dickson-Swift, Kenny, Farmer, Gussy, & Larkins, 2014; Sørensen et al., 2012), defined it differently. Most widely used definition mentioned, health literacy as an "individual skills to obtain, process and understand health information and services necessary to make appropriate health decisions" (Dickson-Swift, Kenny, Farmer, Gussy, & Larkins, 2014; Sørensen et al., 2012). Dan Nutbeam preferred three typologies of health literacy mentioned as functional health literacy, interactive health literacy, and critical health literacy (Nutbeam, 2008; Nutbeam, 2000; Sørensen et al., 2012). For the better understanding about health literacy and school involvement in health issues, authors reviewed updated researches and documents. This chapter thoroughly described about global status of health literacy, measurement tools of health literacy, role of school in health literacy, interventions in school setting to improve health literacy, limitations & challenges of health literacy.

BACKGROUND

Health literacy (HL) is an important determinant of both public health as well as individual healthcare and is considered a core element of patient centered healthcare (Altin, Finke, Kautz-Freimuth, & Stock, 2014) where patients play a greater role in gaining and utilizing information about their health (Manganello, 2008). Although the concept prevailed before the term health literacy was coined first in 1974 in discussions regarding health education (Peerson & Saunders, 2009; Sørensen et al., 2012), since then its importance has increased as it is concerned with the individual's capacity to meet the complex health needs in this modern world (Sørensen et al., 2012). It covers the fields of health and education and builds an individual's ability to enjoy good health throughout the life span (Ghanbari, Ramezankhani, Montazeri, & Mehrabi, 2016).

Healthcare sector around the world rotates an ostensibly endless process of communicating health information clearly and tries to make sure that it is comprehended clearly. To provide safe and effective practice in the healthcare sector, the system is designed in such a way that structure, processes, tools and techniques should be in place for proper delivery of health information. Health care system should include and provide facilities related to health literacy (Osborne, 2012). It has been considered as a key determinant of health (Watson, 2011; Kickbusch, 2001) and its improvement is a practical approach to implement preventive strategies among the general population (Diemer et al, 2017). Recent evidence suggests that, health literacy has gained increased importance in public health, health promotion and clinical care (Liu, Liu, Li, & Chen, 2015). It is closely linked with knowledge, motivation, competency to access, understand, appraise and apply information to form and to make decisions related to healthcare (Sørenson, 2013). For adults with limited literacy or numeracy skills and with reduced functional skills, health literacy is viewed as a contemporary effort to foster adults' ability to manage their health (Marks, 2012).

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HEALTH LITERACY

Global Scenario

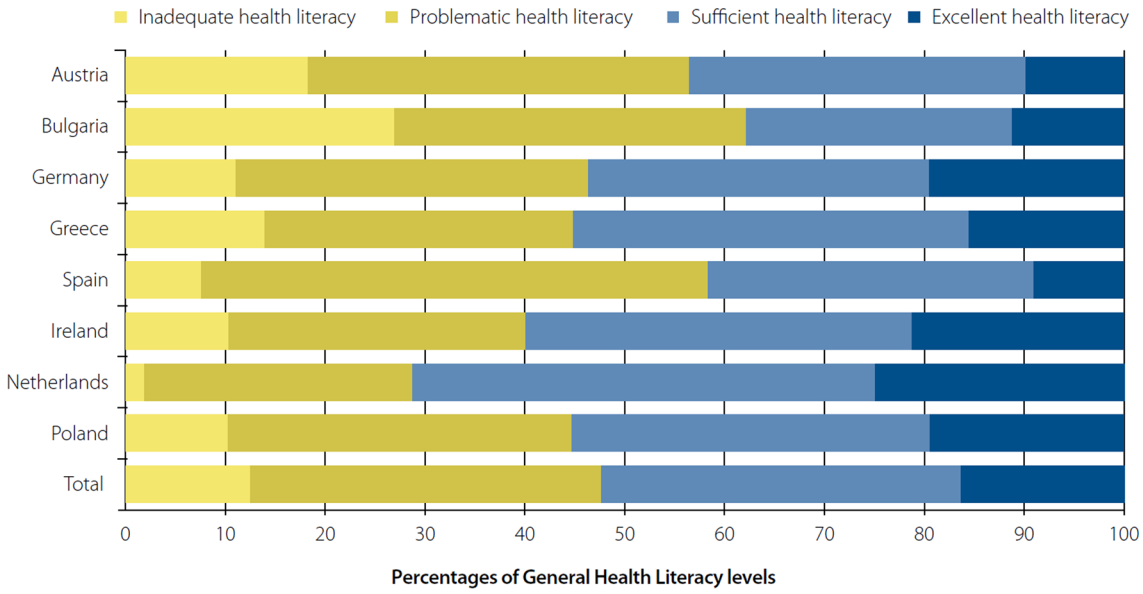
Currently optimum health literacy is a prime concern globally and poor literacy in health is a silent epidemic that is threatening the health service across the globe (Palumbo, 2015; Sørensen et al., 2012; Parker & Ratzan, 2010). Inadequate health literacy is a concerning problem both in developed and developing countries and the portion with poor health literacy ranges from a quarter to a third of the population (How, 2011). In United States National Assessment of Adult Literacy (NAAL) in 2003 revealed only 12% of US adults were found to have proficient health literacy (Koh et al., 2012), 52% were found to have intermediate health literacy, 22% were found to have basic percent, 14% were found to have below basic health literacy (Vernon, Trujillo, Rosenbaum, & Debuono, 2007), & approximately 90 million (Safeer & Keenan, 2005) of adult American peoples have below basic or basic health literacy (Koh et al., 2012; Bailey et al., 2014; Cajita, Cajita, & Han, 2016; McCaffery et al., 2013; Vernon, Trujillo, Rosenbaum, & Debuono, 2007; How, 2011; Muscat et al., 2016). The proportion was found more in Australia, where it was about 60% (Muscat et al., 2016). A comparative report on health literacy in eight European Union state members revealed that 12% of all respondents have inadequate general health literacy and 35% have problematic health literacy. Therefore, limited health literacy in Europe is a significant burden which does not affect a minority of the population. However, there are marked differences between different countries as demonstrated by the European Health Literacy Survey (HLS-EU) which was conducted in 2011 in eight European countries (Fig 1) (HLS-EU Consortium, 2012). In Asia, research in health literacy is not a priority. In India, a study was conducted to see dental health literacy among patients and it revealed that, 60.4% having low health literacy score (D'Cruz, & Aradhya, 2013). In Bangladesh, the literacy rate and the enrollment in the schools are increasing day by day but the health literacy is still untapped (Arafat & Ahmed, 2017). Moreover, there prevails multiple misconceptions those direct the people to pursue abnormal health seeking behaviors such as attending the traditional healers instead of registered physicians even in the major illnesses (Arafat, 2017a). Inadequate health literacy is much worse in case of older persons. Previous studies in different cultures revealed majority of patients older than 60 years found to have the lowest levels of literacy, and 80 percent were found to have limited skills to fill out forms when they were asked even in the waiting rooms (Safeer & Keenan, 2005). One of the major effects to poor health literacy is failure to take medications results in approximately 125,000 deaths annually in US, that costs from $106 to $238 billion yearly (Bailey et al., 2014; How, 2011).

Importance in Relation to Health Outcome

People with poor health literacy often perceive poor self-efficiency in regards to deal with their health conditions (Palumbo, 2015; Serper et al., 2014; Andrus & Roth, 2002); usually are not willing to take part in the health care services appropriately; associated with inadequate in management of chronic health conditions and diseases, prone to greater risk of hospital admission and increased mortality (Palumbo, 2015; Serper et al., 2014; Koh et al., 2012; Cajita, Cajita, & Han, 2016; Andrus & Roth, 2002; Vernon, Trujillo, Rosenbaum, & Debuono, 2007; Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Muscat et al., 2016). Limited health literacy is also likely to exhibit impairment in recalling the provided health information (Palumbo, 2015; Cajita, Cajita, & Han, 2016; DeWalt & Hink, 2009; Manganello, 2008). People with lower HL, are less efficacious in understanding the prescription as well as taking medications

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Figure 1. European Health Literacy Survey (HLS-EU): Levels of general health literacy index in selected European countries (Source: Sorensen et al., 2015)



as per direction, unable to implement appropriate strategy to improve the compliance (DeWalt & Hink, 2009; Andrus & Roth, 2002; Cajita, Cajita, & Han, 2016; Palumbo, 2015; Koh et al., 2012); usually show serious medication errors repeatedly (Palumbo, 2015; Koh et al., 2012; Safeer & Keenan, 2005; Manganello, 2008; Vernon, Trujillo, Rosenbaum, & Debuono, 2007) that ultimately tolls high medical expenses (Palumbo, 2015; DeWalt & Hink, 2009; Manganello, 2008; Vernon, Trujillo, Rosenbaum, & Debuono, 2007; Muscat et al., 2016). Low health literacy is associated with poor knowledge in health, unhealthy behavioral pattern, lower preventive health services utilization (Vernon, Trujillo, Rosenbaum, & Debuono, 2007; Dickson-Swift, Kenny, Farmer, Gussy, & Larkins, 2014) ultimately acts as a strong barrier to access health care services (Palumbo, 2015; Kabir & Khan, 2013); as a catalyst of poor health and high hospitalization (Dickson-Swift, Kenny, Farmer, Gussy, & Larkins, 2014; Cajita, Cajita, & Han, 2016; Safeer & Keenan, 2005; Andrus & Roth, 2002; Vernon, Trujillo, Rosenbaum, & Debuono, 2007). Importantly poor health literacy affects three points as mentioned in access and utilization of health care, interaction with services provider and self-care (Osborn, Paasche-Orlow, Bailey, & Wolf, 2011; Sørensen et al., 2012) and negatively influence the motivation of the patient, problem solving ability, self-efficacy, appropriate self-care behavior (Osborn, Paasche-Orlow, Bailey, & Wolf, 2011). It is troublesome to process health information for the people with low health literacy those affects reading, understanding the medication labels, making appointments as well as understand the appointment slips, comprehending the verbal communications with health care services providers, understand and follow the educational and self-care materials to adapt the preventive services (Cajita, Cajita, & Han, 2016). Better or improved status of health literacy leads to improved health status, lowered health expense, shorter hospital stay, less frequent hospitalization, less utilization of the health resources (Sørensen et al., 2012; Safeer & Keenan, 2005). Adequate functional health literacy enables to understand the risks and related health services, improved compliance; adequate interactive health literacy enables to improve individual motivation, self-reliant capacities, as well as to be self-sufficient; adequately critical health literacy enables to

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be resilient to surrounding adversities such as social and economic (Sørensen et al., 2012). Along with the enormous personal benefits adequate health literacy ensures very impactful community and social benefits. Adequate functional health literacy increases the participation in community health programs; interactive health literacy accelerates influencing capacity of an individual to affect the social norms and more interactions between the surrounding societies; critical health literacy enhances community based empowerment and enables to act as social and economic determinants of health (Sørensen et al., 2012). Low, inadequate, poor health literacy substantially affects treatment compliance, self-control for chronic diseases and ultimately the treatment costs (Safeer & Keenan, 2005). Previous studies revealed a significant difference in health outcome between the highest and lowest health literacy groups and the finding recommended to improve the health literacy of lower group (How, 2011). Even poorly literate people are unable to pick up the benefits aimed from media campaigns, interventions, and educational programs (Manganello, 2008). With this increasing importance previous authors like to consider health literacy as the sixth vital sign along with other traditional vital signs mentioned as temperature, pulse, respirations, blood pressure, and pain and it should be assessed in the same way other vital signs are assessed (Heinrich, 2012).

Health Literacy and Economic Growth of a Nation

Key international declarations considered literacy as a right, both for children and adults. The Hamburg Declaration conceived literacy "as the basic knowledge and skills needed by all in a rapidly changing world, is a fundamental human right" (UNESCO, 1997). Everyone should have 'the same opportunities for access to programs of continuing education, including adult and functional literacy programs'. Literacy skills provide a number of benefits to individual e.g. informed decision-making, personal empowerment, participation in social activities etc.

Link Between General Literacy and Health

The impact of education or general literacy on population and public health, especially women's health, is a well-researched (Kickbusch, 2001) and it was demonstrated that literacy program also has a greater impact on health. Many studies reported the positive impact of education and literacy on population health, in particular women's' health and the health of children (Bledsoe, Casterline, Jonson-Kuhn, & Haaga, 1999; Sen, 1999; Nussbaum, 2000). Female literacy rate is considered to be one of the 10 key indicators to assess 'women's well-being' (Save the Children, 2000; Kabir, Rahman, Monte-Serrat, & Arafat, 2017). In a study in Nicaragua, lower infant mortality was recorded among mothers who had participated in an adult literacy campaign than those who had not (Sandiford et al., 1995). Other studies showed literacy and basic education programs (Burchfield et al., 2002a), and radio broadcasts and other health interventions (Burchfield et al., 2002b) improved health-related knowledge and health seeking behavior of the women.

Impact of Low Health Literacy on Health Development

Health literacy is increasingly becoming important area to support people to utilize the opportunities available in the healthcare to improve and manage their own health. The Center for Health Care Strategies Inc. (Center for Health Care Strategies, 2013) used a simple definition of health literacy: "the degree

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to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy helps people to "obtain, process, and understand basic health information and services needed to make appropriate health decisions" (U.S. Department of Health and Human Services, 2000). The relationship between literacy and health is complex and widely studied area. It represents a group of skills required for public and patients to understand and interpreted healthcare information and take necessary action in a health care environment when necessary. These skills include interpretation, print literacy, numeracy, and oral literacy (Agency for Health Care Research and Quality, 2011). So, health literacy is more than reading which also encompasses writing, numeracy, listening, speaking, and conceptual knowledge. Effective communication is critical to successful health care. Low health literacy is linked to poorer health status, higher morbidity, mortality, lack of medical care knowledge, more hospital visits and hospitalization, lack of knowledge about medical conditions, utilization of expensive services (e.g. emergency care and inpatient admissions), non-utilization of health promotion services, low self-reported health profile, poorer compliance rates with treatment modalities, and increased health care costs (Andrus & Roth, 2002; IOM, 2004; Agency for Health Care Research and Quality, 2011). Low health literacy can result in: medication errors; low rates of treatment compliance due to poor communication between providers and patients; reduced use of preventive services and unnecessary emergency room visits; ineffective management of chronic conditions, due to inadequate self-care skills; longer hospital stays and increased hospital re-admissions; poor responsiveness to public health emergencies; and higher mortality (Berkman, et al, 2004). Improving health literacy reduces health care costs and increases the quality of health care. It is now well-established that there is a relationship between educational attainment, literacy skills and economic growth (Coulombe, Tremblay, & Marchand, 2004).

Economic Implications of Health Illiteracy

Health care sectors in both developed and developing countries deal with limited resources. Healthcare activities, especially in developed countries, consume a large portion of economic resources. Healthcare spending has grown from 13.2% of GDP in 2000 to 17% in 2010. Low health literacy has a huge impact on a country and it is one of the important causes of economic inefficiency. The average annual health care costs of persons with very low literacy were found to be four times greater than for the general population (Weiss et al., 1994). It was found that adults with low health literacy experience 6% more hospital visits, 1.5 times more physician visit, 3 times more prescriptions and 2 day-longer hospital stays in comparison to those with proficient health literacy (The Ohio State University-Office of Outreach & Engagement, 2008). All these unintended activities as a result of low health literacy cost the U.S. economy up to $236 billion every year which represents between 7-17% of all personal health care expenditures (Vernon et al., 2007). As a whole, low functional literacy causes 3 to 6% greater health care expenditures (The Ohio State University-Office of Outreach & Engagement, 2008). This is a real blow for other sectors of the economy not only in the USA, the picture is the same for all developed and developing countries. This situation places health care system and the economy of a country at risk. The combination of low health literacy, demographic and epidemiological shifts, technological advances, and patients' high expectations places additional financial burden on the health care system and in a long run hinders economic growth of country.

Health literacy is also becoming increasingly important public health issue and found to contribute to social, economic and health development of a nation (Kickbusch, 2001). Health literacy enables

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individuals to protect themselves, their family and their community from various disasters and able them to take control of their health. It is evident that people with higher levels of health literacy are more likely to adopt healthier behaviors and decrease the undue utilization of healthcare. Moreover, they are far more able to understand available health-related information and would be empowered to make healthier choices. Benefits can be achieved across the life course and inter-generationally and the saved resources can be utilized to support priority health issues or can be channeled to other sectors for positive economic growth (WHO, 2016).

Access to reliable health information and usable health services are fundamental for the economic growth of a nation (Adams & Corrigan, 2003). The promises of medical research, health technology and healthcare delivery can only be implemented when a national action plan has been designed. The action plan needs to have specific steps connected to this direction. No single action will be sufficient. Actions should include partnerships among all levels of educators, health care providers, public and private healthcare institutions and government; should be based on feasibility, effectiveness and suitability; should evaluate the short and long-term effects of the efforts; and should involve continued public education, law and other policies to support health literacy (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2010).

MEASUREMENTS OF HEALTH LITERACY

There are many measures globally which can qualify and quantify the status of health literacy. The tools aim to detect physical health literacy are: Rapid Estimate of Adult Literacy in Medicine (*REALM*) (Safeer & Keenan, 2005), Test of functional literacy in Adult (*TOFHLA*) (Baker, 2006), Wide Range Achievement Test-Revised (*WRAT-R*) (Bass, Wilson, & Griffith, 2003), Medical Achievement Reading Test (*MART*) (Hanson-Divers, 1997), Slosson Oral Reading Test (*SORT-R*), Peabody Individual Achievement Test Revised (*PIAT-R*) (Ojio, 2015), Instrument for Diagnosis of Reading (*IDL*) (Vernon, Trujillo, Rosenbaum, & Pfizer, 2007), Newest Vital Sign (*NVS*) (Peerson & Saunders, 2009), European health literacy questionnaire (*HLS-EU-Q47*) (Duong et al., 2017), High Blood Pressure-Health Literacy Scale (*HBP-HLS*) (Zhang et al., 2016), Health Literacy on Social Determinants of Health Questionnaire (*HL-SDHQ*) (Matsumoto & Nakayama, 2017), The Health Literacy Questionnaire (*HLQ*) (Nolte et al., 2017), The Eastern-Middle Eastern Adult Health Literacy (*EMAHL13*) (Nair, Satish, Sreedharan, & Ibrahim, 2016) etc.

Many reading cognition tools to assess patient's knowledge about health care terminologies are available and among them *REALM* is one of the most widely used instrument that can measure functional health literacy within 2 to 3 minutes by nurse or other staff (Safeer & Keenan, 2005). *TOFHLA* measures reading literacy, consists of 50 items assessing prose reading and 17 items assessing capacity to read and understand actual hospital documents and labeled prescription vials (Baker, 2006). The *WRAT-R* is a 57-item test that requires 3 to 5 minutes to respond and can measure reading, spelling and arithmetic (Bass et al., 2003). *MART* is designed to resemble a prescription label with its use of small print size, glossy cover, and medical terminology. This design allows practitioners and researchers to assess patients' inability to read the test (Hanson-Divers, 1997). *PIAT-R* is an individually administered tool measure six domain like: General information, Reading recognition, Reading comprehension, Mathematics, Spelling and Written expression (Ojio, 2015). Instrument for Diagnosis of Reading (*IDL*) is a reading comprehension bilingual (English-Spanish) tool for all ages. Subjects given time to read text

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of their own and then examiner asks series of questions of various difficulties (Andrus & Roth, 2002). Health literacy survey questionnaire (*HLS-EU Q47*) consists of 47 items that assess the capability to deal with health information like: access or obtain, understand, appraise, judge or evaluate, and apply or use health information) in three domains: health care, disease prevention, and health promotion (Duong et al., 2017). High Blood Pressure-Health Literacy Scale (*HBP-HLS*) is the only available hypertension specific HL instrument consists of 43 items assess knowledge about hypertension and its management (Zhang et al., 2016). *HLSDHQ* consists of 33 items clarifies 10 social determinants of health (Matsumoto & Nakayama, 2017). Health Literacy Questionnaire (*HLQ*) composed of 44 items which can assess nine distinct domains of health literacy like: support of health care providers, having adequate information for managing health, active management of health, social support for health, appraisal of health information, active engagement with health care providers, navigating health care system, ability to find good health information and understanding health information well enough to know what to do (Nolte et al., 2017). Eastern-Middle Eastern Adult Health Literacy (*EMAHL 13*) is brief screening tool can assess patient's ability to distinguish health and non-health related items (Nair et al., 2016).

In addition, regarding mental health literacy, a recent systemic review by Kutcher et al found 16 different tools in 17 studies mentioning mental health literacy tool (Wei, McGrath, Hayden, & Kutcher, 2016). The tools that measures knowledge about schizophrenia are: Knowledge About Schizophrenia Questionnaire (*KASQ*), Knowledge Questionnaire on Homecare of Schizophrenia (*KQHS*) and Knowledge about Schizophrenia Test (*KAST*). To detect literacy about overall mental health and illness there are few tools and these are: Multiple-Choice Knowledge of Mental Illnesses Test (*MC-KOMIT*), Mental Health Knowledge Schedule (*MAKS*), Mental Health Literacy Scale (*MHLS*), Journey of Hope (*JOH*) Outcome Survey, Knowledge of Mental Disorders (*KMD*), Mental Health Disorder Recognition questionnaire (*MDRQ*), Mental Health Knowledge Questionnaire (*MHKQ*). Others tools to detect knowledge about depression, anxiety and ADHD are: Depression Multiple Choice Question (*DMCQ*), Depression Literacy (*D-Lit*), Knowledge about Depression and Mania Inventory (*KDMI*), Adolescent Depression Knowledge Questionnaire (*ADKQ*), Anxiety Literacy Questionnaire (*A-Lit*), Test of Knowledge About ADHD (*KADD*). (Wei, McGrath, Hayden, & Kutcher, 2016).

KASQ consists of 25 multiple choice questions, *KQHS* contains 32 item multiple choice questionnaire on four aspects and *KAST* is 21 multiple choice questions on knowledge of schizophrenia. and *MC-KOMIT* is 33 multiple-choice items on knowledge of common mental illnesses, *MAKS* is 6-point Likert scale on 12 items of stigma knowledge of mental illness. *DMCQ* is 27 multiple-choice items, D-Lit is 22 true/false items, *ADKQ* is a tool consists of 13 dichotomous and 2 fill-in-the- blank questions and *KDM* is consists of 44 true false questions. *MC-KOMIT, MAKS, MHLS* tool containing multiple choice on 35 items regarding knowledge and attitudes about help-seeking, and ability to recognize disorders, *JOH* is a 4-point Likert scale on 15 items on mental health, *KMD* is tool having "Yes, "No", and "I don't know" responses to assess knowledge on the name and characteristics of mental disorders and ability to distinguish them from somatic illnesses, *MDRQ* is a 7-point Likert scale on 20 statements of mental illness descriptions in which 15 are real and 5 are false, *MHKQ* is tool having "yes", and "no" responses to 20 general mental health knowledge questions. *KDD* is tool containing 22 error-choice items to assess knowledge and attitudes toward students with ADHD. Among the measuring tools having good internal consistency are *DMCQ, KDD, JOH, KMD* and *ADKQ*. The tools having good to excellent content validity are: *KQHS, KAST, MC KOMIT, MAKS, KDM,* and *MHLS*. *KAST* and *KDM* are the two tools having fair criteria validity (Wei, McGrath, Hayden, & Kutcher, 2016).

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ROLE OF SCHOOL IN HEALTH LITERACY

In 1986, WHO declared the Ottawa Charter and applauded the health promotion concept as health promotion is more than the disease prevention (Arafat, 2017b). Schools can have a very important role in health promotion and development of the future of the nation as well as the globe. Health literacy is a concept that can be extensively embraced by schools (St Leger, 2001). Schools across the world can play an important role in facilitating the achievements of health literacy as a public health goal along with the other educational commitments (Nutbeam, 2000). Nutbeam (2000) proposed a three-level hierarchy in health literacy. This would include: a) basic/functional literacy, b) through communication/ interactive literacy and c) critical literacy. Critical literacy is generally defined as a set of skills that enable people to obtain, understand and use information to improve their health and is something that can be developed, thus; it should be an important goal of school education (Chinn, 2011). Although school may play an important role, in health literacy, it is important to be pointed that their core business is education, whilst the level of expertise in health issues is limited. Children are supposed to spend about 80% of their waking hours in school (Wang, Li, Siahpush, Chen, & Huberty, 2017) and they are also engaged in different school related tasks before and after school (Karczewski, Carter, & DeCator, 2016). Moreover, large numbers of adolescents work with childrenin schools to get them engaged (Demissie & Brener, 2017). In addition, schools are responsible for social and emotional knowledge along with the academic education (Weisman, Kia-Keating, Lippincott, Taylor, & Zheng, 2016). With the gradual physical and mental development adolescents are involved with their health care, interact with the health system and like to have access to health information (Manganello, 2008) as they pose both the responsibility and freedom. Addressing the health literacy positively at early age can have global improvement in aspects of interactions with the health system that ultimately drives to positive health outcome across life (Manganello, 2008). Schools can empower the youths by promoting health literacy (Hagell, Rigby, & Perrow, 2015). Schools can provide an excellent opportunity and critical facility in which many agencies can work together for the betterment of the youths as well as the economy. Schools play a facilitative role to bring the societal components together in which children act members of families, peers, schools, and communities (Valois & Hoyle, 2005). Like a silent epidemic, appropriate educational programs are necessary even before the assessment of health literacy in the clinical settings and schools can be most appropriate point to start (Heinrich, 2012). Moreover, adolescence is usually the starting point of different chronic diseases such as asthma, diabetes, cystic fibrosis and mental illness between the age ranging from 0–17 years (Manganello, 2008). Usually with the increase spread of internet, teenagers are more interested in seeking information regarding the management of their illness and health service providers consider the habit as an important one for the youths with chronic illness to have adequate health literacy skills to perceive the right meanings (Manganello, 2008). With physical, emotional, cognitive change, greater freedom and autonomy, improved reasoning and abstract thinking adolescence is to begin thinking about health literacy interventions (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005; Ghanbari, Ramezankhani, Montazeri, & Mehrabi, 2016; Manganello, 2008). Working on health literacy in adolescence would improve health literacy in later life and adolescents are used to carry their modified behavior across the life as they transition into adulthood (Manganello, 2008). IOM proposed to incorporate health-related tasks into lesson plans of schools and recommended that teaching the young people will be a good investment for future population health (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005; Manganello, 2008). Previous literature has shown that there is a strong relation between good health and educational achievement (World Bank, 1993; WHO, 1996). Therefore, a perception has

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been developed by schools and educators that if health and social issues will be addressed in schools, the learning outcomes will also be maximized (Cameron and McBride, 1995). St Leger and Nutbeam (2000) suggested that the health promoting school contributes to four main school-related outcomes: (i) lifelong learning skills; (ii) competencies and behaviors; (iii) specific cognate knowledge and skills; and (iv) self-attributes. Of course, these four school-related health/education outcomes are closely related to the three-level hierarchy in health literacy proposed by Nutbeam (2000) provided that they have been achieved by the students.

The effectiveness of school health and its outcomes has been reported by several reports and meta-analyses (Peters and Paulussen, 1994). Overall, the role of school in health literacy should include the following characteristics (adopted by St Leger, 2001):

1. Focusing on cognitive and social outcomes in conjunction with behavior change within an educational framework;
2. Occurring over several years and be relevant to young people's social and cognitive development;
3. Be adequately resourced;
4. Provision of significant professional development for teachers;
5. Be holistic in addressing strategic combinations of the curriculum, the school's physical environment, the school's social environment, health services, partnerships with parents and the local community and school policies;
6. Be based on effective learning theories; and recognize the limitations and opportunities of schools in bringing about substantial health improvements.

INTERVENTIONS IN SCHOOL TO IMPROVE THE HEALTH LITERACY

General Interventions

Some authors suggested a focus on the formal educational systems across the years such as elementary schools, high schools, junior schools, colleges and universities (Freedman et al., 2009). The approach should focus to prepare the students to address the public health concerns in from multiple perspectives rather to build them as public health specialist (Freedman et al., 2009). Educational materials distribution to the youths by health providers, schools and intervention programs can effective but further attention is needed regarding the readability of materials should be evaluated and sometimes it might be difficult for the youths to guide their choices about health behavior if they fail to understand the provided materials (Manganello, 2008). However, previous research revealed that school newsletters are being underutilized as a source of health promotion and health literacy in the school community (Merga & Hu, 2016).

Judicious use of media for the adolescents is a crucial part of health literacy as media is an important source of information nowadays. Past research revealed that youths aged 8–18 spend almost 6.5 hours per day with some type of media and their physical, social, mental, moral development is influenced by media. Educational television has been found to be linked with advances in literacy. Moreover, media is linked to development of health behavior and health literacy. So, justified use of media is an important area to improve health literacy in schools (Manganello, 2008) and limited abilities of using media should also be considered (Ghanbari, Ramezankhani, Montazeri, & Mehrabi, 2016). Educational programs implemented in schools or conducted via the mass media, can teach adolescents about health issues though

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the success of the interventions is dependent on their target group having the ability to understand the provided messages (Manganello, 2008). Creating a health promoting school environment is not just the focusing on the youths but also focusing the entire work force and a holistic approach involving every part is the best way to combat (Hagell, Rigby, & Perrow, 2015).

In this 21st century internet plays an important role in health, literacy, health literacy as well as internet has also a threatening role in regard to the novelty & validity of the available information (Ghanbari, Ramezankhani, Montazeri, & Mehrabi, 2016). Recent studies revealed respondents aged 15–24 years surfed internet for their expected information and they surfed several regular topics such sexual health, mental health, weight change, cancer, diabetes (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005). Limited internet facility, limited search abilities, low literacy skills affect the outcome and make difficult for adolescents to find, perceive the quality information. If there is nothing in the school health curriculum the adolescents would not achieve adequate health literacy (Ghanbari, Ramezankhani, Montazeri, & Mehrabi, 2016).

Specific Interventions

There are various school based interventions related to health literacy including physical and mental health. Specifically addressed areas are regarding: Obesity, Oral health, HIV, Fruit and vegetables intake, Nutrition, Bully behavior, Food literacy, Hand washing, Physical exercise, Adolescent dating violence, School based health centers (*SBHC*), Evidence based curriculum, Health Promotion School (*HPS*), School based health education, Physical education, Mental health teachers curriculum etc.

Interventions for Physical Health

High prevalence of childhood obesity predisposes children to various morbidities like insulin resistance, hypertension, dyslipidemia and liver disorders and risk of developing type 2 diabetes and cardiovascular diseases (Levy, Saenger, Steffes, & Delvin, 2017). In a study, school based health promotion program through scheduled extra school-day physical activities result increased habit of doing more aerobic activity among school children. "*KidMinutes*" is an easy measure that evaluates school activity program (Cluss et al., 2016). However, School-based intervention including counseling is not effective in reducing BMI or key obesogenic behaviors (Pbert et al., 2016). School based obesity prevention program is an effective approach to influence BMI among students (Karczewski, Carter, & DeCator, 2016). Academic lessons regarding physical activity has positive effect on BMI (de Greeff et al., 2016). The HealthCorps program is an effective health literacy program which significantly increases students' knowledge and behavior on issues like: nutrition, physical activity and mental health (Moonseong et al., 2016). It is evident that schools having Physical Exercise Lesson (*PEL*) program result more Physical Activity (PA) in both boys and girls (Frömel, Svozil, Chmelík, Jakubec, & Groffik, 2016). A Physical Activity program focusing school teachers is effective to increase PA and also improves early literacy (Kirk & Kirk, 2016). Go Wild with Fruits and Veggies (*GWWFV*) and fruit and vegetables snack program (FFVSP) is another curriculum based school program that increases the fruit and vegetables intake among students. Building a Healthy Me (*BHM*) is an effective nutrition intervention for classroom and family (Larsen et al., 2017). Team Nutriathlon is another school based program that can raise vegetables, fruits and dairy product consumption (Loosier et al., 2016; Drapeau, V. Savard, BA. Gallant, A. Nadeau, L. Gagnon, 2016). Brighter Bites is a school based intervention that includes three components like: fresh produce

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deliveries, recipe demonstration and nutrition education. The intervention helps to learn some crucial lessons like: importance of leveraging existing infrastructure of food banks and engagement of parent, school and staff (Sharma et al., 2017). There is a discrepancy in the knowledge and comprehension about oral health differs from dental professional to students. In a study researcher used mouth drawing as tool of measuring health literacy among students prior and after health education. The study finds that 72.8% students answered better after the health education then they answered about the health education queries prior education (Ueno et al., 2014). Over the last 10 years, the Health Promoting School (*HPS*) concept developed and provided positive outcomes. HIV risk is not proportionate among sexual and gender minority (SGM) youth. School can play a valuable role for educating young students regarding primary prevention measures regarding such issue (Rose & Friedman, 2017).

Interventions for Mental Health

There are many specific interventions or programs focusing mainly on student's mental health. The Guide mental health literacy curriculum for school students is an effective way in raising mental health literacy. An MHL resource from Canada (*The Guide*) is the curriculum contains basic understanding of mental health, mental disorders and treatment in brief, about stigma, about help seeking behavior (Mcluckie, Kutcher, Wei, & Weaver, 2014). Teen Mental Health First Aid (*teen MHFA*) is training program for students effective to raise mental health literacy (Hart, Mason, Kelly, Cvetkovski, & Jorm, 2016). "Mental health education program", "Mental health for everyone" are the similar approaches to raise mental health literacy among students (Ojio, 2015; Mcluckie, Kutcher, Wei, & Weaver, 2014). To assess the status of knowledge and attitude about mental health and improving that issue can be solved by Focus Group Discussion (*FGD*) (Okello, Abbo, Muhwezi, Akello, & Ovuga, 2014). Other than these intervention, school based interventions were tried previously in different ways. Among them intervention for bully prevention reduces bully behavior among students (Educational Intervention Using the Integrated Model for Behavior Change, 2016), community based dating violence prevention program reduces dating violence behavior in adolescent school students (Joppa, Rizzo, Nieves, & Brown, 2016). In a review, it was found that sexual abuse among children age group occurs frequently in family setting and abuse victims are often bullied and isolated in school. In order to prevent serious mental health problems, teachers and school counsellors play an important role in identifying and offering help (Sawyerr & Bagley, 2017). A good portion of adult mental health and substance use (MH& SU) disorders starts in adolescent age. In another review it was found that, along with other intervention school can take part a significant role in prevention program (Dunne et al., 2016). Continuing innovation, adaptation and evaluation of programs is now required, especially in low-income countries, to integrate mental health promotion in the public health agenda of countries worldwide (Herrman & Jané-llopis, n.d.). Suicide is the second leading cause of death for adolescents. Whereas school-based prevention programs are effective, obtaining active consent for youth participation in public health programming concerning sensitive topics is challenging. The current authors explored several active consent procedures for improving participation rates. Although passive consent produces the highest student participation, these methods are not always appropriate for programs addressing sensitive topics in schools. In-person active consent procedures may be the best option when prioritizing balance between parental awareness and successful student recruitment ("Procedures for School Programming: Addressing the Sensitive Topic of Suicide," 2017). Differences in the use of school-based behavioral health services (autism, attention deficit hyperactivity disorder [ADHD], conduct/oppositional defiant disorder, and ''other'') by racial and

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ethnic groups suggest the need for culturally appropriate outreach and tailoring of services to improve service utilization (Locke et al., 2017). Findings suggest that school engagement is a potentially modifiable target for interventions aiming to ameliorate the negative influence of mental health problems on school functioning for adolescent girls with histories of abuse or neglect (Threlfall, Auslander, Gerke, Mcginnis, & Myers, 2017).This study tested the influence of a training intervention to improve teachers' ability to accurately identify preschool children's emotional and behavioral problems in 24 schools in Addis Ababa, Ethiopia. Sensitivity and specificity of teacher identification, and overall agreement with an established measurement criterion (*Strengths and Difficulties Questionnaire*) were examined 2 years following training compared to pre- intervention baseline, and a non-intervention control group of 12 schools. Results indicate that the teacher training was significantly associated with more accurate identification of children's problem (Desta et al., 2017). Depression and anxiety often emerge for the first time during youth. The school environment provides an ideal context to deliver prevention programs, with potential to offset the trajectory towards disorder. These results suggest that the refinement of school-based prevention programs have the potential to reduce mental health burden and advance public health outcomes (Newby & Christensen, 2016).

CONTROVERSIES IN HEALTH LITERACY

In recent years, the volume of research on health literacy has grown. However, the definition of health literacy is yet to be universal. Moreover, few authors compare the concept as a repackaged form of health promotion (Sørensen et al., 2012; Nutbeam, 2000; Tones, 2002; Chinn, 2011). Some authors, clinicians and scholars like to consider health literacy as an individual responsibility and consider that itis the personal fault of the patient to have low health literacy (Koh et al., 2012; Serper et al., 2014). On the other hand, others consider health literacy as a dynamic & complex issue this reflects the available health information and service availability (Koh et al., 2012). IOM recommended it as a shared function of the society and the individual (Sørensen et al., 2012). IOM explains the source of relationship is the interaction of individual's skills and the sociomiety system demands. Health literacy is generated in the society as a whole but it can also be originated in an individual context based on different programs such as educational learning in the family setting, health promotion in the school, patient education programs, different patient self-management programs (Eichler, Wieser, & Brügger, 2009). WHO, IOM as well as different other professional societies mentioned repeatedly that poor health literacy is the result of low education, poor opportunity and limited healthcare access (Bailey et al., 2015). In addition, as mentioned in previous chapters, although schools may play an important role, in health literacy, it is important to be pointed that their expertise includes general education, whilst the level of expertise in health issues is limited (Chinn, 2011). Literature shows that educational programs particularly in schools, can promote the increase of the literacy levels of health care through a health curriculum however; at the moment there is no agreement on what a healthcare school curriculum design should include, probably because of the long-term nature of these educational programs (Parker and Kreps, 2004). Another limitation of school but also of other health literacy educational programs is that they focus solely on reading, writing, speaking, and listening skills and not on the larger set of communication strategies that consumers need to get the most out of the modern health care system (Cegala, 2003; Jones, Kreps & Cresskill, 1995).

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RECOMMENDATIONS

Educators, school administrators and policy makers need to be well informed about the strengths and limitations of the current database on the effectiveness of currently available health literacy programs in schools (Schachter et al., 2008). Effectiveness of school-based health literacy programs will help establish strong foundation for addressing health promotion, prevention and intervention among adolescents in school establishments. Provider (teacher) health literacy is as important as student health literacy and taking full advantage of provider-student relationship in child and adolescent health promotion helps the preparation of the teacher (Peterson et al, 2001) and to achieve them teachers needed to adopt, learn and practice about new concepts such as critical health literacy and successive changes required in school structure to achieve beneficial outcomes which heavily depends on funding (St. Leger, 2001).

However, applications of interventions not know to be effective could be a waste of the limited public funds (Wei et al., 2013). According to AMA four areas should be further explored for research such as screening of the health literacy, communication improvement focusing the low literacy patients, expenses and outcome of inadequate health literacy, and causal relationship of low health literacy and health (Sørensen et al., 2012). Authors recommended that schools can act as a vehicle for promoting health literacy as well as overall health though there is limited evidence to support any specific level of school such as primary or secondary (Hagell, Rigby, & Perrow, 2015). Health promoting school concept is recommended to be embraced to initiate and sustain the positive changes (Valois & Hoyle, 2005). As schools influence directly both the education and development of the youths, IOM highlighted the need for playing important role in improving the health literacy (Manganello, 2008). WHO recommends few things after reassessment of the effectiveness of Health Promoting Schools such as curriculum modification with inputting the issues, changing the school ethos and further engagement of the families and communities (Hagell, Rigby, & Perrow, 2015).Parents play an important role in the lives of students and teachers should engage parents during the process delivery of health education which is a great part of family life (Begoray et al, 2009).

CONCLUSION

Health literacy is a global concern of this century. Although healthcare is moving towards the patient-centered approach poor health literacy is still a silent epidemic that affects health outcomes holistically. School is a potential area to improve the health literacy nationally and globally. Different measures are available to assess literacy. As schools influence directly both the education and development of the youths, IOM highlighted the need for playing important role in improving the health literacy. After reassessment of the effectiveness of Health Promoting Schools, the WHO recommends curriculum modification with inputting the issues, changing the school ethos and further engagement of the families and communities. Multiple interventions are implemented across the globe. Educational programs particularly in schools, can promote the increase of the literacy levels of healthcare through a health curriculum however; at the moment there is no agreement on what a healthcare school curriculum design should include, probably because of the long-term nature of these educational programs. Moreover, health literacy educational programs focus solely on reading, writing, speaking, and listening skills and not on the larger set of communication strategies that consumers need to get the most out of the modern healthcare system.

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Multisectoral collaboration such as health, education, finance, media, communication; and locally proved effective strategies should be considered as a priority.

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Chapter 54
Understanding and Addressing the Stigma in Mental Health Within the Asian and Asian-American Culture

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ABSTRACT

Mental health stigma can be defined as the display of negative attitudes, based on prejudice and misinformation, in response to a marker of illness. Stigma creates mental distress for individuals, which furthers stigmatizing attitudes, thereby making it a relentless force and as incompetent in achieving life goals such as living independently or having a good job. Over the years, researchers have consistently highlighted the problem of mental health service underutilization within the Asians and Asian-Americans communities. As such, understanding the cultural contexts that facilitate good outcomes may offer a lever or stigma reduction. Thus, the purpose of this chapter is to understand and address the sociocultural and psychological paradigms of the stigma in mental health within Asians and Asian-Americans. This chapter will cover the history of stigma within the Asian culture, Asian's mental health, mental health services utilization within the Asian culture, and methods of addressing the stigma within the Asian culture to promote the utilization of mental health services.

INTRODUCTION

Mental health stigma can be defined as the display of negative attitudes, based on prejudice and misinformation, in response to a marker of illness (Sartorius, 2007). Link and Phelan (2001) describe four characteristics that distinguishes mental health stigma from other social phenomena: (1) it is fundamentally a label of an out-group; (2) the labelled differences are negative; (3) the differences separate the 'normal' from the out-group, and (4) label and separation leads to discrimination. Stigma creates mental distress for individuals, which furthers stigmatize attitudes, thereby making it a relentless force (See-

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man, Tang, Brown, & Ing, 2016). Nevertheless, it is widely acknowledged that psychiatric diagnoses are stigmatized, and associated with negative public attitudes (Angermeyer & Matschinger, 2003). Hence, social cognitive models pin point stigma as a relationship between stigma signals (cues), stereotypes (attitudes), and behaviors (discrimination) (Corrigan, 2000), stemming from socialization (Abdullah & Brown, 2011). People with mental illness are perceived as dangerous and unpredictable, incompetent at achieving life goals such as living independently or having a good job (Angermeyer & Dietrich, 2006), and often blamed for their own illlnesses. Prejudice arises when people endorse such stereotypes and discrimination is the behavioral result of prejudice (Corrigan, Druss, & Perlick, 2014; Jenks, 2011).

On a macrosocial level, institutional policies endorse mental health stigma by restricting opportunities for people with mental illness (Corrigan, Markowitz, & Watson, 2004). According to the Global Burden of Disease Study (Murry & Lopez, 1996), stigma lies in the world-wide impact of mental illness on overall health and productivity. Profoundly under-recognized, mental illness constitutes 11% of the global burden of disease, with major depression alone currently ranking fourth and expected to rise to second by 2020. In some regions of the world, mental disorders already represent the largest contributor to the total disease burden, and there is great concern with the *morality crisis* related to mental illness in Eastern Europe (Rutz, 2001). In the face of these concerns, the World Health Organization's (WHO) International Pilot Study of Schizophrenia (IPSoS), the International Study of Schizophrenia (ISoS), and the Study of the Determinants of Outcomes of Severe Mental Disorders (DOSMD), have all documented enormous heterogeneity in the outcomes of mental illness within and across countries (Hopper & Wanderling, 2000; Kulhara & Chakrabarti, 2001; Sartorius, Gulbinat, Harrison, Laska, & Siegel, 1996; Sartorius, Jabensky, & Shapiro, 1978). While it is generally agreed that the reasons for these differences are "far from clear" (Kulhara & Chakrabarti, 2001), one predominant explanation revolves around culturally defined processes.

Scholars and policymakers suggest that stigma may be the reason behind such findings and lies at the root of recovery from mental illness (Remschmidt, Nurcombe, Belfer, Sartorius, & Okasha, 2007). As such, understanding the cultural contexts that facilitate positive outcomes may offer stigma reduction. In particular, whether individuals and others around them recognize mental illness, stigmatize these conditions and support seeking care is critical, since each represent key aspects of culture that can influence the outcome of mental illness (Pescosolido, 1991; 2006). The purpose of this chapter is to understand and address the sociocultural and psychological paradigms of stigma in mental health within Asian culture. For the purpose of this chapter, within the focus of Asians, emphasis will be on Chinese and Chinese Americans. This chapter will cover the history of stigma within the Asian culture, Asian's mental health, mental health services utilization within the Asian culture, and methods of addressing the stigma within the Asian culture to promote the utilization of mental health services.

ASIANS: THE CHINESE

Based on U.S. Census information from 2011, according to Ali (2014), it is estimated that 18.2 million persons of Asian descent living in the United States, and that Asians comprise approximately 5.8% of the total population (Pew Research, 2012; United States Census, 2013a) and growing. Of the 50 states in the United States, California and New York have the largest numbers of Asians in 2010 (United States Census, 2013a). Asians were the fastest growing racial group with the largest proportional population increase between the 2000 and 2010 census, even compared to Hispanic and Latinos, which was one of

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the largest increase in population (United States Census, 2013a; United States Census, 2013b). Among Asians of Chinese descent, followed by Filipino Americans, Indian Americans, Vietnamese Americans, Korean Americans, and then by Japanese Americans (United States Census, 2013a). Not surprisingly, after English and Spanish, Chinese is the third most widely spoken language in homes in the United States. While Asians are making tremendous strides in acculturation since the first Chinese and Japanese immigrants came to the United States in the mid 1800's, Asians are still largely a population made up of immigrants, with 74% of Asian adults having been in another country (Pew Research, 2012).

Among Asians, 28% live in a multigenerational family, defined by having at least two adult generations in the same household, which is higher than Whites, Blacks, and Hispanic Americans (Pew Research, 2012). On the whole, Asians have a relatively high educational status, with approximately 85% of adults over age 25 having attained a high school diploma, 49% of Asian adults over age 25 are college graduates, compared to 28% of the general population. However, there is a disparity in the percentage of college graduates in different Asians ethnic groups. For example, according to Ali (2014), only 26% of Vietnamese Americans over age 25 are college graduates, which is lower than the general population. Approximately half of Korean, Chinese, Japanese, and Filipino Americans over age 25 are college graduates. Indian Americans have a much higher percentage of college graduates over age 25 (70%). These interethnic differences may reflect different immigration patterns from the countries of origin. While the median income of an Asian household is $66,000, and higher than the national median, 12.5% of Asians lived in poverty in 2009 and 17.2% were without health insurance (United States Census, 2013a). Additionally, Asians households are often larger than those of other ethnic groups. While these facts and figures do not reflect the diversity of the Asians population, they help to provide a broad characterization of the group (Ali, 2014).

Brief Immigration History: The Chinese

The first Asian category of immigrant to the United States arrived from Japan in 1843 and were soon followed by Chinese men who came in 1850s and 1860s to work on the trans-continental railroad, gold mines, and in agriculture (Takaki, 1998, pp. 80-98; United States Census, 2013a). The Chinese Exclusion Act of 1882, which put an end to all immigration from China, was a reflection of the opposition to Asians immigrating to the United States and becoming permanent residents. The Asian Exclusion Act of 1924 was a continued response to concern about Asian immigration, which limited the new immigrants per year from East Asia, Southeast Asia, and South Asia (Pew Research, 2012). Asian immigrants were thought to be unable to assimilate into the U.S. population due to phenotypic differences in appearance, unlike European immigrants. A Supreme Court case in 1923 of U.S. vs. Bhagat Singh Third denied an Indian immigrant the ability to apply for citizenship citing this concern in the official decision (Takaki, 1998, pp. 80-98). The doubt about the allegiance of those of Asian origin to the United States lasted well into the middle of the twentieth century. During World War II, over 80,000 U.S.-born citizens of Japanese origins were held in concentration camps by the government (Takaki, 1998, pp. 80-98).

Immigration from Asia radically changed over the course of the twentieth century with different ethnic subgroups greatly increasing as a response to the loosening of governmental restrictions and quotas. For example, according to Ali (2014), in the middle of the 20th century, naturalization and immigration of the war brides of U.S. soldiers from Japan, Korea, and Vietnam became permissible (Cottrell, 1990; Lopez & Yamazato, 2003; Takaki, 1998, pp. 80-98). In 1965, the Immigration and Nationality Act ended quotas with regard to Asian immigrants from Asia. This act also changed the ethnic landscape of Asian

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immigrants, who until that time had largely been from Japan, China, and the Philippines. In the 1970s, there was an influx of refugees from war-torn Laos and Cambodia (Tseng & Strelzer, 2001). Currently, Asian immigrants are most likely to come to the United States with work visas, but also come through student visas, temporary visas, and unauthorized status (Pew Research, 2012).

Moving forward, as a result of the varied historical waves of immigration, there is tremendous diversity among the immigration and acculturation experiences among Asians. The term Asian captures the breadth of experience of an elderly Japanese American man whose family has been in the United States for many generations and the 18-year-old female refugee from Myanmar who recently arrived to the United States. Despite their age gap, the Japanese American man whose grandparents immigrated in one of the early waves of immigration will likely be more acculturated than the 18-year-old who arrives to resettle in a very foreign culture. As the chapter's focus turns toward mental health in Asians, specifically the Chinese, it will be important to continue to consider each patient or family's immigration history as it informs aspects of who they are and what issues may arise when they present themselves to mental health professionals.

Brief History of the Prevalence of Mental Health Disorders in Asians and the Utilization of Mental Health Services

According to Ali (2014), the Surgeon General's Report on Mental Health in 2001, now well over 15 years old, there was little adequate data about the prevalence of mental health disorders in Asians. One of the larger studies mentioned in this report, the CAPES study, demonstrated that Chinese Americans in the Los Angeles area had a moderate rate of depression, with 7% of the studied participants endorsing having experienced depression in their lifetime and 3% in the prior year (U.S. Center for Mental Health Services, 2001; U.S. National Institute of Mental Health, 2001; U.S. Office of the Surgeon General, 2001; United States Substance Abuse and Mental Health Services Administration, 2001). Studies in the 1980s and early 1990s that assessed symptoms of depression rather than the diagnosis of depression in the Asian population found higher rates of depressive symptoms in Japanese American, Korean Americans, Filipino Americans, and Chinese Americans in various major cities in the United States (U.S. Center for Mental Health Services, 2001; U.S. National Institute of Mental Health, 2001; U.S. Office of the Surgeon General, 2001; United States Substance Abuse and Mental Health Services Administration, 2001). One of the concerns underscored in the Surgeon General's report is the lack of adequate data about DSM diagnoses in the Asian population and the report questioned whether or not Asians truly have lower rates of psychiatric disorders compared to other populations. Due to the potential cultural bias in the reporting of and asking about symptoms, it was unclear whether or not accurate data about mental health conditions in Asians were captured by numerous studies. Culturally informed ways of expressing symptoms, prevalence of somatization, and culture-bound syndromes were all raised as possible confounding factors. The report clearly states that there were inadequate data about the prevalence of disorders in Asians who did not report mental health concerns and did not see mental health professionals. Rather than demonstrating that Asians were a resilient model minority group (Tran, 2016, 2017), the report showed that the scope of mental health problems of Asians were not adequately detected. Without perceiving a realistic mental health need, treatment could not occur, except for high-acuity populations, like Southeast Asian refugees with post-traumatic stress disorder, whose need was more evident (U.S. Center for Mental Health Services, 2001; U.S. National Institute

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of Mental Health, 2001; U.S. Office of the Surgeon General, 2001; United States Substance Abuse and Mental Health Services Administration, 2001).

Moving forward, large-scale studies have yielded more useful data about the prevalence of mental health diagnoses in Asian Americans and utilization of mental health services. However, diagnosis-specific studies have focused only on ethnic subgroups of Asians and there is no reliable data on the prevalence of psychiatric diagnoses in Asians as a whole. One of the large-scale studies is the National Latino and Asian American Study (NLAA) that reflects the prevalence of psychiatric diagnoses to be 0.8%. This study was designed to assess the 12-month prevalence of mental health disorders from 2002 to 2003 among Asians and Latinos, to assess the psychosocial context of the emergence of the disorders, and to determine how often mental health services were sought, in comparison with White, Hispanic, and Black populations (Alegría, Takeuchi, Canino, Duan, Shrout, Meng, Vega, Zane, Vila, Woo, Vera, Guarnaccia, Aguilar-Gaxiola, Sue, Escobar, Lin, & Gong, 2004). In one analysis by Dr. Jennifer Abe-Kim of the NLAAS data, 8.6% of the population surveyed sought mental health treatment compared to 17.9% of the general population when assessed in other large-scale studies (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegría, 2007). In the general population, 41.1% of persons with a probable DSM-IV diagnosis sought psychiatric treatment compared to 34.1% of Asians. Additionally, the propensity to use mental health services was inversely correlated to generation of immigration, such that second generation immigrants were more likely to use mental health services than immigrants, and third generation immigrants were more likely to use mental health services than second generation immigrants at a rate more similar to the general population (Abe-Kim et al., 2007).

In the NLAAS study, the prevalence of lifetime suicidal ideation in Asian populations were found to be 8.8% and the prevalence of suicide attempts were found to be 2.5%. Factors that were positively correlated with suicidal ideation and attempts include being female, conflict with family, a history of depression or anxiety, and perception of discrimination. Stronger identification and sense of belonging with one's ethnic group was negatively correlated with suicidal ideation and attempts (Cheng, Fancher, Ratanasen, Conner, Duberstein, Sue, & Takeuchi, 2010). The 2010 National Drug Use Survey on Health by the Substance Abuse and Mental Health Services Administration (SAMHSA), a large-scale survey on mental health and alcohol, tobacco and drug use patterns among over 60,000 responders over 12 years old, showered that the rate of illicit drug use was 3.5% in the month prior, lower than Whites, Native Americans, Blacks, or Hispanics. Among the 38.4% of Asian Americans who endorsed alcohol use in the month prior, 8.8% were binge drinkers and 2.4% were heavy drinkers of alcohol (The 2010 National Drug Use and Survey on Health, 2012). Rates of substance abuse or dependence were lower among Asians at 4.1% compared to other ethnic groups, which is consistent with what others studies have found (The 2010 National Drug Use and Survey on Health, 2012).

Smaller scale studies in specific ethnic populations of Asians have identified prevalence rates in these subgroups, but conclusions from these studies do not necessarily generalize to the heterogeneous group of Asians. For example, according to Ali (2014), Yeung, Chan, Mischoulon, Sonawalla, Wong, Nierenberg, and Fava (2004) found the prevalence of major depressive disorder among Chinese Americans in a primary care setting in Boston to be 19.6%, much higher than the estimate from the CAPES study in Los Angeles described earlier (Yeung et al., 2004). Another study from 2000 found that the prevalence of panic disorder in Cambodian refugees being treated at a psychiatric clinic disorders in Asians based on data from NLAAS study and found overall low prevalence of eating disorders in Asians, less than 1% for anorexia and bulimia. Women had a higher lifetime prevalence of binge eating disorder than men, 2.67% compared to 1.35% (Nicadao, Hong, & Takeuchi, 2007). The author believes that it is difficult

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to draw conclusions about a particular individual based on these heterogeneous data. One interpretation of these data is that mental health professional should expect that refugees from Asia will likely exhibit symptoms of anxiety disorders. However, with less high-acuity populations, the mental health professional should be more vigilant for mental health symptoms, which may be underrepresented or may manifest in different ways.

The Surgeon General's Report in 2001, according to Ali (2014), in addition to emphasizing the need for better epidemiological data on mental health conditions, also highlighted the low utilization of mental health services by Asians compared to other minority groups, which has continued to be true when compared to Whites, Blacks, and Hispanics (Sue, Yan-Cheng, Saad, & Chu, 2012; U.S. Center for Mental Health Services, 2001; U.S. National Institute of Mental Health, 2001; U.S. Office of the Surgeon General, 2001; United States Substance Abuse and Mental Health Services Administration, 2001). Since that time, many studies have examined this question with differing results, because barriers for the individual Asian patient may include any of the following: cultural bias in how the patient describes his symptoms, bias in how the clinician or researcher assesses the symptoms, decreased perception of need for treatment, stigma, foreign-born status, wishing to save face, initial use of family support and traditional healing methods, focus on somatic symptoms, length of time in the United States, lack of culturally appropriate services, lack of language appropriate services, and lack of health insurance (Abe-Kim et al., 2007; Lu, 2010; Sue, et al., 2012; U.S. Center for Mental Health Services, 2001; U.S. National Institute of Mental Health, 2001; U.S. Office of the Surgeon General, 2001; United States Substance Abuse and Mental Health Services Administration, 2001). According to Ali (2014), for every 100,000 Asian and Pacific Islanders, there are 70 Asian and Pacific Islander mental health care providers, which is less than half of the number of providers for Whites. Also, Asians may have difficulty accessing the U.S. health care system in general, as suggested by the fact that Asians who are Medicaid eligible are much less likely to have Medicaid than their White counterpart (Lu, 2010). While it is not possible to review all of the nuances of the methodological difficulties in assessing the prevalence of mental health disorders in Asians and the disparity in their treatment, excellent reviews are provided elsewhere (Lu, 2010; Sue et al., 2012).

There have been calls for systematic, comparable studies of stigma within and across social and cultural contexts in order to understand its origins, meanings and consequences (Aggarwal, Cedeño, Guarnaccia, Kleinman, & Lewis-Fernández, 2016; Caracci & Mezzich, 2001; Hopper & Wanderling, 2000; Ng, 1997; Rutz, 2001; Slu, 1989). Despite these calls and findings that document the pervasive existence and impact of stigma in different countries (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Fabrega, 1991; Pescosolido, Martin, Link, Kikuzawa, Burgos, & Swindle, 2000; Stuart & Arboleda-Flórez, 2001; Wahl, 1999), relatively little about the cross-cultural distribution of stigma. Researchers across the global have collected data on stigma, but differences in samples and instrumentation make it difficult, if not impossible, to compare findings. Thus, questions about whether and how the social reaction to mental illness varies across countries, whether the underlying operative processes are similar, and whether it maps onto the distribution of outcome heterogeneity remain unanswered. Thus, the important question of whether these differences can offer a wedge into decreasing stigma's negative impacts, also remains unanswered. In sum, while the influence of cultural context on health and well-being is widely acknowledged, the empirical literature on the cross cultural nature of stigma remains underdeveloped (Aggarwal et al., 2016; National Research Council and Institute of Medicine, 2000). The World Psychiatric Association's (WPA) Global Programme Against Stigma and Discrimination because of Schizophrenia (Sartorius, 1997) has encouraged the developed the development of a comparative catalogue of informa-

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tion and, to date there have been only a few large-scale studies. Even recent cross-national effort, while springing from and being influenced by the WPA initiative, have not been linked in practice, making inference about comparative influence difficult. Moreover, according to Pescosolido, Olafsdottir, Martin, and Long (2008), there has never been a methodologically coordinated attempt to understand the extent to which mental illness is understood and stigmatized across countries (Townsend, 1975).

Mental Health Disorders and Stigma: Asians

The concepts of stigma and shame play an important role in Asians' low services use (Chu & Sue, 2011). According to Chu and Sue (2011), *Haji* among Japanese, *Hiya* among Filipinos, *Mianzi* among Chinese, and *Chaemyun* among Koreans are terms that reveal concerns over the process of shame or the *loss of face* (Sue, 1994). Many Asians tend to avoid the juvenile justice or legal system, mental health agencies, health services, and welfare agencies, because the utilization of services for certain problems is a tacit admission of the existence of these problems and may result in public knowledge of these familial difficulties. Older adult Korean Americans, for example, report greater misconceptions and stigmatizations about mental health as a weakness that would bring shame to a family if one were to reveal their mental illness by seeking treatment (Jan, Chiriboga, & Okazaki, 2009). Other studies have confirmed that greater personal stigma and lower stigma tolerance predicts a lower likelihood to seek help among Asian students, and that stigma about mental illness is higher among Asians (Eisenberg, Downs, Golberstein, & Zivin, 2009; Ting & Hwang, 2009).

System-level and care process factors also contribute to the considerable problem of mental health care disparities in Asians. Higher rates of poverty and rates of being uninsured or underinsured, particularly among Southeast Asians like the Cambodians, Hmong, or Laotians, can prevent access to needed mental health services (Reeves & Bennett, 2204). Compounding this problem of financial resources is the dearth of available language-appropriate and culturally-appropriate services for many Asian individuals. Beyond the need to increase the availability of Asian-language clinicians, research has pointed to the need for culturally-competent providers who are able to understand and deliver mental health treatments with similar worldviews and cognitive styles to that of Asian clients (Aggarwal et al., 2016; Zane, Sue, Chang, Huang, Huang, Lowe, Srinivasan, Chun, Kurasaki, & Lee, 2005). Asians who make the difficult decision to initiate contact with mental health providers may be more likely to stay in treatment if they encounter these culturally-congruent aspects of the care process (Aggarwal et al., 2016; Ivey, Ivey, & Simek-Morgan, 1997; Sue & Sue, 1999).

ASIANS: MENTAL HEALTH

Asians in the United States are comprised of many subgroups including Cambodians, Chinese, Japanese, Filipinos, Koreans, Laotians, Asian Indians, Vietnamese, etc. who speak over thirty languages. Asian comprise 58% of the U.S. population but 60% of the world's population (Chu & Sue, 2011). Despite the fact that Asian groups are heterogeneous, researchers have often studied the subpopulations as an aggregate group because Asians often show similar cultural values that are in contrast to Westerners (Chu & Sue, 2011). Despite the high prevalence of mental health-related problems, mental health is commonly overlooked in Asian communities, and cultural barriers have been identified as the most imperative

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factor (Aggarwal et al., 2016; Lee, Juon, Martinez, Hsu, Robinson, Bawa, & Ma, 2009). Nguyen and Anderson (2005) stated that some Asians hold the belief that individuals who have mental illness may be possessed by supernatural entities such as demons or spirits. Therefore, mental illness is highly stigmatized in many Asian cultures, and the root of mental illness stigma can be found in Asians' cultural beliefs toward mental health (Kung, 2004; Lee et al., 2009; Masuda, Anderson, Twohig, Feinstein, Chou, Wendell, Stormo, 2009; Nguyen & Anderson, 2005). Indeed, among Asian immigrants, extra-familial intervention is often considered shameful, as it indicates the inadequacy of family members and causes them to *lose face* within their community (Chu & Sue, 2011).

Consequently, instead of seeking professional help, Asians may try to change this behavior through self-control and willpower or may try to keep out bad thoughts by keeping busy (Zhang, Snowden, & Sue, 1998). When these attempts fail, they may choose to address problems and needs first, within the family system (Hsu, Davies, & Hansen, 2004). External help is sought only after all other resources are exhausted or when legal or social services force the issue. Even when seeking mental health services, many Asians might first seek medical services or traditional resources such as herbalists, acupuncturists, fortunetellers, or religious/spiritual leaders for help, which are less stigmatized sources of help (Nguyen & Anderson, 2005). Depending on the severity of their illness, they may then seek a mental health professional (Kung, 2004). If the Asian culture and stigma play a significant role in help-seeking behaviors, given the interconnected nature of culture, stigma, and the acculturation process among ethnic minorities (Hsu, Davies, & Hansen, 2004), it follows that acculturation might predict help-seeking behaviors.

MENTAL HEALTH SERVICES UTILIZATION WITHIN THE ASIAN CULTURE: ACCULTURATION, PREFERENCE FOR COUNSELORS, AND HELP-SEEKING BEHAVIORS

In the Asian culture, empirical studies have shown that the identification, express and acknowledgement of psychiatric problems are influenced by culture. According to Han and Pong (2015), studies show that many Asians believe that emotional anguish is seen as the consequence of bad thoughts, a lack of will power and self-control, and personality weakness, and therefore disclosing that one has mental illness is considered to be shameful (Kung, 2004; Lee et al., 2009). These beliefs may deter individuals from seeking help for their symptoms. Furthermore, in Asian cultures, mental illness often is not considered as an individual problem. Rather, mental illness potentially represents a negative reflection on the immediate family as well as their ancestors. For Asian immigrants, stigma attached to mental illness is a multifaceted phenomenon which is related to loss of face and status that us beyond the individual level (Chu & Sue, 2011). It is likely that such an intense and complex stigma attached to mental health issues further exacerbates disparities in mental health service utilization. Indeed, among Asian immigrants, extra-familial intervention is often considered shameful, as it indicates the inadequacy of family members and causes them to *lose face* with their community (Chu & Sue, 2011). Consequently, instead of seeking professional help, Asians may try to change this behavior through self-control and willpower or may try to keep out bad thoughts by keeping busy (Zhang, Snowden, & Suc, 1998). When these attempts fail, they may choose to address problems and needs first within the family system, such as immediate nuclear family, then extended family (Hsu, Davies, & Hansen, 2004). External help is sought only after all other resources are exhausted or when legal or social services force the issue.

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Another cultural-bound contributor to low mental health service utilization is one's level of acculturation. Acculturation is a process of changing one's culture by incorporating elements of another culture and entails a mutual blending of culture, both psychologically and behaviorally (Berry, 1997). Thus, acculturation reflects the extent to which individuals learn the psychological and behavioral aspects of the dominant culture (Zane & Mak, 2002). Thus, Asians' reluctance to seek professional help and their lack of acceptance of Western psychotherapy, based on their level of acculturation, is known as a contributor to barriers in seeking mental health services (Wong, Marshall, Schell, Elliott, Hambarsoomians, Berthold, & Chun, 2006). Furthermore, studies also show that many Asians, in addition to the cultural factors such as stigma and acculturation, do not feel comfortable speaking to a mental health professional who does not share their same ethnic background, primarily due to cultural/language difference (Lee et al., 2009).

Mental Health Services Utilization Within the Asian Culture: Characteristics and Professional Mental Health Help-Seeking Behavior

Most existing studies have emphasized the cultural contextual factors in Asians' professional mental-health-seeking behavior. Previous research has shown that demographic characteristics seem to play a role in the willingness to seek professional help among Asians (Takayama, 2010). According to Han and Pong (2015), Asian females tend to have more positive attitudes toward seeking help than do Asian males (Leong & Zachar, 1999; Yoo, Goh, & Yoon, 2005). Also, while some studies have not found any relationship between age and seeking formal psychological help (Abe-Kim, Takeuchi, & Hwang, 2002; Abe-Kim et al., 2007; Shea & Yeh, 2008), some argue that younger Asians, especially those who ae male, may be less traditional, which results in a positive view of psychological help-seeking behavior (Solberg Ritsma, Davism Tata, & Jolly, 1994).

Cultural-Bound Syndromes

Culture-bound syndromes are repeated clusters of symptoms and behaviors specific to a geographic region which can cause both physical and mental distress in an individual and may result in impairment of functioning and help seeking behavior. The symptoms may include somatic symptoms as well as symptoms that may or may not overlap with a psychiatric disorder classified in the DSM (Task Force on DSM-IV, 2000). Various culture-bound syndromes are associated with particular Asian populations and are a continued area of study as psychiatric researchers and clinicians alike determine how best to approach their diagnosis and treatment. Identification and management of culture-bound syndromes is a continued controversial area of inquiry. A recent review challenged the notion of this being only a culture-bound syndromes given the more frequent episodes of violence and aggressive behavior in Western countries as well as Asian countries, by people of Asian descent and non-Asian descent (Saint Martin, 1999). The prevalence of culture-bound syndromes may also continue shift. In Lee and Kleinman's study (2007), reviewing the history and prevalence of neurasthenia in China, Lee and Kleinman (2007) postulate that the worldwide impact of the DSM has made it less likely that Chinese psychiatrists use the diagnosis of neurasthenia in China (Lee & Kleinman, 2007). Culture-bound syndromes continue to evolve over time, particularly as technology and communication continue to impact cross-cultural exchange of information and ways of understanding illness.

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Shame and Stigma

According to Wynaden, Chapman, Orb, McGowan, Zeeman, and Yeak (2005), Asians reported that their communities stigmatized people who had a mental illness and that the ill person experienced feelings of shame. Several Chinese elaborated that for the community, the meaning of *shame* had a very intense and profound meaning. Wynaden et al. (2005, p. 90) found it difficult to describe in English the intensity of the expression of the feeling of *shame* that a person with a mental illness would feel: "The [Chinese] feel shame, the meaning of shame is [non-Chinese people] can't understand the meaning of shame. For Chinese people shame is very deep meaning. It means that you can't go out and face other people (p. 3)". Thus, shame and stigma prevented people from seeking help from mainstream mental health services. According to Wynaden et al., (2005, p. 91), the family tried to manage the problem and isolated themselves from the community to prevent knowledge of the family member's illness from becoming public: "They [family] don't want to accept it and those that do [they feel that they] will be stigmatized and bring bad onto the family…migrants that live in Australia still often live in their own culture…They know that there is a problem but they do not want to accept it (p. 5)". A person with a mental illness, according to Wynaden et al., (2005, p. 91), and his/her family isolated themselves because they believed that they would be labelled as different by their community and viewed negatively: "I think that they [people who are ill] are very sensitive to being labelled being seen as different. You know they are very sensitive to people looking at you in a strange way that you have a mental problem. In Chinese it [a mental problem] is mad! (p. 3)".

Causes of Mental Illness

Asians stated that knowledge about the cause of mental illness depended on the person's: (1) level of education; (2) country of origin; and (3) age According to Wynaden et al. (2005). People who had migrated from countries such as Singapore, with a western lifestyle, were more open to the western concepts of education and scientific information regarding the causes of mental illness. Educated people were also better informed and viewed mental illness as having a genetic/hereditary link. They understood disorder such as depression and schizophrenia. In contrast, migrants from more remote villages who were less educated and elderly migrants held more traditional beliefs. Hence, religion, and in particular Buddhism and Taoism, was reported to be important in determining the health beliefs of community members. According to Wynaden et al. (2005, p. 91), Buddhists believed in reincarnation and, inherent in this belief is, the philosophy of karma. Karma, the law of cause and effect in eastern spirituality, emphasizes that there is a consequence for every action. Therefore, positive actions result in positive reactions and negative actions result in negative reactions in a later reincarnation. Subsequently, people who produced a child who had a mental illness were perceived as being punished for their conduct in their past lives: "Traditionally they [parent] feel they may have done something wrong for this [mental illness] to happen. What you did in your past lives reincarnation [(前 世) the previous life]. You have not done anything right in your previous life. It is a sin very simply (p. 3)".

Other beliefs, according to Wynaden et al. (2005, p. 91), about the cause of mental illness are linked to the person being possessed by evil spirits: "When you are unwell, people will try to treat you with a witch doctor or spiritual leader…They relate psychiatric problems to spiritual causes (p. 10)". Traditional beliefs were also reported to have a sociological base. This belief was associated with the concept of *bad blood*: "In the old times they thought it was some bad blood in your family that caused it [mental

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illness]. Sometimes if the child has this problem [mental illness] then it must be the mother's fault, not the father. The mother brought all this to the family. It has a lot to do with the sociological thinking at that time society how they see women and men's roles (p. 6)". Furthermore, refugees from China were identified as an extremely vulnerable population because of the traditional beliefs they held. Many of the customs among this group did not facilitate resolution of problems associated with mental illness. According to Wynaden (2005, p. 91), the family may not attend funerals of a member who had committed suicide: "The refugee group from China…this is the group of people that are really very isolated and have nobody and no support at all…They don't know how to deal with it…Language is a problem culture is another major problem in fact I came across quite a few refugee families and they have a huge problem to adjust to the way of life (p. 6)".

Family and Reputation

According to Wynaden et al. (2005, p. 91), the need to maintain family reputation was reported by all Asians and Asian Americans and were not dependent on people's level of education or country of origin: "They are reluctant to talk about it [mental illness] even if you [a general practitioner] ask them questions. It is something to be ashamed of it is a weakness and there is a stigma attached to it. You will be branded (p. 9)". Maintaining family reputation was particularly important if the problem was viewed as having a hereditary cause. It was reported that many Asian migrants have high expectations for their children. If these children succeeded it gave a good impression for the family. However, if the child developed a mental illness the family's reputation was disgraced (Wynaden et al., 2005, p. 91).

Hiding Up

According to Wynaden et al. (2005, p. 92), hiding up involved keeping the mental illness hidden from the community and/or not doing anything about the ill person's behavior: "There is still a large group of people who hide their [mentally ill] children away. They refuse to believe that they have a history of mental illness…They hide them [the child] they let them stay in the house and they do not let them leave the house (p. 2)". Hiding up meant that the family would not actively look for treatment and they would hide the ill person away hiding that as the child matured the problem would go away. The family would not bring people into their home, they would keep to themselves: "A lot of Chinese families [with a family member with a mental illness] hide up, they do not come out and they do not feel comfortable n going out…If you get an illness like a mental illness you do not understand and it has connotations and there is a lot of pressure to keep it hidden. If a family has mental illness they never want to talk to it. Only the family people know about the illness (p. 3)".

Seeking Help

Seeking help was a difficult process and it was usually left until the ill person's behavior was so bad that it could not be managed any longer within the family: "People who get treatment do it as the last resort (p. 5)". Generally, Asians do not voluntarily seek help from mainstream health services. Instead, they prefer to use prayer and visit temples and churches. Taoism was an important religion as it provided direction about the cause and treatment of mental illness. The family sought help when they were not able to manage the ill person. Some accessed help from a general practitioners (GP) from their country

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of origin because they believed that the GP would be more likely to understand. Other went to a non-Asian GP to maintain family confidentiality and prevent the risk of information being leaked to their community. Furthermore, language barriers were experienced by people accessing non-Asian doctors, and the use of interpreters was costly.

Lack of Collaboration

Asians explained that health professional had to reach into the community to access people if they wanted to demystify mental illness. According to Wynaden et al. (2005, p. 92), one way was to make contact with spiritual/religious leaders as places of worship played a very important role in determining the health belief of these communities. Health professionals need to understand the impact of mental illness on the family: "[Health professionals need to] develop more understanding of how Asian people feel about having a family member with a mental illness. If they can understand the traditional thinking, how people think about it. Health professionals can support them and let them know that they are not different…You need to make them feel that they are not disrespected (p. 3)". Health professional have to act with compassion, establish rapport and maintain confidentiality (p. 8)".

FUTURE RESEARCH AND RECOMMENDATIONS

Asians may have needs for certain resources that are not reflected in lower service utilization patterns. Experts have criticized the mental health services currently available within the US mental health system as disjointed, culturally mismatched with the treatment preferences of ethnic minority clients, and non-representative of cultural ideas about illness and health (Aggarwal et al., 2016; President's New Freedom Commission on Mental Health, 2003; United States Department of Health and Human Services, 2001). In recent years, culturally-specific service options have emerged to improved fit with the mental health needs of Asians. Cultural treatment adaptations, for example, refer to the process by which evidence-based practices (EBPs) validated in mainstream populations are tested and modified for the specific cultural needs of ethnic minorities like Asians. Culturally-adapted EBPs systematically consider language, culture, and contextual issues consistent with client's cultural values, beliefs, and practices, and have demonstrated beneficial outcomes in diverse populations (Bernal, Jiménez-Chafey, & Rodríguez, 2009; Griner & Smith, 2006; Pan, Huey, & Hernandez, 2011; Sue, Zane, Hall, & Berger, 2009). Several of these culturally-adapted treatment options have emerged as viable options for Asian individuals, including Problem Solving Therapy for depressed Chinese older adults (Chu, Huynh, & Arean, 2012), a culturally-adapted one-session treatment for Asians with phobia (Pan et al., 2011), a culturally-adapted cognitive behavioral intervention to accommodate the somatic symptoms that accompany PTSD in Cambodian refugees (Hinton, Pich, Chhean, Safren, & Pollack, 2006), and a Cantonese language CBT for depressed Hong Kong immigrants in Vancouver Canada (Shen, Alden, Söchting, & Tsang, 2006).

As a relatively new field of study, the science of cultural adaptation has shown recent advances with strides in guideline for when, how, and to what extent treatments should be adapted for a cultural population without significantly compromising fidelity to essential treatment components (Castro Barrera, & Holleran-Steiker, 2010). In fact, several models for the cultural adaptation process have been offered, such as the ecological validity framework (Bernal, Bonilla, & Bellido, 1995), cultural accommodation model (Leong & Lee, 2006). Most of these models recommend variations around four basic adaptation phases:

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information gathering, developing of initial adaptation design, pilot testing, and additional refinement (Barrera & Castro, 2006). These culturally-adapted treatments show considerable promise to provide treatment options that are congruent with the cultural preferences, coping and interpersonal styles, and psychopathology expressions of Asian clients. Continued work is needed to further develop and refine culturally-adapted treatments, and translational implementation efforts are sorely needed to transport such treatments from research to applied community settings. Unique challenges for the validity of mental disorder research arise from the heterogeneity of Asians populations, cultural biases in reporting style, and cultural idioms of distress. First, the nature of the Asian population is that it is small, diverse, and ever-changing. Second, cultural variations in response style, particularly on self-report rating scales, present important challenges for researchers and mental health professionals in the interpretation and cross-cultural validity of questionnaires. Third, Asians choose to express their distress is that of language terms utilized on research instruments (Chu & Sue, 2011).

CONCLUSION

Over the years, researchers have consistently highlighted the problem of mental health service underutilization within the Asians communities (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegría, 2007; Cheung & Snowden, 1990; Sue, Yan-Cheng, Saad, & Chu, 2012; Sue & McKinney, 1975). This mental health disparity manifests in a multifaceted manner, such as lower services utilization rates relatives to Whites (Matsuoka, Breaux, & Ryujin, 1997), presenting for professional help with more severe symptoms compared to other races (Chen, Sullivan, Lu, & Shibusawa, 2003), and a preference for receiving help from sources outside of professional mental health services (Ruzek, Nguyen, & Herzog, 2011). What is especially troubling is the recent evidence based on national data indicating that Asians continue to lag behind other groups (African Americans, Hispanics, and non-Hispanic Whites) in mental health service utilization, even while factoring in rates of distress (Sue, Cheng, Saad, & Chu, 2012). Therefore, a continued effort among researchers to unpack the contributing factors behind this mental health disparity is needed. That said, Kim and Kendall's (2015) study confirmed the recent and powerful data presented by Sue et al. (2012), indicating that the Asians underutilization trend still holds, even after taking into account psychopathology, only serve to further underscore the need for more research addressing this mental health disparity. Such that, the nuanced understanding of when an explanatory mechanism of help-seeking [Asian values → help-seeking attitudes → willingness to see a counselor] is attenuated, is when spiritual and biological etiology beliefs are strongly endorsed

Religion, Philosophy, and Health Beliefs

Many values and beliefs common among Asian populations have underpinnings in Asian religions and philosophy. These value systems are comprehensive, describing the integration of the body and the mind as well and an approach to managing both one's internal and external world. Asians and Asian Americans are an extremely diverse group, and while all Asians and Asian Americans will not uphold these beliefs, it is useful to briefly review them here as they inform the conceptualization of mental health and illness as well as general cultural values in many Asian cultures. That being said, much of Eastern philosophy is based on principles in Confucianism, Taoism, Hinduism, and Buddhism. Confucian thought brought order to Chinese civilization by emphasizing concepts such as interpersonal harmony, acceptance of a

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person's place in society, hierarchy within the family with older adults and males in higher positions, unconditional obligation toward the family, and orientation toward the group rather than the individual (Uba, 1994; Yang, Narayanasamy, & & Chang, 2011). Taoism emphasizes the importance of maintaining balance and harmony both internally and with the larger world, respecting nature, and maintain personal qualities of humility and receptivity (Stevenson, 1996; Yang, Narayanasamy, & Chang, 2011).

In Buddhism, the individual cultivates compassion for the suffering of others, acceptance of one's fate, or karma as a result of acts in a past life, and an acceptance of the ephemeral nature of life, as well as emphasis on non-attachment to aspects of the self (Hinton, Tran, Tran, & Hinton, 2008; Plakum, 2008). Elements of animism, belief in the existence of spirits, gods, and ghosts and the belief in a larger spirit would infused in natural inanimate and animate objects, has informed elements of Asian philosophy from Taoism, Confucianism, and Buddhism that include respect or worship for ancestors as a virtue (Hinton, Tran, Tran, & Hinton, 2008). Hinduism and Islam are the most common religions in South Asian nations. Aspects of Hindu beliefs have overlap with Buddhism such as the values of knowledge of life, emotional regulation, control-over-desire, the value of humility, and the importance of societal duty (Jeste & Vahia, 2008). Muslims also have a strong belief in destiny or fate, similar to karma, in that events occur because of the will of God, and similar ideas of sin to Judeo Christian religions. Many Muslims also believe in the spirit world of the jinn and some may have supernatural beliefs about the evil eye (Walpole, McMillan, House, Cottrell, & Ghazala, 2013). Hence, for example, a Chinese patient may believe that his low energy and mood are the result of an imbalance of yin and yang and may wish to take traditional herbs from a root doctor along with the antidepressant recommended by his psychiatrist (Castillo, 2002). Understanding traditional beliefs may also help mental health clinicians, researchers, and educators gain insight into a family's approach to managing a particular condition in a family member and the challenges that may arise. The breadth of religious and philosophies upheld by Asians was briefly reviewed here, but the mental health clinician can improve their understanding of the individual Asian patient's approach to his/her mental health by learning more about his/her particular belief systems.

Asian American Family Culture

Based on the deeply ingrained idea of filial piety in the vast majority of Asian cultures, the family is the unit on which society is based. Filial piety is a core value based on Confucian principles. It emphasizes the importance of family throughout the life cycle of the individual. The interdependence of family, members among Asians manifests itself in various ways, one of which is when Asians contemplate making major life decisions. In surveys of Asian adults with children over age 18, 68% felt that parents should have some influence in determining what career their child pursues, and in the same group, approximately 66% felt that parents should have at least some influence in their child's choice of spouse (Pew Research, 2012). On the other hand, behavior against the family or cultural values, such as delinquent behavior, a suicide attempt, being gay or lesbian, or taking a partner from a different religion or ethnic background, may be viewed as bringing shame to the family, or causing the family to *lose face*, and lead to conflict within the family (Rho & Rho, 2009; Walpole et al., 2013). Cultural values of displaying more tempered emotions, and family harmony may lead to more indirect or restrained communication between family members than in non-Asian families (Rho & Rho, 2009; Uba, 1994). Additionally, the emphasis placed on respect and obedience to parental authority can also decrease the likelihood of open communication between different generations as detailed in immigrant families. Acculturation and enculturation are related concepts. Both reflect aspects of the process of change an individual undergoes when one moves to a new culture.

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Acculturation and Families

Connections among family members undergo transition as immigrants move to a new culture and attempt to adapt to the culture. In a process known as acculturation, the individual adapts with regard to identity, beliefs, and values in relation to the new dominant culture (Kim, Ahn, & Lam, 2009). Enculturation, a related concept, functions in the opposite manner and is a process in which a person strengthens their ties to social norms and values of their culture of origin (Kim, Ahn, & Lam, 2009). Hwang (2007) has referred to the term as acculturation family distancing (AFD) to combine the parent and child generation in immigrant households may acculturate at different rates, leading to a difference in values and also difficulties in communication (Hwang, 2007; Uba, 1994). Other researchers have referred to this phenomenon as dissonant acculturation and suspect that this is particularly relevant in conflict between parents who may struggle to maintain ties to the older culture and children who because of their age and desire to connect with peers may have greater exposure to the new culture (Kim, Ahn, & Lam, 2009). According to Ali (2014), this acculturation gap can also occur between elderly relatives that are coming from the country of origin, to live in the United States with their children. Grandparents may be brought to the United States with the idea that they can benefit from better health care or provide childcare for the family. Immigration is often alienating for older immigrants, who likely face greater functional limitations and language limitations than younger generations (Baker & Takshita, 2002; Uba, 1994). It is also more challenging for the elderly to establish a peer group and a grandparent new to the United States may experience an acculturation gap with their children and an even greater one with their grandchildren. Acculturation is part of the process of making a cultural and geographic transition and can lead to significant intergenerational conflict in Asian families.

Hence, in previous section, existing evidence of the breadth and depth of stigma across countries and provocative cross-national findings in what empirical work exists. Thus, while stigma is seen as *cross culturally ubiquitous* (Dovidio, Major, & Crocker, 2000; Neuberg, Smith, & Asher, 2000), the earliest work (Goffman, 1963) to the most recent (Dovidio, Major, & Crocker, 2000; Fabrega, 1991) conceptualizes stigma as a phenomenon shaped by cultural and historical forces. Early on, anthropologists described the different ways that cultures shape how individuals with mental illness are viewed and treated (Benedict, 1934; Townsend, 1975). Lefley (1990) contends that chronicity, itself, is a cultural artifact based, at least in part, on differing worldviews, religious traditions, the role of alternative healing systems, and difference in the cultural value of interdependence. Even studies that have documented differences in outcomes for persons with mental illness across countries point to and call for further investigations across cultural contexts (Dovidio, Major, & Crocker, 2000; Ng, 1997). These studies suggest that future research must identify the collective properties of social, cultural, economic and physical environments that influence health and disease outcomes. For example, according to Pescosolido et al. (2008), Sartorius (1998) reports that the ratio of psychiatrists to the population ranges from 1:1,000-5,000 in the more developed societies to 1:50,000-100,000 in the developing world to only 1:5,000,000 in some African countries. Of course, this is not independent of the availability of economic capital in a society which needs to be considered as well, because the World Health Organization (WHO) reports that countries in Western Pacific Region devote less than 5% of their small health budgets to mental health and neurological disorders (World Health Organization, 2005, p. 121). Thus, existing research suggests that researchers and practitioners in the field of mental health need to examine cross-cultural issues directly, rather than making assumptions about their correlation with broad categories.

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I am a certified bilingual [Cantonese and English (and not certified Mandarin)] Senior Vocational Rehabilitation Counselor, Qualified Rehabilitation Professional (SVRC-QRP) with DOR. I am currently the top performing SVRC-QRP, among 36 counselors in 6 teams in the San Francisco District with the State of California, Department of Rehabilitation. I single-handedly manage the RAMS/Hire-Ability mental health contract, and achieved a 97% successful rate (66/68). The first time since the contract tenure with DOR (approximately 20 years). I am also the only bilingual liaison with the Disabled Students Programs and Services (DSPS) Department for Chinatown North Beach Campus at City College of San Francisco (CCSF) for DOR.

Hire-Ability is non-profit vocational services program partnered with San Francisco Department of Public Health and California State Department of Rehabilitation which serves the San Francisco Bay Area community by connecting employers with trained, assessed and pre-qualified employees. Hire-Ability specializes in providing employers with a pool of employees that reflect the diverse and multicultural population of the region. Specifically, Hire-Ability assists employers in achieving their diversity goals by matching them with qualified individuals with disabilities. Hire-Ability Vocational Services is a division of RAMS, Inc. (Richmond Area Multi-Services, Inc.), which was established in 1974 and has over 30 different community programs that operate in the San Francisco Area. RAMS, Inc. is a private, non-profit mental health agency that is committed to advocating for and providing community based, culturally-competent, and consumer-guided comprehensive services, with an emphasis on serving Asian & Pacific Islander Americans. Founded in San Francisco's Richmond District in 1974, our agency offers comprehensive services that aim to meet the behavioral health, social, vocational, and educational needs of the diverse community of the San Francisco Area with special focus on the Asian & Pacific Islander American and Russian-speaking populations.

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KEY TERMS AND DEFINITIONS

Asian Americans (Americans of Asian Descent): The term refers to a panethnic group that includes diverse populations who have ancestral origins in East Asia, Southeast Asia, or South Asia, as defined by the U.S. Census Bureau. This includes people who indicate their race(s) on the census as Asian or reported entries such as Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese, and Other Asian.

Asian Exclusion Act of 1924: A continued response to concern about Asian immigration, which limited the new immigrants per year from East Asia, Southeast Asia, and South Asia.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5): Used by clinicians and researchers to Diagnose and classify mental disorders.

Hiding Up: Involved keeping the mental illness hidden from the community and/or not doing anything about the ill person's behavior.

Karma: The law of cause and effect in eastern spirituality, emphasizes that there is a consequence for every action.

Mianzi: Refers to one's own sense of dignity or prestige in social contexts. It is a strategy that protects self-respect and individual identity.

Multigenerational Family: Having at least two adult generations in the same household.

Stigma: Stigma can be defined as the display of negative attitudes, based on prejudice and misinformation, in response to a marker of illness.

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Chapter 55
Religious Coping Among Muslims With Mental and Medical Health Concerns

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ABSTRACT

Studies suggest that a lack of understanding and sensitivity around religious issues by healthcare professionals may be a noteworthy barrier for Muslims seeking treatment. One way to help bridge the gap between Muslims' healthcare needs and healthcare utilization rates may be through fostering awareness and sensitivity about the influence of Islam on how Muslims cope with their illness experience. Using a biopsychosocial-spiritual theoretical framework, a main aim of this chapter is to consider a variety of ways that Muslims use religion to cope with physical and mental health challenges. Religious coping can take a variety of forms: Positive religious coping involves making use of Islam in beneficial manners. Negative religious coping, referred to here as r/s struggles, often involves tension or conflict regarding matters of religion. Understanding the role that religion/spirituality can play in how Muslims cope with their physical or mental illness may help to foster higher quality, more culturally sensitive care. Recommendations and limitations are discussed.

INTRODUCTION

A growing body of literature suggests that people often turn to their spirituality and/or religious beliefs when coping with a stressful life event (e.g., Ano & Vasconcelles, 2005; Jim et al., 2015; Pargament, 1997). This may be particularly true among individuals who identify religion and/or spirituality as a salient component of their identity (Pargament, Tarakeshwar, Ellison, & Wulff, 2001). As most research

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on religious coping has been conducted among Christians in the United States, there is a dearth of scholarly work that examines the important role that Islam may play for U.S. Muslims dealing with a mental health or medical illness. Thus, the primary purpose of this chapter is to consider the variety of ways that Muslims may use religion to cope with physical and mental health challenges.

Muslims constitute nearly one-fourth of the world's population and form the second largest religion in the world (Hackett & McClendon, 2017). Despite the current and projected rapid growth (Lipka & Hackett, 2017) of this population, Muslims continue to represent an understudied and underserved heterogeneous group of individuals. This is particularly true in the field of healthcare (Tackett et al., 2018). For example, researchers examining breast cancer screening practices among South Asian and Middle Eastern Muslim women found that only 52% of the participants indicated utilization of mammography services (Hasnain, Menon, Ferrans, & Szalacha, 2014), a percentage that is substantially lower than recent data gathered from a national health survey suggesting that about 72% of women in the United States received a mammogram within the past two years (Hall et al., 2018). Such results from the United States are comparable to findings from places around the world where Muslims may be in similar minority status (Gyimah, Takyi, & Addai, 2006).

In terms of mental health, researchers conducting a study among Somali, Palestinian, and Egyptian community members and college residents ($N = 276$) found that about 90% of the participants reported no utilization of mental health services in the past three years (Aloud & Rather, 2009). Likewise, Muslim immigrants with Obsessive-Compulsive Disorder (OCD) reported between 5-13 years between symptom onset and seeking professional help (Mahintorabi, Jones, & Harris, 2017).

A number of factors may influence and contribute to the low rates of healthcare seeking behaviors among Muslims not only in the United States but also in other places around the world where Muslims are a minority group (e.g,.Gyimah et al., 2006). First and foremost, Muslims may lack understanding and familiarity with the healthcare system (Hasnain, Connell, Menon, & Tranmer, 2011) or lack trust towards providers (Hasnain et al., 2011). Furthermore, both qualitative and quantitative studies suggest that many Muslims report feelings of perceived discrimination in healthcare (Martin, 2015; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015). The lack of same-gender providers (McClean et al., 2012; Padela & del Pozo, 2011) and stigma associated with seeking help (Youssef & Deane, 2006) have also been proposed as factors that reduce health service utilization by Muslims. On a similar note, qualitative responses regarding cervical cancer screening suggest that Muslims' values may often differ from traditional values of Western medicine (Matin & LeBaron, 2004). Specifically, feelings of discomfort surrounding modesty concerns have been found to be associated with delayed healthcare seeking (Vu, Azmat, Radejko, & Padela, 2016).

Above all, multiple studies have suggested a lack of understanding, sensitivity, and competency regarding cultural and religious issues to be a noteworthy barrier in seeking medical and mental health treatment among Muslims (e.g., Hasnain et al., 2011; Padela & Zaidi, 2018; Weatherhead & Daiches, 2010). For example, a semi-structured interview with a heterogeneous Muslim sample revealed the inclusion of religious and cultural values to be an important component of the therapeutic discourse and relationship not only to better understand the individual but also for the provider to ask well-informed questions (Weatherhead & Daiches, 2010). Likewise, Muslim women have reported feeling misunderstood by healthcare practitioners regarding their religious needs, which can be a barrier to maternity health care services (Reitmanova & Gustafson, 2008).

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Furthermore, perceptions of being labeled as "ignorant" or having "abusive" spouses have also been reported among Muslims as examples of religious and cultural barriers in healthcare settings (Shah, Ayash, Pharaon, & Gany, 2008). Researchers have found that more than half of Muslim Americans report perceptions of being "ignored or excluded," and about one-third of Muslim Americans describe experiencing offensive or insensitive remarks (Martin, 2015) within the healthcare setting. Similarly, in a study conducted among Pakistani Muslim adults with chronic conditions in the UK, participants reported they were less likely to reveal how their religious beliefs influenced their health behaviors due to a fear of being misunderstood or having their values being undermined by clinicians (Mir & Sheikh, 2010).

Despite underutilization of healthcare services, Muslims continue to experience mental and medical health-related concerns. Although research on prevalence rates remains scarce, available data suggest that Muslims in the United States are most likely to experience adjustment disorders followed by anxiety, obsessive-compulsive, and posttraumatic stress disorders (Basit & Hamid, 2010). Likewise, Muslims may also experience mental health concerns stemming from experienced or perceived discrimination; in a nationally representative survey, 60% of Muslims reported experiencing some degree of discrimination due to their religious beliefs, which is significantly greater than the levels of religious discrimination reported by Jews (38%) and Catholics (11%) in the United States (Mogahed & Chouhoud, 2017).

With respect to physical health, in a recent study examining cardiovascular disease risk factors, about 43% of the Muslim sample met criteria for being overweight (Budhwani, Borgstede, Palomares, Johnson, & Hearld, 2018), and physical inactivity rates have been found to be higher in Muslim countries compared to non-Muslim countries (Kahan, 2015). Along similar lines, a study conducted among Arab Americans in Michigan found that diabetes and hypertension rates were of high prevalence (Aswad, 2001).

Bridging the gap between Muslims' healthcare needs and healthcare utilization relies to a great degree on clinicians within helping professions fostering awareness and sensitivity towards the influence of Islam on health. Similar to gender, ethnicity, sexual orientation, and/or race, religion can also be considered a dimension of diversity that shapes both one's psychosocial (Vieten et al., 2016) and physical functioning (Carroll et al., 2007). Thus, when working with Muslim patients, culturally sensitive care involves the acknowledgement and appreciation of the role that Islamic religiousness and spirituality may play in how Muslims interpret and respond to their illness experience (Padela & Curlin, 2013).

Essentially, providing sensitive care entails not only understanding the basic tenets of Islam but also knowing how Muslims make use of their religion/spirituality in coping with their physical and mental health issues. Accordingly, a primary purpose of the current chapter is to inform Muslim and non-Muslim clinical providers about how Muslims may use religion to cope with mental and physical illnesses, including positive religious coping and religious and/or spiritual (r/s) struggles (also termed negative religious coping). We will first briefly provide a theoretical framework for the inclusion of religion and spirituality in healthcare, followed by a discussion on positive religious coping and r/s struggles. We conclude by offering some tentative recommendations for practitioners.

BACKGROUND

Theoretical Framework

The biomedical model posits a pure biological explanation of diseases and defines health as the absence of disease (Brannon & Feist, 2009). A biomedical conceptualization of illness and health has been the

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traditional approach in mainstream Western medicine. Although such an approach has historically been effective for infectious diseases, researchers and clinicians began to question the effectiveness of the biomedical model in the treatment of chronic illnesses (Brannon & Feist, 2009). Thus, over the past several decades a biopsychosocial model has been proposed as an alternative way of understanding and treating diverse mental health and chronic medical conditions (e.g., Barker, Gumley, Schwannauer, & Lawrie, 2015; Day et al., 2016). A biopsychosocial model considers the biological, psychological, and social dimensions of an illness (Borrell-Carrió, Suchman, & Epstein, 2004). Within this model, however, religion and spirituality are often overlooked as factors playing a role in the understanding and treatment of illnesses. Overlooking these factors can particularly be an issue of concern when considering demographics surrounding religion/spirituality in the United States. According to a national survey conducted in 2014 by the Pew Research Center, about 80% of Americans report a belief in God and 77% of Americans find religion to be either very important or somewhat important in their lives. Similarly, more than half of the survey participants endorsed feeling "spiritual peace and well-being" at least once a week (Pew, 2014).

Results for Muslims are similar: In the same national survey, 96% of Muslims reported having a belief in God and about 88% viewed religion to be very or somewhat important in their lives. Moreover, approximately 70% of Muslim participants endorsed praying at least daily (Pew, 2014). Specific Muslim groups may endorse even a greater sense of religious importance. For example, among Saudi patients undergoing dialysis, 85% reported experiencing the presence of God in their everyday lives and 80% endorsed that their religious beliefs were the foundation to approaching life experiences (Al Zaben et al., 2015). Given the vital role that religion may play in Muslims' lives, the addition of a religious and spiritual dimension to the biopsychosocial model could be a crucial part of competent and holistic care. Over the past two decades, researchers have now proposed the biopsychosocial-spiritual model (e.g., Sulmasy, 2002; Taylor, Stotts, Humphreys, Treadwell, & Miaskowski, 2013) to better understand how religion and spirituality shape well-being. Within a biopsychosocial-spiritual model, healing involves not only biological, cognitive, emotional, and social components, but also a spiritual component. The biopsychosocial-spiritual model of healthcare is particularly pertinent within the context of Islam, which supports a holistic view of health in which the mind, body, and spirit all play a role in the healing process (Saniotis, 2018).

Studies have revealed that religious variables are associated with both mental and physical health outcomes (Cohen & Koenig, 2003). For example, a review of studies examining church attendance revealed that weekly involvement in religious services played a protective factor against cardiovascular disease (Powell, Shahabi, & Thoresen, 2003). Similarly, greater involvement in religious or spiritual (r/s) activities has been associated with lower blood pressure, heart disease, hypertension, and even lower levels of mortality (Koenig, King, & Carson, 2012). Higher levels of religion/spirituality have also been linked to lower levels of depression (Baetz, Griffin, Bowen, Koenig, & Marcoux, 2004; Hirsch, Nsamenang, Chang, Kaslow, 2014) and anxiety (McCoubrie & Davies, 2005).

Similarly, in times of distress, religion and spirituality (r/s) are often a major means through which people cope with negative emotion (Pargament, Smith, Koenig & Perez, 1998). This may particularly be true for Muslims. For example, in a study conducted among diverse religious groups on a university campus, Muslim participants reported the highest levels of belief in the effectiveness of all forms of religious coping, such as faith in God, prayer, and engaging in religious practice, in addressing their depression (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Similarly, in a recent qualitative study conducted among Moroccan Muslim women, Islamic beliefs and turning to God played a critical role

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in how participants responded to their illness (Ahaddour & Broeckaert, 2018). Thus, the available evidence provides preliminary support for a biopsychosocial-spiritual model in which the r/s domain is acknowledged as a clinically relevant dimension of life.

RELIGIOUS COPING

When facing stressful situations such as physical or mental health disorders, individuals may turn to their r/s beliefs in order to cope. Religious coping can serve key functions by providing a sense of meaning, intimacy, and comfort (Pargament, Koenig, & Perez, 2000; Pargament, Falb, Ano, & Wachholtz, 2013). Researchers have suggested two overarching forms of religious coping: positive religious coping and religious and/or spiritual (r/s) struggles, which are also referred to as negative religious coping (Pargament et al., 2013; Exline, Pargament, Grubbs, & Yali, 2014). Both forms of religious coping have been associated with health outcomes (e.g. Trevino et al., 2010; Ellison & Lee, 2010). The following sections will discuss both positive religious coping and r/s struggles among Muslims. Specifically, we will discuss the unique role that Islam may play as a source of comfort and guidance or as a source of distress and tension among Muslims coping with stressful medical or mental health experiences.

Positive Religious Coping

Positive forms of religious coping often reflect a secure relationship with God, a spiritual connection with others, and a greater sense of meaning in life (Pargament et al., 2000). For example, positive religious coping may involve looking towards religion to discover a new direction in life, asking for prayer and support from faith leaders, or building a relationship with the transcendent (Pargament et al., 2000). Positive religious coping methods have been found to be associated with indicators of good mental health such as greater well-being (Tarakeshwar et al., 2006), life satisfaction (Trevino et al., 2010), spiritual growth (Pargament, Koenig, Tarakeshwar, & Hahn; 2004), and posttraumatic growth (Abu-Raiya, Pargament, & Mahoney, 2011). Likewise, positive religious coping has also been linked with better physical health (for a review, see Koenig et al., 2012).

Researchers investigating religious coping among Muslims have found that positive religious coping is associated with greater optimism (Ai, Peterson, & Huang, 2003) and purpose in life (Abu-Raiya, Pargament, Mahoney, & Stein, 2008). Several studies have revealed that Muslims endorse positive forms of religious coping significantly more than negative forms of religious coping (e.g., Ai et al., 2003; Abu-Raiya et al., 2011; Ghorbani, Watson, Hajirasouliha, & Chen, 2016). Positive r/s coping has been found to relate to Muslims' health in positive ways. For example, among Iranian Muslim patients undergoing hemodialysis, researchers found that religious coping factors contributed to about 40% of the variance in quality of life and about 25% of variance in participants' health status (Saffari, Pakpour, Naderi, Koenig, Baldacchino, & Piper, 2013). Furthermore, an Islamic religious coping mindset among immigrant Muslims in New Zealand was related to greater life satisfaction, regardless of participants' stress levels (Adam & Ward, 2016). Greater Islamic religious beliefs and practices have also been found to be associated with greater psychological functioning, lower depression levels, less smoking, and greater physical functioning despite greater severity in illness status in comparison to participants with lower levels of Islamic religious beliefs (Al Zaben et al., 2015).

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Positive forms of religious coping can take place in a variety of ways among Muslims. For many Muslims, Islam may provide a framework for coping with major life events. An Islamic understanding of health promotes an interplay between turning both to medicine and to God (Khan, 1986; Ypinazar & Margolis, 2006; Ahaddour & Broeckaert, 2018). Thus, Muslims may often engage in a collaborative form of religious coping in which they may view both themselves and God playing a role in the healing process. For example, in a sample of older Muslim adults with good and poor health conditions, participants reported believing that God is the ultimate controller and creator of one's of body, health, and life, and that both illnesses and cures are created with God's permission (*bi-idni Allah*) (Ahaddour & Broeckaert, 2018).

Along similar lines, Muslims may engage in putting their full trust in God, referred to as *tawakkul*, which is an essential component of belief and faith in Islam (Al- Khattab, 1997). However, at the same time, participants report recognizing their own role in the illness and healing process (Ahaddour & Broeckaert, 2018). Researchers have found that Muslims describe actively seeking treatment to be one's religious obligation as the body God has given them is a trust (*amanah*) that they must take care of even in cases of terminal illness (Ahaddour & Broeckaert, 2018). For example, qualitative research suggests that Muslims might not only engage in seeking help from God but also adhere to their medication regimen or educate themselves on the illness to make progress in the treatment (Eltaiba & Harries, 2015).

When afflicted by a mental or physical illness, many Muslims may share the belief that their illness is a trial in life. Qualitative responses from Muslims emphasize the belief that illnesses are a test from God (Ahaddour & Broeckaert, 2018). Specifically, Muslim participants report Prophetic examples of suffering such as the story of Prophet Ayyub (Job) and state that God inflicts illness to the ones he loves the most (Ahaddour & Broeckaert, 2018). Similarly, Muslims have described their conditions as a trial sent by God that is part of their destiny (Eltaiba & Harries, 2015). Muslims may also appraise the situation as a means through which an individual becomes purified from their sins, as evidenced by the *Hadith* (sayings of the Prophet): "Never a believer is stricken with a discomfort, an illness, an anxiety, a grief or mental worry or even the pricking of a thorn but Allah will expiate his sins on account of his patience" (Al-Bukhari, 1990).

Physical and psychological illnesses may be viewed as God's mercy, as the affliction results in not only moral purification but also an eternal reward of entering paradise in the afterlife (Ahaddour & Broeckaert, 2018). Muslims may also turn to Qur'anic scripts or Prophetic traditions in order to seek guidance and comfort. For example, the saying of Prophet Muhammad "There is no disease that Allah has created, except that He also has created its remedy" (Al-Bukhari, 1990) suggests not only to put trust in God but also fosters a hopeful stance towards illnesses. This is in line with research conducted among Muslim physicians who described the influence of Islam as providing a hopeful state of mind among patients (Al-Yousefi, 2012). Thus, Muslims may incorporate a hopeful mindset that God may ultimately provide recovery from their mental or physical illness.

The role of virtue development in coping with physical and psychological illnesses is also promoted in the Qur'an and *Sunnah* (actions of the Prophet). Specifically, gratitude (*shukr*) and patience (*sabr*) are two virtues that has been proposed to form and reflects one's faith *(iman)* (Al- Khattab, 1997). Verses from the Qur'an such as "O you who have believed, seek help through patience and prayer. Indeed, Allah is with the patient" (2:153) and "And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient" (2:155) highlight for Muslims the role of cultivating patience in times of distress. During times of hardships, Prophet Muhammad displayed gratefulness and stated, "The believer is fine whatever the situation; even when his soul is being pulled

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from his body and he praises Allah, the Mighty and Sublime" (Ibn 'Abbas, 1843). Likewise, the Arabic word "al-hamdulillah" which translates as "Praise be to God" is presented 38 times in the Qur'an and is a word that suggests expressing gratitude towards God under *all* circumstances as He is Praise-worthy both in times of ease and prosperity and in times of distress and challenge.

The emphasis on patience and gratitude in Islam may encourage Muslims to practice such virtues when coping with an illness. For example, Muslim elderly adults with diverse health conditions such as hypertension, arthritis and headaches expressed gratitude towards God for their health status in qualitative interviews; participants also viewed their health condition as *ni'ma* (blessing) from God (Ahaddour & Broeckaert, 2018). Similarly, in a study of Arab American immigrant community participants, responses from all of the Muslim females involved a sense of gratitude towards God, specifically when discussing positive health outcomes (Shah et al., 2008). Muslims have also been found to present with a mindset of patience towards suffering and a belief that God was with those who displayed patience (Ahaddour & Broeckaert, 2018). Moreover, Muslims may cope with life stressors through a *dhikr* ritual, which involves the continuous utterance and remembrance of God. Muslims may engage in a *dhikr* ritual for various purposes such as wanting to feel closer to God, expressing gratitude, connecting with the transcendent, obtaining God's forgiveness and mercy, or fostering humility (Hamsyah & Subandi, 2017).

Researchers have suggested that Muslims may seek help from Allah by uttering specific *dhikrs* to eliminate or decrease mental and physical health-related concerns (e.g., Suryani, 2013). Notably, researchers have found *dhikr* to explain about 34% of unique variance in Muslims' subjective well-being (Hamsyah & Subandi, 2017). An examination of qualitative responses from Indonesian Muslim Sufi participants revealed that *dhikr* was reported to be associated with increased optimism, positive emotions, and mental stability in the face of life's problems (Hamsyah & Subandi, 2017). Muslims can also hold the belief that their recovery can be achieved through maintaining a close relationship with God (Eltaiba & Harries, 2015). Thus, prayer (*dua*) may be a way in which Muslims strengthen their relationship with the Divine (e.g., Loewenthal et al. 2001; Heidari et al., 2017).

A focus on one's relationship with God as a form of coping has also been reported among Muslim youth who describe being able to overcome adversity through incorporating a "God-conscious" mindset (Mitha, & Adatia, 2016). Muslims may also deal with distress by increasing their religious involvement. For example, Muslims may increase their mosque attendance or take part in their religious community activities in order to alleviate symptoms of depression and anxiety. Among young Australian Muslims the majority of which were experiencing mental health stressors, researchers found that participants reported feeling a sense of community, strength, and belonging when taking part in their faith community (Mitha, & Adatia, 2016).

Religious and Spiritual Struggles

While religion/spirituality can be a source of comfort and guidance, religion/spirituality can also be a source of distress when coping with life stressors. R/s struggles or negative forms of religious coping often reflect tension, conflict, or questioning related to supernatural, intrapersonal, and/or interpersonal matters of religion/spirituality (e.g., Exline et al., 2014; for reviews, see Exline, 2013; Exline & Rose, 2013). Certain forms of religious coping may be more dysfunctional or ineffective when dealing with stressful situations. Specifically, researchers have proposed various types of r/s struggles. Divine struggles may involve negative thoughts or feelings focused on God (Exline et al., 2014), which might include questioning God's love, fears of divine punishment, or anger towards God (see also Exline, Park, Smyth,

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& Carey, 2011). Demonic struggles may reflect feeling attacked by supernatural forces that are evil in nature, such as the devil or demons (Exline & Rose, 2005; Exline et al., 2014). Interpersonal struggles arise when an individual experiences conflict with religious individuals or institutions (Pargament, Murray-Swank, Magyar, & Ano, 2005; Exline et al. 2014). Moral struggles often reflect guilt or worry associated with following ones' moral principles (Exline, Yali, & Sanderson, 2000; Exline et al., 2014). Finally, doubt-related struggles pertain to questioning one's beliefs, whereas ultimate meaning struggles involve distress about perceptions that one's life lacks deep meaning (Exline et al. 2014). Although positive forms of religious coping are generally endorsed much more than r/s struggles, research has shown that many Muslims do indeed experience r/s struggles (Abu-Raiya, Exline, Pargament, & Agbaria, 2015; Saritoprak & Exline, 2016).

Researchers examining r/s struggles among U.S. adults have found that Muslims report greater overall r/s struggles in comparison to Christian, Jews, Buddhist, agnostics, and atheists (Saritopak, Exline, & Stauner, 2016). Specifically, Muslims appear to endorse moral, interpersonal, and ultimate meaning-related struggles the most in comparison to other forms of struggles (Abu-Raiya et al., 2015; Saritoprak & Exline, 2016). Prevalence rates of r/s struggles have ranged between 1% (divine) - 40% (supernatural) among an Israeli-Palestinian Muslim sample (Abu-Raiya et al., 2015). Reviews of r/s struggles have revealed significant links between struggles and health (e.g., Cummings & Pargament, 2010; Exline & Rose, 2013). Studies have shown links between struggles (usually labeled as negative religious coping) and a lack of social support (e.g., Tarakeshwar et al., 2006), greater pain experience (Sherman, Simonton, Latif, Spohn, & Tricot, 2005), lower quality of life (Lee, Nezu, & Nezu, 2014), and even mortality risk (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Likewise, Muslims experiencing interpersonal and ultimate meaning struggles endorsed lower life satisfaction and more symptoms of depression and anxiety (Abu-Raiya et al., 2015).

At the same time, r/s struggles have also been associated with positive, growth-oriented outcomes (Desai & Pargament, 2015). Specifically, researchers are suggesting that perhaps the response to struggles-such as an attempt to collaborate with God-may predict spiritual growth more than struggle itself does (Exline, Pargament, Hall, & Harriott, 2017). Specifically, in our prior work, we have proposed the notion of responding to r/s struggles with an Islamic growth-oriented mindset referred to as *spiritual jihad* (Saritoprak, Exline, & Stauner, 2018; Saritoprak & Exline, in press). Muslims with a spiritual jihad mindset may display a conscious effort in struggling against life's trials for the sake of God; despite experiencing hardships, they may engage in thoughts and behaviors that foster a closer relationship with God. Thus, for example, in the face of distressing moral struggles, Muslims may view their struggle as a temptation of their *nafs* that is brought as a test from God, and that a positive response may draw them closer to God; or they may believe that there is some good (*khair)* in the struggle because there is *khair* in all works of God (Saritoprak et al., 2018). Endorsing a *spiritual jihad* mindset in response to r/s struggles has been found to be associated with reports of greater spiritual and post-traumatic growth (Saritoprak et al., 2018).

Although limited, research on specific ways in which Muslims cope with r/s struggles suggests that some Muslims may view their illness experience as a punishment from God, perhaps for past sins or wrongdoings (Ahaddour & Broeckaert, 2018). Likewise, in a semi-structured interview conducted among five Muslim women with OCD symptoms, all participants reported washing their hands for fear of punishment such as going to hell (Mahintorabi, Jones, & Harris, 2017). Similarly, Islamic religiosity has been found to be associated with greater perceived discrimination among Muslim immigrants in

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the United States (Ghaffari & Çiftçi, 2010), which may potentially lead to greater general psychological distress and ultimately r/s struggles, especially interpersonal struggles.

It is important to keep in mind that r/s struggles can be considered a sensitive topic among Muslims. This may particularly be influenced by the core value of *submission* in Islam, as the Arabic word Muslim translates to *the one who submits*; thus, Muslims may perceive or fear that any expressed tension, conflict, or distress related to God or other matters of religion in the face of an illness to be a transgression against God's Will, which would go against a fundamental belief of their faith. However, more research is necessary to confirm such speculations.

LIMITATIONS OF THE EXISTING LITERATURE

There were several limitations in the presented research that should be noted. First, most studies presented in this chapter employed qualitative approaches to data collection such as conducting semi-structured interviews. These methods provide rich descriptive information, but due to small sample sizes, they can lead to some biases in results and may make the data less representative of the broader Muslim population. Lastly, the samples in the mentioned research studies generally endorsed high levels of religiousness and spirituality, which prevent the results from being generalized to Muslims who are non-practicing or who report low levels of religiousness and spirituality. Future research may benefit from examining larger sample sizes which include a greater range of diversity in terms subjective religiousness as well as cultural background. Finally, it would also be helpful to introduce more quantitative studies with larger number of participants, both to help with the process of identifying consistent patterns and to provide greater odds of generalizability to the broader Muslim population.

TENTATIVE RECOMMENDATIONS

Given the prevalence and importance of religion/spirituality in the coping process in addition to the associated health and well-being outcomes, medical or mental health providers working with Muslim patients may consider the following recommendations.

First and foremost, understanding and becoming informed on how patients make use of Islam in dealing with their psychological or physical issues is crucial in developing a culturally sensitive case formulation (Rassool & Gemaey, 2014; Rassool, 2015). One way that this can be initiated is through inquiring about how the patient historically has incorporated and currently incorporates religious beliefs and practices in their illness experience. Clinicians may ask about the role that God (or other supernatural agents) may play in making sense of hardships or what methods of religious and/or spiritual coping responses have worked (or not worked) in the past.

Furthermore, providers can ask specific questions such as "How is your religion and spirituality related to your symptoms?" "Is Islam relevant to your treatment?" or "Do you think your religious beliefs or practices are associated with your condition?" (Rosmarin, 2018). Perhaps clinicians may also consider administering subscales from the Religious Coping Questionnaire (RCOPE) (Pargament et al., 1998; Pargament et al., 2000) or Religious and Spiritual Struggles (RSS) Scale (Exline et al., 2014) to initiate a conversation related to r/s. Asking questions and having a discussion surrounding Islam may not only foster greater quality of care but also help improve the quality of communication between the

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patient and clinician, which has been shown to mediate the relationship between religiousness and mental health symptoms among Muslim ICU patients (Bashar et al., 2018). Clinicians working closely with Muslim patients may develop a list of Qur'anic scripture and stories of the Prophet regarding health and illness and discuss what patients may find helpful in coping with their concerns. Moreover, providers and patients may work together in implementing spiritual interventions such as finding ways to promote patience and gratitude or practicing specific *dhikrs* or prayers.

Likewise, being respectful and mindful of religious issues may foster greater comfort among Muslims within the healthcare setting and potentially result in greater treatment adherence. For example, simply asking Muslim patients if they wish for a prayer area and, if so, providing a place for prayer may put some Muslims more at ease. Furthermore, providers may facilitate connecting Muslims with resources such as chaplain services within the healthcare setting or an Imam within the community, both of which may help Muslims to feel a sense of spiritual support or provide them with an opportunity to process their illness within an Islamic framework

At the same time, Muslims may present with more negative forms of religious coping and experience r/s struggles. In such cases, clinicians may help patients by providing a nonjudgmental, supportive stance. Prior studies among largely Christian samples have shown that many people see certain r/s struggles, such as anger toward God, as morally wrong (Exline, Kaplan, & Grubbs, 2012), and can benefit greatly from having these struggles normalized (Exline & Grubbs, 2011). As such, Muslim clients may benefit from being reminded that many people, including Muslims (e.g., Saritoprak & Exline, 2016), experience r/s struggles (e.g., Abu-Raiya, Pargament, Krause, & Ironson, 2015) and by framing such struggles not only as acceptable but as possible avenues for growth.

Clinicians may also work with Muslims in processing and framing struggles within an Islamic framework to cultivate meaning. For example, providers may integrate Islamic sources into their clinical work and consider addressing the struggles through referencing Qur'anic scriptures that promote hope and trust in God such as "..indeed, with hardship will be ease" (94:5) or scriptures that promote God's mercy despite perceived transgressions, such as in the verse "…who have transgressed against themselves by sinning, do not despair of the mercy of Allah. Indeed, Allah forgives all sins. Indeed, it is He who is the Forgiving, the Merciful" (39:53). Clinicians can also explore stories of the Prophets in Islam and process the struggles and difficulties they experienced despite being the chosen loved ones of God. Patients may identify with the belief that God tests the ones He loves in this world.

A failure to recognize and/or incorporate Muslims' religious beliefs and practices within clinical practice may contribute to increased feelings of bias, discrimination, or a lack of feeling understood among Muslim patients (See Haque, Tubbs, Kahumoku-Fessler, & Brown, 2019 for specific client-centered recommendations on coping with discrimination). Such negative experiences can not only lessen Muslims' likelihood of utilizing healthcare services but may also increase Muslims' vigilance and suspicion (Rippy & Newman, 2006), lack of willingness to engage in activities (Livengood, & Stodolska, 2004), and symptoms of depression (Hodge, Zidan, & Husain, 2015). Thus, addressing r/s may play a vital role in fostering higher quality and more culturally sensitive care.

CONCLUSION

As the Muslim population continues to grow around the globe, understanding and addressing the gaps in healthcare service will be of even more importance. Currently, research suggests low rates of healthcare

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utilization among Muslims, specifically in places where Muslims are of a minority status. There may be several factors that influence Muslims' healthcare utilization such as a sense of mistrust, perceived discrimination, and stigma associated with seeking help. Notably, several studies conducted among Muslims suggest that a lack of sensitivity and understanding of religious beliefs and values by providers to potentially be a barrier to seeking healthcare services and thereby contribute to Muslims' low rates of healthcare utilization; this may particularly be true for Muslims who express making use of Islam in their recovery process. Thus, an attempt to close the gap can be initiated through helping professions developing awareness and sensitivity towards the influence of Islam on health.

A biopsychosocial-spiritual model approach to healthcare is particularly pertinent to Muslims, as Islam fosters a holistic view of health which involves the mind, body, and spirit. Given Muslims' perceived importance of religion, many Muslims are likely to make use of r/s beliefs in coping with their physical or psychological concerns. Although much of the religious coping by Muslims appears to be positive, many do report some level of r/s struggles as well. Given the potential for both positive and negative religious coping among Muslims, it is important for clinicians to be able to do assessments and interventions related to religious beliefs and coping strategies in ways that are sensitive to Muslim belief and experience. For example, recommendations such as developing a culturally-sensitive case formulation, connecting Muslims with religious resources, and implementing spiritual interventions may not only increase utilization rates and provide better quality service to Muslims, but also potentially improve healthcare outcomes.

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KEY TERMS AND DEFINITIONS

Dhikr: A form of ritual which involves the utterance and remembrance of God.

Dua: A prayer of supplication to God.

Hadith: Sayings of the Prophet Muhammad.

Islam: Submission and peace; also, refers to the second-largest religion in the world.

Qur'an: The sacred book of Islam revealed to the Prophet Muhammad and is believed to be the direct word of God.

Religious Coping: Methods grounded in religion and spirituality that are utilized when coping with a stressor.

Sunnah: Customs and practices of the Prophet Muhammad.

Tawakkul: Trust; reliance.

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Chapter 56
Violence:
Mental Health, Family, and Media Reporting

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ABSTRACT

This chapter explores the extent to which journalists draw on long-standing mental health narratives when telling their stories about the "mentally ill" and, in particular, their tendency to depict the mentally ill as violent and dangerous. The chapter is divided into three sub-categories based on the perpetrators of violent crime committed against members of their immediate family. These were "fathers," of which 24 articles were dedicated to the stories of 11 men; "mothers," where 22 articles documented the stories of 24 mothers who harmed their children; and finally, "progeny," where 58 articles presented 17 cases of sons or daughters who killed, or planned to kill, one or both of their parents. Despite differences in the way Australian journalists explain the violence depicted in these stories, particularly when the perpetrator was a female, they continually drew on mental health as an explanatory device to account for how and why these crimes took place. This provides evidence for a continuation of the confinement narrative presented in Chapter 1.

INTRODUCTION

The stories told in this chapter represent a continuation of the history of confining the mentally ill person, albeit in an invisible form presented in Chapter 1 of this text. In the years preceding the fifteenth century, the mentally ill were placed on boats and dumped on foreign lands. The seventeenth century saw institutions formerly built for lepers come to house the mentally ill and any other minority that threatened enlightened progress. The twentieth century witnessed the four-walls confinement of the asylum overtaken by the segregation of the doctor-patient relationship and medicalization. This chapter

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illustrates the emergence of a complementary form of confinement – that of the stigmatized identity – reinforced through the telling of stories that use mental illness as an explanation for violent crime in the media. The purpose of this chapter is to assess the extent to which journalists draw on historically-derived mental health narratives when telling their stories about the mentally ill, and in particular, their tendency to depict the mentally ill as violent and dangerous. It is therefore a broad study focused on all types of mental disorder. Three cases involving fathers are presented followed by two cases involving mothers and four cases involving progeny. The chapter adopts Mindframe's guidelines for mental health reporting that recommend using language that separates an individual from their experience of mental illness (Hunter Institute of Mental Health, 2014). For example, describing a person as "having been diagnosed and treated for paranoid schizophrenia" is a more sensitive description than using the description "a paranoid schizophrenic". The authors have chosen to preserve the use of the phrase "the mentally ill" when it has been used by the journalist whose reporting is the subject of examination.

BACKGROUND

Author and journalist Sonya Voumard (2016) wrote about the intricacies of constructing news stories in her work entitled *The Media and the Massacre*. She wrote the following in regard to how journalists can use accounts provided by interviewees:

As a journalist you want something out of a subject: good quotes, insights, preferably controversial material. You must strike a rapport, conversationally win over the subject … Back at the office, the reality hits that journalism is an inexact science with great limitations. Variables like space, time, objectivity, editors and other points of view mean you can never guarantee that you will tell the exact story the subject wants told … you reject what you don't want, select and prioritize what you do.

Voumard's argument offers insight into the reality of assembling newspaper articles for print or online publication. Most revealing is the statement "you reject what you don't want, select and prioritize what you do". The analysis presented in this chapter offers support for this practice, evidenced in the way the mental health explanatory narrative was used differently across the mothers and fathers samples. It is remarkable how often journalists chose to select and prioritize mental illness in stories of violent crime and murder, and this was most evident in those articles devoted to mothers who killed their children.

This chapter is about storytelling, and in particular, the extent to which Australian journalists draw on mental health narratives when they tell their stories about the mentally ill. As explained in Chapter One, these narratives have changed over time, but still operate today in both subtle and overt ways. The authors conduct an analysis of the way journalists draw on and inform these narratives using discourse and narrative analysis techniques. The articles included in the analysis were collected from eight hard-copy Australian newspapers sourced through Factiva. Factiva was used to source articles published between November 2000 and May 2015. The analysis sourced those pieces containing both search terms "mental illness" and "mentally ill". Hard copy was chosen as it is considered a "trusted" source of news compared with online news mediums.

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FATHERS

Case 1: Bribie Island, Queensland, Australia

The fathers sample contains eleven individual cases, three of which are addressed in this section. Five articles published between January 2008 and April 2009 told the story of a 39-year-old unemployed man who moved his family into a holiday home on Bribie Island and within days raped and murdered his 10-year-old daughter. Three of these articles were published in *The Courier-Mail* (Jan. 2008, Apl. 2009) and two in *The Australian* (Jan. 2008). The broad focus of this sub-sample was on a neglected health system and most representative of this narrative was Margaret Wenham's (2009) article entitled "System failure – warnings ignored before man raped and killed daughter". Wenham summarized the crime as follows:

The state's largest hospital was warned, so were police and a doctor, but no one stopped a mentally ill man from taking a family holiday which ended with him raping and killing his 10-year-old daughter.

Wenham reported that the unnamed father had been sole custodian of his four children since 2004 before he "ritualistically killed his daughter and spared her three younger siblings". Details of the graphic nature of this crime were a central component in the five articles that reported on this case, along with frequent mention of a "communications breakdown within the public sector" and persistent "underfunding"; descriptions which portrayed the rape and murder as the result of a neglected health system, one that failed to control a violent individual.

Co-authors Margaret Wenham and Janelle Mills argued in *The Courier-Mail* on 25 April 2009 that even an improved Queensland health system would not prevent a similar event from occurring again. This argument had been presented previously in an editorial published in *The Australian* in January 2008, which argued that "no system, however watertight, can prevent some dysfunctional individuals in fraught situations from harming those around them". The editors argued in this piece that "the frequent connection between mental health and violent crime [needs] to be addressed", and this statement was reinforced in four of the five articles that reported on the Bribie Island murder. While these articles explored some aspects of the broader social context that contributed to the murder of a 10-year-old girl, the journalists framed this broader context as relevant only in its ability to control a mentally ill man, who, without medication and/or involuntary admission to a mental health triage center, would be violent. Just one article addressed the reality of the link between mental illness and violence:

Crime and mental illness do not automatically go together. And anyone who does suffer from mental illness of whatever description has every right to be treated with compassion and sensitivity. (The Courier-Mail, 2008)

The effect of this statement is to remind the reader that while the crime was abhorrent, the case may not necessarily reflect the broader experience of mental illness. Short statements like this help to reduce the spread of stereotypes surrounding individuals with mental illness and their tendency to engage in violent criminal behaviour.

The editorial published in *The Australian* on 4 January 2008, entitled "Lessons must come from tragedy", shifted the focus from the publication's belief that a neglected health system led to this crime,

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to the safety of children who have mentally ill parents, and this relates to the principal argument of this section concerning the tendency for journalists to report abhorrent cases, and frame them as representative of broader social problems. The editors presented the Bribie Island murder alongside a number of other violent crimes, and in doing so, portrayed them as mental health cases. They wrote that "a report tabled in Queensland parliament in November [2007] revealed that 57 children known to the Department of Child Safety died in 2006-2007". It is unclear how many of these deaths were at the hands of parents being treated for mental illness. This detail was not mentioned and instead the editors continued with a discussion of how the problem was one that extended beyond Queensland's borders:

In Victoria in 2006, serial rapist William Craig Forde told a prison psychologist before he was released from jail that he would rape again. Three months later he took a young Ballarat mother captive at knife-point and raped her repeatedly during a 29-hour ordeal.

It is not clear how the actions of "serial rapist" William Craig Forde relate to the Bribie Island murder. Because the Bribie Island story is framed as a case of a mentally ill father raping and killing his daughter, one must assume that the additional stories and statistics presented by the editors are also related to mental illness and have been included to strengthen the claim that mental illness can help to explain violence. This point was not stated explicitly in the article, but was implied when the authors stated that "Prime Minister Kevin Rudd [would] inevitably need to look at care for the mentally ill". It is not unreasonable for a journalist to argue that a health system has been neglected, or an underfunded sector needs reform. But it harms the public's image of those being treated for mental illness to conflate mental illness and violence without an appreciation for the broader social context within which these crimes take place. Without consideration of other possible explanations for violent crime, the mental health narrative can continue to foster a belief in society, among lawyers, judges, journalists, academics, and the general public, that mental illness explains violent crime in domestic settings.

Case 2: Tyabb, Victoria, Australia

The second case that involved a father killing one or more of his children was no less graphic than the Bribie Island murder. In a summary of the death of 11-year-old Luke Batty, John Silvester portrayed Luke's father, Greg Anderson, as a man with motive. Silvester reported in *The Age* (2014) that after leaving his Frankston accommodation on 12 February 2014, Anderson "told fellow residents he would not be coming back". He concealed a knife in his backpack, caught public transport to Tyabb Recreation Reserve, and "it was there the mentally ill Anderson killed his son".

Silvester outlined some of the broader social circumstances involved in this case. He described Greg Anderson as "alone", "unemployed", and "unemployable". According to Silvester's account, jobs had dried up, Anderson's marriage to Rosie Batty had ended, and "he knew he would never be granted shared custody of his son or even allowed overnight visits". These details are important as they offer the reader a picture of the circumstances of Luke Batty's death, and, perhaps, the father's state of mind. Yet despite consistent reference to the social stressors involved, Silvester still asserted that the young boy's death was an outcome of mental illness. He explained that Anderson's plan was "borne from madness … he knew his tenuous links to his son were fraying [and] through the fog of his mental illness he saw it as the only possible release for both of them".

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Silvester also portrayed Batty's death as reflective of a broader social problem concerning "the mentally ill", a method used by journalists who reported on the Bribie Island murder. Where the actions of the Bribie Island father were portrayed as the result of a neglected health system, John Silvester presented Greg Anderson as representative of other violent mentally ill individuals. He assumed a similar link between mental illness and violence as was assumed by the writers of *The Australian* when they tried to account for the Bribie Island murder:

The real issue is our inability to deal with the mentally ill, and the problem is getting worse. It is a massive problem, so much so that all police are being retrained to deal with the deeply disturbed. In 2009 the police dealt with 4798 people so disturbed they were taken to a mental health triage center.

By including these statistics, where 4798 individuals were involved in incidents so problematic they required intervention from law enforcement, Silvester implied that there is a casual link between mental illness and violence. Of the 4798 "deeply disturbed" individuals mentioned above, one could assume that their stories offer a deeper complexity than could be explained by a diagnosis of mental illness. Some individuals may be homeless, some addicted to illicit substances, some mentally ill, and any of these three in isolation would be incapable of explaining the malicious crime depicted in these articles. This lack of complexity illustrates the dangers present in relying on police testimony and court transcripts to construct stories for newspapers. While police have an important and often difficult role to play in incidents like the one that took place at Tyabb Recreation Reserve, where Luke Batty was murdered, they are not trained in diagnosing mental illness, and their appreciation for the broader contexts involved in crime often appears to be obscured by their tendency to make a layman's judgement about the mental state of male perpetrators of violent crime in domestic settings.

A similar pattern where journalists described an abhorrent event and portrayed it as representative of a broader social problem was present in *The Age* editorial published in February 2014, entitled "A bereft mother's insightful message". Its purpose was to commend Rosie Batty, who spoke to media less than 24 hours after the death of her son to explain that "no one loved Luke more than his father … I want to tell everybody that family violence happens to everybody, no matter how nice your house is, no matter how intelligent you are". If the editors had followed Rosie Batty's narrative, this article would have focused on the problem of family violence, yet two sub-sections, one that outlined family violence statistics and the other that paired these statistics with mental illness, dominated the 637-word editorial. In one paragraph, the authors explained that "family violence was involved in 80 per cent of child deaths … in 2013, up from 62 per cent in 2010". The following paragraph stated that "this year, 4 million Australians will have mental health problems … half of us will encounter such difficulty at some stage in our lives". The placement of these statistics can again have the effect of reinforcing a causal relationship between mental illness and family violence. The significance of this relationship, however, is dubious at best. While a large portion of Australians will deal with a personal experience of mental illness across their lifetime, the vast majority of this group will never engage in family violence. Is it not conceivable that the small percentage that do, do so for reasons beyond their mental illness? The murder of Luke Batty at the hands of his father might represent an intersection of family violence and mental illness, but the extent to which this story is reflective of most cases of family violence is questionable, and to reinforce the "mental illness-family violence" relationship is to offer an explanation to all perpetrators of abuse.

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Case 3: Melbourne, Victoria, Australia

At 9.15am on 29 January 2009, Arthur Freeman threw his daughter Darcey from Melbourne's West Gate Bridge. The sample contained four articles which addressed varying aspects of this event (*The Age*, Mar. and May 2011, Aug. 2014; *The Herald Sun*, June 2010). In 2011, Andrea Petrie was the Supreme Court reporter for *The Age*. Her piece was a 1636-word summary of Darcey's death, and the discussion that took place in the Supreme Court two years later. Petrie's emotive opening sets the tone for the rest of the piece:

The only thing cold on the morning of January 29, 2009, was the heart of Arthur Phillip Freeman. But the nation felt a chill of horror when news broke that a little girl had been thrown off Melbourne's West Gate Bridge. Dozens of people in peak-hour traffic at 9.15am saw her tossed over the railing "like a rag doll". It was such a long way to fall: 58 meters. She sustained massive internal injuries and ultimately drowned.

In contrast with the sample that reported on mothers who took the lives of their children, explored in the following section of this chapter, Petrie's article represents an inclination of some reporters to provide multiple explanations for murders that are committed by fathers against their children. Where it appears unfathomable that a mother would knowingly and intentionally take the life of her child, Petrie presented an image of Freeman as possibly mentally ill, but more likely "cold" and "motivated by spousal revenge". This narrative is exclusive to the fathers sample.

Petrie began her analysis by quoting defence lawyer David Brustman, who asked in court whether Freeman was "mad" or "bad", and then argued that the father's actions were unintentional, unconscious, involuntary, and the result of a "highly disordered mind, a mind suffering mental illness". Petrie then contrasted this observation with the prosecution's claim that Freeman was "angry at his ex-wife" and "deliberately threw his daughter off the bridge because he was motivated by spousal revenge". The article underpinned this view with a quote from a relative of Arthur Freeman, who asked to remain unnamed:

A relative of Freeman's … has told The Age of a comment the father-of-three made at a family dinner at the height of his custody concerns in 2008. "We were discussing the custody of his children, and Arthur said 'She [his ex-wife] would regret it if he lost custody of the children' … it was only later that the comment began to play over and over in my mind".

This comment was representative of a broader stance the author took in this article. While even weight was given to all aspects of the trial, Petrie was transparent in her belief that Freeman acted knowingly when killing his daughter. This is significant as it contrasts with the central argument of this chapter; that mental illness is used as a default explanatory device to explain abhorrent events when no clear explanation is available to the journalist or the reader. In the case of Arthur Freeman, the presence of a mental illness was debated, and its relevance to the crime committed was obscured by a focus on "spousal revenge".

An interesting narrative that ran through the four articles that dealt with this case was the reputation of Professor Graham Burrows, described by Andrea Petrie as "the only one of six psychiatrists to conclude Freeman did not know what he was doing was wrong". According to Petrie, Professor Burrows had testified that the perpetrator "was suffering from a major depressive disorder at the time of the crime …

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was psychotic, out of touch with reality and was in a dissociative state". Yet the reputation of Burrows was questioned and then attacked in the next two articles, one published in *The Age* on 12 May 2011 and the other in *The Herald Sun* on 23 June 2011. *The Age* journalist Selma Milovanovic reported that a Liberal MP "accused Professor Graham Burrows of giving concocted evidence at the trial of Arthur Freeman". This article was titled "Expert witness in Freeman case should be sacked: MP". *The Herald Sun* provided additional evidence one month later, compounding this attack on Burrows. Lucie Van den Berg reported:

The Medical Board is monitoring allegations made by patients against high profile psychiatrist Professor Graham Burrows to determine what action may be necessary to protect the public. A Seven News Investigation raised a list of allegations against the doctor including over-medication of drugs, consultations of 30 seconds and a conflict of interest involving pharmaceutical companies.

The effect of these two articles, alongside Petrie's commentary on the event and the subsequent court case, was to discredit the defence witness in the Arthur Freeman trial. In contrast with the articles explored in the following section, there was an apparent reluctance on the part of the journalist to attribute Freeman's actions to mental illness. This is significant in its distinction with the rest of the sample, where consistently Australian journalists tend to draw on the mental health narrative as a means to explain abhorrent or abnormal behaviour. It would appear that in cases like that of Arthur Freeman, where a father has taken the life of a child, other explanations are likely to be explored and/or offered, and the mental illness explanation is not so readily the "default' stance". In the following section this trend is contrasted with 22 articles that reported on mothers who took the lives of their children.

MOTHERS

The articles that reported on mothers who killed their children are best considered in light of research relating to our constructed understanding of women and their role in western culture. American sociologist Arlie Hochschild's (1979) term for the unpaid domestic labour that falls predominantly on the shoulders of women is "emotion work", and George Levinger (1964) argued in his study on social behaviour in marriage that this work, which includes maintenance of family emotions and interpersonal relationships, has been an aspect of married life in the west since the middle of the twentieth century. Where this relationship has long been interpreted as a product of the "male breadwinner-female nurturer" model, today, women who are engaged in full time paid employment still take on the bulk of routine housework and childcare.

Rebecca Erickson (2005) argues that it is the socio-cultural construction of gender roles that informs this unequal division, meaning we generally come to see being an emotional caretaker as "something women *are* rather than something women *do*" (p. 349). A woman's performance in the household is interpreted as a "natural" expression of her love for her partner and her children, and Erickson (2005) explains that some women are driving this understanding:

Women themselves often discount the time and effort involved in caring work not only because it is expected to be a spontaneous expression of love but also because the illusion of effortlessness is part of doing the work well. (p. 338)

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For many women, performing household labour with ease has become a core aspect of their identity construction. One must also consider the weight of traditional beliefs and theories of socialization that assert women continue to perform most of the work associated with "being female" because it is to these tasks that they are most suited (Erikson, 2005, p. 340). While this perspective is supremely archaic, some of this sentiment persists in the west.

It is in this context that 22 articles were examined, which documented the stories of 24 mothers who harmed their children. This is more than double the number of stories dedicated to fathers who killed their kids, of which there were eleven men in total. This group contained nine articles where mothers heard voices and/or messages from God compelling them to harm their children, while in all but three of the 22 articles the crime was murder. This section examines the reporting identified as unique to this sub-sample of articles that reported on mothers who murdered their children, and in particular, the tendency for journalists to portray mothers as psychotic and delusional, and to be more sympathetic to the plight of mentally ill mothers than fathers. Following is an analysis of those nine articles that involved mothers who reportedly heard voices that compelled them to kill their children.

Case 1: Houston, Texas, United States of America

On 20 June 2001, Andrea Yates drowned her five children in the bathtub of their home in Houston, Texas. The story gained national prominence across North America, and was overshadowed only briefly by the attacks on the World Trade Centre in New York City and the Pentagon in Washington on 9 September 2001. Journalist Andrew Cohen wrote in 2012 that a hearing to determine Yates's competency to stand trial for the murder of her five children was cancelled on September 11 because of the attacks. Two articles from the sample of eight east-coast Australian newspapers documented her crime (*The Australian*, 6 Dec. 2001; *The Herald Sun*, 20 Mar. 2002). *The Australian* ran the headline "Mama's deadly state of mind", and described the case as follows:

What police found inside the Yates's modest home shocked the nation. Neatly lined up under a sheet on a bed were the still-wet bodies of the couple's four youngest children: Mary, 6 months, Luke, 2, Paul, 3, and John, 5. Their eldest child, Noah, 7, was still in the bathtub in which Yates had drowned her children. Seeing what was happening to his siblings, Noah tried to run – but Yates chased and caught him.

Yates was described by the editors of *The Australian* as having suffered from "a bout of post-partum depression so devastating, so mind-altering, that she was incapable of judging right from wrong". She told psychologist Steven Rubenzer in one of eight interviews in Houston's Harris County Jail – where she was held and treated with anti-psychotic medication following her arrest – that she believed she was "Satan … George Bush will kill Satan", in the belief that the President at that time was still the governor of her home state. The editors portrayed Yates's actions as irrational, delusional, and the result of mental illness, and claimed "few would disagree that Yates is mentally ill. Her 1000-page medical record chronicles … a history of severe depression marked by delusional episodes". They then drew on statistics from "health experts" to support the link they were wanting to make between mental illness and the death of Yates's five children:

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Health experts estimate about 40 per cent of women experience mood swings after having a baby ... However about two women in every 1000 ... can become delusional, have visions and hear voices urging them to harm themselves or their babies.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (APA, 2013) notes that depressive episodes that include psychotic features during pregnancy or following the birth of a child occur in 'from 1 in 500 to 1 in 1000 deliveries' (cited in Stone, 2013) and may be more common for women having their first child. Even though the statistics the editors cited were at odds with those from the DSM-V, they still portrayed the case as rare, and this appeared to be one moment in the article where the authors had the opportunity to emphasize and reiterate the extraordinary nature of Yates's crime in the broader story of mental illness. That Yates was severely mentally ill appears to be beyond dispute, but again, the fact is, the majority of severely mentally ill people would never contemplate a crime of this magnitude, and in the case of women who give birth, this story is exceptionally rare.

The editors that documented Yates's crime used mental illness as a default explanation for violence. The editorial published in *The Australian* in 2001 quoted Dianne Clements, from a Texas-based victims' rights group known as Justice For All, who argued that we "just can't conceive of someone in their right mind doing what [Yates] did". The previous analysis of the fathers sample showed that journalists can conceive of fathers committing the same acts in their "right mind". They seem to find it easier to imagine a father committing a similar act of violence deliberately and knowingly against his own children. Arthur Freeman, for example, was portrayed as someone "motivated by spousal revenge" when he threw his daughter Darcey off the West Gate Bridge. And journalist John Silvester framed Greg Anderson's "descent into homicidal madness" as calculated and deliberate. Anderson told fellow residents at his Frankston accommodation house that he "would not be coming back", and then took his son's life with a knife he had stowed in his backpack. Even the story of Robert Farquharson (Garner, 2014), the man who drove his three children into a dam between Geelong and Winchelsea on Father's Day in 2005, while not a mental health story in this sample, was still portrayed as a deliberate murderous act by an embittered and estranged father. Mothers from this sample, like Andrea Yates, are defined by contrast as psychotic, hearing voices, and out of control, and mental illness is presented as the only plausible explanation for their actions.

Case 2: Sydney, New South Wales, Australia

Shan Shan Xu was another mother who reportedly heard voices that compelled her to harm her child. She drowned her four-year-old son in 2003 and was later found not guilty by reason of mental impairment. John Stapleton followed Xu's trial in the NSW Supreme Court, and reported in *The Australian* on 19 February 2005 that after making suicide threats in 2002, Xu was admitted to the Caritas Centre, an acute-psychiatric unit in NSW. It was here that the hospital noted she had "thoughts of killing herself and her son … and sees nothing wrong with this". An interesting aspect of this article is the way Stapleton presented evidence he sourced from the NSW Supreme Court trial. He portrayed Xu as having acted in a calculated manner when she drowned her son, and then overlooked any further discussion on the perpetrator's mental culpability in committing this crime. Stapleton (2005) reported that:

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[Xu left] a note for her mother that said they would not be returning home to their western Sydney unit. "We are not coming back home. Please look after yourself. Just treat it as if we'd had an accident. I've really had enough", the note said.

Stapleton reported that Justice David Kirby oversaw this trial and accepted the evidence of two forensic psychiatrists that Xu "was suffering [from] a major depressive illness" at the time of the murder. This conclusion was reported by Stapleton but not given the subsequent analysis and discussion it deserved, and that I suspect it would have received had the perpetrator been a father. Instead of a debate about the mental health of the perpetrator, as was present in the case of Arthur Freeman, Stapleton concluded by using mental illness as an explanation for the crime. Stapleton did not point out that these sorts of crimes are extremely rare, and occur in roughly one in a thousand births. He also overlooked evidence that suggests when mothers do kill their children in circumstances like that presented in the cases of Andrea Yates, Christine Gifford, and Dena Schlosser, they often experience acute psychotic symptoms (Wondemaghen, 2013). One could argue that the scarcity of discussion presented in Stapleton's article reflects the Australian legal system's understanding of the killing of children by their parents. Section 6 of the Crimes Act (1958) (FindLaw Australia, 2017) defines infanticide as follows:

If a woman carries out conduct that causes the death of her child in circumstances that would constitute murder and, at the time of carrying out the conduct, the balance of her mind was disturbed because of: (a) her not having fully recovered from the effect of giving birth to that child within the preceding 2 years, or; (b) a disorder consequent on her giving birth to that child within the preceding 2 years.

This definition is significant because it provides for a defence of infanticide only in cases involving mothers. This suggests the disparate discussions surrounding mental culpability for mothers and fathers who kill their children could be reflective of the understandings of these crimes as they are presented in court.

While there were differences in the way journalists reported on mothers and fathers who took the lives of their children, some common reporting methods were evident across these two categories. The analysis showed that journalists who write about either mothers or fathers who have killed their children tend to use additional examples of what they perceive are cases of mental-health-related violence as a means of adding interesting or valuable content/context to an article. Andrea Yates's case is not used as an exemplar, or as evidence of a broader problem involving the mentally ill, but the authors of the editorial published in *The Australian* in 2001 did document other cases where mothers and/or spouses "got off" using a "not guilty by reason of mental impairment" defence. The editors reported:

Lorena Bobbitt, who cut off her husband's penis, got off. Susan Smith, who drowned her two sons by strapping them into the back seat of her car and rolling it into a lake, did not.

This technique was common across many articles in the family violence sample, with these stories seemingly used as a means to sensationalize and dramatize a story. Their purpose appears to be not to inform the reader, but to excite and incite (Uribe & Gunter, 2007).

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Gendered Reporting

This analysis of cases where mothers heard voices that compelled them to harm or kill their children illustrates a clear distinction between two types of reporting: one involving fathers who murder their children, and the other involving mothers. While mental illness was the "default" position most frequently used by journalists to explain violent crime, the tendency to use this explanation was dependent on the identity of the perpetrator of the violent act. The notion of spousal revenge, preferable in cases involving fathers, was never used in the 22 articles that are the subject of this section of the chapter on mothers, as women were instead portrayed as generally psychotic, hearing voices, and in touch with a God who compelled them to kill their children. One could contextualize these reporting trends in the context of concrete social phenomena: first, that men are incapable of experiencing postpartum psychosis, and second, that men are more likely to be motivated by spousal revenge because they are more often rejected in their quests for custody of their children. But as feminist and writer Elaine Showalter (1987) argued in *The Female Malady*, attributing types of mental illness to some form of gendered psychology is a dangerous practice, one that has been common for many centuries and has disadvantaged women through the reinforcement of an "hysterical" woman narrative. What an analysis of this sample has shown is that journalists have overemphasized a very rare form of psychotic disorder, one that affects women giving birth at a rate somewhere between one in five hundred and one in one thousand. One could safely assume that the percentage of these mothers who act on voices that command them to harm their children is even more rare. Slightly less than half of the mothers sample accounted for women who heard voices. While these articles were accurate in their coverage of events, no piece contained a clear statement referring to the rarity of the case in question, or how it failed to reflect the broader reality of mental illness.

Mad or Bad

Concluding this section on mothers is an analysis of three newspaper articles that told the story of 31-year-old Louise Scotchmer, who killed her two-week-old son Shane in 1994 and 13-month-old daughter Melissa in 1996. Scotchmer was not charged with these murders until 2001, after she "drunkenly confessed" the crime to her husband. The three articles that reported on this crime were published in March 2003, two in *The Australian* and one in *The Herald Sun.* An account of this story contrasts with previous articles examined in this chapter, because while the three articles stated that Scotchmer committed the murders while in a "disassociated trance-like state", they explored the broader social circumstances involved in the crime, and so framed the killer as a victim.

Vanda Carson wrote in *The Australian* in March 2003 that Scotchmer's brother and husband planned to continue supporting the 31-year-old perpetrator because she had experienced "a horrible life and needed more support from mental health professionals". Scotchmer's younger brother, Anthony Gordon, was a central figure in both articles published in *The Australian*, and Carson used Gordon's commentary to structure a large portion of the piece:

Mr Gordon said the prison system had not been able to provide appropriate treatment for his sister's mental illness since she was detained in September last year [2002]. He said Scotchmer had been physically and sexually abused as a child and had been let down by the mental health system since her first counselling session as a five-year-old.

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Vanda Carson also wrote the second article published in *The Australian*. The failing health system was the focus of this article, as the headline read: "Mental health system 'failed' mother jailed for killing babies". *The Herald Sun* focused on Scotchmer's husband in the same way *The Australian* made use of Scotchmer's brother, Anthony Gordon.

Mr Scotchmer, 49, said the sentence was unfair and he would support his wife, who engaged in acts of self-harm and was "quite fragile mentally". He said he was able to forgive her "because I don't believe she was in a normal frame of mind when she committed those acts". Mr Scotchmer said the surviving child, Jamie, visited his mother every fortnight.

The analysis presented here considers these three articles as an interwoven mosaic. The backdrop is the research presented to open this section concerning emotion work and traditional interpretations of women's "natural" role as nurturers and carers. These three articles, and their framing of the Scotchmer case, are placed within the context of that literature. It is difficult to comprehend a mother killing her children, but the framing in these articles is such that the mother, the killer, has become the only victim. A quantitative analysis of the type of language used in these three pieces showed that a total of 26 words were dedicated to the two children who died, two-week-old son Shane and 13-month-old daughter Melissa. This is a fraction of the 1055 words devoted to this story. We hear virtually nothing about the children and learn little of their short lives. The overwhelming majority of the content presented to the reader is instead devoted to Scotchmer's treatment, the support her family has and continues to provide her, her own history of physical and sexual trauma, and the fact she is "mentally fragile" and engaging in acts of self-harm.

In cases where a parent takes the life of his/her child, there are multiple victims, yet in the three articles examined above, Scotchmer appears as the sole victim, and the perpetrator is her mental illness. The children Scotchmer killed are mentioned infrequently and are secondary in the framing of this story. This contrasts with those pieces presented in the fathers sample, where the deceased are central figures, and they are remembered: Luke Batty, Darcey Freeman. The fathers are portrayed as lonely, unemployed, mentally ill, and often revenge-driven men with motive. The antithesis of a victim. In contrast, mental illness in women appears as tragic, and this would perhaps explain the "victim status" some have received in the articles explored in this chapter. The question "Was she mad or bad?" is rarely raised because our socio-cultural understanding of women and mothers tells us that no woman in her "right mind" could take the life of her child. This was most evident in the Scotchmer case, and also John Stapleton's account of Shan Shan Xu, who left a note for her family explaining that she would not return home as she intended to drown herself and her four-year-old son. The intention and calculation evident in this act did not prevent Stapleton from concluding that Shan Shan Xu was mentally ill at the time of the killing, and that this explains the crime. In men, mental illness is more appalling. Fathers are still described as mentally ill, but are portrayed as colder and more calculated killers, and are more often defined as "bad".

PROGENY

The final section of this chapter examines 58 articles that presented accounts of sons or daughters who killed their parents. A total of thirty-three articles from this progeny group were dedicated to four individual murder cases, suggesting that while this sub-sample is much larger than the fathers and mothers groups examined earlier in this chapter, its size is reflective of a more pronounced coverage of these four particular stories in Australian newspapers. These four cases are explored in this section,

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and they include the stories of Mark Briscoe, a "criminally insane killer" who took the life of his father "with a cane knife" and five years later escaped from a Brisbane mental health facility; Kylie Fitter, the 15-year-old girl who helped her older brother and father kill her mother in the New South Wales town of Glossodia in October 2001; Malcolm Robert Potts, a "paranoid schizophrenic" who killed his father following an argument over a birthday present; and Anthony Waterlow, another person reported as a "paranoid schizophrenic", who killed both his father and his sister.

Case 1: Brisbane, Queensland, Australia

Between January 2002 and February 2003, eight articles reported on "criminally insane killer" Mark Briscoe and his escape from a Brisbane mental health facility, with seven of these published in *The Courier-Mail*, and one in *The Australian*. Mark Briscoe went missing on 18 January 2002 for a total of 83 hours after being last seen eating lunch at Wolston Park mental health facility in Brisbane. Slightly short of a non-event, Briscoe never left the grounds of the facility. Wayne Smith reported for *The Courier-Mail* on 24 January 2002 that Briscoe appeared to have taken refuge in a cricket pavilion before he was found:

A fellow patient saw him there and telephoned The Hub … where two registered nurses and an enrolled nurse were on duty. They immediately called the three rostered security staff who quickly made their way to Jacaranda House. Not finding Briscoe there, they looked outside and saw him about 100m away on a grassed area … "Mark, where are you going?" one of them called. Briscoe stopped, turned, and then came over to them. There was no violence used by or against him and he walked meekly with nurses and security staff to the vehicle that took him to the high security unit. He told staff he was sorry he had caused them any concern but had wanted to spend some time alone.

Briscoe never left the 320 hectares hospital grounds, yet the coverage in response to this event was alarmist and fear inducing. Three articles published in the days following his "escape" and "recapture" described Briscoe as a "criminally insane killer", three as a "mentally ill killer", and two as "a paranoid schizophrenic", descriptions in stark contrast with *Mindframe's* guidelines for mental health reporting. To compound this prescribed identity were the descriptions of the crime committed by Briscoe in 1997, which lead to his admission to Wolston Park. Two articles published in *The Courier-Mail* in 2002 reported that "he beheaded his father with a cane knife", Chris Jones described Briscoe as "a paranoid schizophrenic who hacked off his clergyman father's head", while *The Australian* stated more plainly that "[Briscoe] killed his father with a cane knife". A cane knife is similar to a machete, and to be beheaded is to have one's head completely separated from his/her body. The effect of the language used by journalists reporting on this case is to convey a barbaric and brutal image of Briscoe's crime. A description of the brutality of the crime solidifies the legitimacy of the community safety narrative being presented in these articles; the more dangerous the man who committed the murder, the more reason to fear for public safety. The language used by journalists who reported on this case reinforced the supposed danger Briscoe posed to the general public.

And so, upon the descriptive foundations of a barbaric murder that took place five years earlier, the journalists framed their articles on Briscoe's escape from a Brisbane mental health facility around the issue of public safety. *The Courier-Mail* noted that "understandably, the community was alarmed by Briscoe's disappearance". Chris Jones drew on Premier Peter Beattie's response to the event, and framed his comments in the context of concerns for public safety, saying "Mr Beattie conceded there was no

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way to guarantee another criminally insane killer would not escape". Paula Doneman's response in *The Courier-Mail* (2002) mirrored Jones's:

While the Beattie Government has been using the soon-to-be implemented Mental Health Act as a shield to fend off criticism over the escapes, the truth is these provisions will not stop another determined killer from absconding.

This fear of determined killers undermining a neglected health system was drawn on and reinforced in articles examined earlier in this chapter, particularly in the cases of the unnamed Bribie Island father, who raped and murdered his daughter, and Greg Anderson, who killed his son. Wayne Smith's article published in *The Courier-Mail* in January 2002 reported that "from the community's viewpoint, the primary issue is not how such patients are returned but how they come to be in a position to go missing". The tone of all of these articles, coupled with descriptions of Briscoe's act as an "escape" and "recapture" situation, create a sense of an animal on the loose, one with the capability of inflicting indiscriminant violence on an unsuspecting public. The reality of this case is that Briscoe never left the grounds of Wolston Park. He was not violent, posed no threat, and hid in a cricket pavilion for the 83 hours he "went missing". Journalists took this event and turned it into a broader story about a crisis in Queensland, involving "determined killers" absconding from mental health facilities, and the danger they pose to an unsuspecting public.

Case 2: Sydney, New South Wales, Australia

The second case explored in this section of the chapter illustrates again how journalists tend to use mental illness to explain brutal crimes, even when this explanation appears insufficient. It also sheds light on the challenges journalists can face when constrained by sub-judice law. A particular crime is considered sub-judice when it is "before a judge", and sub-judice law is in place to prevent journalists publishing material that prejudices a fair trial, with punishment ranging from small fines to imprisonment (Pearson & Polden, 2011). In England and Wales, sub-judice law is applied when a case is "imminent", so when a crime has been committed but the suspect has not been apprehended, while in Australia the threshold is "pending", meaning that until an individual has been charged, journalists can report on a case and any relevant details without consequence. So, in the days before the apprehension of a suspect, journalists are free to document background information regarding the alleged offender and any additional details, such as criminal history or mental health status, identified as in the public's interest. As soon as that individual is charged, sub-judice law applies and journalists are restricted to documenting the facts of the case as they are presented in court.

If a case is before a judge, the journalist is restricted to reporting only on the facts presented within the courtroom. This constrains a journalist from engaging in deeper discussion and speculation about possible motives and likely causes of a crime. It restricts one from discussing the mental health history of an alleged killer if this is not a matter raised in court proceedings. It also allows for the identification of the accused as mentally ill, but then restricts the journalist from providing additional content if it was not raised before a jury.

The one newspaper article (*The Daily Telegraph,* 2 June 2001) that detailed the case of Malcolm Robert Potts contained similar reporting techniques to those that were described in the analysis of the Mark Briscoe case. Brad Clifton reported for *The Daily Telegraph* in 2002 that "an argument over a

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son's failure to buy his father a worthwhile birthday present ended with one of the men being stabbed to death". The accused, Malcolm Robert Potts, was described by Clifton as a "paranoid schizophrenic". After giving his father an unsatisfactory birthday present, and being insulted for doing so, Potts "threw a shopping trolley at [him]" and sprayed him with a can of insecticide.

The language used in this particular article published in *The Daily Telegraph* was detailed and unambiguous. The purpose of describing the shopping trolley and can of insecticide as weapons is unclear, but the effect was to dramatize the event that took place. The fact the argument preceding the murder was based on a birthday present trivializes the death of the father, encouraging the reader to view the event as abnormal and exceedingly violent given the circumstances. The assertion is that the killer must have been insane. The article concludes that "the jury would be satisfied that Mr Potts [the perpetrator] was suffering from an abnormality of mind at the time of the killing". Mr Potts took the life of his father and was clearly very angry, potentially psychotic. But whether he suffered from a mental illness at the time of the killing, and whether his story is representative of the broader experience of most mentally ill Australians, must certainly be questioned.

What is clear from the article is that more information about the circumstances surrounding the murder is required. As was evident in the articles detailing the murders of Luke Batty and Darcey Freeman, the inclusion of one alleged diagnosis of mental illness does little to explain the extreme events that took place. In the case of Mr Potts, Brad Clifton offers a description of the trigger for the event – a disappointing birthday present – and two of the weapons involved in the attack, these being a shopping trolley and a can of insecticide. What these details suggest is a complex and tempestuous relationship between a father and his son, perhaps living on the margins of society. Certainly, the presence of a shopping trolley in the family home indicates some issues within the relationship that may have class origins. More contextual information is required, and this is something lacking in Clifton's account, one suspects as a result of the restrictions placed on journalists by sub-judice law. Clifton quoted Crown Prosecutor Terry Thorpe, who stated "Malcolm Potts is mentally ill … and has been since 1985". The presence of a mental illness that had persisted since 1985 is insufficient to explain the death of a father at the hand of his son.

The story of Malcolm Robert Potts illustrates both the need for improvement in some reporting methods, but also the constraints that are placed on journalists telling mental health stories that are also the subject of criminal proceedings in courts. Clifton's description of Potts as a paranoid schizophrenic reinforces the public's misunderstanding of mental illness as a life sentence. A more suitable choice of words might have been to describe Potts as "an individual being treated for, or diagnosed with, paranoid schizophrenia"; a description that separates the individual from their illness. Setting aside these concerns with language, Brad Clifton was clearly restricted in reporting only those facts that were subject to scrutiny within the court. Sub-judice law constrained Clifton's ability to provide these additional details and explore this case in-depth. While the article was still sensationalized, and the focus on a birthday present trivialized the murder of a father by his son, Clifton reported the facts of the case as they were presented in court.

Case 3: Glossodia, New South Wales, Australia

The third progeny case explored in this section is detailed in six articles published between August 2002 and March 2009 describing the murder of Fiona Fitter by her "estranged husband and two teenaged children". Two of these articles were published in 2002 in the months immediately following the killing, while the other four articles were published between 2006 and 2009, and shifted the focus from

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the circumstances surrounding the crime to the rights of Fiona's daughter, Kylie, who was involved in the murder and had been a resident of a mental health facility since her mother's death.

Fiona Fitter's death took place in the town of Glossodia in New South Wales on 16 October 2001. Both articles published in 2002, in the months immediately following the killing, presented mental illness as an explanation for the violent crime. Lorna Knowles's description of the event, published in *The Daily Telegraph*, is representative of both articles:

The victim came home from work. Neighbours said they saw her run screaming across the road, with her son in pursuit. She sought refuge in a neighbour's house but the two men – her son holding two carving knives in the shape of a cross – kicked the front door in and chased her outside. Witnesses said they saw the trio kick her on the ground … the daughter held both her mother's legs, while the husband and son bashed and stabbed her.

Knowles explained that the mother was killed because her husband and two children "believed she was a devil-worshipping witch", and all three would later plead not guilty "by reason of mental illness" in the NSW Supreme Court. The husband was described as a 40-year-old "cannabis dependent paranoid schizophrenic", his son, 18 years of age, "had attention deficit hyperactivity disorder and drug-induced psychosis", and his daughter "had learning difficulties and suffered depression".

It is unclear how relevant or reliable these diagnoses are. In considering the unnamed daughter's contribution to her mother's death, depression and learning difficulties are entirely insufficient to explain such actions. One has to wonder the effect of the association of this crime with the diagnoses offered by Knowles on those who suffer from clinical depression. For the victim's son, a diagnosis of attention deficit hyperactivity disorder could never legitimately explain or justify an individual's propensity for violence, and yet mental illness was still used by Knowles to explain the murder. The last line of the 384-word piece reads "the hearing will continue on Thursday", suggesting Knowles faced the same restriction as was faced by Brad Clifton, who reported on the murder committed by Malcolm Robert Potts, described in the previous section. This is a clear example of the restrictions of sub-judice law hindering a journalist from exploring the broader social circumstances involved in a crime. Knowles alludes to the fact that both the father and the son had been abusing drugs and that this could have induced a psychosis that led to the killing.

Like those journalists who reported on the Mark Briscoe case, Lorna Knowles made the decision to include details of the murder weapons and how they were used by the perpetrators in the murder. These were a "large carving knife" held by the son in the shape of a cross, and "a pair of surgical scissors", which were inserted up the victim's nose and "into her brain". How useful these details are for the reader's understanding of the event is unclear and their inclusion has only added to the sense of horror and terror that this story conveys. The four articles published between April 2006 and March 2009 shift the focus away from the horrific murder, and focus on the rights of Kylie Fitter, the 20-year-old daughter of the deceased victim. All four of these pieces were published in *The Sydney Morning Herald*, with three written by Adele Horin and one by health reporter Louise Hall. Unrestrained by the sub-judice restrictions faced by Lorna Knowles when she reported on this case in 2002, Horin's three articles described some of the broader circumstances involved in Fiona Fitter's murder, and campaigned for the rights of one of her killers, her youngest daughter. Two of Horin's articles were significant in length; one was 1162 words and the other was 2506. Both described Kylie Fitter as a "prisoner", both of her "past" and of "the state". They also portrayed the young woman as a victim:

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Kylie was as much a victim as her beloved mother. A victim three times over: of an upbringing that made her unfit for the world, of a psychotic father and brother, and now of political expediency.

Throughout the article, Horin provided the details that Knowles was unable to offer when she reported on this case during the Supreme Court trial in 2002. She explained that Kylie Fitter's father was the primary source of her anguished upbringing, and had filled "her head with extreme Christian beliefs". He was described by Horin as "passionate about God and his family", and had "suffered mild psychosis" at different points during his life. Unrestrained by sub-judice restrictions, Horin was then able to present a fuller account of the challenges Kylie faced as a child:

Both Kylie's parents suffered abuse as children. Out of love for their children, they kept them close and fiercely protected. They moved a lot; there were several schools, and charismatic churches. By 13 Kylie was on Prozac. She left school at 14, a social misfit, believing she was stupid, and in isolation filled her days with computer games. Her brother was spiraling into schizophrenia, hearing "demons' voices" and becoming fixated on harming his mother.

A significant portion of the article was also dedicated to the challenges faced by Kylie's father, who was portrayed as having the greatest responsibility for the murder of Fiona Fitter, his former wife. Horin explained that the unnamed father lost his job in 1999 because of a back injury and that the resulting pain lead to him self-medicating with the use of cannabis. Horin stated that "for a devout Christian his heavy drug use was bizarre and it triggered outlandish behavior". He was known to share joints in the back shed of their home with his son, and he began to collect knives (though for what purpose is not made clear by the journalist). To consolidate the portrayal of Kylie as another victim of this crime, Horin concluded that "there were good days and bad … [Kylie's] father and brother lived in their shared world of demons, angels and paranoid delusions".

In a shorter piece, she wrote for *The Sydney Morning Herald* on 18 September 2006, Horin described Fitter as being "held prisoner by politics", and gave attention in the article to Ms Fitter's advocate, Bob Johnston, who stated that "Kylie is a virtual political prisoner because of the minister's concern that releasing her would damage the Government in the [upcoming] election". In March 2009, Louise Hall reported for *The Sydney Morning Herald* that the laws surrounding this issue had changed, and that "people who are declared unfit for trial or not guilty because of mental illness will no longer be detained or released 'at the Governor's pleasure', following widespread concern that patients' detention was being continued unfairly for populist or political reasons". Adele Horin interviewed Kylie and described her in an article published on 29 April 2006 in *The Sydney Morning Herald* as follows:

She is so gentle and polite as she offers tea and biscuits in a child-like voice that it defies imagination Kylie Fitter helped kill her mother in a crime of biblical proportions. Seated in the living room of an inner-city terrace, the willowy, 20-year-old spun-sugar blonde, sweetness itself, is out on weekend leave from jail. But in the view of her many supporters, Kylie is a political prisoner.

Remember that in later descriptions of the brother and father, also published by Horin in 2006, the two "lived in a shared world of demons, angels and paranoid delusions". According to Adele Horin, Kylie "lost capacity for rational thought and came to share the delusions of her father and brother" who

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believed Fiona Fitter was evil, and that she "drank babies' blood". Kylie was presented in these articles as separate to her delusional brother and father, and the victim of their paranoid thinking.

The purpose of this analysis has been two-fold. First, it offers insight into the potentially negative consequences of the constraints placed on journalists by sub-judice law. In contrast, the four articles published between 2006 and 2009 were not constrained by sub-judice law, and so engaged in broader questioning of the social circumstances that lead to Fiona Fitter's murder, in particular, the links between religion, the abuse of illicit drugs and alcohol, and paranoid and delusional thinking. While the articles still described the perpetrators as mentally ill, the reader was presented with a more complex (and more thorough) account of how such a horrific murder could take place. Second, the four articles published between 2006 and 2009 portray Kylie Fitter as a victim of multiple circumstances: a victim of her father's delusional thinking, a victim of her upbringing, and a victim of the state. This reinforces a pattern identified earlier in the chapter, where mental illness in women is portrayed as tragic, whereas in men it is abhorrent and despicable. Certainly, Fiona Fitter's son and father are portrayed as psychotic, drug dependent, paranoid schizophrenics who acted coldly and brutally. Kylie Fitter is presented as the 15-year-old who was seduced and hypnotized by their delusional thinking.

Case 4: Sydney, New South Wales, Australia

On 9 November 2009, Sydney-based curator, gallery director, and academic Nick Waterlow was killed by his son Anthony, described as a 43-year-old man "suffering from paranoid schizophrenia". A total of eighteen newspaper articles reported on this case and were published between 12 November 2009 and 7 November 2014; eleven in *The Sydney Morning Herald*, four in *The Australian*, two in *The Daily Telegraph*, and one in *The Courier-Mail*. This is the fourth case explored in this section of the chapter and the purpose of the analysis that follows is to explore the tendency for journalists to document explanations for violent crime that reside outside the individual. I examine the case of Anthony Waterlow and the eighteen newspaper articles devoted to the murders he committed in 2009, and assess the extent to which journalists were willing or able to explore some of the broader social circumstances involved in violent crime committed by individuals described as mentally ill.

Jodie Minus presented a full account of the two murders committed by Anthony Waterlow in a piece published in *The Australian* on 13 April 2011. Minus explained that despite the son killing both his father and sister, there was love in the Waterlow family, and a deep care for the suffering Anthony that persisted "to the very end":

Just moments before his mentally ill son came lunging at him with a 34cm kitchen knife, the 68-year-old cried out "I love you". Anthony, suffering from paranoid schizophrenia, then turned the knife towards his sister, Chloe, who pleaded, "No, don't – stop," as her three young children screamed and cried. Silence descended on the Randwick house, in Sydney's east, for a brief spell as Waterlow, his shirt soaked in blood, walked out the front door … leaving Nick and 37-year-old Chloe on the floor.

A piece published just three days after the killings, at a time when Nick Waterlow had still not been apprehended by police, and so sub-judice restrictions were not applicable, sought to reduce mental health stigma by making it clear that there are no inherent links between violence and mental illness. Rick Feneley reported for *The Sydney Morning Herald* that the revelation that Waterlow "is a schizophrenic has raised concerns that people with mental illness will be demonized". Feneley explored some of the

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structural factors involved in the murders, and so looked beyond a simple explanatory link between mental illness and violence common to many of the articles explored in this chapter. He drew on SANE Australia's deputy director at the time, Paul Morgan, who explained that "when tragic cases do occur, it perhaps leads people to a mistaken impression that people with mental illness are more violent than they are". Feneley noted that males aged between 18 and 25 are the most violent group in Australia today, "but people [do] not live in fear of every young man".

That Feneley drew on the views of Paul Morgan is significant. SANE Australia is a mental health charity aimed at helping Australians affected by mental illness, both personally and through family, to lead a better life. A significant focus of their campaigning is the reduction of stigma. By including Morgan's expertise and insight, Feneley helped to balance and moderate the obviously horrific crime and its associations with mental illness. Feneley used Morgan's expertise most significantly when he placed emphasis on some of the structural factors involved in the murder:

Mr Morgan said … there was a "very small by significant" correlation between schizophrenia and an increased risk of violence. "But that is concentrated in people who are generally younger males, who may have a propensity to violence anyway … who are not getting treatment, and especially if they are mixed up in drugs and alcohol". Anthony Waterlow has a history of drug and alcohol abuse, and violence.

An article written by three authors, David Barrett, Rhett Watson, and Gemma Jones, published in *The Daily Telegraph* on 14 November 2009, explained that Anthony Waterlow was a "loner" who lived in "a lonely world". Barrett, Watson, and Jones explored some of the broader issues involved in the crime, looking beyond Waterlow's battle with mental illness. They documented a history of physical violence by Waterlow against his family that was compounded and exacerbated by his refusal to take anti-psychotic medication. They explained that as a young man he was officially diagnosed with paranoid schizophrenia, "but friends say he refused to take medication … [and] bursts of violence against family members as the delusions gripped him eventually led to court-ordered apprehension violence orders". His sister, Chloe, who he would later kill after murdering his father, "had already made it known to others that she feared for the safety of her family" and that he had "once attacked her in a hotel". The three journalists documented more cases of violence:

In 2007 he twice appeared in court. Once for bashing friend and prominent jewelery designer Bridie Lander. He also tried to smash down two doors of neighbours in an Elizabeth Bay block of flats … Even those who have previously been victims of Anthony's violence are loathe to blame him. Instead, there is a feeling that, like too many of the mentally ill, he fell through the cracks.

The purpose of this article, as it was in Feneley's piece, was to explore some of the broader social circumstances involved in the murders committed by Anthony Waterlow. The explanatory narrative so often reinforced in articles explored in this chapter was also tempered, with more attention given by Barrett, Watson, and Jones to Waterlow's history of violence, and reluctance to take anti-psychotic medication. This drew emphasis away from a simple cause-effect explanation between mental illness and violence. Anthony Waterlow was instead portrayed as someone who suffered greatly, and perhaps was as much a victim of this story as the deceased family members he killed. The three journalists consolidated this view when they concluded that he had fallen "through the cracks" of the mental health system.

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SOLUTIONS, RECOMMENDATIONS

As was the case in accounts of fathers, mothers, and progeny, nearly all cases involved murder, and journalists used mental illness more frequently than any other explanatory device to account for how and why these crimes took place. Further research and scrutiny of media reporting guidelines is required on the reporting of violence, separate to further research on fair and accurate reporting related to mental health, so that journalists do not inadvertently cause harm and increase stigmatizing attitudes and discriminatory practices toward people experiencing mental health issues.

CONCLUSION

This chapter was divided into three sections based on the perpetrators of acts of violence that took place in the family setting. Categories were fathers, of which there were 24 articles dedicated to the stories of eleven separate men; mothers, where 22 articles reported on the stories of 24 mothers who harmed their children; and finally, progeny, where a total of 58 articles presented 17 cases of sons or daughter who killed, or planned to kill, one or both of their parents. The argument that unites these three sections is that in cases where violence occurred in the family setting, whether the perpetrator was a father, a mother, or their sons and/or daughters, Australian journalists used mental illness to explain how and why these crimes took place. But the analysis presented in this chapter has shown that the explanatory mental health narrative, while used in the vast majority of newspaper reports on family violence, was not employed uniformly across all three categories. This analysis offers support for an argument presented in chapter one of this text relating to the construction of mental health reporting for publication in newspapers. The analysis presented in this chapter yielded three additional findings that were common across all three categories. The first was the tendency for journalists to portray abhorrent murders as reflective of broader social problems, the second was the use of additional examples of violence as a means for sensationalizing news stories, and the third was the restrictions placed on journalists by sub-judice law and the effect these constraints had on the construction of news stories.

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Chapter 57
Finding Strength in the Struggle:
Addressing the Mental Health Needs of Children and Families Living in Rural Poverty

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ABSTRACT

Poverty is an intersectional issue, as children; women; men; people of color; people who identify as lesbian, gay, or transgender; and immigrant groups are all prone to experience the multifaceted impact of poverty. People who live in rural poverty are likely to experience more severe and persistent mental health disorders. This chapter provides an overview of how rural poverty impacts the mental health and wellbeing of diverse children and families. The authors discuss issues faced by residents living in rural poverty and provide multiple strength-based strategies that behavioral service providers can use to provide culturally relevant mental healthcare in impoverished rural communities. Lastly, the authors offer suggestions for future research.

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INTRODUCTION

"I don't see class." This claim echoes the more popular statement "I don't see color," which is a faulty claim made by individuals who want to ignore issues of structural power, privilege, and other topics related to race (Burke, 2019). Like the phenomenon of colorblindness, being class-blind dismisses the reality of social class differences and lessens one's ability to recognize and discern how to provide equitable resources and services to those who experience poverty. Over 40 million Americans live in poverty, with the most concentrated areas of poverty in non-metro, rural locales (United States Department of Agriculture [USDA] Economic Research Service, 2019). While poverty is commonly considered to be an urban issue, persons in rural areas experience poverty in higher rates (USDA Economic Research Service, 2019), with 16.4% living in rural areas versus 12.9% in metropolitan areas. The physical and psychosocial stressors attributed to poverty, such as malnutrition, increased morbidity, and homelessness are detrimental to the wellbeing of children and families (Zalaquett & Chambers, 2017). Therefore, scholars, policymakers, and the public must acknowledge the chronic life stressors that adversely impact the mental health and wellbeing of individuals living in rural poverty as well as identify protective factors that promote their healthy development and resilience.

In order to address the mental health-related concerns of children and families living in rural poverty, it is vital that professionals recognize the challenges residents face while simultaneously noting the strengths present in these communities. Individuals living in rural poverty possess remarkable assets that help them to overcome environmental and personal stressors (Williams, Bryan, Morrison, & Scott, 2017). However, in order to recognize the capacities (i.e., potential to withstand adversity) of individuals living in rural poverty, scholars from multiple disciplines (mental health, education, and allied professionals) suggest a need to shift from a deficit-oriented ideology to a culturally responsive, strength-based framework when providing services in these communities (Crumb, Haskins, & Brown, 2019; Harms Smith, 2017). Strengths based frameworks focus on the empowerment of people living in poverty and the acknowledgement of their capabilities (Harms Smith, 2017).

The objective of this chapter is to help readers develop an understanding of the mental health needs of children and families living in economically disadvantaged, rural communities. The authors provide strategies that providers of rural mental and behavioral healthcare services can use to address the concerns extant in impoverished communities using strength-based approaches. The authors outline ways that providers can alter services to address the unique mental health concerns of residents living in rural poverty and methods providers can use to engage in individual and systems-level advocacy interventions to promote equity and positive systemic changes in rural communities. The chapter concludes with recommendations for how mental healthcare providers can collaborate with schools, local organizations, and faith communities to improve mental healthcare for residents living in rural poverty.

DEFINING POVERTY

Poverty is a complex sociopolitical phenomenon that presents in various ways. Consequently, there are multiple poverty definitions, including: (a) absolute poverty, (b) relative poverty, and (c) income poverty (UNESCO, 2019). *Absolute poverty* is commonly understood to mean "poverty in relation to the amount of money necessary to meet basic needs such as food, clothing, and shelter" (UNESCO, 2019, p. 1). This definition is limited to the basic needs and resources that a person needs to survive. *Relative poverty* is

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a more commonly used definition of impoverished experiences in the United States (U.S.) and is understood as poverty in which "people are 'poor' if they fall below prevailing standards of living in a given societal context" (UNESCO, 2019, p. 1). Meanwhile, *income poverty* is the metric used to determine if individuals or families meet standards to qualify for government assistance (UNESCO, 2019). In the U.S., this is represented by the Federal Poverty Level (FPL). While these measures of income poverty are important sociopolitical definitions, they do not take into account the relational or social aspects of impoverished experiences (relational poverty). If individuals earn slightly more income than the FPL, they will not meet the federal definition of poverty, and thus have less access to Federal Safety Net programs serving low-income persons (e.g., Temporary Assistance for Needy Families; Women, Infants, and Children; Supplemental Nutritional Assistance Program).

In addition to the resource and income definitions of poverty, poverty experiences can also vary by time and circumstance, leading to episodic, chronic, or generational poverty (Portland State University [PSU], 2019). It is critical to examine the differences in chronological poverty experiences, as time spent experiencing poverty will have a different impact on individuals' experiences with access to various resources, such as food, housing, healthcare, education, and employment. *Episodic poverty* lasts for less than two months; an example of episodic poverty may be when a parent loses a job and a family experiences a significant financial loss for a period of time, but when that parent returns to work, the family no longer experiences the financial strain and poverty. *Chronic poverty* is defined as poverty that is experienced by a person or group of people for four years or longer (PSU, 2019). In addition to chronic poverty, poverty can be conceptualized as generational in that it is something that families have experienced for two or more generations (PSU, 2019). *Generational poverty* can be characterized in some cases as families who have never owned property, do not have family members who have engaged in or benefitted from higher education, and have very little or no employment mobility (PSU, 2019).

THE FACES OF RURAL POVERTY

In 2017, 13.7% of U.S. residents experienced poverty, with an individual yearly income below $12,060 (Bishaw & Benson, 2018). While 13.7% represents the poverty rate of all Americans, poverty is an intersectional issue - children, women, people of color, and people who identify as lesbian, gay, bisexual, or transgender all experience higher rates of poverty than persons occupying non-marginalized statuses (Bishaw & Benson, 2018). Poverty is an important issue for families, especially those with women heads of household, which are more apt to experience poverty than households headed by men or those with multiple parents. Furthermore, children living in the U.S. experience higher poverty rates than adults (Bishaw & Benson, 2018). Racial and ethnic minorities experience poverty at increased rates in rural areas, as they do in urban areas and overall (USDA Economic Research Service, 2019). Coupled with the mental stress associated with financial concerns, many persons with historically marginalized identities also experience racism, sexism, homophobia, and transphobia. These experiences can lead to multiple minority stress and adverse physical and mental health outcomes associated with multiple oppressions (Bockting, Miner, Swinburne-Romine, Hamilton, & Coleman, 2013; Meyer, 2003; Wong, Schrager, Holloway, Meyer, & Kipke, 2014).

Regardless of identity status(es), persons experiencing poverty are more likely to experience mental health concerns and psychological disorders (Weissman et al., 2015; World Health Organization [WHO], 2007). Mortality, chronic physical illness, developmental delays, violence, and barriers to health care

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and housing are all risks associated with poverty experiences (Kaminski et al., 2013; Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005). Persons in poverty may have difficulty finding and maintaining employment, causing further mental distress (Weissman et al., 2015; WHO, 2010). These mental, financial, and physical stressors deepen the adverse experiences of poverty.

While experiencing poverty is not a direct cause of negative outcomes, the lack of access to economic and other resources significantly impacts an individual's daily life, health, and overall wellness (Kaminski et al., 2013). Beyond the specific physical, mental, and educational effects, persons experiencing poverty are also likely to live in overcrowded or poor-quality housing (Anakwenze & Zuberi, 2013; Goodman, Pugach, Skolnik, & Smith, 2012), to be exposed to community or interpersonal violence (Anakwenze & Zuberi, 2013; Goodman et al., 2012; Logan, Walker, Cole, Ratliff, & Leukefeld, 2003), and to experience food insecurity, relational instability, underemployment, and higher rates of incarceration (Goodman et al., 2012; Myers & Gill, 2004; WHO, 2007). Overall, children and families living in rural poverty are likely to have little to no access to health care, mental health services, or adequate educational opportunities (Goodman et al., 2012; Myers & Gill, 2004; WHO, 2007).

The noted issues highlight a need to conceptualize rural poverty from a socioecological perceptive (Bronfenbrenner, (1986) considering how individuals are impacted on the micro (individual level), meso (community level), and macro levels (society as a whole). A socioecological perceptive takes into account the broader social, political, and economic forces that impact an individual's wellbeing. Notably, individuals living in rural poverty are affected by systemic concerns and policies that do not contribute to equitable education, safe environments and housing, economic development, access to healthy foods, and employment (Thornton et al., 2016). Policymakers play an integral role in overall functioning and progression of these communities. Disparity-reducing policy interventions targeted at education, healthcare, and rural community development and employment are warranted.

MENTAL HEALTH AND RURAL POVERTY

Mental health, a component of overall health, is a measure of an individual's overall mental status, psychological health, and wellness (WHO, 2004). Mental health can be measured on a continuum from well to ill with every individual having a unique mental health status (WHO, 2004). Mental illness is commonly understood as the psychological state of experienced mental distress or a diagnosed mental disorder (as per the Diagnostic and Statistical Manual [DSM-5], American Psychiatric Association [APA], 2013). These mental health diagnoses include neurodevelopmental disorders such as Attention Deficit Hyperactivity Disorder [ADHD], depression, anxiety, psychotic disorders, trauma, and stress-related disorders (APA, 2013). The relationship between poverty experiences and mental health is well documented, and persons living in poverty are more likely to experience mental health disorders as well as more severe and persistent mental health disorders such as schizophrenia (Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007).

Experiencing poverty is frequently associated with higher incidences of mental illness (Hanandita & Tampubolon, 2014; Lund et al., 2010; Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007) just as higher incomes are linked to lower levels of psychological distress (Weissman et al., 2015). Persons living in poverty often report higher levels of depression, post-traumatic stress disorder (PTSD), and substance use (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010; Mickelson & Hazlett, 2014).

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The relationship between poverty and mental illness is not only correlated, it is cyclical and bi-directional (Weissman et al., 2015; WHO, 2007, 2010). With an increased risk for mental illness, a person is also more likely to experience poverty, as mental illness often makes engaging in sustainable work or educational/training programs challenging if not impossible (Anakwenze & Zuberi, 2013; Hanandita & Tampubolon, 2014; Lund et al., 2010; Mickelson & Hazlett, 2014; Weissman et al., 2015; WHO, 2007, 2010). For example, persons with a severe and persistent mental illness like schizophrenia are four times as likely to be unemployed (WHO, 2007). In sum, poverty experiences and mental illness can be mutually reinforcing.

These challenges can be even more difficult to navigate as many persons experiencing poverty have great difficulty accessing mental health treatment (Goodman et al., 2012; Weissman et al., 2015). Persons in poverty are less likely to receive mental health treatment, often due to systemic barriers such as unaffordability or lack of insurance coverage (Goodman et al., 2012; Nadeem, Lange, & Miranda, 2008; Weissman et al., 2015; WHO, 2010). Beyond these financial obstacles, simply finding a means of transportation to and from appointments can be a significant barrier to accessing care for many persons experiencing poverty (Goodman et al., 2012; Myers & Gill, 2004).

Rural Mental Health Needs

People living in rural communities face unique difficulties related to poverty and mental health beyond those presented above. There are higher incidences of deep poverty in rural locations (USDA Economic Research Service, 2019). Specifically, rural poverty rates are highest in the south, Appalachia, and Native American lands (USDA Economic Research Service, 2019).

Persons living in rural areas are often at a greater risk for mental health and substance use and have a greater need for mental health services than persons in metropolitan areas (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Despite this, there is a shortage of mental health service providers in rural areas (Rural Health Information Hub, 2019). Because of this shortage, people in rural areas are often forced to travel to metropolitan areas for mental health services, which for persons experiencing poverty may be incredibly difficult beyond the distance traveled. It requires having access to a personal means of transportation. Moreover, finding funds for gasoline, maintenance, and auto insurance, being able to take time off from work, and arranging childcare all present significant barriers.

CLASSISM AND RURAL POVERTY

Classism is a form of prejudice due to which marginalization, ostracism, and oppression occur in response to an individual's social class (Liu, 2013). Classism is both individual (i.e., individuals can hold classist beliefs and use them to stereotype and discriminate against others) and systemic (i.e., structural inequalities exist to privilege those in upper social classes and oppress those in lower social classes; Liu, 2013, Lott, 2002, 2012; Smith & Redington, 2010). The prevalence of classism often stems from the idea that success is based on merit, and social class barriers such as poverty are due to an individual's deficits, such as laziness or lack of intelligence (Liu, 2013; Lott, 2002; Smith, 2005). Classism can further oppress those already impacted by the barriers of poverty via separation from "mainstream" culture, causing social isolation in housing, employment, and education as well as in other areas (Liu, 2001; Lott, 2002; Smith, 2005). Research has shown that significant classist biases exist towards persons who experience

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poverty and that many people believe experiencing poverty is an individual's fault (Cozzarelli, Wilkinson, & Tagler, 2001; Hunt, 1996). Beyond the general population, even mental health providers have been found to have negative beliefs about persons experiencing poverty (Schnitzer, 1996; Smith, Mao, Perkins, & Ampuero, 2011; Toporek & Pope-Davis, 2005; Weiss-Gal, Benyamini, Ginzburg, Savaya, & Peled, 2009). Persons living in rural poverty who experience classist exchanges with mental health providers are unlikely to return for necessary mental healthcare due to fear of discrimination and judgment.

MAIN CONCERNS OF MENTAL HEALTH IN RURAL POVERTY

Mental healthcare disparities in impoverished rural areas is a four-part problem related to the (a) acceptability, (b) accessibility, (c) availability, and (d) affordability of mental health services (Smalley, Warren, & Rainer, 2012). The majority of persistently poor rural communities are designated as Mental Health Professional Shortage Areas, signifying a dearth of mental healthcare professionals and resources in these locations. The professional and resource shortage may lead to the underutilization of mental healthcare services as well as inadequacies in the quality of mental health treatment provided to residents living in rural poverty (Smalley et al., 2012).

In terms of acceptability, mental illness stigma is one of the most common reasons why residents living in rural poverty are apprehensive about seeking mental healthcare services (Crumb, Mingo, & Crowe, 2019; Stewart, Jamison, & Curtin, 2015). Mental illness stigma denotes the labeling and devaluing of a person based on negative beliefs, attitudes, and perceptions about mental health issues that result in status loss, stereotyping, or discrimination (Crowe, Averett, & Glass, 2016). Mental illness stigma is further designated as self-stigma, public stigma, and stigma by association. *Self-stigma* occurs when a person internalizes the negative attitudes of others about mental health issues, resulting in lowered self-esteem and self-worth (Crowe et al., 2016). *Public stigma* represents disdain toward those who have a mental illness from the general public (Crowe et al., 2016) and *stigma by association* occurs when a person is stigmatized by virtue of association with a person who has a mental illness (e.g., negative attitudes towards parents from school administrators regarding their child's mental health concerns).

All forms of stigma deter children and families living in rural poverty from seeking mental healthcare services (Heflinger, Wallston, Mukolo, & Brannan, 2014). For example, Crumb et al. (2019) conducted a qualitative analysis to examine the mental health treatment experiences of low-income adults living in rural areas across the United States. Participants were candid in reporting experiences of stigma, stating that they were reluctant to seek services because their relatives would perceive them as "weak" for having a mental illness. Similarly, Polaha, Williams, Heflinger, and Studts (2015) surveyed rural parents' experiences of seeking mental healthcare services for their children. The researchers found that stigma by association (i.e., stigmatizing attitudes from teachers and school administrators) deterred parents from seeking treatment for their children in school settings (Polaha et al., 2015). The findings from this study are alarming because schools are essential for children's access to mental healthcare services in impoverished rural communities, with school-based services circumventing common mental health treatment barriers such as transportation difficulties and parents' time constraints (Nichols, Goforth, Sacra, & Ahlers, 2017). Due to issues related to the acceptability of mental illnesses in impoverished rural communities, residents who experience mental health-related concerns postpone seeking professional services and often require more intensive treatment when concerns arise (Smalley et al., 2012).

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The accessibility of mental healthcare services is also a significant problem in rural areas. Issues such as long distances to treatment facilities and a lack of transportation present barriers for children and families in need of mental healthcare. As a result of accessibility issues, rural children and families often forego timely mental health treatment (Nichols et al., 2017). Rural residents typically seek mental health services only after their symptoms have progressed, necessitating more extensive treatment, which is often unavailable in rural areas and too costly for persons of limited economic means (Gore, Sheppard, Waters, Jackson, & Brubaker, 2016). Furthermore, although rural youth may have professional school counselors who can help them access mental health services, the utilization of these services is still dependent upon parental consent and participation in the treatment process.

Likewise, the availability of treatment in impoverished rural areas is fragmented due to the shortage of service providers in these communities. The provider shortage is primarily attributed to the difficulty in recruiting and retaining mental healthcare professionals in such communities. Additionally, many providers have a limited understanding of cultural norms and effective interventions for addressing the mental health-related concerns of this particular group (Fifield & Oliver, 2016). Most impoverished rural communities do not have mental healthcare professionals, and if one is present, this person is often the sole provider. Moreover, mental healthcare providers practicing in these areas are paid less, have larger caseloads and fewer resources and support networks, and face personal and professional issues related to burnout (Reed & Smith, 2014). Rural providers also face ethical dilemmas, such as maintaining confidentiality and navigating multiple roles (Bowen & Caron, 2016). Furthermore, researchers have suggested that rural providers are not often well-trained in specialty areas of mental healthcare (e.g., substance abuse, trauma-informed care; Fifield & Oliver, 2016). Consequently, rural residents often depend on informal, nonprofessional sources to address mental health concerns such as friends, clergy, or other affiliates in faith-based organizations (Bryant, Moore, Willis, & Hadden, 2015).

Finally, the affordability of mental healthcare services is an ongoing concern, as most uninsured children and families are those living in rural poverty (Foutz, Artiga, & Garfield, 2017). Adults living in rural areas with concentrated poverty are more likely to work for small businesses that do not provide health insurance coverage, which is often necessary to receive adequate treatment for acute mental health concerns (Zalquett & Chambers, 2017). Furthermore, when low-income adults have access to government-supported health coverage such as Medicaid, they often need professional assistance to stay abreast of the ongoing changes to criteria that must be met to qualify for these services (Crumb et al., 2019). Consequently, individuals living in rural poverty may ignore the prevalence of mental health symptomology altogether.

MENTAL HEALTH LITERACY

In addition to issues related to acceptability, accessibly, availability, and affordability, mental health literacy is also important to consider in relation to impoverished rural communities. *Mental health literacy* is the knowledge and beliefs about disorders that assist in the recognition, prevention, or management of mental health concerns (Jorm, 2012). Individuals living in rural poverty are less aware of mental health symptomology and have less ability to appraise the level of symptom severity (Smith, Li, Dykema, Hamlet, & Shellman, 2013). For example, a study using focus groups to examine the perspectives of mental health problems among rural African Americans found that most participants did not know how to recognize mental illnesses and would, therefore, not understand when treatment was needed (Sullivan

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et al., 2017). These results convey the difficulty those living in rural poverty may have in appropriately assessing whether treatment is necessary or when to seek help.

Mental health literacy is associated with overall mental, physical, and social wellbeing (Cheng, Wang, McDermott, Kridel, & Rislin, 2018; Coles & Coleman, 2010; Kelly, Jorm, & Wright, 2007). Individuals who are aware of their personal mental health needs are more likely to seek treatment in a timely fashion and are more likely to recommend professional help to others (Coles & Coleman, 2010). However, limited levels of mental health literacy may cause individuals to delay seeking mental health services—if they seek services at all—ultimately exacerbating mental health conditions (Crumb, Haskins, & Brown, 2019; Kelly et al., 2007). Individuals with both limited mental health literacy and a lack of social and financial resources are especially vulnerable (El-Amin, Anderson, Leider, Satorius, & Knudson, 2018).

Individuals with limited mental health literacy living in rural poverty generally have poorer health outcomes, including smoking, alcoholism, nutritional deficiencies, lack of physical activity, and premature death (El-Amin et al., 2018; Hartley, 2004). Furthermore, mental health literacy, coupled with perceived stigma, may affect help-seeking attitudes for residents living in rural poverty (Cheng et al., 2018; El-Amin et al., 2018). While high levels of mental health literacy are positively associated with help-seeking, high levels of stigma, including self-stigma, negatively affect this relationship (Cheng et al., 2018; El-Amin et al., 2018). In some rural communities, discussing mental health concerns is considered to be inappropriate, embarrassing, and a violation of privacy, and may even be perceived as an insult (El-Amin et al., 2018; Polaha et al., 2015). These issues present significant barriers to the utilization of mental healthcare services in impoverished rural communities.

TRANSFORMING DEFICIT-BASED PERSPECTIVES OF RURAL POVERTY

Unfortunately, much of what is said about the rural poor is largely negative or grounded in deficit-based ideology. Deficit ideology proposes that: (a) people from poor rural communities are fully at fault for issues related to their living circumstances; (b) individuals do not have the capacity or motivation to change their circumstances; (c) children and parents do not value employment or educational endeavors; and (d) the cultural background, home environment, beliefs, and value systems of individuals living in poor rural communities are substandard (Smith, 2010). The use of a deficit approach weakens a practitioner's or researcher's ability to identify the strengths and positive experiences of children and families living in impoverished rural communities. Focusing only on the negative attributes of impoverished rural communities perpetuates classism, discrimination, prejudices, and stigma toward residents. Moreover, deficit-based ideology further increases the invisibility of the poor and stymies the allocation of various resources that may enhance fiscal restoration in these areas, both of which represent social and economic injustice.

Scholars (Cook & O'Hara, 2019; Reed & Smith, 2014) have called for increased research and interventions that focus on the assets and strengths amongst individuals living in impoverished rural communities. As an example, Williams et al. (2017) used a strength-based framework to explore the educational experiences of low-income middle school students. Instead of focusing on barriers to student success, the researchers investigated protective factors and processes that contribute to their academic success. Results from the study indicated that low-income students had a plethora of intrinsic and extrinsic factors that influenced their academic success, such as peer social capital, caring teachers, and family and community assets. Likewise, Crumb, Haskins, and Brown (2019) conducted a qualitative study

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to intentional capture the positive experiences of mental health counselors practicing in rural poverty. Counselors in the study reported that they showed appreciation for their clients' worldviews by learning about their family structure, leading with curiosity, and displaying cultural humility, which allowed them to acknowledge that their clients were resourceful, motivated to change, and capable of finding solutions to mental health-related issues. Moreover, due to the close relationship developed with their clients and their clients' families, counselors in the study were more readily willing to immerse themselves in the rural community and engage in social justice advocacy initiatives with and on behalf of their clients.

Additionally, increased training in poverty and multicultural counseling competence also has a significant impact on poverty beliefs (Clark, Moe, & Hays 2017; Greene & Manner, 2019). In a quantitative study examining the relationship between multicultural counseling competence and poverty beliefs using a sample of 251 counselors, Clark et al. (2017) found that higher levels of multicultural competence and training decreased poverty biases and helped counselors to understand the structural causes of poverty.

STRENGTH-BASED SOLUTIONS AND RECOMMENDATIONS

Mental health professionals have an ethical responsibility to support the overall wellbeing of children and families living in rural poverty through widespread interventions and advocacy efforts on the micro, meso, and macro levels (American Counseling Association, [ACA], 2014). The following section outlines ways in which professionals may positively impact the personal and social development of all persons living in rural poverty.

INCREASING MENTAL HEALTH LITERACY

Improving mental health literacy is important for empowering and reducing health disparities among vulnerable groups (El-Amin et al., 2018; Kelly et al., 2007). Early recognition and intervention of mental health conditions promote holistic health and wellbeing (Coles & Coleman, 2010; Kelly et al., 2007). Several interventions aim to improve mental health literacy, including mental health first aid, peer support groups, family-focused programming, school-based programs, and bibliotherapy (El-Amin et al., 2018; Rural Health Information Hub, 2018).

Mental health first aid is an especially useful strategy for increasing mental health literacy in rural communities (Rural Health Hub, 2018). Rural mental health first aid is a way to increase knowledge about mental health, substance use, and the stigma associated with mental health conditions (Rural Health Hub, 2018). This training can be applied on the micro, meso, and macro levels (Bronfenbrenner, 1986) such as with individuals, families, law enforcement, first responders, school personnel, policymakers, and the public to provide knowledge and skills related to mental illness, crisis intervention, and available referral sources within the community (Rural Health Hub, 2018).

Additional interventions that may improve mental health literacy include whole-of-community campaigns that aim to distribute information about mental health and available resources via pamphlets, posters, print media, and educational videos (Kelly et al., 2007). Community and school-based interventions may include teaching help-seeking skills, mental health literacy interventions, resiliency building, and crisis intervention training. School counselors or mental health professionals may facilitate these types of training (Kelly et al., 2007). Mental health professionals must take a socioecological approach

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(Bronfenbrenner, 1986) when conceptualizing the issues and concerns faced by those living in rural poverty, such as helping clients to specifically identify and discuss how rurality and poverty influences family dynamics, occupational choices, and environmental resources or the lack thereof considering the influence of community norms, and public policy.

BUILDING COMMUNITY PARTNERSHIPS

It is imperative for mental health professionals within rural communities to build connections with community partners, including religious organizations, schools, law enforcement, social service agencies, and medical service providers (Rollins, 2010; Rural Health Hub, 2019c). Community partnerships such as these help to alleviate health disparities in rural communities, where health resources are limited (Rural Health Hub, 2019c). Establishing community relationships is also a means to combat stigma and promote the utilization of mental health services in impoverished rural communities. The close-knit nature of rural communities is a strength and can help facilitate help-seeking for mental health concerns (Polaha et al., 2015; Rural Health Hub, 2018).

Partnering With Faith-Based Organizations

Individuals living in rural poverty with mental health concerns frequently rely on their religious beliefs, prayer, or spirituality to cope with mental illness (Crumb et al., 2019). Thus, faith leaders and pastors may serve as liaisons in connecting community residents to professional services (Avent, Cashwell, & Brown, 2015). Mental health professionals could meet with members of the pastoral community to provide psychoeducational workshops, distribute mental health information, or serve as consultants when mental illness concerns arise. Building connections with the pastoral community may also serve to build rapport and trust between mental health professionals and parishioners, who may be uncomfortable seeking services on their own (Avent et al., 2015). Ultimately, appreciating and integrating the values and culture of the rural community (e.g., spirituality, family, and interdependence) is essential to bridging the gap and engaging with rural families in making decisions that influence their mental health (Rollins, 2010; Rural Health Hub, 2018).

School-Based Mental Healthcare

School-based mental healthcare improves access to services for children in rural areas by providing onsite care within the school and community (Rural Health Hub, 2018). School counselors are uniquely situated to serve rural communities. School counselors in rural communities are considered role models and can provide guidance related to legal issues, domestic problems, and sexual abuse (Breen & Drew, 2012). Because of their ability to serve as examples and foster close-knit relationships within rural communities, they are a useful resource for connecting students and families to mental health resources (Breen & Drew, 2012; Rural Health Hub, 2018). Also, school counselors can support mental health efforts through screening for mental, behavioral, and developmental disorders; wellness examinations; medication management; individualized education plans; and referral services (Rural Health Hub, 2018). School counselors should advocate for the needs of students and families and collaborate with mental health providers in order to provide comprehensive care. Furthermore, school counselors can equip teachers on

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how to identify and handle mental health concerns observed in the classroom through practical hands-on training and classroom demonstrations. In cases in which school-based mental health professionals are not accessible or allowed, families can consider alternative options such as home-based counseling or seeking services from community mental healthcare providers; educators can ascertain trainings in mental health from online sources. It is important to note that managing mental health in schools is not the sole responsibility of the school counselors, as some rural schools may not have a counselor on staff.

Integrated Behavioral Healthcare

Resource scarcity, structural barriers, and stigma hinder rural families from seeking mental health services (El-Amin et al., 2018; SAMSHA, 2013). Integrated behavioral healthcare can increase access for rural communities, reduce stigma, and streamline services and collaboration among professionals by offering holistic healthcare in one facility (SAMSHA, 2013). There are three categories of integration between behavioral and primary healthcare (SAMSHA, 2013). The first level of integration is *coordinated care,* which involves minimal collaboration among professionals, who interact from a distance; separate systems and facilities are maintained. The second level of integration is *co-located care,* which includes close collaboration on site. *Integrated care* is the third level of integration and involves full collaboration and merging of services between providers in one facility. It is crucial to determine the level of integration that is most appropriate for a community and the availability of specialists and providers within the region (SAMSHA, 2013). Rural communities may consider implementing integrated behavioral healthcare in other settings such as schools and nursing homes and through the use of technology in order to increase access in cases where professionals are not able to adopt an integrated model (SAMSHA, 2013).

In addition, collaboration with other helping professionals working in impoverished rural communities (e.g., medical doctors, social workers, school counselors, case management providers) may increase the utilization of services by enhancing the visibility of mental healthcare through education and advocacy (Crumb et al., 2019; Crumb, Larkin, Johnson, Smith, & Howard, 2018; Polaha et al., 2015). This can be achieved if helping professionals provide brief screenings for mental health conditions in their respective offices, or if professionals provide psychoeducational pamphlets about mental health to the individual and families they serve. If mental illness is indicated, the professionals can then easily refer the person to mental health service providers within the community. Furthermore, helping professionals could establish interdisciplinary mental health and wellness coalitions within their communities to exchange resources and discuss ways to support rural families. This coalition should include community residents as collective partners to amplify community voice and focus on the needs of the families and the community at large.

ASSET MAPPING

Asset mapping is a method of cataloging a community's strengths and resources in a systematic way (Rural Health Hub, 2019a). Asset maps are developed from the strengths and capacities of a community rather than focusing on deficits (Dorfman, 1998). Assets may include individual skills (e.g., youth, older adults, parents, students, entrepreneurs), organizational resources (e.g., charitable groups, nonprofits, schools, universities, hospitals, and social service agencies), and local resources (e.g., business associa-

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tions, merchants, banks, foundations; Dorfman, 1998; Rural Health Hub, 2019a). Asset mapping generally adheres to the following principles:

Every person has talents, skills, and gifts important to a community. Each time individuals use these abilities, the community in which they live is strengthened and these people feel a sense of empowerment. Strong communities are places where the capacities of local individuals are identified, valued, and used. The development of the community is built upon the talents and resources of its members. (Beaulieu, 2002, p. 5)

Asset mapping also requires an assessment of a community's physical spaces (e.g., gardens, parks, forests, and bike paths; Dorfman, 1998; Rural Health Hub, 2019a). Furthermore, asset mapping shows the interconnection of assets in order to network and establish interconnections among community assets to support the needs of the community (Dorfman, 1998, Rural Health Hub, 2019a).

There are several approaches to developing a community asset map; however, the Asset Mapping Model is a straightforward framework for creating one (Dorfman, 1998; Beaulieu, 2002). The Asset Mapping Model is a five-step process that has been applied to rural communities for economic growth although, theoretically, this same approach may be applied more broadly (Dorfman, 1998; Beaulieu, 2002). The first step involves mapping the assets of the community by completing an inventory of the skills and assets of local residents, emerging leaders of the community, local institutions, and existing community leaders who are committed to building the wellbeing of the community and its residents (Beaulieu, 2002). Next, the model builds relationships and broadens local leadership by including strategies for the long-term success of the community.

Then, skills and resources are mobilized by building upon what already exists within a community in addition to developing the resources and services that are needed (Beaulieu, 2002). The fourth step involves convening the community to develop a vision for a sustainable future; this can be achieved by establishing a dialogue with community residents about what they wish to see for their community in the next 5 to 10 years and beyond (Beaulieu, 2002). This team approach to community building helps to support long term initiatives and ensures the wellbeing of residents in rural communities. The final step is utilizing resources outside of the community by establishing partnerships and making use of them to support community priorities (Beaulieu, 2002). These steps can assist in strengthening the health and wellbeing of individuals, families, and the overall community (Dorfman, 1998; Beaulieu, 2002).

NON-TRADITIONAL MENTAL HEALTH SERVICE DELIVERY AND OPTIONS

Home-Based Counseling

Rural communities may benefit from services delivered in non-traditional formats, including home-based counseling and technology-based counseling (Freidman, 2012; Polaha et al., 2015). Home-based counseling is grounded in an ecological approach that considers the individual and family in the context of their system. It is also beneficial in monitoring how the family system operates (Freidman, 2012). Home-based counseling services may be particularly useful for rural communities due to barriers to mental health treatment such as a lack of transportation (Friedman, 2012). In addition, home-based counseling may be

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culturally congruent for rural families who value connectedness and sense of community as this allows professionals to develop deeper relationships with them (Freidman, 2012).

Telehealth

Structural barriers exist for communities living in rural poverty, including limited transportation, a lack of mental health specialists, the cost of services, and poor access to healthcare (Orlowski et al., 2016; Polaha et al., 2015). Technology-supported mental health or telehealth provides rural communities with access to services that they might otherwise not receive and may mitigate the health disparities faced by families living in rural poverty (American Telemedicine Association [ATA], 2017; Gloff, LeNoue, Novins, & Myers, 2015; Orlowski et al., 2016; Polaha et al., 2015). Telehealth refers to "using internet and communication technologies (ICTs), such as videoconferencing, chat, and text messaging to provide health information and treatments in real time" (SAMSHA, 2016, p. 1). In addition, telehealth includes sending information and delivering services asynchronously through secure email, webinars, and video-recording (SAMSHA, 2016).

Telehealth programs increase access to mental health care in regions with limited resources, provide treatment, and improve adherence to medication regimens (ATA, 2017; Rural Health Hub, 2019b; SAMSHA, 2016). Technology-supported health care functions within four primary applications: (1) information provision, (2) screening, (3) assessment, and (4) monitoring (Orlowski et al., 2016). Additionally, telehealth is a vehicle for providing mental and behavioral health services through evaluation, diagnosis, case consultation, treatment, medication management, continuity of care, and education (ATA, 2017; Rural Health Hub, 2019b). The use of technology has been shown to increase rates of disclosure to mental health professionals by rural communities; however, barriers for engaging in technology-based services are important to consider (Orlowski et al., 2016).

Barriers for telehealth in rural communities include internet infrastructure, limited access to smartphones, credentialing and licensing, interoperability, lack of insurance coverage for telehealth services and reimbursement, technological challenges (e.g., transmission interruptions and connectivity), confidentiality and privacy concerns, and a lack of trust in healthcare and technology (Rural Health Information Hub, 2019a; SAMSHA, 2016). While technology-based mental health may increase access, significant barriers to wide implementation exist and must be addressed (Rural Health Information Hub, 2019a). Mental health professionals should be prepared to engage in advocacy efforts to increase access for telehealth services for rural and impoverished communities.

ONGOING PROFESSIONAL DEVELOPMENT

All behavioral health service providers working in rural poverty should seek opportunities for professional development. Furthermore, professionals working with vulnerable populations must be prepared to address systems of discrimination, oppression, and marginalization for individuals and families living in rural poverty (Crumb et al., 2019; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). The ACA *Code of Ethics* and the *Multicultural and Social Justice Competencies* (MSJCCs) call for mental health professionals to examine their worldviews and those of their clients, be knowledgeable and aware of multicultural issues, and employ culturally appropriate counseling and advocacy interventions (ACA, 2014; Ratts et al., 2016).

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Addressing Personal Biases and Stereotypes

Mental health professionals must be aware of their own biases, assumptions, and stereotypes in relation to rural poverty. Mental health professionals should engage in self-reflection as it relates to their unique beliefs and assumptions about poverty and rurality as this is congruent with multicultural and social justice praxis (Ratts et al., 2016). It is recommended that mental health professionals seek opportunities to engage with communities in which they work in order to gain a deeper understanding of the culture. Immersion experiences are vital for professionals to advocate and support rural communities with consideration of distinctive cultural values.

Integrating Social Justice Advocacy

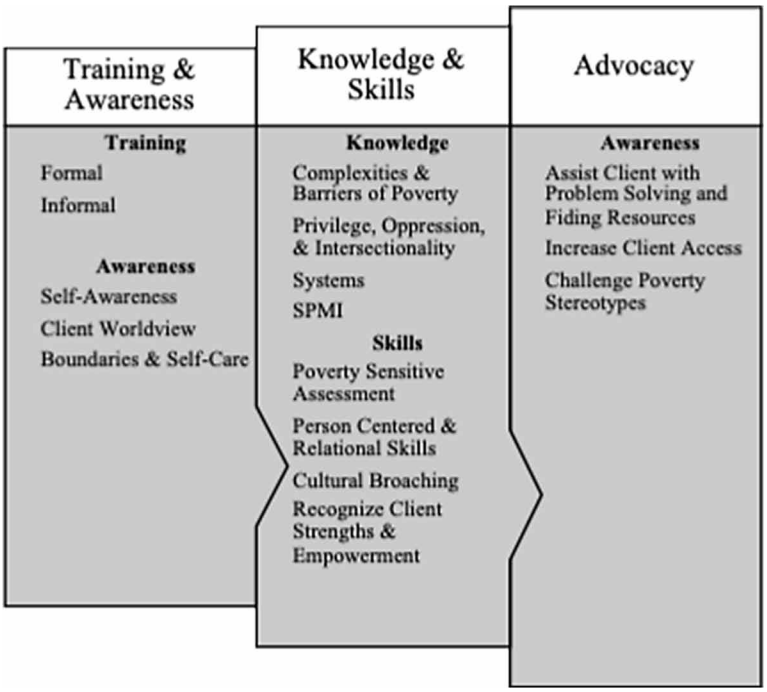
Mental health professionals working with children and families living in rural poverty must demonstrate multicultural competence in order to provide both ethical and culturally responsive counseling to this population. The MSJCCs (Ratts et al., 2016) provides a framework for mental health professionals to examine their biases, skills, and their privileged and marginalized identities. The MSJCCs can also assist professionals in acknowledging the intersecting identities of clients as they relate to power, privilege, and oppression as children and families living in rural poverty (Ratts et al., 2016).

Mental health professionals must prepare to intervene with and on behalf of clients on multiple levels of advocacy, including intrapersonal, interpersonal, institutional, community, public policy, and global levels (Ratts et al., 2016). Advocacy efforts should occur in systems such as housing, school systems, social services, and the criminal justice system (Crumb et al., 2019). At the local and state level, counselors should advocate for policies and programming to alleviate resource hardship and increase access to community amenities for rural communities (Centers for Disease Control and Prevention, [CDC], 2019). Additional efforts on the meso level include collaboration with school systems and primary care settings to deliver mental and behavioral healthcare (CDC, 2019). Increasing parental and caregiver support programs, and screening families for mental health conditions and coordination of resources is essential in promoting the health and wellbeing of impoverished rural communities (CDC, 2019). Macro-level advocacy efforts include writing to national policymakers regarding funding (e.g., Medicaid) and policies that benefit residents living in rural poverty (Crumb et al., 2019). Individual- and systems-level advocacy efforts are critical in promoting equity and systemic changes that directly influence the wellness of this marginalized group. Therefore, mental health professionals must practice from a social justice framework in order to provide effective and ethical services to families in rural poverty.

Counseling scholars have developed specific competencies that help practitioners and researchers develop culturally responsive, advocacy-oriented counseling practices when working with economically disadvantaged populations (See Figure 1 for Poverty Competencies). These poverty competencies (Clark et al., in press) help to enhance the training, awareness, knowledge, skills, and advocacy capability of researchers and practitioners. Respecting clients' worldviews, understanding the complexities of poverty, and recognizing the intersectionality of clients' identities (e.g., people of color or individuals who identify as lesbian, gay, bisexual, or transgender and living in rural poverty) allow them to demonstrate to their awareness of the systemic issues that contribute to poverty (Clark et al., in press).

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Figure 1. Poverty competencies



Specialized Training for Rural Mental Health Providers

Graduate courses specifically focused on rural populations could assist counselors in training (CITs) in elevating their understanding of culture and counseling practice in rural settings (Crumb et al., 2019; Rollins, 2010). CITS must have an understanding of poverty and its barriers for individuals and families. The importance of an understanding of the intersections of poverty and rurality cannot be overstated as it is critical to providing culturally responsive counseling (Ratts et al., 2016). CITs must also have an understanding of the nuances of boundaries between counselor and clients within a rural community and how they may ethically navigate those experiences (Breen & Drew, 2012).

Strategies for enhancing CITs' learning about rural communities can include specific coursework, group work, individual assignments, role plays, and field experiences focused on impoverished rural populations. Counselor educators should discuss the specific needs, barriers, and strengths of this population and have focused conversations about rural life and implications for professional praxis, including coverage of topics related to intersectionality, power, privilege, and social class (Breen & Drew, 2012). CITs need to have a rich understanding of rural culture. CITs must explore, understand, and appreciate rural cultural values in order to provide ethical and quality services to rural families (ACA, 2014; Breen & Drew, 2012).

Counselor educators could require CITs to complete their professional field experiences (e.g., practicum or internship) in rural communities as an immersion experience. Counselor educators could also require CITs to interview a counselor practicing in a rural community to gain a deeper understanding of the roles, culture, and implications of counseling within a rural context (Breen & Drew, 2012). Most counseling programs are focused on urban populations and exclude rural areas from classroom conver-

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sations; this is preventing CITs from gaining a broad understanding of counseling in various settings, cultures, and values (Breen & Drew, 2012; Rollins, 2010).

In addition, CITs should engage in reflective experiences that require them to examine their biases and assumptions related to social class and rurality. One way to achieve this is by asking CITs to engage in self-study in order to better understand their worldview and enhance their skills when counseling communities in rural poverty; this is a component of a multicultural and social justice framework (Ratts et al., 2016; Rollins, 2010). Self-study questions may include: "In what ways does the rural setting help your counseling practice?", "In what ways does it challenge your practice?", and "How does it change your concept of the role of a counselor?" (Rollins, 2010, n.p.). Lastly, supplemental materials such as readings, trainings, and audiovisual materials related to rurality, social class, and family may assist CITs in understanding the lived experiences of impoverished rural communities.

Professional Consultation and Supervision

Due to the limited resources and remoteness of impoverished rural areas, professional support is vital for mitigating frustrations related to consistently seeing poor, rural clients navigate difficult life circumstances. It is recommended that rural mental health professionals seek both informal and formal professional support such as consultations and ongoing supervision with other mental health professionals to help examine prejudicial beliefs, prevent the development of biases, and explore other areas of vulnerability and skills deficiencies (Crumb et al., 2019). However, it is important to note that professionals may face various challenges when seeking professional support. Foremost, supervision can be time consuming and costly (Breen & Drew, 2012). In addition, acquiring supervision in rural areas may require professionals to miss a day of work to seek supervision (Breen & Drew, 2012). Mental health professionals working in a rural community can consider alternative methods for supervision. For example, distance or online supervision may be a valuable tool for counselors, enabling them to receive supervision without sacrificing an entire day of work (Breen & Drew, 2012; Rollins, 2010). Mental health professionals and supervisors can also consider conducting conference calls for supervision when practicing in impoverished rural areas. Finally, rural service providers may connect with other professionals via listservs, face-to-face meetings, or the use of other technologies. This would help facilitate support for counselors working with impoverished rural communities in providing best practices for clients (Breen & Drew, 2012).

FUTURE RESEARCH DIRECTIONS

There are emerging opportunities for addressing the mental healthcare needs of highly underserved rural populations, despite the noted disparities. The content of this chapter presents various possibilities for future research. First, there is an ongoing need to increase the utilization of mental health services in impoverished rural communities. One strategy that has received attention is the use of telemental health services. Researchers can further explore how the use of technology can help children and families living in impoverished rural communities communicate with mental health providers and allow providers to integrate traditional office-based interventions online. Second, fostering the mental wellness of children and families living in impoverished rural communities require collaborative approaches (Williams et al., 2017; Reardon & Leonard, 2018). Researchers across disciplines (e.g., counseling, teacher education, educational leadership) can use multiple designs to explore the effectiveness of whole-school, whole-

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child approaches or examine if family-community-school-university partnerships can increase social capital and resources in these communities and contribute the resilience of children and families living in rural poverty. Researchers can frame these studies using strengths-based ideology. Furthermore, there is a need for policy analysis at the macro level to create interventions that target inequities in education, healthcare, housing, and rural community development.

Finally, there is a continued need to explore the efficacy of training received by mental health providers, teachers, and other professionals who work in impoverished rural communities as the recognition of social class as a critical component of multiculturalism is developing slowly. Thus, studies are needed to evaluate whether university educators are comfortable and competent in teaching topics related to poverty, rurality, and classism. Researchers could use surveys and focus groups to investigate if university educators recognize social class and rurality as important components of cultural identity and how often topics related to economic disadvantage are reflected in the curriculum.

CONCLUSION

Poverty and poverty experiences are complex and have a distinct impact on a variety of diverse groups, including women, children, families, people of color, and LGBTQ persons (Bishaw & Benson, 2018; PSU, 2019; UNESCO, 2019). Poverty is more prevalent in and complicated by rurality (USDA Economic Research Service, 2019). Persons who experience poverty are at risk of a variety of health (Kaminski et al., 2013) and mental health issues (Weissman et al., 2015) that can impact wellbeing; these health and mental health issues are complicated and often worsened by the obstacles individuals may face in engaging in work and educational experiences (WHO, 2010). In addition to these increased mental health risks, persons experiencing rural poverty are less likely to have access to services, either because of a lack of providers or due to stigma (Crowe et al., 2016; USDA Economic Research Service, 2019).

Mental health professionals should stay abreast to the current issues, needs, and dynamics of impoverished rural families and communities (Ratts et al., 2016). For many providers, this will require adjustment of service delivery to include community connections, advocacy, and a focus on strengths-based approaches (Clark et al., in press; Dorfman, 1998; Ratts et al., 2015; Rollins, 2010; Rural Health Hub, 2019c). These community partnerships may include integrated care models that involve working with medical professionals and case managers, school-based mental health services, and faith-based organizations (Crumb et al., 2019; Avent, Cashwell, & Brown, 2015). Beyond these partnerships, providers can also consider ways in which they can modify their service delivery methods to serve rural families in poverty, including home-based services (Freidman, 2012; Polaha et al., 2015) and telemental health (American Telemedicine Association [ATA], 2017; Gloff, LeNoue, Novins, & Myers, 2015; Orlowski et al., 2016; Polaha et al., 2015). In addition to these logistical adjustments, providers must address their own capabilities to work with rural families in poverty, including their own multicultural and social justice competence (Ratts et al., 2015), and utilize strengths-based interventions like asset mapping to focus on client strengths and abilities, not deficits (Dorfman, 1998).

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KEY TERMS AND DEFINITIONS

Integrated Healthcare: The coordination of behavioral health services with primary care settings in order to attend to the overall healthcare needs of those seeking services.

Mental Health: A measure of an individual's overall mental status, psychological health, and wellness.

Mental Health Literacy: The ability to accurately identify mental illnesses, attributions of mental disorders, and the knowledge and beliefs about risk factors related to mental health disorders.

Resiliency: The capacity to withstand significant challenges that threaten stability, viability, or personal development.

Social Class: An economically and socially stratified group who share similar norms, values, and cultural experiences.

Social Justice: Awareness and actions related to changing social institutions, and political and economic systems that perpetuate unfair practices in terms of accessibility, resource distribution, and human rights in an effort to enhance the academic, career, and personal/social development of individuals and groups.

Strength-Based Ideology: A perspective that allows one to explore and identify people's strengths and integrate these strengths to build resiliency, competencies, and resources.

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Chapter 58
Advocating for the Mental Health Needs of Children Living in Rural Poverty

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ABSTRACT

A person's mental health involves their social, psychological, and emotional wellness, all of which are important to their development. Lack of resources and access to effective mental health services can have a negative impact on the mental health of children residing in poverty-stricken rural communities. In advocating for this population, the authors have highlighted five factors that work as barriers in the mental health of children living in rural poverty. These factors were identified as early development, healthcare accessibility, parental/caretaker's educational level, educational system, and mental health stigma and stress. Furthermore, the authors presented a multi-layered approach for addressing these barriers. The components of the multi-layered approach include school-based resources, community-based resources, medical-based resources, and government-based resources. A case illustration is used to demonstrate the practical application of one aspect of the multi-layered approach – the school-based resources. Lastly, the authors stated that more research is needed for this population in regard to the effects of rural poverty on the mental health of children.

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INTRODUCTION

A snapshot of a mental health update across the United States found that one in five Americans (46.6 million) have a current mental illness. It has been reported that mental illness is not only the main cause of disability in youth but has also resulted in more deaths than any other health condition (Sawyer et. al, 2012 & World Health Organization [WHO], 2014). Reports like these highlight the importance of addressing mental health issues especially in younger populations (Petruzzelli, 2018). Mental health involves an individual's social, psychological, and emotional well-being (MentalHealth.gov, n.d.). In 2018, approximately 38.1 million Americans lived in poverty (Semega, Kollar, Creamer, & Mohanty, 2019) with people under the age of 18 representing 31.1% of these individuals. One out of every five children living in a rural area are considered to be living below the poverty line (Mammen, Dolan, & Seiling, 2015). Those who live in poverty face several stressors that impact their quality of life, one being access to mental health care (Fifield & Oliver, 2016; Hill, Cantrell, Edwards, & Dalton, 2016). The mental health concerns of families and individuals living in rural and poor communities are often overlooked and under-researched (Tickamyer, Sherman, & Warlick, 2017). Not only are their mental health concerns overlooked, but individuals living in rural communities are less likely to seek help for psychological distress than their urban counterparts (Cheesmond, Davies, & Inder, 2019).

Rural poverty can negatively affect the mental health of children. It is the opinion of the authors of this chapter that leaders and advocates of this population need to understand the mental health issues affecting these children. Consequently, the authors of this chapter will discuss the various barriers that affects the mental health of children and families living in rural poverty and present a multi-layered approach that will provide leaders and advocates with means in which they can address these barriers. The specific barriers that will be discussed are early development, healthcare, parental/caretaker's education, the education system, and mental health stigma and stress.

BACKGROUND

The United States government defines poverty as a state of living below the federal poverty line or earning less than $24,000 a year for a family of four (Kena et al., 2015). In 2013, approximately 21% of school-age children were living in households considered to be in poverty (Kena et al., 2015). A child in poverty can be negatively affected by a variety of environmental and situational factors ranging from lack of proper nutrition, differing parental level of education, stress, and lack of care, both physically and mentally (Conger, Conger, & Martin, 2010). These factors affect a child's ability to learn, regulate their emotions, and fight against hopelessness (Evans, 2016). A deficiency in these skills negatively influences the child's mental health. Mental health skills from early childhood and adolescence are vital to a person's success later in life.

According to the American Psychiatric Association (2019), experiencing healthy relationships, adapting in the face of change and adversity, and engaging in productive activities all allude to mental health. Mental illness can also occur when one experiences problems and/or dysfunction in family, social, or work relationships (American Psychiatric Association, 2019). Mental illness is a treatable medical condition. Unfortunately, Americans residing in rural environments face higher rates of mental illness, depression, and suicide compared to those residing in urban areas (American Psychiatric Association, 2019). Despite discrepancies such as these, rural residents are less likely to receive or seek mental health services than

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urban residents (Carpenter-Song & Snell-Rood, 2017). Furthermore, rural poverty can be seen to have a more significant effect on mental health compared to urban poverty due to the lack of care, proper mental health education, and counseling services (Valluri, Mammen, & Lass, 2015). As stated earlier in the text, one out of five children residing in rural areas, live below the poverty line (Mammen et al., 2015). Poverty not only affects younger children, but it continues to affect these children as they mature into adulthood. Poverty is often seen as a never-ending cycle of low income, inadequate education, and lack of resources (Sigelman & Rider, 2015). Comeau and Boyle (2018) found an association between exposure to chronic poverty in children's early years and lower levels of mental health. This association was only found to increase as the child aged (Comeau & Boyle, 2018). Disorders such as learning problems, attention-deficit/hyperactivity disorder (ADHD) and anxiety often start in early childhood and can affect a person's well-being and life-long health (Centers for Disease Control and Prevention, 2019). According to the Centers for Disease Control and Prevention or CDC (2019), about one in seven American children between the ages of two and eight have been reported by a parent to have a mental disorder. Research has demonstrated that children with mental disorders and their families experience financial and personal challenges more often than those without mental health disorders (Centers for Disease Control and Prevention, 2019). It was further stated that the type of community, rural versus urban, may increase these challenges. Consequently, there has been a call from some researchers to examine how social inequality in rural America has affected the experiences of mental illnesses in rural communities (Carpenter-Song & Snell-Rood, 2017).

MAIN FOCUS OF THE CHAPTER

In response to the call of addressing the many influences that affect the mental health needs of children living in rural poverty, the authors of this chapter have proposed a multi-layered approach. The integration of family, community, and school-based resources is the key to providing mental health care services to children regardless of socio-economic status and can be especially effective for children living in rural poverty (Bullock, Zolkoski, & Estes, 2015). Consequently, the authors of this chapter have posited that advocacy has to be delivered in a multi-layered approach. This multi-layered approach includes school-based resources, community-based resources, medical-based resources, and government-based resources. However, before this approach is explored, it is important for leaders and advocates to have a comprehensive understanding of some of the influences that impact the mental health of children living in rural poverty. Following is an examination of the following influences: early development, healthcare accessibility, parental/caretaker's education, the education system, and mental health stigma and stress.

Influences on the Mental Health of Children Living in Rural Poverty

Early Development

Mental disorders and intellectual disabilities are significant public health concerns in America (Linn, Chuaqui, Wilson, & Arredondo, 2019). Two circumstances that threaten the emotional and social development of young children is a lack of resources and poor supplemental care settings (Fitzgerald, Weatherston, & Mann, 2011). Children are constantly learning and developing through their interactions and experiences with their environment and the people around them. Learning begins early, as babies have

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been found to remember certain sounds such as their mother's voice before birth (Sigelman & Rider, 2015). How then does poverty affect early development? In a study analyzing the brain development of 77 children between five months and four years old, researchers observed that there were changes in the brain growth of the participants as they were exposed to poverty (Hanson et al., 2013). Researchers found differences in cortical gray matter in infants within their first beginning months of life. Hanson et al. (2013) measured the averages of total gray matter volumes in infants across a variety of socioeconomic backgrounds and races and found that children from poverty and low-income households had significantly lower average total gray matter volumes. These children were also found to have significantly lower average frontal and parietal gray matter volumes (Hanson et al., 2013). Gray matter is known to play a role in memory, language, reading and comprehension, and thought processing (Ruitenberg & Cassady, 2019). Researchers have further concluded that "Contemporary developmental sciences have linked interpersonal relationships to brain development…" (Fitzgerald et al., pg. 181, 2011). Brain development is negatively affected by poverty and poverty is often associated with disruptive behavioral problems (Hanson et al., 2013).

Healthcare Accessibility

It is important for parents to seek the help of a healthcare or mental health professional trained to diagnose and treat mental disorders if they suspect that their child is experiencing a mental disorder (Linn et al., 2019). Unfortunately, specialized professionals are scarce in rural areas, especially mental health professionals. Access to healthcare is especially important because in addition to the increase in the amount of stress in a child's life, there are also other medical disadvantages to living in rural poverty. Individuals living in rural poverty have been found to be more likely than their urban counterparts to die from five causes: cancer, heart disease, chronic lower respiratory disease, stroke, and accidental injuries (Weeks, 2018). Even though these causes of death are mostly preventable, people living in rural poverty do not have access to care compared to their counterparts living in urban poverty (Weeks, 2018). Many researchers have looked into the cause of this disparity. Weeks (2018) attributes this disparity to stress, hopelessness, bleak job markets, family dysfunction, poor social support, and addiction which causes individuals to turn to other forms of coping such as food, alcohol, tobacco, opiates, and suicide. As mentioned previously, the lack of medical professionals in rural areas plays a role. One-fifth of Americans live in rural areas while only one-tenth of physicians practice in rural areas (Weeks, 2018). Since 2010, 83 hospitals in rural areas have closed due to lack of funding and physicians (Weeks, 2018).

Along with lack of resources and financial concerns, transportation is a major issue. The public transportation infrastructure does not exist in most rural areas of the United States which further limits a person's ability to access mental health resources that are available in larger populated areas. Transportation is not only an individual issue but a community-wide issue because even when public modes of transportation do exist, they are often not flexible enough to meet individual needs (Pullman, VanHooser, Hoffman, & Heflinger, 2010; Blackstock, Chae, Mauk, & McDonald, 2018).

Healthcare Providers' Competency

Even if medical providers are located in rural areas, the providers might not be trained to help individuals suffering with mental illnesses. After interviewing medical providers in rural areas, Matsea, Ryke, and Weyers (2018) found that 43% of their population of medical professionals hadn't attended training on

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mental illnesses or mental health related issues in the past 12 months. Mental illness is just as prevalent in urban areas as it is in rural areas, but rural areas cannot provide residents with adequate services in order to treat those who are living with mental illnesses (Matsea et al., 2018). Researchers discussed a few reasons for the lack of adequate care in rural areas which include lack of comprehensive service providers, lack of accessibility to available services, and poor quality of service.

It is imperative for healthcare providers, especially mental healthcare providers, to seek out training and become competent in specific mental health issues impacting children living in rural poverty. This competence is important because parents, unless taught by professionals, are unaware that a concern exists in regards to their child's mental health. How can we expect parents who are not aware of mental health concerns to be aware of the resources available to support them (Handley, Lewin, Perkins, & Kelly, 2018). Poor mental health literacy hinders mental health service use and can be seen as a barrier to adequate care (Handley, Lewin, Perkins, & Kelly, 2018). Mental health literacy is seen as knowledge about mental disorders (Bullock et al., 2015; Chambers, Murphy, & Keeley, 2015).

Parental/Caretaker's Educational Level

Effects of Poverty

A child's health, both physical and emotional, is influenced by their parent's lifestyle choices and socioeconomic status (Sigelman & Rider, 2015). Due to the lack of employment opportunities, high cost of life's necessities, and legislative measures, many families living in rural poverty are stuck in a never-ending cycle of poverty (Annie E. Casey Foundation, 2004). This results in the child being directly impacted by the parent's income, motivation, and perception of higher education (Sigelman & Rider, 2015). Maslow's Hierarchy of Needs states that a person must meet certain innate physical needs such as breathing, food, water, shelter, clothing, and sleep before they can progress up the hierarchy to higher order needs such as self-actualization (Maslow, 1943). Some people believe that these needs are accessible and available to everyone, yet those living in poverty struggle with meeting these basic foundational survival needs daily. A child who is hungry and living on the streets cannot meet higher level needs, such as achievement and acceptance (Noltemeyer, Bush, Patton, & Bergen, 2012). This might explain why 30% of children living in poverty do not complete high school (Johnson, Lawrence, Perales, Baxter, & Zubrick, 2019; Kerns, Newschaffer, Berkowitz, & Lee, 2017).

Taylor (2005) found that children that qualified for free lunches scored lower than students who did not qualify for free lunches on educational assessments. This pattern starts in middle school and continues into high school. Even Scholastic Aptitude Test (SAT) scores have been found to correlate with a family's income (Taylor, 2005). Children living in poverty not only achieve lower test scores than their more affluent peers, but they also drop out of school at higher rates (Taylor, 2005). Nogurea and Wells (2011) explain how poverty affects children's performance at school through a limited access to academic and social support, the influence of negative conditions on a child's health and well-being, and lack of social structures leading to adverse conditions. This never-ending cycle is nearly impossible to overcome due to situations out of the individual's control such as recessions and lack of employee benefits (Mammen et al., 2015).

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Effects of Low Educational Level

Research from a study by Noble et al. (2015) found that for each additional year of education an individual had an increased amount of cortical surface area in the areas related to language, reading, and self-regulation. A groundbreaking study by Hart and Risley (2003) found 86% to 98% of the words used by children by the age of three were from their parent's vocabulary. Due to this finding, researchers were able to identify a difference in the number of words a child could speak that correlated to socio-economic status. Children from lower socio-economic households were found to hear about 616 words per hour from their parents while the children from middle and upper socioeconomic levels heard anywhere from 1,251 to 2,153 words per hour (Hart & Risley, 2003). Not only was there a difference in the number of words heard, but a difference in the content of the words was also identified. Children from higher-income families tended to hear more words of praise and admiration compared to children from lower-income families who tended to receive more negative reinforcement from their parents (Hart & Risley, 2003).

Educational System

School Mental Health

It has already been established that resources in poverty-stricken rural regions are scarce which translates to scarce resources in those local schools (O'Malley, Wendt, & Pate, 2018). These limited resources are not sufficient to address the care of students who are struggling with poor mental health. Additional constraints faced by rural schools are the lack of trained community and school-based mental health personnel. There is a gap between the increasing mental health needs of youth and the resources available to them at school (O'Mallley et. al., 2018). As a result of these limited resources, education agencies need to efficiently allocate resources by utilizing innovative public health models. A study focused on the school principals' perspectives identified that mental health was one of the greatest needs among teachers, school staff, and students (Iachini, Pitner, Morgan, & Rhodes, 2016). This finding is similar to a growing view of educational priorities emphasizing that school improvement models should be expanded to include mental health support. Principals have found that these models improve student learning (Iachini et. al., 2016). School mental health is an increasing priority across the United States for policy-makers and principals have highlighted that it is crucial to address the mental health needs in schools (Frabutt & Speach, 2012; & Iachini et. al., 2016).

Achievement Gaps

Another issue experienced by students from low-income families is what is known as the achievement gap. The achievement gap is the difference between the test scores of minority and/or low-income students compared to their more affluent peers (Von Stumm, 2017). Achievement gaps are present from preschool all the way through high school and into college (Kena et al., 2015). Standardized tests such as college admissions tests provide researchers with data that outlines a gap in achievement across socioeconomic statuses (Von Stumm, 2017). Thirty percent of children living in poverty do not complete high school (Clotfelter, Ladd, & Vigdor, 2006) and those children are also more likely to have lower scores on tests compared to children from wealthier households (Clotfelter, Ladd, & Vigdor, 2006). According to Williams, Bryan, Morrison, and Scott (2017), the income-related achievement gap is the reason that children entering kindergarten who are from families living in a higher socioeconomic status score 60% higher than children from lower socioeconomic households on cognitive tests.

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In conclusion, school-based mental health programs are important because there is increasing interest and acknowledgement in the role that mental health plays in promoting positive early learning experiences which will help in closing the gaps between children in varying socioeconomic status households (O'Connor, O'Connor, Gray, & Goldfeld, 2018).

Mental Health Stigma and Stress

Stigma

A low level of mental health is an ongoing concern in rural areas and is only compounded by factors such as low rates of seeking help and utilizing professional care than urban areas (Caldwell, Jorm, & Dear, 2004; Hilton, Scheurer, Sheridan, Cleary, & Whiteford, 2010). Poor mental health literacy has been found to contribute to the lack of mental health service use in rural areas (Handley, Lewin, Perkins, & Kelly, 2018).

There is a stigma that is attached to seeking care for mental illnesses, especially in rural communities (Johansson et al., 2019). While mental health is a universally applicable concern, people living in rural communities have unique fears of stigma. Although mental illness stigma has been extensively researched, limited studies have investigated youth perspective and how they respond to it (Haug, 2019). Furthermore, fear of stigma as a belief consists of three separate components: trust, stigma, and attitude (Blackstock et al., 2018). The lack of trust for a mental health professional, who is often an "outsider" in rural communities, makes parents less likely to seek out or follow through seeking help for mental health. Attitude feeds into stigma. In rural communities, the pervasive attitude is that people should be stoic and self-reliant, neither of which bode well when someone needs mental health treatment (Blackstock et al., 2018). This type of attitude only serves to isolate and shame those who do need help, for instance, rural children. For youth and children experiencing a mental health issue, mental illness stigma is a serious concern for not only them but also their immediate family (Liegghio, 2016).

Stress

While stress is something everyone experiences, it is more common among low-income households. Studies measure the effect of poverty on a child's mental health and overall functioning with results confirming that poverty increases the amount of stress placed on a child (Evans, 2016). Evans (2016) found that children who grew up in poverty had a diminished ability to recall patterns compared to children who did not grow up in poverty. This finding is important since short-term memory affects other aspects related to basic cognitive skills and achievement, ultimately affecting educational success. Evans (2016) also measured the feeling of helplessness among these groups and found that adults who grew up in low-income homes were eight times more likely to give up on tasks than adults who did not grow up in poverty. This feeling of helplessness was present even with those adults who were able to escape the cycle of poverty (Evans 2016). Kim et al. (2013) found an association between childhood poverty and an adult's neural activity during attempts to regulate their emotions.

Stress has a significant impact on physical, mental, and emotional health (Kim et al., 2013). Stress affects a person's feelings and has also been found to affect certain areas of the brain; specifically, the amygdala and prefrontal cortex (Kim et al., 2013). The amygdala is responsible for perceiving and feeling the emotions of others, such as fear, sadness, and happiness (Sigelman & Rider, 2015). The prefrontal cortex makes up 10% of the brain's total volume; therefore, it is responsible for many tasks. Studies have

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found that the prefrontal cortex plays a critical role in executive functions, memory, language, visual search, and gaze control as well as cognition and decision making (Sigelman & Rider, 2015). Researchers have also identified certain disorders that are associated with damage to the prefrontal cortex such as depression, anxiety, schizophrenia, as well as ADHD, ASD, and conduct disorders (Siddique, Chatterjee, Kumar, Siddique, & Nishant, 2008).

The Family Stress Model, first introduced in 1994, predicts that economic hardships contribute to the deterioration of marital relationships and therefore an increase in the amount of stress in the household (Conger et al., 2010). Since its introduction, researchers have not only found that stress affects the marital relationship, but it also affects a child's development (Neppl, Senia, & Donnellan, 2016). Neppl, et. al. (2016) found this to be true through their study, where connections between marital stress, harsh parenting, and child externalizing behaviors were tested with the family stress model. Researchers found that economic pressure, emotional distress, and couple conflict were associated with harsh parenting and therefore, may contribute to externalizing problems for children as they age. Economic pressure was related to emotional distress, which was associated with higher levels of harsh parenting. In conclusion, stress affects parents and children, both directly and indirectly (Neppl, et. al., & Donnellan, 2016).

CONCLUSION

All children experience stressors and difficult times in their lives (Padmore, 2016). In this chapter, the authors focus on the mental health of children living in rural poverty. The barriers discussed in this chapter, based on a study of research literature, were early development, healthcare, parental/caretaker education, the education system, and mental health stigma and stress on barriers to mental. Understanding the influences presented in this chapter will inform leaders and advocates on the pressing need to address these issues. Detection, early intervention, and support for children and their parents are crucial in building resiliency in this population (Padmore, 2016) These problems reduce the chance of academic and social success and increase the risk of substance abuse and misuse, self-harm, and suicide (Padmore, 2016). Consequently, a multi-layered approach is detailed next with the goal of ensuring that the mental health needs of children living in rural poverty are addressed.

Multi-Layered Approach Addressing the Mental Health for Children Living in Rural Poverty

Research is on-going into how meta-systems across the United States can more effectively address mental health concerns of children and adolescents living in rural poverty (Kazak, Hoagwood, Weisz, Hood, Kratochwill, Vargas, & Banez, 2010). This research has pointed to a need for a systemic overhaul that encourages cross-organizational collaboration as seen in states like New York, Hawaii, Tennessee, and California (Kazak et al., 2010). Although systemic change is shown as necessary to have a long-standing impact, research also stated a multi-layered approach of integrating family, community, and school-based resources is the current key to providing mental health care services to children regardless of socio-economic status. Collaborative efforts among parents/caregivers, schools, primary care managers, and community programs are essential. Implementing all of these resources lessens or even eliminates the negative impact of barriers parents face when finding and helping their children through prevention and treatment of mental health issues. These barriers could be a lack of availability of resources, insur-

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ance limitations (financial cost), transportation challenges, lack of knowledge of resources, and fear of stigma (Searcey van Vulpen, Habegar, & Simmons, 2018). Previously in this chapter, early development, healthcare, parental/caretaker education, educational system, and mental health stigma and stress were addressed that impact the mental health of children living in rural poverty.

The authors of this chapter have posited that there are opportunities in a multi-layered approach for leaders and advocates to be effective in addressing rural poverty children's mental health. When informed on effective resources, individuals will be able to seek leadership and advocacy opportunities to address the influences that affect the mental health of children living in rural poverty. The following is a review of this multi-layered approach that includes school-based resources, community-based resources, medical-based resources, and government-based resources. A case illustration is used to demonstrate the practical application of the first element of the multi-layered approach - the school-based resources.

Case Illustration Overview

The following is a retrospective case analysis used for educational purposes. This case involves a 7th grader Caucasian male who resides in a low SES south-east region rural community. His school implements Positive Behavioral Interventions and Supports (PBIS) and Social Emotional Learning (SEL). He receives free and reduced lunch and was referred to the school counselor by his math teacher. The math teacher referred him as a result of poor academic performance and disruptive behavior in class. His teacher's school counseling referral reported that he would often disrupt class by engaging his classmates in conversation rather than do his work. The teacher also stated that she worries that he may have low self-esteem. He was very excited to see the school counselor and the attention given to him. The student appeared inappropriately dressed for the weather- wore a T-shirt and shorts in cold weather. He also had an odor. After the second session with the school counselor the student shared with the counselor that he found math "hard" and did not understand the work so he preferred to be sent to In-school suspension. In order to further understand the living conditions of the student the counselor rode his bus to see the area. The counselor discovered that he lived in a single-wide older trailer with compromised roof and shingles, no other houses were visible, and no heat and hot water. The student was referred to the social worker.

School-Based Resources

School-Based Mental Health Programs

To address the challenges faced by families living in rural poverty, SBMH programs, such as Positive Behavioral Interventions and Supports (PBIS) and Social Emotional Learning (SEL), help provide resources, increase knowledge of services, reduce or eliminate parent financial costs and transportation issues, and help reduce fear of stigma with parent and caregiver-centered psychoeducational training sessions (Bullock et al., 2015; Searcey van Vulpen et al., 2018). Schools are key resources because, even though the exact cut-off age varies by state, federal law mandates school attendance across the country (National Center for Educational Statistics, 2019). Infrastructure is already in place to transport students to schools which helps remove the transportation barrier; consequently, schools are able to directly impact a child's life through SBMH programs. The National Alliance on Mental Illness (2019) explained that evidence-based practices include "integrated expert opinions, observable scientific evidence, and client/patient experience" to gauge whether a program is successful (para. 2). Research has shown that SBMH

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programs such as PBIS and SEL are integral evidence-based practices in the fight against mental health issues in poverty stricken rural areas. In addition to PBIS and SEL, school-based mental health programs also provide psychoeducational opportunities to the community via school personnel. Following is a discussion of how SBMH can assist in addressing the mental health of children living in rural poverty.

Positive Behavioral Interventions and Supports

Funded by the U.S. Department of Education's Office of Special Education Programs (OSEP) and the Office of Elementary and Secondary Education (OESE), the Technical Assistance Center on PBIS provides systemic support to schools, districts, and states to build systems capacity for implementing a multi-tiered approach to social, emotional and behavior support (OSEP Technical Assistance Center Positive Behavioral Interventions & Supports, 2019). According to the Technical Assistance Center on PBIS (2019), integrating PBIS in the school setting incorporates behavior as a part of the curriculum. Each school develops three to five behavioral expectations with standards that are clearly stated, easily measurable, and consistent throughout all areas of the school (para 1). Time is built into the school's beginning of the year calendar to teach and set these behavioral standards (para 5). Part of this process includes a consistent discipline referral matrix. This matrix delineates exactly what types of deviations from the behavioral standards are handled at what level of administration; certain behavior deviations are handled in the classroom and certain behavior deviations are handled by the front office (para 6).

The core principles of PBIS are as follows:

1. We can effectively teach appropriate behavior to all children.
2. Intervene early.
3. Use of a multi-tier model of service delivery.
4. Use research-based, scientifically validated interventions to the extent available.
5. Monitor student progress to inform interventions.
6. Use data to make decisions.
7. Use assessment for three different purposes. (OSEP Technical Assistance Center Positive Behavioral Interventions & Supports, 2019)

PBIS uses a 3-tiered approach to intervention: Tier 1 is universal for ALL students, Tier 2 is targeted group support for SOME students, and Tier 3 is individual support for a FEW student (https://www.pbis.org/school/tier2supports, 2019). For more information regarding how PBIS is integrated into schools, visit www.pbis.org.

Application of Case Illustration

Based on established PBIS program guidelines, the middle school set the following PBIS expectations:

1. Responsible for our actions
2. Organized and ready to learn
3. Achieving at our highest level
4. Respectful towards ourselves, others, and property.

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These expectations were displayed throughout the school on posters in the hallways, classrooms, cafeteria, and all common areas. These expectations were introduced the first few days of school with examples of how to demonstrate these expectations. For example, a student demonstrates "Responsible for our actions" in the classroom by following directions the first time they are given. Teachers often referred back to these expectations. For minor deviations from these expectations, the following progressive discipline steps were used.

In the case of our student, the math teacher noticed poor academic performance and disruptive behavior during class. Instead of paying attention and completing his work, the student would talk to his peers and distract them. This student was clearly deviating from all four of the behavioral expectations but in a minor way. The math teacher began with Step 1 of the Progressive Discipline chart above, but the student kept up the disruptive behavior. Using Step 2, the math teacher sat down for a conference with the student. This is when the math teacher realized that the student needed more support than he could give. The school counselor's office was a well-established place to get more support resources. The math teacher referred the student to the school counselor's office which is a Tier 2 level support.

In the initial session with the school counselor, the student presented as excited to be in the office which the counselor identified as a need/want for attention. The counselor also observed that the student was inappropriately dressed for the season and cold. The student had an unkempt appearance and an unwashed odor. After discussing the reason, the student was referred to the counselor, the student admitted struggling to understand the work in the classroom. The student had hoped his behavior would result in In-School Suspension (ISS) and ultimately a way to escape from the situation. Instead of escaping to ISS and further falling behind in academics, the student was now able to get the support he needed. The school counselor helped the student admit that he needed math tutoring. Together with the math teacher, the counselor made arrangements for extra intervention time during the student's daily school schedule. In order to monitor progress and to follow up on other noted concerns, the school counselor met with the student the following week.

During the second session with the school counselor, the student said what a help the extra intervention time had been, and the counselor shared positive comments from the math teacher regarding classroom behavior improvement. Even though this intervention went well, the counselor still noticed the same issues from the previous session of inappropriate dress for the season and an unkempt appearance. By asking a few direct questions about the student's home life, the counselor learned that this student lived in a single-wide trailer on a dirt road without heat or hot water. This information, combined with the student's current appearance, warranted a referral to the school social worker. The school counselor knew that the school social worker could help make contact with the family and provide them with resources to improve their living conditions.

By following the PBIS program, the school administration was able to intervene in constructive ways to better serve this student before punitive discipline such as in school suspension was used. The root of the child's issue was discovered, and steps were taken to assist based on the PBIS steps.

Social Emotional Learning

The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines SEL as "the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions" (The Collaborative for Academic, Social, and Emotional Learning, 2019). CASEL uses 5 core

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competencies to teach children and adults: 1) self-awareness, 2) self-management, 3) social awareness, 4) relationship skills, and 5) responsible decision-making (The Collaborative for Academic, Social, and Emotional Learning, 2019). Research has proven that incorporating these skills into a child's daily life helps them develop skills that serve to fight against the conditions leading to poor mental health.

Organizations such as CASEL (casel.org) and the Substance Abuse and Mental Health Services Administration's (samhsa.org) National Registry of Evidence-Based Programs and Practices (NREPP) provide a variety of SEL curriculums that can be implemented in a school setting. For more information regarding these programs, visit the referenced websites.

Application of Case Illustration

The student in our illustrated case study attends a school that employs Collaborative for Academic, Social, and Emotional Learning (CASEL). Utilizing this approach in this case, the teacher along with the school counselor utilizes social emotional learning (SEL) with the goal being to ensure that this student develops integral life skills that go beyond academics. SEL can be applied in the classroom and school. In the classroom, utilizing the following activities, the teacher will provide the student with the ability to work toward academic goals; consequently, improving his self-esteem. In this case, the goal is to improve in math. Two strategies the teacher applied were 'daily check-ins' and 'work buddy'. Check-ins were applied since the student responds positively to personal individual attention. This will allow the teacher to make a personal connection with the student at the start of every class. In using a 'work buddy' will enable the student to utilize social skills when the teacher will place the student with an assigned partner to work on class assignments. The goal is to strengthen the student's math skills while learning how to appropriately socialize with others. Along with the school counselor, the teacher will work with both students to apply rules to having a productive working buddy. Some examples of the rules are: to focus only on the class assignment, listen to each other, ask the teacher questions when the assignments are not clear, and complement each other. The school counselor will ensure that the student understands that the school counselor's office is a safe place he can use as a refuge when he is frustrated or upset. The school counselor also works with the student to understand emotions and how to properly convey them. Furthermore, the school counselor will work with the student on improving his self-esteem.

School Personnel and SBMH

Psychoeducational opportunities are also presented to the community via school personnel. SBMH programs are implemented as a part of the learning environment for every student which not only builds resilience skills for the community but also helps to educate the community regarding overall mental health wellness models. This psychoeducation reduces the fear of stigma associated with mental health in general, as well as reduces the fear of seeking help from outside resources. With collaboration between community and school resources such as school counselors, licensed professional counselors and social workers, more extensive mental health treatment can be offered at the schools. The school faculty and staff spend countless hours with students each week which gives them the opportunity to identify certain mental health needs above and beyond basic SEL (Bullock et al., 2015). With minimal additional training, basic mental health screening can be used by school faculty and staff such as teachers and nurses.

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Application of Case Illustration

In our case, the student was referred to the counselor by his math teacher. If this teacher had not noticed that the child was having difficulties in class, he might not have received the care he needed. Unfortunately, counselors are not able to have individual time with students each day. There is not enough time for them to notice inconsistencies in children's behavior or assess for their needs, unless they are referred by either the teacher or a parent. Teachers are able to recognize if a student is in need due to a high rate of absenteeism, behavioral issues, and their academic record. Because the teacher referred the student in our case due to his poor academic performance and disruptive behavior, the counselor was able to look at the child holistically and determine if his needs were being met. It is imperative that teachers take the time to notice their students and are aware when a student is in need. If this teacher had not noticed and had instead dismissed the child in our case, they might not have received the help and support they needed from the counselor and social worker. The child in our case lacked the basic needs to live such as hot water, heat, and proper clothing for the weather. He was living in rural poverty and it wasn't until the counselor in our case drove by where he lived did she realize that his living situation lacked basic needs. Had the counselor not driven out, she would have not been able to empathize as much with the child, as he did not directly tell her about his living situation. The counselor was able to refer the student to a social worker in order to help him and his family gain access to basic necessities.

For rural areas, it is also important for SBMH programs to focus on healthy self-care, depression screening, and anti-bullying programs (Searcey van Vulpen et al., 2018). School counselors play an integral role in SBMH programs in their respective schools with the buy-in from parents/caregivers, administration and faculty. This means that counselors must find ways to empathize with the worldview of people living in rural poverty in their communities because it will help identify the needs of that population (Crumb, Haskins, & Brown, 2019). School counselors are also a source for parents, school, and community members by maintaining a mental health services resource lists and contacts in the community and by distributing this information through flyers and pamphlets to parents and caregivers (Searcey van Vulpen et al., 2018).

SBMH programs exist and have proven effective; however, it is important for leaders and advocates to ensure that rural schools are implementing these programs. Collaborating with rural schools will also ensure that the specific needs of communities are addressed. Programs should not forget to address cultural concerns in the lives of its families (Yohannan, Carlson, Shepherd, & Batsche-McKenzie, 2017). These multi-layered approaches have to be as diverse as the populations they serve (Hefflinger, Shaw, Higa-McMillan, Lunn, and Brannan, 2015).

Community-Based Resources

In a qualitative study eliciting views from rural patient and family members', participants did not identify community-level solutions that addressed mental health problems (Robinson et. al., 2012). Furthermore, they stated that mental health problems in the community were handled as a legal and law enforcement issue. Following are some community-based resources that are available in rural communities to help address the mental health of children and families living in poverty.

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Community Centers

The United States Department of Agriculture (USDA): Rural Development provide affordable funding opportunities to develop essential rural community facilities (United States Department of Agriculture, n.d.). The USDA defines essential community facility as a place that provides a crucial service to the local community in a town, townships, villages, and cities with no more than 20,000 residents. Health care facilities, child care centers, telemedicine, and food pantries and banks have been identified as essential community facilities. As has been demonstrated by the research literature presented in this chapter, a mental health facility for children and families residing in rural communities would qualify as an essential service. Community leaders and advocates are encouraged to take advantage of such a program as priorities are given to low-income communities (USDA, n.d.). Further information can be found at the USDA: Rural Development website.

Non-Profit Organizations

Organizations that offer rural children the opportunity to engage in social and physical activities are important. According to Sigelman and Rider (2015), the benefits associated with exercise go beyond physical fitness for physical activities enhances psychological functioning. Some organizations that are available in rural areas are:

- 4-H: 4-H provides youth to engage in civic, healthy living, and science programs that results in these young people building confidence and life skills like resiliency and leadership (4-H, n.d.). 4-H programs are available in every parish and county in the United States. Information on programs available in rural areas can be found at the local 4-H office or online at https://4-h.org/find/.
- Boy Scouts of America: An organization for boys and girls, kids are given fun hands-on achievement and learning opportunities that prepare them for today and for life (Boy Scouts of America, n.d.). Information on programs available in rural areas can be found at the local Scouts office or online at https://beascout.scouting.org/?utm_source=scouting&utm_medium=FSYA_welcome&utm_campaign=ongoing.
- Girl Scouts: This organization prepare every girl for a lifetime of leadership. Some activities experienced by the girls are night-time hiking, lobbying city council, or running her a cookie business (Girl Scouts, n.d.). Information on programs available in rural areas can be found at the local Girl Scouts office or online at https://www.girlscouts.org/en/about-girl-scouts/the-girl-scout-difference.html

Medical-Based Resources

Access

Affordability and Transportation

Rural poverty is often associated with a lack of access to health care and proper education (Mammen et al., 2015). This never-ending cycle of poverty is real and makes it difficult for those born into poverty to escape from it (Mammen et al., 2015). People living in rural poverty are at a disadvantage when needing to access medical services (Valluri et al., 2015). Individuals living in rural poverty are more likely

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to report a lack of medical services. Detrimentally, there is a lack of insurance for mothers (Valluri et al., 2015). Nearly one-quarter of individuals living in rural poverty under the age of 65 are uninsured (Annie F. Casey Foundation, 2004).

The Centers for Disease Control (2019) has recommended that some opportunities for mental and behavioral health care services to be available to rural children and parents can be through school systems. By integrating these services into systems that are already accessible – schools – children will be able to receive care. A detailed school based mental health system has been discussed earlier in this chapter. Utilizing options available via the internet has been discussed as another option for those living in rural areas to access mental health services (Carpenter-Song, & Snell-Rood, 2017). According to their study analyzing the he impact of rural social change on mental health these researchers have proposed the use of utilizing mental health-related information to this population via the widely available internet. They further discussed telepsychiatry as an option to mitigate the barriers in accessing mental health treatment options in rural areas. The American Psychological Association has defined telepsychiatry as providing health care through technology such as videoconferencing (American Psychological Association, n.d.). Video-based telpsychiatry not only helps to meet the mental health needs of patients, but also provides readily-accessible and affordable services.

Competency

In order to allow for culturally sensitive programs, it is imperative that the services of these multi-layered programs remain flexible and include local community programs and primary medical care providers (Yohann et al., 2017). Without having ever lived through the same experiences related to racism or suffering from poverty themselves, counselors cannot begin to provide effective help to the people they serve (Crumb et al., 2019). Consequently, primary medical and mental care providers need to be culturally competent to the unique mental health needs of children and families in rural communities.

Culturally competent mental and medical providers ensure that they address the specific needs of rural children living in poverty. These are included in the professional ethics and cultural competency guidelines for these professions. The ethics of the different medical and mental professions dictate that providers consider and respect the needs of clients, ensuring that social justice is applied. These cultural competence guidelines for the different professions encourage them to provide multicultural competent services (APA, n.d.). Some examples of different professions' cultural competency guidelines are:

- The American Psychological Association's Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. This version was adopted in August of 2017
- The American Counseling Association's Multicultural and Social Justice Counseling Competencies. This version was endorsed in July 2015.
- Association of American Medical Colleges' Cultural Competence Education. This version was published 2005.

According to the Centers for Disease Control (2019) another consideration for primary care clinicians in effectively assisting rural communities address mental health issues is by connecting families with early learning programs, parenting and caregiver support programs, and mental and behavioral health care (Centers for Disease Control, 2019). Further assistance can be provided by screening parents for mental health problems and then help them connect with the appropriate resources.

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Continuing Education

In a focus group of rural mental health patients and families, they stated that they believed that they received inadequate medical interventions and that primary care providers did not have the proficiency to effectively treat mental health issues (Robinson et. al., 2012). The American Psychological Association website provides resources for continuing education that focuses on rural mental health issues. Two such research and publications are:

- Journal on Rural Mental Health, this is a publication of APA and the National Association for Rural Mental Health, and
- RHIhub: Rural Health Information Hub, a national clearinghouse on rural health issues (American Psychological Association, n.d.).

Government-Based Resources

As has been previously stated in this chapter, there are multiple barriers that prevent those residing in poverty rural areas from accessing mental health services. It is important to be knowledgeable about resources available through federal, state and local government to assist in addressing these concerns. For instance, in recognizing the importance of improving access to health care services to rural communities, the United States Department of Agriculture (USDA) invested more than $1 billion to this initiative (U.S. Department of Agriculture, 2017). There are several policy-oriented research that provides crucial data on rural health (Sigounas, 2018). This information is essential in understanding the unique challenges faced by those residing in rural communities and how these areas can be impacted by government policies in areas such as population health, health insurance, and access to healthcare. The following are some governmental organizations that can provide mental health service assistance to children and families living rural poverty.

- Federal Government
- United States Department of Agriculture
- State Government
- Department of Education
    - Department of Family and Children Services
    - Public Health Department
- Local Government
- City Government
    - Law Enforcement

FUTURE RESEARCH DIRECTIONS

Those living in rural poverty are faced with stressors as a result of their environment (Fifield & Oliver, 2016; Hill et al., 2016). One such stressor is being unable to access adequate mental health care. This in turns impacts their quality of life. Despite these concerns, the extent of the mental health needs of those residing in poor rural communities have remained overlooked and under-researched (Tickamyer

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et al., 2017). More research is warranted on the needs of this population. Focusing on the mental health needs of children in rural poverty will enable leaders and advocates to be informed and foster economic and social justice.

CONCLUSION

Despite an increase in mental health literacy, mental illness is often still under recognized (Handley, Lewin, Perkins, & Kelly, 2018). This is especially applicable to those residing in rural poverty. This chapter presented an overview of rural poverty and its effects on the mental health of children. Five influences were discussed: early development, healthcare, parental/caretaker's educational level, educational system, and mental health stigma and stress. Furthermore, the authors introduced a multi-layered approach for addressing these barriers. The components of the multi-layered approach include school-based resources, community-based resources, medical-based resources, and government-based resources. A case illustration was used to demonstrate the practical application of school-based resources to aide in the improvement of mental health of rural poverty children. A call to action is for leaders and advocates to expand the scope of understanding regarding the mental health needs of this population by encouraging further research and applying some of the resources outlined in the multi-layered approach

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KEY TERMS AND DEFINITIONS

Mental Health: A person's emotional and psychological wellbeing.

Mental Health Competency: Mental and medical healthcare provider's understanding and recognition of the effect of a client's environment on their health.

Mental Health Literacy: The understanding of mental health wellbeing information.

Mental Health Stigma: The negative belief or attitude towards mental illness and someone suffering from mental illness.

Mental Illness: Medical conditions that affect behavior, thinking, or emotion.

Multi-Layered Approach: Utilizing several pathways to address a problem.

Positive Behavioral Interventions and Support: Strategies that are used to assist students who are displaying behaviors that are preventing them from learning.

School-Based Mental Health Programs: Initiatives used in schools that provide early intervention and prevention to improve the emotional and social development of students.

Social Emotional Learning: The means by which people manage and understand their emotions.

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Chapter 59
Syrian Youth, War, and Community Approach to Stigma Surrounding Psychological Intervention

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ABSTRACT

This chapter will discuss why countries that emerge from prolonged civil wars need to provide their citizens with adequate mental health services and make a reference to Syria as a case study. It will demonstrate an association between mental disorders and violence which threatens the stability, national security, and the aspired recovery of the country. The chapter will refer to young people as they are the future in process and the makers of the future change in Syria. However, rather than listing or discussing solutions, the chapter will take a community approach to stigma and discuss how a shift in the way the Syrian society views and approaches mental illness is necessary to alleviate stigma and its impact. The chapter will also show how minority groups among the Syrian youth are subject to an aggravated level of stigma. In doing so, the chapter will address various social concepts such as youth, masculinity, community, and society.

INTRODUCTION

Although a global phenomenon, stigma impacts societies on various levels and in different ways. Stigma surrounding mental illness and psychological interventions is discussed in this chapter. It will address why mental illness is stigmatised and how this may discourage individuals with mental illness to seek help and support. The chapter will discuss how this situation may amount to disorder and deviance in societies that were and are hit by wars and conflicts. This chapter will discuss why countries that emerge from prolonged civil wars need to provide their citizens with adequate mental health services and make a reference to Syria as a case-study. It will demonstrate an association between mental disorders and

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violence which threatens the stability, national security and the aspired recovery of the country. The chapter will refer to young people as they are the future in process and the makers of the future change in Syria. However, rather than listing or discussing solutions, the chapter will take a community approach to stigma and discuss how a shift in the way the Syrian society view and approach mental illness is necessary to alleviate stigma and its impact. It will also show how minority groups among the Syrian youth are subject to an aggravated level of stigma. In doing so, the chapter will address various social concepts such as youth, masculinity, community and society.

Stigma as a Global Issue

According to the World Health Organization (WHO), mental illness precedes any other health issue in the world. It estimates that 450 million people worldwide suffer from mental health conditions, whereby 60% do not receive any form of care. It also reports that 90% of people in developing countries are receiving no form of care. Those labelled as mentally ill are subject to more severe stigma than individuals with other forms of non-mental illnesses (Corrigan et al., 2000). With the concealable nature of mental illnesses, impacted individuals may decide to circumvent treatment and psychological intervention to avoid stigma surrounding it (Corrigan & Matthews, 2003). Hence stigma has been identified as one of the reasons that prevent people from receiving the necessary care and support they need. It manifests itself in social distancing, whereby people with mental issues feel isolated and labelled. Among many reasons, stigma originates from personal, social and family sources. It is further augmented by social factors such as lack of awareness, lack of education, lack of perception, and the nature and complications of the mental illness manifested in the individual.

Gaining increased awareness of the long-term impact of mental illness and the way it shapes the present and future of mentally ill individuals, many societies have taken robust measures to alleviate its impact. This is done by various means on both official and public levels. Many campaigns have taken to the media to address mental health, with the aim of breaking through the barriers that prevent people from seeking the help they need. This involved celebrities who shared their experiences and how about they sought help and support. This, arguably, might have contributed to individuals with past or present mental disorders, increasingly stepping forward and sharing their experience.

However, as it appears to be the case, raising awareness is not enough. Whether the response action commensurate with the seriousness of mental health and its impact on both global and international levels is disputed matter. While the capacity of national health systems to accommodate and provide services that deal with mental illness varies across countries and nations, stigma remains an issue that hinders a lot of people with mental illness to receive the support appropriate to their situation.

What is noteworthy here is that stigma is a common concept across the globe. One of the most cited definitions of stigma is that of Goffman who referred to it as ‘an attribute that is deeply discrediting’ (Goffman 1963: 13). Further definitions that developed over times indicate a lack of consensus among scholars about the definition of stigma. The World Health Organisation defines stigma as ‘a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society’ (WHO, 2001). It is composed of interpersonal or public stigma and intrapersonal or self-stigma. The role of stigma as a barrier to seek psychological support emerges when individuals endorse and internalise negative attitudes and opinions about mental illness and intervention means (Sewilam et al., 2014).

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Contrary to the common belief, stigma is identified as a more significant barrier in high-income countries than in low-income countries (WHO, 2005). Although it is a common factor observed across the globe, stigma is dependent on social and cultural contexts and hence may vary as a result of different cultural norms (Pescosolido et al., 2008) and its role in the help-seeking process can vary across cultural groups. For instance, unlike other illnesses, mental illness is still considered to be a sign of weakness, as well as a source of shame and disgrace in Middle Eastern countries (Sewilam et al., 2014).

With the ongoing conflicts in Syria, Iraq, Afghanistan and Yemen, the need for mental health awareness interventions that are not hindered by stigma is even greater. The impact of mental illness resulting from war experience is unmeasurable and its impact may be sensed for decades if not treated and approached. As early as 1921, Oliver established a link in his thesis 'Emotional States and Illegal Acts' between the emotional and mental distress experienced during war and crime in the post-war society (Oliver, 1921). More recent research in this field also indicates an interlink between traumatic experiences and criminal and violent behaviour (Jakupcak et al., 2007) revealing that offenders present a higher prevalence of Post-Traumatic Stress Disorder (PTSD). It also suggests that that criminal and violent conduct could be both more widespread and more extensive among mentally ill individuals (Levy & Sidel, 2008), which is likely to be a significant challenge faced by many people scarred by wars and conflicts.

The accumulated evidence indicates that mental illness is one of the post-war features found in civilians and combatants. Violence, exploitation, displacement and deprivation are all unfortunate factors that fundamentally affect the well-being of the individual subject to them (Brick et al., 2017). For instance, 799 adult household members aged 15 and above were surveyed in Afghanistan in 2014. Symptoms of depression were found in 67.7% of respondents, symptoms of anxiety in 72.2%, and PTSD in 42% (Murthy and Lakshminarayana, 2006). Such exposure to the violence of the war does not only amount to social and mental dysfunction, (in addition to the depression and PTSD) among civilians (Ardino, 2012), but also among combatants (Orth & Wieland, 2006). These dysfunctions manifest themselves in both family and community contexts creating 'a link between experiences of violence as victims and later experiences of violence as a perpetrator' (Garbarino, 2002). Moreover, a considerable body of literature has documented the relationship between trauma and child abuse and subsequent aggressive and criminal acts. The abuse of children during the armed conflict, their poverty and witnessing of violence are the most common risk factors for causing future aggressive and antisocial behaviour (Finkelhor, 2008).

Having said that, the relationship between mental disorders and crime should be approached with caution. While not every person with mental illness is a project of a violent person, the importance of the traumatic event here is not whether it is a determining factor towards violence, but identifying it as a risk factor. On a larger scheme, the central point here is that mental illness in conflict countries could threaten the aspired post-conflict stability and hinders peacebuilding, recovery and reconstruction. Rather than taking steps to build a better future, people become caught in the cycle of violence. This becomes even more cause for concern if we consider the level of devastation which the health sector and its infrastructure has endured during the conflict.

Syria: Stigma and Youth

In January 2011, and following a series of events that has later become better known as the 'Arab Spring', the Syrian president Bashar al Assad dismissed the opinion saying that the wind of the Arab Spring will eventually reach Syria. Apparently, his prophecy proved wrong and the domino effect of the Arab Spring reached Syria two months later, resulting in the country becoming 'the worst man-made disaster since

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World War II' according to Zeid bin Ra'ad, the United Nations High Commissioner for Human Rights, as (Collins, 2017). What began as peaceful protests in the city of Dar'aa in response to the detention and torture of school children who wrote 'It is your turn, doctor'[1] on their school's wall (Sterling, 2015), gradually turned into armed clashes in September 2011 and escalated to an armed conflict (civil war) in July 2012 (UNHCR, 2012).

The destruction, devastation and atrocities in this war are unprecedented. In 2017, the United Nations Development Programme reported that 'many basic infrastructure systems including provision of water, electricity and sanitation, in addition to social infrastructure such as schools and healthcare centres, have been damaged or destroyed, eroding the living conditions of people in affected communities' (UNDP, 2017). Beside the basic infrastructure which has been severely damaged, the impact of the ongoing war will affect the Syrian community for generations to come. The war has seen the death of half a million people and has resulted in four million refugees and around seven million internally displaced people, resulting in wide scale human devastation. In addition, millions of children and young Syrians have been deprived of education, displaced from their domiciles and neighbourhoods and/or recruited as soldiers in the course of the conflict. Their extensive involvement in the war, whether as a participant, a witness or a victim, has resulted in war associated mental illnesses such as PTSD and exposed them to risks of dysfunctional behaviours and serious criminal conduct (Save the Children, 2017).

While dealing with mental illness in conflict societies, the society and its role, including all age categories, should be considered. However, this chapter attaches particular importance to young people since youth are the future in process and the hope for the aspired recovery and the reconstruction of Syria. The hope and resilience in the Syrian society in general, and among the youth in particular, for a better future for the country is evident. They have shown a high level or resilience (Underwood, 2018), which is a promising factor to invest in for the future of the country.

The important role of the youth in their societies has recently received an international acknowledgement. In a solid recognition of their vital role in the prevention and resolution of conflicts, the United Nations Security Council culminated that attention by adopting unanimously Resolution 2250 in 2015 concerning the role of the youth in maintaining the peace and security in their societies. The resolution has also recognised the role of the young people in contributing to 'lasting peace and economic prosperity if inclusive policies are in place' (UNSC, 2015, p. 2). The resolution also urges the Member States to 'facilitate an inclusive and enabling environment in which youth actors, including youth from different backgrounds, are recognised and provided with adequate support to implement violence prevention activities and support social cohesion' (UNSC, 2015, p. 2). It also highlighted the political, financial, technical and logistical needs of the youth in conflict and post-conflict societies by inviting the member states to provide the necessary assistance in that regard.

The role of the youth is evident in the development of conflict and post conflict countries. As such, the role of the youth in the future of Syria, its development, stability and security manifests itself in various way. The Syrian demography is predominantly young (Dawlati, 2016). The latest figures reported by the Central Bureau of Statistics in 2011 estimates that 34.9% of the Syrian population is between 15 and 34 years of age. It also reveals that 20.2% are between 15 and 24 years of age (CBS, 2011). This could also suggest that the youth will be a vital force to bring about the aspired change in Syria. Their presence in the early protests in 2011 (Haj Saleh, 2017) testifies to that end.

There is no clear definition in the Syrian society as to what constitute a 'young person'. The relationship between youth and age varies with different social factors and events. For instance, Syrians refer to those in their 20s as young. Yet, when someone passes away in their 40s they too are referred to as 'hav-

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ing died quite young'. In the absence of an official indicator as to what is meant by 'young' and 'youth' in Syria, this chapter will opt for the age range between 15 and 24. This is for various reasons. Social scientists often consider 24 to be the age of childhood transition to adulthood (Altschuler et al., 2009; Crone & Corbin, 2010). Having said that, the 'completion of developmental tasks', cultural, upbringing and environmental factors should be taken in consideration while deciding where the transition happens (Thomson, 2013). The United Nations Educational, Scientific and Cultural Organisation observed that definition of youth perhaps changes with circumstances, especially with the changes in demographic, financial, economic and socio-cultural settings (UNESCO, 2018). Moreover, including the Syrian youth between 15-24 years of age does not only mean that we have included 20.2% of the Syrian population (according to the 2011 figures of the CBS), but will also captured those who are recruited in the Syrian army as well as those who are dismissed from the service with all the struggles they encounter while they aim to integrate in the civil life again.

Millions of young Syrians were and are involved in the war, or exposed to its impact in one way or another and have subsequently been deprived of education, displaced from their homes and, or recruited as soldiers during the conflict (Dawlati, 2016). In 2015, the United Nations High Commissioner for Refugees (UNHCR) reported that the 'the most prevalent and most significant clinical problems among Syrians are emotional disorders, such as: depression, prolonged grief disorder, Post-Traumatic Stress Disorder and various forms of anxiety disorders' (UNHCR, 2015, p. 15). Once the war is over, those groups will not only pose a serious challenge to Syrian society, but also raises significant challenges to their life opportunities and well-being. It is still unclear how the Syrian government and society will confront this issue. It is often the case that countries that emerge from prolonged civil-wars place different priorities. Their immediate concern is establishing order and security while running vital services become secondary issue (O'Connor & Rausch, 2007).

The present level of mental health care in Syria does not correspond to its ancient past, whereby Damascus was the home to one of the first psychiatric hospitals in the world in 1270 AD, along with Baghdad in 705 AD and Cairo in 800 AD (Okasha et al., 2012). While current reports from humanitarian organisations suggest that the crippling effect of the conflict on the health sector across the country, mental health services were already inadequate prior to the war. In 2008, Syria's residential mental health services comprised two mental hospitals in Aleppo and Damascus, with the latter hosting an addiction treatment center (Assalman et al, 2008). In addition to these, community health centers could be found in major cities as well private clinics. However, the ratio of practitioners to the population is 1 to 100,000, which is drastically low. Very few of these practitioners have specialty in child and adolescent mental health. Shortly after the eruption of the conflict, Okasha et al. (2012) reported that Syria is among other conflict countries (such as Iraq, Libya, Somalia, Sudan, and Yemen), which have less than 0.5 psychiatrists for 100,000 population.

In March 2017, the World Health Organisation estimated that more than half of the Syrian population is in need of mental health support and psychological intervention. Later in August, Mr. Ramadan Mahfouri, the head of the mental health department in the Ministry of Health, estimated that the war in Syria resulted in 300,000 individuals in need of psychological treatment (Al-Saleh, 2017). However, in February 2018, Mr. Mahfouri increased the number of Syrians suffering from severe psychological disorders to one million. He attributed this rise to destruction caused by the conflict and suffered by the health sector in general, and mental health services in particular, which are unable to cope with increased numbers of service users and lack of practitioners who fled the country (Al-Saleh, 2018). Such arbitrary statements, coming from the highest authority concerning itself with the mental wellbeing of the Syrians,

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are deeply regrettable. This, if anything, shows the arbitrary attitude of the Syrian government toward the statistical and scientific approach to a serious issue such as the society mental health. It also shows the incredibility of the governmental data related to the mental health in Syria and the absence of present and an effective mental health policy.

Now some law provisions in Syria recognise mental illness among young people. For instance, dealing with the juvenile delinquents is entrusted with the Juvenile Delinquents Act 1974 (and its 2003 amendments). Article 5 invites the court to apply rehabilitative measures in the light of the social and psychological conditions of the juvenile. Should the juvenile commit their offence due to an identified mental disorder, they will be placed in an appropriate mental asylum (Article 16). The practice, however, seems quite different. In 2010, the United Nations Development Programme, in cooperation with the Syrian Government, assessed the juvenile justice system in Syria with a view to enhance the juvenile justice in Syria as well as the juvenile reform institutions in Syria (UNDP, 2010). The assessment noted the lack of familiarity within the court system in Syria on juvenile issues. It also found that there is 'a lack of judges specialised in dealing with juvenile crime in Syria', although Article 34 of the Juvenile Delinquents Act 1974 clearly states that the juvenile judges must be selected based on their experience in the juvenile affairs. The assessment then provides some examples which indicate shortcomings in the juvenile justice system. For example, the assessment revealed that 'juvenile offenders between the ages of 15-18 are transported to the courts and back to the holding prisons with adult prisoners, exposing them to mental and physical abuse from older and more seasoned criminals' (UNDP, 2010:4).

Should an effective mental health policy be in place, and should mental health services be available and function efficiently, it is questionable whether Syrians with mental illness shall resort to them for support. Syrians, like their fellow Middle Easterners, consider religion, traditional practices and cultural beliefs as important factors while discussing mental illness and well-being in general (Ahmad & Dardas 2015). This often leads to certain prejudicial beliefs about mental illness that are shared globally and is found across cultures, although to different degrees (UNHCR, 2015). As we have seen earlier in this chapter, mental disorders are one of the tragic outcomes of the war. Such disorders will greatly benefit from psychological interventions that seek healing and wellbeing for the concerned youth. However, some Syrian communities might be adamant in their refusal to accept psychological care treatment. To appreciate why this might be the case, it is important to examine the factors under which stigma is socially constructed. In other words, whether psychological interventions will work or not, depends on how the Syrian society, as well as young people, the potential subscribers to these interventions, understand the reality of mental illnesses (Orlikowski & Baroudi, 1991) and the impact of producing local solutions, interventions and means (Alexander et al., 2008).

In Syria, religion and social norms are fundamentally intertwined (UNHCR, 2015). In this sense, certain social dynamics contribute to shaping the views of Syrians of the person and their relationship with their society and the world around them. Religion, ethnicity, tradition and history are the chief forces. Not only on social level where concepts are formed and shaped, but these forces also contribute to the individual identity and the place the individual inhabits within their community. This needs to be beard in mind while we approach stigma surrounding mental health of young Syrians. Mental disorders are often viewed by Muslim communities as shameful (Aloud & Rathur, 2009) and a punishment from God (Abu-Ras et al., 2008). Dr. Zaher Sahloul, a Syrian doctor and the past president of the Syrian American Medical Association, noted during his relief work in Syria that mental illness remains a taboo in Syria (Sahloul, 2018). Similar to Dr Sahloul's findings, Germany has reported some difficulties in promoting psychological therapy among the new Syrian refugees on its soil due to stigmas surrounding

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the psychological interventions (Rubin, 2016). Religion, however, is not always the reason. Traditional beliefs in the curative powers of black magic and spells as well as their ability to provide healing to mentally ill people remain central belief among a wide sector of the Syrian society. Many Syrians, from all religious and ethnical backgrounds, resort to this practice rather than subscribing to or visiting a mental health service. Since mental illness is regarded as a shame, these traditional practices ensure secrecy and privacy whereby the case remain between the "service" provider and their patient.

The complexity of understanding the reality of mental illness exceeds that of the personal belief, reaching to other sectors such as media and other influential platforms. In December 2017, Mr. Humam Hout, the host of 'The Scenario', a Syrian talk show and satire television programme discussed the character of Hassan Nasrallah, the chief of Hezbollah, a Lebanese terrorist group, by referring to the character of the 'scoundrel boy'. He said:

It is said that each family has a sewer. This sewer is often the scoundrel boy. He is out and about in the streets all the time…That kid is creative in being harmful… He set the street rubbish bin on fire... He punctures the cars tyres. He hates his school and his family… This scoundrel is a target for every gang's master, drugs dealer or a pimp, for he has all the qualification of being a bastard. Crime runs in his blood. All he needs is someone to adopt him and turn him unto a real criminal. Today I will introduce you to one sample of these scoundrels… Hasan Nasrallah. (Hout, 2017)

The image of the scoundrel boy is not the creation of Mr. Hout's imagination. The 'It is said' at the beginning of the quote is in fact the stereotyped image made by the Syrian society of the young children with difficult childhood and upbringing. Mr. Hout has simply used it to make a political inference. Such an opinion, coming from supposedly a media person who devoted a big part of his life (and continues to do so) to promote social justice, freedom and institutional reform through theatre plays and recently his TV show, is deeply regrettable. It also draws various questions as to whether Syrians have the culture of tolerance, understanding and rehabilitation. A rehabilitative culture is where all the aspects of a given culture supports the efforts of rehabilitation (Mann et al., 2018). The resilience of the Syrian communities in the face of the tragic outcomes of the war is evident, as well as their hope for a better future. However, the belief of the Syrian society in its understanding of the seriousness of the issue beforehand, that is to say the mental wellbeing of young Syrians, will be vital for destigmatising psychological intervention.

On global level, media could play a significant role in forging a better understanding of mental illness. Rather, it continues to misrepresent and portray individuals with mental illness as dangerous to society and a source of violence and disorder (Clement et al., 2013). Hurtful representations of the person with mental illness, discrediting them and treating them as being different from others all are attributes of social stigma (Dardas & Simmons, 2015). Although the portrayal above has taken place on a media platform in Syria, it nevertheless coincides with a global phenomenon where adults stigmatise children with ADHS and depression more than adults suffering from similar mental illnesses (Pescosolido, 2007). Stigma's impact in Syria is even more significant among young vulnerable groups, such as the LGBTQ community, survivals of sexual abuse and young people with existing disabilities (Fraser, 2019). These community members face an elevated risk of stigma. Male and female victims of sexual abuse neither report these incidents nor seek treatment because of shame and their fear of how society will stigmatise them (HRW, 2015). An LGBTQ young individual in Syria faces two kinds of stigma. The first is imposed on their sexual orientation. Syrian society continues to foster a hostile environment against gay people in general, including youth based on cultural and religious grounds. Article 520 of the penal code of 1949

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prohibits 'carnal relations against the order of nature', and provides for up to three years imprisonment. Now should young people seek psychological support for emotional and mental distress resulting from such intense level of harassment and threat, they encounter the second stigma surrounding mental illness.

Community Approach to Stigma

Dealing with the mental health of Syrian youth and stigma surrounding it at an early stage will be vital for the future of the country, its security, order and development. However, this is not going to be an easy task for various reasons. The country has just started its long journey to recover from a fierce civil war that devastated it at every level and sector. The needs for innovative and culturally sensitive interventions are necessary to meet the need of post conflict mentally ill population. But before discussing plans and roadmaps, the Syrian society should probably question its approach to stigma as a concept since it is socially constructed.

An effective approach will have to consider a long list of societal factors. Among these are the socio-economic difference between urban and rural areas, strong belief in traditions, and the stark social gap between males and females. The Syrian conflict, the Syrian Centre for Policy Research reports, had 'caused huge differences between individuals and communities regarding shared values and visions of the future, at both local and national levels' (SCPR, 2017, p. 10). Therefore, we probably should adopt a short-term plan, and a longer one. The former should aim at reducing the impact of stigma and familiarise Syrian communities with the benefits of psychological intervention, while the latter should be a long-term campaign to eliminate stigma altogether from the Syrian society. This strategy will be about changing people's mentality towards psychological treatment and challenge certain cultural perceptions. However, before working on community level, it is important to distinguish between society and community.

The term 'community', according to the United Nations may refer to 'small neighbourhoods, areas within a city, or small villages or towns, or in some cases groups of citizens with particular concerns' (UNODC, 2010, p. 13). In his book 'Community and Association', Tonnies (1955) noted that association in the community is conceived as real and organic life, whereas the concept of society bases itself on imaginary and mechanical structure. Therefore, society members are separated despite all uniting factors while community members remain united despite all separating factor. He further highlighted that social co-existence in community is familiar and comfortable because people in community associate based on their free will, whereas the latter is rational in societies. Drawing from Tonnies, Willimot (1987) named three categories of communities. He argued that first there is territorial community (the group of people living in a particular area), second, those who have common factors that go beyond the limitation of geography and may be identified as the 'interest community', and finally the people who have a sense of a belonging to a place and fall under the 'attachment community'. However, Willmot is cautious not to limit our understanding of a community to one of these categories. He asserts that a community's experience may comprise of one, two or all of them. Similarly, Cohen invites us to understand a community 'by seeking to capture members' experience of it' and 'what does it appear to mean to its members' (Cohen, 1985, p. 20). Dismissing the structural forms to identify a community, he argues that the latter 'lies in the mind, in the meanings which people attach to them, not in their structural forms' (Cohen, 1985, p. 98). Mooney and Neal (2009) breaks down these meanings to subjects such as: language, food, dress, religion and faith-based custom (Mooney and Neal, 2009). These common themes are present in every Syrian city and village; a diverse country that remains as such even during the war (Atasi, 2015).

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Stacey (1969), on the other hand, adopts a cautious approach, in that the word community falls short from accommodating the complexity of social organization and practices. We could also question here how could community be the source of stigma, yet be the solution? Rose (1999) advocates for a community that becomes an 'antidote to social ills' (p. 175). He argues that communities are increasingly being 'transformed and programmed into an expert discourse and professional vocation' (p. 187). In the same vein, the significance and the vital role which community played in the life of the individual is put beautifully and succinctly by Bauman in that community is like a 'fireplace at which we warm ours hands on a frosty day' (2001, p. 1). Probably less poetic, but Mooney and Neal provides us with a similar description of what community is. To them, community is about social bonds which have an emotional dimension that goes beyond the word 'group' (Mooney & Neal, 2009); Community is 'connected groups of people who care about and for each other' (Mooney & Neal, 2009, p. 2). In fact, community could be the centre of norms and moral values (Aspin & Chapman, 2007). It could also be, 'both the source of problems and the means of solving them' whereby 'proper communities deliver solutions, whereas dysfunctional communities work to reinforce and reproduce failure' (Cochrane and Newman, 2009, p. 44).

Therefore, a shift in how Syrian communities (subsequently the society) approach mental illnesses is vital. They also need to take into consideration the close and intimate connection between young people and their communities. This relationship exceeds the sentimental link to dependency. In 2007, a research entitled 'Youth Exclusion in Syria' (Kabbani & Kamel, 2007) reported a significant reliance among the Syrian youth (between the age of 15 and 24) on family and community connections to secure employment, marriage and housing whereby 90% identified 'family, relatives and friends' as the source for job search. Placing the young people's interest as a priority will require the society to take a lead in creating an environment of development, opportunities and community. Cantillon et al. (2003) found that a sense of belonging to their community could compensate for the outcomes of young people growing in disadvantaged community.

A research conducted by 'International Alert' in 2016 revealed not only the significant role of the family in the decision process of youth joining armed groups, but also pulling them back to the community. The role model and religion were also noted in the research. Another study conducted by 'Dawlati' noted that young people's perception of what constitutes crime is affected by the existing stigma fused in their society and communities' views (Dawlati, 2016). This suggests a significant role that could be played by the communities in Syria to integrate psychological support and intervention for young people with mental illness, in their overall efforts to recover from the aftermath of the conflict. It also suggests the influence which communities may have over young people when challenging certain conceptions and understanding is appropriate. Challenging stigma probably start from both the school and the family simultaneously. Existing evidence suggests that schools could play an effective role in reducing stigma toward mental illness (Watson et al., 2004). Clerics and priest could use their position and platforms to promote mental health and wellbeing and encourage those who are mentally ill among their congregations to seek help. This could also be advocated and promoted by community leaders, actors and actresses, media and societal personalities. In doing so, they will also challenge certain conceptions such as 'boys don't cry'; an expression that has probably been heard by the vast majority of Syrian children and young boys. As the young man grows, the 'boys don't cry' is then transformed into 'man up'. It will be vital that young boys and children learn that vulnerability is not weakness, and to seek help and ask for it when they need it.

This approach will probably clash with the general conceptual understanding of masculinity in the Syrian culture. Syria is patriarchal social structure where men still consider themselves to be the fam-

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ily provider. Connell (1995) defined hegemonic masculinity as 'the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women (p. 77). Masculinity is Syria is related to everyday life, to the domestic and public life, to economics and history, social class, ethnicity, family relations, sexuality and culture. It is also related to symbolism. Daoud (2018) observed how the moustache represents to the ordinary Muslim man the maleness in its full sense. He also noted that 'a luxurious moustache was a boundless treasure, given that a single hair would suffice as surety for a loan or a promise' (p. 60). It is from these perspectives that masculinity in Syria needs to be approached and analyzed. This is important because traditional masculinity norms are determining factors in whether men with mental illness seek help or not (Yousaf et al., 2015). Existing research found that the endorsement of dominant masculinity corresponds to higher levels of self-stigma and less favourable attitudes toward seeking help (Vogel et al., 2011; Heath et al., 2017).

To increase seeking help opportunities, the World Health Organisation promotes community mental health services. It notes that they are more accessible to individuals living with severe mental disabilities and are more effective than mental hospitals (WHO, 2007). Thornicroft et al., (2011) identified Community Mental Health (CMH) as a 'population-based approach to promote mental health and prevent mental disorders'. They argue that such initiative will need to address the needs of the community in accessible and acceptable manner. It will also capitalize on the experience of people who experienced mental illness, which will enable CMH to promote its services and support it has the capacity to provide. The aim, as UNHCR (2015) highlights, should be 'providing safe, non-stigmatizing and supportive services with trained specialized staff'. This is even more needed when these services deal with victims of sexual and gender-based violence. Ensuring a confidential and appropriate manner will not only put these victims at ease to disclose and access services, but it will also establish trust and connection with the community members who will feel confident enough to step forward either to share their experience, or ask for help and support. Furthermore, UNHCR (2015) recommends that mitigating difficult living conditions is vital for community-based protection mechanisms. It also recommends navigating through 'models and sources of help that may include the formal and informal medical system, as well as religious, community, family and individual resources' (p. 40).

Through the Mental Health Gap Action Programme, the World Health Organisation has been able to provide mental health services across Syria despite the challenges and difficulties caused by the ongoing war. The Organisation reported in 2017 that more Syrians than ever have used its 150 primary and secondary health centres in 11 governorates (WHO, 2017). To fill gaps in qualified staff, the World Health Organisation has also reported that mental health services are provided by non-specialist general practitioners that it trained, under the supervision of national specialists. As Syria emerges from a long conflict with devastated infrastructure and stagnant economy, foreign expertise will be welcomed and approbated. Syria may also consider visiting the experience of other countries which survived an internal conflict and successfully installed programs that addressed and dealt with mental illness of their population. However, the international support should not replace the domestic experience which informed by its own social and cultural background. Any international initiatives will need to complement and empower rather than replace and install.

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CONCLUSION

It should be clear by now that this chapter does not attempt to address stigma from a medical angle. Rather, it reflected on whether mental illness and dealing with stigma that surround it should be approached on a community level. It also made the case that communities should have approach this issue based on their needs, social capital, circumstances and their own vision. A good starting point is probably the values embedded in the community that are embraced by its members. This is not to suggest that the mental health of young people in general, and those coming from conflict zones should are merely a domestic issue that need to be death with on domestic level. Rather, this should be of a global concern.

Whether in Syria or on a global level, stigma and its impact is an area that is still developing and being informed by research. A lot of concepts still need unpacking. Any suggested roadmap that aim to overcome stigma should listen to people with mental illness who avoid mental health services because they fear stigma, and practitioners. Syria still has a long way to go. However, it is important to start this conversation on national level both publicly and officially. While it may not provide immediate responses and solution, community approach to mental illness that challenges stigma is and will be needed on long terms.

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ENDNOTE

[1] Referring to president Bashar Al Assad.

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Chapter 60
Mental Health Access Issues by People of Refugee Backgrounds in Australia

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ABSTRACT

This chapter presents a critical discussion on the understanding and access of mental health services by people from diverse refugee backgrounds delivered in a Western cultural setting. Mental health services are heavily influenced by a biomedical approach, but there is a growing understanding of the importance of culture and biopsychosocial approaches. This chapter highlights some of the institutional and cultural issues that need to be addressed for the services to be effective. Practical approaches that have worked in different places are explored and critically discussed. A recovery-oriented model that recognizes that the individual is part of the community and the importance of spirituality are canvassed.

INTRODUCTION

Mental health work with migrant and refugee communities settling in developed countries like Australia is both challenging and rewarding for the wide range of professionals involved. While all the professional knowledge in mental health is important, the biggest challenges are presented by the diversity of cultures, diversity of prior experiences, settlement challenges, social and political dynamics and the negotiation of divergent worldviews. While cross-cultural mental health work would include working with a wide range of cultures, in this chapter only migrants and refugees are considered, while other cultural groups

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such as Indigenous people or Lesbian, Gay, Bisexual, Transgender, Queer and Inquiring (LGBTQI) are not considered except in passing where necessary.

Regular migrants and forced migrants including refugees, asylum seekers and undocumented migrants, have radically different issues on arriving at their destination. However, they also face similar issues such as displacement and dislocation, discrimination and a desire to rebuild disrupted lives. A study of migrants in Europe identified eight types of problems: language-based problems, lack of health insurance cover, poverty and trauma experience, lack of knowledge about services, divergent notions of diseases and treatment, unhelpful attitudes among both migrants and staff and missing medical history (Priebe, Sandhu, Dias, Gaddini, Greacen, Loannidis, … Bogic, 2011). Weiss (2015) has noted that in Switzerland migration worsens physical and mental health risks because migrants encounter cultural barriers. At the same time clinicians also experience challenges related to the complicated circumstances of their patients. Considering this is important due to the rapidly growing numbers involved in international migration. The number of international migrants globally reached 244 million in 2015, an increase of 41 per cent compared to 2000, and includes 20 million refugees (UN Sustainable Development Goals, 2016). The main direction is from developing to developed countries but there is also movement of refugees from developing to developing countries; indeed, most refugees are located in developing countries like Pakistan, Lebanon and Uganda. Turkey is the exception, as a European country with very high numbers of refugees.

In Australia, a wide range of disciplines including social workers, psychologists, nurses and psychiatrists assist patients suffering from mental health disorders. For that reason, the dynamics could be described as both multidiscipline and multicultural interaction. Experience with clients of ethnic Arabic people has shown that mental health services may be viewed by migrants with mistrust and suspicion and because of the stigma associated with mental illness, mental health services may be viewed negatively and therefore underused (Al-Krenawi & Graham, 2000). Building trust in this situation is a high priority. Defining mental illness and what is normal or abnormal varies between cultures and a cultural understanding is therefore critical in any mental health intervention (Kleinman, 1988; Weiss, 2015). Migration is stressful and migrants have been reported to be at higher risk of developing mental health disorders. Cultural factors, for example, affect the care-seeking behaviours and attitudes of older Iranian migrants in the United States (Martin, 2009). These older Iranians are reported to mistrust prescribed medication, hold a holistic view about mind body and spirit and their conceptualisation of mental health, including the language used, is at variance with that of service providers.

A recovery-oriented framework is currently supported by the government in Australia. The *National Standards for Mental Health Services* (2010) defines the principles of recovery oriented mental health practice and notes:

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose of life, and a positive sense of self. (State of Victoria Department of Health, 2013, p. 7)

Recovery is not the same as cure but rather puts the recovering person at the centre of what they want in life. The framework recognises the importance of partnerships between different professionals in supporting the recovering person to achieve their goals.

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The aim of this chapter is to critically discuss the challenges of working with refugee groups experiencing mental health problems. It highlights the important role played by social workers and advocates a strength-based community development approach that forms a recovery partnership with people with refugee backgrounds. The barriers that stand in the way of such partnership such as individualism and boundaries set by codes of ethics are explored. The strength-perspective based on acceptance of the cultural worldviews of people from non-Western backgrounds are noted as important starting points.

SOCIAL WORK ROLE IN CROSS-CULTURAL MENTAL HEALTH

In the multidisciplinary care for people experiencing a mental health disorder, social work plays a fundamental role in engaging, motivating, advocating, counselling and supporting individuals, families and communities. This is consistent with the internationally agreed definition of the role of social work:

The social work profession promotes social change, problem solving in human relationships and empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the point where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (Australian Association of Social Workers [AASW], 2010, p. 7)

Given the vulnerability of people experiencing mental health disorders, the ethical commitment to human rights and social justice is critical and all professionals are expected to operate in an ethical manner and uphold human rights. World Health Organisation (WHO) defines mental health as 'a state of wellbeing in which every individual realizes his or her own potential, can cope with normal stresses of life, can work fruitfully and productively, and be able to make a contribution to her or his community' (WHO, 2017, para. 1). This broad view is consistent with WHO constitution definition of health that is considered wellbeing and not just merely absence of disease: 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 2017, para. 2). These definitions show clearly that social work is philosophically well positioned to play a key role in both physical and mental health and underscores the bio-psychosocial dimensions in the ideal approach to mental health. It is well documented that in Western countries gender and power relations are rooted deeply within the dynamics of medical and mental health and are systemic in nature. Social workers often experience ethical strain in balancing the biomedical view of psychiatry against their commitment to non-hierarchical and genuinely collaborative processes, culturally informed and respectful practices and human rights perspectives (Probst, 2012). But social workers ought to develop, refine and use their collaborative skills and standpoint to bring these issues to the table in the interdisciplinary context of the medical and mental health care of migrants and refugees, rather than capitulating to or avoiding their effects. Social workers in mental health care have a responsibility to meaningfully collaborate, with integrity and a clear purpose, with other health professionals as well as other service providers and networks to ensure the wellbeing of their clients:

The purpose of practice is to promote recovery, restore individual and family wellbeing, to enhance the development of each individual's self-determination and to advance principles of social justice. (AASW, 2014)

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Among the allies in achieving these goals are the cross-cultural psychiatrists who also realise the limitations of a biomedical modal in meeting the mental health needs of multicultural communities, or anyone else for that matter.

Cross-Cultural Psychiatry

Cross-cultural psychiatry is also known as transcultural psychiatry or cultural psychiatry and refers to psychiatry that is concerned with the cultural context of mental health. What is considered as 'new transcultural psychiatry' is traced back 40 years ago in the work of Arthur Kleinman (Kleinman, 1977; Krimayer, 2006). The approach demonstrated clearly the critical cultural dimension of mental health. Krimayer identifies some key features for ongoing development in transcultural psychiatry: that it is multidisciplinary and integrative and views culture as a key feature of human biological theory; psychological processes are important in understanding the individual but social factors are equally fundamental; and, local and global systems of knowledge need to be critically examined in the context of a globalizing world (Krimayer, 2006). In practical terms psychiatrists engage their migrant patients in an open way about their understanding of their problem in order to understand the meaning the problem has to the patient and how they might have approached it in their cultural setting (Weiss, 2015).

The increasing number of refugees and migrants in Western countries has renewed an interest in cross cultural and cultural psychiatry. It is considered that being able to appreciate the patient's background and develop rapport with patients and their families or communities will enhance the treatment and recovery (Bracken, Thomas, Timimi, Asen, Behr, Beuster, ... & Downer, 2012; Bracken & Thomas, 2001; Double, 2002; Wintrob, 2010). A study with Chinese migrants in Australia found that communication about mental health was hampered by lack of understanding of cultural norms and values and this affected diagnosis (Blignault, Ponzio, Rong, & Eisenbruch, 2008). Communication, however, was only one aspect affecting awareness and access to services, as stigma, quality of services and lack of trust are also factors. A focus on the social context avoids the pitfall of a narrow view of mental health and brings to the fore important but complex social problems that demand political, social and economic solutions (Krimayer, 2006).

The challenge remains then for psychiatrists and other professionals as to how they apply diagnostic tools like the DSM V to people from other cultures who may not conform to the Western formulation of mental health symptoms. How symptoms are perceived and manifested is governed by both culture and context (Fried, Bockting, Ajard, Borsboom, Amshoff, Cramer, … Carr, 2015; Krimayer, Gomez-Carrillo & Veissiére, 2017). This concept challenges the notion of a universal human biology and argues for an understanding of the dynamic interaction between culture and biology. Simply adding the extra observed symptoms to a diagnostic manual is not considered good enough, as a completely different approach is called for:

Unfortunately, simply adding more symptoms to the ontological category does not rid the process of Western cultural bias and might make it worse by over-extending the category to include syndromes or patterns of distress that are better conceptualized in other terms. (Krimayer, Gomez-Carrillo, & Veissiére, 2017, p. 167)

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A biopsychosocial approach in mental health takes into consideration the wide range of issues that contribute to wellbeing including biological and social factors. A variety of approaches then that take into consideration cultural and community factors would be preferable to a narrow focus on a specific disorder (Fried, Bockting, Ajard, Borsboom, Amshoff, Cramer, … Carr, 2015; Jordans, Tol, Komproe & de Jong, 2009; Krimayer, Gomez-Carrillo, & Veissiére, 2017). This would also be consistent with a social work approach to mental health.

COMMUNITY DEVELOPMENT AND CROSS-CULTURAL MENTAL HEALTH

The concept of individual autonomy pervades Western thinking and approaches and informs the biomedical model of mental health. The biomedical model of mental health is the dominant approach to mental health and is based on the belief that mental disorders are brain diseases that are treatable through pharmacological interventions to correct specific biological abnormalities (Deacon, 2013). The biopsychosocial alternative is less established and regarded as not evidence-based to the same level as the biomedical or biological model. The biopsychosocial model has been in development over the last four decades and suggests that biological, psychological processes are integrated and how the processes interact is important in understanding both physical and mental health (Suls & Rothman, 2004; Wade & Halligan, 2017). That mental health involves more than chemical imbalances in the brain is gaining more acceptance in the west and hopefully moving closer to the more holistic view in traditional societies.

Traditional societies tend to view the individual as part of a larger group rather than a solitary and autonomous unit. Many non-Western communities prefer to seek solutions to mental health within the family, extended family or community rather than focusing on the individual autonomy favoured in the West. That is claimed to be the case within Arabic communities for example, where it is noted that:

Contrary to a Western therapeutic emphasis on the individual, all interventions with Arab clients need to be couched in the context of the family, extended family, community, or tribal background (Al-Krenawi & Graham, 2000, p. 13).

The African communities also identify with this communal approach as the best way to address problems faced by members of their communities. This communal approach is underpinned by the concept of Ubuntu that posits that individuals exist within a web of interconnection with others and the world and the wellness of one is dependent on the wellness of the whole (Mungai, 2017). The community development approach has been used by Foundation House trauma counsellors to address the issues of torture and trauma within the Sudanese community resettled in Melbourne (Mungai, 2014; Mitchell, Kaplan & Crowe, 2007). Kenny (2011) supports the community development approach with communities with collectivist cultures because group and individual decisions tend to be made in consultation with the group. Failure to recognise this process can be detrimental to social work intervention as well as psychiatric treatment.

The WHO comprehensive mental health action plan 2013-2020 clearly shows the broad view necessary in addressing metal health through 'six cross-cutting principles' identified as: universal health coverage, human rights, evidence-based practice, life course approach, multisectoral approach and empowerment of persons with mental disorders (WHO, 2013). This broad approach is consistent with a community development approach. Empowerment in particular aligns with a community development approach and

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it calls for involvement of people with mental disorders in advocacy, and all possible activities relating to research, policy and services delivery that affect them. Ife (2010) argues that community development is intricately associated with human rights and identifies seven dimensions underpinning community development as: social development, economic development, political development, cultural development, environmental development, spiritual development and survival-based development. At different times, and for different programs, these dimensions would apply rather than assuming that they would all be there in every community development program.

Mental illness is often accompanied by multiple problems including stigma and isolation. WHO (2013) points out that mental disorders put people at risk of poverty and homelessness, imprisonment and other forms of vulnerability. A community development approach would be a suitable way to address the issues of marginalisation, isolation and stigma while promoting a sense of belonging (Francis, Pulla & Goel, 2014). Communities may be people who share a common identity such as nationality, ethnicity or religion or live in a common geographical area (Kenny, 2011). Community development is therefore appropriate to address mental health disorder issues given the major implications for the lives of individuals and their families and communities. Medication alone could never address all the implicated social and biological issues adequately. Focusing on the strengths of the individual and community is regarded as the starting point in recovery and rebuilding lives that are affected by mental health disorder (Francis, Pulla, & Goel, 2014).

Community development is not the answer to all problems related to mental disorder but an important part of the response. There are people who may not identify with a particular community or even family and would prefer to be treated as individuals and that has to be respected. Communities can be wonderful and nurturing but can also be a source of stress when they impose conformity. Traditional cultures cannot be assumed by virtue of people's ethnicity as other influences including religion, education, globalisation, colonisation, migration and the media have their impact on these cultures. Experiences such as war, systematic state based violence and insecurity during refugee displacement can rupture community trust bonds and cultural norms. It has also been argued that both past and current indigenous knowledge concepts could be hard to ascertain as history is contested and the indigenous knowledge that is unaltered by modernity could be an illusion (Bar-On, 1999). The Africans, for example, have a culture that has been described as based on a triple heritage: indigenous cultures; European capitalism and religions imposed through colonialism; and, Islam imposed through jihad and evangelism (Mazrui, 1986). This diversity underscores the importance of allowing people to define themselves and the best way to work with them. Williams (2018) notes the importance of checking the relevance of culture to the issue at hand and suggests letting people determine their cultural identity and what it means to them should be standard practice.

Community Trauma

A model of healing communities after trauma suggests that linking individuals, families and communities to rediscover their resilience and collective resources, is far more effective than working with individuals. It also argues that the resilience of families and communities is inseparable and therefore the role of the worker or therapist is to assist in rekindling this connectedness that is disrupted by grief, loss, trauma and other stressors that negatively impact on individuals, families and communities. This model known as LINC and developed by Linking Human Systems LLC trains communities to help themselves:

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The LINC Model as a means of extending social support systems to help empower individuals, families, and communities to bind their own wounds by leveraging their collective power to overcome adversity and sustain long-term change with minimum of time and effort on the part of outside professionals (Landau, 2007; Landau-Stanton, 1986). (Landau, 2010, p. 517)

The model has evolved from Transitional Family Therapy and focuses on strengths, rather than deficits, of families and communities. It is a whole system approach focused on change and elimination of guilt and shame while mobilising resources for the healing process. The model has been applied with good results in: Buenos Aires, Argentina in a province afflicted with violence and HIV/AIDS; in Kosovo after the war with a whole country focus on general health and mental health including trauma, grief and loss; and, a Romanian border village with child welfare, gang violence-related issues and social inequalities (Landau, 2010). The outside professionals do not impose their culture. They start by identifying the cultural strengths in the community and train and resource the local people that the communities can trust and are seen as the key to success of the programs.

True to its origin in family therapy, the LINC model is based on the importance of connection to the family and community. In Kosovo, the connection to the family and culture of origin has been found to be correlated with reduced risk-taking behaviour, sexual risk-taking and a reduction in a range of mental health disorders (Agani, Landau & Agani, 2010). Agani and colleagues (2010) found that closeness to the family, whether, emotional, physical or spiritual (shared stories), was beneficial while distance was detrimental. An effective community-wide intervention then had to involve all the systems and have the people design the content and priorities that would contribute to trauma recovery, healing and resilience.

FRIENDS AND PROFESSIONALS DILEMMA

The concept of 'professionals' can sometimes be alien to people from non-Western backgrounds who are used to seeking help from friends and relatives. It can be confusing enough in Western cultures too but in cross-cultural contexts it can be more complex. In some professions like medicine it is easier to identify the boundaries of friendship and professional relationship than in social work where establishing good rapport is critical to the helping process. In medicine, the idea of the physician as friend can be traced back to ancient Greece but the consensus now is that friendship can help in the healing process but there are also ethical, practical and institutional barriers that suggest a healing relationship is the better option (Davis, 2000). In social work the concept of setting boundaries is emphasised in codes of ethics for legal and practical reasons but there is a need to review the impact this has on social work and cross-cultural social work in particular (O'Leary, Tsui & Ruch, 2013).

It can be confusing as to where one draws the line between friendship and professional engagement with the objective to help. Summers (2010) suggests that there is a clear distinction between professional relationships and friendship. One notable distinction is that the professional has a formal legal and ethical relationship with the client while friends generally have informal relationships and could be intimate and could also involve exchanging gifts. This still does not show where the clear boundaries are, as a worker and a client could still exchange small gifts, for example. One way of understanding boundaries is considering situations where the worker may have interests that are outside the working relations and is hence considered to have 'dual relationships'. However, even that may be unavoidable in small communities where interaction between a worker and a client in multiple roles is unavoidable

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as the client could be the worker's child's school teacher or both worker and client sing in the church choir. The main boundary issue then would be whether there is anything harmful or illegal occurring between the worker and client:

Boundary crossings are harmful when the dual relationship has negative consequences for the social worker's client or colleague and, possibly for the social worker as well. For example, a clinical social worker who discloses to a client personal, intimate details about his or her own life, ostensibly to be helpful to the client, ultimately may confuse and compromise the client's mental health because of complicated transference issues produced by the social worker's self-disclosure. (Reamer, 2003, p. 123)

O'Leary and colleagues (2013) argue that the notion of boundaries in the social work relationship is derived from a situation that has relevance for professions such as medicine and law, but has a restrictive application for social work relationships, where aspects of the relationship share many of the qualities of friendship (Beresford, Croft, & Adshead, 2008; Doel, Allmark, Conway, Cowburn, Flynn, Nelson, & Tod, 2010). Commonly, effective social work relationships are built through the practitioner's expertise and skills in establishing connection through informal conversations and contacts. Very often, these relationships establish an atmosphere in which highly personal information and feelings are shared (O'Leary, Tsui, & Ruch, 2013). The realities and philosophy of social work practice demands connection rather than separation, mutuality rather than hierarchy, and Western conventions and understandings of a professional boundary create restrictive artificial barriers that are not in keeping with the profession's values (O'Leary, Tsui, & Ruch, 2013).

There can be no argument against avoiding anything that could be harmful to the client, if that can be predicted. The problem here is predicting the outcome as even self-disclosure could be therapeutically helpful if applied properly and could help normalise the client-worker relationship (Reamer, 2001). The literature and codes of ethics clearly suggest having an awareness of the boundaries and workers should avoid clear issues such as intimate relationships, criminal activities or other exploitative relationships (Reamer, 2003; 2001). There are also grey areas on issues such as touching, hugging, accepting gifts, accepting food or drinks and friendship after ending therapeutic relationships.

When working with clients from diverse refugee backgrounds, there are many situations where friendship is assumed or expected in the helping relationship. Many social workers are asked to be friends in real life or in social media. Food is also offered during home visits and refusal could be regarded as rude and could potentially ruin the relationship. The worker then has to consider the issues that could enhance or threaten trust. A fundamental virtue is therefore creating an environment of trust – trusting self, client, institutions and clients – and reflective practice (O'Donovan, 2000). Making an effort to understand the client's cultural expectation and the worker also explaining their expectation is one way of minimising the risk of misunderstanding. Reflection is therefore needed both at the individual level and discipline level on the ontological basis of practice in order to establish relevance to clients served by social work (Bell, 2012). Acknowledging that boundaries can become walls between social workers and clients and clarifying what the clients mean when they want to be friends with the social workers is a starting point.

To be a friend may also mean more than a personal friend to one client in a collective culture but being accepted and trusted by the community. In this situation, to reach the individual the social worker has to reach the community. This is well known by workers with Aboriginal Australians but it is also suggested as the case with ethnic Arab communities:

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Individual's interests unite with those of their group of allegiance, and the general good supersedes the personal. Individual problems draw the members of the group in common pursuit of solutions. Individuals in trouble do not choose, in isolation from others among the alternative courses of action. (Al-Krenawi, 2000, p. 13)

This can make the work frustratingly slow but it is important to take the time to understand what works best for the individual client and the community. It is equally important to bear in mind the diversity between and within ethnic communities and even within one family. Factors like age, education, religion, acculturation, size of the community, gender and migration status have significant impact on the culture of origin. Recognising this heterogeneity is important to avoid oppression through stereotyping and generalising:

The practitioner's lens must be clear to recognise heterogeneity among groups, patterns that may be responses to years of indifference or oppression, and other underlying factors that impact perceptions. It is through the sensitivity of the ethnic lens that barriers associated with ethnicity can be removed. (Cox & Ephross, 1998, p. 158)

Appreciating the common issues faced by ethnic groups and at the same time taking time to understand the specific individuals and communities with their particular lived experience, background, history and culture, makes for effective practice. This is achieved through respect and genuine curiosity. In addition, the principles of inclusion, participation and building credibility and trust between the worker and the client as well as the community and institutions.

The ideal to the question of friendship or professionalism remains ambiguous in social work and other professional codes of ethics. Schiele (1996) suggests, from an Afrocentric perspective, to do away with boundaries between the helper and the helped and practice engaged relationships for an emotional, trusting and transformative connection. This radical approach assumes that the worker identifies with the client's problem and collaborates to find a solution as equal interested parties.

Challenges of Serving Own Community

There is not much literature on social workers working in their own ethnic communities. There can be both advantages and disadvantages. Cox and Ephross (1998) suggest that families with ethnic identities may prefer workers from their own ethnic group but competence may be valued more and, at the other extreme, members of the same ethnicity may be mistrusted. Ethnicity alone is clearly not enough for one to be accepted. However, for those who are accepted and can be regarded as part of the community they can be integral part of their community's endeavours at self-help in addressing a wide range of issues such as mental health and housing. This is articulated in the Afrocentric paradigm that notes that:

Black self-help from an Afrocentric perspective is politically and economically necessary to guard African Americans against both the planned and capricious forces of continued racism and Eurocentric oppression (Karenga, 1993; Shujaa, 1994; Wilson, 1993). (Schiele, 2000, p. 148).

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There is therefore a need to decolonise social work and therapeutic practices so that non-European clients are not seen through Eurocentric perspectives. Akinyela (2014) calls for cultural democracy in therapeutic work. That means moving beyond multiculturalism and inclusion to actually having knowledge produced by non-Western cultural groups. Attempting to fit non-Western cultural groups into therapies produced within a Eurocentric worldview only entrenches the domination over the 'other'. What is needed, then, is that 'other voices are being identified as world communities speak on behalf of their own healing in their own cultural languages with their own cultural meanings' (Akinyela, 2014, p. 49). This will mean that Indigenous healing practices from around the world can speak between themselves and with Western practices as equals and learn from each other.

Social workers use anti-oppressive practices to address oppression experienced by their clients. Anti-oppressive practice acknowledges the diverse forms of oppression within societies and the harmful effects of inequality (Connolly & Healy, 2013). In this sense, social work takes a political position against oppression and rejects such oppressive practices as sexism, racism and ageism and other generalisations that lead to stereotypes and oppression. Schiele (1996) argues that while these practices raise awareness about the problems faced by minority groups, they fall short of embracing their worldview and cultural values.

THE ROLE OF CULTURAL RITUALS AND DANCES IN HEALING

The biological basis of mental health problems like depression are well understood in the Western cultures and the treatments that include both medication and counselling are well-established. How other cultures understand and treat depression is far less understood. Solomon (2001) has reported that other cultures have different ways and the rituals and community-approach in Senegal, West Africa, are examples of the different approaches. The Senegalese, despite the Islamic faith, exhibited a belief in sprits and the role of blood rituals and communal dancing movements to exorcise the spirits that caused depression. Solomon notes that different practices were also found in Rwanda (Solomon, 2015). It was clear from the experience in Rwanda that if Western-trained practitioners did not take the cultural differences into consideration they could be ineffective or rejected in Rwanda as an informant suggested to Solomon in regard to Western therapists after the genocide:

Their practice did not involve being outside in the sun, like you're describing, which is, after all, where you begin to feel better. There was no music or drumming to get your blood flowing again when you are depressed, and you're low, and you need to have your blood flowing. There was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy. There was no acknowledgment that the depression is something invasive and external that could actually be cast out of you again.

Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to get them to leave the country. (Solomon, 2015, p. 41)

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Not all communities in Africa continue to perform these rituals as the major religions have tended to discourage cultural practices which they see as satanic and contrary to modern religions and enlightenment-inspired science. Nevertheless, it would be worthwhile checking what people's beliefs are and how they interpret the causes of their illness. It is not unusual for people to be educated, Christian or Muslim and still use traditional healers alongside Western medicine. Western practices, including medication and counselling, can play a role but they have to be adapted to the cultures of the people.

Culture as a Strength

Where people are able to reconnect with their culture, they can begin to regain their self-esteem and rediscover their strengths. Successful programs that have helped people to reconnect with their culture also help them to find their strength even after the program ends. Work with American Indian and Alaska Native (AI/AN) has demonstrated this view in a culturally grounded program that also focused on skills to address problems of substance abuse among the tribal youth (Donovan, Thomas, Sigo, Price, Lonczak, … Bagley, 2015). This educational program grounded on cultural practices demonstrated the effectiveness of the approach to increase connection to the tribe and prevent important issues such as suicide, substance abuse and behavioural health issues:

Community-derived, culturally grounded prevention curricula represent promising practices. Integrating evidence-based components of positive youth development and tribal-specific culture, traditions, and values, the curricula have the potential of reducing substance use; increasing hope, optimism, and self-efficacy; and facilitating cultural identity. (Donovan, Thomas, Sigo, Price, Lonczak, … Bagley, 2015, p. 67)

The challenge is taking time to work with the concerned people and identifying what is significant to them, what can be adapted to address the problem being experienced and making it work positively for the people. The canoe journey in this case was based on long traditions that people could easily identify with so the community participation, the dancing and the celebrations reconnected people to those traditions and rekindled pride in their heritage and the motivation to live better and purposeful lives.

Dance, songs and storytelling are part of the important cultural expressions that communities use to promote cohesion and explore culturally appropriate ways of healing. A good example of this is the native dance called Danza Azteca in the United States as practised by the Chicanos/Mexicans. Yañez (2014) found that the dance was a powerful means of reclaiming political space, spiritual awakening and healing from colonisation trauma that was the root cause of many mental health issues:

At its most fundamental level enacting "your culture" and promoting community cohesion is a political act because it disrupts narratives that have been essential to the nation-state and Euro-American values such as the idealization of individuality verses community well-being and the accumulation of capital and resources with little regard for communities of color, group cohesion, or spiritual wellness. (Yañez, 2014, pp. 36-37)

The role of the social worker is assisting people to identify what cultural activity would be ideal in their healing process. It is empowering for the participants to get involved in the selection of activities that work well for them and the worker can assist in accessing the resources needed and how to embed

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the intervention into the activities. Where people might not have a cultural identity to fall back on they could choose to have modern dances like rap or opt for sporting activities like soccer matches. These activities can go a long way in addressing issues like isolation and break the barriers between the worker and the clients. Crafts and gardening are other activities that are possible and could have other benefits like generating income or food.

Hip Hop and Rap

The health benefits of music and dance for mental health and general wellbeing are well established. A relatively new area of interest is using rap music particularly with youth who are marginalised. Rap music in therapy has been used for listening, performing, composition and improvising. Hip hop is a culture that young people identify with as their own and is particularly identified with young African Americans.

Hip hop as an urban culture evolved in the streets of the Bronx, New York, in the 1960s and early 1970s. Its roots are the oral expression traditions from Africa maintained and promoted by poor black youth but has since become part of a popular global youth urban culture and a visible subset of it is rap music (Price, 2006). Rap represents a powerful form of storytelling. Its power arises from the Bantu notion of Nommo, the African belief in the power of the spoken word to change and reconstruct reality. Stories are formed by reality and they also form and shape reality (Yancy & Hadley, 2011). Crooke and Travis (2017) note it is now being taught in mainstream universities, such as Melbourne University, as a therapeutic tool for healing when working with young people. They suggest it is important to recognise more than the profanity in some rap music and note the core of it is a struggle for social justice, peace, respect, self-esteem, community and simply a good time. There are genres that range from feminist to anti-drugs and violence and reject homophobia (Rine, 2013). In Brazil, hip hop is regarded as an artistic movement of social protest to claim recognition and social citizenship (Alves, Oliveira & Chaves, 2016). Rap music has been found to be an effective culturally specific form of therapeutic individual and group intervention with vulnerable or at-risk young people (Tyson, 2011; Yancy & Hadley, 2011).

Religion and Spirituality

Religion and spirituality are very fundamental to the way people understand the world and in particular how they understand mental health. The importance here is for social workers to pay attention to how the individual or community interpret their reality. The workers also need to have an awareness of their own religious beliefs including not having any. Minority groups, like Muslims, have experienced problems in the Western counrties and these may make them wary of the workers. There is a history of 'Christian West' and 'Muslim East' being in conflict dating back to the crusades, the holy wars between the Christians and Muslims starting about 900 years ago. But the more relevant history is the current issues with terrorism that is associated with a small but violent radical group within the Muslim faith that destroyed some buildings in America on 11 September 2011 (or 9/11):

Next to the people who lost their life [sic], Muslims were the worst sufferers of the 9/11 attack on the Twin Towers. Although some Muslim fanatics accomplished the terrible task of destroying the towers, the entire Muslim community had to suffer for this. They suffered immediately from the hate-crimes and discrimination although these were initially sporadic. Later, because of the US government's social, local

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and foreign policy, the Muslim community started to suffer from what can be labelled as "institutional discrimination." (Abdullah, 2015, p. 58)

What this demonstrates is that even though faith and spirituality can be regarded as personal issues, there are also political, social, identity and even economic implications. Given the implication of discrimination on oppression and mental health, workers cannot afford to ignore the role religion plays in people's lives and life-chances. Religious beliefs can also be a source of strength as conveyed in the word the Muslims use when committing to a future action, inshallah, meaning if Allah wills or God willing.

In traditional African and Eastern traditional belief systems, spirituality is not separate from mind and body or even the material world, as it is in the Western empiricist view of the world. In the Eastern traditions, everything and every aspect of life is linked to spirituality which is the web that links all beings. Religion and spirituality in African traditions is inseparable from other aspects of life such that "religion permeates into all departments of life so fully that it is not easy or possible to isolate it" (Mbiti, 1989). Spirituality in traditional societies is also linked to morality and ethics and it has been argued that in social work this can have a role in addressing problems such as mental health problems, alienation, drug use and violence (Belgrave, Cherry, Cunningham, Walwyn, Letlaka-Rennert, & Phillips, 1994; Schiele, 2000). Social workers therefore need to take these spiritual factors into consideration:

The spiritual factors for social workers will involve the notion of identity and the sense of being. There will be consideration of hope and optimism, consideration of the sense of aesthetics, consideration of the sense of purpose, understanding of religion and consideration of ontological and existential issues. The social worker ought to have a well-considered position on these issues. (Pawar & Anscombe, 2015, p. 53)

Spirituality is not emphasised in social work, but Hay (2012) suggest that it would be beneficial to have a spiritual component in the social work curriculum. Even when a social worker does not believe in the existence of a spiritual dimension, they need to understand the significance of the spirit world and its influence on the people they work with. For the people who believe in the spirit world then there could be symbolic ways of appeasing the spirits. When something is considered evil or taboo, it is considered a threat, not only to the individual but to the entire community, so some ritual cleansing is important for the stability of the community and avoidance of shame (Ekeke, 2011). The Igbo people of Nigeria, for example, had a substitute for the community in the form of an animal or a human being dragged through the polluted places in the community so they could symbolically absorb the uncleanliness, then the soiled victim is thrown away (Ikenga-Metuh, 1985).

The healing power of rituals is important for those who subscribe to it and this is consistent with the ethical basis of social work, which respects people's belief systems. Research has shown that Congolese and Somalis settled in the United States turn to traditional healers and religious leaders in times of distress before they consider accessing western mental health services (Piwowarczyk, Bishop, Yusuf, Mudymba & Raj, 2014). This in part could explain the low utilization of mental health services among different African refugee groups, despite rates of posttraumatic stress disorder that are higher than the general population (Kinzie, 2006; Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014). The traditional and religious rituals approach to mental health are based on a worldview that accepts the existence of a spirit world. Complications could arise where the rituals to address mental health may contradict the laws for example, in terms of cruelty to people or animals and where the human rights of others may be

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impinged upon. The duty of the social workers then is to explain to the individual or community why there might be objections to their practises outside of their place of origin.

CONCLUSION

This critical review of cross-cultural social work in mental health has demonstrated the challenges that social workers and other professionals working in the field face. The authors have underlined that awareness of own culture and making effort to understand the cultural worldview of the mental health service user is important for engagement. Understanding of seemingly ordinary issues such as friendship and what that means in other cultures, may prevent misunderstanding. While codes of ethics and organisational codes of practice may have good reasons for proscribing against expression of friendship, it is important to review the implications for the helping professions.

The important aspects of culture like collective orientation and spirituality have been identified as critical in understanding why people with refugee backgrounds may not utilise services even when their symptoms suggest such services are needed. Respecting how people define their understanding of mental health is consistent with a recovery-oriented framework that the Australian government promotes. While there are inevitable generalizations in the discussion, it is important to understand the unique situations for individuals and communities and hence the importance of maintaining a genuine curiosity and an open mind at all times. There is need for research to continue informing how mental health services can be made more responsive to people from minority cultures.

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KEY TERMS AND DEFINITIONS

Afrocentricity: This refers to scholarship on African people and people of African descent that treats them as subjects, rather than objects. African history, culture, and philosophy is put at the center while a Eurocentric approach, by contrast, would use a European lens that marginalizes the African people.

Hip Hop: Hip hop or hip-hop refers to the African American urban culture that evolved in the streets of Bronx, New York, in the 1960s and early 1970 and the practices within that culture. Rap music and its sub-genres are one component of that hip hop culture that has now spread around the world. In therapy, it is used to engage young people who identify with that culture or art form.

Nommo: *Nommo* comes from Bantu languages in Africa and represents the power of the spoken word to create harmony and balance. This is power of the spoken word suggests that language is important for the community and change and healing can be generated from speaking if it is done well.

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Chapter 61
Facebook Depression or Facebook Contentment: The Relation Between Facebook Use and Well-Being

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ABSTRACT

Within the literature, Facebook has received much attention in order to understand the potential positive and negative effects associated with using the social networking site. The current chapter provides a discussion of the empirical support for the differential outcomes associated with actively posting and chatting on Facebook vs. passively browsing Facebook, as well as the underlying mechanisms for the effects. Specifically, the current chapter will discuss two perspectives related to the differential effects of active and passive Facebook use: Facebook contentment (a wellbeing enhancing effect) and Facebook depression (a wellbeing diminishing effect). The authors also discuss the extension of the results to other social media platforms and provide suggestions for future research.

INTRODUCTION

Social networking sites are rapidly changing the way that people interact with one another, and have the potential to influence psychosocial functioning and emotional distress. Of the variety of social networking sites that exist, Facebook has rapidly gained popularity since its induction to the general public in 2005. Facebook users create online profiles containing personal information about the self that are

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broadcasted to other online users, which can be updated with additional information at the discretion of the profile owner. The information shared is also open to the reception of quantitative or qualitative feedback from Facebook friends.

Subjective well-being is a phenomenon that is comprised of people's personal evaluations of their lives, including emotional responses to life events, as well as a personal assessment of one's overall satisfaction with life (Diener, Suh, Lucus, & Smith, 1999). Research on the social aspects of well-being has revealed that interpersonal relationships and social engagement are associated with positive affect and enhancements in subjective well-being (see Diener, Suh, Lucas, & Smith, 1999 for review). With the opportunity to stay connected with others online, Facebook may benefit subjective well-being, resulting in a potential for "Facebook Contentment". However, not all aspects of being social enhance subjective well-being; for example, if a person compares him/herself to others who are doing better off than he/she is, then subjective well-being is reduced (Michalos, 1985). Similar emotional distress may arise when negative feedback is received for information about oneself that is shared on Facebook. In either case, Facebook users are at risk of "Facebook Depression".

Overall, this chapter will synthesize the current literature regarding Facebook and its relation to psychosocial functioning, which may aid in the advancement of research, increase in public awareness, policy development, and clinical applications. The chapter is divided into the following sections. First, the chapter will summarize statistics about the frequency of Facebook's use and its most popular users. Second, the authors will synthesize the literature examining the relationship for active and passive Facebook use separately with subjective well-being and present theoretical background to explain these associations to support the potential for Facebook Contentment and Facebook Depression, respectively. Third, a summary of the literature regarding the effects of posting selfies will be provided, and the authors will present an evidence-based argument that active Facebook use is not always positive when considering selfie-posting behavior. Fourth, the authors will evaluate the uniqueness of the findings related to Facebook in comparison to offline interactions and other social networking sites, which highlights the real but rather small magnitude of effect Facebook has on social interactions and mental health. Finally, the gaps in the literature will be discussed and future research suggested.

AN OVERVIEW OF FACEBOOK USE AND USERS

Internationally, over 1.7 billion people visit Facebook every month, with over 1.2 billion visits every day, and 85% of the logins occurring outside of North America (Stats, 2016). In relation to North American use, in November of 2016, the Pew Research Centre reported that Facebook remains the most popular social networking platform in the United States by an overwhelming margin (Greenwood, Perrin, & Duggan, 2016). Furthermore, in a 2015 study conducted by Forum Research on social media usage, Facebook remained the top social network in Canada, with 59% of respondents indicating they use Facebook and visit about nine times each week (McKinnon, 2015). On average, Facebook users are comprised of young adults between the ages of 18 and 39, with female users being slightly more common than male users (Greenwood, Perrin, & Duggan, 2016).

While on Facebook, users are able to create a personal profile, known as the Facebook 'Timeline' that contains an amalgamation of image and text-based information about the user, which can then be shared with the user's Facebook 'friends'. In the context of Facebook, 'friends' consist of a combination of close friends and acquaintances met offline, and family members, for which the average ranges from

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around 150 (Ellison, Steinfield, & Lampe, 2007) to over 400 friends (Manago, Taylor, & Greenfield, 2012). Young adults often turn to Facebook to aid in the maintenance of their relationships (e.g., to post or send messages, stay in touch with friends), to pass time, or for entertainment purposes (e.g., to see other people's pictures and read their profiles; Davis, 2012; Sheldon, 2008; Smith, 2011). Therefore, users can interact with Facebook in a passive or active fashion. First, Facebook is often used to *observe* Facebook friends by anonymously scrolling through the newsfeed, or browsing friends' photos/timelines, without any form of direct communication with their Facebook friends. This type of Facebook behaviour is regarded as passive Facebook use or surveillance (Ryan & Xenos, 2011). Second, during active use, individuals communicate with others by *sharing* text-based information or photos when directly messaging friends, posting status updates, sharing memories, posting on timelines, or reacting to others' posts.

The taking and sharing of selfies, a specific type of image shared on Facebook (Weiser, 2015), falls under the umbrella of active Facebook use. A selfie consists of a photograph of one's self alone or with others that is taken with a camera held at arm's length or pointed at a mirror (Sorokowski, Sorokowska, Oleszkiewicz, Frackowiak, Huk, & Pisanski, 2015). Selfies are shared as a means for communication, to attract attention from others, for entertainment, and to archive memories (Sung, Lee, Kim, & Choi, 2016). According to American surveys of 18 to 24 year old participants, 98% took selfies, 46% had shared selfies within the past day, and 69% tended to share selfies three to 20 times daily (Katz & Crocker, 2015). There are mixed findings regarding who frequently posts selfies. On the one hand, there is some support that frequent selfie-posters tend to be those who score high on narcissism (Moon, Lee, Lee, Choi, & Sung, 2016; Weiser, 2015) or extroversion (Kim & Chock, 2017; Sorokowska, Oleszkiewicz, Frackowiak, Pisanski, Chmiel, & Sorokowski, 2016), as well as adolescents and younger adults (Dhir, Pallesen, Torsheim, & Andreassen, 2016). On the other hand, researchers have also reported no such relationships between behaviour and characteristics of the poster (Barry, Doucette, Loflin, Rivera-Hudson, & Herrington, 2017; Sung, Lee, Kim, & Choi, 2016). Given the increasing popularity of selfies, it is important to consider the effect of this Facebook activity on its own.

Taking into account how and why Facebook is being used, there are potential consequences for subjective well-being. The following sections present an overview of subjective well-being, and outlines why active (including selfie posting behaviour) and passive Facebook use may influence well-being in a positive (Facebook Contentment) or negative (Facebook Depression) way.

FACEBOOK USE AND SUBJECTIVE WELL-BEING

Facebook provides opportunities for users to disclose personal information about themselves, to receive reactions from others, and to compare how they are doing relative to their Facebook friends. These activities have the potential to contribute to subjective well-being by influencing feelings of social connectedness and self-esteem. Social connectedness is characterized as the feelings of belonging and staying in touch with ongoing social relationships (Van Baren, IJsselsteijn, Markopoulos, Romero, & De Ruyter, 2004). Self-esteem is considered as the level of value you place on yourself, which is influenced by the reactions of and comparison with others (Argyle, 2008). The popularity of Facebook has given rise to a body of research investigating the association between Facebook use and well-being or one of its related constructs (e.g., depression, life satisfaction, and loneliness), which has uncovered inconsistent results. On the one hand, spending more time on Facebook was associated with increases in depressive symptoms (Steers, Wickham, & Acitelli, 2014), as well as feeling lonely (Lou, Yan, Nickerson, &

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McMorris, 2012), ostracized from their friends (Tobin, Vanman, Verreynne, & Saeri, 2015), and less satisfied in their own lives (Blachnio, Przepiorka, & Pantic, 2016; Valenzuela, Halpern, & Katz, 2014). In fact, when Facebook users take a break from using the social networking site, it enhances both the cognitive and emotional aspects of subjective well-being (Tromholt, 2016). On the other hand, research also supports that more time spent on Facebook enhances life satisfaction (Valenzuela, Park, & Kee, 2009), self-esteem (Burke, Kraut, & Marlow, 2011), and psychological well-being (Burke & Kraut, 2016; Liu & Yu, 2013). Still, others report no relationship between time spent on Facebook and depressive symptoms (Jelenchick, Eickhoff, & Moreno, 2013), or life satisfaction (Glynn, Huge, & Hoffman, 2012). The challenge with measuring Facebook use as a single dimension is that it may cancel out the effects associated with different activities. While activities directed at the sharing of information may enhance social connectedness and has the potential for Facebook Contentment, the viewing of others' posts may elicit negative feelings because of social comparison, which increases the risk for Facebook Depression. Therefore, the following sections present a synthesis of the literature for active and passive Facebook use and explains their unique association with subjective well-being.

Facebook Contentment and Active Facebook Use

Active Facebook use is characterized by making social contributions while on Facebook, including broadcasting information about one's self and writing what's on a person's mind (through posting photos, status updates, or sharing links, memories, or memes), communicating with others (by writing on friends' timelines, and sending messages on Facebook), and providing feedback to others [by liking, commenting, and reacting to friends' Facebook posts (Burke, Kraut, & Marlow, 2011; Verduyn, Lee, Park, Shablack, Orvell, Bayer, & Kross, 2015). It should be noted that social networking activities usually involve the sharing of authentic information and content without malicious intent (Fox & Moreland, 2015; Reinecke & Trepte, 2014), and thus a discussion of false identities and cyberbullying or similar contexts are considered beyond the scope of the chapter. Typical active Facebook use has the potential then for Facebook Contentment, a phenomenon suggested by the authors that emphasizes the positive consequences for psychosocial functioning associated with the use of Facebook (and other social networking sites). In other words, active Facebook use results in enhanced subjective well-being and related constructs. In support of this principle, active use is typically associated with heightened subjective well-being (Kim & Lee, 2011). Greater active use is also correlated with enhancements in social well-being (Burke, Marlow, & Lento, 2010), and self-esteem (Csepeli & Nagyfi, 2014), as well as decreases in depression (Frison & Eggermont, 2016), and loneliness (Ryan & Xenos, 2011).

Social connectedness, a key underlying mechanism for enhanced mental health in general (Baumeister & Leary, 1995), has been put forward as the variable that links active Facebook use and subjective well-being. When considering social connectedness in the context of traditional offline interactions, those with greater subjective well-being also report greater levels of social connectedness (Baumeister & Leary, 1995), and social support (Helliwell, Huang, & Harris, 2009). In a three-year longitudinal study of over 1700 adolescents, researchers found that youth who reported higher levels of social connectedness would subsequently report higher well-being, but there was no support for a reciprocal relation (Jose, Ryan, & Pryor, 2012). These benefits of social connectedness also extend to online social interactions. In particular, individuals who are more active on Facebook report greater social connectedness (Köbler, Riedl, Vetter, Leimeister, & Krcmar, 2010), social capital (Burke, Kraut, & Marlow, 2011), and social support (Wright, Rosenberg, Egbert, Ploeger, Bernard, & King, 2013). In addition, when researchers test

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the features that fall under the classification of active Facebook separately, only certain active behaviours enhance users' life satisfaction. In a longitudinal study, Wenninger, Krasnova, and Buxmann (2014) measured each active component separately (i.e., posting, chatting, liking, and commenting), as well as users' life satisfaction over the course of one week. Posting on and chatting with friends via Facebook were associated with increases in users' life satisfaction over the course of one week, while liking and commenting on friends' posts were not related to life satisfaction. Therefore, only the specific Facebook features that enabled users to make social contributions, that are required for enhancements in subjective well-being, actually contributed to life satisfaction.

There is also direct empirical support for social connectedness as a mediating factor that explains the positive association between actively posting on Facebook and users' subjective well-being. Correlational studies indicate that the feelings of social connectedness that occur when actively using Facebook are associated with decreases in depressive symptoms (Grieve, Indian, Witteveen, Tolan, & Marrington, 2013). Similarly, Frison and Eggermont (2016) identified that for females, actively interacting with friends either publicly or privately while on Facebook led to the perception of being supported by friends, which then decreased depressive mood. Since correlational studies can only support a relationship between variables, and cannot distinguish the directionality of the effect between Facebook use and social connectedness, Deters and Mehl (2013) conducted an experimental study to investigate the proposed directional effect that Facebook use leads to increases in feelings of connectedness. In their study, participants in the experimental condition were asked to post on Facebook more frequently than they typically would, while their control counterparts were instructed to use Facebook as usual over the course of one week. The results indicated that the Facebook users in the experimental (active) condition experienced decreases in loneliness, which was attributed to feeling more connected to their friends.

In sum, the findings from the research centered on active Facebook use provides overwhelming support for Facebook Contentment. More specifically, the studies suggest the following two principles: (1) the phenomenon of Facebook Contentment is an accurate depiction of what users experience when they are engaging in active behaviour on Facebook; and (2) social connectedness is the causal link between active use and subjective well-being. It can then be inferred that when users log onto Facebook and utilize the features that enable them to make active social contributions such as sharing information about themselves, or communicating with friends, the feelings of social connectedness that result resemble feelings that occur during traditional offline interactions, and consequently so do the enhancements in subjective well-being.

Facebook Depression and Passive Facebook Use

In general, researchers and society have become concerned with the potential harmful effects elicited by Facebook use. This has led to the introduction of Facebook Depression. In the current literature, Facebook Depression refers to a phenomenon where users experience increases in depression and loneliness, and decreases in self-esteem and psychological well-being as a result of spending too much time on Facebook (Kross, Verduyn, Demiralp, Park, Lee, Lin, … Ybarra, 2013; O'Keeffe & Clarke-Pearson, 2011). Facebook Depression is not an overarching result of Facebook use; rather, the negative effects of Facebook have been associated only with passive use. Passively observing friends on Facebook is negatively associated with several constructs that are related to subjective well-being, including increased loneliness (Ryan & Xenos, 2011), and depression (Frison & Eggermont, 2016), as well as decreased social well-being (Burke, Marlow, & Lento, 2010), and life satisfaction (Wenninger, Krasnova, & Buxmann,

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2014). In fact, in an experimental study by Verduyn et al. (2015), participants in the passive experimental condition were asked to use Facebook solely passively (i.e., scrolling through Facebook with no posting or interacting) for 10 consecutive minutes. Although there was no change in well-being immediately following Facebook use, participants reported decreases in affective well-being at the end of the day. Even after controlling for the changes in affective well-being that occurred via passive use, the reverse path (affective well-being resulting in higher levels of passive use) was not significant.

What is it about passive Facebook use that would be detrimental to subjective well-being? Social comparisons are a rather automatic consequence of being social (Festinger, 1954). Festinger's (1954) social comparison theory postulates that individuals engage in self-evaluation by comparing themselves to those who are similar. Social comparison provides individuals with the ability to gather information to evaluate their own capacities and characteristics so they can develop stable and accurate evaluations about the self. During social comparison, individuals gain social information, think about social information and then react to the comparative information (Diener, Suh, Lucas, & Smith, 1999). Building on social comparison theory, Suls, Martin, and Wheeler (2002) argued that social comparison can be both upward and downward, and that there are differences in the outcomes of social comparison depending on whether the evaluator is engaging in upward or downward social comparison. Upward social comparisons (aka negative social comparison) refer to instances where the targets of social comparison are doing better than oneself (Suls, Martin, & Wheeler, 2002). Michalos (1985) postulated that a person's subjective well-being depends on the discrepancy between a person's current life circumstances compared to a standard set by comparing him/herself to others' current life circumstances. If the target(s) that a person compares him/herself with is perceived to be more successful, happier, wealthier, more attractive than him/herself, then there is a tendency to develop a negative self-image and exhibit decreases in subjective well-being (Michalos, 1985). On the other hand, a person can also compare him/herself to a target who appears to be worse off. This downward social comparison (aka positive social comparison) is typically associated with a more positive self-image and increased subjective well-being (Suls, Martin, & Wheeler, 2002).

Facebook users do compare themselves to their Facebook friends (Feinstein, Hershenberg, Bhatia, Latack, Meuwly, & Davila, 2013; Joseph & Desjarlais, 2017; Vogel, Rose, Roberts, & Eckles, 2014). And, the more time users spend on Facebook, the more likely they are to negatively compare themselves to others, which often leaves users feeling as though their friends are doing better off in life than they are (Chou & Edge, 2012; de Vries & Kühne, 2015). Similar to offline contexts, the act of negatively socially comparing while on Facebook is associated with increases in depressive symptoms (Nesi & Prinstein, 2015; Steers, Wickham, & Acitelli, 2014). The challenges associated with negative social comparison online are only evident for passive Facebook use. Scrolling through Facebook has been associated with increases in negative social comparison and thus decreases in users' self-esteem (Vogel, Rose, Roberts, & Eckles, 2014), and increases in feelings of envy (Appel, Crusius, & Gerlach, 2015; Krasnova, Wenninger, Widjaja, & Buxmann, 2013). Furthermore, passive use is not related to users' depressive symptoms unless the browsing Facebook has led to feelings of envy (Tandoc, Ferrucci, & Duffy, 2015).

Negative social comparison in the context of Facebook is especially troublesome because when people are comparing themselves to others on Facebook, they may not actually be comparing themselves to a realistic target. In general, people are concerned about the way they are perceived by others (Goffman, 1959), and thus attempt to manage the impressions others on Facebook form and their evaluations by presenting oneself to others in a positive and socially desirable way (Zhao, Grasmuck, & Martin, 2008). Applications that enable users to touch up their photographs with filters, thus promoting users to hide their flaws (Walther, 2007), have become increasingly popular (Lup, Trub, & Rosenthal, 2015). As such,

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the information visible while scrolling through Facebook probably is comprised of images and statements that represent users' idealized selves (Manago, Graham, Greenfield, & Salimkhan, 2008). Thus, if social comparison occurs while passively using Facebook, and the information posted on Facebook sets a standard for a level of unrealistic perfection, then users find themselves comparing to an unrealistic target. It is not surprising then that users feel as though they do not measure up to their friends.

In conclusion, the literature regarding passive use support a real risk for Facebook Depression. Consistent with social comparison theory, negatively comparing one's self to Facebook friends, and the feelings of envy that ensue, appear to be driving the negative association between passive Facebook use and subjective well-being. Due to selective presentation and impression management strategies common on Facebook, users need to be cautious they do not get wrapped up in a fantasy where everyone else's lives are near perfection.

SELFIES: THE POTENTIAL FOR FACEBOOK CONTENTMENT AND FACEBOOK DEPRESSION

As aforementioned, active Facebook use is positively associated with subjective well-being and related constructs. However, within the literature on the psychological effects of Facebook use, a specific type of active behavior has not received attention - that is, the posting of a specific type of photo, the selfie. Unlike active Facebook activities in general or other specific active behaviors (posting and instant messaging), sharing selfies has disparate effects on subjective well-being. Selfie-posting behavior may lead to enhanced subjective well-being through self-disclosure and positive reactions from others. On the other hand, sharing selfies can deflate self-esteem when the photos receive negative attention. Since there is limited research explicitly investigating the link between selfie-posting behavior and subjective well-being, the authors can only postulate the potential for Facebook Contentment and Facebook Depression.

Facebook Contentment: Selfies Facilitate Connections With Others

Intimate friendships have implications for adolescent psychosocial adjustment and the quality of future relationships. For example, a lack of close friends has been associated with feelings of loneliness, alienation, depression and low self-esteem among adolescents (Buhrmester, 1990; Cohen & Willis, 1985), as well as life satisfaction during adulthood (Marion, Laursen, Zettergren, & Bergman, 2013). Learning to maintain close relationships prepares adolescents for adult intimate relationships (Sullivan, 1953), such that high-quality adolescent friendships are related to greater adult romantic relationship commitment (De Goede, Branje, van Duin, VanderValk, & Meeus, 2012). Self-disclosure, or the sharing of personal thoughts, feelings, and experiences, is an important feature of adolescent and adult intimate friendships (Berndt, 1989).

Social networking sites are providing users with the ability to meet these social needs. Valkenburg and Peter (2009; 2011) formulated the Internet-enhanced self-disclosure hypothesis, which postulates that online interactions stimulate online self-disclosure and in turn enhances closeness with friends. Therefore, Facebook may offer users a comfortable environment for sharing information, including anonymity, accessibility, asynchrony, and the absence of nonverbal cues. In direct support of the Internet-enhanced self-disclosure hypothesis, Valkenburg and Peter (2009) found that the relationship between online communication and friendship quality was fully mediated by self-disclosure. Other studies have

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also provided support for portions of the hypothesis. Specifically, more frequent use has been associated with greater online self-disclosure (Desjarlais & Joseph, 2017). Moreover, online disclosure consistently has been associated with increases in friendship quality (see Desjarlais, Gilmour, Sinclair, Howell & West, 2015 for a review), which then enhances users' well-being (Valkenburg & Peter, 2007, 2009).

When asking about people's motivations for posting selfies, they do indicate that some selfies are shared as a means to communicate with others. Instead of posting notes that one is starting a new job, is on a vacation, or feeling upset, the poster can share a selfie of him/herself in her new uniform, sitting on a beach relaxing in the sun, or visually crying. As a snapshot of one's life, selfies offer a medium to express emotions and reveal insights (Wortham, 2013). In this context, the intention for posting the selfie is not to present the best polished self, but rather to share honest information, natural insights, and emotions with friends, family, and acquaintances in an effort to build intimacy (Choi, Sung, Lee, & Choi, 2017; Diefenbach & Christoforakos, 2017). Group selfies also provide information about the poster through social cues, such as relationships with others and behaviour in a group (Wang, Yang, & Haigh, 2017). In terms of the outcomes of such disclosure activities, results suggest that self-disclosure through selfies may open the line of communication, earn sympathy, and result in positive emotional experiences for posters (Diefenbach & Christoforakos, 2017). Therefore, it is reasonable to postulate that the selfie contributes to connections made with friends and family, supporting the Facebook Contentment perspective.

Facebook Depression: Selfies May Deflate Self-Esteem

In general, people are concerned about the way they are perceived by others, and as such, their reactions can raise or deflate self-esteem (Goffman, 1959). Compliments, praise, and indications of liking serve to enhance self-esteem, whereas criticism and rejection deflate it. In order to elicit esteem-enhancing reactions, people attempt to manage the impressions others form and their evaluations by presenting oneself to others in a positive and socially desirable way both offline (Walther, 2007) and online (Hart, 2017). People often put work into selfies in order to present the best image of themselves. They have worked on finding the right angle, and will edit the pictures before posting in order to present one's ideal self (Hart, 2017). In interviews regarding social media use, adolescent girls indicated that editing photographs and making oneself look good on social media has become a necessity (Chua & Chang, 2016). All admitted to using filters and editing photos with software to, for example, brighten the skin, conceal facial imperfections, and enhance colors. One-third of the girls went so far as to change their facial features, including modifying their face line, and altering the size of their eyes and noses. According to one teen, the purpose of putting so much effort into perfecting the selfie is so posters can share pictures that meet the standard and to impress their friends (Chua & Chang, 2016). Consistent with this, attention seeking has been acknowledged as a driving motivation behind the taking and sharing of selfies. People post selfies with a desire to attract attention, to be acknowledged by others, to gain self-confidence from others' reactions, and to receive affirmation from others (Sung, Lee, Kim, & Choi, 2016).

Individuals seem to place high importance on the number of likes and followers they receive, believing that the numbers are more important than comments, and that the numbers serve as an indication of peer attention, benchmark against peers, and their position in their peer group (Chua & Chang, 2016). By manipulating the number of likes individuals receive, Burrow and Rainone (2017) examined the extent to which self-esteem was sensitive to the number of likes received on selfies posted to a mock Facebook site, and if this depended on individuals' sense of purpose. They did find that for those reporting a lower

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sense of purpose in life, the number of likes was positively associated with self-esteem; whereas, there was no relationship between the number of likes and self-esteem among those with a greater sense of purpose. Other researchers have argued that frequent likes may affirm the ideal self that one presented in a selfie and make an individual feel good about him/herself, thereby increasing self-esteem (Bazarova & Choi, 2014; Shin, Kim, Im, & Chong, 2017). On the positive side, selfies do generate a high number of likes compared to natural pictures (Souza, de Las Casas, Flores, Youn, Cha, Quercia, & Almeida, 2015). So long as selfies receive a high number of likes, self-esteem may be boosted.

However, other research regarding selfie-posting does not suggest such esteem-enhancing effects, which is particularly concerning for girls and women given that they exhibit higher selfie-posting frequency as compared to males (Dhir, Pallesen, Torsheim, & Andreassen, 2016; Sorokowska, Frackowiak, Karwowski, Rusicka, & Oleszkiewicz, 2016; Weiser, 2015). With the exception of a few studies (Barry, Doucette, H., Loflin, Rivera-Hudson, & Herrington, 2017; McCain, Borg, Rothenberg, Churillo, Weiler, & Campbell, 2016), research tends to suggest a negative association between selfies and self-esteem for the profile owner. In an experimental study, participants who took selfies, whether they were saved or posted to social media, showed decreases in self-esteem (Shin, Kim, Im, & Chong, 2017). In general, selective self-enhancement is negatively related to self-esteem and well-being (Robins & Beer, 2001), and instead, it is the honest self-presentation that enhances perceived social support and thereby has positive implications for subjective well-being (Kim & Lee, 2011). Adolescent girls believe that insecurity and low self-esteem are the root of the need to edit photographs to perfection (Chua & Chang, 2016). Furthermore, there is also increasing support for a link between selfies and self-esteem related to body image. For adolescent girls, sharing selfies correlated with over-evaluation of shape and weight, body dissatisfaction, and thin idealization (McLean, Paxton, Wertheim, & Masters, 2015).

Shin and colleagues (2017) argued that taking and sharing selfies may hinder self-esteem because of heightened self-awareness that one does not meet social standards. Specifically, according to objective self-awareness theory (proposed by Duval & Wicklund, 1972), self-awareness increases when individuals view images of themselves, which leads people to become more anxious about others' judgments about themselves, and make social standards and norms more salient. Since people often think they do not meet social standards when self-awareness is heightened (Gonzales & Hancock, 2011), there is the possibility that taking selfies would lower self-esteem. In fact, in one experiment, participants were instructed to take a selfie or a picture of an object using their own smartphone and then either post it on social media or save it (Shin, Kim, Im, & Chong, 2017). Those who were instructed to take a selfie, especially those who also posted it, showed heightened concern for other people's judgments and reactions to themselves compared to those instructed to take a picture of an object. This supports the objective self-awareness theory, suggesting that people became more socially sensitive after taking a selfie.

Although selfies do grab the attention of viewers over other types of photographs on social media sites (Ford, 2016; Souza, de Las Casas, Flores, Youn, Cha, Quercia, & Almeida, 2015), the attention may not be as positive as one hoped. Placing importance on the reactions of others may be detrimental to subjective well-being, given that selfies are not perceived in the best light. There is a clear preference for non-selfie, natural pictures of the self over selfies (Diefenbach & Christoforakos, 2017). Furthermore, the negative perceptions that people have of those who post selfies may translate into the quantitative and qualitative feedback selfies receive, and thereby influence one's self-esteem. In a study of perceived positive and negative aspects, people indicated that selfies are fake, a threat to self-esteem through the receipt of negative reactions, and result in negative impressions by others (Diefenbach & Christoforakos, 2017). Selfies are regarded as an inauthentic way of showing off (Lobinger & Branter, 2015). Consis-

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tently, selfie-posters are judged as being narcissistic, with males judged more harshly than females, and external raters assume posters are motivated to seek attention (Diefenbach & Christoforakos, 2017; Krämer, Feurstein, Kluck, Meier, Rother, & Winter, 2017; Re, Wang, He, & Rule, 2016; Sung, Lee, Kim, & Choi, 2016). Even though these comments come from people who post their own selfies, they justify their own selfie-posting behavior with the belief that their self-portraits are more authentic and self-ironic (i.e., selfie-bias; Diefenbach & Christoforakos, 2017).

In conclusion, on the one hand selfies may have positive implications for subjective well-being by establishing and maintaining relationships online. Alternatively, there is much more support for the risk of decreasing self-esteem, and thus for Facebook Depression, simply by taking selfies. The negative perceptions the public holds for selfie posters in general can translate to negative reactions posted online for all Facebook friends to see. In effect, the attempt to manage others' impressions and evaluations may be to no avail.

IS FACEBOOK UNIQUE?

Facebook facilitates communication with friends and family, social comparisons, and feedback from others, resulting in both positive and negative consequences for users' subjective well-being. These social factors and the associated ramifications, however, are not novel to Facebook. That is, Facebook is not the only setting in which people are able to acquire information about their friends and broadcast information about oneself; instead, individuals may socialize within a multitude of social networking sites as well as offline settings. In a study by the Pew Research Center (2017), the most-widely used of the major social media platforms after Facebook were Instagram, LinkedIn, and Twitter, with just under a third of Americans using each of these sites. In addition, roughly half of Instagram users and 40% of Twitter users visit these sites at least once a day. Also considered among the most popular social media sites is Snapchat (Duggan, 2015). The following provides an overview of the unique features and audiences for three other popular social media platforms - Twitter, Instagram, and Snapchat.

Twitter is a micro-blogging social media platform that restricts users' posts (known as tweets) to 140 characters. Users can and do typically follow other individuals with whom they do not have a relationship, such as celebrities, politicians, and organizations (Jin & Phua, 2014). On Instagram, users are also likely to interact with others they do not know in real life, but to a lesser degree than Twitter. Instagram provides users with a platform to take photos, edit them using a series of filters, and share them to their profile instantaneously (Ting, Wong, de Run, & Lau, 2015). Other users have the ability to follow individuals on Instagram, which allows the follower to view the owner's profile and photos, and for recently uploaded pictures to appear in the follower's Instagram newsfeed. Unlike Facebook where friending gives both partners access to each other's profiles, the action of following someone on Instagram does not automatically result in reciprocal following. Having followers as opposed to friends creates more acceptability and opportunity to view strangers' posts. In contrast, Snapchat is a photo-sharing application where users can send snaps (i.e., pictures and short videos that can include text and drawings) with friends that dissolve after a few seconds (Vaterlaus, Barnett, Roche, & Young, 2016). Therefore, in contrast to Facebook where posts are long lasting and often visible to a large audience, information shared on Snapchat is transitory and relatively private and thereby reducing the need to self-censor. In effect, communication via snaps has been viewed as more intimate (Utz, Muscanell, & Khalid, 2015).

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There are relatively few studies investigating the psychosocial outcomes of Twitter, Instagram, or Snapchat use. Of the research that is available, these social media platforms do appear to have similar outcomes as Facebook. It is argued that people do use Twitter to connect with others by staying updated about the lives of friends and acquaintances (Boyd, 2009), and that Twitter activity may be related to decreases in loneliness (Pittman, 2015) and increased feelings of camaraderie (Chen, 2011). Moreover, the multitude and variety of people being followed can increase social capital (Phua, Jin, & Kim, 2017). Similarly, social interaction is a key motivation for using Instagram (Lee, Lee, Moon, & Sung, 2015), and Instagram activity has been associated with positive effects for social capital (Phua, Jin, & Kim, 2017) and happiness (Pittman & Reich, 2016). However, there is a potential for negative effects on self-esteem when using Instagram that mirror Facebook. The combination of frequent selfie-posting by users (Hu, Manikonda, & Kambhampati, 2014), the ubiquitous selective self-presentation (Lee, Lee, Moon, & Sung, 2015; Ridgway & Clayton, 2016), and the frequent use for surveillance purposes (Sheldon & Bryant, 2016) may give rise to negative social comparison and decreased self-esteem. In contrast, Snapchat may offer the most positive outcomes of the social media platforms when considering social connectedness. From interviews of young adults for perceptions of how Snapchat behaviors influenced their interpersonal relationships, it was clear that Snapchat was praised for being a valuable communication tool (Vaterlaus, Barnett, Roche, & Young, 2016). Users felt that the ability to present messages using a combination of picture and text allowed for better understanding of the emotional context of the conversation (i.e., emotion can be shown in a picture and attached with a text message). Young adults indicated that Snapchat provided a way to remain close with their most important friends.

In addition to social networking sites, Facebook users still do interact with their friends face-to-face. Adolescents use social media predominantly to supplement rather than replace offline interactions with friends (Valkenburg & Peter, 2011). Social connections, social support, and social comparison are all associated with face-to-face social interactions in the same fashion as was discussed in the context of Facebook (Berkman & Glass, 2000). The socialization that occurs on Facebook, and other social networking sites, mirror those in offline settings. Thus, the increases and decreases in subjective well-being associated with sharing information, social connectedness, and social comparison are something that people experience regularly, and regardless of whether they use Facebook or any other social networking sites. What is different when face-to-face however, is the presence of verbal cues and body language. So although someone may present only the most positive and socially desirable information, his/her body language, clothing, tone of voice, eye contact, and so on when face-to-face may inadvertently reveal the truth. It may be then that the ability to selectively present and filter personal information posted on social networking sites make the negative effects in subjective well-being more salient online compared to offline interactions.

FUTURE RESEARCH DIRECTIONS

This chapter presented a review of the literature pertaining to Facebook, its features, and subjective well-being. The vast majority of research reviewed in the current chapter is cross-sectional and correlational. While this research can reveal the relationship between variables (e.g., passive use and poorer subjective well-being, or selfie-posting frequency and decreased self-esteem), the directionality and causal links among variables are speculative. Facebook Contentment and Facebook Depression present the perspective that Facebook use leads to increases and decreases for subjective well-being, respectively. However,

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it is equally plausible that those with already strong connections with friends turn to Facebook to share information. Alternatively, people with emotional distress may be inclined to view others' successes in Facebook without posting their own feelings of failures, which results in negative social comparison. Although there have been a few longitudinal studies that examined the directional effects of Facebook use, they were at the end of day (Verduyn, Lee, Park, Shablack, Orvell, Bayer, & Kross, 2015) or end of the week (Deters & Mehl, 2013). Examining relationships over a greater span of time would provide information on the long-term effects of Facebook use and provide perspective on just how detrimental or facilitating activities are for subjective well-being. In addition, a few studies have involved experimental manipulations of activity engagement to investigate causal implications (Deters & Mehl, 2013; Shin, Kim, Im, & Chong, 2017; Verduyn, Lee, Park, Shablack, Orvell, Bayer, & Kross, 2015). Similar research is needed to assess the relationship between selfies and subjective well-being. Specifically, it is relatively unknown whether the negative perceptions associated with selfie posting translate into the quantitative or qualitative feedback that a selfie poster receives, and whether this information has any meaningful long-term effects for the target.

Longitudinal studies are also necessary to evaluate the practical significance of the relation between Facebook activity engagement and subjective well-being, or related constructs. Although passive Facebook use and selfie-posting are correlated with decreased subjective well-being and self-esteem, respectively, there is no evidence to suggest a major concern for users. On the other hand, however, Facebook use may have additive effects over time, ultimately resulting in decreases in subjective well-being to levels that would significantly affect an individual's psychosocial functioning. The questions that arise then are: Does passive Facebook use or sharing selfies over time lead to depression at a clinical level? Moreover, does this effect exist after controlling for overall mental health? Therefore, longitudinal research would be valuable for understanding any reciprocal relationships between use and psychosocial functioning as well as additive effects.

Furthermore, research investigating who is most affected by using Facebook and posting selfies is scarce. While some studies suggest that females may be most at risk (Dhir, Pallesen, Torsheim, & Andreassen, 2016; Weiser, 2015), there are other factors that also need attention. For instance, given the fact that cultural values and expectations are important factors that influence subjective well-being (Diener, Oishi, & Lucas, 2003) and social relationships (Kim, Sherman, & Taylor, 2008), it may be that the effects for subjective well-being derived from using Facebook and posting selfies are culturally dependent. In addition, researchers have identified that individuals who are shy or socially anxious may exhibit benefits from online interactions in general (social compensation hypothesis; Valkenburg & Peter, 2007). Last, people who have particular expectations of their Facebook friends regarding the content and frequency of feedback to postings may also exhibit the largest effects to self-esteem. Although Facebook users typically report receiving the amount of feedback they expect (Joseph, 2017), there is evidence that sharing information online without receiving a response leads to feeling ostracized (Smith & Williams, 2004). Thus, it is plausible that how using Facebook and posting selfies affect subjective well-being depends on cultural values, current level of shyness, or expectations of other users.

CONCLUSION

What is clear across the current Facebook literature is that Facebook serves as a double-edged sword - a communication medium that could lead to feelings of inadequacy and envy, but at the same time facilitate

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social relationships. Offering support for the Facebook Contentment perspective, active Facebook use often correlated with enhancements in subjective well-being through feelings of social connectedness. This was true for active use in general and when examining activities that resulted in some level of self-disclosure. In contrast, selfie-posting behavior, when driven by attention seeking motives, presents consequences that are more negative. Similarly, passive Facebook use typically was associated with emotional distress as a function of negative social comparison, which supports the risk for Facebook Depression. It should be noted that the mediating factors in the associations between active and passive Facebook use with subjective well-being (i.e., self-disclosure, jealousy, negative social comparison, feedback from others, and selective presentation) are not unique to Facebook. People engaged in these social activities prior to the advent of the Internet and social media, and will continue to engage in these when they move on to the next popular social media platform. Therefore, more longitudinal and experimental studies are required to truly understand the significance of active and passive Facebook (or any other social media) use for long-term changes in mental health.

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KEY TERMS AND DEFINITIONS

Active Facebook Use: An approach by which Facebook users interact with other users through sharing textual and pictorial information, sending messages, and reacting to others' posts.

Facebook Contentment: A phenomenon related to Facebook use that is characterized by positive outcomes for psychological functioning and wellbeing.

Facebook Depression: A phenomenon related to Facebook use that is characterized by negative outcomes for psychological functioning and wellbeing.

Negative Social Comparison: Instances where the targets of social comparison appear to be doing better than oneself.

Passive Facebook Use: An approach by which Facebook users surveil others through scrolling the newsfeed, and browsing timelines.

Positive Social Comparison: Instances where the targets of social comparison appear to be doing worse than oneself.

Self-Esteem: A global self-evaluation of one's own self-worth or value.

Selfie: A photograph of oneself, alone or with others, taken with a smartphone held at arm's length or pointed at a mirror.

Social Connectedness: Feelings of belonging and staying in touch with ongoing social relationships.

Subjective Wellbeing: The evaluation of one's own life including an assessment of overall life satisfaction and emotional responses to life events.

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Chapter 62
From Medical Student to Medical Resident:
Graduate Medical Education and Mental Health in the United States

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ABSTRACT

The transition from medical school to board-certified medical practice includes a period of intense, practical training known as medical residency. Medical residents are at risk for greater mental health distress than the general population. Interns, which are first year residents, are most at risk for, at worst, depression and suicidal ideation, and, at best, negative outlooks on the medical profession. Risk factors include role transition, decreased sleep, relocation, isolation, stigma toward mental health problems and treatment, and health care industry changes. Untreated mental health problems can lead to burnout later during a physician's career. Residents thrive on social and organisational support which can include systematic screening and treatment of mental health problems. Although research regarding best practices for addressing mental health problems during residency is limited, we offer four core strategies for preventing and addressing mental health problems in medical residents: education, screening, treatment, and support.

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INTRODUCTION

The purpose of graduate medical education (i.e., medical residency) is to cultivate competency, enthusiasm, and confidence within new medical school graduates and prepare these newly minted physicians for a rewarding and successful career in medicine. Residency training in the United States is primarily distinct from medical school education. Residents, unlike medical students, are fully responsible for the treatment of large panels of patients which means they order laboratory and diagnostic tests, perform surgical procedures, make referrals, and design treatment plans. In addition, residents spend long hours during inpatient and outpatient shifts including night rotations and on-call hours. This particular training is necessary for physicians to develop the skills and temperament required for medical practice. However, such training also exposes residents to isolation, role transition, fatigue, and stress.

While it is clear that residents are at greater risk for depression and suicidal ideation than the general population, researchers have not yet identified the best practises for addressing resident mental health (de Oliveira et al., 2013; Goldman, Shah, & Bernstein, 2015; Govardhan, Pinelli, & Schnatz, 2012). Some qualitative data shows that social support is crucial (Mata, Ramos, Kim, Guille, & Sen, 2016). The medical school literature shows promising results for physical activity, organisational changes and support (e.g., pass/fail grading, faculty advisors, and student retreats), and mindfulness training (Drolet & Rodgers, 2010; Kötter, Tautphäus, Obst, Voltmer, & Scherer, 2016; Slavin & Chibnall, 2016). In this chapter, the authors will describe the transition from medical school to residency training, the relationship between residency training and resident mental health, the effect of chronic stress on resident wellbeing, and a four-part programme for supporting resident mental health.

BACKGROUND

Residency selection is a long and cost-intensive process. During the fourth year of medical school in the United States, students apply to multiple residency programmes devoting significant money and time. Concurrently, residency directors and coordinators spend substantial resources recruiting and interviewing students for a limited number of slots. After interviews conclude, faculty members meet and rank all applicants according to programme fit and quality. Osteopathic students match to their respective residency programmes at the beginning of February while allopathic student match in the middle of March. Residency selection is a long and arduous process for both sides. New residents report to their programmes in June or July, complete orientation, and begin their first rotations.

First-year residents (interns) hit the ground running. Even during orientation, interns are signing medical orders and patients charts. They assume responsibility of continuity patients from recently graduated residents and make treatment decisions at the hospital. With a limited patient panel and under the watchful supervision of attending physicians, interns act like fully-functioning physicians. During the first three months of residency, incidences of depression can increase from 4% to 27% while suicidal ideation can increased nearly 400% (Sen et al., 2010).

In an effort to curb resident fatigue and distress, the Accreditation Council for Graduate Medical Education (ACGME) mandated resident duty hour reforms which, among several requirements, capped residents' weekly duty hours at 80 per week (Bolster & Rourke, 2015). There is no doubt that residents work long and hard hours; yet, it is unclear if limiting resident hours is beneficial to patient care and resident well-being (Bolster & Rourke, 2015; Lin, Lin, Auditore, & Fanning, 2016). Under long periods

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of duress, residents can experience allostatic load (i.e., chronic stress) which puts them at risk for mental health problems like depression (McEwen, 2003). Chronic stress can lead to feelings of isolation and helplessness, social withdrawal, and impaired immunity function. In addition to stress, residents also grapple with mental health stigma and poor work-life balance (Billings, Lazarus, Wenrich, Curtis, & Engelberg, 2011; Mata et al., 2016). These experiences can create negative frameworks of patients and medical practice and lead to future burnout.

Transition From Medical School to Medical Residency

The mental health of residents is partially understood when examining the experience of medical school and the transition to graduate medical education. Life transitions, such as those experienced by new medical students, are times of high stress. The impact of stressors is reduced when people have high levels of mastery, high self-esteem, and/or have social support (Thoits, 2010).

Medical school curricula vary. In most U.S. medical schools, the initial two years of school are taught in the classroom, a familiar setting for students who have recently completed four years of undergraduate education following twelve years of primary education. The structure of medical school is such that there is a high level of social support built into the first two years. All first year students take the same courses together. Synchronised schedules give students time off concurrently, creating an opportunity to socialize, celebrate, and commiserate together. The large medical school class is frequently divided into smaller work groups (e.g. a group of four that share a cadaver; groups of eight to twelve that meet for problem-based learning) that naturally form social networks. These social networks and social support help medical students cope with the increased stresses inherent in medical school.

Medical school is a time of high stress (MacLean, Booza, & Balon, 2016). The pace of medical school is much faster than anything students experienced during college. Prior to medical school most students are the best or brightest in their class. In medical school, these students are surrounded by others who have achieved as much as they have, and are in competition with other high achievers for grades if they desire the most coveted residency positions.

By the end of the second year of medical school, students are required to pass the first of three parts of the United States Medical Licensing Examination (USMLE). The USMLE is designed to assess a physician's ability to apply knowledge, concepts and principles to demonstrate fundamental patient-centered skills. The first step tests classroom knowledge. This test generates anxiety: If students do not pass, they are not promoted to the next year of medical school and may not graduate. If students pass but do not excel, they may not be considered for residency spots in highly competitive medical specialties (e.g. dermatology, ophthalmology, radiology).

During the initial two years of medical school, there is a gradual introduction to patient care. In some U.S. schools, students are first exposed to patients during a physical diagnosis course taught in the latter half of the second year of school. In other schools there is longitudinal exposure to patients beginning in the first year. This controlled exposure to patient care is used to prepare students for the final two years of medical school, the clinical clerkship years. During the third and fourth year of medical school (the clerkship years) students interact with patients in hospitals and in physicians' offices.

The clerkship years bring new stressors. Beginning in the third year of medical school, students are no longer in a single large cohort. Due to the limited ability to provide teaching/learning activities for all the students at once, students rotate through the different clinical disciplines at different times. Each students' peer support group grows much smaller as schedules are no longer synchronised.

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The clerkship years are frequently the first-time students are exposed to death and dying (MacLean et al., 2016). There is usually not time to process these new experiences and there is typically no guide or structure to do so. Medical students may not know what to do with their feelings, and may be encouraged to ignore them or bury them, leading to increased stress.

During the preclinical years, students typically have learned that there is a 'right answer' or a 'wrong answer' to questions that are posed regarding medication choice, test ordering, and diagnosis. Once in the clerkship years, students see that there are multiple possible answers to every clinical question. This can be frightening to the learner and can lead to a feeling of lack of control (MacLean et al., 2016). It can be stressful to the learner who does not know if the reason there is no clear answer is because they are inadequate or if there truly is no answer.

Medical Residency Training

Changing roles from medical student to physician is a major life stressor. After spending 20 years as students receiving financial and other support from parents and others, the new resident physician may now be facing life issues for the first time (Coates, Spector, & Uijtdehaage, 2012). College students and medical students typically accrue debt. Once they are graduates, residents are now members of the adult work-force, many for the first time in their lives. While in school the burden of debt felt theoretical; now that loans have started to come due, the debt is real. Financial concerns are atop the list of stress producing situations for new residents (Coates et al., 2012).

For those residents who never held full-time employment prior to residency the reality of work is shocking. Resident hours are long and inflexible. Residents work on weekends, holidays, and special occasions (e.g. birthdays). Calling in sick is not an easy option. Lateness is not excused or overlooked.

The biggest stress for new residents is assuming responsibility for patients' lives. Medical schools give students the opportunity to observe and participate in patient care, but at no point are medical students solely responsible for patient care decisions. They may suggest a diagnostic test or medication, or list potential diagnoses, but ultimately the resident and attending physicians are responsible for making decisions. No medical student orders are taken off the chart unless cosigned in hospitals, and no prescriptions solely signed by a medical student can be filled at a pharmacy. From the first day of residency, residents are given the responsibility of responding to pages, writing patients' prescriptions, writing orders, and making clinical decisions. The realisation that every decision needs to be made and that each of these decisions have implications for patients' wellbeing can be harrowing to the new resident (Abuhusain, Chotirmall, Hamid, & O'Neill, 2009).

When medical students graduate medical school, they are no longer students; they are now 'doctors'. This title change alters perceptions. Faculty, peers, and even family members look at these newly minted physicians as professionals who have sworn an oath to put patients' needs above their own. From day one in residency, these doctors are responsible for their patients' care, and will be held to the same standards as physicians in practice for twenty years. Patients in the hospital and in the office do not distinguish between a resident starting her first day and a resident who has completed her training. Patients look at these new physicians as competent professionals, even if the resident does not feel competent. A new resident can feel like an imposter.

Residents in training are given progressive responsibility. From day one, residents are responsible for their own panel of patients. As they progress through residency training, the size of the resident's panel grows. Early in training residents are directly supervised. As they develop competence and confidence,

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the residents are directly observed less frequently, and instead report to a preceptor during each patient encounter. During this report, the preceptor gives the resident feedback on presentation skills, thinking and organization, and patient care. Residents are asked to make assessments and plans which are reviewed by the preceptor. The resident-preceptor relationship is integral for developing confidence and competency.

Second year and third year residents have fewer required rotations and more elective rotations. As they progress through training they have increased responsibility in the inpatient and outpatient settings. In outpatient care, their patient panel grows dramatically at the conclusion of their first year. By the end of third year, residents see patients at a pace similar to community physicians. Residents are required to precept all patient encounters during their first year of residency. After successful completion of their first year in residency, residents are no longer required to universally precept, and subsequently have less time allotted into their schedule to see each patient.

In addition to office and hospital-based experiential learning, residents are taught in longitudinal seminar series. Humanism and professionalism are taught by example but also through readings and discussion. Practice management, likewise, is taught by example and through didactics. As residents grow in medical knowledge and develop a professional identity, they develop a sense of mastery which helps to mitigate residency distress. Residents are required to teach themselves, alongside faculty instruction, in order to obtain this competency.

Residency training challenges new physicians on a variety of personal and professional skills. Program directors identify a lack of medical knowledge as only one of the common struggles interns face. Lack of self-reflection and improvement, poor organisational skills, and underdeveloped professionalism were identified as deficits in a study of thirty residency program directors across ten specialties (Lyss-Lerman et al., 2009). These deficits are developmentally appropriate and expected for young residents and can lead to frustration and undue distress when not addressed by the resident and supporting faculty.

Residents are evaluated on each rotation (with both formative, mid-rotation evaluations and summative, end-of-rotation evaluations) and longitudinally. Evaluations allow faculty to measure the progress of residents and identify any deficits in patient care or professionalism. Knowledge is evaluated during rotations and by standardised exams administered annually. Physicians in practise are required to maintain certification once they have been specialty board certified. Residents are introduced to this process during residency and complete certification modules during each of their three years of training.

As residents progress through the training their patient care ability matures. They are treated more as colleagues when they are PGY-3 residents than they were when they were PGY-1 residents. By the time they are allowed to graduate, residents are ready to be independent practitioners.

Medical Residency and Mental Health

Mental health is the combined emotional, psychological, and social well-being of an individual and determines how that individual handles stress, relates to others, and makes choices. Burnout is a state of chronic stress that leads to physical and emotional exhaustion, cynicism and detachment, and feelings of ineffectiveness and lack of accomplishment. Burnout is more common among physicians than other US workers (Shanafelt et al., 2012). Over the past several years, physician burnout has increased with one estimate that more than half of US physicians are experiencing professional burnout (Shanafelt et al., 2015). Mental health support and treatment can help medical residents develop resiliency and alleviate the effects of stress from graduate medical education.

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The purpose of graduate medical education (i.e., medical residency) is to cultivate competency, enthusiasm, and confidence within new medical school graduates and prepare these newly minted physicians for a rewarding and successful career in medicine. The process by which residents grow and develop is purposefully intense and, consequently, places residents at risk for experiencing poorer mental health. Compared to the general US population, medical residents are at greater risk for poorer mental health (Dyrbye et al., 2014). The importance of addressing resident mental health cannot be overstated. Untreated mental health can undermine residents' professional development, negatively affect patient care, and lead to mental illness and suicidal ideation (Dyrbye & Shanafelt, 2016).

It not entirely clear why residents are at risk for poorer mental health due to a lack of large, prospective studies. However, it seems that factors within the learning and work environment, rather than individual attributes, are the main drivers of mental health problems (Dyrbye & Shanafelt, 2016). Moreover, resident distress does not seem to be the result of poor medical knowledge and suboptimal clinical performance (Beckman, Reed, Shanafelt, & West, 2012). Rather, it seems that unmitigated burnout and distress lead to increased medical errors (Fahrenkopf et al., 2008; West, Tan, Habermann, Sloan, & Shanafelt, 2009), decreased empathy (West et al., 2006), and unprofessional conduct. One common result of burnout is depersonalisation which causes physicians to act callous or detached towards patients (Dyrbye et al., 2008; Shanafelt, Bradley, Wipf, & Back, 2002).

Risk and Protective Factors

There are several risk factors that can lead to poorer mental health outcomes for medical residents: prior history of mental illness, poor work-life balance, organisational stressors, and health care industry change. The first three apply to all US workers while the latter is unique to physicians. Whether due to family genetics, adverse childhood events, or ineffective coping strategies, residents with a history of depression, anxiety, trauma-related disorders, or serious mental illness (e.g., bipolar disorder, schizophrenia) are at greater risk for poorer mental health during residency training. Mental health stigma in the medical profession can discourage residents from recognising their own mental illness and seeking support and treatment. Some may minimize or veil their personal struggle with mental illness in order to be accepted into and complete residency training (Cooley-Wilder, 2016).

Work-life balance is the sense that one's work schedule allows time for personal and family activities. Dissatisfaction with this balance is a symptom of either an overburdening employer or a resident who does not schedule time for activities outside of work. Most residents are young adults with limited life experience and few if any robust coping strategies for stress. In addition, graduate medical education places residents in a variety of new health care systems with long hours and heavy responsibilities. When not directly taking care of patients, residents spend time completing medical charts, preparing for examinations, and other residency requirements. Residents with a poor work-life balance may not engage in physical activity, nutritious eating, good sleep hygiene, and social and community activities.

Organisational stressors include chronic high workload, lack of training and support, and unclear roles and responsibilities (Kapinos, Fitzgerald, Greer, & Rutks, 2012). The workload of a resident depends on the rotation and medical setting. For example, a resident on a hospital medicine rotation will work long shifts for several days in a row treating very sick patients. Meanwhile, a resident on an outpatient clinic rotation will work a shorter shift and have more time to rest. A high workload is normal in residency training and is offset by the change in responsibilities and stress. For example, the resident who completes a demanding rotation with long hours may then start a new rotation with a lighter load. This oscillation

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of schedules allows residents to recover and build stamina over time. Chronically high workloads do not allow residents to recover and lead to distress and burnout.

Residents need orientation training (e.g., didactics, shadowing, training modules) to learn electronic medical record systems, clinical policies and protocol, organisational hierarchies, academic requirements, building layouts, and more. Residents also need peer and faculty support to recover from stress, answer questions, and receive feedback. Residents who relocate from far away for residency training may especially need social support. A lack of training and support is a sign that a residency programme has few resources, is disorganised, or is not invested in resident mental health.

The third organisational stressor, unclear roles and responsibilities, is a direct consequence of the second stressor (WHO, 2003). Residents work in multiple health care systems with multiple providers during their training. When residents consider their role and responsibilities as unclear, they feel a lack of control with their environment and experience distress. For example, a resident who does not know which patients are under her responsibility and which attending physician to report to will experience distress. A resident who covers hospital admissions at night but does not know the protocol will experience distress as well. Most residents will quickly learn how to work in various systems but residents who are constantly confused about their place in a system will flounder.

Most of the risk factors listed thus far are not unique to residency training; most individuals are at risk for poorer mental health with mental illness, poor work-life balance, and little social and organisational support (World Health Organisation, 2012). A risk factor that is unique to residents is the constant change in the US health care industry. Residents are beginning a medical profession at a time of massive change and regulation in US health care including pressure from government, payers, and patients. Since the passing of the Affordable Care Act in 2010, physician burnout has increased by 10% compared to the US working population, even after controlling for other factors like number of hours worked, age, sex, and relationship status (Shanafelt et al., 2015). Some medical specialties report burnout rates of well over 50%. This is a concerning trend which may influence medical students to choose medical specialties that are less stressful but sorely needed.

In a large review of nearly 400 meta-analyses, researchers identified three major risk factors as genetic (e.g., multiple gene polymorphisms, gene networks), psychological (e.g., self-esteem, emotional intelligence, learning disabilities, mental health history), and physiological and health (e.g., physiological vulnerabilities and strengths, illness and disability, obstetrical and perinatal factors) (Furber, Leach, Guy, & Segal, 2016). These findings fit with a World Health Organisation report that states, in addition to individual characteristics, mental health is influenced by social circumstances and environment across the life span (World Health Organization, 2012). The worst outcome of resident mental illness is suicide. Residents are at greater risk for suicidal ideation than the general population (Sen et al., 2010). It is not clear how many residency programs screen for depression and suicide much less talk about it as well. Mental health treatment is effective and can help those residents struggling with feelings of hopelessness and helplessness. Residency programmes can even go further by investing in preventive services to help residents manage stress and avoid a journey toward burnout and possible mental illness.

Protective factors for residents include wellness activities that benefit virtually all human beings. Residents need social and organisational support to mitigate the effects of stress and orient themselves to new health care systems. Residents also benefit from a work-life balance that includes activities of self-care like physical activity, restful sleep, and healthy eating habits. Mindfulness training can specifically help residents alleviate the effects of burnout (Krasner et al., 2009).

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One of the most significant changes in 21st century graduate medical education is resident duty hour restrictions (DHR). Historically, residents would complete 30 hour shifts and then rest. In 2002 the Accreditation Council for Graduate Medical Education (ACGME) mandated that intern resident shifts be restricted to 16 hour shifts, and a maximum of 80 hours per week (Philibert, Friedmann, & Williams, 2002). In 2011, the ACGME revised the 2002 rules and added more extensive guidelines for resident supervision and patient handoffs. Since the inaugural restructuring, DHRs have remained a source of controversy and empirical inquiry. Despite the numerous publications on the subject, studies on the impact of DHRs suffer from limitations.

It is not clear if DHRs are good or bad for residents (Bolster & Rourke, 2015; Lin et al., 2016). Obviously, the field needs large, prospective studies of interventions over a long period of time to further distil trends. The current research suggests that DHRs have not delivered on their promise for significantly improving resident wellness. Some reforms like night float have the opposite intended result. This suggests that DHRs are not the main strategy for preventing poor mental health outcomes among residents. Indeed, some may intuit that residents need lighter workloads and shorter shifts when perhaps the most effective strategy is an organised programme of resident wellness and support in tandem with a demanding education experience.

The Spectre and Spectrum of Stress

Sound mental health does not equal the absence of stress. Stress is a natural phenomenon and provides the functional benefit of recognizing physical and psychological reactions to external stimuli. This operational view of stress is counterintuitive to many clinicians and to society as a whole who typically perceive stress as a 'killer' that requires elimination. It is impossible to eliminate stress and research shows that a negative perception of stress is harmful. In a large study of nearly 30,000 U.S. adults, 34% of survey respondents perceived that stress affected their health a lot or to some extent (Keller et al., 2012). This negative perception of stress increased the likelihood of worse medical and mental health outcomes. Those who reported high stress and believed stress affected their health a lot had a 43% increased risk of premature death.

There are two implications of this study on resident mental health. First, residents can benefit from a holistic perception of stress as signals that the body is energised and ready to meet a challenge. Residents who perceive stress as a sign of incompetence or failure do not understand the correct role of stress in their lives as well as the nature of residency training. Such residents may attempt to remove or diminish stress using avoidance behaviours (e.g., not collaborating with peers and attending physicians, not seeking feedback and instruction) or creating unrealistic expectations for themselves (e.g., 'I should not feel stress'). Stress is undoubtedly uncomfortable and when experienced at high levels and for long periods of time is detrimental (Schneiderman, Ironson, & Siegel, 2005). Research indicates that a stress-as-enhancing mindset moderates cortisol reactivity and induces a desire for performance feedback (Crum, Salovey, & Achor, 2013).

The second implication is that faculty can teach residents to recognise stress and respond in a healthy manner. Faculty can also set the example by effectively managing their own stress and creating a residency culture that allows safe discussions on stress and wellness. Residents are acutely observant of faculty behaviour and what is known as the 'hidden curriculum' which are unintended messages conveyed by faculty, staff, and senior residents (Billings et al., 2011). A hidden curriculum condones certain behaviours and results in creating a residency culture that may not be intended by the faculty. For example,

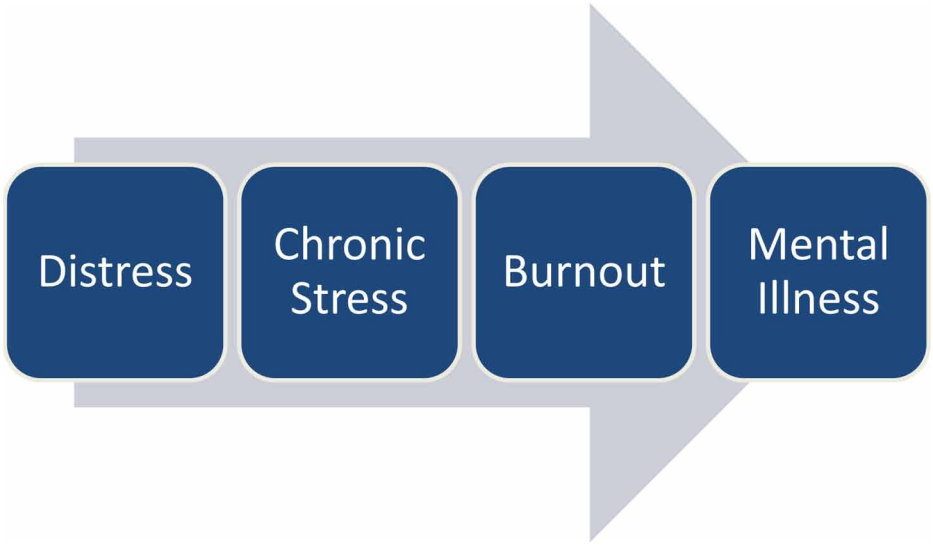
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faculty who disrespect others in front of residents passively excuse such behaviour. Faculty who have a poor work-life balance and complain about work convey unintended messages of poor stress identification and management.

Stress is not a spectre that residents and faculty should fear. Through education, residents can see stress as a vital alert system that connects them to the inherent wisdom of their bodies. This alert system developed over eons of times. From an evolutionary standpoint, the primitive ancestors of the human race who survived the jungles and savannahs of the past were the ones with an effective stress response that alerted them to dangers. Humans today carry that same alert system in relatively safe towns and cities of the modern era. In addition, the cardiovascular response to stress includes an increase in heart rate and blood vessel constriction which is similar to the physiological state of positive emotions like joy and courage. People who view their stress as helpful still experience increased heart rates but without the constriction of blood vessels which is a risk factor for cardiovascular problems. This stress-as-enhancing mindset does not always fit neatly with American ideals like rugged individualism. Through teaching and leading by example, residents can learn to see stress as an ancient ally and not a spectre.

One helpful tool for teaching residents is the spectrum of stress which includes distress, chronic stress, burnout, and mental illness (McEwen, 2003, 2004; see Figure 1). Each stage represents not only the accumulated level of stress but the response of the individual as well. The first stage, distress, is a common experience caused by a sense of real or implied threat that activates involuntary mechanisms (e.g., elevated heart and respiratory rates, increased alertness). The sympathetic nervous system becomes active and primes the body for attention and action by increasing the flow of oxygen to vital areas of the body like the brain.

Figure 1. Spectrum of Stress



Consider the following example: a resident is paged for a possible hospital admission and upon meeting the patient recognises several distressing personal medical symptoms. Her physiological response to the situation provides energy and focus for the task at hand. As she completes the admission, her

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parasympathetic system returns her body to a state of rest until the next activation. If the resident feels inadequate to address the patient's health status and does not have peer or supervisory support, then the resident's distress level will increase in both time and intensity. Even this uncomfortable situation has a functional role in that the resident's body is alerting her to the lack of knowledge and support. The resident can actively address the medical knowledge deficit or develop a strategy for collaborating more effectively with peers and supervisors. If the resident does not address the knowledge deficit or avoids collaboration, then the distress can become a prolonged experience and increase the chance of repeating in the future (Gross & Levenson, 1997).

Residents can cope with distress when it comes in short episodes followed by periods of rest. This allows for physical and psychological resources to replenish. Chronic or prolonged states of arousal and alertness can lead to fatigue, burnout, and even mental illness, especially when the individual perceives the stress as bad. The accumulation of stress over time is usually gradual and can include small stresses that combine into a generalized or continuous feeling of distress. Accumulated stress, however, is not the sole cause for chronic stress. The resident's reaction to the daily stress is just as important, if not more so, as the amount of stress (Crum, Salovey, & Achor, 2013). For example, a resident who works in a low income, urban area with a very sick patient population and with few resources may experience daily distress with little alleviation. If the resident has strong social and organisational support and begins a new rotation in a less stressful setting, then he will likely return to a state of respite. If instead he worries about his ability to care for very sick patients, begins avoiding similar patients in the future, and does not disclose his feelings to peers and supervisors, he may begin to experience chronic distress over the issue. His avoidance reaction exacerbates and extends a normal stress experience (Gross & Levenson, 1997).

Chronic stress affects all systems in the body. When the body is stressed, muscles tense to protect the body from injury and pain. Long-term musculoskeletal tension can lead to other problems like headaches and physical pain. Prolonged periods of stress can contribute to cardiovascular problems possibly due to the inflammation of coronary arteries. Cholesterol levels can rise as people develop a sedentary lifestyle and unhealthy eating habits in response to stress. When stress hormones (e.g., cortisol, epinephrine) are released, the liver produces more glucose for energy. People with diabetes are at risk for complications when extra glucose is released due to stress. Chronic stress also affects the gastrointestinal system leading to stomach pain, diarrhoea, and constipation. All of these bodily changes contribute to an overall state of exhaustion as the nervous system is constantly aroused. Residents and faculty can attend to these physical symptoms and prevent chronic stress from developing into burnout and even mental illness (Drolet & Rodgers, 2010).

Burnout is a syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings (Maslach, Jackson, & Leiter, 1996). Burnout affects physicians and their families, impacts patient care, and contributes to physician turnover. One study estimates that over half of all US physicians are currently experiencing burnout (Shanafelt et al., 2015).

In regard to residents, one study of 47 Dutch residents found 31% met the criteria for burnout which was significantly associated with work-family conflict, work-related autonomy (amount of control over work activities), and work-engagement (level of vigour, dedication, and absorption at work) (Ringrose, Houterman, Koops, & Oei, 2009). A study of anaesthesiology residents found 41% met burnout criteria (de Oliveira et al., 2013). Risk factors for burnout included working over 70 hours a week, consuming more than five drinks with alcohol a week, and female gender. One large study of over 1,700 residents found a 60% burnout rate, higher than medical students and early career physicians (Dyrbye et al., 2014).

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Residents were more likely to report high levels of depersonalisation (50%) than medical students (37%) and early career physicians (37%).

Burnout is the result of working with difficult patients or being exposed to patient suffering for extended periods of time without adequate opportunities for recuperation. Physicians can feel a sense of psychological numbness, a disconnection from others, and apathy to the suffering of others. This is similar to symptoms found in trauma-related disorders like post-traumatic stress disorder in which people survive highly stressful events and then experience a debilitation of adaptive abilities.

The most common measure for physician burnout is the Maslach Burnout Inventory (MBI; (Maslach et al., 1996). There are three domains within the MBI: emotional exhaustion, depersonalisation, and personal achievement. Emotional exhaustion includes items like 'I feel emotionally drained from my work' and 'I feel used up at the end of the workday'; depersonalisation includes items like 'I feel I have become more callous toward people'. One major limitation of the MBI is that it was normed for physicians and other US workers, not for residents who are under supervision and moving to and from various medical settings. This raises serious questions about the validity of the MBI in measuring resident burnout. Yet the vast majority of studies on resident burnout use the MBI (Dyrbye & Shanafelt, 2016). Futures studies should develop an inventory normed to the unique experience of graduate medical education.

Another limitation for any burnout inventory is that it does not focus on resilience which is the ability to adapt in the face of significant adversity, past or present. Burnout denotes pathology and deficits in positive adaptability and subtly minimises ways in which residents successfully cope with difficult tasks. Resilience is a resident's ability to struggle well during his or her training. It includes multiple individual and environmental factors that provide a protective benefit to the resident. Resilience incudes periods of accumulation and maintenance and does not necessarily mean that the resident accomplishes every single goal. Rather, resilience helps the resident to persevere even when temporarily failing. Resilience can be taught but must be practised. Resilience can help a resident to recover from burnout and avoid developing a mental health disorder.

Resident mental illness has received national attention in the past few years. In the first two months of the 2014-2015 academic year two medical interns in New York City died from two separate suicides. Soon thereafter, an intern from Yale School of Medicine wrote an op-ed in the *New York Times* about the effects of medical training on mental health (Sinha, 2014). Rates of depression can increase sevenfold for medical interns during the first three months of training while rates of suicidal ideation can increase by 370% (Sen et al., 2010). In one study of paediatric residents, 20% met criteria for depression and were six times more likely to commit medical errors (Fahrenkopf et al., 2008). It is not clear how many residents seek mental health treatment. In one study of 385 medical students, 34% who reported depression or anxiety sought mental health counselling (MacLean et al., 2016).

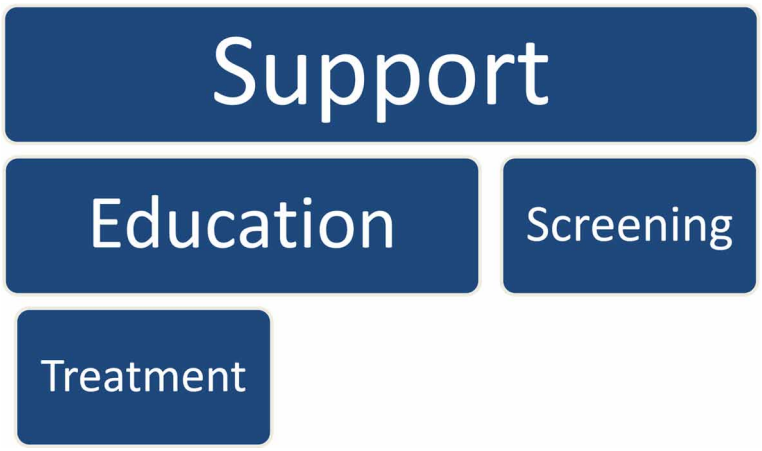
Whereas burnout is emotional exhaustion from working in a highly stressful environment, mental illness refers to specific diagnosable health conditions in which an individual's capacity to think, behave, and interact with others is affected. Mental illness is correlated with increased rates of morbidity and mortality (Walker, McGee, & Druss, 2015). There is no current literature on pathways between physician burnout and mental illness. Moreover, the genesis of mental health problems for any individual is multiple and varied.

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Mental Health Programme for Medical Residents

The goal of a mental health programme for medical residents is to train residents in self-awareness and self-care and develop a culture of wellness and support. Programme directors and faculty play a vital role in ensuring residents are equipped for thriving during residency training. The authors offer a four-part template that residency programmes can use for tailoring their own distinctive programme (see Figure 2).

Figure 2. Mental Health Wellness Program



Support

The most significant mental health benefit a residency programme can offer is a culture of wellness and support which requires a concerted and intentional effort by all faculty, staff, and residents. Organisational support does not happen spontaneously. Residency leaders must diligently structure wellness activities and nurture key relationships between faculty and residents to generate any mental health benefits. The authors offer four ways to give organisational support.

First, nurture relationships between faculty members and residents. In a highly supportive residency culture, faculty advisors and supervisors take a genuine interest in the lives of their residents, including their experience in residency training and what happens outside of medicine. The same advisors are assigned to residents throughout their entire training and advocate for their wellbeing, including asking direct questions about mental health. Advisors and preceptors give direct, effective feedback and help residents clearly understand what they are doing well and what needs improvement. This feedback is both formative and summative and does not require a request from the resident. Continuous feedback instils confidence and trust between the faculty and the residents.

Second, identify and buffer stress points. Stress is a natural part of graduate medical education. In a highly supportive programme, faculty and staff identify time periods in which residents will experience high levels of stress (e.g., intern year, examinations, demanding rotations, life transitions) and design activities that alleviate the stress as much as possible. For example, a long period of orientation helps interns to fully understand the residency culture, their roles and responsibilities, and resources for sup-

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port. Orientation helps interns to quickly develop relationships with faculty and upper-level residents. In another example, faculty use weekly didactics during examination periods to prepare residents for upcoming exams (e.g., question banks, exam topics) which supplements the residents' personal study. Finally, faculty assist residents who are experiencing a life event or transition (e.g., marriage, loss of loved one, new-born) to create a rotation schedule that fits the resident's current needs. Programmes that anticipate and acknowledge stressful time periods will more effectively manage the unanticipated events (e.g., faculty departure).

Third, include resident leadership in designing and implementing a mental health programme. Supportive programs include residents in designing activities that promote wellness (e.g., residency retreat, lunch meetings, walking groups, and movie and dinner clubs). Residents feel part of the organisation and believe that their ideas matter. Supportive programmes ask chief residents to regularly report any concerns about residents and even consider assigning upper-level residents as peer-support to incoming interns to help with housing options, orientation, schedules, and more. Faculty request ongoing feedback from residents about the residency culture using online surveys, informal focus groups, and advisor meetings. Residents have the advantage of being newcomers to a residency culture and can provide a fresh perspective on strengths, weaknesses, opportunities, and threats.

Fourth, design formal and informal wellness activities. Supportive programme design formal activities like residency retreats, lunch meetings, and didactics that are fun, engaging, and informative. The benefit of formal activities is that they can be scheduled during normal residency hours which protects the time residents have for themselves. Informal activities can include dinner groups at the home of a faculty member or resident, movie clubs, coffee meetings, and volunteer service projects. Some residents will form social groups and events on their own while other, more reserved residents will benefit from faculty-supported activities.

Volunteer service helps residents to become involved in the community, meet new people, develop empathy for vulnerable populations, and reflect on their own personal and professional values. Service has a stress-buffering effect on health, especially for residents who value the service (Poulin, 2014). Supportive programmes create opportunities outside of residency requirements for residents to serve in the community (e.g., homeless shelter, soup kitchen, school tutoring, sports events, natural disaster relief, free medical clinics, and health fairs). Faculty members lead by example in serving the community and invite residents but do not require they join them.

Education

The second most important mental health benefit a residency program can offer is to educate residents about the spectrum of stress and the importance of self-care. It is ideal that a mental health professional (e.g., psychiatrist, psychologist, or counsellor) use curricular time (e.g., grand rounds, didactic conferences, or small meetings) to discuss signs and symptoms of stress as well as the pathway from distress to burnout to mental illness. Residents learn how unmitigated stress affects themselves and their patients and different types of effective coping strategies. The instructor normalises the experience of stress and explains the functional role it plays in alerting and energizing the body and mind. The instructor also explains that stress by itself is usually not the problem; instead, the reaction to stress is what determines a successful outcome. For example, a resident who seeks collaboration and support during a difficult rotation will cope better than a resident who avoids peer and faculty interaction and who believes that

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they are incompetent. Residents learn to accept stress as part of their training and identify personal ways to become 'psychologically flexible' in the face of ongoing challenges.

One effective tool for teaching residents how to monitor stress levels and increase self-care is mindfulness which is the ability to focus on the present moment with purpose. One study of 70 physicians who participated in an eight-week intensive program of mindfulness training found improvements in well-being and attitudes associated with patient-centred care (Krasner, Epstein, Beckman, et al., 2009). Mindfulness allows residents to slow down, focus on their breathing and emotional state, and see themselves from a different perspective. For most of residency, a resident is either thinking about the patient she just treated or preparing herself mentally for the next one. The resident lives in the cognitive past and future of her mind on a daily basis. Mindfulness gives the resident permission to step out of the past-future dichotomy, create cognitive space for a moment, and connect with her present physical and emotional state.

Mindfulness also allows residents to develop important skills for monitoring stress. As a resident practices mindfulness on a daily basis, he becomes more in tune with physical and emotional signals of stress which empowers him to respond in healthy ways. Programmes can include mindfulness training as part of resident retreats or didactic conferences. Faculty can lead residents in mindfulness exercises at the beginning or end of a meeting or lecture. More simply, residents can incorporate deliberate moments of quiet reflection into their daily schedule (e.g., turning off the radio or phone while driving to work, spending five minutes in contemplation before leaving work at the end of the day).

Supportive programmes also teach residents how to recognise burnout and mental illness and what resources are available for support and treatment. Residents learn that burnout is a syndrome of emotional exhaustion and can lead to psychological numbness, loss of empathy, and a lack of connection with others. They learn that mental health treatment is effective and private and should not have any repercussions on job security, medical licensure, malpractice insurance, and disability coverage. Residents also learn how to access local-based treatment options and hotline-based mental health resources.

Screening

Mental health and physician wellness screening helps identify those residents at risk for mental health problems. Supportive programmes include a psychiatric and substance use history during required annual occupational health history and physical examinations. Programmes also use validated scales (e.g., Patient Health Questionnaire-9, Alcohol Use Disorders Identification Test, and Drug Abuse Screening Test) within the first three months of residency training, a vulnerable time period for new residents (Sen, Kranzler, Krystal, et al, 2010). Programmes assure residents that screening is confidential, not part of a formal evaluation process, and reviewed by a mental health professional who only discusses results with the resident and the programme director. Programmes encourage wide-spread participation by allowing residents time to complete the screening, using web-based programmes which deliver efficient data collection and analysis. Residents receive feedback about the screening from the web-based programme or a mental health professional who follows up in person. The resident understands the results of the screening and, if appropriate, receives a referral for treatment.

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Treatment

The final part of the mental health programme is to make mental health treatment access on par with other medical conditions which includes providing a list of trusted professionals in the community who understand graduate medical education and are connected with residency faculty and staff. Residents also have access to confidential settings where they can discuss the challenges and successes of their training in a group or individual format. Some residents prefer a group format which fosters social connection and support. Groups are led by an experienced mental health professional and offered on a regular basis. Supportive programmes develop protocol for team debriefing when a seminal event occurs (e.g., resident leaves programme, patient's death, medical code situation, or a serious medical error). Team debriefing protects time for a resident to express his concerns and feelings, process his experience aloud while peers listen, and receive support and advice. They occur soon after the event and include an experienced faculty member who provides perspective and wisdom.

SOLUTIONS AND RECOMMENDATIONS

Residency programme directors need strategies for identifying and addressing mental health problems. Most residents will not experience depression or suicidal ideation during residency training. However, many will experience chronic stress which affects interprofessional relationships, patient care, and overall quality of life. The authors recommend that programmes adapt a comprehensive strategy that addresses at least these four domains: education, screening, treatment, and support. First, residents can learn the continuum of distress, from burnout to depression to suicide, ways to self-identity, and strategies for increasing resiliency and wellness. Second, programmes can require annual occupational health history and physical examination to screen for potential distress and depression. Staff should provide timely feedback on screening results including treatment options. Third, residents should have access to mental health treatment including counselling and psychiatric care. Faculty can also address any concerns about the potential repercussions of receiving mental health care on job security, state licensure, malpractice insurance, and disability coverage. Finally, residents can attend group support meeting especially during the first year to discuss the challenges of their experience in a confidential setting. Residents can also meet for team debriefings following the conclusion of a seminal event like a patient's death, a code situation, or a serious medical error.

CONCLUSION

Residency training is a time to prepare young physicians for a rewarding and fruitful career. Although residents will undoubtedly experience stress and be at-risk for mental health problems, programme directors and faculty can create an environment that mitigates the expected strain and pressure of training. The authors recommend that residency mental health programs include support, education, screening, and treatment as four pillars of prevention. If faculty do not have a programme in place, it is suggested that they partner with mental health professionals in the area who can consult with them in building a robust and systematic approach to strengthening residency resiliency and preventing physician burnout.

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Residents will experience stress during residency training. Although it is unclear which interventions are best for supporting resident mental health, residency programmes can go a long way in preventing normal stress from turning into psychopathology.

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KEY TERMS AND DEFINITIONS

Burnout: A syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings.

Chronic Stress: Prolonged states of arousal and alertness in response to stress.

Distress: A sense of real or implied threat that activates involuntary mechanisms.

Graduate Medical Education: Any type of formal medical education pursued after completion of medical school.

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Intern: First-year medical resident.

Medical Resident: A physician in graduate medical education who practices medicine under the supervision of an attending physician.

Mental Health: A person's condition with regard to their psychological and emotional well-being.

Mental Illness: A wide range of mental health conditions that adversely affect moods, cognitions, and behaviours.

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Chapter 63
Occupational Risk Factors and the Mental Health of Women Firefighters

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ABSTRACT

Firefighting is an inherently dangerous occupation, yet little is known about the mental health of firefighters, and even less is known about women firefighters specifically. The purpose of this chapter is to examine relevant literature pertaining to firefighters and mental health with a specific focus on behavioral health aspects that may impact the mental health of women firefighters. There are key issues women in the fire service face that are likely related to their mental health including bullying and harassment, substance use, job satisfaction, fitness, protective gear, and injury. By identifying issues related to the mental health of women firefighters, the authors provide direction for future research and guidance for policy guidelines for the fire service.

INTRODUCTION

Firefighting is an inherently dangerous occupation, yet little is known about the mental health of firefighters, and even less is known about female firefighters. The objective of this chapter is to examine relevant literature pertaining to firefighters and mental health with a specific focus on behavioral health issues that may impact the mental health of women firefighters.

BACKGROUND

Firefighting is a dangerous and highly stressful occupation with high rates of injuries and line of duty deaths (Fahy, LeBlanc, & Molis, 2018; Evarts & Molis, 2018; Poplin, Harris, Pollack, Peate, & Burgess, 2011). The National Fire Protection Association (NFPA) estimated 58,835 firefighter injuries and 60

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firefighter fatalities occurred in the line of duty in 2017 (Evarts & Molis, 2018). Additionally, there were 7,345 documented exposures to infectious diseases and 44,530 exposures to hazardous conditions (Evarts & Molis, 2018). Despite public perception of the sexy, muscular firefighter, firefighters also struggle with poor physical health (Jahnke, Poston, Haddock, & Jitnarin, 2013; Soteriades et al., 2005), high rates of being overweight and obesity (Soteriades et al., 2005; Kales, Polyhronopoulos, Aldrich, Leitao, & Christiani, 1999; Poston et al., 2011) and low fitness levels (Poston et al., 2011; Tsismenakis et al., 2009). On average, firefighters experience significant weight gain over the course of their career, and may put on 29-85 additional pounds (i.e., 1.15-3.4 lbs/year) (Tsismenakis et al., 2009). As a firefighter's weight increases, their cardiorespiratory fitness plummets and their risk of cardiovascular disease (CVD) increases (Durand et al., 2011). Other diseases related to being overweight and obesity include heart disease, stroke, type 2 diabetes, and certain types of cancers which are highly prevalent among the firefighter population (Poston et al., 2011; CDC, 2015). In 2017, 29 firefighters died while on duty due to cardiovascular events (Fahy et al., 2018). While there is a wealth of research that examines firefighters' physical health, there is limited data concerning the psychological health of these important tactical athletes.

Recent studies demonstrate that first responders suffer from elevated rates of depression, post-traumatic stress disorder (PTSD; Heyman, Dill, & Douglas, 2018). According to the Firefighter Behavioral Health Alliance (FBHA), 79 firefighters and 19 emergency medical technicians (EMTs) and paramedics died as the result of suicide in 2018 which is a rate higher than on-duty deaths (Firefighter Behavioral Health Alliance, 2018). Large metro departments have seen a spike in clustered firefighter suicides in recent years (Gist, Taylor, & Raak, 2011). With a rise in behavioral health issues amongst firefighters, the fire service is trying to address these issues through national standards, behavioral health programs, peer support, and research focused on these issues. Yet, often, academic research in the field of firefighter health and safety is not translated into fire service training nor reflected in policies and procedures. Although NFPA 1500: Standard on Fire Department Occupational Safety and Health Programs requires access to a behavioral health program that proposes assessment, counseling and treatment for such issues as stress, anxiety, and depression (National Fire Protection Association, 2018), many departments lack the resources to adequately implement such programs. Additionally, little is known about the physical or mental health impacts of firefighting for women (Jahnke et al., 2012; Stanley, Hom, Spencer-Thomas, & Joiner, 2017).

Women represent an incredibly small proportion of the fire service, even lower than the U.S. Marine Corps, where all members are expected to be combat ready (Women in Military Service for America Memorial Foundation, Inc. 2010). Despite representing a small percentage, over 85,100 women are on the front lines protecting communities across the U.S. (Haynes & Stein, 2017). According to the NFPA, women represent approximately 8.9% of volunteer and 3.7% of career firefighters (Haynes & Stein, 2017). Due to the fact that women represent a small percentage of the fire service, they often are overlooked in studies and excluded from statistical analysis due to their small sample size (Jahnke et al., 2012; Hollerbach et al., 2017). While all firefighters face environmental and occupational stressors, women in the fire service face additional barriers adversely affecting their health and wellness. The goal of this chapter is to explore what is known regarding the mental health of women in the fire service and to identify important gaps in that knowledge. Guidance for changing policies and procedures to better protect and diversify the fire service as a whole also will be addressed.

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MAIN FOCUS OF THE CHAPTER

Recruitment and Retention

According to iWomen, the largest organization of women firefighters in the U.S., the low proportion of women in the fire service results from a combination of limited recruitment and low retention rates (Hulett, Bendick, Thomas, & Moccio, 2008; Horvath, 2013). Despite statements from national fire service organizations, including the International Association of Firefighters (IAFF; Fox, Hornick, & Hardin, 2006) and the International Association of Fire Chiefs (IAFC, 2018), promoting gender diversity within the fire service, rates of women firefighters remain extremely low (Jahnke et al., 2012; Haynes & Stein, 2017). There are many possible explanations for such low numbers of women in the fire service, including the psychological and physical strains of firefighting. Additionally, the culture of the fire service has been traditionally unaccepting of women (Hollerbach et al., 2017; Hulett et al., 2008; Horvath, 2013).

The Person-Environment Fit (PE-FIT) Model suggests that as the burdens and demands of one's occupation begin to exceed the ability of an employee to deal with them, this "lack of fit" contributes to overload, burden, role ambiguity, and conflicting role demands (Quick & Tetrick, 2003, p. 187). The resulting physical and psychological stress can lead to adverse behavioral consequences such as reduced productivity, increased absenteeism, turnover, employee burnout, and health-related issues (Quick & Tetrick, 2003). Research has found that women often are often given 'feminized' job tasks that restrict and challenge their success in non-traditional occupations. The same employment practices that favor men effectively lessen women's opportunities for promotion and lowers their chances of being seen as authoritative in their role (Reskin & Bielby, 2005). There is still a certain air of masculinity associated with the fire service, limiting the entry of women into the occupation (Perrott, 2016).

The collective intelligence of a diverse organization allows for differing points of view and strengths in working together to achieve the department's mission. Just as a government and its elected officials and leadership should reflect the demographics of the community they serve, so too should government agencies, such as the fire service, be representative of the citizens they protect (McNeil, 2008). Further diversifying the fire service begins with an examination of mental health issues affecting women, a growing minority group within the fire service.

Bullying and Harassment

The effects of workplace harassment on mental health are well-defined in the literature (Kessler, Mickelson, & Williams, 1999; Todorova, Falcon, Lincoln, & Price, 2010). Rosell et al. (1995) analyzed the difference in behavioral health outcomes of women firefighters that reported being sexually harassed and those that did not. They found that sexually harassed women firefighters reported higher job stress, sexual stereotyping, and acts of violence. Participants feared coming to work and used more sick leave than their non-harassed peers (Rosell, Miller, & Barber, 1995). Research has found more than 80% of women firefighters reported experiencing differential treatment based on gender, although only a small proportion of men felt that way (14%; Hulett et al., 2008; Griffith, Roberts, & Wakeham, 2016). This differential treatment included high levels of shunning/isolation (50.8%), verbal harassment (42.9%), sexual advances (30.2%), and assault (6.3%; Hulett et al., 2008).

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Over 40% of women firefighters in current research reported that they frequently felt they had to work twice as hard to get the same treatment or evaluation and that they were watched more closely than other workers (Jahnke et al., under review). Of the specific types of gender-based harassment, women firefighters reported experiencing verbal (37.5%) and written harassment (12.9%), hazing (16.9%), sexual advances (37.4%), and assaults (5.1%) because of their gender while in the fire service (Jahnke et al., under review).

Research consistently finds an association between discrimination and harassment and a variety of mental (e.g., anxiety, depression, PTSD, self-rated health) and physical health outcomes (e.g., blood pressure, cardiovascular disease, diabetes, overall stress response, and a number of other medical conditions; Hulett et al., 2008; Kessler et al., 1999; Todorova et al., 2010; Rosell et al., 1995; Hom, Stanley, Spencer-Thomas, & Joiner, 2017; Krieger, 1999; Okechukqu, Souza, Davis, & de Castro, 2014; Pascoe & Smart Richman, 2009; Williams, Neighbors, & Jackson, 2003). Current research indicated that female firefighters who experienced a high severity of bullying and harassment were 300% more likely to report significant depressive symptoms (Jahnke et al., under review). Women firefighters who experienced moderate and severe discrimination and harassment also had negative mental health outcomes including higher prevalence of depressive symptoms, anxiety, and symptoms of PTSD. Additionally, women who experienced severe discrimination and harassment reported over 40% more poor health days in the last 30 days (Jahnke et al., under review). Hom and et al. (2017) found that a history of sexual harassment, discrimination, and other threats/harassment were significantly associated with a history of career suicidal ideation, in addition to other severe psychiatric symptoms including heightened anxiety, depression, more severe PTSD, and insomnia. Discrimination and harassment have significant impacts on physical and mental health outcomes on women in the fire service. Prevention efforts, training, and peer-support programs focused on this issue should be further explored.

Depression and Anxiety

Although firefighters are incredibly resilient, research suggests that many suffer negative psychological consequences from their experiences in the fire service. Studies have found high rates of acute stress disorder (26.5%) and elevated rates of those currently in the range of concern for depression (10.8-16.4%) among men in the fire service (Carey, Al-Zaiti, Dean, Sessanna, & Finnell, 2011; Fullerton, Ursano, & Wang, 2004). This is extreme when compared to the national average for civilians; in 2016, only 6.7% of all U.S. adults had at least one major depressive episode (National Institutes of Mental Health, 2019). Additionally, studies have found that firefighters in the depressed range reported significantly more poor mental health days than those not in the depressed range (Pyle et al., 2009). Depressed firefighters are more likely to be sleep deprived and to display hazardous drinking behaviors as well (Carey et al., 2011). While only about 4% of respondents reported low levels of social bonding among firefighters, those with poor mental wellbeing were more likely to report poor social bonding (Carey et al., 2011) which is an important mechanism for firefighter coping.

Firefighters often experience increased stress due to repeated exposures to trauma and they seem to know their jobs put them at risk. A study by Jahnke et al. (2012) found that firefighters across the country actually expressed a belief that their career would shorten their lives. Firefighters are plagued by psychological stress resulting from repeated exposure to trauma, sleep disruptions, injuries, and the risk for infectious disease (Jahnke et al., 2012). There is an emotional toll from repeated exposure to trauma that can lead to adverse mental health consequences (Jahnke et al., 2012). However, firefighters

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have consistently reported that talking with other firefighters was the most useful way of managing the emotional toll of their experiences, highlighting the importance of a supportive organization and access to peer support.

Jahnke et al. (2012) examined the health of women firefighters and found that, similar to their male colleagues, nearly a quarter of female firefighters were at risk for depression. Approximately 30% reported feeling nervous and stressed fairly or very often and 22% reported feeling angered because things were often outside of their control (Jahnke et al., 2012). To make matters worse, female firefighters with a history of discrimination or harassment on the job had significantly higher levels of anxiety and depression (Hom et al., 2017). Overall, female firefighters tend to have similar prevalence of mental health issues when compared to male firefighters. The problem arises when they are subject to adverse and pervasive differential treatment which has been shown to impact their health.

Posttraumatic Stress Disorder

Firefighters respond to incredibly dangerous and traumatic emergency incidents putting them at heightened risk of Posttraumatic Stress Disorder (PTSD). Depression and PTSD symptomatology (i.e., 'posttraumatic stress') often occur together (Martin et al., 2017) and, considering the high rates of depression found among firefighters, they are undoubtedly at risk for PTSD as well. Recent studies have, in fact, found between 14.0-31.8% of firefighters suffer from PTSD (Martin et al., 2017; Boffa et al., 2017; del Ben, Scotti, Chen, & Fortson, 2006) compared to only about 7-8% of the general population (US Department of Veterans Affairs, 2018). In addition, Boffa et al. (2017) found that 15.6% of firefighters in their study reported at least one suicide attempt during their firefighting career. PTSD has been shown to amplify the risk of suicide among firefighters (Boffa et al., 2017).

In addition to being linked to increased suicide risk, PTSD significantly impacts quality of life (QOL) and greater sleep disturbance (Chen et al., 2007). Jahnke et al. (2016) examined experiences of repeated exposure to trauma (RET) in a national sample of firefighters and found that RET resulted in a number of negative outcomes for firefighters including desensitization, irritability and cynicism, and intrusive flashbacks (Jahnke, Poston, Haddock, & Murphy, 2016). While some firefighters had a specific incident that they identified as negatively affecting them, most discussed the impact of repeatedly being exposed to traumatic events and the psychological toll that resulted from such experiences (Jahnke et al., 2016).

While research has examined PTSD among firefighters, published PTSD prevalence rates are not currently available for female firefighters. However, there have been numerous studies that show that differential treatment such as bullying, harassment, sexual assault, and other threats increase rates and severity of PTSD among women firefighters (Jahnke et al., under review; Hom et al., 2017). It is extremely important that more research be conducted to identify the prevalence of PTSD among firefighters, especially women. Additionally, interventions and treatment options should be explored to help firefighters manage PTSD symptoms.

Suicide

Elevated rates of depression and PTSD symptoms may be associated with increased suicide risk among firefighters (Stanley et al., 2019). Firefighters report high rates of suicidal ideation, plans, and attempts (46.8%, 19.2%, and 15.5%, respectively) when compared to both general (5.6–14.3%, 3.9%, and 1.9–8.7%, respectively) and military (3.8–13.9%, 5.3%, and 0.4–2.4%, respectively) populations (Nock et al., 2008;

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Nock et al., 2014; Stanley, Horn, Hagan, & Joiner, 2015). The Firefighter Behavioral Health Alliance (FBHA) reported 98 firefighters died by suicide in 2017 (Firefighter Behavioral Health Alliance, 2019), which is more than the 86 total line of duty deaths that occurred in the fire service that year (US Fire Administration, 2019). The number of emergency responders who lose their lives to suicide may be even higher as the FBHA suggests that only approximately 40% of firefighter suicides are reported as such. Large metro departments have seen a spike in clustered firefighter suicides in recent years (Gist et al., 2011). Boffa et al. (2017) found 15.6% of the firefighters in their study reported at least one suicide attempt during their firefighting career.

So, what do we know about suicide and women firefighters? A recent CDC report on suicide rates by occupational group revealed that, among women workers, the highest rate of death by suicide was among protective service workers—a group that includes firefighters (Stanley et al., 2017; McIntosh, 2016). In 2017, Stanley et al. (2017) examined 313 women firefighters and found they reported elevated rates of suicidal thoughts and behaviors. For example, percentages of women firefighters reporting suicidal ideation, plans, and attempts were 37.7%, 10.9%, 3.5%, respectively (Stanley et al., 2017). While these rates may be higher than the general population, they appear lower than rates for men firefighters seen in the current literature. Further research is necessary to understand suicide risk among women firefighters. Further, research should explore firefighters' access to employee assistance including behavioral health programs tailored specifically to the fire service.

Substance Use

Substance use is common among first responders and includes problematic use of alcohol, tobacco, and prescription drug use, though little is known regarding the latter. According to the Dietary Guidelines for Americans 2015-2020 and the U.S. Department of Health and Human Services, moderate alcohol consumption is defined as up to one drink per day for women and up to two drinks per day for men. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "binge drinking" as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL. This typically occurs after four drinks for women and five drinks for men, over a time span of two hours. Heavy alcohol use is defined as binge drinking on five or more days in the past month (National Institutes of Health, 2019). In similar populations (e.g. military), heavy drinking patterns can be as high as 67% among men and 9% among women, with binge drinking patterns occurring in 48% of men and 31% of women, higher than the general population (Fear et al., 2007).

Research has shown that firefighters "believed alcohol played an important role in the fire service, that high consumption was common, and the social norms supported alcohol consumption" (Jahnke, Poston, & Haddock, 2014). In a large study of male firefighters, Haddock et al. (2015) found that 85% of firefighters reported drinking alcohol, nearly half reported excessive drinking, and approximately one third reported binge drinking when off duty.

As with male firefighters, heavy and problem drinking are prevalent among women firefighters and are associated with negative occupational outcomes (Haddock, Poston, Jahnke, & Jitnarin, 2017). Haddock et al. (2017) examined over 1,000 women firefighters and found that more than 60% of the women in their study averaged two or more drinks (moderate to heavy drinking) on days when they consumed alcohol. Chief officers were more likely to consume two drinks per day compared to firefighters; otherwise, rank did not predict average consumption or binge drinking (Haddock et al., 2017). Problem drinking also was associated with negative health outcomes. For example, problem drinkers were more than 2.5

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times more likely to have been diagnosed with depression or PTSD. Problem drinkers were nearly 40% more likely to have sustained an injury on the job in the past year and were less likely to recommend a career in the fire service to other women (Haddock et al., 2017). Recent research found that women experiencing moderate to high levels of workplace discrimination were also significantly more likely to be in the range of concern for alcohol misuse (Jahnke et al., under review).

Among 947 male firefighters, 21% were tobacco users. Of those who smoked, 34.5% used cigarettes, over half (53.2%) used smokeless tobacco (SLT), and 12.2% used both cigarettes and SLT (Jitnarin, Poston, Haddock, Jahnke, & Day, 2015). Tobacco users were significantly younger, had served fewer years in the fire service, were significantly more likely to engage in heavy and binge drinking, and were more likely to show signs of depressive symptoms compared to non-tobacco users (Jitnarin et al., 2015). Tobacco use rates were generally higher among women firefighters than their male colleagues and rates among women firefighters were similar to the rates of women in the military (Jahnke et al., 2012). Resources for substance use/misuse specific to firefighters should be identified and examined for validity in this population.

Job Satisfaction

Job satisfaction is an indicator of overall wellbeing and is related to individual health outcomes (Antecol & Cobb-Clark, 2006). Reported levels of job satisfaction are, however, difficult to accurately assess and may differ among different groups. For example, women and African Americans in the general population tend to report higher levels of job satisfaction even though on many objective measures their jobs are worse, which could stem from these groups having lower expectations (Antecol & Cobb-Clark, 2006; Bartel, 1981, & Clark, 1997). Most studies report that men firefighters have a high level of job satisfaction (Traut, Larsen, & Feimer, 2000; Wagner & O'Neill, 2012). Despite the barriers and differential treatment some women in the fire service face, those who stay in the profession tend to report higher levels of job satisfaction. In fact, 78% of the female firefighters in recent research reported they are satisfied with their job in the fire department (Jahnke et al., under review).

There are benefits of a collective and supportive fire service culture. The concept of "brotherhood" is deeply rooted in the American fire service (Crosby, 2007). The social bonds and connections among firefighters and within the firehouse are important factors in attenuating adverse mental health outcomes (Carey et al., 2011). It is important to feel a sense of belonging as a part of a group, as well as feeling supported by others. However, the adverse treatment many women in the fire service face can impact their job satisfaction, which research has shown impacts their health and their ability to do their jobs (Jahnke et al., under review).

Fitness

According to the Centers for Disease Control and Prevention (CDC; 2018), physical activity (PA) can be one of the best ways to improve both physical and mental health. However, male firefighters struggle with poor health and low levels of fitness. Overweight and obesity are highly prevalent, and in some cases >80% (Poston et al., 2011; Tsismenakis et al., 2009; Soteriades et al., 2008). Cardiac-related events consistently account for the majority of firefighter fatalities. In 2017, 29 line of duty deaths were related to sudden cardiac events (Fahy et al., 2018).

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Female firefighters, on the other hand, seem to maintain a high level of fitness throughout their careers. For example, Jahnke et al. (2012) found that compared to male firefighters, women had more favorable body composition among both career and volunteers. Based on body mass index (BMI), the majority (66.7%) of female firefighters were classified in the normal weight category (range, 18.5–24.9 kg/m2), while only 16.7% were overweight and 16.7% were obese (Jahnke et al., 2012). Kirlin et al. (2017) found that, on average, female firefighters of all age groups met or exceeded the 12-MET professional standard for cardiorespiratory endurance; however, cardiovascular fitness declined with age (Kirlin, Nichols, Rusk, Parker, & Rauh, 2017; NFPA 1582; International Association of Firefighters, 2008). Current research found that 78% of female firefighters were regular exercisers according to the Self-Report Physical Activity Questionnaire (SRPA; Jahnke et al., under review). PA improves mental health and prevents weight gain (CDC, 2018). Fitness may be a key to improving the overall mental and physical health of firefighters. Research should examine women-specific fitness training for its efficacy in the fire service.

Gear

Most firefighters probably do not give the fit of their personal protective equipment (PPE) a second thought, but women often report ill-fitting PPE hinders their ability to do their job safely and effectively. According to iWomen in 2008, nearly 80% of the female firefighters surveyed reported ill-fitting protective gear. In addition, 14% reported ill-fitting self-contained breathing apparatus (SCBA) face pieces, a critical line of defense in a fire (Hulett et al., 2008). Nearly a decade later, a majority of the participants in a recent study still noted ill-fitting gear as a major threat to safety (Hollerbach et al., 2017). Women reported that bunker gear in their respective departments was made for men and they often had difficulty getting a good seal with an SCBA facepiece (Hollerbach et al., 2017). One participant said her department had to go through a lawsuit before they offered female-specific PPE (Hollerbach et al., 2017). Additionally, a number of chronic injuries may be due to inappropriately fitting gear. Feeling out of place or not having the necessary resources to do one's job has physical and psychological consequences such as lower productivity, absenteeism, turnover, burnout, and health-related issues (Quick & Tetrick, 2003). How can women be expected to survive in the fire service if they can't even get properly fitting PPE?

Injury

For years, the majority of fire service research has focused on male firefighters. The NFPA released its first report specific to the patterns of injury among women firefighters in 2017 (Campbell, 2017); however, unlike the NFPA annual injury report, this women-specific report only examined injuries that occurred on the fireground and likely underestimates the prevalence of injury among women firefighters. Despite its limitations, the report found that women firefighters experience similar injury causes (the majority overexertion/strain) on the fireground as their male counterparts (Evarts & Molis, 2018; Campbell, 2017). The NFPA report on women examined a five-year period and estimates that women firefighters sustained an average of 1260 injuries each year in the five-year period (from 2010-2014; Campbell, 2017).

Though they may experience the same types of injury, Liao et al. (2001) found that women firefighters experienced injuries more frequently than their male peers, with women firefighters reporting 33% more injuries than men. This relationship persisted even after controlling for factors such as age, race, tenure,

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personality, and secular trends (Liao, Arvey, Butler, & Nutting, 2001). Current research has shown that women often note a need to "prove" themselves in the firehouse and on the fireground, leading to taking on more than they are physically able or not asking for help, which puts them at increased risk of injury (Hollerbach et al., 2017). Further research should examine the types of injuries women firefighters sustain and policies and training programs should be explored to lessen the burden of injury in the fire service.

Reproductive Health

Limited research has examined reproductive health outcomes among firefighters. There is some data from the 1980's and '90s (Evanoff & Rosenstock, 1986) that reviewed the potential risks women firefighters face, but in general this area remains relatively unexplored. Reproductive risks for women include fireground and other hazardous response exposures (McDiarmid, Lees, Agnew, Midzenski, & Duffy, 1991), as well as the impact of shift work and sleep disturbances, high ambient temperatures, loud noises, and the physical and psychological strain of firefighting (Agnew, McDiarmid, Lees, & Duffy, 1991; Amani & Gill, 2013; Mahoney, 2010; Nurminen, 1998; Puttonen, Harma, & Hublin, 2010).

A recent study found an increased risk of male-factor infertility (46%) among Danish firefighters (Petersen, Hansen, Ebbehoej, & Bonde, 2018). It appears that the number of years serving as a firefighter attenuates the relationship with infertility, with those serving as a firefighter longer having a higher risk for infertility (Petersen et al., 2018). Firefighting hazards associated with increased risk of infertility include hyperthermia, loud noise, chemical and biological exposures, emotional trauma, and stress (Petersen et al., 2018). These hazards can reduce testosterone, weaken libido, and ultimately cause impotence (Agnew et al., 1991).

While there is some concern and limited research examining infertility in male firefighters, there is significant concern among women in the fire service who might want to have children (Jahnke, Poston, Jitnarin, & Haddock, 2018). Recent research suggests the uncertainty regarding the effects of firefighting on reproductive health may affect recruitment and retention of women in the fire service (Kehler et al., 2018). A study by Jahnke and colleagues found that only about a third of women firefighters reported a pregnancy during their career as a firefighter (Jahnke et al., 2018). It is unclear whether women firefighters choose to give birth before entering the fire service or if there are specific factors related to firefighting that discourage childbearing (Jahnke et al., 2018). Data suggests that, when women work in occupations in which formal limitations are high for reproduction (e.g. low benefit levels, gender segregated policies), women tend to delay or limit childbearing (Chesnais, 1996; Mills, Rindfuss, McDonald, & Te Velde, 2011; Neyer & Andersson, 2008). It is also possible given high rates of discrimination and harassment women face in the fire service (Hulett et al., 2008) that they decide against becoming pregnant because childbearing would limit their ability to fully participate in firefighting activities (Jahnke et al., 2018).

Additionally, for women in the fire service who do choose to get pregnant, few departments that have official policies in place to help them and their supervisors make decisions about when to restrict duties or disclose pregnancies to the department. Jahnke et al. (2018) found that, on average, women firefighters were at the end of their first trimester before they reported their pregnancy to their department, and most did not restrict their duties until the second or third trimester, while approximately 10% of women did not restrict their duties at all throughout their pregnancy (Jahnke et al., 2018). More research however is necessary to examine how long it is safe for women to remain on full active duty while pregnant.

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There also is very little guidance for women firefighters regarding breastfeeding and how long after battling a fire it is safe to save breast milk. The only guidance currently available is pilot data from Burgess et al. (2015), which suggests that in order to limit potential exposure of toxins to their breastfeeding infants, women firefighters should pump and discard their breastmilk following a structural fire for 72 hours, and supplement using an alternative source. Further research is necessary to identify links between firefighting and infertility, as well as mechanisms to protect firefighters and their offspring. Further, practitioners need guidance specific to firefighters to give appropriate advice for new and expecting mothers.

SOLUTIONS AND RECOMMENDATIONS

There are initiatives, such as the IAFC Bullying, Harassment, and Workplace Violence Prevention Task Group, The First Twenty Tactical High Performance Program (TF20), and the Front Line Behavioral Health Intervention, targeted at improving the health and wellness of firefighters. The overall goal of these initiatives is to create a culture of dignity and respect in the fire service and improve the physical and mental health of firefighters. The fire service should continue to collaborate and combine efforts such as those mentioned above to enhance firefighter safety and promote diversity within its ranks.

FUTURE RESEARCH DIRECTIONS

Further research should examine policies and training in other occupations that may transfer to the fire service culture. Additionally, resources for assessing and treating mental health issues among firefighters are warranted. Future research is necessary to better connect firefighters to behavioral health providers and physicians and better train the providers specially trained to work with this unique population.

CONCLUSION

In a properly supported department, these numbers look much better. It is not just the fire service that is dangerous, it is what goes on behind the scenes where there is a real impact of bullying, harassment, and sexual assault. Research has found high rates of mental health concerns among firefighters, but some speculate that elevated rates among women means they cannot do the job. When one evaluates mental health in supportive environments, women perform nearly the same as men. A lot of these issues related to women firefighters and mental health are the product of being in an unsupportive and potentially toxic job environment. Current research is limited for female firefighters, especially regarding mental health outcomes. The data that exists suggest that there are limited trainings or resources specific for female firefighters and that women are still experiencing significant differential treatment in the fire service (Jahnke et al., 2012; Hollerbach et al., 2017; Hulett et al., 2008; Horvath, 2013; Fox et al., 2006; IAFC, 2016; Griffith et al., 2016; Jahnke et al., under review; Sinden et al., 2013). The barriers female firefighters face (e.g., harassment, inadequate training, ill-fitting gear, and a lack of resources) may lead to poor coping mechanisms including substance use and abuse, poor mental health, and an increased risk of injury. These barriers and the associated poor health outcomes may contribute to the low rates of recruitment and retention of women in the fire service.

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KEY TERMS AND DEFINITIONS

Behavioral Health: The study of one's behavior and its influence on their health (both mental and physical).

Differential Treatment: Negative and pervasive inappropriate behavior directed at an induvial or individuals including bullying, harassment, assault, sexual assault, and threats.

Mental Health: The state of health (lack of disease or impairment) specific to one's mental status including an examination of stress, depression, anxiety, sleep status, and PSTD.

National Fire Protection Association: U.S. national governing body responsible for development and standardization of standard operating procedures and guidelines for the U.S. fire service.

Occupational Risk Factors: Refers to health risk factors associated with one's occupation.

PTSD: Posttraumatic stress disorder as defined in the literature; referring to a clinical stressful reaction to a traumatic event.

Tactical Athlete: Referring to a worker in a physically demanding and often dangerous occupation usually including military, police, and firefighters.

Women Firefighters: Referring to females in the occupation of firefighting including firefighters as well as leaders such as captains and chief officers.

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Section 6
Critical Issues and Challenges

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Chapter 64
Adolescent and Adult Mass Shooters:
Trauma, Mental Health Problems, and Early Prevention

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ABSTRACT

Understanding why people commit mass shootings in the United States is perplexing and discerning perpetrators' motivations is difficult because there have been a fairly limited number of shootings. In addition, there is incomplete research on mitigating historical evidence about the perpetrators. Thus, this chapter takes a broader approach to understanding why these shootings may have happened by reviewing the empirical literature to identify possible correlations from childhood and adolescent trauma experiences (and subsequent mental health problems) to later adult violence. This review supports a hypothesis that these experiences are potential links to explaining mass shooting outcomes. The trauma experiences that are identified to be most impactful include maltreatment, poverty, witnessing violence, domestic violence, deaths (violent and non-violent) of family and friends, and adolescent bullying.

MASS SHOOTINGS

Mass shootings are rare events and the reasons for these tragedies are not well understood. Because so few mass shooting events have occurred, though their impact can be dramatic and disproportionate in media coverage or policy changes (Luca, Malhotra, & Poliquin, 2016), limited research on the perpetrators has been completed (Knoll & Annas, 2016). However, within such limitations, some themes have emerged.

The Federal Bureau of Investigations studied 150 mass shooter incidents and found 70 percent of the shootings took place at work or school locations, 98 percent were carried out by the person alone, 40 percent of the shooters committed suicide, and 96 percent were male (Blair & Schweit, 2014). In a more specific review of 37 targeted school violence incidents, the perpetrators had often considered

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or attempted suicide before the violence, had leaked their intent to peers, or engaged in behaviors that showed intent - weapon seeking, disturbing writings, odd behaviors, et al. (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). And in a more limited review of five mass shooters, all were found to have been bullied during childhood and socially alienated as young adults, had paranoid tendencies, and held grudges and past humiliations that evolved into violent revenge fantasies (Mullen, 2004).

Mass shooting events have been most notably found to not be the result of a single event or incident that the perpetrator experienced, but a process of troubles and difficulties over time. Typically, it is the interaction and intersection of these difficulties that impact the person to such a degree that mass shootings and murders are the outcome (Fox & DeLateur, 2014). Across the research literature, these difficulties have been identified as psychopathology (to varying degrees), traumatic life events, emotional turmoil, and unique precipitating factors for each person (for example, job firing, home violence, or substance abuse) (Declercq & Audenaert, 2011; Knoll & Meloy, 2014; Martone, Mulvey, Yang, Nemoianu, Shugarman, & Soliman, 2013). Regarding psychopathology or mental health disorders, there is not a direct link from these difficulties to mass shootings or extreme violence. However, there are common characteristics (symptoms, not diagnoses) across mass shooting perpetrators – depression, suicidality, narcissism, and paranoid outlooks. Many of these symptoms are evident during the perpetrators' adolescent and young adult years (Knoll, 2012; Modzeleski, Freucht, Rand, Hall, Simon, Taylor, et al., 2008; Mullen, 2004).

Because of the empirical findings to date on mass shooters, this paper reviews two broad themes – childhood and adolescent trauma experiences and related mental health problems. It is postulated that these difficult younger person experiences do indeed have a lasting and cumulative (or comorbid) impact, and that in young adult and adulthood, the graver impact of other difficulties increases the risk to commit heinous crimes, including mass shootings. So by recognizing that the histories of mass shooters to date do include certain trauma histories, and that across the literature these experiences place adolescents and young adults at much greater risk of externalizing violence (a much more likely outcome for males), it is important to continue to research this possible link and to know there are prevention and intervention approaches available for younger people. Thus, this chapter first reviews the prevalence and impact of young people's trauma experiences and related mental health disorders, followed by an overview of prevention approaches that have been found effective in addressing these problems for this population.

The Prevalence of Childhood and Adolescent Trauma

Trauma impacts many children, adolescents, and their families. Some of these traumatic experiences are more readily identified – growing up in poverty, living in unsafe and violent neighborhoods, and being victimized by abuse. However, other traumas – including neglect, school bullying, and losing family members or friends (by death, prison, or other unexpected reasons) - are less frequently cited as significantly impactful, though may be just as difficult for young people to handle. These traumas often lead to nefarious difficulties both in the short- and long-term, including mental health problems, and for some, long-standing disorders. In addition, children's exposure to more than one form of trauma, referred to as **poly-victimization**, and traumas experienced over time are of serious concern, increasing the risk for school problems, youthful and adult offending, and violence. In other words, trauma is cumulative: the greater the number of experiences, the greater the impact on the young person's development, mental health, and offending behaviors (Greenwald, 2002; Klain, 2014).

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Child Maltreatment

There are four categories of child maltreatment: physical abuse, sexual abuse, emotional (psychological) abuse, and neglect (including medical), depending on state law definitions. Typically, the following definitions of these maltreatment types are found: physical abuse being the injuring or death of a child, not by an accident; sexual abuse being any act of sexual contact of any type toward a child; emotional abuse being chronic acts or attitudes by caregivers that interferes with or impedes the psychological or social development of a child; and neglect being inadequate or dangerous child-rearing practices by caregivers. Such maltreatment has increasingly been found to evoke serious, long-lasting repercussions for many of the victims (Buffington, Pierkhising, & Marsh, 2010). Both one-time and ongoing victimizations can be sufficiently traumatic to induce symptoms and to predispose young people to poor young adult trajectories and outcomes (Copeland, Keeler, & Angold, 2007; National Child Traumatic Stress Network, 2008; Widom, DuMont, & Czaja, 2007).

Maltreatment (abuse and neglect) reports are provided by the U.S. Department of Health and Human Services' Administration of Children and Families. There is concern by stakeholders that these counts underreport actual victimizations because of narrow state definitions of abuse. Nonetheless, with these official counts over the past ten years, approximately 680,000 to 1,000,000 children and adolescents nationwide each year have been victims of substantiated maltreatment. This represents approximately 20 percent of all referrals to children's services that are investigated (Administration for Children and Families, 2010; 2017).

Over the past five years, the majority of maltreatment victims have been neglect cases (75 to 80 percent; with an additional 2 percent for medical neglect), followed by physical abuse (17 to 18 percent), sexual abuse (8-9 percent), and emotional/psychological abuse (6-9 percent); with some significant variation across the states. Almost 10 percent of these victims had a reported disability, including learning, behavioral, intellectual, and/or physical. Over 91 percent of these victims' perpetrators were a parent, either acting alone or with other parental caregivers. Males and females were equally at risk; however, they were disproportionately younger (over 60 percent are under the age of 10 and 24 percent are less than one year old) and minority (black, American Indian, and Pacific Islander) (Administration for Children and Families, 2010; 2017).

Broader reviews of maltreatment victimization are available through nationally representative samples of victim self-reports and parental reports: the National Survey of Children's Exposure to Violence, the National Survey of Adolescents, and the National Comorbidity Study (Finkelhor, Turner, Shattuck, & Hamby, 2013; Kessler, Avenevoll, Costello, Green, Gruber, Heeringa, Merikangas, Pennell, Sampson, & Zaslavsky, 2009; McCart, Zajac, Danielson, Strachan, Ruggiero, Smith, Saunders, & Kilpatrick, 2011; Saunders & Adams, 2014). Additional trauma experience studies have utilized other (regional and local) school-based populations, though the findings are limited to just these localities (Banyard & Cross, 2008; Costello, Erkanli, Fairbank, & Angold, 2002; Drake, Lee, & Jonson-Reid, 2009).

Physical Assault and Abuse

Expanded physical assault and abuse definitions include acts of hitting, kicking, beating a child, or events that required medical attention. Correspondingly, lifetime prevalence rates of physical assault for adolescents are reportedly significantly higher and have been found to range from 17 to 71 percent (Finkelhor, et al., 2013; McCart, et al., 2011). In addition, some have identified and included threats,

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harassment, and bullying in identifying as physical abuse, with 29 percent of adolescents reporting these experiences during their lifetime (Finkelhor, Turner, Ormrod, & Hamby, 2009). Additionally, between 3 and 33 percent of high school students reported being shot at, and 6 to 16 percent being attacked with a knife, depending on location of the school (Finkelhor, Omrod, Turner, & Hamby, 2005; Kilpatrick & Saunders, 1997). Though these victimization rates at schools have been decreasing since 2003 (Carlton, 2017).

Sexual Victimization

Expanded sexual victimization definitions includes sexual assault, rape, sexual harassment, statutory sexual offenses, incest (abuse by family members) and sexual exposure by an adult. When including these offense types beyond the narrower child welfare system definitions, many more victims, and in particular adolescents, are identified. Between 8 and 11 percent of adolescents reported a history of at last one sexual assault (three times more likely for girls); 8 percent for attempted or completed rape (four times more likely for girls); and between 13 and 23 percent were victims of any sexual victimization in their lifetime (nearly twice as likely for girls) (Finkelhor, et al., 2013; McCart, et al., 2011). In total, it is estimated that between 8 and 10 percent of adolescents have been a victim of a sexual assault before the age of eighteen, with girls being more than three times more likely victims than boys (Saunders & Adams, 2014).

Witnessing Violence/Domestic Violence

Witnessing violent acts is common for many young people and has serious repercussions including trauma-induced fears, mental health difficulties, increased risk for substance use, and offending behaviors. Seventy percent of older adolescents reported they had witnessed at least one act of violence in their lifetime, and one-third reported witnessing some sort of family violence (Cuevas, Finkelhor, Shattuck, Turner, & Hamby, 2013; Finkelor, et al., 2009). Nearly 40 percent of adolescents have reported witnessing at least one serious community-based violent act (shooting, stabbing, or robbery, among others) over their lifetime, with boys more likely than girls (McCart et al., 2011; Zinzow, Ruggiero, Resnick, Hanson, Smith, Saunders, & Kirkpatrick, 2009).

Domestic violence acts can be either witnessed by a family member, or the family member could be the victim of the threats, assaults, and/or battering. These domestic violence problems - also called intimate partner violence or domestic abuse - include emotional abuse, threatened and actual physical abuse, or sexual violence between adults, both heterosexual and same-sex partners. Between three and ten million children are exposed to domestic violence in the United States annually - encompassing 9 to 10 percent of the child and adolescent population that witnessed a serious violent act between their parents or caregivers - with a majority of these children being younger than nine years of age (The National Child Traumatic Stress Network, 2016; Sickmund & Puzzanchera, 2015).

Deaths – Violent and Non-Violent

Violent deaths of family members and loved ones can be traumatic to young people. These types of deaths are caused by different events, many suicides and homicides. In 2013, over 41,000 people committed suicide and 16,000 people were homicide victims in the United States (Centers for Disease Control and

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Prevention, 2014a). Over 18 percent of adolescents nationwide have lost a family member (which accounts for 47 percent of the total) or close friend (53 percent) to a type of homicide. These homicides included criminal homicide, vehicular homicide, and negligent homicide, among others. When this death impacts younger people, it may cause what is called traumatic grief – whereby the young person cannot understand the death, and experiences very severe grief symptoms that lead to frightening thoughts and images of the deceased (Rheingold, Zinzow, Hawkins, Saunders, & Kilpatrick, 2011).

Non-violent deaths, which can be by natural causes or accidents, may also be traumatic and difficult situations for children and adolescents, particularly when this entails the death of a family member, parent, or peer. Death is often difficult for young people to understand and without support, many struggles to adapt to the new situation. Children and adolescents most at risk for non-violent death trauma experiences include those who were close physically and/or emotionally to the deceased, those with pre-existing mental health issues, those with pre-existing family difficulties or previous loss experiences, and those with a limited support network (Goodman, 2002).

Poverty

Poverty and living in low-income neighborhoods poses serious difficulties and stressor for many families. Living in poverty increases the number of trauma experiences that families and children have in trying to meet their regular daily living needs, leading often to a state of ongoing crisis (Collins, Connors, Donohue, Gardner, Goldblatt, Hayward, Kiser, Streider, & Thompson, 2010; Reeves, Rodrigue, & Kneebone, 2016). Children living in poverty, and in particular urban poverty, have high rates of reported trauma experiences (70 to 100 percent). Often, these experiences include exposure to violent neighborhood crime, drug activity, and family violence. For some children and adolescents these stressors lead to maladjustments, hyper-anxiety, and mental health and trauma-related problems. These trauma difficulties that are ongoing and multi-dimensional impact many children's development, psychological functioning, academic learning, and skill development. These impairments increase the risk for adolescent substance abuse, school failure, and suicide (Collins, et al., 2008; Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Macy, Barry, & Noam, 2003).

Poverty, Violence, and Unsafe Schools

Decades of research has shown the link between poverty and education achievement, whereby poor children and adolescents are more likely to attend underachieving schools with some of the lower per pupil school funding. These children can learn as well as non-poor children, however, they are more prone to school transitions, family joblessness, and increased exposure to violence in the home and community (Books, 2004; Lee & Burkam, 2002). Poor schools in less advantaged neighborhoods also have more crime problems on and around the school campus, impacting the environment, exposing students to violence, and lowering high school graduation rates. Students exposed to violence, those who perpetrate violence (bullying, included), and those who are violence victims are more likely to experience emotional problems, door more poorly in school, and perpetuate the crime problems (Bureau of Justice Studies, 2014; Child Trends, 2015). These school environments can increase fears among students - whereby, in 2013, 18 percent of students reported carrying a weapon while in school, often for protective needs. High school male students were three times more likely to carry a weapon than female students, and white students almost twice as likely as minority students (Centers for Disease Control and Prevention, 2014b).

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Bullying and Cyberbullying

Bullying includes three major types: physical, social, and verbal; and these victimizations may occur in person and through internet and social media connections (cyberbullying). Bullying takes many forms, including insults and name-calling, being threatened with harm, being subjected to rumors, physical assaults, forced to do things against your will, purposefully exclusion from activities, and property destruction. Cyberbullying also has numerous forms, including hurtful information on the internet; sharing private information; unwanted contact via email, texting, online gaming, and other social media sites; and purposeful exclusion from an online community (U.S. Department of Education, 2013).

Bullying is a common experience for children and adolescents, with many of these victimizations occurring on school grounds. National data on bullying across schools was not collected until 2005, when the Department of Education first reported that between 28 and 32 percent of all students were bullied during the school year. Bullying victims continued to report high number of experiences, though there has been a decrease to 21 percent in the 2015 academic reporting year. Female students report higher rates of bullying (23 percent) compared to male students (19 percent), as well as more victimizations due to cyberbullying (9 percent compared to 5 percent for male students). Younger students – grades sixth through ninth – are more likely to be bullied compared to older students – tenth to twelfth grades; with equal bullying victimization rates across low, middle, and high family incomes (U.S. Department of Education, 2013). Reasons for the recent decline in bullying reports are under investigation, though federal and state efforts have prioritized the problem, including a requirement that public elementary and secondary schools report incidents of harassment based on religion, sexual orientation, gender, race, color, national origin, and disability status (U.S. Department of Education, 2016).

Students who are victims of bullying do not perform as well academically in school and more often skip class and are truant. In addition, they are at significantly higher risk for using and abusing alcohol and drugs, suffer from depression, and having higher risk of suicide. Marginalized student populations, including the LGBT community, are most at risk for bullying victimization and these problematic outcomes (Hatzenbuehler & Keyes, 2013; Kowalski & Limber, 2013).

Poly-Victimization

Poly-victimization is the exposure to, and experience of, multiple forms of trauma and/or victimization. Multiple trauma experiences are common for some child and adolescent populations, with up to 20 percent of those ages 13 to 18 (disproportionately male and older) having experienced more than one type of trauma and over 41 percent of physical abuse, assault, or sexual abuse victims had also reported additional trauma experiences. More broadly, for all children and adolescents who experienced any direct victimization, more than two-thirds reported more than one type. Of concern is that there are a small number (between 6 and 8 percent) of adolescents reporting exposure from six to over 15 different traumatic experiences over their lifetime (Finkelhor, et al., 2005; Finkelhor, et al., 2013; McCart, et al., 2011).

Having certain traumatic experiences exposes the young person to much greater risk for another trauma. A young person who was physically assaulted would be five times as likely to have been sexually victimized and more than four times as likely to have been maltreated during a one-year period. And a young person who was physically assaulted during his or her lifetime would be more than six times as likely to have been sexually victimized and more than five times as likely to have been maltreated (any type) during his or her lifetime. The greater the number and severity of the trauma experiences, often

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the greater the impairment for adolescents, including mental health, academic, and behavioral problems. (Finkelhor, et al., 2009; Ford, Elhai, Conner, & Frueh, 2010; Ford, Grasso, Hawke, & Chapman, 2013). In addition, repeated trauma experiences have been found to double the risk for mental health disorders (anxiety, post-traumatic stress disorder, and depression, among others) and this impact lasts for up to three years after the traumas (Copeland, et al., 2007; Perkonigg, Kessler, Storz, & Wittchen, 2000).

Child and Adolescent Mental Health Problems

Risk Factors

Child and adolescent risk factors (experiences, traits, or issues that make the outcome more likely) for the development of mental health problems and disorders have been divided into individual, family, and neighborhood categories. Individual factors include the following: gender (type is dependent on mental health diagnoses); age (risk increases during adolescence for most diagnoses, though not all); ethnicity (dependent on mental health diagnoses); poorer overall physical health; lower cognitive function; exposure to illness; increased physical stress over time; substance use and abuse; poor nutrition; and lifetime history of environmental exposures to toxins, stress, and traumatic life events. Family factors include the following: lower parental education, lower economic and social class; poorer employment and work histories; a more extensive psychiatric and medical history; parental history of mental disorders; and poor family functioning and structure. Neighborhood factors include the following: increased number of trauma or violent events; lower income neighborhoods; and poor environmental health (Brauner & Stephens, 2006; Goodman, Hoven, Narrow, Cohen, Fielding, Alegria et al., 1998; New Freedom Commission Report, 2003).

Prevalence Rates/Treatment Access

Most children and adolescents do not suffer from mental health disorders. It is only between 3 and 20 percent of children and adolescents that have an identified mental health disorder that impairs their functioning to a moderate or significant degree. The impact for older children and adolescents, ages 9 to 17, is greater with 21 percent having a diagnosable mental health issue that causes moderate impairment to their daily living.

However, the risk and experiences with mental health problems and symptoms is more expansive than a medical diagnosis. In broader, self-report surveys of young people, nearly half of the adolescent population self-reported having met diagnostic criteria for at least one disorder over the lifetime, with 20 percent of this group reporting symptoms severe enough to impair their daily living; almost 10 percent reported a behavior disorder; more than 8 percent reported being severely impaired by an anxiety disorder; over 11 percent similarly impacted by a mood disorder; and 40 percent who reported one disorder also reported a comorbid second disorder, more often those with a mood disorder. Many of these difficulties began during childhood with symptoms of anxiety emerging at age 6 (median), behavior disorders by age 11, and mood disorders by age 13 (Angold, Erkanli, & Farmer, 2002; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Costello, Mustillo, Keeler, & Angold, 2004; Costello, Egger, & Angold, 2005; Merikangas, Burstein, Swanson, Venevoli, Cui, Berjet et al., 2010; Roberts, Roberts, & Xing, 2007).

Unfortunately, when these problems are identified, upwards of 75 percent of this group does not access or receive adequate treatment or services. However, for those young people with the most severe

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symptoms or mental health difficulties, most do access and receive community or school-based services. Reasons for this higher level of access to services is because of the young person's significant impairment, the family's recognition of the problem, comorbidity across other problem areas, and if there was a suicide attempt by the young person. Those who access services through their schools, though are unlikely to transition to community-based or specialty mental health programming when school services end (DeRigne, Porterfield, & Metz, 2009; Ford, 2008; Gudino, Lau, Yeh, McCabe, & Hough, 2009; Reddy, Newman, De Thomas, & Chun, 2008).

Behaviorally-based Disorders

Within the child and adolescent population that have professionally identified mental health problems, behaviorally-based disorders are some of the most common with between 4 and 14 percent prevalence rates. This includes lower rates in younger children – more often oppositional defiant disorder (ODD) and attention-deficit hyperactivity disorder (ADHD) – and higher rates for older school-age children – more often conduct disorder (CD) (Costello, Angold, Burns, Stangl, Tween, Erkanli, & Worthman, 1996; Nock, Kazdin, Hiripi, & Kessler, 2007). Oppositional defiant disorder – impacting slightly more than 3 percent of the child and adolescent population - and conduct disorder - impacting 4 percent - are characterized by persistent violation of age-appropriate societal rules and expected behavioral expectations, as well as persistence of these behaviors for a minimum period of time. Attention-deficit hyperactivity disorder has the opposite prevalence trends, with almost all diagnoses made prior to the age of 12 (prevalence is between 3 and 5 percent), though for many children the difficulties continue into the secondary school age period. All three of these disorders – conduct, oppositional defiant, and attention-deficit hyperactivity disorder – are twice as prevalent for boys than for girls (American Psychiatric Association, 2013; Costello, et al. 2005; Roberts, et al., 2007).

Anxiety Disorders

Anxiety disorders that are identified through professional diagnosis account for between 2 and 4 percent of the child and adolescent population with some significantly higher rates in a number of community-based surveys (median prevalence rate of 8 percent). These disorders impact both the primary and secondary school-age populations equally, though with different diagnoses for each group. Separation anxiety and some related anxiety difficulties are more often found in primary school-age children; while panic disorder, agoraphobia, social phobia, overanxious disorder, and generalized anxiety disorder are more often found within secondary school-age adolescents. Girls are slightly more often diagnosed with certain anxiety difficulties, primarily post-traumatic stress disorder and obsessive-compulsive disorders, and are overall at greater risk for any anxiety problems (American Psychiatric Association, 2013; Costello, et al., 1996; Kessler, Berglund, Dermier, Jin, Merikangas, & Walters, 2005; Merikangas, et al., 2005; Rappaport, Inoff-Germain, Weissman, Greenwald, Narrow, Jensen, et al., 2000).

Depression

Depression and related disorders are not common for children younger than 12 years of age, accounting for less than 2 percent of all cases identified through professional assessment. However, depression rates rise dramatically within the adolescent population, and impact between 4 and 5 percent of this group;

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greatly increasing the risk for suicide (American Psychiatric Association, 2013; Costello, Pine, Hammen, March, Plotsky, Weissman, et al., 2002; Simonoff, Pickles, Meyer, Silberg, Maes, Loeber, et al., 1997). Depressive disorders, including major depressive disorder, have been found to be more prevalent within white adolescent populations when compared to black adolescent populations; as well as more common in female adolescents than male adolescents (Angold, et al., 2002; Gonzalez-Tejera, Canino, Rameriz,, Chavez, Shrout, Bird, et al., 2005).

Post-Traumatic Stress Disorder (PTSD)

Five percent of adolescents meet criteria for PTSD during their lifetime, with a higher prevalence rate for girls (8.3 percent) than boys (2.3 percent). Higher overall prevalence rates (7 to 11 percent) have been found in reviews of adolescents living in larger urban areas, with similar gender differences found in these populations (Kessler, et al., 2012).

Many children and adolescents who have experienced trauma, and in particular maltreatment, will develop symptoms, or partial symptoms, of PTSD (as well as other related anxiety or depression problems). Post-traumatic stress disorder can occur at any age, even for children as young as one or two years old; though there may be a delay of months or years before symptoms are able to be identified. Different reactions, stressors, and symptoms may vary over time and for children at different developmental stages. A diagnosis of PTSD includes a history of trauma(s) event exposure that impacts the person and leads to avoidance, negative reactions, and changes to daily living (American Psychiatric Association, 2013).

One of the symptoms of PTSD, and related trauma difficulties, is a state known as "hypervigilance." Often defined as "abnormally increased arousal, responsiveness to stimuli, and scanning of the environment for threats" (Buffington, et al., 2010, p. 3). For children and adolescents this can look like jumpiness, nervousness, quick to react or startle, high defensiveness, and/or an inability to feel calm or relax. Many highly traumatized young people are in a consistent state of hypervigilance, always worried or fearful of what trauma may impact them next. This "flight or fight" response can be debilitating for many, very tiring, and may look like symptoms of other problems: attention-deficit hyperactivity disorder, conduct problems, aggressive behaviors, paranoia, and social interaction or relationship difficulties.

A fight or flight response to trauma may also harm or damage a child's brain functioning and development. When traumatic events cause this response, stress hormones (cortisol and adrenaline) are released to prepare the body for either escaping the threat or staying and "fighting" the threat. Although this is an effective response for dealing with an immediate danger, children's and adolescents' bodies are not meant to live in this stressed state for extended periods of time. The hormones released during stressful events can have cumulative, long-term damages on the body. This is potentially harmful for those who are still experiencing sensitive periods of growth and development, and may have significant consequences on brain development. The child or adolescents' brain is adapting to help the individual survive in a traumatic and stress-filled environment. This stress-induced damage can disrupt normal development and lead to emotional, cognitive, and behavioral problems. Potential cognitive impacts include language delays, attentional issues, and memory difficulties. Behavioral issues may include increased aggression, poor social skills, an inability to moderate emotional responses, attachment problems, and an increase in risk-taking behaviors and impulsivity (Substance Abuse and Mental Health Services Administration, 2014).

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Interplay of Mental Health and Trauma

Mental health and trauma problems are inexorably linked. Childhood abuse and neglect victimizations that lead to out-of-home placement into a foster home increase the risk for delinquency and recidivism to delinquency. These trauma experiences often also lead to more severe mental health problems (conduct and other externalizing type behavior problems, depressive episodes, and PTSD) that are linked to youthful offending outcomes, with the risk highest rate for those victimized during adolescence (Barrett, Katsiyannis, Zhang, & Zhang, 2013; Cottle, Lee, & Heilbrun, 2001).

Living in poverty also impacts children and adolescent's mental health, in that a far greater number report these problems: 21 percent of children in poverty in 2010 had diagnosed mental health disorders; those not living in poverty reported mental health disorders between 3 and 18 percent (Stagman & Cooper, 2010). Experiencing poverty, and particularly over time, is a dynamic process with some experiences impacting other difficulties (family violence, witnessing violence, substandard housing, unsafe neighborhoods, and family separation, among others) and these interacting further with children and adolescents' coping capacities. Also, poverty during earlier childhood and poverty experienced over time are linked to worsening and progressively harder to treat mental health problems for adolescents and young adults (Evans & Cassells, 2013; Yoshikawa, Aber, & Beardslee, 2012).

Trauma Assessment and Intervention

Identifying childhood and adolescent trauma experiences can be difficult. The type of trauma or stress, developmental stage (age), cognitive and emotional capacities, and levels of resiliency are all factors that impact the emergence of trauma symptoms Fortunately, there are a number of assessment measures that can be used to identify trauma experiences, PTSD, and related problems (See Table 1).

Trauma-Informed Care

Over the past decade, a proliferation of program development has occurred on what is commonly called "trauma-informed care." Significant advances in treatment for childhood trauma have been made, including some programs and interventions with strong or growing empirical support. Most of these programs range in treatment time from four to 36 sessions or weeks, and take place in the community family setting. Table 2 includes a number of trauma treatment programs; the last two on the table are specifically designed for use in schools (Duke University School of Medicine, 2015; The National Child Traumatic Stress Network, 2015):

One of the effective interventions is Trauma-focused Coping in Schools (also known as MMTT). This program uses a skills-based and peer-mediated group design to help with trauma and related difficulties for children (4th grade through high school). The curriculum is based upon cognitive-behavioral techniques focused on teaching coping skills around anger, grief, and anxiety. The intervention is most helpful when started at least one month after the traumatic event (fire, suicide, homicide, or other violence exposure), and typically includes 14 group session with six to eight students per group, held weekly during classroom time (Jaycox, Morse, Tanielian, & Stein, 2006).

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Table 1. Trauma assessment

The CROPS (Child Report of Post-traumatic Symptoms) is a self-report measure for children and adolescents that assesses a broad range of post-traumatic symptoms, with or without an identified trauma, and can be used to measure changes in symptomatology over time.
The Child PTSD Symptom Scale (CPSS) is a self-report measure that assesses the frequency of all DSM-defined PTSD symptoms and was also designed to assess PTSD diagnosis. The first 17 items measure PTSD symptomatology and yield a total Symptom Severity score. Seven additional items assess daily functioning and functional impairment.
The CTSQ (Child Trauma Screening Questionnaire) is a 10-item self-report screening which helps in the identification of children at risk of developing PTSD. The questions are designed to assess traumatic stress reactions in children following a potentially traumatic event.
The Child's Reaction to Traumatic Events Scale is a 23-item self-report measure designed to assess psychological responses to stressful life events.
The Children's PTSD – Inventory (CPTSD-I) is a structured clinician-administered interview for those ages 6 to 18 years old that assesses PTSD symptoms and diagnoses, qualifying event, and current functioning.
The Clinically Administered PTSD Scale for Children (CAPS-CA) assesses the frequency and intensity of the 17 symptoms of PTSD, with items developed to be consistent with the DSM. It also evaluates the impact of the symptoms on the child's social, occupational, and developmental functioning; subjective distress; global severity; and validity of the interview. A global improvement rating since baseline can also be made, as can ratings of associated symptoms and Acute Stress Disorder symptoms.
The Parent Report of Post-traumatic Stress Symptoms (PROPS) is a parent-report measure for children and adolescents that assesses a broad range of post-traumatic symptoms, with or without an identified trauma, and can be used to measure changes in symptomatology over time.
The PTSD Semi-structured Interview and Observational Record is used to assess PTSD in children 0-7 years of age. The measure assesses whether the child has experienced 11 specific traumas or an alternative trauma; and collects data regarding the first occurrence, last occurrence, and the number of times the event occurred. It includes questions for caregivers and collection of information for observation of the child during the interview.
The Response to Childhood Incest Questionnaire (RCIQ) was developed to measure PTSD symptomatology and cognitive and affective stress response themes in female adult survivors of childhood incest.
The Trauma Symptom Checklist for Children (TSCC) measures severity of post-traumatic stress and related psychological symptomatology (anxiety, depression, anger, dissociation) in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters.
The Trauma Symptom Checklist for Young Children (TSCYC) is a 90-item caretaker-report instrument developed for the assessment of trauma-related symptoms in children ages 3-12. The scales allow a detailed evaluation of posttraumatic stress symptoms and a tentative PTSD diagnosis. It also provides information on other symptoms such as anxiety, depression, anger, and abnormal sexual behavior.
The UCLA PTSD Reaction Index is a self-report questionnaire to screen for exposure to traumatic events and assess PTSD symptoms in school-age children and adolescents. The scale assesses the frequency of occurrence of PTSD symptoms during the past month.

MENTAL HEALTH PREVENTION AND INTERVENTIONS

Effective child and adolescent interventions and programs to deal with the mental health problems have been developed and are available for use across community-based agencies, as well as other settings including schools and other youth-caring systems. These interventions are offered across numerous formats including individual, family, and group formats, among other approaches.

Children

Anxiety Disorders

Many children respond to a number of interventions that help decreasing or managing their anxiety symptoms and disorders, though other children are unresponsive and struggle with these problems into adolescence, even after intervention. Studies that examined a range of interventions found two with the

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greatest impact: cognitive-behavioral therapy and pharmacotherapy (medications), though he evidence is stronger for the former and thus should be utilized as an initial treatment (Muris & Broeren, 2009; Walkup, Albano, Piacentini, Birmaher, Compton, Sherrill, et al., 2008). When children do not respond well to the initial efforts by cognitive-behavioral therapy, then pharmacotherapy, in particular using Selective Serotonin Reuptake Inhibitors (SSRIs), can be recommended in addition to cognitive-behavioral therapy. It should be cautioned, though, that while this combination of interventions improves the symptoms in the short term, there are side effects and tolerance buildup, often in reaction to the pharmacotherapy regimen (American Academy of Child and Adolescent Psychiatry, 1997; RUPP Anxiety Group, 2001).

Effective behavioral and cognitive-behavioral therapies typically include components of different programming alternatives, including exposure therapy (systematic desensitization), cognitive restructuring, psycho-education on anxiety and its effects, contingent reinforcement, and modeling. Through the use of these components, children learn to recognize anxious feelings and reactions to anxiety, develop a coping mechanism for anxiety-inducing situations, clarify thoughts in anxious situations, and reinforce these new skills and behaviors (Amaya-Jackson & DeRosa, 2007; Kendall & Suveg, 2006; Suveg, Kendall, Comer, & Robin, 2006).

Table 2. Trauma-informed care

Alternatives for Families: A Cognitive Behavioral Therapy - ages 5 to 17; 20 sessions; most appropriate for physical abuse or excessive physical punishment victims
Trauma-Focused Cognitive Behavioral Therapy - ages 3 to 21; for sexual abuse, domestic violence, traumatic grief, and complex traumas experiences
Parent-Child Integrative Therapy - ages 2 to 12; for physical, sexual, or emotional abuse victims
Child and Family Traumatic Stress Intervention - ages 7 to 18; 4 sessions; for a wide range of trauma victims including poly-victimizations typically in early or acute stage
Integrative Treatment of Complex Trauma for Adolescents - ages 12 to 21; for a wide range of traumas
Trauma Affect Regulation: Guide for Education and Therapy - ages 10 and older; for complex and poly-victimization traumas
Trauma and Grief Component Therapy for Adolescents - ages 12 to 20; for interpersonal violence and traumatic loss
Attachment, Self-Regulation, and Competence: A Comprehensive Framework for Intervention with Complexly Traumatized Youth - ages 2 to 21, for complex traumas
Trauma-Focused Coping in Schools (MMTT) - ages 6 to 18; used in a classroom setting; a skills-based approach to address single incident trauma and PTSD symptoms; group setting with 6-8 participants
Cognitive Behavioral Intervention for Trauma in Schools - ages 10 to 15; addresses community and other violence, most appropriate with ethnic minority students; uses a skills-based group setting with 6-8 participants

Behaviorally-Based Disorders (Conduct and Oppositional Defiant Disorders)

Programs and interventions for dealing with behaviorally-based disorders target both parents and children. Parent management training, also called parent training and family training, has been found effective in working with children who have behaviorally-based and/or aggression problems, and particularly demonstrates short-term improvements in the development of pro-social behaviors and in minimizing maladaptive behaviors. Parent management training involves teaching parents how to respond consistently and more positively to their children while changing maladaptive interaction habits within the

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relationship that lead to continued aggressive or antisocial behaviors. In doing so, this training, based on social learning theory, utilizes operant conditioning procedures to reduce these problem areas. It is important to provide interventions as early as possible because of the increased chance of additional behavioral disorders while the decreased chance of later adverse behaviors (Bernazzani & Tremblay, 2006; Farrington & Welsh, 2003; Piquero, Farrington, Welsh, Tremblay, & Jennings, 2008).

A related parent management training program type, sometimes called behavioral parent training, is also based in social learning theory but has a stronger focus on behavioral management. In this, the emphasis is on the importance of observing and modeling the behaviors and attitudes of others to help the child with behavior problems. The programs teach broad behavioral principles for producing and reinforcing positive child behaviors which can be adapted in the home environment through the use of rehearsing and coaching (Dretzke, Frew, Davenport, Barlow, Stewart-Brown, Sandercock, et al., 2004). Reviews of these programs have found that they are high quality and effective in decreasing children's behavior problems (Barlow & Parsons, 2002). A number of meta-analyses further supported these findings, with results showing effectiveness of behavioral parent training programs in a number of specific areas: working with children with conduct disorders (Gould & Richardson, 2006); improving overall child and parent functioning levels, in particular with older children (ages nine to eleven) (Serketick & Duman, 1996); in decreasing classroom disruptions (Wilson, Lipsey, & Derzon, 2003); and modifying behavior problems (Maughan, Christiansen, Jenson, Olympia, & Clark, 2005).

Because children with behaviorally-based disorders and problems often struggle in the home, school environments, and community, programs or interventions addressing multiple locations/environments may be necessary. Interventions that focus on behavioral and cognitive behavioral orientation treatment when working with children with behavioral problems and emotional disturbances have been found to have positive impacts (Beard & Sugai, 2004). Interventions include behavioral therapy, individualized therapy, social skills training, medication, and art/play therapy, with the social skills training and a behavioral approach to daily living (token economy model) being two of the more common (Reddy, Newman, DeThomas, & Chun, 2008).

The Promoting Alternative Thinking Strategies (PATHS) Curriculum is an effective school-based program that decreases aggressive behaviors and improves social problem solving through teaching children developmentally-based lessons and instructions on emotional literacy and ability to identify feelings, self-control, interpersonal problem-solving skills, and positive peer relations. Sessions take place two to three times a week in elementary classrooms, led by teachers, to connect cognitive understandings to the daily life situations that children face (Child Trends, 2011; Greenberg, Kusche, & Mihalic, 2006). This is one of numerous programs that have the therapeutic goal of improving self-control. These interventions focus on increasing skills for friendship and social skills, social problem-solving abilities, and understanding and communicating emotions. These can take place in multiple settings – school, home, or community – and involve the child, family, and/or peers. A thorough review of 34 programs found these efforts that attempt to improve self-control among children were an effective intervention in reducing problem and offending behavior risks for those under the age of ten (Piqueo, et al., 2010).

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Adolescents

Behaviorally-Based Disorders (Conduct and Oppositional Defiant Disorders)

Cognitive-based parent training focuses on teaching practical skills to caregivers to address conflict and interpersonal problems and improve communication has been found effective. Cognitive-behavioral treatment interventions more broadly utilized with both adolescents and their families have demonstrated effectiveness in reducing aggressive and antisocial behaviors (Little, 2005). Additionally, these interventions improve positive behavioral and other psychological outcomes. Cognitive-behavioral interventions are designed to identify cognitions - thoughts, expressions, perceptions - and to then alter cognitions that are negative or detrimental in order to reduce maladaptive or dysfunctional thinking, attitudes, or behaviors. Such approaches may include teaching social skills, parenting skills, problem-solving skills, anger management, and related efforts (Andreassen, Armelius, Egeland, & Ogden, 2006; Lipsey & Landenberger, 2006; Turner, MacDonald, & Dennis, 2007).

Functional Family Therapy (FFT), a short-term program of that targets the family, is designed to motivate the adolescent and family members to change adolescent behaviors and family member's reactions to these behaviors. Interventions with eleven- to eighteen-year-old adolescents with behavioral disorders lasts from eight to thirty hours through various engagement and treatment phases, depending upon the level of problem severity. FFT has been found to significantly decrease delinquency offending as well as out-of-home placement due to family instability or delinquency involvement (Alexander, Barton, Gordon, Crotpeter, Hannson, Harrison, et al., 2007; Howell, 2009).

Schools can also have an impact on decreasing aggressive behaviors. Many adolescents report troubles dealing with violence, bullying, and related problems within their schools, leading a majority of school districts to offer some sort of preventative programming (Gottfredson, Gottfredson, Czeh, Cantor, Crosse, & Hantman, 2000). Most of these programs use social processing and cognitive-behavioral techniques to inform and educate students on improving problem-solving skills, identifying consequences to their plans, identifying aggression, and response options. These preventative and intervention programs are offered in both a universal format - to all students in a classroom - or on a selective, individualized basis – students who are identified as having aggression or violence problems. Both social skill development formats, universal and selective programming, have been found to significantly decrease adolescent aggressive and disruptive behaviors, and that the affect for some adolescents was long-term (Wilson & Lipsey, 2006a, 2006b).

Depression and Suicide Prevention

Numerous approaches have been utilized to decrease the symptoms and impact of adolescent depression and related disorders, including various individual and group therapeutic modalities, psychopharmacology, and public education, among others. While some of these approaches, primarily psychopharmacology, are important in stabilizing the most serious depressive symptoms including suicidal ideation and behaviors, others do not appear to be effective in achieving symptom reduction goals, including therapy, psychotherapy, and psychoanalysis (March, Silva, Petrycki, Curry, Wells, Fairbank, et al., 2004).

A smaller set of interventions may be helpful for some adolescents with significant depression problems. Interventions that are more likely to be effective include cognitive-behavioral approaches attuned to adolescent development and focused on peer to peer social activities, problem-solving abilities, new

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thinking patterns, psycho-education for parents and adolescents, and mood and emotion regulation. However, little long-term follow-up research has been completed, so whether or not lasting effects can be achieved though these approaches is not yet known. In addition, when working with adolescents with multiple or comorbid problems that significantly complicate treatment planning and coordination efforts, care should be taken because, once again, only few long-term intervention outcomes targeting this population of adolescents are known (Clark, Boyde, Redditt, Foster-Johnson, Hardy, Kuhns, et al., 2001; Horowitz & Garber 2006).

A number of risk factors correlate with suicidal behaviors, though having suicidal risk factors does not always lead to suicidal tendencies. Risk factors include depression and other related mental health problems, a prior suicide attempt, a family history of suicide or family violence, firearms in the house, and incarceration. When working with adolescents, a number of suicidal behavior signs or symptoms can be identified, thus allowing immediate and concerted preventative actions. These signs include feelings of hopelessness or worthlessness, a decline in or lack of family or social activity participation, changes in sleeping or eating patterns, feelings of rage or need for revenge, consistent exhaustion, low concentration abilities at home and/or school, regular or frequent crying, lack of self-care, and reckless or impulsive behaviors (Centers for Disease Control and Prevention, 2015; National Institute of Mental Health, 2011).

Of concern among adolescents is the effect of comorbid problems that increase the risk for suicidal behavior. As the number of risk factors increases, the risk for suicidal behavior among adolescents also increases, though this is further complicated by the impact of other mental health or substance abuse problems. Depression, disruptive behavior disorders (conduct and oppositional defiant), and substance abuse are strongly linked to increased suicide risk (Conner & Goldston, 2007; Shaffer, Gould, Fisher, Trautman, Moreau, Kleinman, et al., 1996).

Chapter Summary

This chapter discusses the wide impact and prevalence of childhood and adolescent trauma and related mental health problems and reviews the empirical link to later life difficulties, including violence. In so doing it is postulated that these experiences are even more involved in the histories of mass shooters than reported to date and that increased use of preventative efforts may help decrease the risk of tragic outcomes. There are effective ways to both identify and treat trauma related problems and mental health difficulties for this younger population - in schools, their homes, and the community. This review includes some of the most effective evidence-based approaches to preventing youthful offending and violent outcomes by addressing these difficulties.

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KEY TERMS AND DEFINITIONS

Behaviorally-Based Disorders: Mental health problems and disorders that are externalized; in other words, where acting out or physical violence is involved.

Child Maltreatment: There are four official, legal categories of child maltreatment: physical abuse, sexual abuse, emotional (psychological) abuse, and neglect (including medical), depending on state law definitions.

Cognitive Behavioral Therapy: A type of psychotherapy in which negative patterns of thought about the self and the world are challenged in order to alter unwanted behavior patterns or treat mood disorders such as depression.

Domestic Violence: Includes emotional abuse, threatened and actual physical abuse, or sexual violence between adults, both heterosexual and same-sex partners.

Functional Family Therapy: An effective intervention that attempts to modify individual behaviors and cognitions, with an emphasis on the larger family or groups as the focal area needing change rather than only on the adolescent.

Mental Health Disorders: A diagnosis by a mental health professional of a behavioral or mental pattern that may cause suffering or a poor ability to function in life. In the United States, diagnosis is through the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Poly-Victimization: The exposure to, and experience of, multiple forms of trauma and/or victimization.

Post-Traumatic Stress Disorder: A diagnosis of PTSD includes a history of trauma(s) event exposure that impacts the person and leads to avoidance, negative reactions, and changes to daily living

Risk Factors: Experiences, traits, or issues that make an outcome (delinquency or mental health problems, for example) more likely.

Seriously Emotionally Disturbed: A designation for young people who have ongoing mental health problems, often more severe and difficult to treat – including psychotic diagnoses, bi-polar disorder, and mood disorders.

Trauma: A deeply distressing or disturbing experience; one that impacts the person either in the short- or long-term.

Trauma-Informed Care: A treatment framework that involves understanding, recognizing, and responding to the effects (psychological, social, and biological) of all types of trauma.

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Chapter 65
EHealth Interventions for People Suffering From Sleep Problems and Depressive Symptoms: Qualitative Findings and Future Research Directions

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ABSTRACT

This chapter highlights qualitative findings from two field studies that focused on supporting people with sleeplessness (Study 1) and moderate depression (Study II). Both the studies were designed to examine the prospective impact of reminders and rehearsal on the effectiveness of web- based eHealth interventions. The interventions were incorporated with Acceptance and Commitment Therapy. In this chapter, qualitative findings are reported with an aim to highlight issues that are at times overlooked. Further, the findings are expected to help researchers better understand eHealth interventions for mental health care. Results from the two studies uncover interesting contrasts. While the participants of the Study I (Sleeplessness) generally did not find reminders to be helpful, on the contrary, the participants of study II (Moderate Depression) largely approved reminders especially in terms of task completion. In terms of rehearsal, participants from both the studies approved the virtual exercises in terms of learning desirable self-help behaviors. Finally, the chapter highlights some of the grey areas in the field of eHealth interventions for mental health care. The identified grey areas are expected to create opportunities for further research and advances in the field of mental health care.

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1. BACKGROUND

A relatively under-studied area in the field of Mental Health Care is identifying the factors that contribute to continuous use of eHealth interventions for mental health care. In order to design and implement effective interventions, it is important to gain a richer insights about users' perspectives with a special focus on areas such as User-system feedback, Online support, Use of Reminders or prompts, Content of the interventions, Trust and Privacy. Despite bulk of published literature about Internet- and Mobile- based interventions for mental conditions, it appears that there is a lack of transparency as well as unified understanding on the part of system developers as well as researchers (Barak et al. 2009). In recent years, most of the studies in the area of mental health care have focused on areas such as adherence (Kelders et al. 2012), dropouts rates, perceived benefits (Drozd et al. 2012) and persuasiveness of eHealth interventions. Further, the overlap in terminologies as well as imprecise narratives (Langrial et al. 2012) have caused the field to become rather diffused and unnecessarily complex. Yet another issue in the area of mental health care is that there is more focus on technological aspects while designing the interventions and overlooking the significance of incorporating psychological content.

Technological advances have opened new opportunities to develop Internet- and Mobile- based Interventions that can support people suffering from mental conditions including but not limited to depressive symptoms, mild depression, acute depression, hypertension, stress, anxiety, trauma and sleeplessness. Both Internet- and Mobile- based interventions have shown promising results in supporting people with several mental conditions (Mohr et al. 2013). We propose that Internet- and Mobile- based eHealth interventions for psychological betterment is a step farther from more traditional behavior change interventions. Behavior change interventions have been studied and categorized differently; for example, Persuasive Technologies (PT), and Behavior Change Support Systems (BCSSs) (Langrial, 2012). However, we propose that designing an eHealth intervention is perhaps the easier part! The real challenge is to continuously monitor an intervention and make needed improvements by identifying the actual needs of users. In addition, involving users or in some cases their immediate caregivers would certainly help in re-shaping the very paradigm of Internet- and Mobile- based interventions for mental health care.

Information systems that are developed to support behavior and/or attitude change are often studied as digital interventions (Langrial, 2012). We cautiously argue that labeling behavior change technologies as digital interventions is a holistic approach. Research on eHealth interventions dates back to the early 90s where they were predominantly used for preventive medical area mostly through intermediations (paper- based and/or telephonic calls). A large number of studies have been carried out that aim to intervene health- related behaviors. For instance, Revere and Dunbar (2001) highlight that personalized digital interventions are moderately effective. Similarly, Langrial et al. (2014) propose that digital interventions have shown promise in supporting people's behavioral change process.

The research area of designing eHealth interventions that support people in improving mental health has received a great deal of attention (Eysenbach, 2000). Such interventions aim to support users in managing health- related disorders. Presently, different platforms are available for developing behavior change technologies i.e. Internet- and Mobile- based eHealth interventions delivered through portable devices and smart phones (Eysenbach, 2000). Still, the task of designing such interventions manifestly maintains its coherent challenges, for example, how would users interact with a given intervention and how would they process and experience the interaction (Or et al. 2011). Additionally, it is necessary that both researchers and system designers systematically understand how users anticipate benefiting from such technologies, what is their user experience (UX) and what are the factors that encourage them to

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continue using such interventions. The list of challenges in designing eHealth interventions aimed at supporting mental health care goes on like an endless loop.

Designing effective and engaging eHealth interventions is challenging for several reasons therefore designers need to concentrate on the actual needs and expectations of the users. Generally, there is a lack of understanding of theoretical paradigms that are aimed at changing or influencing human behavior (Benbasat, 2010) and, lack of emphasis on HCI- related methodologies being employed during the design process. According to Perkins et al. (2007), systems developed in the HCI discipline are neutral in nature however, this argument is subjective. On the contrary, bringing HCI into eHealth interventions can, for example, improve the aesthetics of the systems/intervention and lead to prolonged interaction. One of the decisive objectives of designing therapeutic eHealth interventions is to effectively support and guide users to achieve enduring self- confidence that would lead to a feeling of self-control and empowerment. Effective strategies influence users and their perceptions when behavior change techniques are supported by Socio- psychological theories. It is for this reason that several researchers from Health Informatics and behavior change technologies have highlighted the importance of theory- driven design for behavior change technologies and interventions (Consolvo et al. 2009).

It is a promising to observe that researchers and system designers have recognized the significance of theories in the design process. For instance, Consolvo et al. 2009 have proposed Theory- driven approaches for designing behavior change interventions and have incorporated the Transtheoratical Model and Presentation of Self in Everyday Life (Consolvo et al. 2009). A detailed conception of Socio-psychological theories is essential in the design process nevertheless there is a technical side for developing and implementing eHealth interventions. As discussed by Andersson and Cuijpers (2009), technical support ought to be incorporated in such a way that the system (intervention) integrates seamlessly in users' everyday lifestyle.

Effectiveness of eHealth interventions that are incorporated with Cognitive Behavioral Therapy (CBT)- based techniques are emphasized in available literature (Seligman & Ollendick, 2011). Practicality of CBT- based interventions for mental well-being is also supported by (Forman et al. 2010). It is frequently proposed that these treatments are superior to other forms of available treatments. Incorporation of psychological components in behavior change interventions has shown promising outcomes. While there are several studies that highlight the practicality of traditional behavioral therapies, Acceptance and Commitment Therapy (ACT)- based interventions are fairly understudied (Lappalainen et al. 2014) despite the fact that Acceptance and Commitment Therapy is recognized for its positive influence on psychological flexibility (Hayes & Strosahl, 1999).

This chapter presents qualitative findings from two field studies that focused on supporting people with sleeplessness (Study I) and moderate depression (Study II). Both the studies were designed to examine the prospective influence of reminders and rehearsal on the efficacy of the web- based interventions that were developed by employing selected persuasive software features and incorporated with Acceptance and Commitment Therapy- based exercises/modules. Sleeplessness and moderate depression were chosen because first, they are interrelated and, second, they are essential for an individual's mental health. Quality of life depends on different factors, and both sleeplessness and depression, if not attended, can lead to serious negative consequences. In this chapter, qualitative findings are reported with an aim to highlight underlying issues that are at times overlooked. The findings are expected to help designers better understand the dynamics of eHealth interventions that are developed for mental health care. For data collection, we used semi- structured interviews and Likert- scale questionnaires. Although, we used SPSS V. 20 to perform statistical analyses on pre- and post- study psychological measures for both Study

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I and II, however in this chapter only qualitative findings are reported. This is because in the context of healthcare- related research, qualitative methodologies have been promoted as a practical approach. The results from the two studies reveal interesting differences. While the participants of the Study I (Sleeplessness) did not generally find reminders to be helpful, on the contrary, participants of study II (Moderate Depression) largely approved reminders, especially in terms of task completion. In terms of rehearsal, participants from both the studies approved the virtual exercises (ACT- based modules) in terms of learning desirable self- help behaviors. Based on the qualitative findings, we have identified six emerging themes that are expected to open further research opportunities for mental health care researchers.

1.1 Sleep Deprivation

Suitable amount and quality of sleep is necessary for healthy minds. Sleeplessness or insomnia is among serious mental disorders however this area is rather understudied (Langrial et al. 2014; Alhola & Polo-Kantola, 2007). Available literature suggests that sleep deprivation and insomnia are negatively correlated with an individual's intellectual performance (Water & Bucks, 2011; Durmer & Dinges, 2005; Aloha & Polo-Kantola, 2007). According to van Starten and Cuijpers (2009), physical fatigue, mood disorders, emotional anxiety and psychological stress are among the consequences of sleeplessness. It is generally argued that the consequences of sleeplessness and related disorders are alarming (Orzel-Gryglewska, 2010). For example, people who suffer from sleep deprivation face a higher risk of cardiovascular diseases, diabetes, despair and obesity (Faubel et al. 2009). There is a decent amount of litrature that focuses on promoting healthy diet and regular exercise with an aim to improve people's sleeps behaviors (Tang et al. 2010; Purpura et al. 2011; Albanina et al. 2009). However, it is surprising that less focus has been paid on managing sleeplessness and related disorders. It is essential that mental health care researchers accept the stern challenge of designing effective eHealth interventions that have the potential to provide novel health care solutions. The potential effect of Internet- and Mobile- based interventions when combined with Cognitive Behavioural Therapy (CBT) has been fairly well studied and encouraging findings have been reported for people suffering from Insomnia (Ong et al. 2012; Ritterband et al. 2009). Such findings highlight the potential of eHealth interventions that support people with sleeplessness and moderate depression.

1.2 Moderate Depression

Another major mental disorder is that of depressive thoughts, mild and/or moderate depression. It is well-known that sleeplessness and depression are positively correlated (Benca & Peterson, 2008). Depression whether mild or moderate, is among the most widespread mental disorders in modern day world (Johansson & Andersson, 2014; Kessler, 2012). It is a serious mental health condition that affects nearly 350 million people around the world (Lappalainen et al. 2015). Similar to sleeplessness, depression has been reported as a cause of high mortality rates, poor life quality, social isolation and even restlessness (Aromaa et al. 2011; Galatzer-Levy & Bonanno, 2014). Depression has also been correlated with tendency to commit suicide, alcoholism and social stigma (Langrial et al. 2014). Depressive disorders have been estimated to increase the ailment problem substantially by the year 2030 (Kleine-Budde et al. 2013). Health Information Systems (HIS) and Behavioural Psychology are well-studied research areas and provide ample openings for developing novel eHealth interventions for mental disorders such as depression especially by incorporating Cognitive Behavioural Therapies (Aromaa et al. 2011). Current literature

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underlines that eHealth interventions that are developed for mental health care can be improved when augmented with Cognitive Behavioural Therapy (CBT) (Meyer et al. 2009; Warmerdam et al. 2008).

It is worth noting that various hindrances have been identified that prevents people from using online or more traditional treatments both for sleeplessness and depression. Some of the deterring reasons include but are not limited to low motivation, difficulty in finding psychological experts, lack or absence of professional services, unwillingness to discuss personal matters, high treatment costs and humiliation (Langrial et al. 2014). It is however encouraging to observe that researchers have been working on developing eHealth interventions (both Internet- and Mobile- based) that could help overcome the said limitations. Further, there is substantial evidence in the existing literature about the effectiveness of e Health interventions that employ Cognitive Behavioural Therapy (CBT) (Andrews et al. 2010; Andersson & Cuijpers, 2009). However, interventions that employ Acceptance and Commitment Therapy (ACT) are relatively uncommon (Lappalainen et al. 2015).

2. RELATED LITERATURE

According to Oh et al. (2005) computing technologies provide an appropriate medium to deliver healthcare solutions. This is particularly true because computing technologies support cost effective delivery of innovative methods and practices to promote sustainable healthcare solutions (Kuonanoja et al. 2015). Ritterband and Tate (2009) point out that healthcare interventions that are delivered over the Internet have shown promise mainly in terms of scalability and reduced costs. As a result, Internet- based healthcare interventions have received growing attention (Kraft & Yardley, 2009). Carefully designed eHealth interventions for mental health care can offer innovative solutions that are convenient for people who either cannot reach healthcare professionals or, are not motivated enough to discuss psychological problems in person (Kuonanoja et al. 2015, Langrial et al. 2014). Accessible literature also supports the effectiveness of Internet- based psychological interventions that are integrated with Cognitive Behavioural Therapy (CBT) (Andersson & Cuijpers, 2009). There is an obvious support for the effectiveness of CBT- based interventions for mental health care (Seligman et al. 2011). While Cognitive Behaviour literature underscores substantiation pertaining to the usefulness of CBT- based eHealth interventions, it is remarkable to observe that a few studies have focused on exploiting Acceptance and Commitment Therapy (ACT), which is the latest wave of CBT (Hayes et al. 2005). What makes Acceptance and Commitment Therapy (ACT) an effectual tool is that it is known to improve an individual's psychological flexibility and is therefore positively correlated with improved mental health (Lappalainen et al. 2015; Hayes et al. 2005). Research efforts have been made to comprehend the particulars of eHealth interventions that are developed to support people with mental health conditions including insomnia, depression, stress and anxiety. Researchers from the fields of Information Systems and Human Computer Interaction (HCI) have also developed and evaluated the efficacy of selected software features and their likely impact on task completion (Mohr et al. 2014), user satisfaction (Kelders et al. 2011), task adherence and overall psychological outcomes (Langrial et al. 2014).

HCI researchers have emphasized on designing eHealth interventions/information systems that simplify the process of behavior change. For an instance, Consolvo et al. (2009) support the use of Theory- driven design for such interventions. On the other hand, Choe et al. (2011) propose that information systems, eHealth interventions and technological innovations have the potential to improve mental health care. They further add that designing such interventions is a challenging task therefore there is a need for deeper

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understanding of different aspects including cultural sensitivities, privacy issues, trust, user perceptions as well as individual drives and routines. While design strategies and broad agendas for theorizing and developing eHealth interventions for improved mental health care are frequently found in available literature, nevertheless it is manifest that the prospective influence of credible software features either in a selected combination or isolation have been generally ignored (Langrial et al. 2014). Reminders and cues have been among the most commonly reviewed software features that can be defined as prompts or triggers (see Masthoff et al. 2013) in the form of text messages, email- based messages, nudges or instant feedback that is delivered to users during their interaction with a given intervention (Lappalainen et al. 2015; Patrick et al. 2009; Neff & Fry, 2009). The effect of reminders could be further enhanced if they were to be supplemented by tailored content, appropriate timing and meaningful content. This could lead to more effective reminders designed for task completion (Schneider et al. 2013).

In contrast to reminders as a software feature, rehearsal/practicing has previously been used mostly in the area of Cognitive Behavior studies. Billet (2010) highlights that channelled learning practices when repeatedly exercised could help formation of new behaviours. Although Billet's work is focused on learning in the context of workplaces, however, we cautiously deduce that appropriate design and employment of learning methods, individuals' enthusiasm to learn and well-designed strategies could lead to the development of new skills and behaviours. Scholars from the field of Psychology have acknowledged cognitive progresses through performance- based processes (Thorpe et al. 1987). The basic idea of rehearsal could possibly be related with "learning through practice". According to Billet (2010), practice (rehearsal) pertains to routine exercise of a given skill, ability or vocation. It is further proposed that learning through practice is not only limited to developing an individual's faculties but equally to enable the user in dealing with existing or new tasks. Hence, we propose that exercising or practicing is related with rehearsal as a technique to learn new skills and behaviours. We have observed that there is little research in the area of mental health care that explores the prospective effect of rehearsal as a software feature. This research gap was identified and helped us in setting the tone for the two field studies concentrating on sleeplessness and moderate depression respectively.

Building upon Fogg's influential work (2002), several researchers have come up with their own theories and models. The Persuasive Systems Design Model (Oinas-Kukkonen & Harjumaa, 2009) is among one of them. Oinas-Kukkonen and Harjumaa (2009) propose that persuasive information systems should encourage users through reminders to perform desired behaviors. They further underline the use of virtual rehearsal as a software feature for assisting users in changing behaviors. Similarly, Fogg (2002) argues that rehearsal is a mean of providing a setting where people can rehearse and learn new behaviours. We propose that the concept of rehearsal as a method to learn new behaviours can be grounded on the Social Cognitive Theory (SCT) (Bandura, 1986). Bandura (1986) proposed that learning process is, "an information processing activity in which information about the structure of behaviour and about environmental events is transformed into symbolic representations that serve as cognitive guides for the construction of complex modes of behavior" (Bandura, 1986, p.51).

A persistent issue in e-Health interventions is low task completion and high dropout rates as pointed out by Eysenbach (2005). However, we have shifted away from a relatively well-studied area such as attrition rates and have focused more on task completion (by analysing the possible effect of reminders) and learning new behaviors (through the use of rehearsal). We propose that task completion is a distinctive phase of interaction that could lead to prolonged user commitment hence reducing dropout rates. Literature highlights valuable information about task completion, however, by emphasizing on the use of material rewards, admiration or social approval, and positive feedback (Volpp et al. 2008). We argue

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that it is vital for healthcare researchers not to confuse adherence with low attrition or high drop out rates. For example, dropouts generally pertain to participants of a given intervention who do not fulfil the entire research protocol (Kelders, 2013). Eysenbach (2005) describes adherence as the extent to which participants of a given intervention "experience" the content. Adherence has also been reported as the extent to which participants' behaviours balance with the guidance and suggestions enthused by an intervention (Aronson, 2007). These interpretations provide a better understanding of a fairly overlapping phenomenon. However, we propose that task completion can be improved by developing engaging interventions that are supplemented with consequential and meaningful content. In other words, task completion is more about forming compliance, completing anticipated tasks and it could be the first step in overcoming lack of devotion and high drop out rates in the area of eHealth interventions for mental health care. We also propose that both researchers and system developers need to pay meticulous attention to psychological theories in order to recognise causal accounts for high dropouts. Further, it is our conjecture that task completion can not only decrease high dropout rates but can also helps users reach a state of higher self- efficacy leading to self- confidence in learning new skills and performing desired actions. The following part of the chapter highlights our attempts to examine the above-mentioned issues particularly. This is because low task adherence and complications in learning new skills remain a challenge when it comes to mental health care (Mohr et al. 2010).

2.1 The Field Studies

Both the studies were carried out using a mixed- method research approach, which is occasionally known as triangulation and is applied in various disciplines (Östlund et al. 2011; Brewer & Hunter, 1989). In addition, mixed- method approach helps researchers explore research problems by using a blend of qualitative and quantitative methods (Onwuegbuzie & Leech, 2005; Wood et al. 1999). The different methods complement each other by revealing exhaustive results. According to Kaplan and Duchon (1988), mixing qualitative and quantitative methodologies offer a greater understanding for inferring and authenticating research conclusions. Applying qualitative research method is known to be constructive as it helps in reducing uncertainties about analytical views and themes. In other words, it could be taken as a developmental approach that advances the overall understanding of a research problem and helps in gaining expressive responses (Sofaer, 1999). Qualitative research becomes particularly valuable for performing research analyses as it elucidates participants' experiences, behaviours, interactions and their social interactions (Strauss & Corbin, 1990). In the context of mental health care research, qualitative methodology has been highlighted as a constructive approach.

3. PROCEDURES

3.1 Recruitment

Study I was conducted between October 2013 and November 2013. Participants were enrolled through newspaper advertisements. The advertisements elucidated that we were seeking people who were suffering from sleep problems. The eligibility criteria were: 1) Access to Internet, 2) Having an email account, 3) Access to telephone, 4) Not being part of a therapy for sleep disorders in parallel, 5) and aged 18 years or over. In response, 122 individuals contacted the university clinic (Department of Psychology, Uni-

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versity of Jyväskylä, Finland) for initial screening process. From the 122 individuals, 14 were excluded, as they did not meet the inclusion criteria. Another 22 were excluded from the study because of limited research resources. Accordingly, the final number of participants for Study I was eighty-six (N=86).

Study II was carried out between September 2012 and January 2013. Participants were recruited through newspaper advertisements that described that we were seeking individuals who felt depressed. The inclusion criteria were: 1) Self-reported depressive symptoms, 2) Depressed mood, 3) No parallel therapy for depression, 4) Access to Internet, 5) Having an email account and 6) Age 18 years of over. In response, a total of 42 individuals contacted the university clinic (Department of Psychology, University of Jyväskylä, Finland) for initial screening. After initial screening, measurement packages and informed consent forms were sent out to the selected participants. One participant dropped out before the screening process and another two did not meet the inclusion criteria therefore the final number of the participants was Thirty-nine (N=39).

3.2 Ethical Approval

Because both the studies included people with sleep- related issues and depressive symptoms, the studies followed the Declaration of Helsinki and the Research. Further, Ethical Approval was officially obtained from the Ethical Committee at the University of Jyväskylä, Finland and the Central Finland Healthcare District (Diary no: 15U/2012).

3.3 Randomization Process

Randomization for Study II was performed on the 13th of September 2012. The participants were divided into two groups: (1) Intervention group 1 (n=19) that received the measurements, automated reminders and complete access to the weekly rehearsal modules, and (2) Intervention group 2 that first served as a waiting list control group and had to wait for a period of six-weeks before they could access the complete intervention. Although the Intervention group 2 had access to the weekly rehearsal modules, however, they did not receive automated weekly reminders. A total of 28 (71.8%) females and 11 (28.2%) males with an average age of 51 years comprised the total sample. Upon completion of the six weeks from Intervention group 1, login credentials for the intervention were sent to the participants of the Intervention group 2. For Study I, randomization was performed using a randomization tool (https://www.random.org/lists) on the 9th of October 2013. Again the participants were divided into two groups: (1) Intervention group (n=43) that received the measurements, and had complete access to the intervention supplemented with two automated weekly reminders, and (2) Wait-list control group (n=43). For ethical reasons, the Wait-list group received access to the complete intervention but no reminder were sent out. A total of 31 (72.1%) females and 12 (27.9%) males comprised the Intervention sample aged between 24 to 73 years.

3.4 Designing the Web- Based Interventions

The Web- based interventions were designed and developed in partnership between research groups from the Department of Information Processing Science, University of Oulu and Department of Psychology, University of Jyväskylä, Finland. A research team from the University of Oulu was responsible for implementing the software features whereas a research group from the University of Jyväskylä developed ACT- based rehearsal modules for both the studies. Rehearsal as a software feature was used to

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improve mindfulness, acceptance skills, value- based actions, and psychological flexibility with the help of vigilantly created metaphors, experiential exercises and behavioural activation (Hayes et al. 2006). Table 1 and 2 exhibit an outline of the modules that were used for the rehearsal content for Study II and I respectively.

Table 1. Acceptance and commitment therapy modules for rehearsing to overcome moderate depression

Week	Acceptance and Commitment Therapy Modules Used for Rehearsal
1	Creative hopelessness and values
2	Value-based actions
3	Contact with the present
4	Cognitive defusion
5	Self as context
6	Acceptance

Table 2. Acceptance and commitment therapy modules for rehearsing to improve sleeplessness

Week	Theme	Content
1	Values and value-based actions	Knowing what matters the most for an individual in users' life and acting in accordance
2	The present moment	Living in the present moment (mindfulness)
3	Cognitive defusion	Understanding that an individual's thoughts could be different
4	The observer stance	Learning to view one's thoughts and feelings from an observer's stance
5	Acceptance	Accepting one's feelings, and thoughts and admitting that one cannot change things
6	Summary	Rehearsing ACT exercises from the past five weeks

3.5 Qualitative Data Collection

Upon completion of the Study II, the participants were asked questions about system usefulness, influence of reminders on task completion, effect of rehearsal on learning new behaviors, impact of rehearsal on self-confidence and their intent to practice newly learnt (if any) skills in future. The questionnaire used Five-point Likert-type scale ranging from 1 = Strongly agree to 5 = Strongly disagree. In addition, the participants were interviewed in a post- intervention sitting where their experiences and overall observations were recorded, coded and analyzed. In Study I, participants' experiences with the intervention and its general practicality was evaluated by employing Likert-scale (Likert, 1932) questionnaires at the beginning and end of the intervention. The questions focused on participants' anticipations and perceived practicality of the system (pre- study) while their actual experiences, system usefulness, ease of use, influence of reminders on task completion, effect of rehearsal on self-confidence and impact of rehearsal module to improve sleep behaviors (post- study). Finally, the participants were interviewed (exit interview) in a post- intervention satisfaction survey where their experiences and interpretations were recorded, coded and analyzed.

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4. RESULTS

4.1 Moderate Depression

In Study II, email- based reminders were sent to Intervention Group I only, in order to assess how the participants perceived the influence of reminders on task completion. A high majority of the participants (83.3%) approved the reminders and gave encouraging comments that; for example, it is easy to forget important tasks in a chaotic world. Some of the descriptive remarks are listed below:

P1: *Reminders assured me to remember doing the assignments (weekly modules); I use my email very often.*
P2: *They (reminders) reminded me of doing my homework (weekly modules) and I found the link (URL to the system) very handy.*
P3: *Reminders give you a feeling that you are not alone. They encouraged (me) and gave a boost for replying to the (weekly) assignments (modules).*
P4: *In addition to email-based reminders, SMS could be beneficial.*
P5: *Add supportive criticism, enveloping criticism in a way that it won't depress the person.*

Participants from the intervention group that did not receive reminders however they pointed out that reminders would have been useful in helping them completing important tasks. Some of the representative quotes are as below:

P6: *…If one has a tendency towards forgetting things that need to be done (reminders would have helped a great deal).*
P7: *Yes (reminders would have been useful), because I forgot since there were no reminders, the due dates were hard to remember.*

There were some varied comments and a few representative quotes are stated below:

P8: *I did not need to be reminded. I was already committed to the program (intervention).*
P9: *I would try to make the reminders and rehearsal (exercise modules) less demanding.*

Majority of the participants acknowledged the effect of rehearsal in helping them to learn new skills. Some of the representative comments are listed below:

P10: *Exercises (weekly rehearsal modules) were good. All in all, the interaction (experience) was excellent.*
P11: *Weekly themes (modules) were very good. They brought me in touch with my (core) values and I learned to be consciously present in the moment.*
P12: *I found the rehearsal (content) to be supportive. It kept me on track.*
P13: *I think the weekly rehearsal (modules) improved my understanding about life.*

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4.2 Sleeplessness

In Study I, 41 out of the 43 participants gave comments about reminders. Some of the representative statements are listed below:

P1: *Reminders worked fine. Adding SMS – based reminders would have been better.*
P2: *The system was good. I found the reminders and rehearsal to be beneficial.*
P3: *I expected a little more from the system. The rehearsals were good and so were the reminders (they were much needed).*

Participants generally appreciated the rehearsal feature as well as its content. Some of the representative quotes are listed below:

P4: *I go to know myself (better) and now I have new (better) viewpoints (about my life).*
P5: *I had no problems with the systems. It was (indeed) a positive experience. The entire program was well built (designed) both technically and content wise.*
P6: *There was a lot of new information. The program provided broad (comprehensive) approaches towards (tackling) sleep problems, it was engaging. Although my sleep problems are still the same, I will continue to rehearse.*
P7: *Rehearsals were easy to use and reasonable (logical). It was (indeed) an interesting experience. Now I can sleep and breathe better.*
P8: *It was a positive experience. Working the exercises (rehearsals) has improved my situation.*
P9: *It was a surprising and exciting experience. I committed myself to the program (intervention) and I learnt new skills.*
P10: *The system (rehearsal modules) taught me to listen, breathe and mediate well. It helped me accept that there are bad times. Thank you.*

Some mixed remarks were also noted. Some of the representative quotes are stated below:

P11: *A little more interaction (prolonged study period) would have been better (desirable).*
P12: *The program (intervention) did not help me. The study period should have been longer.*
P13: *I expected more from the system (intervention). However, my own laziness influenced my learning process.*

4.3 Identified Themes

Based on the collected responses and criticisms, we identified six themes for researchers in the area of mental health care using eHealth interventions:

- **Provision of Positive Feedback:** Participants of a given eHealth intervention appreciate receiving positive feedback. The process of providing the participants with constructive feedback can lead to improved interaction between the users and the intervention. It is generally accepted that positive feedback improves the learning process (Mitrivic et al. 2013). It has also been observed that positive feedback improves the overall interactivity and engagement (Schubart et al. 2011). The

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effect of positive feedback through technological interventions can motivate participants to develop what could be termed as a reciprocal relationship. If this stands true, enhanced adherence could be achieved (Mohr et al. 2011; Ritterband et al. 2009) Therefore, it is important that interventions for mental health care and support offer carefully crafted feedback (content) to the participants.

- **Provision of Constructive Criticism:** People with mental conditions are usually sensitive towards criticism however, some might benefit from it by focusing on the constructive content of the feedback. However, such a strategy would perhaps best suit those individuals who are willing to receive criticism and have the motivation to benefit from it for individual progress (Bergner, 1995). The significance of a balance between using positive and negative feedback (criticism) is also highlighted in several studies (Iwashita, 2003; Cinquin & Demongeot, 2002) This could be an interesting area for further research in the research field of mental health care eHealth interventions.
- **Use of SMS to Supplement Email-Based Reminders:** Email- based reminders could be supplemented with short messaging service (SMS). The use of SMS- based reminders has been recommended for e-Health interventions (Pop-Eleches et al. 2011). The role of SMS- based prompts has also been supported by researchers in the area of mental health care as well as in behavior change (Sims et al. 2012; Neff & Fry, 2009). It is argued that mobile phones are like constant partners therefore making it easier for the reminders to be sent. This could be particularly useful for people who do not have access to computers or they rarely check their emails.
- **Adding Supportive Content to the Reminders:** It is important that people suffering from mental conditions such as depressive symptoms, stress, anxiety and trauma are not left in a situation where they feel secluded. One of the key themes identified from the interviews was that participants emphasized on the need for adding supportive content to the reminders. We therefore propose that when developing the content of reminders, carefully crafted aspects of support and compassion should be incorporated. By adding the element of empathy, we can redesign the interventions that are more of supporting in nature and could lead to desired outcomes including higher adherence or lower dropout rates (Mohr et al. 2011). By virtue, human beings are social animals and the significance of social relationships can never be overlooked. It is hence argued that social relationships are highly significant for mental wellbeing. Sharma and colleagues (2015) also advocate use of proactive thinking in terms of designing supportive and empathetic interventions.
- **Reminding People of Their Core Values:** An intervention should be designed in a way that it prompts people and reminds them of their core values. Further, eHealth interventions for mental health care should assist the users to reflect upon their values (Ploderer et al. 2014). The content of the interventions should be designed in a way that it helps people to recognize what is really important for them, what are their aims and beliefs (Powers et al. 2009). Once people identify their core values, they are more likely to take actions to overcome challenging and impulsive circumstances hence making life easier for them (Kuonanoja et al. 2015). The use of behavioural therapies especially Acceptance and Commitment Therapy underscores the importance of core values in various studies in the area of mental health care (Lappalainen et al. 2014; Räsänen et al. 2016).
- **Engage Users by Developing Logical Content:** Mental health care eHealth interventions should be designed with an aim to provide participants with a rich and engaging user experience (Hefferman et al. 2016). In other words, the content of eHealth interventions for mental health should be meaningful and affective. By adding logical content, it would be easy to involve users emotionally because user engagement depends on elements that include but are not limited to be-

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havioural actions, cognition and threads of logical arguments (O'Brian, 2010). In addition, logical content could perhaps be related with rich user experience (UX). While there is an array of definitions about UX, we propose that UX under the umbrella of Human Computer Interaction could support users in achieving desired goals as well as adhering with the entire period of the intervention. Andersson and Kjerrman (2013) support our proposition by underlining the significance of pragmatic and logical arguments and their influence on task adherence.

5. DISCUSSION

The main objective of the chapter is to highlight qualitative findings from two field studies that focused on two mental conditions namely moderate depression and sleeplessness. In this chapter, participants' subjective considerations about web- based interventions' effectiveness, influence of reminders on task completion, effect of rehearsal on learning new skills and behaviors, and participants' general experiences with the interventions have been underscored with an aim to identify budding themes that could help researchers in designing efficient eHealth interventions for mental health care. It is noted that the participants of both studies generally regarded reminders as being useful. However, a noteworthy finding was the there was a lack of influence of the reminders on the overall psychological outcomes.

Yet, reminders supported participants in completing their weekly tasks (rehearsal modules). Rehearsal on the other hand, markedly enhanced participants' self-efficacy by subsiding cognitive burden and perplexity. The moderately lower influence of reminders could be attributed to the rich, engaging and logical content of the ACT- based rehearsal modules because the participants reported them as highly beneficial and effectual. Yet another reason could be the intrinsic motivation of the participants. This is because notwithstanding the distress from stern mental conditions, they volunteered to partake the studies without any financial enticements. This suggests that people have a natural propensity to look for and try out different means that can help them manage and perhaps overcome mental health care issues.

Whereas lack of effect for reminders was spotted, it is worth noting that some of the participants felt that while receiving the reminders, they were being treated on an individual basis. This is an exciting observation and opens up further research occasions to develop and evaluate tailored reminders. In terms of rehearsal, it was observed that nearly all participants from both the studies not only favoured but also found it as a positive method to learn new skills leading to improved state of self-confidence. This observation is not only supported by the post- study questionnaires and interviews but also by obvious decline in the severity of depression and sleeplessness. Therefore, we cautiously propose that while patients with mental conditions is largely dealt in face-to-face therapeutic sessions, however, vigilantly devised eHealth interventions with no or minimal face-to-face contact can be as effective in treating such conditions. In both the studies, we observed noteworthy improvements in post- study psychological measurements where participants felt better mental state and improved self- confidence to manage such conditions. However, reporting the psychological measurements and their outcomes is beyond the objective and scope this chapter.

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6. LIMITATIONS

Presented work has its limitations. First, an effort has been made to combine the qualitative findings from two field studies with slightly different research settings. The number of participants for the studies are not the same, however, it should be considered that the basic building block of the interventions for both the conditions was Acceptance and Commitment Therapy (ACT) that provides a solid ground to combine the qualitative findings. Second, the entire focus has been paid to qualitative comments and interpretations because reporting the quantitative and psychological measurements was outside of the objective and beyond the scope of this chapter. Further, even though presented work combines two field studies with real patients of moderate depression and sleeplessness, yet the overall sample size is rather small therefore it is hard to generalize the results.

7. CONCLUSION AND RESEARCH IMPLICATIONS

Presented chapter highlights qualitative findings from two field studies that examined the efficacy of reminders and rehearsal in web- based eHealth interventions for sleeplessness and moderate depression. The interventions were incorporated with Acceptance and Commitment Therapy (ACT), which is the latest wave of Cognitive Behavioural Therapy (CBT). Reminders were studied to observe their possible influence on task completion that is proposed to be a way forward to solve the established drawback of high dropout rates in health care interventions. Rehearsal was assessed to find out whether it could improve participants' self-efficacy and self-belief to manage mild to moderate mental conditions. The descriptive quotes underline participants' experiences with the interventions and offer notable insights that can have substantial implications for researchers in the area of mental health care. The chapter contributes to available literature relating with task completion and improved self- confidence and highlights the prospective usefulness of web- based eHealth interventions as a medium to deliver novel solutions for mental health care.

8. FUTURE RESEARCH AGENDA

Worldwide dissemination and acceptance of computing technologies have paved the way for developing novel eHealth solutions that can have a positive impact on the mental health of people suffering from a range of mental conditions. Irrespective of the economic conditions of a country, public access to eHealth interventions has already become a phenomenon. Hundreds of Web- and Mobile- based interventions / applications are available designed to promote general and mental health. However, from researchers' point of view, we argue that the field of eHealth interventions (web- and mobile- based) have various areas that need further investigation. These include the lack of clarity, biased designers' intent, overlapping terminologies, lack of communication between health care researchers, lack of collaborative efforts, overlooking the significance of privacy and ethical issues, and other issues such as continuous monitoring of the interventions, understanding users' expectations, involving users in the design process and trust in eHealth interventions. In future, we are planning to design an eHealth intervention for children's psychological wellbeing in collaboration with psychologists as well as prospective users for their feedback. We also aim to study various constructs especially "Perceived Concerns about Privacy",

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"Soft Trust", "User Experience" and "User Involvement in the Design Process". We are hopeful that our future studies will lead to advancements in the area of eHealth interventions of mental health and make scientific advances.

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KEY TERMS AND DEFINITIONS

ACT: Acceptance and Commitment Therapy.

CBT: Cognitive Behavioural Therapy.

Depression: Feeling of hopelessness, dejection and despondency.

eHealth Interventions: Healthcare solutions offered through technological platforms.

Persuasive Technology: Technologies developed with an aim to persuade people to adopt desirable behaviors.

Rehearsal: Software feature utilized in eHealth interventions to support users perform desired actions regularly.

Reminders: Software features utilized in eHealth interventions for reminding users to perform an action.

Sleeplessness: Lack of appropriate sleep.

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Chapter 66
Facebook, Social Comparison, and Subjective Well-Being:
An Examination of the Interaction Between Active and Passive Facebook Use on Subjective Well-Being

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ABSTRACT

Facebook use has implications for subjective well-being. Previous research has revealed that passive Facebook use is typically related to deficits in subjective well-being, which is thought to be linked through upward social comparison. In contrast, active Facebook use is typically related to enhancements in subjective well-being. The main objective of the present study was to synthesize findings related to Facebook use and subjective well-being and to expand by proposing and testing whether the benefits associated with active Facebook use compensate for the negative effects associated with passive use. The second objective was to discuss policy and research directions. A total of 310 undergraduate students completed an online survey with questions regarding Facebook use, social comparison, and subjective well-being. Bootstrapping analyses revealed that active Facebook use did not buffer the negative effects for subjective well-being that occur during passive Facebook use. Recommendations for future research and education programs are discussed.

INTRODUCTION

Subjective well-being is a phenomenon that is comprised of people's personal evaluations of their lives, including emotional responses to life events, as well as a personal assessment of one's overall satisfaction with life (Diener, Suh, Lucus, & Smith, 1999). Subjective well-being is influenced by many factors (Diener, et al., 1999), but the factor most relevant to the current study is social comparison. Given that social media is pervasive among young adults today and offers, opportunities to connect with friends and

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expose them to the successes of others, in other words offering ample opportunities to compare oneself to online friends, it too has the potential to contribute positively or negatively to subjective well-being. There are three aims of the present chapter: First, to provide an overview of how passively and actively using Facebook impacts users' subjective well-being; second, to further investigate these relationships by proposing and testing a model, as well as explore individuals' perceptions of the positive and negative consequences of Facebook use; and third, to provide recommendations for future research and potential policy applications.

AN OVERVIEW OF THE CURRENT LITERATURE

Social media has become pervasive in society today, with the potential to influence psychosocial functioning. Among the most popular of these sites includes the social networking site, Facebook. While on Facebook, users are able to create online profiles that contain personal information (photos, personal disclosures, memories and so on) about the self, which are then broadcasted to a network of individuals that the user deems a Facebook "friend." The content posted by a Facebook user is done so at the discretion of the profile owner and may be updated at any time. The information broadcasted on Facebook is then open to receiving both quantitative (i.e., likes, reactions), and/or qualitative (i.e., comments, messaging) feedback from the user's Facebook friends. Since Facebook was introduced to the public in 2005, the basic function of creating a personal profile, which is then viewed, and responded to, by friends has remained consistent, although Facebook has continued to create features (e.g., reactions, Facebook messenger) that make connecting with friends' content even easier (Gramlich, 2018).

Facebook has rapidly gained popularity since it's induction to the general public. Internationally, over 2.27 billion people visit Facebook every month, with over 1.49 billion visits taking place every day (Stats, 2018). In fact, in October 2018 the Pew Research Centre reported that Facebook remains the most popular social networking site among adults in the United States by a large margin (Gramlich, 2018). Further, Facebook was rated second in the United States (to video sharing site YouTube) for most visited social media website in 2018 (Gramlich, 2018). One of the potential reasons for its immense popularity is that there are a multitude of features on Facebook, as well as a variety of different ways to use the social networking site—all of which offer the user the ability to instantaneously connect with their friendship network. For instance, people can passively observe their Facebook friends by scrolling through the newsfeed, or browsing friends' photos/timelines; this type of Facebook behaviour is typically regarded as *passive Facebook use* (e.g. Ryan & Xenos, 2011; Tandoc, Ferrucci, & Duffy, 2015). In addition, people can engage more actively while on Facebook, such that users are able to disclose information about themselves in the form of photo and status updates (writing what is on a person's mind), as well as sharing links, memories, or memes that one affiliates with. These types of Facebook behaviours are typically referred to as *active Facebook use* (e.g., Ryan & Xenos, 2011). Due to the huge popularity and variety of social functions while on Facebook, researchers have begun to examine how this particular site may actually impact users' subjective well-being.

Early investigations of the relation between Facebook use and subjective well-being presented inconsistent results. Some research indicated that time spent on Facebook may be detrimental to users' subjective well-being (Valenzuela, Halpern, & Katz, 2014; Steers, Wickham, & Acitelli, 2014; Lou, Yan, Nickerson, & McMorris, 2012). Others found that time spent on Facebook may, in fact, enhance subjective well-being (Burke, Kraut, & Marlow, 2011; Valenzuela, Park, & Kee, 2009). Still, others suggested no

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relation (Benjanin, Benjanin & Dimitijevic, 2014; Glynn, Huge, & Hoffman, 2012; Jelenchick, Eickhoff, & Moreno, 2013). While investigating the discrepancy among the preceding results, researchers found that the direction of the relationship between Facebook use and subjective well-being is dependent on how Facebook is used. Specifically, whether the user was actively (e.g., posting a photo/status update) or passively (e.g., browsing the Facebook newsfeed) engaged while on Facebook.

Typically, passive Facebook use is related to decreases in subjective well-being (Ryan & Xenos, 2011), while active Facebook use is associated with enhancements in subjective well-being (Burke & Kraut, 2016; Csepeli & Nagyfi, 2014; große Deters & Mehl, 2013). In an experiment, Verdyun et al. (2015) dichotomized Facebook use into two conditions, such that participants were asked to use Facebook either solely passively (scrolling through Facebook without posting or interacting), or solely actively (constantly posting, liking, or commenting) for 10 consecutive minutes. At the end of the day, participants were asked to answer questions regarding their affective well-being. The results revealed that participants in the passive Facebook condition experienced decreases in well-being, whereas participants in the active condition did not experience any negative effects (Verdyun et al., 2015). It should be noted that while there are a variety of factors that have been studied to explain *why* passively browsing Facebook leads to deficits in subjective well-being, most researchers agree that the underlying mechanism responsible for this negative relationship is upward social comparison (see Verdyun et al., 2017 for review). As such, the present study focuses on upward social comparison as the mediating variable in the relationship between passively browsing Facebook and subjective well-being.

The Link Between Passive Facebook Use and Subjective Well-being

Humans possess a fundamental drive to compare themselves with others viewed as similar to themselves (Festinger, 1954). Social comparison helps individuals establish their standing (Brown, Ferris, Heller, & Keeping, 2007), as well as provides information about what is considered attractive, acceptable, powerful, popular, and so on (Verduyn et al., 2017). Self-evaluation also depends on how one compares oneself with other people, with the evaluative outcomes depending on whether the comparisons being made are in an upward or downward direction (Major, Testa, & Bylsma, 1991). In upward comparisons, one perceives the other as better on a particular dimension, which typically leads to feelings of inadequacy, jealousy, or negative affect. Downward comparisons, on the other hand, are those comparisons for which the individual perceives the self as better than the target, which typically results in enhancements for subjective well-being.

Empirical research has well-established the influence of social comparison on subjective well-being (Fujita, 2008), such that people's emotions, moods, and subjective evaluations are significantly influenced by how people perceive they compare to the people in their social circle (Gilbert, 2000). When considering the structure of Facebook, where a mouse click can link users to friends' and friends of friends' social media posts, social comparisons can be carried out on an unprecedented scale. Because of this, when individuals passively browse through the social information posted on Facebook they are inundated with the power, popularity, and physical attractiveness exemplified by their Facebook friends and followers, and compelled to compare themselves accordingly (Tandeoc et al., 2015). This may be especially problematic given that Facebook also provides an opportunity for users to set-up, retake, and edit images which allows people to portray themselves in the most flattering ways, also referred to as selective self-presentation (Walther, 2007). When users do selectively self-present online, this can create an exaggerated expectation of power and attractiveness, which are then confirmed and reinforced through

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the social interactions that occur online (Walther, 2007). Evidence suggests that social comparisons, both upward and downward, do exist on Facebook, although only upward comparisons impact subjective well-being (Vogel, Rose, Roberts, & Eckles, 2014). Further, the upward social comparisons that exist on Facebook are consistently associated with deficits in subjective well-being (Nesi & Prinstein, 2015; Steers et al., 2014; Vogel et al., 2014). In other words, while Facebook users passively browse through their friends' information on Facebook they are comparing themselves, on a massive scale, to unrealistic targets, feeling as though they do not measure up, and thus feeling less satisfied in their own lives.

The current literature has well established that passive Facebook use leads to upward social comparison, and ultimately then deficits in subjective well-being (see Joseph, Desjarlais, & Herceg, 2019 for review). It is also clear that actively sharing/interacting on Facebook is at least marginally better for subjective well-being than passively browsing (Verdyun et al., 2015). However, one limitation in the literature is that when Facebook users are dichotomized into either passive or active users, researchers are not able to investigate the interaction effects of passive and active Facebook use on subjective well-being. In effect, this approach neglects the instances where users use some combination of both the passive and active features of Facebook. In a study by Joseph and Desjarlais (2016), participants were asked to indicate how passively or actively they used Facebook on a scale from 1 (*solely passively*) to 10 (*solely actively*). The results revealed that the vast majority of participants reported their Facebook use as a reasonably equal combination of both the passive and active features of Facebook, with some tendency to favour passive Facebook use. Thus Facebook use could potentially be viewed on a continuum where users use some combination of the active and passive features of Facebook, rather than in an either or fashion. Moreover, the findings suggest that all users passively observe Facebook and what differs among users is their level of active Facebook use. Considering that when using Facebook actively, to a greater extent, users exhibit increases in their subjective well-being (Csepeli & Nagyfi, 2014), or at the very least they do not experience the deficits for subjective well-being that are associated with passive Facebook use (Verdyun et al., 2015), the question that arises is: Could actively posting on Facebook compensate for the negative experiences associated with passively browsing Facebook? The current study addresses this question.

THE PRESENT STUDY

There are two main purposes for the current study. First, the author sought to replicate findings in the current literature and provide further support demonstrating passively browsing Facebook leads to upward social comparison, which then leads to deficits in subjective well-being. Second, the present study will expand the current literature by (1) identifying whether the preceding indirect relationship is moderated by active Facebook use by examining whether active Facebook use buffers the deficits in subjective well-being that result from the upward social comparison that takes place while passively browsing Facebook; and (2) examining individuals' perceptions of the positive and negative outcomes associated with using Facebook.

Based on the positive relationship between active Facebook use and subjective well-being reported previous research (Kim & Lee 2011), it is plausible that if users actively post on Facebook they feel better about themselves (Kim & Lee, 2011) and thus be less impacted by the upward social comparison that accompanies passive Facebook use. Specifically, the author hypothesized that: The negative indirect relationship between passive Facebook use and subjective well-being through upward social comparison

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will only exist if the frequency of active behaviours is low. If the frequency of active Facebook use is high, users who passively use Facebook and negatively compare themselves to their friends will not experience the deficits in subjective well-being.

METHOD

Participants

A total of 310 introductory psychology students from a Canadian undergraduate university (76.77% female) between the ages of 17 and 50 years ($M = 21.21$ years; $SD = 4.26$) completed an online survey between November 1, 2016 and January 29, 2017. Participation lasted approximately 15 minutes as they completed the scales in the order listed below.

Materials

Demographic Variables

The following scales were included to gain information regarding who is using Facebook and how relevant Facebook is relative to other social networking sites, in order to investigate whether the impacts of Facebook use are still meaningful.

Understanding Facebook Use

The Facebook Intensity Scale (FBI; Ellison, Steinfield, & Lampe, 2007) was used to gain a better understanding of participants' Facebook use. The FBI assessed participants' level of Facebook engagement (i.e., the amount of time spent on Facebook), the size of participants' friendship networks on Facebook (i.e., number of Facebook friends), and participants' emotional connection to Facebook. This scale has demonstrated high internal consistency in previous research ($\alpha = .83$; Ellison et al., 2007; Whitman & Gottdiener, 2015).

- *Facebook Engagement*. To measure how engaged participants are on Facebook, the amount of time participants spend on Facebook was measured using the FBI (Ellison et al., 2007). Participants were asked to indicate how much time they spend on Facebook on a scale from 1 (*less than 10 minutes*) to 8 (*more than 3 hours*). Higher scores indicated more time spent on Facebook.
- *Number of Facebook Friends*. To gain an understanding of the size of friendship networks on Facebook across the sample, I used the number of friends subscale from the FBI (Ellison et al., 2007). Participants were asked to indicate the number of friends they currently have on Facebook on a scale from 1 (*10 or less*) to 9 (*more than 400*). Higher scores indicated a greater number of Facebook friends.
- *Emotional Connection to Facebook*. This FBI subscale (Ellison e al., 2007) assessed participants' emotional connection to Facebook. Participants were asked to indicate the extent to which they agree or disagree with six statements (e.g., I would be sorry if Facebook shut down) on a scale from 1 (*strongly disagree*) to 6 (*strongly agree*). The scores were then averaged, where higher

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scores indicated higher levels of emotional attachment to Facebook. This subscale demonstrated high internal consistency ($\alpha = .88$).

General Social Media Use

To gain an understanding of the popularity of a variety social media sites used across the sample, a social media use scale was created. Participants were asked to indicate on a scale from 1 (*never*) to 7 (*several times a day*) how often they used a variety of social media websites, including social networking sites (e.g., Facebook, Twitter); photo sharing networking sites (e.g., Instagram, Snapchat); messaging networking sites (e.g., Facebook messenger, WhatsApp); and video sharing sites (e.g., YouTube). Higher scores indicated higher levels of engagement for each social media site presented.

Variables Included in the Hypothesized Model

Subjective Well-Being

Chan's (2013) adaptation of Diener et al.'s (2009) Psychological Well-being Scale, which included eight items, was used to assess participants' subjective well-being. Participants were asked to indicate the degree to which they agreed or disagreed with each of the eight statements (e.g., "I lead a purposeful and meaningful life") on a scale from 1 (*strongly disagree*) to 6 (*strongly agree*). The scores were then averaged, where higher scores indicated higher levels of subjective well-being ($M = 5.01$, $SD = 4.41$). This scale demonstrated high internal consistency ($\alpha = .89$).

Facebook Use

To get an accurate depiction of participants' use of both the passive and the active features of Facebook, the author collected the duration of passive Facebook use and the frequency of active use separately.

- *Passive Facebook Use.* Using a single item, participants indicated the amount of time they spend per day passively using Facebook (i.e., browsing their newsfeeds/friends timelines) on a scale from 1 (*Less than 10 minutes*) to 8 (*More than 3 hours*). Higher scores indicated more time spent passively using Facebook ($M = 2.79$, $SD = 0.48$).
- *Active Facebook Use.* Based on previous research assessing active Facebook use (Verduyn et al., 2015; Ryan & Xenos, 2011), the author created an active Facebook use scale for the current study. Participants indicated the frequency that they engage in five of the most prominent active Facebook features: Status updates, sharing links/memories, uploading photos, commenting on friends' posts, and like/reacting to friends' posts. Participants indicated how often they use each of the preceding five active features during a typical Facebook session on a scale from 1 (*never*) to 7 (*always*). The five scores were then averaged and higher scores indicated higher frequency of active Facebook use ($M = 3.24$, $SD = 1.18$). This scale demonstrated high internal consistency ($\alpha = .86$).

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Social Comparison

To assess participants' level and direction of social comparison while on Facebook, Allan and Gilbert's (1995) Positive and Negative Social Comparison Scale was adapted to be specific to Facebook. To address upward social comparison specifically, participants were asked to indicate on a scale from 1 (*never*) to 6 (*always*) how often they feel 11 negative constructs (e.g., inferior) when comparing themselves to their Facebook friends. The negative comparison scores were averaged for a total upward social comparison score, where higher scores indicated higher levels of upward social comparison on Facebook ($M = 2.71$, $SD = 1.07$). This scale demonstrated high internal consistency ($\alpha = .95$).

Supplementary Information

Qualitative Question

For supplementary information regarding participants' perception of the positive and negative consequences of Facebook use, one qualitative item was created. Participants were asked to reflect on their Facebook use and determine how Facebook has been either positive or negative in their lives. This was an open-ended question that was coded for common themes among participant responses.

RESULTS

Describing the Sample

To gain information regarding who is using Facebook and whether investing the impacts of Facebook use is still meaningful, frequency procedures were run on all demographic variables. The five most frequently used social media sites included Facebook ($M = 6.12$, $SD = 1.24$), Snapchat ($M = 5.92$, $SD = 1.90$), Instagram ($M = 5.81$, $SD = 1.98$), YouTube ($M = 5.18$, $SD = 1.72$), and Twitter ($M = 3.07$, $SD = 2.48$). Furthermore, as depicted in Table 1, participants were avid users of Facebook, who typically had over 400 friends (45.2%). Although participants were frequently engaged on Facebook, they were not typically emotionally connected to Facebook.

Testing the Model

The hypothesis was tested via bootstrapping analyses using the SPSS PROCESS macro developed by Hayes (2013). The bootstrapping analyses created a 5,000 participant sample from the original data set through a process of sampling with replacement, and constructed a 95% confidence interval (CI) around the proposed indirect effects. Indirect effects were significant when the range across the CI's did not contain a zero (Hayes, 2013).

It was predicted that the indirect negative association between passive Facebook use and subjective well-being, through upward social comparison, is moderated by active Facebook use. Active Facebook use was predicted to buffer the negative association between upward social comparison and subjective well-being after passively using Facebook. The hypothesis was analyzed using model 14 of the PROCESS macro (Hayes, 2013). This model simultaneously added active use, passive use, upward social

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Table 1. Results for understanding Facebook use

	%
Time Spent (in Minutes)	
< 10	16.1
10 – 30	30.6
31 – 60	23.5
60 – 90	10
Number of Friends	
251 – 300	10.3
301 – 400	13.9
> 400	45.2
Emotional Connection to Facebook	
Not emotionally connected	57.3
Somewhat emotionally connected	22.7

Note. $N = 310$. % = Percentage of participants who reported each category.

comparison, and the interaction between upward social comparison and active use as predictors of subjective well-being. The analysis revealed that the overall model was significant, $F(4, 305) = 5.166$, $p = .001$, $R^2 = .122$; passive Facebook use was positively related to upward social comparison ($B = 0.095$, $t = 2.400$, $p = .017$), which was negatively related to subjective well-being ($B = -0.194$, $t = 4.053$, $p < .001$). Further, active Facebook use was positively related to subjective well-being ($B = 0.106$, $p < .05$). The interaction between upward social comparison and active Facebook use however, was not significant ($B = 0.051$, $t = 1.112$, $p = .267$). An index of moderation was also calculated (Hayes, 2013) and it was not significant, 0.005, $SE = .005$, 95% CI [-0.002, 0.019]. Thus, the moderated mediation did not occur, and deficits in subjective well-being that came from the upward social comparison that accompanies passive Facebook use were not buffered by active Facebook use.

Qualitative Analysis

The qualitative item was coded for major themes based on the frequency in which participants referred to specific subjects in their responses. A total of 292 of the 310 participants responded to this question. Multiple themes were identified for each participant. Overall, 125 participants indicated that Facebook was both positive and negative in their lives. In addition, 110 participants indicated that Facebook was only positive in their lives, 33 participants indicated that Facebook was only negative, and 24 participants indicated that Facebook did not affect them.

In total, 226 participants reported that Facebook positively impacts their lives. The most prominent positive outcomes reported were as follows: Relationship maintenance ($n = 193$), anytime participants indicated that they found Facebook was positive because they could be in touch or connect with their friends and family, this was coded as relationship maintenance; entertainment purposes ($n = 52$), anytime participants indicated that they found Facebook positive because of the news, memes, videos, or quotes found on the SNS this was coded as entertainment; and posting information about the self (n

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= 7) anytime participants indicated that Facebook was positive because of the ability to post or share information about themselves, this was coded as posting personal information on Facebook.

On the other hand, 156 people reported that Facebook negatively affects their lives. The most frequently reported negative outcomes were as follows: Spending too much time on Facebook ($n = 64$), anytime participants indicated that they spent too much time, or waste their time on Facebook, this was coded as spending too much time on Facebook; negative social comparison ($n = 36$), anytime participants indicated that they negatively social compare on Facebook, or that they feel worse about themselves after comparing to their Facebook friends, this was coded as negative social comparison; and feeling bullied ($n = 8$), anytime participants indicated that they feel bullied, marginalized, or received mean comments on Facebook, this was coded as feeling bullied.

DISCUSSION

The purpose of the current study was to identify whether the positive effects of active Facebook use compensate for the negative effects of passive use on subjective well-being. Consistent with previous studies, and the fact that users in this sample typically reported that using Facebook positively impacted their lives, actively posting on Facebook was associated with enhancements for users' subjective well-being. Contrary to expectations however, the benefits associated with actively posting on Facebook were not strong enough to compensate for the deficits in subjective well-being that are produced by the upward social comparison that accompanies passive Facebook use.

Replicating previous findings, passively browsing Facebook led to increases in upward social comparison, which then led to decreases in subjective well-being. In addition, there were participants in this sample who referenced that negatively comparing themselves to their Facebook friends as a negative outcome for using Facebook. These findings reaffirm the negative consequences for subjective well-being that accompany passive Facebook use.

Although active use was associated with enhancements to users' subjective well-being, the enhancements were not strong enough to buffer the deficits in users' subjective well-being after passively browsing Facebook and negatively comparing themselves to their Facebook friends. In general, there are inconsistencies in the literature regarding whether active use does in fact enhance subjective well-being (see Verdyun et al., 2017 for review). Among the studies that have found that active Facebook use enhances subjective well-being, a commonality among them is including Facebook messaging when measuring active Facebook use (Ryan & Xenos, 2011; Kim & Lee, 2011). In fact, in a recent review of the relationship between Facebook and subjective well-being, active Facebook use was categorized as actively self-disclosing through communicating with Facebook friends (Verdyun et al., 2017). Considering that it is self-disclosure via communicating online has been linked to increases in friendship quality (Desjarlais & Joseph, 2017) and subjective well-being (Valkenburg & Peter, 2009), and that communication with friends on Facebook is typically accomplished through the chat and messaging and features (Pempek, Yermolayeva, & Calvert, 2009), it may be that the posting of photos, status updates, memes and so forth used to measure active Facebook use in the present study did not capture enough meaningful self-disclosure to enhance users' subjective well-being enough to compensate for the observed negative effects.

In addition, it may also be that how and why people use Facebook is evolving. In early Facebook research, social networking sites such as Facebook were typically used to publically share information to offline friends (boyd & Ellison, 2007), as well as maintain friendships (Davis, 2012). In the present

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study, although users reported that Facebook positively impacted their lives via some form of relationship maintenance, few people reported using Facebook to post information about themselves or communicate with friends in any deep or intimate way. In fact, users more frequently reported enjoying the funny, or inspirational, memes and videos on Facebook than communicating or disclosing with friends. Furthermore, only one participant mentioned using social networking sites to express themself, and they indicated that they used Instagram and Snapchat to do so. In fact, more recent research has shown that Instagram and Snapchat are more popular than Facebook messenger (Lee, Lee, Moon, & Sung, 2015), especially among adolescents (Gramlich, 2018). Given the rise in popularity of Instagram and Snapchat among adolescents and emerging adults (Lee et al., 2017), it may be that Facebook is no longer being used to disclose information, but rather be entertained with friends online, and that disclosing about oneself on social media may now take place on either Instagram or Snapchat, which are more photo and feedback based sites as opposed to the sharing of content/memes that occur on Facebook.

Despite the rise in popularity of other social networking sites like Instagram and Snapchat, young adult users in this sample did report using Facebook more frequently than the preceding sites. However, due to the changes in the how people are using Facebook, it may be that studying the effects of actively posting on Facebook may not be as meaningful as it was in earlier studies. To clarify whether actively using Facebook enhances subjective well-being enough to buffer the deficits in subjective well-being associated with passively browsing Facebook, future research will need to target the features of Facebook that allow for meaningful communication and self-disclosure such as direct messaging via Facebook messenger.

RECOMMENDATIONS FOR RESEARCH AND POLICY

Although previous researchers have advocated for encouraging posting on Facebook to decrease the likelihood of experiencing negative effects, the results of the present study indicate that posting photos, status updates, and memes on Facebook are not enough to compensate for the negative effects from the upward social comparison that occurs while browsing Facebook. Therefore, the way people use Facebook is evolving and these changes should be reflected in how researchers study the effects of Facebook in future research.

As suggested in previous research, support networks such as clinicians, educators, and parents should be aware of negative consequences associated with browsing Facebook. If members of an individual's support network are aware of the effects on subjective well-being associated with browsing Facebook, they could encourage emerging adult users to lessen their browsing behaviours, or encourage them to recognize and avoid the negative social comparison that results from passive browsing. It should also be noted that the upward social comparison that occurs while passively browsing only accounted for 12% of the variability in subjective well-being. Thus, the effects found in the present study are meaningful, but not large enough to warrant a complete boycott of Facebook. Additionally, relatively few people in this sample recognized that they engaged in upward social comparison when using Facebook, and thus awareness alone may be enough to alleviate the deficits in subjective well-being and related constructs such as depression and loneliness.

In addition to awareness, positive strategies for coping with the upward social comparison that occurs online could also be promoted. For instance, Facebook users could be encouraged to develop self-compassion using mindfulness techniques while on Facebook (Rumsey, 2018). Given that social

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comparison is an automatic process (Festinger, 1954), perhaps especially on Facebook (Vogel et al., 2014; Feinstein et al., 2013), users could be encouraged to employ mindfulness skills once they notice they are comparing themselves to their Facebook friends. For example, users could be encouraged to overcome any negative emotions by taking a moment to practice expressing gratitude for the things they do have, and compassion for themselves (Rumsey, 2018). Further, social comparison theory states that upward social comparison can be used as motivation for self growth and improvement (Festinger, 1954). As such, users could be encouraged to use the target's information to create goals for themselves and promote personal growth as opposed to feelings of inadequacy (Rumsey, 2018).

Social media users could also be encouraged to manage their Facebook newsfeeds to set themselves up for more positive experiences while browsing. In essence, users could organize the content they are exposed to on their Facebook newsfeeds by setting boundaries and removing content that triggers negative emotions. For example, users could block, or unfollow any accounts that make users feel badly about themselves (Rumsey, 2018). This could include removing friends, or celebrities, that consistently present themselves as perfect, removing friends who constantly boast about body image, or removing people that represent a negative part of their past, such as a former partner (Miller, 2017). In addition to blocking or unfollowing, which are more permanent forms of removing users on Facebook, in December 2017 Facebook unveiled a 'snooze' feature to help users organize their newsfeeds and prevent negative experiences (Muraleedharan, 2017). This feature allows users to take a 30 day break from Facebook users by temporarily unfollowing them for 30 days.

In what context should these techniques be taught and/or employed? Given that, roughly 85 percent of American adolescents (13-17 years) are exposed to online social environments (Anderson & Jiang, 2018), and that social comparisons and peer feedback is an imperative part of adolescents' self evaluations and development (Harter, 1999), an ideal setting to start conversations about the impact of social media and employ these techniques would be as part of the educational curriculum in middle schools. For instance, in May 2018 the New Democratic Party in Alberta, Canada suggested that the government donate 5 million dollars to Alberta schools to implement mental health education in schools (Ferguson, 2018). These programs were developed in response to complaints from parents and educators regarding the need for mental health programing in schools, and are aimed at reducing mental health stressors, including the stressors students face while on social media (Ferguson, 2018). These mental health programs could potentially then offer a venue for educators, parents, and counsellors to inform adolescents about the upward social comparison that occurs on Facebook, and the consequences for subjective well-being that ensue, possibly before social media becomes ubiquitous in their daily routine. Further, these programs could promote the preceding positive strategies that could act as protective factors and enable youth to combat the consequences for subjective well-being that accompany passive Facebook use. In essence, programs like these could be implemented in schools across North America to help young social media users avoid these deficits in subjective well-being.

CONCLUSION

A clear theme in the current literature, and consistent with the results of the present study, is that passively browsing Facebook leads to upward social comparison, which then leads to deficits in subjective well-being. Further, active Facebook use may produce some enhancements for subjective well-being, albeit not enough to compensate for the deficits associated with passive use. While the effects are not

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large enough to encourage users to boycott Facebook altogether, users should be aware of the negative consequences for subjective well-being that accompany passive Facebook use. An avenue to spread awareness and employ protective strategies, such as using mindfulness skills and controlling content while browsing Facebook, would be in the education system. Given that parents, educators, and clinicians have advocated for mental health programs in schools, and that there is some notion of progress in some Canadian provinces (Rumsey, 2018), the author proposes that the consequences for subjective well-being associated with Facebook use, and the skills to combat them, be incorporated into such programs across North America.

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KEY TERMS AND DEFINITIONS

Active Facebook Use: An approach by which Facebook users interact with other users through sharing textual and pictorial information, sending messages, and reacting to others' posts. Instances where the targets of social comparison appear to be doing better than oneself.

Downward Social Comparison: Instances where the targets of social comparison appear to be doing worse than oneself.

Passive Facebook Use: An approach by which Facebook users surveil others through scrolling the newsfeed and browsing timelines.

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Selective Self Presentation: The idea that users are able to manipulate the information presented about themselves on social media so that it is framed in the most attractive, desirable, socially acceptable way.

Social Comparison: A process by which individuals compare themselves to others as means of gaining information on what is most popular and acceptable, then making self-evaluations based on these observations.

Social Media: Any technological medium that enables individuals to connect with their social networks (e.g., texting, e mail, social networking sites).

Subjective Well-Being: The evaluation of one's own life including an assessment of overall life satisfaction and emotional responses to life events.

Upward Social Comparison: Instances where the targets of social comparison appear to be better than oneself.

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Chapter 67
Interpreting in Mental Health, Anything Special?

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ABSTRACT

This article discusses some of the key issues of mental health talk in general, both in attitude as well as in words, and dwells upon the difficulties this can pose for interpreters. Subsequently, ways to deal with these difficulties are given. The issue of empathic stress is touched upon. It is argued that, with general background knowledge of disorders and treatment methods and with support to deal with emotional situations, interpreting in mental healthcare will be a very rewarding type of work. Without such preparation and ongoing support, interpreters may not always be able to join into the therapeutic communication properly, which may harm the progress of the treatment and may also hamper their own feelings of well-being and job satisfaction.

INTRODUCTION

The medical sector is a wide and differentiated field. So, it is probably true that each medical specialisation poses specific challenges to interpreters and has its own specific requirements for them. In this chapter, the focus is on interpreting in mental healthcare which differs from the somatic sector on at least one very important point: complaints can nearly only be expressed in words, next to some additional observation of behaviour. Analyses of various bodily fluids, palpation, testing of reflexes, listening to bodily sounds et cetera are relevant in the somatic realm; in mental healthcare only as far as somatic checks relating to medication are at hand. In mental healthcare there is a strong dependency on words in interaction with the patient for both diagnosis and cure. For interpreters this implies a heavy responsibility. The objective of the chapter is to provide the reader with some background knowledge of the characteristics of mental health talk in general and the specific ways interpreters have to relate to these in order to do a good job and to ensure long lasting job-satisfaction.

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Some of the key issues of mental health talk in general; both in attitude as in words will be outlined. After that, the influence of these issues on the attitude of the interpreter is described in some depth and the amendments that interpreters may need to make – deviations from most Codes of Conduct – in order to ensure effective communication. Following that, some problems that the words of both therapist and patient may give the interpreter, are outlined in some detail; solutions are discussed. Specific problems, interpersonal and emotional, can arise in mental health talk due to what is called 'empathic stress' and this is discussed as a third aspect. Empathic stress may pose a challenge to the emotional welfare of the interpreter and may affect his proper functioning in the sessions. As far as possible, issues are illustrated on the basis of scientific investigations of interpreter mediated mental health talk or on basis of the authors ample experience with interpreter-mediated mental health talk as a practising psychotherapist working with patients with severe psychiatric disorders and her discussions with interpreters both while working together in actual mental health talk and in training situations.

MAIN FOCUS OF THE CHAPTER

Within the field of mental health care there is much variation in aim, method and style that is impossible to capture in a single chapter. Necessarily, the focus is on the general characteristics and three important aspects of mental health talk.

The Therapeutic Relationship and Therapeutic Interaction

Psychotherapy both refers to a general psychotherapeutic conversation technique and to specific treatment methods.

First and foremost, in both modes, attitude is of utmost importance and there is remarkable agreement amongst the various schools of psychotherapeutic thought about how this attitude should be. The basic characteristics of the attitude of the therapist are: understanding and non-judgmental. The therapist has a positive approach, he conveys empathy, he is authentic and shows a healthy trust in his own treatment methods.

In fact, this psychotherapeutic attitude is seen as the 'common factor' in psychotherapies which, together with the relationship between therapist and patient, has proven to be the most important factor contributing to therapeutic improvement (Wampold, 2010; Wampold & Imel, 2015). Since the early 80's of last century, therapists' qualities as perceived by patients have been given research attention. Rating scales have been developed and the most important factors (does the patient see the therapist as attractive, trustworthy and as an expert) determined (Corrigan & Schmidt, 1983). Evidence is arising that the early (immediate) impression the patient has of the therapist has a significant effect on the outcome of the therapy (the better the impression, the better the outcome) (Reefhuis et al., 2019).

The relationship between therapist and patient is an asymmetric one. The patient talks about his problems and innermost feelings, thoughts and behaviour. The therapist listens and his reactions are directed at understanding the patient and helping him to improve. Sometimes, however, some talk about himself, by the therapist, can be helpful in the therapeutic process. In psychotherapeutic terms this is called call 'self-disclosure' and it may be used as a technique.

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Secondly, therapeutic talk focuses on problems that are usually not spoken about frankly and openly in everyday social talk. Therapeutic topics are often connected with feelings of shame, guilt, aggression, jealousy; feelings that one usually finds difficult to admit and speak about.

Thirdly, therapeutic talk deals with feeling, thinking and behaving and focuses on changes that specifically fit this particular patient. Patients will only adhere to new ways of behaving, thinking, feeling, when these new ways feel 'good', are 'fitting' and when they have been actively involved in the process of finding, discovering and experiencing these new ways. This implies that therapists usually do not prescribe (new ways of feeling, thinking and behaving) but negotiate, suggest and in general encourage the patient to actively cooperate in finding these new ways. And sometimes, therapists just listen.

On top of this, the development of the interaction between therapist and patient and the evaluation thereof by the therapist, is a diagnostic tool in itself: it helps the therapist to understand some of psychological and relational problems and the psychodynamics of the patient. The (developing) interaction is also an important constituent part of the patients cure, as a 'corrective emotional experience' (term coined by Alexander & French, 1946). For example, the simple fact that the therapist has a genuine interest in the patient and his problems and listens actively and carefully can be a completely new and healing experience to a patient with a history of neglect and abuse.

Therapeutic Communication: Therapists Interventions and Patients' Utterances

As far as the words are concerned, the focus in this chapter is on general characteristics of psychotherapeutic talk, using mainly the classification of Hill called the Hill Counsellor and Client Verbal Response Modes Category System (Hill, 1986), which is meant to be pan-theoretical. The various psychotherapeutic schools of thought that have developed over the last century each have a specific terminology and a specific way of phrasing interventions of which only some salient features are mentioned.

Therapists phrase their interventions cautiously and meticulously and they listen carefully to the words the patient utters and observe his non- and paraverbal behaviour in order to build the therapeutic relationship, to involve the patient in the treatment and to make sure the treatment becomes a proper corrective emotional experience. Therapists do not only listen to the content of the patients' words, but also to how the patient phrases his utterances and which words he uses. He is also attentive to what the patient does not say.

In the 1980's Hill developed a pan-theoretical categorisation system that could and has been used both for research and for training (Hill, 1986). Very briefly, Hill's categories comprise the following. Therapists encourage the telling of the patient with minimal continuers such as mmm, yes, and go on. Silence is also used as a technique: the therapist listens and does not immediately react to patients' words. Either because he expects more to come, or because the thinks about what to say next or because he just feels some pause is necessary. Therapists give approval and support, they sometimes give information, they may give instructions about the therapeutic process itself or because homework needs to be done (exercises for example in behaviour therapy). They reformulate what patients just said and reflect on what has been expressed. Therapists ask numerous questions, both open and closed. These can be questions into facts or past events, or for feelings felt or they probe for feelings underlying the facts and happenings, or for feelings underlying the expressed feelings or they ask for a reflection on those feelings. They can also give feedback. Self-disclosure and social talk are also part of the toolbox of therapists. From this very brief overview it already becomes clear that there are many categories that are not as easy to understand and to differentiate between. Maybe it suffices to say that therapists' questions are

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often geared to explore, dig up and understand feelings and thoughts that are hidden under the surface talk about facts and actions and that are often difficult to talk about.

On top of these categories, therapists also shape, at least partly, their attitude in words. They do this, for example, by using phatic communication, i.e. the use of words to build up social contact while it does not add to the content of the conversation. This often takes the form of short introductory statements to an interventions like 'you just said…'. Although those words do not add information to the conversation, they signal reciprocity, they signal 'I heard you' and thus add to the building of rapport.

Many therapeutic schools of thought exist, each with their own treatment methods. Most of them use specific vocabulary to phrase their interventions; often, ordinary words are used in a specific way with a specific meaning.

The reactions of patients to therapists' interventions are, of course, not bound to specific rules belonging to the school of psychotherapy they are treated in. For therapists it is important to know when their patients have a specific language-use that deviates from general norms. For example, are they using words that they have invented themselves, are they incoherent in their talk, speak unusually ungrammatical and so forth. Also, grammatical issues like speaking in a passive or active tense, are important. Does the patient speak about himself as an acting person, or as someone who is passively undergoing ('victim') things that happen (to him)? Does he maybe speak of himself in the third person? Does he use a specific style? Therapeutic listening comes to close 'reading' of what the patient conveys.

Empathic Stress

People who work a lot with other peoples' traumata, like physicians, nurses, psychotherapists and emergency workers, may develop symptoms in response to their patient's suffering. It can make them ill and it can also influence their attitude towards the work they do and the patients they treat: empathic stress.

The stress that their patients are experiencing is sometimes that overwhelming that health providers find it difficult to remain stable and professional. The originally felt empathy and compassion can turn into unproductive reactions and negative feelings and thoughts (such as disbelief, 'they are overdoing their stories') or they may feel their own effort is not enough and may feel helpless facing so much misery and start to do more than they should do like helping with practical issues (over-committed). The phenomenon has been thoroughly investigated for all sorts of health providers (see for example Pearlman & McCann, 1990; Pearlman & Mac Ian, 1995). Specifically, the empathy, necessary to understand the patient, is a risk factor for developing symptoms (Palm et al., 2004) which may not only lead to an unproductive stance in the work these health workers are doing but may also lead to their own burn-out due to secondary traumatisation.

It is not difficult to see that when an interpreter is engaged in the process of therapeutic talk, this will have an impact on the therapeutic relationship and on the interaction which are both shaped in words, but also in all sorts of nonverbal and paraverbal behaviour.

What Does This Mean for the Interpreter Attitude?

A Workgroup

In general, it means that interpreters have to be aware of the fact that in mental healthcare sessions, building, analysing and working with the relationship between therapist and patient is the main constituent part

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of the cure. This relationship is shaped both with words and with gesture, gaze, posture and paraverbal means. Interpreting in such a situation means that the interpreter becomes part of this relationship – irrevocably, whether the interpreter wants this or not. In order to help the treatment, it is important that the interpreter plays a constructive role – supporting the therapeutic attitude.

How should this be done? It is important that the behaviour of therapist, interpreter and patient is well attuned, all for the common goal of a smooth-running session. A theoretical background to this importance of the cooperation between all three participants – therapist, interpreter and patient - comes from the group dynamical work of the British psychiatrist Bion in which he defines the term 'workgroup' (Bion,1961). A 'workgroup' is a group of people who work together constructively to achieve a common goal, it implies that they know how to solve problems in the cooperation might they arise. The trio therapist – interpreter - patient should function as a 'workgroup'. According to Bion, the formation of subgroups within such a group, is counter-productive. One person being out of tune may disrupt the working process. When in such a workgroup problems in the cooperation arises, they will be solved openly and effectively. For example, in a workgroup of therapist, interpreter and patient it sometimes happens that a patient does not agree with his therapist or with another professional he has to deal with, or with the interpreter. The patient may be angry with the therapist for example for not granting an extra session or with the co-treating psychiatrist for not prescribing certain medication, or with the interpreter for not 'translating well'. Any of these issues needs to be solved, not by siding with the patient against the person he is angry with – a subgroup would then emerge - but by talking about the issue at hand and encouraging the patient to deal with it. So, the issue about the extra session needs to be talked about with the therapist; the patient has to be encouraged into telling his psychiatrist that he is not happy with the medication he gets and thus finding out if anything can be done about it. And the problem with the interpreter can be talked about in the session with as a starting point: the interpreter tries to interpret faithfully but he might have misunderstood or misheard. How can we solve this? What did you mean to say? And of course, the interpreter has to interpret this discussion to both sides. Siding with the patient may seem helpful at first, the patient feels supported at that moment. But such formation of a subgroup hampers the cooperation within the group patient-interpreter-therapist or within the group of people involved in the treatment of this patient. And the patient does not learn to solve problems that arise in any relationship and that have to be talked about in order to make the relationship long-lasting and sustainable and the workgroup repaired. It means that the interpreter has to know and understand this principle and has to be willing to engage is such a discussion.

In order to be able to function as a workgroup it is necessary that the therapist and interpreter know about each other's 'trade'. The therapist has to understand that he cannot ask the interpreter to function as a 'cultural informant' as that would be way out of the interpreters' job description. He also has to know that 'faithful interpreting' does not mean that the interpreter renders a 100% equivalent of the patients (and the therapists) words. They both have to understand that it is sometimes necessary to meta-communicate about the meaning of words. And interpreters have to know that they sometimes have to step out of their role of neutral and uninvolved participants, in order to support the flow of communication in the session. Being too neutral can hamper feelings of security and thus the free flow of the conversation.

The First Impression

Patients' first or early impression of the therapist is a codeterminant for a positive treatment outcome. It seems safe to extrapolate these finding to the interpreter: a good first impression of the interpreter

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helps to create an atmosphere in which the patient feels free to talk about sensitive issues. The three most important factors that are used to assess this first impression are: is the therapist seen as attractive, trustworthy and as an expert. These three factors are measured by asking the patient to rate the therapist on 12 factors: friendly, likeable, sociable, warm, experienced, expert, prepared, skillful, honest, reliable, sincere and trustworthy (Tracey et al 1988). It is wise for interpreters to keep these in mind. Although it is hard to tell how exactly one should manipulate one's behaviour in order to make this good impression, it is good to bear in mind that a favourable score on these factors may help in being experienced as professional and that this helps to create a favourable environment for treatment.

The Therapeutic Attitude and the Interpreter

Sometimes it is necessary for an interpreter to step across the line of non-involvement in order to fit into the therapeutic attitude. For therapists, some social talk and sometimes also self-disclosure, i.e. saying something about oneself (facts, opinions, feelings), is a necessary ingredient to a therapeutic session, to ease the conversation and strengthen the relationship. For interpreters counts the same. The next example shows that trespassing the neutrality-boundary can be helpful.

In a Dutch mental hospital setting, a therapist is working with a young woman from a war torn country. She has been heavily traumatised, she is psychotic and some personality problem is assumed. She feels 'the enemy' is still everywhere around her. The sessions with her are difficult as she mistrusts everyone, but especially her country-people. In the session here described, a female interpreter is involved. The interpreter is of Dutch origin and the therapist knows that. The patient, as expected, is mistrustful and wants to know where the interpreter comes from. The interpreter, professionally, renders this to the therapist and suggests she tells the patient she is Dutch. The therapist agrees, hoping this will diminish patients' distrust of the interpreter. The interpreter tells the patient she is Dutch and studied her language in the Netherlands.

So far so good. Here we see an interpreter who deals professionally with a request to cross a professional boundary. In 2003, I already wrote about this phenomenon (Bot, 2003):

In the psychotherapeutic literature, the difference between boundary transgressions and boundary violations is made (Gutheil & Gabbard 1993). Violations are crossings of the boundaries that are harmful to the patient and his or her treatment, while transgressions are made within the context of ethical and adequate treatment. In psychotherapy, it has become clear that boundary transgressions can be initial steps leading to boundary violations when the therapist has not specifically defined why this transgression can be made in this specific situation (Gutheil & Gabbard, 1993).

The boundary transgression in this case consisted of some self-disclosure that was in this case useful to therapeutic relationship building and meant to do just that by the therapist. Boundary transgressions are OK, but also tricky, as the sequel to the above example shows.

The above situation continues, and suddenly the therapist finds himself listening to an entire discussion in a language he does not understand. Sometime later the interpreter renders this to the therapist. They have been talking about the quality of some specific food that is much better over there than in the Netherlands. The interpreter then tells the patient that she regularly receives parcels with this specific

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product from friends. This sparkles patients' mistrust again: as the interpreter receives parcels, she must have contacts with the secret service – is my patients' reasoning.

Here we see that, just as Gutheil and Gabbard (1993) warn for, one transgression leads to the next. The therapist knew why the first transgression was useful. The interpreter not trained in the intricacies of therapeutic boundary keeping and the ins-and-outs of this patient's diagnosis and treatment, was not aware of that and, seemingly happy to talk about some common interest, continued far beyond the first useful self-disclosing intervention. Informally, amongst therapists, the golden rule is to 'never volunteer information': answering a question from a patient is one thing, taking initiative in giving information about oneself is quite another. Not only can it give rise to undesired effects, as in the above example, it also directs the attention to oneself – and there it should not be – and turns the therapeutic sessions in a friendly tea-party. Self-disclosure should always be functional: concise, helping the therapy to takes a proper course.

In the above example, the patient addressed the interpreter directly, stemming from strong distrust based on severe traumatisation and a personality problem. A patient addressing the interpreter directly is a phenomenon that happens rather frequently when working with patients with severe mental illnesses specifically when personality problems are involved. In general, personality disorders have to do with problematic ways of making and establishing personal relationships, including problems in recognising, understanding and respecting (social) roles. The division of roles and tasks between therapist, interpreter and the patient him/herself is maybe not recognised and understood, and sometimes not respected. Specifically, with patients with a borderline personality disorder, a split between a good interpreter and a bad therapist - or the other way around is sometimes acted out aloud (Lidberg, 2001). It happens that interpreters get scolded or ridiculed, or praised far beyond reality, just as this happens to therapists. Interpreters have to know how to deal with this professionally. This means: being prepared (knowing that such a thing might happen); reacting calmly and friendly, not taking it personal and reacting offended, or too pleased; rendering the utterance of the patient to the therapist, asking (in words or gesture) the therapist how to deal with it, just as the interpreter did in the first part of the above example.

The patient presented here above was interested in the interpreters' origin. But patients may also ask for interpreters' opinion (about the therapist, about the treatment, about his or her own behaviour and actions et cetera) or help and can be quite persistent in demanding a reaction.

A patient is very angry with his therapist about something the therapist said in the session last week. When entering the therapy room, he is talking to the interpreter. The therapist does not understand, it sounds agitated and angry to her. The interpreter reacts to the patient, it sounds calm and soothing. As soon as they all sit down, the interpreter says something to the patient and renders this immediately: 'I just said to him that he should tell you what he just told me'. The patient still looks angry and fidgets in his chair. The therapist addresses him 'something seems the matter, can you tell me what it is about?' which is rendered by the interpreter.

Here we see an interpreter who takes an active role in the conversation after having been addressed directly just before the sessions start. Instead of refusing to get into contact with the patient (which probably would have increased his anger), the interpreter enters into a dialogue but directs it gently to the therapist – where it should be. Later on, the therapist asked, it turned out the interpreter told the patient 'what you say sounds serious, I think it is best you ask the therapist about what he meant with it'. The interpreter thus validated the feelings of the patient without giving an opinion (it sounds serious, not: it

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is serious) and without entering into further communication. After this the patient talks about his anger and frustration and it is discussed further during the session. Talking about the irritation and misunderstanding strengthen the workgroup functions and the therapeutic relationship.

Now, an example of how things can go wrong. Here it shows that the interpreter lacks general knowledge of a therapeutic attitude and the goals and methods of mental healthcare.

A patient with a severe alcohol addiction is in treatment with a psychotherapist. He wants to stop drinking, he makes plans for a better life, start an education, get a job. He manages to abstain for a while, but then meets some of his old drinking-fellows, gets seduced and starts drinking again. As a result he has been truanting from school. The patient feels miserable about it and feels that all is lost now and he thinks that he will probably never manage to stay clean. The interpreter who helps them to communicate shows subtle discomfort during the session (sighs, slight frowns) and she tells the therapist after the session that she feels irritated and embarrassed by this fellow country-man who 'messes up', 'abuses the social services' and in general 'gives us migrants a bad press'. She feels 'the treatment is bound to fail'.

Although this feeling of irritation and embarrassment may be understandable, it is not a therapeutic attitude. The basic therapeutic attitude is being understanding and non-judgmental. And a therapist is empathic, positive, and authentic and has a healthy trust in his own treatment methods. The therapist knows that (a) it is very hard to abstain from an alcohol-addiction, that relapse occurs often and does not mean that 'all is lost' but that a restart needs to be made. In this particular case, he also knows (b) that there have been understandable reasons why the patient started drinking as a way of self-medication, (c) he supports the patient in his wish to improve and (d) has trust that the treatment may help the patient maybe not to abstain completely but at least to get some grip on his drinking behaviour. His attitude of 'understanding' may show in words that express his empathy with what has happened ('what a pity' and such words), he does not get angry nor judgmental but, contrary, gives hope by showing trust in the treatment ('good that you have started treatment here and that you tell me frankly that you relapsed last week, so we can work together in how you can possibly avoid this in the future'). The therapist does not judge the patient as a weak person who does not know how to resist temptation, but feels with the patient (empathy) about the disappointment, and is supportive. He may say something like 'it is hard to stop a habit with such a strong physical addictive power'. So, the therapist may, with the patient, have a negative attitude about this particular behaviour, but he will still be empathic with the patient as a person, struggling to overcome his addiction. Authenticity is maybe the hardest characteristic of therapeutic talk. It may show, in this case, in words that acknowledge the pleasant effect of a little alcohol on feelings of wellbeing. In general, it means that the therapist does really believe in his treatment and genuinely feels empathy with the patient and this will translate itself in non-verbal and paraverbal behaviour.

In this example, patient, therapist and interpreter did not function as a 'workgroup'. The critical and negative attitude of the interpreter showed. This was felt by the therapist, and probably by the patient too (he was not asked about it). It cost the therapist energy to overcome the feeling of being criticised.

In the above example, the interpreter doubted the use of the treatment and this affected the therapist negatively. Therapists are sensitive and do worry about what interpreters may think of them and the treatment they give (Bot 2005). This sometimes intensifies the therapist's own doubts and insecurities. One therapist said that she herself feels sometimes that she can do so little for the asylum seekers she treats, and she worries what the interpreter might think of her work. Therapists usually know that interpreters work with many different therapists and, especially inexperienced ones, fear the interpreter may judge

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them negatively. This worry may be imagined, i.e. not felt by the interpreter. But interpreters should be aware that their expressions - verbal, nonverbal, paraverbal - count in all detail.

Summary

In general, it feels as helpful to therapists when interpreters follow their attitude towards the patient (Bot, 2005). They have to blend into the atmosphere of the session at hand. Preferably they shadow the therapist, i.e. they should portray the same attitude albeit in a somewhat softer way. For example, when the therapist laughs about something the patient said, the interpreter will smile. If, in that case, the interpreter would refrain from smiling and keep a 'poker face', this could hurt the patient (and therapist) in their sharing of something pleasant and may even give them the feeling of being ridiculed. 'Neutrality' can be perceived as 'not interested' and could as such form a hindrance to the patient; he may not feel invited to speak openly about his problems.

The therapist pays a lot of attention to shape a therapeutic relationship fitting this particular patient and the most he can hope for from the interpreter is to follow suit. Without feeling a real interest and empathy with the patient one is treating, it is hard, if not impossible, to do this type of work effectively. And the same applies to the interpreter. Without an interest in his clients (both therapist and patient) and the words they utter, he will not be able to blend in properly and to interpret faithfully

What About Interpreter Renditions?

Therapist Interventions and Patient Utterances

There is not much research that systematically focuses on the words and their renditions in interpreter-mediated (mental) health talk. Ever since Wadensjö's seminal work, more attention goes to the coordinating role of the interpreter (Wadensjö, 1998). Some people say, even therapists, that the exact words do not really matter. They emphasise the importance of attitude plus the fact that 'something' is being said. On the other hand, in psychotherapeutic theory and technique, there is an emphasis on the importance of wording experiences, feelings and thoughts (sharing, making them explicit, allowing to reflect); on 'finding new words' for these experiences and feelings and thoughts (giving a different perspective, meaning or to replace 'unrealistic thoughts') and on the importance, for therapists, to listen carefully to exactly how their patients phrase their utterances. The approach followed here is that words and attitude matter both. This is supported by findings of research in psychotherapy that attitude explains part of the therapeutic success, together with a properly explained and systematically carried out therapeutic technique. And technique is shaped in words. Which technique exactly is of less importance (Bot & Schaepkens, 2018). Also, rendering words of the primary speakers is the 'bread and butter' of the interpreter; it is their *raison d'être*.

In the introduction, the Hill Counsellor and Client Verbal Response Modes Category System (Hill, 1986) was mentioned. The author used this system to analyse interpreters renditions in the material collected for her PhD research to assess one of the aspects (therapeutic equivalence) of the equivalence concept that was developed to assess the interpreters' renditions: if the original utterance and its rendition scored in the same Hill category, the rendition was assessed as faithful on this aspect. Several of therapists' interventions were actually a sequence of several categories, glued together in one turn.

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A brief overview of the Hill categories and the difficulties in rendering some of these interventions follows here together with some reflection on what would help interpreters to render faithfully.

The first three categories of Hill's system seem simple enough: minimal encourager, silence and approval/support/reassurance. These usually concern short interventions. A minimal encourager is a neutral intervention, the therapist showing the patient that he is following, understanding, it serves mostly as a continuer and often overlaps with the primary speaker. Silence could be a thinking pause, it can serve as a time-out to let emotions either sink in or decrease; it may have an explicit function as time-out when irritation arises and seems to turn into aggression. Approval, support, and reassurance could also serve as a continuer, but is not neutral: it provides emotional support, approval or reinforcement - may imply sympathy or may be meant to alleviate anxiety. Although these three are simple interventions, they serve an important function. They often signal reciprocity (I'm listening; I'm hearing you; still with you), they steer the pace of the session and of emotional involvement, they convey empathy (good; you did well; yes, that is okay). Next to the words, the tone of voice is usually an important factor in its effect.

Very often the interpreter does not render such brief interventions. Often, they occur during the turn of the patient and are clear without translation (mmm, yes). But remarkably, when these kinds of interventions appear in the form of brief phrases, such as yes or good (often placed at the beginning of a much longer intervention) it is also relatively often skipped by the interpreter. Interpreters, so they told in an interview, see this often as unimportant 'fringe'. They seem to see it as phatic communication that does not deserve rendition. Albl-Mikasa and her research team found out that phatic tokens, just as modalisations, and hedges are often not rendered in doctor-patient communication (Albl-Mikasa et al., 2015). Interpreters do not see this as the core of the communication, while it serves an important role in the building of a therapeutic relationship, which is 'core business' and needs to be rendered.

It seems obvious that silence does not need to be interpreted; it is clear as it is. Specifically, when the interpreter works over the phone, it can give rise to misunderstandings. The interpreter does not hear anyone speaking and may think the line is disconnected and intervenes with 'do you still hear me', thus disrupting whatever was going on. Therapists should be aware of this and give some verbal clue to the interpreter that they are silent for a while. Some people find silence, in an on-going session, awkward. Interpreters should make sure they can bear it.

The categories of information giving and instruction do not usually pose many problems. Information, given by the therapist, may be about something external, information that does not concern the therapeutic process as such, but for example explains procedures in the asylum procedure of how to get help to find a house. Information can also be about the therapeutic process itself, explaining theoretical or technical aspects of the therapy. This information can also be helpful to the interpreter, as it explains the rationale of the therapy and as such gives background information that can help the interpreter to shape his renditions. The same applies to the category instruction, which can be a process-directive or advice or homework to be done by the patient. It also serves a double function as it may also help the interpreter to understand the process of the treatment.

In general, interventions that give most problems to interpreters are all sorts of questions and reflections that focus on the exploration of inner feelings or that reflect on expressed or underlying experiences (Bot, 2005). Therapists have the tendency to probe: to ask for feelings and emotions that lie beneath the surface and which may explain why the patient is suffering as he does and/or is so persistent in his problematic behaviour or distress. This often leads to series of questions, each going a step further into finding out what is 'really' the problem. Problems in rendering are sometimes related to questions that are phrased tentatively or differ only in a subtle way from what the patient had just said (Bot 2005). The

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interpreter might thus have problems in identifying the question-format or in recognising the difference in phrasing. An example is the following:

A therapist is exploring the feelings of a patient whose leg is amputated and which still gives him a lot of pain. He doesn't want to know the people around him to know he is suffering as he does not want to be pitied by them, that would be 'psychologically heavy' for him.

The therapist then asks 'can you explain why it is psychologically heavy for you when people express compassion?'

Which is rendered as 'can you tell me why you don't talk about it? Maybe because they will feel sorry for you?' (Bot, 2005)

Here we see that the interpreter, apart from rendering in a very loose way, does not translate the step to *why* getting compassion is difficult, but stays with 'getting compassion may be difficult', which is what the patient had just said himself.

Therapists can be taught to help the interpreter by wording their inventions clear and unambiguous. In this case, for example, they could introduce such a question with a short phrase in which they explain that they are going to ask a little further. For example, 'yes, I understand it is heavy for you but I would like to know why is it difficult when people are compassionate with you.' In this way both interpreter and patient are helped to understand the process they are in.

The above problem might have arisen because of ambiguous phrasing of the question by the therapist. However, there might also be another, underlying, problem at stake.

In training sessions (mental health specialisation for interpreters) the author makes use, amongst other training material, of training videos made for therapists. One of these is a training video for schema therapy for borderline patients and one of the episodes used is about a patient in the 'angry child' modus. Immediately after entering the treatment room the patient starts venting his anger, fulminating against the fabulous parking fees he has to pay when seeing his therapist, smashing his car-keys on the table. The therapist listens, does not go into the issue of the parking fees but starts asking what else the patient is angry about. Step by step, always asking 'what else' questions, therapist and patient arrive at fundamental issues between the patient and his father that still make him very, very angry, but also 'sad', 'not seen', over-asked' et cetera.

In these teaching sessions it has appeared that interpreters find this episode, the probing, 'odd' and sometimes 'ridiculous', they do not see 'the point' in those questions; they even become angry, finding the repetitive way of questioning nonsensical. And when interpreters find the interventions of the therapist strange, odd, ridiculous or when they make them angry, they will have some problems in carrying out their task: it will be hard to be empathic towards the therapist, to support his strategy and it probably also interferes with his capability to translate faithfully. If one doesn't understand the purpose of a question, it could be difficult to find the right words to render it. So, the problems found in these renditions may well have to do with a general lack of background knowledge of therapeutic techniques and their underlying principles with the interpreters.

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Another issue in the 'questions category' is the difference between open and closed questions. Open questions are used by the therapist to invite a telling, to make the patient give information. But they are also used, more often, to invite the patient to probe his own mind and to come up with underlying feelings, motivations and thought. Most often, the therapist takes the 'not-knowing' stance and puts the patient in the 'expert' role: the patient is the expert, the knowing person, of his inner life. When an open question is rendered as a closed question, the therapist already points into a specific direction, putting him in a more 'knowing' position. And this happened relatively often in Bot's material (2005). The difference with reflections is also a difficult one. A reflection, from the part of the therapist, formally takes the form of a question. But because it reflects something the patient has just said, albeit most often in different words, it also has some element of a statement in it. An example is the following phrase, a reflection on an underlying feeling, from the therapist, directed at the patient: "because you feel in fact, you ask forgiveness, you feel in fact guilty to the fact that father has been in prison?" (Bot, 2005).

Just before this intervention, the patient had said that he asked his father forgiveness and it could be derived from former utterances that this was because father had been imprisoned and the patient thought that this had to do with his actions. 'You feel in fact' is a statement, but the phrase has a rising - question- intonation and is meant for the patient to think for himself whether this could be 'true' or not. Minor changes in the rendition - including a change in intonation profile – could thus change this turn into a statement with a therapist stating that the patient does feel guilty.

Some other categories did not clearly give problems in the interpretation per se, although of course here and there, deviations were found. The category 'self-disclosure' – as in self-disclosure by the therapist - did not give rise to specific interpretation problems. When asked of the interpreter it is a different story - as discussed here above.

Of course, the Hill system is only one way to categorise therapists' interventions and their renditions. Some psychotherapeutic techniques use ordinary words in a special meaning. For example, 'protecting' often gets a negative connotation as it is equated with 'over-protection'. But when the interpreter connects it with 'caring for' (Bot, 2005) it loses this negativity. In motivational conversation techniques, often used to help people overcome their ambivalences in therapy, it is customary that the therapist asks permission to touch a topic. He may say 'you just mentioned your drinking habits, is it alright with you if I ask some more questions about that?' Interpreters find this often a bit weird, specifically when this is done more often in a session. And when they find it weird, do not understand its purpose, they may often 'forget' to render it. So, the pitfalls are numerous and will of course never be covered completely. Even the wise advise 'if in doubt, ask' will not cover all misunderstandings. Sometimes you just do not know that you misunderstood.

Bot (2005) found few changes in therapeutic perspective in patients' turns. The Hill categories for patient turns are not dealt with in this chapter. Illustrated with examples, some general remarks can be made about difficulties specific to mental health, in rendering patients' turns.

In a mental health clinic, a judge interviews a patient in order to assess the justification for a forced admission in the clinic. The patient speaks French. In the Netherlands, judges have to speak Dutch in their official sessions ('Dutch is the language of the court'), a French interpreter is asked for. He works over the phone. The patient is a quiet man, who enters the session with some large dictionaries in his hand, which he puts before himself on the table. During the session he leafs through the books. After the judges first question, he starts a long monologue. After some minutes, the interpreter breaks in. He says: 'I'm very sorry, I can understand the words that are spoken, but I cannot interpret this for you'.

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The judge replies in fluent French and says he completely understands the problem of the interpreter - he is not to blame and he thanks the interpreter for his meta-communication.

Here we see a proper way to use meta-communication: some patients speak in such a way that interpretation is impossible. A sequence of random words, maybe loosely connected through alliteration, could probably be translated, if one has enough time, but are nearly impossible to interpret. In those cases, the interpreter should explain the characteristics of patients' talk to the other primary speaker.

The style patients use to phrase their utterances may also pose problems sometimes.

A male patient, quite a rough type, has been working as construction worker before a war started that changed his life completely. He enters therapy, with an interpreter, because of serious anxiety problems. In a session, the interpreter suddenly, before rendering patients' words, turns towards the therapist and says 'he is using such beautiful words, I cannot interpret that properly, but you should know this, it is really poetic.' The therapist acknowledges this to the patient and he tells her that he used to read a lot, but now feels unable to do so because he cannot concentrate. Thus an entire new aspect of a patient's life was uncovered.

Also here the interpreter successfully meta-communicated about patients words which opened up new material in the treatment.

What About Empathetic Stress?

Empathy is a risk factor for the development of symptoms of secondary traumatisation and other stress reactions in care providers. Interpreters also need to be empathic in order to understand the clients they are working for. So, one would expect interpreters to be prone to secondary traumatisation as well. Baistow (2000) did a survey in several European countries and found that half of the respondents sometimes suffered from anxiety or changing moods due to the interpreting work. The fact that interpreters are often not very well paid, adds to their general personal stress levels which is also known as a risk factor for the development of this kind of negative reactions (Baets, 2013). Although these empathic stress reactions may occur in a lot of situations in health care, mental health care might be more burdening than other specialisations. In general, the level of expressed emotion is high in mental health talk. Interpreters have to render their patients' traumatic experiences, preferably in the 'I'-form, which may pose problems when talk is about ugly events (Wallmach, 2002). And when they have gone through traumatic events themselves this could evoke their own memories and feelings of distress. Interpreters, who have been asylum seekers themselves, do sometimes recognise their own experiences in their patients' stories. A sign language interpreter told in an intervision group about the difficulties she had in signing about sexual violence and its graphic nature in sign language.

So, there is reason to assume that interpreters run the risk of developing empathic stress reactions that may interfere with their functioning.

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SOLUTIONS AND RECOMMENDATIONS

Unfortunately, in the Netherlands, the country this paper is written from, most interpreters have not been trained specifically for their work in (mental) healthcare, nor are they part of a team. They are being hired per session and have no information about the session beforehand. They usually have a training focussing on their work in the judicial realm in which they have been told to be 'impartial' and 'neutral', fitting with the adversarial system of the court. In therapeutic talk a somewhat different attitude is usually more helpful but as it implies deviating from the neutral stance, this sometimes feels 'risky' for the interpreter. The therapeutic attitude may be called 'neutral' and 'impartial' in the sense that the therapist is non-judgmental about the person of the patient; he may be judgemental of some actions of the patient, though. But more important, the therapist empathises with the patient; he is positive and authentic and the other adjectives mentioned above – and this differs from the neutral and impartial stance. It is not easy to shape such an attitude in coordination with the therapist: it means a continuous alignment between therapist and interpreter.

Interpreter-mediated session in mental healthcare ask for close cooperation between therapist and interpreter. Therapist, patient and interpreter together form the therapeutic relationship, which is necessary to make the treatment successful.

To make this happen, it is necessary that both interpreters and therapists be trained in this type of communication. Interpreters need generic knowledge of mental healthcare (its organisation, basic knowledge of the most important disorders and treatment methods) and skills training in attitude issues in mental health sessions. Therapists need training in the intricacies of interpreter-mediated talk. They should know what they can expect from an interpreter and how they can help the interpreter to blend into the session. They also need to be aware of the importance of chairing the session properly to avoid overlapping speech and too long turns. And they have to be aware of the importance of phrasing their interventions unambiguously, in properly constructed and grammatical sentences – which not only helps the interpreter to render faithfully but also helps to keep focus in therapy.

Finally, in order to keep empathic stress (also called vicarious trauma or secondary trauma) at bay, it is important that interpreters get support through intervision and supervision.

CONCLUSION

This chapter dealt with the question whether there is anything special about interpreting in health care. The answer is 'yes, there is'. Basically, there are five fields that ask for special attention.

Firstly, mental healthcare deviates not a small bit from 'ordinary' talk. Although the set-up of the sessions may not be very formal and may seemingly not follow a specific format, the topic of talk does not follow 'normally accepted' social rules. In mental health sessions patients talk about topics they do not speak about in social interactions because they may feel ashamed or do not want to be judged as 'crazy'. On top of that, therapists do not react to those stories in ordinarily accepted ways: they may be confronting, they 'ask permission to ask a question', they may 'bluntly' ask how the patient feels about the therapeutic relationship, and they may give very personal feedback. Instead of 'covering up' ugly histories, they may probe for all details. These are all things that we usually, in ordinary social talk, refrain from. The unaware and unprepared interpreter may feel awkward in such a situation. Notwith-

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standing, there are exceptions; for example, EMDR sessions do follow a strict format with prescribed wording of interventions.

Secondly, in mental health care, the relationship between therapist and patient is of utmost importance in order to create the atmosphere in which change can take place. But is also a diagnostic tool and is used as an instrument of change. The interpreter is part of the process and has to know how to fit into this process. This may include behaviour that does not fit into the, most often, very strictly formulated codes of conducts for interpreters.

Thirdly, in mental healthcare talk can be emotionally burdening for both the therapist and the interpreter. Rendering patients' words about trauma in the first person poses a heavy load. In sessions with asylum seekers and refugees, the stories of the patient may seem very familiar to an interpreter who shares the same asylum seekers background. The stories he has to render - about atrocities, a difficult flight and so on - may be very much like his own history. This can evoke emotional reactions that the interpreter has to deal with.

Fourthly, patients with severe mental disorders, specifically when personality disorders are concerned, may try to drag the interpreter into the conversation, as a conversation partner. Or they may be aggressive, overtly disrespectful or they may praise the interpreter beyond reality. To steer clear, the interpreter needs to know how far he can go in reacting directly; he should not take it personally but at the same time he should give a personal reaction that also fits in with the attitude of the therapist. Being neutral can easily be perceived as too neutral in such circumstances.

Fifthly, the language therapists use is sometimes difficult to understand as he may use words in a different connotation as we are used to; moreover, words that feel like 'fringe' are also of importance and need to be rendered. Patients can tell hard or impossible to understand stories, may use newly coined words and speak haphazardly – forcing the interpreter to meta-communicate with the therapist.

For the unprepared interpreter, who has only had a general training that is usually focussed on interpreting in the judicial realm, interpreting in mental healthcare may be rather difficult. The unprepared interpreter will find various situations in mental healthcare odd, he will not understand therapists interventions and / or patients utterances and will feel awkward when boundary crossings are clearly asked for but feel out of bound for him. Interpreters need to be prepared well for working in mental healthcare sessions: they need to know the background of interventions and have a basic knowledge of the most occurring disorders. And they need skills training to learn how to deal with interpersonal and emotional situations in practice. In order to cope with the mental burden of stories of trauma and other emotionally difficult situations, interpreters need to be embedded in intervision or supervision groups which can help them to stay clear from unproductive reactions.

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Chapter 68
Health and Mental Health

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ABSTRACT

As healthcare organizations use approaches such as structural empowerment theory and nurse residency programs to engage new graduate nurses in becoming productive members of the organizational culture, bullying and incivility experienced by these nurses can undermine organizations' efforts. Chapter 3 introduces the Reporting of Uncivil Conduct Chain of Command to provide support and direction to nurses that are experiencing bullying by perpetrators in the workplace. Unresolved and persistent uncivil conduct can result in health and mental health problems for affected nurses. Hence, in order to protect nurses' overall health and safety, it is necessary for organizations to adopt zero tolerance for bullying and incivility. Additionally, nurses may benefit from screening programs that can identify risks for self-harm secondary to stress and depression that could be caused by incivility in the workplace.

INTRODUCTION

Incivility impacts the health and mental health of affected nurses. For nurses, increased call-outs from work because of fatigue, frustration, anxiety, and depression associated with being bullied, not only places constraints on their colleagues, but impacts patient care. Annually, healthcare organizations have a financial loss of as much as $30,000 to $100,000 (Becher & Visovsky 2012) for each employee that has been effected by incivility within the workplace.

The very nature of the nursing profession and the interactions that nurses daily have with patients, families, and other health disciplines, can be emotionally and physically demanding. Nurses must arrive at the workplace attentive, well rested, and physically capable to complete patient assessments (i.e. physical, neurological, withdrawal from substances or alcohol), perform skilled care (i.e. wound dressings, administration of intravenous medications), and meet the psychosocial needs of patients and their family members. Bullying distracts nurses from performing well, the job they were trained to do, providing health care to patients.

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Uncivil Behaviors Psychological Impact

Oyeleye, Hanson, O'Connor, and Dunn (2013) conducted a quantitative study using exploratory correlational methods. The purpose of the study was to explore the relationship of stress, burnout, and workplace incivility on nurses' turnover intentions (decision to leave their job) and psychological empowerment. A total of 61 nurses participated in the study; 87% (n= 53) were female and 28% (n= 8) were male. The ages of the participants ranged from 23 to 61 years and participants' races were white (n= 50, 82%), other, (n=1, 2%), African American (n=3, 5%), and Asian (n= 7, 12%). The nurses' years of experience in the profession varied from 1 year to 40 years.

Oyeleye et al. (2013) used the following five instruments in the study: Maslach Burnout Inventory (MBI), the Uncivil Workplace Incivility Scale (WIS), Spreitzer Psychological Empowerment Scale (PES), the Perceived Stress Scale (PSS10), and a Turnover Intention scale. Results indicated that there were statistically significant correlations between stress and burnout (p= .000), burnout and turnover intention (p= .005), and stress and incivility (p=.001). Study findings suggest that nurses experiencing increases in burnout and stress may leave their jobs.

Kang, Jeong, and Kong (2018) conducted a qualitative study using a grounded theory approach (Corbin and Strauss, 2015) to explore nursing students' experiences with incivility. Sixteen nursing students participated. The 16 nursing students had all experienced incivility during their clinical placement. Kang et al. (2018) invited the students to participate in one-on-one interviews. Results indicated that nursing students felt they were outsiders within the organizational hierarchy and culture of their clinical placement. Students verbalized feeling marginalized and in response became passive, submissive, and shocked that incivility had occurred in a professional setting.

Kang et al. (2018) concluded that when nursing students experience incivility during their academic preparation to enter the profession of nursing, their identity is threatened. Students undergo role conflict and have low self-esteem. Study findings suggest that nursing students that experience incivility should be provided counseling services and educational programs be developed by nursing programs to address the incivility and offer coping strategies. Schools of nursing are recommended to have guidelines that ensure students learn within supportive clinical environments that they feel safe within.

Structural Empowerment

Structural empowerment is a theory that views workplaces that empower employees as having a positive impact on work performance (Kanter, 1977). Power in the workplace can be attained both through informal and formal ways. Employees exhibit informal power when they form interpersonal allegiances and networks of peer groups, with subordinates and superiors within their organization, as well as outside of the organization. Formal power occurs within an organization when employees have roles that are visible and align with organizational missions and vision statements, and employees have jobs that have flexibility. According to Kanter (1977), employees tend to thrive, have job satisfaction, and are committed to their organizations success, when opportunities to learn and grow professionally are made available to them.

Structural empowerment, although developed in 1977, has been referenced within new graduate nurse residency programs such as the American Association of Colleges of Nursing Vizient (2019) programs, in the development of evidenced-based practice (EBP) projects as a prerequisite for completion of residency programs. The length of residency programs are usually one year and culminate in EBP projects such as

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unit-based reduction of central access device infections or examining ways to reduce turnover intentions. These EBP projects are presented to the new graduate nurses' colleagues and key stakeholders within the organization (i.e. Vice President of Nursing Services, Chief Nursing Officers, Nurse Managers, or Healthcare Providers). Structural empowerment can be instrumental in health care facilities retaining nurses through engagement with their units and the organization as a whole.

Wing, Regan, and Laschinger (2015), used a predictive, non-experimental design to examine structural empowerment in relation to workplace incivility and new graduate nurses experience of mental health symptoms. Their sample size was 394 new graduate nurses working within a hospital in Ontario, Canada. Instruments used were the following: the Conditions for Work Effectiveness Questionnaire (CWEQ-II, Laschinger et al., 2001) to measure structural empowerment, the Workplace Incivility Scale (WIS, Cortina et al., 2001), and the State of Mind subscale from the Pressure Manager Indicator (PMI, Williams & Cooper, 1998). The CWEQ measured structural empowerment and had Cronbach alphas that range between 0.78 to 0.94. The WIS assessed incivility that was experienced by the new graduate nurses in their interactions with co-workers and supervisors. And lastly, PMI measured anxiety and depressive symptoms experienced by the new graduate nurses.

Wing et al. (2015) found that high levels of structural empowerment experienced by new graduate nurses, was associated with less mental health symptoms. Incivility experienced by the new graduate nurses, by supervisors and co-workers, was found to diminish the positive effect of the work environment. Hence, although health care facilities can strategically set in place, positive opportunities (i.e. training, promotions, awards, and career ladders) for nurses to grow and learn, uncivil behaviors in the workplace still can negatively impact the mental health of new graduate nurses.

An Attack on One's Self-Concept

Perpetrators of incivility seek to discredit their targets professionally by openly questioning their expertise (public humiliation) and knowledge in front of others. Additionally, the perpetrator may seek to sabotage the completion of work in progress or take credit (destabilization) for the nurse(s) work for whom they are bullying (TJC, 2016; WBI, 2016). Perpetrators further isolate their targets by withholding information. The latter behaviors can cause nurses that are experiencing bullying in the workplace to feel physically ill and mentally fatigued, anxious and depressed.

Case Study 4 is a hypothetical case study on workplace incivility. All characters within the case study are fictional. This case study explores the transition of a new graduate nurse from the academic environment to clinical practice.

Case Study 4: Maria



Maria graduated from college with a bachelor of science in nursing 11 months ago. She was hired to work at a large teaching hospital within her desired specialization of critical care nursing. Maria

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relocated from a small town in the south, to a large metropolitan city in the north of the United States. Maria's orientation to her unit was comprehensive and her preceptor Ann was a critical care nurse for 31 years and enjoyed teaching her.

Maria's preceptor Ann was supportive, engaging, and provided her with opportunities to learn new skills daily. Ann and Maria even attended critical care conferences together. Maria had learned so much quickly, that her patients would inquire how long she had been a nurse because she was so confident and knowledgeable.

Ann, after commending Maria on her progression after 10 months of preceptorship, informed Maria that she would be retiring. After Ann retired, Maria still felt confident and enjoyed coming to work each day. One day, as Maria was talking to a patient and their family member, another nurse entered the patient's hospital room and started correcting the information that Maria had just provided. Maria felt humiliated and quickly excused herself and exited the room.

When Maria later approached the nurse to ask why she had interrupted her as she was talking to her patient, the nurse laughed and walked away. The nurse repeated this behavior the following week with a different patient. Although Maria tried to ignore the behaviors, the situation escalated out of control as the nurse began challenging her skills and humiliating her in front of co-workers and healthcare providers.

Maria hated going to work. She was depressed and felt alone and isolated. Maria developed acid reflux and experienced headaches. Her thoughts both at home and at work focused on the incivility she was experiencing at work.

Maria's nurse manager asked to meet with her after noticing on the unit schedule that she had begun to call-out from work ill several times during a one-month period. Maria was tearful as she explained to her manager what had happened and how the bullying she had been enduring had affected her health. The nurse manager instructed Maria to begin documenting the dates and times the bullying occurred and who was present. Three months after the bullying had begun, it abruptly ended when the nurse was placed on progressive disciplinary action by the nurse manager for uncivil conduct within the workplace.

The perpetrating nurse was placed on a different shift than Maria. The two nurses did not interact. Maria's acid reflux eventually resolved and her depression gradually lifted. Maria learned from this experience the importance of addressing bullying behaviors immediately. In addition, the necessity of informing a supervisor or manager of the bullying as soon as possible.

Maria' Story—Addressing the Problem

Maria's experience with being bullied in the workplace ended when a nurse manager, while addressing Maria's pattern of sick call-outs, discovered that Maria was experiencing incivility. Nurses being bullied in the workplace may feel isolated and that no one cares. This perception (Moola, Ehlers, & Hattingh, 2008) is not always accurate because it is clouded by the stress nurses experience related to the uncivil behavior from perpetrators. It is often when nurses begin to share their story of incivility experiences with a trusted source (i.e. a counselor, manager, peer, Human Resources representative), that healing can begin and recognition of the inappropriateness of the perpetrator's behavior can be processed and validated.

Nurse Residency Programs

Nurses that live in silence and tolerate the bullying, are at risk for not only physical and mental health problems, but job stress and burnout (Wu et al., 2007; Chen, Lin, Wang, & Hou, 2009). For retention

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of new graduate nurses, it is imperative that they receive support in addressing incivility during their period of orientation and acclamation to the nursing role. Many health care facilities, in response to the need to support new graduates and retention, have developed nurse residency programs.

The purpose of nurse residency programs are to support the Institute of Medicine (IOM, 2003) and Quality and Safety Education for Nurses (QSEN, 2019) initiatives of introducing patient-centered care, evidenced-based practice, informatics, quality improvement, safety, and teamwork and collaboration (QSEN, 2019) to new graduate nurses (and experienced nurses re-entering the field). Nurse residency programs focus on the development of nurses' roles within health care systems, evidenced-based practice, leadership skills, and awareness of how their work and roles impact patients' health outcomes. Nurse residency programs, have been instrumental in decreasing new graduate nurse turnover and preparing nurses to apply critical thinking and decision-making skills within the clinical environment (Vizient/AACN, 2016; Vizient/AACN, 2019).

Within nurse residency programs, new graduate nurses are trained in cohorts. The establishment of cohort training facilitates connectedness among the new graduates and creates a forum whereby the nurses can safely share their experiences on the clinical units; positive and negative, this includes incivility. For new graduate nurse Maria, sharing with her cohort or a member(s) of the cohort, could have also helped her address the uncivil conduct on her unit.

Coordinators of nurse residency programs are a wonderful resource for new nurses because they can maintain objectivity. The sole purpose of the coordinator role is to prepare new graduate nurses and nurses re-entering the nursing profession (or a new clinical area of practice) with their transition to the health care facility. Coordinators of nurse residency programs may hire the part-time assistance of what are referred to as nurse residency facilitators. Nurse residency facilitators are experienced nurses that meet with hired nurses to facilitate discussions on planned topics that the nurses may experience within the clinical environments such as when *patients' conditions decline, coping with the loss of a patient, providing support to family members in crisis, or coping with difficult relationships* in the health care environment.

Nurse residency programs are instrumental in helping new graduate nurses and nurses re-entering the field, recognize the importance of communication skills, respect in the workplace, coping with stress, self-care, being unafraid to challenge their colleagues when a potential procedural error is identified (i.e. a break in sterility during a surgical procedure or dressing change) or they disagree with a treatment regimen prescribed for a patient. The number of skills taught are too many to write. Nurse residency programs also encourage scholarly research, as nurse cohorts work collaboratively to identify areas in need of improvement on their units and develop EBP quality improvement projects that contribute greatly to patients and staff on their designated units they work on, as well as the health care facility itself.

Nurse residency programs serve as a reminder of the responsibility that each nurse has to educate the next generation of nurse professionals. New nurses must be well-informed of the nature of bullying in the workplace and the necessity of having an intolerance for incivility. Change begins with every nurse from multiple generations, novice to expert alike.

Case Study 5 is a hypothetical case study. All characters within this case study are fictional. This case study provides an example of a nurse who is a caregiver of older parents that must contend with bullying in the workplace.

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Case Study 5: Maritza



Maritza has been a nurse for 32 years. She recently relocated to Florida from North Carolina to care for her aging parents. After three months residing in Florida, her father died of a heart attack. Maritza then became the primary caretaker for her mother who has Alzheimer's disease.

Maritza worked day shift at a local hospital and hired a nurse assistant as a companion to provide care to her mother while she was at work. Her mother became combative and paranoid. The nurse assistant was assaulted by Maritza's mother on a daily basis for a week and Maritza's mother constantly accused the nurse assistant of stealing money and jewelry. One day Maritza received a phone call at work from the agency that the nurse assistant was employed, and was informed that it was unsafe for them to provide companions for her mother. Effective that day, the companion service ended.

Martiza spoke with her nurse manager and assistant nurse manager about her dilemma. It was perfect timing, an evening shift nurse had resigned so Maritza took this position and started two days later. Working in the evening allowed Maritza to provide care to her mother during the day and provide overnight care of her mother as well. A neighbor who was a retired nurse, agreed to take care of her mother while she was at work. Maritza paid her neighbor $500.00 a week.

Ann, a new graduate nurse was hired to work the evening shift. Ann was very bossy and opinionated. She had already worked in three different hospitals since graduating 18 months ago. She was not experienced enough to make the clinical decisions she attempted to make on some of the unit's complex postoperative patient cases on the surgical unit. However, Ann, a skilled liar, would falsify her level of experience and clinical competency.

Concerned that Ann's lack of integrity and ethics could eventually place a patient or patients at risk for harm, Maritza decided to go and speak with the assistant nurse manager. The assistant nurse manager and Maritza spoke at length about ways to help Ann adjust to her role on the unit and feel more comfortable seeking advice and assistance with patient care from more experienced nursing staff.

I Don't Need Your Help

The following evening, Ann approached Maritza and pushed her left shoulder from behind, startling Maritza. Ann stated, "Oops, my mistake Maritza! By the way, do me a favor, don't talk about me to my boss and no, I don't need your help." Ann then walked down the hallway quietly as if the interaction had never taken place.

One evening after work as Maritza went into the hospital parking garage to prepare to go home, she noticed a deep scratch, on the driver's side of her car that covered the full car length. The following week, her tires were slashed. Maritza reported to the hospital security what had occurred. Because of the angle of the garage camera, the perpetrator could not be identified. As a caregiver to her elderly mother, Maritza was already stressed. However, the vandalism had taken her stress to a different level, as Maritza now feared for her safety.

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Maritza went to the Police Department to report the damage to her car. She was recommended to park her car in a well-lit area within the garage with clear visualization from a camera in the garage. Maritza began arriving early at work to secure parking near the surveillance cameras. Within nine days, Maritza's driver side window was smashed, glass covering the seat floor and dashboard. This time, surveillance cameras had a direct view, and a visitor exiting the garage on foot to spend the night with an ill family member had witnessed the event and reported it to a hospital security officer. Maritza was immediately notified.

Hospital security viewed the surveillance camera footage the following day and saw Ann, Maritza's co-worker, smashing her car window with a hammer. Maritza was informed, the police were contacted by the hospital security department and a statement was taken on the grounds of the hospital. The witness' description of the perpetrator and picture on camera, confirmed that it was Ann, Maritza's co-worker.

Ann was arrested and in court, denied any wrong doing. She later faced charges and Maritza acquired a restraining order. The hospital fired Ann. Maritza had no further problems, but the physical pushing and destructive damage to her car, left her shaken.

When Bullying Becomes Violent

When perpetrators physically lay hands on victims with the intention of intimidation or to do harm, it is important that these incidences are documented and reported. Maritza did not report the pushing incident on the unit, and Ann continued to escalate her attacks by damaging Maritza's property, her car. If a victim of bullying in anyway feels threatened for their safety or the safety of others in their workplace, follow the report of uncivil conduct (see Diagram 1.) chain of command and involve hospital security and or the police to document the pattern of deviant behaviors. Of concern would be if the bullying leads to self-harm or harm of others. Reported, deviant behaviors can be addressed and the perpetrators, witnesses, and victims, kept safe.

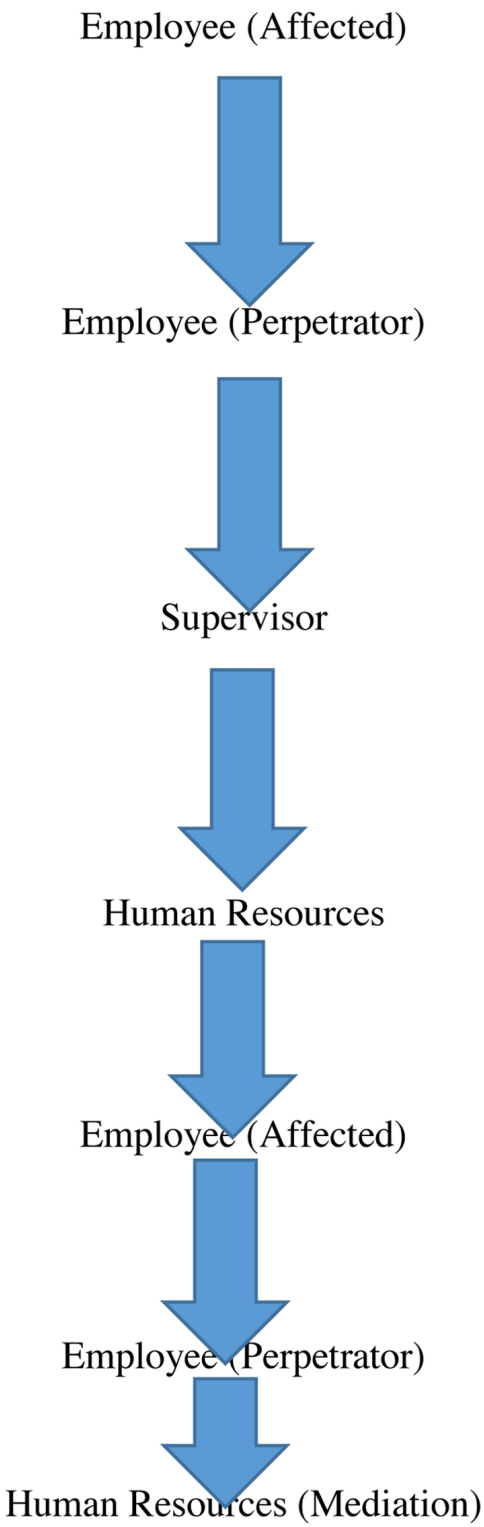
Professionalism and Confrontation

Nurses are encouraged in workplaces, to follow the chain of command. The chain of command consists of a hierarchy of leadership established for the maintenance of function and order within institutions. By following a chain of command, issues can potentially be rectified employee-to-employee, prior to being escalated to a manager, director, president, or vice president of a health care facility. Figure 1 is an example of a chain of command in an organization.

The restoration of order is the goal of the chain of command within organizations. Whenever possible, nurses should seek a solution to the bullying with the offending nurse. This provides the offending nurse the opportunity to explain their behavior, and if in fact they are aware of the implications of their patterns of communication. If bullying persists, nurses should then meet with their immediate manager or supervisor to discuss the situation.

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Figure 1. Reporting uncivil conduct chain of command



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The Hollow

Incivility may cause the affected individual to feel hurt, sad, misunderstood, and embittered. These feelings can be referred to as *the hollow*. *The hollow*, accompanied by perseveration of incidences of negative behaviors from the perpetrator to the victimized nurse, can lead to illness; both mental and physical. For nurses experiencing *the hollow*, symptomatically, they tend to lack energy, enthusiasm, and focus. These symptoms arise in-part, because of the perseveration component of the hollow. As nurses mentally recall negative words said to them and the situations in which they felt vulnerable and attacked by the bullying perpetrator, anxiety and frustration are heighted, as events are replayed over and over again.

The Hollow and Work Productivity

The term *the hollow* was created by the author to explain symptomatology that victims of incivility can experience. Nurses may feel overwhelmed by the bully's continuous attacks on their character and their abilities to perform the job. This can lead to nurses having the sensation that they are sinking and enveloped in deep sadness. Nurses affected by *the hollow* may experience intermittent periods of worry and anxiety, accompanied by perseveration on events at work involving the bully or bullies, and intermittent tearfulness.

Nurses experiencing *the hollow* will inevitably, have a change in their work productivity. Preoccupied in their thoughts with perseveration of the incidences of negative bullying interactions, affected nurses may have a decrease in their ability to concentrate, think logically, and think analytically. The danger of *the hollow* for nurses that are in direct care practice, is that intellectually, nurses' thought processes may become clouded and they may have difficulty critically thinking within the clinical environment. The latter may compromise nurses care of patients related to their disrupted thought processes, secondary to *the hollow*.

Nurses can overcome the feelings associated with *the hollow* by either deciding to leave their work environment shared with the perpetrator(s), request a change of shifts to avoid all interaction with the perpetrator(s), or report the perpetrator(s) and seek the mediation help of a nurse manager or Human Resource Department representative. Additionally, nurses should seek counseling through their company's employee assistance programs (EAP). Untreated, *the hollow* can develop into a clinical depression.

Case Study 6 is a hypothetical case study and all characters are fictional. In this case study, Alice, a nurse employed within a surgical intensive care unit (SICU) experiences bullying by her mentor and other nurses on the unit. Alice must learn self-care as she endures the bullying and incivility.

Case Study 6: Alice



Alice experienced bullying on her job. The bullying started shortly after she was hired to work as a critical care nurse within a surgical intensive care unit (SICU). Alice's bullies were four nurses; one of

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the four was her mentor. The nurses would go out of their way to attempt to prove that Alice was incompetent in front of not only her patients and other healthcare disciplines, but other nursing colleagues. Alice had never did anything to these women. She did not have work a history with them or anyone in the hospital for that matter. Alice was new to the state and institution after deciding to relocate one year ago after a divorce.

For Alice, relocating to a new state seemed exciting since her ex-husband and she had no children; this was truly like starting over. Alice had worked as a critical care nurse for 10 years before marrying her former husband. She was an experienced nurse who was certified within her specialization.

Alice was already emotionally fragile when she relocated secondary to the divorce, so the bullying made it even more difficult. One evening as Alice prepared to leave work after completing a 12-hour shift, she walked into the nurses' breakroom to get a cup of coffee. She did not see that one of the perpetrators had placed their foot in the way to trip her. Alice fell and hot coffee spilled all over the floor and onto her uniform.

Alice informed her nurse manager about the bullying and that it was escalating, but her complaints seemingly were ignored. The perpetrators were comfortable bullying others because it was tolerated on the unit. No one questioned the perpetrators' behaviors.

Alice went to speak to Human Resources (HR) about the problem and they instructed her to "keep track of the incidences." Alice documented the dates and times of incidences and if a witness was present. The HR representative suggested Alice meet again with her nurse manager to discuss the problem. Alice met with the nurse manager who listened to her concerns, but did nothing.

Alice was not sleeping well, had lost weight, and had difficulty concentrating. She had a few friends in the apartment building she lived within and had shared with one, a nurse that worked at another hospital, what was happening at work. Alice's friend recommended she contact an attorney. Alice did not contact an attorney and continued to reach out to HR, but to no avail. Alice applied for a position on the cardiac intensive care unit (CCU); however, Alice's nurse manager delayed the transfer to the CCU because the SICU had a shortage of staff.

Alice seldom felt happy and was anxious upon arriving at work. Alice was very cautious when administering medications and completing procedures for her patients because her mind was so preoccupied with rewinding and playing back things that were said to her by the perpetrators. Alice's self-esteem and self-confidence had suffered a great deal. It was as if she had no experience in nursing at all. She felt depleted of energy and lived in a constant state of fatigue. Because Alice was alone in a new state, she felt that she could not just leave her job given her financial responsibilities.

Alice's thoughts were always racing and replaying the painful bullying events. She began to withdraw from friends, went only to work, and came home. Alice's sleep and appetite were poor. One night, while driving over a small bridge in the middle of the night coming from the grocery store, Alice stopped her car and stood on the bridge looking at the river below. Contemplating suicide and in turmoil, she changed her mind as she thought of her parents and her Catholic faith. She decided to return to her car and proceeded home.

One day while at work, Alice went to administer a morning injection of subcutaneous heparin (Porcine) to a patient. The patient's family member informed her that the night nurse had administered the injection at 6:00 a.m. The patient was nonverbal and on a ventilator and the family member, whom normally leaves at 6:30 a.m., had forgotten his reading glasses, returned to the patient's room to obtain them. The nurse had not signed off the order, and informed Alice during handoff report at 7:05 a.m. that the 6:00 a.m. heparin injection had not been administered. Alice agreed to do the injection.

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Alice asked the nurse why she had not been informed that the nurse had decided to administer the heparin injection. However, the nurse, one of Alice's perpetrators, insisted that she had not administered the medication. The family member, overhearing their discussion, reiterated the story and verified that it had been administered. The patient's spouse said to the other nurse, "You told me when you came in my wife's room at 6:00 a.m. that you were giving her heparin. Did you tell me the truth or not?"

The nurse manager, entering the unit, overheard the conversation with the family member and Alice's co-worker at the nurses' station. The nurse manager listened intently to the family member and apologized for the "mix up." Alice felt set-up and her suspicions were confirmed when one of the nurses on the night shift shared the perpetrator had informed her that she would be administering the said patient's heparin injection at 6:00 a.m., her last medication for the night shift, as they spoke in front of the medication pyxis. Alice shared this with her nurse manager who stated, "Alice, you have been nothing but trouble since you got here. You work with good nurses that try to support you, why don't you do the same."

Alice was visibly shaken with what had just occurred. She attempted to continue to work, but after this last incident, felt unsupported, betrayed, set-up, and paranoid about protecting her license. She informed the nurses she was working with, her patients and the nurse manager, that she felt ill and would be going home to rest.

Alice went home and fell asleep crying. When she awoke at 5:00 p.m., she could not believe that had slept so long. She finally felt rested after weeks of disrupted sleep. She ordered a salad and sandwich from a local deli and ate the full meal. At about 7:00 p.m., one of Alice's friends in the apartment building came to show Alice a dress she had purchased. They laughed and spoke at length over cups of tea. At 10:00 p.m., Alice cleaned her apartment and sorted through her mail. At 12:00 midnight, she took a shower.

At 3:00 a.m., Alice left her apartment building and drove over the small bridge. She stepped out of her car and looking at the calm waters, climbed on top of the bridge and jumped into the river below. At 5:30 a.m., Alice's car was discovered. Alice's body was recovered at 8:00 a.m.

Examining Alice's Case

In examining Alice's case, one of the factors that may have led to her suicide, was her being bullied at work and feeling unsupported. However, risk factors involved in her being vulnerable were her recent divorce and resulting relocation to a new state. In a new state and still healing from her marital problems, Alice's support system of family and close friends, were no longer a part of her immediate community. Alice had become increasingly emotionally fragile because of the steady escalation of the bullying and for Alice, the final incident of her being set-up to make a potential medication error by one of her perpetrators, made her feel like she had no way out of the situation. Alice left work with the plan to harm herself.

Evidence of Alice's initial contemplation of self-harm was her stopping on the small bridge and viewing the river below. After the final incident with a perpetrator at work and an interaction with the nurse manager that brought no resolution to the situation, Alice decided to end her life. Actual evidence of Alice's decision to end her life was her sudden ability to sleep without disruption, eat and enjoy a meal, have renewed energy to clean her apartment, and spend time with a friend laughing and enjoying the moment. All of the latter had been disrupted secondary to the stress Alice experienced from the workplace bullying.

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The Unspoken Observations

Alice had worked at the hospital for over a year and the bullying had begun shortly after she was hired. It is likely that other nurses observed Alice being bullied in the workplace. However, no one intervened.

Nurses and Suicide

Suicide is when a person decides to end his or her own life. Rates of suicide vary considerably with regard to ethnicity, age, religion, countries in which persons reside, and sex. In 2015, suicide deaths worldwide were 1.4%, and suicide was determined to be the seventeenth cause of death (WHO, 2018). For persons aged 15 to 29 years of age, suicide is the second leading cause of death globally. Approximately 800,000 people die each year related to suicide. The World Health Organization (2018), in examination of indicators for adult suicide, noted that for every successful suicide, there are about 20 self-harm attempts.

Rates and frequency of suicide were trended by occupation. The determination of rates of suicide were calculated by age and sex. According to McIntosh et al. (2016), persons working in the fishing industries, forestry, and farming were at the highest risk for suicide. The overall suicide rate for this group was 84.5 per 100,000 population and 90.5 males. For females, protective service occupations had the highest risk for suicide at 14.1. Library, training, and education had the lowest rates of suicide at 7.5.

A United Kingdom study performed in England over a period of five years; 2011 to 2015, examined occupation, gender, and age in relation to suicide. Results indicated that males within health professions, had a lower risk of suicide (16% lower risk, with a 37% lowered risk for males that were identified as medical practitioners). However, females in health professions risk for suicide was 24% higher than the female national average. The occupation of nursing was the reason the suicide risks was 23% higher than the national average; female health professionals often chose poisoning as a means to end their lives (Windsor-Shellard, 2017).

A National Academy of Medicine (NAM) discussion paper written by Davidson, Mendis, Stuck, DeMichele, and Zisook (2018), examined the lack of information available in the literature on suicides within the nursing profession. The authors conducted an internet search on suicide by rates, year and occupation within the United States. Data examined occupations that provided services to the public. These are the following professions that data were found on during the internet search: military officer (combat infantry closed to women- 37.2/100,000; combat infantry, engineer never deployed and closed to women- 41.2/100,000; combat support medical- 18.5/100,000, all data from 2004-2009), police officer (108 per year, 2016), physician (300 to 400 per year, data from 2015 to 2016), and educator (63 per year, data from 2011). No data were found on nurses.

There are approximately 3.4 million practicing nurses within the United States (ANA, 2017). Statistically, hospitals tend to trend data regarding nurses such as, injuries sustained on the job (worker's compensation), turnover in the hiring of nurses, and stress and burnout risks within the profession of nursing. However, when a nurse self-injures and ultimately commits suicide, none of these data are available by health care facilities. According to Davidson et al. (2018), for nurses that commit suicide, whispers of their death are heard among colleagues and no data to interpret the potential meaning of their loss of life, is known.

Nursing is a profession of caring whereby relationships are developed daily among colleagues, patients' families, and patients. The nurse regularly interfaces between varieties of different disciplines. Nurses must daily meet the needs of patients and the expectations of healthcare systems, while coping

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with deaths of patients and peers they have grown close to. Nurses may also be attempting to thrive in work situations where they have had to cope with the criticism of other nurses, resulting in low self-esteem and disempowerment.

Suicide risks for nurses are similar to those of the public (CDC, 2018). For example, nurses that have a mental (or physical) illness may be at risk for self-harm during periods of exacerbation of symptoms and stress. Also, if a nurse has a history of addiction to drugs or alcohol, these also put the nurse at risk for poor impulse control and self-harm. Nurses that have a history of a relative that successfully committed suicide are also at risk for self-harm as well. Of greater concern for nurses that are suicidal is their clinical knowledge, skills, and accessibility to lethal means to end their lives. For example, nurses have access to a variety of different drugs via pills, injections, sublingual, transdermal patches, and intravenous routes that can abruptly end one's life.

Because of the daily physical, emotional, and spiritual intensity of the nursing profession, nurses experiencing personal problems at home such as divorce, caring for an ill family member, or child-rearing issues, may feel overwhelmed. As the nurse begins to feel overwhelmed, hopelessness and helplessness may become central to their daily thought processes, leaving the nurse feeling depressed. It is when the nurse feels depressed, hopeless and helpless, the potential contemplation for a plan of suicide (suicidal ideation), may develop.

Nurses can be educated on how to recognize and help other nurses who may be at risk for self-harm. Becoming aware of potential warning signs for suicide is a proactive way of understanding how to intervene to keep nurses alive. The following are examples of warning signs:

1. The nurse is preoccupied with dying and death; discussing people who have died or perhaps examining websites or YouTube videos about death
2. The nurse no longer takes an interest in their appearance and may even appear disheveled at times
3. The nurse begins to take risks that are unwarranted such as jumping off a cliff to swim or bungee jumping
4. The nurse talks about having difficulty sleeping and a change in appetite
5. The nurse has mood lability or changes in their behavior that is atypical to how they usually behave
6. The nurse no longer has an interest in work, hobbies, spending time with friends socially, or if a student, disinterested in school
7. The nurse has a prior history of a self-harm attempt
8. The nurse has recently had several losses such as the death of a spouse, child, close friend, the end of an intimate relationship with a partner, or a divorce
9. The nurse has recently suffered significant material, property, or financial loss
10. The nurse begins to use drugs and alcohol by their report, to calm themselves, for sleep and/or to reduce their stress
11. The nurse begins to give away material items of great significance to them
12. The nurse occasionally talks about suicide or brings up self-harm out of the context of a conversation focused on a different topic
13. The nurse visits a funeral home to make arrangements for death or makes out a will
14. The nurse, who is normally very religious, stops going to church and reading their primary religious text (i.e. Torah, Bible, Quran)

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Verbalized Feelings of Suicide

Persons that are suicidal may sometimes voice their feelings, it is however important that someone listens. The subtle words of a person struggling with the decision to live or die can be misinterpreted or misunderstood. Below are statements that can be associated with a person contemplating life or death:

1. "I just can't sleep or eat anymore."
2. "This sadness just will not go away."
3. "No one pays attention to me anyway."
4. "No one listens to what I say."
5. "I just can't get my life together. It all feels out of control."
6. "I feel like I am always going to have pain in my life."
7. "I feel like no one cares for me or cares to be around me."
8. "Why would anyone think I'm smart?"
9. "I have felt depressed for a long time."
10. "It all seems so hopeless."
11. "I just feel so ambivalent about everything. I don't know how I am going to make this decision."
12. "I just cannot gather my thoughts."
13. "I am just in so much emotional and physical pain."
14. "I don't think there are any solutions. I just need to be left alone."
15. "This bullying has become too much for me to deal with. I feel like no one is ever going to help me."

Nurses Supporting Nurses

The American Nurses Association's Code of Ethics encourages collegiality among nurses. For nurses identifying and supporting colleagues at risk for self-harm, it is important to help affected nurses get help. Nurses experiencing the stress of bullying in addition to the normal stress of their job as a nurse and personal life stressors, may feel hopeless. Below are interventions that nurses can implement in helping other nurses who are contemplating suicide:

1. Discuss with the nurse that there are other alternatives
2. Immediately remove stockpiled pills, knives, guns, or other items that can be used by the nurse to harm themselves
3. Never promise to break a confidence or be sworn to secrecy
4. Never dare the nurse to harm themselves
5. Make yourself available for support
6. Show an interest in the nurse's health and well-being
7. Obtain assistance from agencies or a professional that has a specialization in suicide prevention and crisis intervention
8. Never come off as being judgmental toward your nurse colleague
9. Listen intently as they express their feelings. Do not judge them or offer your opinion

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10. Openly discuss suicide and suicidal ideation. Ask your nurse colleague directly whether they are having thoughts of self-harm
11. Ask your nurse colleague if they have a plan to harm themselves. If they answer yes, ask them to describe the plan
12. Never act surprised or shocked about the nurse's disclosure of, or attempt to self-harm. Keep the conversation(s) open

Getting the Suicidal Nurse Help

When exploring available services for nurses who are at risk for self-harm, it is important to be aware of crisis intervention and available professionals in the surrounding area that are convenient and easily accessible. There are crisis intervention services available in every state. For nurses, it may be helpful to begin with contacting a professional through their employer's employment assistance program (EAP). For nurses that do not desire any contact directly or indirectly related to their employment, the Federal Communications Commission (2017) offers the dialing of 2-1-1, as a means to obtain information on available human service agencies in their local area. The 2-1-1 number is accessible to over 270 million people within the United States, Puerto Rico, and the District of Columbia. For nurses unaware if 211 is available in their local area, go to the 211 website, www.211.org.

The National Suicide Prevention Lifeline (NSPL, 2018) is a 24 hour service offered seven days a week. The NSPL is available to provide emotional support to persons in crisis. All information is confidential. The NSPL also provides information on available services within person's immediate areas where they reside, for crisis intervention. For nurses assisting nurses that may be struggling with thoughts of suicide, the NSPL number is 1-800-273-Talk.

Nurse Workplace Bullying and Incivility and the HEAR Program

In exploring a potential program that can be used to assist nurses that may be at risk for self-harm secondary to workplace bullying and incivility, the Healer Education, Assessment and Referral (HEAR) program can be an option. The HEAR program is used to identify doctors that are at risk for self-harm by applying two approaches in helping physicians not harm themselves. The first approach uses educational presentations on the topics of depression, suicide, and burnout. The second provides an anonymous confidential web-based assessment and screening tool for physicians to take privately. The web-based assessment and screening tool is encrypted and is an Interactive Survey Program (ISP) developed specifically to identify physicians at risk for self-harm and depression (Davidson et al., 2018).

At the University of California San Diego Health, a university affiliated health care institution, before the year 2009, each year, a faculty member, medical student, or resident, committed suicide (Davidson et al., 2018). A survey to assess the well-being of physicians was developed and findings revealed significant drinking among faculty and residents at 6%, self-reported depression at 29%, and active suicidal ideation at the rate of 3% or higher (Reinhardt, Chavez, Jackson, & Mathews, 2005). A committee was developed to investigate the creation of a program that could help prevent suicide within this population. The committee, entitled the Physician Well-being Committee (PWBC), working closely with the American Foundation for Suicide Prevention (AFSP), and developed the HEAR program (formerly known as the Suicide Prevention and Depression Awareness Program).

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The HEAR program currently has helped to decrease the suicides at the University of California San Diego Health, from 1 suicide a year, to 1 suicide in 6 years. During the years 2009 to 2016, 502 medical faculty, 341 fellows, 90 residents, and 519 medical students, have completed the web-based survey. Approximately 63 met with a program counselor in person, 112 communicated online with a counselor online, and 9 spoke to a counselor on the telephone (Davidson, et al., 2018). The HEAR program is currently offered within 8 medical schools, over 60 medical teaching campuses, and continues to grow (Davidson, et al., 2018). The HEAR takes a proactive stance on suicide prevention.

Nurses, like physicians, work long hours, and have difficulty balancing their work and personal lives. Compassion fatigue, stress and burnout, workload demands, and one's own values and ethics conflicting with those of the health care organization, can also contribute to nurses feeling frustrated and depressed. Although nursing is a profession that requires collaboration with other health care disciplines and fellow nurse colleagues, nurses can feel isolated in their roles as healthcare professionals, especially when working within dysfunctional workplace cultures with bullying and lateral violence present.

Both nurses and physicians must have a keen eye for assessment and the ability to differentiate disease processes presenting in their patients with subtle symptomatology. Davidson et al. (2018) notes that persons who decide to become nurses, may have the characteristics of perfectionism and are compulsive with an acute attention to detail. While these traits can be beneficial, specifically to patients whom have placed their lives in the capable hands of these health professionals, these same traits increase the likelihood for stress.

Davidson et al. (2018) trialed the HEAR program with a participant group of nurses. Out of 2,475 nurses, 172 completed questionnaires. Upon completion of the questionnaires, data indicated that 98 (55%) nurses were at moderate risk for self-harm, 19 (11%) reported having previously attempted to harm themselves, and 12 (7%) had active thoughts or made actions to self-harm. Seventeen of these nurses agreed to receive help via a referral, for mental health treatment and 44 (26%) received either verbal or in-person counseling services. Based upon the data, nurses were found to have benefited from the HEAR program, and proactive screening for suicide is an effective means of identifying nurses at risk for self-harm.

RECOMMENDATIONS

Given the successful trial of the HEAR program with nurses, it may be beneficial for hospitals and other healthcare facilities to consider adopting this program for both nurses and physicians to promote healthy work environments. This program can help prevent self-harm with these vulnerable health professions. The HEAR program may help screen nurses whom are victims of workplace bullying. Because nurses experiencing bullying and incivility can have depression, stress, and anxiety, in addition to physiological symptoms, use of HEAR program within health care institutions may help identify these nurses early. By identifying nurses at risk for self-harm related to workplace incivility and bullying, nurses can be provided emotional support before suicide becomes an irreversible option.

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Putting Yourself First

It is important that nurses put themselves first when it comes to coping and healing from experiences of bullying. Nurses who decide to place all of their energies into work solely, may feel emotionally empty and have difficulty managing frustrations related to their own victimization. For nurses experiencing uncivil conduct within the work environment, the ability to distance from the actual workplace and focus on the completion of work during actual work hours, can be healthy. Setting boundaries around self-care and the protection of one's mental and physical health, can be beneficial for affected nurses in the preservation of physiological and psychological homeostasis.

Appendix 2 contains activities that further explore job-related stress in relation to workplace bullying. Self-care and the importance of nurses being aware of suicide risks and prevention are discussed. Suicide resource support for nurses and their affected colleagues, are also provided.

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Figure 2. Woman Untitled 2



APPENDIX

Exploration Activities

Directions: The purpose of the *Exploration Activities* are to encourage reflection on the issue of uncivil conduct in nursing by recording one's feelings about the act of incivility. Please answer the questions or statements independently or within a group for discussion.

In your opinion, should health care facilities be more in-tuned to the problem of incivility within the profession of nursing?

_____

Have you experienced job-related stress because of your interactions with an uncivil co-worker?

_____

Are you currently experiencing job-related burnout?

_____

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Do you plan to leave a job that you have enjoyed in the past, because of your experience with incivility?

_____

Do you feel that your decision to resign from a job that you enjoy because of a bully, is the wise choice to make at this time? If yes, why?

_____

If you are currently being bullied in the workplace, have you disclosed to anyone what is happening to you and how it makes you feel?

_____

Do you lose sleep at night replaying thoughts in your head regarding demeaning or stressful interactions you have had with someone that is intentionally bullying you at work?

_____

Have you suffered headaches or stomach discomfort the moment you get to work in anticipation of a stressful day working with a co-worker that is unnecessarily rude or negative toward you?

_____

Do you replay conversations of the uncivil behaviors of the person(s) whom is bullying you at work when you are driving home from work or when you are at home?

_____

Have you spent valuable time with family and friends discussing the stress you are experiencing at work because of a bully?

_____

Are you ready to disempower the negative effects that you have permitted the perpetrator(s) to have in your life? _____
_____

_____

Recognition that a bully exists solely because of their own insecurities, can lead to healing. Do you honestly feel that your bully is confident, or that their uncivil conduct is likely related to their own poor self-esteem and tendency to compare themselves to others?

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_____
_____
_____
_____
_____

Have you ever contemplated self-harm? If your answer is yes, it is important that you seek help. The decision to live is made when the realization that emotional pain and crises in life do not last forever. Dial 1-800-273-TALK, the National Suicide Prevention Lifeline for help.

_____
_____

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Chapter 69
Medical Students' Quest Towards the Long White Coat:
Impact on Mental Health and Well-Being

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ABSTRACT

Every year across the globe, thousands of students begin the quest towards becoming a medical doctor and donning a long white coat. Global research indicates that after beginning medical education, medical students' mental health and well-being dramatically declines. The loss of well-being continues into the residency and practice of medicine. The aim of this chapter is to broadly examine the pressures unique to medical students within the context of medical education training, higher education, and the general population. A call for medical education to adopt innovative policy, plans, and administrative and curricular changes designed to foster a culture conducive to the long-term positive mental health and well-being of medical students during training and into the internship and long-term practice of medicine concludes the chapter.

INTRODUCTION

The 'long white coat' is the symbol of the medical profession and universally worn by physicians (Lippman, 2016). Patients, physicians themselves, medical and health professionals, and the community at large maintain some idea of what it represents. Each year across the world, new medical students slip on a short white coat and begin what the author terms a quest towards the achievement of wearing a long white coat, symbolising to everyone the successful completion of training at the undergraduate medical education level, followed by an internship and residency leading to practice as a doctor. Along the way, evidence-based research over the past eight decades (Rotenstein et al., 2016; Strecker, 1936) has revealed that the prevalence of stress, anxiety, and depression among medical students is higher than the general population (McManus et al., 2009).

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Studies highlight medical students' mental health deterioration over time (Slavin, 2016; Wasson et al., 2016). Clearly, it has been established that the pressures of pursuing a medical degree have a negative impact upon some medical students' mental health and well-being. The problem is considered to have reached an epidemic level (Gunderman, 2016; Hafferty, 1998; Mousa et al., 2016; Slavin, 2016). Given what is known about the academic competencies and personality traits necessary for students to succeed in medical education (Abbiati et al., 2016; Gunderman, 2016; Rotenstein et al., 2016), this chapter offers a brief examination through five general questions of the problems, issues, and controversies contributing to the persistence of the crisis regarding student mental health and well-being during medical school.

- Who are medical students?
- What is the meaning of mental health and well-being and the significance of the long white coat?
- Globally, what pressures contribute to college students' mental health crises?
- What is medical student life like, and what pressures encountered during medical education negatively impact mental health and well-being?
- How can the culture of medicine and medical education create policy, planning, and administrative and curricular innovations to improve the mental health and well-being of future physicians?

BACKGROUND

Who Are Medical Students?

Across the globe, medical students generally have attained an undergraduate degree at a university or college followed by a medical programme of study of 4 to 5 years of medical school (GKEN, 2009). Upon completion of the medical school curriculum, which can include a couple of years of classroom instruction followed by another 2 years of practical experiences, the student is awarded a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree. Graduation from medical school is followed by the residency, with the length of time and training varying according to the chosen speciality. Clinical speciality training can be as little as 3 years and up to 8 years and culminates with board certification. In the United States, medical school training includes a period of 10 to 16 years of higher education, and postgraduate training defines the pathway to becoming a doctor (American Medical Association, 2014).

Medical Student Characteristics

There is current debate on which personal competencies are important for students entering medical school (Abbiati et al., 2016) and which of these characteristics could predict future success as caring, efficient, professional, and empathic doctors (Koenig et al., 2013; Mahon et al., 2013). While the academic requirements necessary to handle the rigour of medical education training are well documented (Monroe et al., 2013; Povis, 2015; Richardson et al., 2013) and include standardised examinations such as the Medical School Admission Test (MCAT), high school GPA, and undergraduate GPA, how to assess the personality characteristics for handling stress, motivation, and learning traits is not a standard process.

Although there is no single answer to the question of what it takes to be a successful medical student, medical school admissions website list many of the following characteristics deemed desired and essential for students to be successful:

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- Strong academic background. Students must possess knowledge of the basic scientific model, biology, and possess scores from college grades and medical school admissions tests indicating the potential to succeed.
- Time management skills. The daily schedule of attending classes, labs, and related requirements is incredibly time-consuming in addition to the long hours of study. These activities pull students in many directions at once, and the ability to prioritise, plan, and stick to a schedule is vital.
- Personal motivation and ambition. Students must be able to persist and persevere through the long and exhausting routines of medical education.
- Interpersonal skills. Students must demonstrate the ability to collaborate with peers, faculty, and staff and to work with healthcare teams. Oral and written communication skills are needed to share information and to convey empathy.
- Professional conduct. This is assessed by personal integrity, honesty, and ethical behaviour. Students must be aware of their own strengths and weaknesses and know when to ask for help. Owning prior experiences where compassion was evident and a commitment to improving the human condition are essential components of professional conduct.
- Genuine interest. This is the ability to delay gratification in social and personal areas of life in order to put in the long hours of work necessary to learn volumes of information. A love of the material and a sense of curiosity are needed to sustain the difficult and sometimes overwhelming challenges encountered.
- Stress management skills. Stress in medical school is a constant. An essential quality for navigating the process is students' abilities to take care of themselves when being intellectually pushed to their limits while being deprived of sleep and exercise. The ability to ask for help is crucial. Psychological resilience demonstrated through emotional stability, coping skills, maturity, an ability to endure hardship and sacrifice, and good judgement are fundamental skills.

In the United States, Belgium, and Canada, admissions departments have added strategies to evaluate personality traits of perspective students by use of the personal statement, letters of recommendation, involvement in extracurricular activities, on-campus interviews, and multiple mini-interviews. Situational judgement tests as well as psychological tests (Abbiati et al., 2016) are also used. Research conducted by Doherty and Nugent (2011) acknowledged that certain personality characteristics influence both medical students' and doctors' performance and that the personality trait recognised as conscientiousness has been found to be a significant predictor of performance in medical school. However, in the same study, the authors noted that the relationship between personality and performance becomes increasingly significant as learners advance through medical training. Other personality characteristics such as sociability (i.e., extraversion, openness, self-esteem, perfectionism, and neuroticism) can impact the mental health and well-being of medical students. Povis (2015) noted that good selection of medical students is 'an unresolved challenge'.

What Is the Meaning of Mental Health and Well-Being and the Significance of the Long White Coat?

The pilgrimage to obtain admission to and graduate from a medical programme is exceptionally competitive, and it is not surprising that the stress associated with undertaking a medical degree poses a significant problem for some students (Adsett, 1968; Dyrbye & Shanafelt, 2011; Hutchins, 1964; Lancet,

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1980; McGuire, 1966; Strecker, Palmer, & Braceland, 1936). Furthermore, as recently as December 6, 2016, a major research study on medical students' mental health released in the *Journal of the American Medical Association* confirmed information about medical students' mental health and well-being known to the medical profession, but it was a shock to many worldwide. Specifically, the study pooled data from more than 195 individual studies of medical student depression and suicide totalling 129,000 medical students from 43 countries and found that 27% of medical students were depressed or had depressive symptoms, while 11% reported thoughts of suicide, and 15% had sought psychiatric care (Rotenstein, 2016). According to this study, the results support the contention that more research efforts are necessary to improve the mental health and well-being of medical students. Specifically, the report stated, 'The overall prevalence of depressive symptoms among medical students in this study was higher than that reported in the general population, which underscores the need for effective preventive efforts and increased access to care for medical students.'

While some studies report the high incidence of medical student and physician suicide, others highlight the deterioration in mental health of medical students over time and attribute its cause to the outcome of stress related to poorer academic performance, substance abuse, eating disorders, decline in personal self-care, and loss of self-confidence in addition to myriad distress symptoms and behaviours such as competitiveness, preparing for examinations, and hidden curriculum issues (Doja et al., 2016; Williams, 2016).

These findings from evidence-based reports on documented medical student distress to the point of decline in this population's ability to embody humanistic qualities and empathy (Schwenk et al., 2010) is at odds with the primary goal of medical education to prepare and graduate knowledgeable, skilled, and professional physicians (Mayo Clinic, 2005). Similarly, other researchers suggested that, on a personal level, some aspects of medical education may have unintended consequences that negatively influence medical students' mental health and well-being (Association of American Medical Colleges, 2016; LCME, 2003; Noori et al., 2016).

In addition to the known stresses associated with medical training, an added pressure is assumed by many students because of the purported prestige and power family, friends, and society believe will be bestowed upon the medical student after graduation. To understand how the perception of wearing a long white coat is viewed in society in contrast to what it means in the health professions is helpful in conceptualising how its attainment may present another unintended negative stressor in the lives of medical students.

The Long White Coat

For centuries, a white coat has symbolised the medical doctor. The long white coat today demonstrates that a medical student has successfully navigated the pilgrimage from student to intern, to resident, and finally, to attending physician. All over the world, students don short white coats to symbolise the beginning of a career that embodies professionalism, caring, and trust. In the United States, a white-coat ceremony is intended to create a 'psychological, intellectual, and ethical contract for the profession and promotes empathy in the practice of medicine from the inception of a student medical education' (Columbia School of Physicians and Surgeons, 2017).

Furthermore, the tradition of wearing a white coat began in the early twentieth century, as doctors previously wore black, formal attire. It is considered that the white coat was adopted to enhance the credibility and image of doctors as learned scientists. At Columbia School of Physicians and Surgeons,

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the tradition of the white-coat ceremony began in 1993 and is practised at more than 130 schools of osteopathy and medicine in America and at four medical schools in Israel and other countries. Today, a long white coat is still a symbol of status in the medical field and communities around the globe. Studies revealed that getting through medical school is challenging in a variety of ways, and the effects of the stress on the mental health and well-being of medical students has been documented (Dyrbye et al., 2005; Rotenstein et al., 2016; Slavin, 2016; Wasson et al., 2016).

MENTAL HEALTH

The beginning of a student's medical training is the best point at which medical schools should explain that mental health conditions are common and that there are students who had mental health issues in the past who went on to successful residencies and practices. Additionally, medical schools ought to clearly explain why it is critical for admissions officers to know about students' health conditions prior to the start of the programme. Open and honest discussions between students and the medical school is necessary so that proactive plans can be implemented on a student-by-student basis as opposed to the reactive measures most medical programmes offer in response to medical student distress. A powerful teaching point for medical schools is to clearly explain what sound mental health and well-being look like as a benchmark for students to understand how to manage their own self-care, and later, their patients' care. The consequences of these disorders in terms of lost health are tremendous. A sound state of mental health and well-being are fundamental to our collective and individual ability as humans to think, interact with one another, earn a living, and enjoy life. On this basis, the promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities, and societies throughout the world.

The implications, then, for medical educators, medical students, their families, and society at large are imperative in understanding what is considered good mental health and well-being.

The constitution of the World Health Organisation ([WHO], 1969) notes, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. WHO (2016) defines mental health as a 'state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'. The WHO (2016) definition clarifies an understanding of what constitutes positive mental health, and these traits can serve as benchmarks in recognizing the following:

- Mental health is more than the absence of mental disorders.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- A range of socio-economic, biological, and environmental factors determines mental health.

According to WHO (2016), some factors to better understand the construct of mental health, as well as some related determinants of mental health, include the following:

- Multiple social, psychological, and biological factors determine a person's level of mental health at any point in time. For example, persistent socio-economic pressures are recognised risks to mental health for individuals and communities. The clearest evidence is associated with indicators of poverty, including low levels of education.

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- Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risk of violence, physical ill health, and human rights violations.
- Specific psychological and personality factors also make people vulnerable to mental disorders.
- Lastly, there are some biological causes of mental disorders, including genetic factors, that contribute to imbalances in chemicals in the brain.

Another report released by WHO (2017) indicated that the number of people living with depression increased by more than 18% between 2005 and 2015. These statistics are also found in a study completed by Global Burden of Disease (2015). A study by Baxter (2013) supports the findings that reveal an overall growth trend of the global population mental health deterioration as well as a proportionate increase in the age groups at which depression is more prevalent. Syntheses of the available epidemiological literature on the prevalence of depression and other common mental disorders have been undertaken as part of earlier iterations of the Global Burden of Disease study and are available through WHO (2015). Globally, the total number of people with depression was estimated to exceed 300 million in 2015. Nearly that number again suffers from a range of anxiety disorders. Since many people experience both depression and anxiety disorders simultaneously (comorbidity), it is inappropriate to simply add these two figures together to arrive at a total for common mental disorders.

Sound mental health is comprised of the emotional resilience that allows us to enjoy life; survive pain, disappointments, and sadness; and contribute to and engage productively in our communities and society. There is a personal sense of self-worth as well as the same in others.

WELL-BEING

There are many documented definitions and models of well-being. In order for administrators, faculty, staff, medical professionals, families, and medical students to embrace the idea of a multidisciplinary approach to proactive care for distressed students, it is necessary to establish a common ground for understanding what well-being entails. In the 2017 book, *Attending: Medicine, Mindfulness, and Humanity*, Ronald Epstein addresses the meaning of well-being by considering the question: 'What is well-being, anyway?'

There is no universal consensus on what constitutes well-being. The foundations of human well-being may be discussed in terms of sustainability of the environment and human spirit. Yet there is no universally accepted definition of sustainability. Despite this lack, maintaining and fortifying the human foundations of well-being is an everyday challenge. The foundations of human well-being are freedom, self-determination, intimacy with another, a social community, protection from the elements, food, water, health, entertainment, accumulation of things of value to promote human well-being, knowledge and opportunity to prosper, and opportunity to use one's talents. These foundations generally are linked to the culture of a community—a tribe or government (Vachon, 2012).

Epstein (2017) noted that when people have a deep sense of meaning and fulfilment, attainment of superficial achievements tends to be less important and may actually serve as distractions. On the other hand, people with a 'sense of purpose, satisfaction, joy and meaning' experience an intrinsic sense of fulfilment, and it is this deeper kind of 'well-being' worth pursuing (Epstein, 2017, p. 168). Another definition of well-being is based upon the 12 pillars of well-being created by Rick Hanson and used in the Foundations of Well-Being Program by applying what Hanson refers to as the four sources of

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well-being—recognising, resourcing, programme, and relating—to three fundamental needs of safety, satisfaction, and connection. The model provides a comprehensive strategy for understanding and applying self-care techniques to improve the quality of life. Other important definitions of well-being are offered by organisations such as the Association of American Medical Colleges (2016), who, in response to the crisis of mental health concerns amongst its professionals and students, launched a new Web site on well-being in academic medicine.

A recent study by the Public Research Bureau (2015) defined well-being as:

[H]aving an objective dimension—by determining whether an individual's basic needs for food, shelter, economic security, social relationships, and health care are being met.

Most researchers have examined two main aspects of subjective well-being as a dimension of well-being and found that because these two measures capture different aspects of well-being, using them together can provide a rich picture of life satisfaction and quality. A third type of subjective well-being, known as *eudaimonic* well-being, measures an individual's sense that his or her life has meaning and purpose (Deci & Ryan, 2008). Although aspects of this measure overlap with the other two, it is distinct in that it is based upon an understanding that people are motivated by factors beyond their own personal happiness or satisfaction (National Research Council, 2013).

A Centres for Disease Control and Prevention (2016) concept paper offers this definition of well-being: 'Wellbeing as judging life positively and feeling good'. From this perspective, the ideal of well-being integrates mental health (mind) and physical health (body), resulting in a more holistic approach to health promotion and disease prevention (Dunn, 1973). Some researchers using experimental, longitudinal, and cross-sectional studies found that well-being is associated with factors in the social and physical environment, with numerous health-, job-, family-, and economically related benefits, such as social connectedness, mental and physical illness, longevity, self-perceived health, healthy behaviours, and productivity (Lyubomirsky et al., 2005). Higher levels of well-being are associated with decreased risk of disease, illness, and injury; better immune functioning; speedier recovery; and increased longevity. Some researchers purport the view that positive emotions—central components of well-being—are not merely the opposite of negative emotions but are independent dimensions of mental health that can and should be fostered (Bradburn, 1969; Dunn, 1973).

Other research has noted that a substantial proportion of the variance in well-being can be attributed to heritable factors (Barry, 2007; Lykken & Tellegen, 1996) and that environmental factors play an equally, if not more, important role (Diener et al., 2006; Frey & Stutzer, 2002). The bottom line in considering well-being is the idea that a good state of mental well-being is possible, although an individual might be diagnosed with mental illness. Another way of thinking about mental health and well-being is to examine how it relates to the concept of wellness. The founder of the National Wellness Institute (NWI), Bill Hetter (1996), developed a six-dimension wellness model that has proven to be effective in the helping professions. This holistic model focuses on the following six aspects of life related to wellness:

- **Occupational Health:** At least two different focus areas contribute to occupational wellness. The first is creating a healthy work environment that can help to reduce stress, such as staying hydrated at work and staying active in the office. The second area focuses on feeling fulfilled. This means the self-recognition of the importance of work in which one is engaged as well as holding the perception that one's career is fulfilling.

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- **Emotional Health:** The ability to balance the different priorities in life contributes to emotional health. Examples include balancing work, volunteering, family, and downtime. Being emotionally healthy means being in control of one's emotions and a general feeling of good well-being.
- **Intellectual Health:** Learning new job skills, vocabulary, life skills, games, or fun habits are all ways to enhance intellectual health. The opportunity to learn new things is an important factor in intellectual health.
- **Social Health:** This involves creating and maintaining healthy relationships. These relationships can help build a strong support system. In today's society, social health can also encompass cultural health—another common wellness dimension.
- **Physical Health:** This includes everything from physical activity and nutrition to hydration and even illness. How a person's body physically functions entails physical health.
- **Spiritual Health:** This can be closely associated with emotional health. Some medical schools attempt to address emotional well-being through activities such as meditation, yoga, and mindfulness training. Spiritual health is generally associated with a range of connectedness, which in turn provides benefits for one's well-being.

According the National Wellness Institute (1996). 'Wellness is an active process through which people become aware of, and make choices toward, a more successful existence'. The following three questions were devised by the National Wellness Institute to help individuals and organisations assess the degree to which wellness is incorporated into a particular approach or programme:

- Does this help people achieve their full potential?
- Does this recognise and address the whole person (multidimensional approach)?
- Does this affirm and mobilise peoples' positive qualities and strengths?

Supporting Hetter's (1996) wellness model, the Centres for Diseases Control and Prevention (2016) suggest that 'Wellness focuses on improving how one's body works rather than meditating or reflecting on a current state of being'. This definition of wellness places the focus on progress. This type of thinking can be useful in helping medical students create and maintain small healthy habits that amount to a complete wellness.

Well-Being and Wellness: Alike or Different?

Well-being and wellness are related concepts. Well-being is associated with numerous health, job, family, and economically related benefits. For example, higher levels of well-being are associated with decreased risk of disease, illness, and injury; better immune functioning; speedier recovery; and increased longevity (Pressman, 2005). Individuals with high levels of well-being are more productive at work and are more likely to contribute to their communities (Frey, 2002; Tov, 2008).

Well-being is a holistic state of being. It is an overall positive existence that includes being emotionally, spiritually, socially, and mentally grounded. A positive state of well-being is characterised by overall contentment and balance in one's life. To ensure a holistic approach to helping medical students cope with the pressures of medical education, concepts of mental health, well-being, and wellness are useful constructs from which the question becomes less about what the problem is and more about promoting

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high levels of mental health, something research has proven is associated with productivity, increased learning, prosocial behaviour, and positive social connections (Diener, 2009; Herrman, 2005).

Ultimately, the author contends that mental health is complex. Having a common ground from which an understanding of what is meant by mental health, well-being, and wellness will go a long way in helping everyone concerned about the deteriorating mental health and well-being of medical students to contribute to the prevention of mental health conditions in an open and honest environment. Students will have different needs and variance in their experience of mental health problems, including how they choose to think about their issues and whether they want to share their difficulties. Therefore, keeping in mind that mental illness or mental health difficulties can beset students at any point in the academic career is essential. All mental health problems are not directly related to the stressors and pressures of medical education. Slavin (2016) called for medical education professionals to recognise that the 'responsibility for student well-being should not be limited to one office and one administrator; student wellness must be everyone's concern'.

ISSUES, CONTROVERSIES, AND PROBLEMS

Globally, What Pressures Contribute to College Students' Mental Health Crises?

University and related organisations worldwide are grappling with many of the same pressures to manage the growing crisis of college students' mental health and well-being. A global scan of the literature in higher education associated with mental health problems and mental illnesses reveals a problem of great magnitude.

Kadison and Digeronimo (2004) noted that the mental health of university students in the United States has suggested that there is a crisis in mental healthcare in colleges. Research conducted by the National Alliance on Mental Illness (2017) on mental health on college campuses shows that the top five mental health issues facing students included depression, anxiety, suicide, eating disorders, and addiction. Other statistics noted from the same study showed the following:

- One in four college students has a diagnoseable illness.
- Forty per cent of college students do not seek help.
- Eighty per cent of college students feel overwhelmed by their responsibilities.
- Fifty per cent of college students have been so anxious they struggled in school.

Mascaskill (2012) found that the rates of mental illness in students equalled those of the general population, but only 5.1% were currently receiving treatment. Second-year students reported the most significant increases in psychiatric symptoms (Maunder et al., 2010). In their work on mental health problems and help-seeking behaviour among college students, Hunt and Eisenberg (2010) summarised much of the current literature on the prevalence of mental health problems in college-age students. The key findings when compared to the mental health state of nonattending college peers include the following:

- A lower prevalence of drug use disorders and nicotine use,
- A higher prevalence of alcohol use disorders,

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- Approximately the same overall 12-month prevalence of mental disorders.

A summary of the scope and prevalence of data examined from the Centre for Collegiate Mental Health Report (2010) confirms that 'There is a general consensus amongst colleges and university counselling centres that the prevalence and severity of college student mental health is on the rise' (p. 16). Canada, the United Kingdom, and Australia were amongst the leading countries noted as having a strong interest in the mental health of youth, including college and university students. Adlaf et al. (2004) cited results from the Canadian Campus Survey that described the prevalence of mental health problems among Canadian undergraduate students. Four key findings from the survey indicated that students seeking higher education were found to present mental health issues, hazardous and harmful drinking, alcohol and other drug use, and gambling.

In the United Kingdom, an increased awareness of the importance of mental health and well-being at the government level is evident in the 2011 publication, *No Health Without Mental Health: A Cross-Governmental Health Outcomes Strategy for People of All Ages*, which sets forth a framework for its mental health system to focus on individuals by combining efforts with the community at large to improve mental health and well-being and to promote mental well-being for all citizens. Similarly, Scotland's (2012) mental health strategy was created to integrate system-wide quality for people with mental health issues. Wales's 10-year plan, *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales* (Wales, 2010), demonstrates the international commitment to improving the mental health and well-being of citizens at large.

Factors contributing to the increase in students presenting with mental health issues are linked to the findings in the literature on mental health generally. For discussion purposes in this chapter, these findings are organised into three broad areas: general societal pressures, pressures associated with higher education settings, and pre-existing mental health issues.

General Societal Pressures

Support for the contention that anxiety and depression are a possible source of the mental health distress seen around the world in higher education settings is based upon recent statistics from WHO (2017), indicating that more than 350 million people in the world suffer from depression and related disorders. It can be said that today's students are living in an age of anxiety, and depression reports similar to WHO's statistics indicate clear trends in the increase of depression. Depression is a common mental disorder—it is one of the main causes of disability worldwide—and more women are affected than men. Specifically, in the WHO European region, statistics show that if anxiety and depression were combined, then 4 out of 15 people are affected by these mental health and related disorders.

Studies show that the rates of depression in America have risen dramatically in the past 50 years. Anxiety disorders are the most common mental illnesses in the United States, affecting 40 million adults age 18 and older, or 18% of the population (National Institute of Mental Health). Nearly half of those diagnosed with depression are also diagnosed with an anxiety disorder. It is not uncommon for a person with an anxiety disorder to also suffer from depression or vice versa (Anxiety and Depression Association of America, 2016).

A possible explanation from the data regarding the college student mental health crisis is the fact that mental health and well-being distress are a global phenomenon. Underlying this assumption, questions about what is causing the deterioration of mental health in society at large should be considered. The

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causes are speculative in nature, but some scholars in the area of mental health and well-being suggest that the current mental health crisis has been influenced by rapid social and academic changes over the past few decades. Some examples of critical areas of change have been observed in areas such as the following:

- Psychopharmacology and the increase of the disease-pill model of mental illness has skyrocketed over the past few decades, reflecting the use of medication to manage psychological symptoms (America's State of Mind, 2011). It is worrisome that an entire report is an inventory of pill usage for the treatment of psychological and behavioural problems.
- Disintegration of the traditional family structure has been viewed as a source of contention globally, as research documented many problems that stem from the unstable environment and lack of structure needed for children to build a secure base. Instances of divorce, 'modern families', and confusion of roles have been cited as an enigma to providing what some scholars consider necessary so that children get what they need the most: predictable family structures and stable, loving, and supportive homes.
- Loss of moral compass and purpose, according to Barry Schwartz in his book *Battle for Human Nature: Science, Morality, and Modern Life* (1987). His work offers a fascinating sociological explanation for the impact the emergence of science has had on society, both positively and negatively. In particular, Schwartz describes how religion has been de-emphasised and replaced by a focus on materialism and hedonism, both associated with lower levels of well-being. Furthermore, Schwartz contends that the displacement of religion in society opens a door for people to construct their own lives based upon their own moral decisions. As a result, people are fundamentally uncertain of what they believe and why. They lack a philosophy of life.
- Along the same lines, another insightful book that presents a view on the inability of today's young adults to ground their actions from a moral perspective is *Lost in Transition: The Dark Side of Emerging Adulthood* by Christian Smith, Kari Christoffersen, Hilary Davidson, and Patricia Snell Herzog (2011). One characteristic described is the confused state of purpose from which deep-seated problems may be created, such as depression, anxiety, and other mental illnesses. Students appear to be pursuing higher education to ensure long-term financial gain as opposed to developing a meaningful philosophy of life.

These examples must be viewed from a context of the larger societal values. It is important to bear in mind that the terminology *emerging adulthood* was coined in 2000 by Jeffrey Arnett to describe a whole additional period of development in the lifespan (18–37 years of age). It is attributed to the rise of the modern society and its complexities, thus requiring a longer period of development before functioning independently. This development is worth considering in respect to its impact on mental health and well-being.

Another possible issue impacting mental health and well-being is the fact that the economic upheaval worldwide in 2008 continues to wreak havoc for many people. The fallout of the economic depression is relevant to college-seeking youth, as more of them have to work to pay for college, fight the rising costs of attending an institution of choice, and live with the uncertainty of job prospects at the end of college. Mounting personal debt at the beginning of adulthood is overwhelming and discouraging, as unemployment or underemployment still pervades (FRB, 2003).

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Pressures Associated With Higher Education Settings

College was traditionally reserved for society's elite until several decades ago. Major strides have made higher education more accessible to a diverse population. As a result, through legal changes, accommodations and support for students with mental health difficulties are available as part of most campus services. However, the transition is extremely stressful, in particular for those students in the traditional age range. In a time of 'helicopter' and 'snowplough' parenting, some students are totally unprepared for the stressful environment and competitiveness encountered.

The significant social upheaval experienced by students seeking higher education is a concern because a major risk factor for affective mood disorders can result from a lack of social support, especially when coupled with major stressors (Kashani et al., 1994). The stress associated with the transition to university life adds additional risk factors (e.g., Bryde & Milburn, 1990; Chemers et al. 2001; Gall, 2000; Montgomery & Côté, 2003). This frequently involves living away from home for the first time, having to make new friends, handling finances, adjusting to new learning regimes, and creating a new identity as a student (Scanlon, Rowling, & Weber, 2010).

Academic expectation and performance factors are often a surprise for students. In particular, those in the traditional age group who have been accustomed to getting top grades in high school may be unprepared when faced with college-level academic performance. Consequently, a vicious cycle of stress associated with poor academic skills and unpreparedness for the rigours of the higher education environment can result in some students' failure in the face of greater pressure to succeed.

Other sources of major distress for students are associated with the spiralling cost of higher education, especially in the United States, where the rise in college fees and tuitions has outpaced the rate of inflation while funding for higher education has continued to be reduced. The financial burden experienced as a result of policy decisions directly impacts students' abilities to attend college without working. In many instances, students work beyond the recommended part-time 10–20 hours; instead, some are forced to work full time, thus resulting in delayed graduation. Other noteworthy areas of problems and issues that have increased include drug and alcohol abuse, sexual assault, gender problems, family and relationship problems, and grief.

Previous Mental Health Issues

Mental illness is more publicised today than it was in the past; yet, in many circles, stigma still follows the people with the problem and is avoided by those around them. The attitude towards mental illness remains a dynamic that requires massive education, awareness, access to care, and a system that fosters well-being rather than avoiding these problems. Mackean (2011) confirmed that students experience mental health challenges right at the period of development in which they are entering the higher education system:

- The years between 15 and 25 are a natural age for the onset of mental disorders, an age where young people are pursuing higher education.
- Pre-existing mental health issues are more prevalent amongst students pursuing higher education.
- The prevailing stigma toward mental illness forces students and families not to disclose pre-existing conditions due to the fear and shame attached to these struggles.

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The literature suggests that the failure of students and their families to disclose information about existing mental health difficulties during the recruitment and admission process creates another barrier at the onset of higher education pursuits. In addition to students' omission of mental health problems, a worrisome trend on many campuses is the inability of counselling departments to keep up with the demands for service from those who do seek help in a timely fashion.

There is a growing recognition that students with clinically recognised levels of mental difficulties are studying in larger numbers. It is important to note that some level of stress does not necessarily have to have a negative impact and can be stimulating. For all students, engaging in higher education can also make a positive contribution to mental well-being in that it contributes to the following:

- Provides a purposeful environment.
- Provides opportunities for personal and academic achievement that can lead to a fuller life, creating a sense of identity and increased self-esteem.
- Offers opportunities to build confidence, as new experiences provide the chance to manage a variety of demands.
- Extends through more diverse student bodies the chance to build new relationships.
- Provides an opportunity to make a contribution to a community while learning how to take care of oneself.

The evidence suggests that, with young people, early intervention can play a crucial role in outcome (Kosky & Hardy, 1992), so the task for universities is to make it easier for students to access specialist treatment by ensuring they provide adequately resourced services. Additionally, institutions need to help students capitalise on the positive mental health benefits of higher education while identifying and providing appropriate support to those who are more vulnerable to its pressures. Research on what causes pressures in students pursuing higher education holds many implications for medical education to benefit from the lessons learnt around the world in a variety of university and college settings.

Models of wellness to support students suffering with mental health issues require higher education institutions to promote self-agency, resilience, and independence in an academic environment that is not based upon a deficit model where only students who reach crisis points are offered support. Higher education institutions are not only seeking to improve the environment for students, faculty and staff, for the sake of students. By its nature, much of the core business of higher education means that student, faculty, and staff concerns are interrelated and interdependent.

The Healthy Universities Initiative (Healthy Universities Network, 2010) is a model for how higher education institutions can create holistic healthy settings for the support and management of mental health issues and problems. Healthy settings are physical and social settings, such as schools, workplaces, hospitals, and communities, that serve as supportive environments for health protection and health promotion activities (Yusoff et al., 2013)

Other lessons from higher education include the awareness that the response to mental ill health is the job of everyone in the institution. But it is imperative to remember that students often prefer to get help from those they know and trust—for example, family and friends. For mental well-being-related information to be effective, dissemination routes should encompass the whole institutional population.

Research on what causes pressures in higher education students holds many implications for medical education to benefit from the lessons learnt around the world in a variety of university and college settings. A conclusion drawn from research by Douce and Keeling (p. 6. 2014) reminds us that 'not all

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students who could benefit from mental or behavioural health services will come to the counselling centre today, or any day. Students may not recognise the need for or recognise the availability of services'.

The purpose of this literature scan was to explore the extent to which the crisis has been documented globally and why this crisis holds implications for medical education. The scan does not purport to be a depth-and-breadth review of the literature on this subject matter. Providing a connected culture of care will maximise learning and produce resilient and healthy world citizens.

What Is Medical Student Life Like, and What Pressures Encountered During Medical Education Negatively Impact Mental Health and Well-Being?

The lived experience of medical students involves a range of activities, pressures, and outcomes. In general, students perceive the medical profession as one that brings power and status. As early as the beginning of medical education, medical students experience feelings of omnipotence reflecting the role of physicians in society. However, at the same time, they face situations of pain, suffering, death, and social realities different from their own. Some students may experience an ambivalence of feeling satisfied coupled with the fears, demands, pressures, and insecurities of the medical profession. They consider that a medical school demands exclusive dedication, and indeed, they devote a large part of their time to it, to the detriment of other areas of their lives. When they compare themselves to other young people from other programmes, they feel that more is demanded from them. They also feel more stressed, more responsible, and less capable of managing their personal and financial lives. Considering these ambivalent experiences, students must learn to leave this 'mesh' and differentiate good from bad experiences in academic life. Thus, in the midst of this mix of sacrifice and renouncement, they also recognise rewards and satisfaction, leading to a sense of personal pride.

The fact that stress is cited as the single greatest impediment to academic achievement by both genders, with depression and anxiety ranked as the top reasons for the crisis in college student mental health distress, is significant. Similarly, issues of depression, stress, anxiety, and related tensions are common pressures experienced by some medical students during the years of medical education. To support this well-known situation, researchers from Singapore analysed 77 studies, examining nearly 63,000 medical students across the globe (Puthran et al., 2016). The results from this meta-analysis found that 28% of medical students are depressed and that 5.8% have considered suicide.

Distress in medical students is not just a first-world problem. The percentage of students with depression or depressive symptoms ranged from 20% in Europe to 31.8% in the Middle East. Medical students in North America had the second highest prevalence at 30.3%. Still, there were no statistically significant differences in depression by region, sex, or even between medical students and nonmedical students (Yusoff et al., 2013). Yusoff et al.'s study supports views that medical training is not an optimal environment for the psychological health of medical students.

It is important to note that the following discussion is a general overview of pressures associated with medical training and the fact that suicide, depression, anxiety, and related tensions appear to be the most prevalent problems experienced by medical students globally and that awareness of the cultural impact on students in different countries will vary. For example, in China, acceptance to medical school is not necessarily as prestigious as it is in the United States. Students with the highest scores pursue careers in computer science; for those whose examination scores are not high enough, medicine is the second career choice

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To understand the range of pressures medical students are exposed to, the author attempted to synthesise from a scan of the literature how these problems manifest into issues, problems, and even controversy during the pursuit of medical education. The discussion is organised into the following three broad categories: academic pressures, social and personal pressures, and medical school debt on medical students' mental health and well-being (American Medical Association, 2015; Claassen et al., 2016; Edwards & Zimet, 1976; Tempski et al. 2012).

Academic Pressures

- **Formal Curriculum Stressors:**

The academic pressures associated with obtaining a medical education exemplify a culture of high achievement, commitment, connection, and focus. However, the configuration of many medical education curricula into three distinct learning and teaching segments as denoted by a formal, informal, and hidden curriculum provides a systematic method of thinking about the particular types of stresses experienced by medical students.

The formal curriculum includes what is to be taught, while the informal curriculum may be defined by how teachers teach and how students and teachers interact. The most controversial area of a medical school culture is known as the hidden curriculum. Hafferty (1998) proposed that a set of influences that function at the organisational structure and culture of a medical school is deemed the hidden curriculum. However, characteristics of the hidden curriculum, such as a commonly held understanding of how to behave, what is really expected of students, and what issues or problems should not be taken on, is implicit in student interactions with administration, staff, and faculty. The controversial nature of the hidden curriculum still needs to be studied in respect to its impact on medical student distress.

Most medical students will admit to becoming stressed out or panicked about life in medical school on a fairly regular basis. The programme of study varies across medical schools around the world in the scope, sequence, and length of preparation. What is common, however, is the transitions that students experience as they progress from one stage of training to another—for example, first year versus third year, then internships followed by residencies requires adaption to new a transition.

Noteworthy pressures experienced by medical students may include some of the following stressors closely related to the formal and informal curriculum.

- **Colossal Information Overload:**

Students are shocked by the extraordinary amount of medical information to be memorised and applied at some point in the near future. For many students, the realization that it is impossible to remember every detail from the extensive medical information, as well as master it, can forge feelings of stress. The vast amount of information in medical school is overwhelming, and during the first half of the programme, many students drop out (Karpf, Perman, & Higdon, 2006; Lazin & Nuemann, 1991; Lorgren et al., 2006).

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- **Fear of Failing:**

The author informally discussed this topic with a third-year medical student who summed up just how distressing the underlying fear of failure can be for students beyond passing the medical school formal curriculum, boards, and other forms of evaluation along the pilgrimage towards becoming a physician: 'Just graduating is fine, but it does not matter if you do not match for residency'.

- **Peer Competition:**

Competitiveness among peers has been reported due to concerns related to continuing education in highly requested residency programmes (usually those with specialisation in areas of potentially better income). For many students, medical school is the first time they encounter equally smart, or perceived smarter, people. They deem them as threats, and this in turn might impact academic performance (Supe, 1998).

- **Mastering Medical Knowledge:**

The ability to not only learn a massive amount of information but also to attempt to master the material at a rapid pace can be a source of distress. This challenge is amplified for students with learning disabilities (Stewart et al., 1999). Additionally, students are faced with learning in an unstructured environment to prepare for the continuous high-stakes examinations at the end of each course and between transition years, such as the USMELE 1 or COMLEX 1, which determine academic advancement. The distress that may result from constant evaluation is also heightened because, as students rotate through clinical training, medical knowledge becomes more specialised, and rather than highlighting students' progress, deficiencies are amplified.

- **Bad Role Models**:

Unfortunately, it has been documented that medical school training is characterised by a decline in humanitarianism and empathy (Crandall et al., 1993; Woloschuk Harasym, 2004). & These traits are highly valued in the helping professions; yet, the apparent cynicism towards students by medical academic faculty, staff, and administrators appears for some to be a normal strategy for interacting with students. Statements such as 'Medical school is extremely rigorous', 'If students are not strong enough to handle the stress, then another career should be pursued', or just the dismay expressed towards students when additional help is needed can negatively impact students (Hafferty, 1998).

In a qualitative research study, Tempski et al. (2009) noted an insensitivity to students' needs and students' perceptions by insensitive faculty: 'Bad teachers and coordinators, and classes without a didactic approach worsen quality of life'. Much of medical student training involves performing in front of colleagues and peers. Students report extreme distress when faced with the negativity commonly observed during routine medical teaching and learning situations. Most medical students have a memory of a negative incident whereby, for example, 'pimping' resulted in a wrong response, and the resident insulted the student. The pain and distress associated with this teaching method—teaching by intimidation—has been reported as adversely affecting the mental health of students. The extent to which this type of teaching strategy is used in medical training is described in the book *How Doctors Think* by (Groopman, 2007),

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in which he explains that physicians are trained to always entertain the worst-case scenarios first in order not to miss important diagnoses. Instructors rely on the dynamic known as negativity bias and use it as a technique for pushing students to think critically. Unfortunately, negative experiences seem to have more influence than positive experiences. This is the thinking behind the continued use of the pimping teaching strategy, to the emotional demise of students (Vaish et al., 2008).

Personal and Social Pressures

- **Hidden and Informal Curriculum:** The pressures associated with the adjustment to the medical school environment extend beyond the stressors related to academic expectations and academic performance. Other sources of distress for many students, such as a deficit in hours of sleep, physical activity, lack of social interactions, and adapting to the myriad behaviours inherent in the informal and hidden curriculum of medical education, are problematic as well as controversial (Lempe, 2004; Parkernson et al., 1990; Tempski et al., 2009).

Students reported a variety of difficulties and crises during medical school (Tempski et al., 2012) that affected them personally and socially. According to Goldman, Shah, and Bernstein (2015), 'Medical training involves numerous risk factors for mental illness, such as role transition, decreased sleep, relocation resulting in fewer available support systems, and feelings of isolation'. Issues associated with the hidden and informal curriculum add to the personal burdens and internal struggles for students that include an inability to handle problems related to the bureaucratised medical school culture.

- **Bureaucratised Medical School Culture:** The organisational structure of many medical programmes is a source of contention for students, and in some instances, for staff and faculty. Specifically, the academic side of the medical programme is operated independently of the student affairs division, as each has its own responsibilities and budgets. Historically, the integration and collaboration between these two divisions remained separated. While this model seems effective, the resources allocated to each has a direct impact on the ability of the medical institution to provide a plethora of services that might be needed to support the mental health of students. For example, most dedicated funds are allocated to the academic side of the institution to support faculty salaries, research, and continuous improvements to the academic environment. The student affairs division that handles the counselling, learning support, and advising of students in academic, personal, and extracurricular activities is usually unable to meet student demands for help in a timely fashion. Additionally, students resist using many of the services offered by the student affairs division for fear that confidentiality might be compromised, thereby forcing a student to go outside the institution for help. Overall, the lack of coordination in meeting student needs between these two divisions is likely to be a barrier to students receiving timely support.
- **Informal Curriculum:** The messages students pick up from interactions with faculty, administrators, other students, and eventually, from residents and physicians appear to negatively influence and impact them. Medical students report being at the bottom of the medical system hierarchy, where they are often disrespected and subjected to abuse by allied health professionals and unsatisfied physicians, are unlikely to take proactive actions in self-defence. Adding to these stressors is the student's need to ensure strong evaluations and recommendations to advance to the next stage of medical training by making good impressions on supervisors.

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- **No Time to Be Sick:** Some students' mental and physical health is compromised because they have not engaged with a personal physician. Others ascribe to the 'hidden' messages collected in the hallways of medical schools, hospitals, and related environments. For example, some students reported a lack of care associated with their own health and well-being according to the harmful habits observed and adopted by teachers (Thislethwaite et al., 2010).

When it comes to mental health and well-being, students afraid of stigma resort to self-care and suffer silently. The hypocrisy endemic in the medical school culture, although being addressed, is far from a reactive disease approach rather than a preventive model. Such a model would advocate first for the health of students and doctors before giving them the responsibility of ensuring the health of society at large. Many reasons are reported for student lack of self-care in addition to problematic scheduling to allow for personal well checks and follow ups with a primary doctor. Finally, studies have shown that doctors self-manage, self-treat, and enter into hallway conversations about their own health needs (Cohen & Rhydderch, 2013). Where issues of ill health are minimised and resilience expected, medical students learn coping methods from the informal and hidden curriculum. Furthermore, students learn to self-manage illness early in the process of medical education, which increases during training, where access to drugs becomes more available.

- **Student Abuse:** Amongst medical students, the perception of being taken advantage of or abused is common and most noted during the clinical years. However, institutional abuse, such as racial discrimination and unfair grades, has been attributed to prolonged stress and anxiety, hostility, low self-esteem, and increased use of alcohol by students who were affected by abuse (Silver & Glicken, 1990). Verbal abuse is the most common stressor within this category of abuse and includes cases of pimping, which involves being humiliated in front of peers, residents, and staff and produces high levels of pressure. The severity of verbal abuse is not reported due to student perceptions of potential reprisals or repercussions on performance evaluations (Elnicki et al., 2002).
- **Gender and Race:** The syndrome known as the invisible white coat describes the behaviour of patients who assume that the student is a nurse even though a white coat is being worn. This issue is a double-edged sword for women of colour (Russo et al.2006; Swift, 2017). used data from a documented study to analyse gender differences in perceived pressures and distress in medical students. Their findings revealed that female students appeared to be at a higher risk for anxiety than male students. Related to the higher level of anxiety found in female students was peer competition compared to male students who reported more anxiety in regards to the long hours. The stress associated with gender and race adds a significant burden to medical students who have to deal with an additional source of stress.
- **General Personal Life Events:** Personal life events such as marriage have proven to have a positive impact on students' stress levels, although having children has proven more stressful for females while in medical school (Katz et al., 2000). Personal illness and death of a family member adds to distress. Greater study into the impact of family member deaths and the illness of peers on medical students is needed.
- **Forming Professional Identity:** Due to the variations in medical school structures, curriculum, missions, and values, many important facets of forming a professional identity are left to incidents and information gathered by medical students' observations, perceptions, and exposures during formal training. Sources of distress related to managing the transition, especially in the third year

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of medical education when students go from classroom and laboratory settings to rotations where decisions and first-time experiences in dealing with patients, presenting cases, dealing with death and suffering, or being present at an unexpected death causes students enormous distress, as most have had very limited training, if any, on how to handle these aspects of the profession. Student training is deficient in this area of the curriculum. The informal curriculum conveys powerful messages about professional norms, values, and character. The unfortunate models of cynicism and unethical behaviour witnessed by students in the clinical setting is often shocking and contradicts the lessons taught in medical school (formal/structured curriculum) versus those learnt in practice. Students are left with conflicted emotions and an ethical conflict between doing what is right or following the examples of seasoned practitioners to whom they rely upon for recommendations to advance. As one third-year medical student noted, finding a balance between being assertive and being an annoying 'gunner' is difficult.

- **Social Pressures:** Educational and clinical demands leave little time for the health and social activities that promote well-being. Many medical schools have buddy schemes and a wide range of societies to help combat isolation; yet, studying medicine can still seem exceedingly lonely. Medical students' schedules are different, which can be a barrier to establishing or maintaining relationships. Some students may not reach the typical milestones of same-aged peers because instead of thinking about buying a house or starting a family, the focus is on studying and working towards the next phase of the pilgrimage towards obtaining a long white coat.

There are varying attributes of social pressures experienced or perceived by medical students, and although not a mental disorder, the issue of the 'imposter syndrome' may cause distress. The imposter syndrome is characterised by chronic feelings of self-doubt and fear of being discovered as an intellectual fraud. The personal expectation set by students once they announce a medical school career to family and friends may compound the problem of pressures. It behoves medical educators to reconsider facets of medical education (i.e., shame-based learning and overall teaching style) and to optimise the medical learning environment (Villwock et al., 2016).

- **Medical School Debt:** Financial debt is a key determinant that predisposes students to depression, as noted by Jenkins et al., (2008) who established a clear link between financial debt and poor mental health. The impact of debt on the mental health of medical students has not been studied to a great extent. However, in the first study of its kind, Walsemann et al. (2015) posed two important questions: 'What is the association between the amounts that students accrue during studies and their wellbeing post-graduation when they are between the ages of 25–31?' and 'What is the association between annual loan student borrowing and the mental wellbeing of currently enrolled students?' This is the first nationally known study in the United States that attempted to examine the effects of student loans on health. According to Walsemann et al., the possible impact of these high debts could influence other life decisions, such as occupational choices. This finding is already evident in the medical profession, where a study by Phillips et al. (2014) indicated that medical students are staying away from family medicine practice because the income and rate of debts owed are not panning out, thus a significant shortage in primary healthcare providers by 2025 is anticipated and will be a be a major issue for healthcare. While medical student debt is increasing, the effect of debt on student well-being and performance remains unclear (Morra et al., 2016).

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Having surveyed the types of pressures associated with the challenges and barriers confronting medical students, what lessons have been learnt, and what ought to be done to prevent medical student distress? The solutions and recommendations offered next result from the considerations of lessons students with similar challenges to mental health and wellbeing: college students, graduate and doctoral level learners.

SOLUTIONS AND RECOMMENDATIONS

How Can the Culture of Medicine and Medical Education Create Policy, Planning, and Administrative and Curricular Innovations to Improve the Mental Health and Well-Being of Future Physicians?

Currently, many of the proposed solutions to address student mental distress are externally designed and managed through changes in the resource allocation of the medical school, institutional policies, and evaluation activities that do not bear on the internal or intrinsic needs of future physicians. Although the hidden curriculum may hold convoluted messages of self-sacrifice that stop students from seeking help, there are solutions aimed at the prevention of common pressures associated with medical training at each major transition point in medical education designed to promote sound mental health and well-being. The following solutions and recommendations are general ideas that warrant further exploration and research:

1. A global network of curricular benchmarks and best practices to help students adapt to entry into medical education, thus preparing them for the huge academic requirements and fostering critical thinking and a realistic understanding of how to take care of themselves.
2. Specific strategies aimed at solutions for subpopulations of medical students who experienced other pressures within the medical school structure. Women, students with disabilities, and students from ethnically and culturally diverse backgrounds in many cases require more support in managing medical school challenges. All struggling students require opportunities for individualised support.
3. Train the trainers programmes designed to teach medical educators how to organise the massive amount of information deemed necessary for students to traverse the medical school system. Pedagogical training in teaching methods will provide a structure within the curriculum to avoid both faculty and student burnout. Research is needed to determine how medical faculty are deciding what, how much, and the rate which medical knowledge should be imparted to students. Collaborative teaching strategies, where two teachers are actually in a classroom at the same time as opposed to the singular approach used to deliver high volumes of information, are more appealing to students. The dynamics of co-teaching have been proven successful in other teaching institutions. Furthermore, the overemphasis on rote learning has been proven ineffective for long-term memorisation and understanding. Bloom's Taxonomy (Bloom 1956) exists as proof that teaching scientific concepts, critical thinking, and higher-order learning techniques whereby subject matter is interrelated contributes to long-term learning.
4. The focus on students' internal motivation when entering medical training where traits such as strong work ethic, altruism, and intrinsic motivation provide a basis for reducing the stress associated with the overreliance on GPA rankings. The success of future doctors as caring, compassionate,

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and competent physicians has to be based upon something other than GPA and high ratings on the board examinations as the strongest indicators for future success.

5. Stakeholders at the national, regional, and institutional levels must collaborate on how funding is to be implemented within the medical education structure to provide prevention education in the systems associated with training physicians. Funding is necessary to train the trainers and to increase staff in the student development and counselling areas so that students receive treatment immediately for problems encountered.
6. Common ground training for recruiters of prospective medical students beginning at the middle-school levels and into college.
7. Common ground information for families, spouses, and professionals close to medical students in layman's terms. Topics should include how to recognise change within the student and how to provide support for and information about what is generally being experienced by the student. The awareness that students have to learn a lot of information does not describe student daily lived experiences of attending lectures and learning massive amounts of material in addition to earlier immersion in hospital settings where they encounter life-and-death situations, sometimes before being academically prepared.
8. Common and realistic pre-entry training for medical school students that includes basic testing for pre-existing mental health problems, learning problems, and issues related to becoming ready to matriculate into the academic rigours associated with medical training. Similar processes are deemed necessary to prepare students to transition between classroom training, labs, early entrance into hospitals, and working with patients to managing the internship and residency experiences. Sharing known literature and best practices based upon practical knowledge of seasoned doctors can help students learn in advance how to prepare for transitions, thus preventing trial-and-error experiences.
9. Revamp the structure of medical education. Theories of how adults learn and lessons learnt from medical schools with best practices should be embraced. The culture of medicine warrants changes in the components of the formal, informal, and hidden curriculum; institutional policies; and culture of medical schools from academically driven agendas to development of physicians as complete people.

FUTURE RESEARCH DIRECTIONS

While new and innovative strategies designed to assist medical students with mental health issues include changing grading systems from letter grades to pass/fail, voluntary classes in mindfulness, and creation of wellness initiatives in many more medical educational institutions, future research is imminent. The following questions remain to be addressed:

- What is the best structure for medical education?
- How do medical students learn best?
- What is the best type of curriculum change requisite to ensure that medical education prepares students on a spectrum of well-being and wellness areas to extend into social, personal, financial, emotional, and physical well-being?

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- How can medical schools educate the public, prospective students, and their families about the rigours associated with medical training?
- How can students seek help without the stigma associated with mental illness impacting future internships, residencies, and job placements?
- How can the dollars and human resources in medical education be allocated beyond the academic side of the programmes to include proactive well-being student support services?

Finally, more research is needed from the perspective of the medical student on the pressures associated with medical school at each stage of training. Outside of medical student blogs, there is insufficient literature from the student perspective.

CONCLUSION

Medical school is supposed to be a time of personal and professional development. There is enough data to show that medical training leads to mental ill health in medical students and residents. The moment to re-engineer medical education is present, and all our lives depend upon drastic measures designed to help medical students navigate medical education with sound mental health and well-being.

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KEY TERMS AND DEFINITIONS

Graduate Medical Education (GME): The period after graduation from a medical education programme. Recognised by entry into an internship and residency period ranging from 3 or more years, depending upon the speciality area of study.

Healthy Universities: Institutions with initiatives designed to create holistic settings that incorporate many interrelated factors in the academic environment. These factors include academic, social, economic, and environmental areas that may impact the mental health of students.

Higher Education: Education provided by a college or university.

Medical Education: Education related to the training of being a medical doctor or physician. The process of obtaining a medical education generally begins after the completion of higher education at the bachelor and/or master's degree level. Across the world, training varies in academic requirements and programme lengths. Generally, medical education programmes include 4 years or more of undergraduate medical training. This programme of study is followed by what is known as graduate medical education and encompasses an internship, residency, and fellowship training. The residency and fellowship training periods vary according to specialities. Graduate medical education leads to licensure. Some countries, such as the United States, the United Kingdom, Canada, and Australia, have specific continuing medical education activities designed to help physicians increase the knowledge, skills, and professional performance necessary to stay current.

Medical School: The educational organisation providing a basic (undergraduate) programme in medicine. It is synonymous with medical faculty, medical college, medical academy, or medical university.

Mental Health Promotion: Improving the capacity of everyone to take control of their lives and to improve their mental health. At the community level, it involves public policy to enhance the personal skills and services necessary for achieving optimal mental health.

Mental Ill Health: A mental health problem can feel just as bad, or worse, than any other physical illness, only you cannot see it.

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Chapter 70
Deliberate Self-Harm and Suicide Ideology in Medical Students

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ABSTRACT

The risk of deliberate self-harm (DSH) and suicide ideology in medical students is a pertinent issue that has received a surge in attention over recent years. Medical students are at risk of normalisation of DSH and suicide ideology despite their mental health literacy levels and are still susceptible to the stigma of help-seeking for their mental wellbeing. This chapter will explore assessment, preventative and management strategies to improve education, awareness and ultimately reduce the rates of DSH and suicide risk. A comprehensive review of practices and techniques that medical training community and their family members could utilise to aid medical students to adequately and safety manage DSH and suicide ideology. This will assist in identifying crucial areas for future research to aid students, professionals, family and friends in supporting medical student health to optimise mental health overall wellbeing of medical students.

BACKGROUND

The risk of deliberate self-harm (DSH) and suicide ideology in medical students is a pertinent issue that has received a surge in attention over recent years (Wu et al., 2016, Rotenstein et al., 2016). Rates of suicide among general adolescents are increasing at staggering rates. This population of young adults

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are considered 'at risk' in 33% of countries around the world (Miletic, Lukovic, Ratkovic, Aleksic, & Grgurevic, 2014). Rotenstein et al. extracted suicidal prevalence data from 24 cross-sectional studies from 15 countries resulting in a pooled prevalence of suicidal ideation of 11.1% in medical students. Wu et al. conducted a cross-sectional study of over 4000 students from 22 Chinese medical universities, and found that prevalence of DSH was 9.6% over 12 months. It is, therefore, important for medical students, professionals, parents, and friends to understand the impact of DSH and suicide ideology on an academic and psychosocial level. Furthermore, because DSH and suicide ideology prevalence can be reduced with early intervention, it is all too important to know how to screen for early signs and symptoms as well as provide appropriate intervention (Downs et al., 2014).

Medical students are a unique population as they are learning about the organic and psychosocial impacts of mental health, including factors that may contribute to poor mental health, whilst being exposed to these exact factors. Stressors that are prominent in medical students include increased contact hours, high academic pressure, assessments, exposure to high-intensity workloads, high-performance expectations, strained social balance and workplace bullying (Chan, Batterham, Christensen, & Galletly, 2014; Osama et al., 2014; Wu et al., 2016). There are multiple factors contributing towards negative mental health sequelae among medical students and it can lead to undeniably anxious and stressful times during their academic and clinical career. These sequelae may involve more common psychiatric presentations such as anxiety and depression, to more formidable presentations such as DSH and suicidal ideology (Wege, Muth, Li, & Angerer, 2016).

Medical schools have an inherent requirement to produce safe working graduates and they must also ensure that students are primed to cope with stress, burnout, and failure. Addressing the negative mental health sequelae is therefore in the best interest of every medical school. Promoting and enhancing medical student well-being will be beneficial for each trainee throughout their career, with benefits in overall education, physician resilience, personal fulfilment, professionalism and of course patient care (Dunn, Iglewicz & Moutier, 2008).

DSH is most commonly associated with borderline personality disorder and is often associated with major depression, antisocial personality disorder, dissociative identity disorder, posttraumatic stress disorder, eating disorders, autism, developmental disabilities and Lesch-Nyhan syndrome (Stanley et al., 2010). At a molecular level, serotonergic and dopaminergic dysfunctions do not appear to be related to DSH, however, it has been demonstrated that those who self-harm have lower levels of CSF ß-endorphins and met-enkephalins, both of which are opioids involved in emotion-induced and physical pain analgesia (Stanley et al., 2010). This is an important distinguishing factor as serotonergic and dopaminergic dysfunctions are usually associated with suicidal behaviour and depression, whereas endogenous opioid deficiency plays a more prominent role in DSH without suicidal intent (Stanley et al., 2010). This relationship will be discussed further in the following sections.

For the purposes of addressing medical student stress, this chapter refers to medicine as traditional Western medicine, not inclusive of any alternative medicine fields.

DEFINING DELIBERATE SELF-HARM

Deliberate self-harm may seem to be a straightforward definition in and of itself, however, many more aspects must be considered, including the frequency and time-period that DSH may occur, the purpose or expectations by the individual and the associations that DSH may have with concurrent moods, feel-

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ings, and thoughts. This section will discuss various definitions of DSH, the types of self-harm and its relation to other mental health disorders.

The definition of deliberate self-harm has been argued in the scientific community without a resolute definition for many years. This phenomenon has also been known as self-harm, self-injurious behaviour, repeated self-injury, self-wounding, para suicide, self-mutilation, episodic and repetitive self-injury and autodestructive behaviour (Mangnall, 2008). Current literature has conflicting definitions including the intention to kill and intention to not kill, which convolutes the distinction of DSH from suicide ideology, as discussed later in this chapter. Based on the literature, DSH may be defined as a 'direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent and that occurs in the absence of psychoses and/or organic intellectual impairment' (Mangnall, 2008).

This definition addresses both cause and purpose of DSH and this is further expanded upon in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for diagnosis (See Figure 1) (Diagnostic and statistical manual of mental disorders, 2013). Key diagnostic features focus around repeated infliction of shallow yet painful injuries with a purpose to reduce negative emotions, such as tension, anxiety, self-reproach and/or to resolve an interpersonal difficulty though with an absence of suicidal intent. The individual may exhibit a behavioural pattern resembling an addiction or describe a compulsive nature due to an immediate sensation of relief during the self-harming process.

Figure 1. Proposed Criteria for Non-Suicidal Self-Injury
Source: Adapted from Diagnostic and Statistical Manual of Mental Disorders, 2013

NONSUICIDAL SELF-INJURY

Proposed Criteria

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, pain (e.g. cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e. there is no suicidal intent.)
NOTE: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behaviour that the individual knows, or has learned, is not likely to results in death.

B. The individual engages in the self-injurious behaviour with one or more of the following expectations :
   1. To obtain relief from a negative feeling or cognitive state
   2. To resolve an interpersonal difficulty
   3. To induce a positive feeling state

C. The intentional self-injury is associated with at least one of the following:
   1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalised distress, or self-criticism, occurring in the period immediately prior to self-injurious act.
   2. Prior to engaging in the act, a period of preoccupation with the intended behaviour that is difficult to control.
   3. Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behaviour is not socially sanctioned (e.g. body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E. The behaviour or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

F. The behaviour does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behaviour is not part of a pattern of repetitive stereotypes. The behaviour is not better explained by another mental disorder or medical condition (e.g. psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder.

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Self-harm may present in a multitude of ways and can be divided into two broad groups: self-injury and self-poisoning (Lilley et al., 2008). Self-injury most commonly presents by cutting oneself, whilst less commonly presenting as swallowing objects, putting objects inside the body, burning, self-bruising or breaking bones. On the other hand, self-poisoning involves overdosing with medicine(s), often over-the-counter medication or swallowing a poisonous substance (Lilley et al., 2008). It should be noted that there are no specifications as to whether the self-harming act is planned or unplanned and infrequent or frequent.

Unfortunately, the large majority of individuals who engage in self-harm do not seek clinical attention, although people who self-poison are most likely to seek professional medical assistance (Diagnostic and statistical manual of mental disorders, 2013; Lilley et al., 2008). It is hypothesised that the positive experiences gained by an individual who is self-harming may deter them from seeking treatment, whilst the absent suicidal intent is apparent in those who self-poison yet present to the emergency department (Diagnostic and statistical manual of mental disorders, 2013; Mangnall, 2008). These positive experiences may include a separation or disconnection from the individual's feelings or pain, and can develop as a method of coping with overwhelming situations or feelings.

DEFINING SUICIDE AND SUICIDE IDEOLOGY

The World Health Organisation defines suicide as the act of deliberately killing oneself. Suicidal ideology encompasses the contemplation of suicide, ranging from a detailed plan to a fleeting consideration. A suicide attempt is defined as a self-inflicted, potentially injurious behaviour with intent to die, however not resulting in death (Wasserman et. al. 2011). The DSM-5 further specifies a proposed criterion for Suicidal Behaviour Disorder, which makes a clear distinction from deliberate self-harm (See Figure 2).

Figure 2. Proposed criteria for Suicidal Behaviour Disorder
Source: Adapted from Diagnostic and statistical manual of mental disorders, 2013

SUICIDAL BEHAVIOUR DISORDER

Proposed Criteria

A. Within the last 24 months, the individual has made a suicide attempt.
   NOTE: A suicide attempt is a self-initiated sequence of behaviours by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. The 'time of initiation' is the time when a behaviour took place that involved applying a method
B. The act does not meet criteria for nonsuicidal self-injury – that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling or cognitive state or to achieve a positive mood state
C. The diagnosis is not applied to suicidal ideation or to preparatory acts.
D. The act was not initiated during a state of delirium or confusion.
E. The act was not undertaken solely for a political or religious objective

Specify if
- **Current:** Not more than 12 months since the last attempt.
- **In Early Remission:** 12-24 months since the last attempt.

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Suicidal behaviour can be categorised into violent and non-violent behaviours. For example, some violent behaviours include jumping from a life-threatening height and firearms, whilst non-violent behaviours may include overdosing with legal or illegal substances (Ajdacic-Gross, 2008). Suicidal behaviour can be associated with a wide variety of mental disorders, including bipolar disorder, major depressive disorder, schizophrenia, anxiety disorders and eating disorders to name a few (Diagnostic and statistical manual of mental disorders, 2013).

Wasserman et al. discuss suicide from the perspective of the Stress-Vulnerability model which explains that genetic make-up and acquired susceptibility both contribute to a person's predisposition or vulnerability to suicidal behaviour. This suicidal process involves an interaction of biological, psychological, environmental and situational factors. The vulnerability may be increased due to early traumatic life experiences, chronic illness, alcohol and drug use and environmental and social factors (Wasserman et al., 2011). The reasons for why people may attempt suicide include, though are not limited to, severe depression, impulsivity, psychosis, lack of help or social support and philosophical desire. Most importantly, many suicidal processes decline and subside by means of individual coping or treatment strategies (Wasserman et al., 2011).

THE RELATIONSHIP BETWEEN DELIBERATE SELF-HARM AND SUICIDE IDEOLOGY

Based on the definitions outlined thus far, the key distinction between deliberate self-harm and suicide ideology is that suicidal intent is absent in deliberate self-harm actions. Despite this difference, evidence suggests that those who engage in self-harm are at an increased risk of likelihood of attempting suicide (Wan, Y., Gao, R., Tao, X., Tao, F., & Hu, C., 2012; Whitlock et al., 2013). Whitlock et al. conducted a longitudinal study of 1466 students across five colleges in the United States and concluded that a history of deliberate self-harm among students significantly leads to concurrent or later suicide ideology. The risk of suicide ideology is usually predicted by the occurrence of >20-lifetime non-suicidal self-injurious incidents and by the history of mental health treatments. The act of self-harm has two important risk factors for suicide; the experience of emotional distress and the experience of self-inflicted pain/injury (Klonsky, May, & Glenn, 2013). This is particularly important because addressing the risk factors, protective factors, finding an appropriate method of screening and determining effective treatment should take consideration of the relation between DSH and suicide ideology.

EPIDEMIOLOGY OF DELIBERATE SELF-HARM AND SUICIDE IDEOLOGY AMONG MEDICAL STUDENTS

Deliberate self-harm and suicide ideology are increasingly common in young adolescents, with particular prevalence in medical students. This section will detail the epidemiology of DSH and suicide ideology amongst the general public and medical students.

According to the World Health Organisation, 'self-inflicted injury [defined as deliberate self-harm and suicide] is the fourth leading cause of death and sixth leading cause of morbidity and disability amongst people aged 15-44 years' around the world (Wu et al., 2016). This is evidently a serious public health concern, although, can be prevented with timely, evidence-based and often low-cost interventions (Wasserman et. al. 2011).

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Deliberate Self-Harm

Prevalence of DSH is difficult to ascertain as individual concealment and unwillingness to seek help can substantially underestimate the true prevalence of DSH. Higher prevalence of DSH amongst general population of students is a universal finding with 12-month prevalence of 7% and lifetime prevalence of 17% in American students, life-time prevalence of 15% in Turkish students, 12-month prevalence of 33% in Indian students and 11-33% in Chinese students (Wu et al., 2016). According to the Royal College of Psychiatrists, 1 in 3 people who self-harm for the first time will have a repeat episode in the following year, whilst 3 in 100 people who self-harm over 15 years will actually kill themselves (Bateman, 2014). The short-term recurrence and long-term consequences further highlight the importance of assessment and treatment.

In a recent study that examined deliberate self-harm among Chinese medical students, the 12-month prevalence was found to be 9.6%. This was lower in comparison to the general student population, however, is possibly due to their 'academic background' which may increase their understanding and implementation of self-care (Wu et al., 2016). Despite this the prevalence being lower than the general population of students, this remains to be an important issue that needs to be addressed. Previous studies from the UK and the USA have found that the amount of self-reporting in medical students is indeed higher than other college students, thereby increasing their likelihood of receiving treatment (Wu et al., 2016). Amongst medical students, male students reported a higher prevalence of DSH than females with one study finding that 11.51% of males self-reported DSH compared to 8.71% of females. The most common types of DSH being hitting in males and scratching among females (Wu et al., 2016).

Several key demographics are found to be linked to DSH including age, academic background and household income (Wu et al., 2016). DSH has become more prevalent among adolescents, young adults and college students, with DSH prevalence highest among freshmen and receding with progression through college. Also, low socioeconomic status has also been associated with higher prevalence of DSH (Wu et al., 2016). DSH appears to be higher amongst students in general, due to both their psychosocial stage of development as an adolescent and added pressures of higher education which predispose them to significant stressors of physical separation from parents, academic demands, independence and new social networks making them more vulnerable to self-harming acts (Amiri et al., 2013; Wu et al., 2016).

Suicide

On a global scale it is estimated that over 1 million people die due to suicide annually (Wasserman et. al. 2011). In fact, suicide itself is the second leading cause of death amongst 15 - 29-year-olds, which is, of course, the key age group of students (Wasserman et. al. 2011). Stressors for students include information and input overload, lack of leisure time, financial indebtedness and work pressures (Amiri et al., 2013).

Worldwide statistics show that medical students and even doctors are at a higher risk of suicide than the general population (Chan, Batterham, Christensen, & Galletly, 2014; Downs et al., 2014). In Australia, 14% of medical students have been found to experience suicidal ideation (Chan, Batterham, Christensen, & Galletly, 2014). In the United States of America, 4% of medical students considered committing suicide during their studies in the medical school (Schwenk, Davis, & Wimsatt, 2010). Additionally, the lifetime prevalence of suicide was between 16.8% and 51.5% and suicide attempts between 1.4 to 5.9% in Norwegian, Austrian, Indian and Turkish medical students (Eskin et al., 2011; Etzersdorfer, Vijaya-

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kumar, Schöny, Grausgruber, & Sonneck, 1998; Tyssen et al., 2001). Studies in developing countries such as Pakistan have also found that '35.6% medical students have considered suicide in the past 12 months and 4.8% had attempted suicide in their lifetime' (Osama et al., 2014).

RISK FACTORS

Deliberate self-harm and suicide ideology are associated with a number of risk factors, some of which are common across both domains and a few of which are specific for medical students. A multitude of biological, social, psychological, economic and cultural factors influence both suicide and deliberate self-harm in young people (Miletic, Lukovic, Ratkovic, Aleksic, & Grgurevic, 2014; Osama et al., 2014).

Generally, major risk factors for deliberate self-harm and suicidal ideology include psychiatric disorders, hopelessness, and impulsivity. Other general factors that have been found to be precipitating factors including male gender, young age, short duration of illness, multiple admissions, recent discharge from hospital, previous and recent suicide attempt, comorbid depression, drug abuse, poor medication compliance, poor treatment adherence, adaptation to new environments, high IQ and suicidal ideations, (Miletic, Lukovic, Ratkovic, Aleksic, & Grgurevic, 2014; Osama et al., 2014). Social exclusion in the form of being institutionalised, imprisoned or homeless, as well as parental neglect, has also been noted as contributing factors (Osama et al., 2014). It should be noted that presence of these risk factors increase the risk of DSH and suicide, however, other internal factors, resilience and coping strategies may influence whether that suicide ideology or DSH eventually manifests (Dunn, Iglewicz & Moutier, 2008).

In medical students, there is increased the risk of DSH and suicide ideology due to specific risk factors which can be classified into medical student stressors, self-care and the culture of medicine (Dunn, Iglewicz & Moutier, 2008). Medical students must withstand more overwhelming levels of psychological stress compared to others of similar demographic in the general population (Chan, Batterham, Christensen, & Galletly, 2014). Medical student stressors arise from various sources including transition into medical school, high-self expectations, time and energy demands, internal conflict and negative personal life events. Most unique to medical students is the transition from being a high academic achiever in secondary school to being surrounded by similarly talented students in medical school (Dunn, Iglewicz & Moutier, 2008). This creates a competitive atmosphere in which they may no longer be able to meet their high self-expectations – this is a major shift which may predispose to increased anxiety and depression.

The time and energy required to maintain a strong academic portfolio alongside high expectations can take a toll on students' physical and mental stamina. The constant drive for knowledge and performance through independent study or extracurricular activities minimises the opportunity for health promoting and socialising activities, not to mention physical and mental fatigue and sleep deprivation. This consequently results in a lack of self-care which further increases the risk of DSH and suicidality. Because medical career paths are arduous in nature, students may often feel ambivalent, conflicted and, even at times, dysphoric about their career path. This internal conflict can drain their emotional reservoir and hinder their ability to cope with the sheer stress of medical training and may even drive them towards utilising negative coping mechanisms, such as substance abuse (Dunn, Iglewicz & Moutier, 2008). Substance abuse was found to increase the risk of suicide among medicals students by 28 fold due to impaired verbal intellectual ability, poor psychomotor processing, and problematic behaviour. Parental neglect in these students is also thought to be associated with increased risk possibly due to lack of internal resources to cope with difficult times and situations (Osama et al., 2014).

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In addition to the stressors already outlined, students are often at the age where negative life events can arise (Chan, Batterham, Christensen, & Galletly, 2014). These may include family breakdown, sickness or death, relationship issues which may compromise their ability to cope, and impact their academic performance (Dunn, Iglewicz & Moutier, 2008). Overall, such risk factors make them more vulnerable to DSH and suicidal tendencies (Wu et al., 2016).

Due to the 'Culture of Medicine', seeking help is often viewed as a sign of weakness rather than empowering act, resulting in stigma and pressure when vulnerable students need support (Dunn, Iglewicz & Moutier, 2008). Furthermore, medical students tend to withhold from help-seeking behaviour due to fear of career implications', 'physician heal thyself' culture, time pressures and concerns for confidentiality (Chan, Batterham, Christensen, & Galletly, 2014; Downs et al., 2014; Yousuf, Beh, & Wong, 2013). Another factor that influences help-seeking behaviour is attitudes towards suicide. Permissive attitudes are associated with more help-seeking behaviour where stigmatisation and sanctioning of suicide leads to the deterrence of help-seeking behaviour (Yousuf, Beh, & Wong, 2013). Attitudes vary among countries with some cultures being more restrictive and others more permissive (Amiri et al., 2013). For example, students in India were found to be more restrictive than Austrian students and Japanese students were more likely to normalise suicide than American medical students (Amiri et al., 2013). Additionally, clinical experience and exposure to suicidal patients may improve knowledge but lead to more negative attitudes to informal help-seeking (Chan, Batterham, Christensen, & Galletly, 2014). Avoidance of and barriers to help-seeking behaviour can, therefore, increase the risk of DHS and suicidal ideations (Wasserman et. al. 2011).

PROTECTIVE FACTORS

Whilst there are numerous factors that precipitate an increased risk of deliberate self-harm and suicide in general, there are also common protective factors. These protective factors range from lifestyle factors such as maintaining a good diet, good sleeping hygiene and keeping an active lifestyle, to personality factors such as one's coping strategy, sense of personal value, confidence, ability to seek help and communicate (Wasserman et. al. 2011). Other protective factors such as social support and family connectedness are also valuable (Goldsmith, 2002).

Similarly, in medical students, general protective factors for mental well-being include psychosocial support and activities, internal characteristics and coping strategy as well as mentorship and intellectual stimulation. (Dunn, Iglewicz & Moutier, 2008). Presence of psychosocial support from family, friends, peers, medical school administration, therapists and religious affiliations and social activities, either spontaneous or structured, act as protective factors which may prevent or reduce DSH and suicide ideations. (Dunn, Iglewicz & Moutier, 2008).

Internal characteristics such as students' personal traits, temperament, and coping style are built upon the developmental task of young adulthood, gender-specific issues, and cultural/ethnic role expectations. Internal characteristics describe students coping reserve and resilience, which may vary between students, can be adaptive and protective. (Dunn, Iglewicz & Moutier, 2008).

Uniquely to medical students, the presence of mentorship from clinical preceptors, research mentors, assigned faculty mentors and/or peers may serve as role models and as one that students may be comfortable to disclose personal information or issues (Dunn, Iglewicz & Moutier, 2008). Additionally, intellectual stimulation whereby students start to appreciate the clinical significance and correlation of

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the basic sciences may serve as protective factors. This may be through enhancing enthusiasm for their career path (Dunn, Iglewicz & Moutier, 2008).

The factors mentioned above are general protective factors that relate to overall mental health and well-being. Unfortunately, as there is limited information in the literature, specific protective factors for DSH and suicide in medical students was not available. Further research in this area would be of interest and yield worthwhile information.

SOLUTIONS AND RECOMMENDATIONS

In this section, the authors explore assessment, preventative and management strategies to improve education, awareness and ultimately reduce the rates of DSH and suicide risk. Presented is a comprehensive review of practises and techniques that medical professionals and medical educators could utilise to aid medical students to adequately and safely manage DSH and suicide ideology. This will include highlighting the benefits of using surveys and questionnaires to assess and identify at-risk medical students, counselling and educational group programmes to increase education and literacy as well as referring for further treatment (Yousuf, Beh, & Wong, 2013). The solutions and recommendations will aim to improve mental health literacy, alleviate the stigma and normalisation of suicide that exists amongst medical students as well as increase self-care principles (Chan, Batterham, Christensen, & Galletly, 2014).

As discussed previously, medical students are at risk of normalisation of DSH and suicide ideology despite their mental health literacy levels and are still susceptible to the stigma of help-seeking for their mental well-being (Yousuf, Beh, & Wong, 2013). Medical students receive minimal training in suicide and DSH prevention (Yousuf, Beh, & Wong, 2013).

Both DSH and suicidal behaviour can be prevented with timely, evidence-based and often low-cost interventions (Wasserman et al., 2011; Muehlenkamp, Walsh, & McDade, 2009). Current approaches towards the prevention of DSH and suicidal ideology targets early screening programmes and psychoeducational interventions.

Primary Prevention

Focusing on preventing DSH and suicidal ideology in medical students should begin with targeted psychoeducational interventions early in their career. The purpose of this is to raise mental health literacy, reduce stigmatising attitudes, limiting normalisation/glorification of suicide (Chan, Batterham, Christensen, & Galletly, 2014).

Suicide prevention and education modules can lead to positive attitudes towards understanding suicide and are well received by medical students (Yousuf, Beh, & Wong, 2013). Specifically, it can reduce negative attitudes towards and stigmatisation of suicide (Yousuf, Beh, & Wong, 2013). For example, a 2-week special studies module (SSM) on suicidology and suicide prevention for undergraduate medical students resulted in reduced negative appraisal, reduced stigmatisation and increased sensitivity towards suicide literacy, all of which are positive attitudes towards suicide (Yousuf, Beh, & Wong, 2013). The course itself covered a variety of topics from risk assessment to prevention and intervention strategies, suicide among health professionals, life, and death as well as skills for overcoming stress through a diverse range of teaching modalities such as presentations, discussions, skills-based training sessions and films.

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DSH primary prevention should idealistically work in the same manner as suicide primary prevention, unfortunately, no specific studies currently exist for medical students. There are, however, prevention programmes which have been trialed in adolescents in a school-based prevention program. Muehlenkamp, Walsh & McDale discuss the use of the Signs of Self-Injury (SOSI) programme which is designed for both staff and students. The programme is divided into two modules, with the staff module providing psychoeducational material about DSH as well as warning signs and methods of response. The student module utilises multimedia presentation to overview DSH signs and symptoms and how to approach for help. This is followed by a group discussion to consolidate all the information. The results indicated that students had improved help-seeking attitudes and intentions and preliminary data demonstrated that the programme may be an effective prevention programme for schools (Muehlenkamp, Walsh, & McDade, 2009). This may be a viable option if adapted for medical students as well as medical teaching faculty.

Secondary Prevention

There is insufficient data to support that suicide screening of the general population in primary care will reduce mortality (LeFevre, 2014; O'Connor, Gaynes, Burda, Soh, & Whitlock, 2013). Despite this, identification of cases based upon risk factors, sensitivity to high-risk situations in depressed patients, and assessment of suicidality in patients treated for depression is appropriate and can reveal occasional patients with suicidal intent and can benefit from interjection and intervention (LeFevre, 2014; O'Connor, Gaynes, Burda, Soh, & Whitlock, 2013).

For medical students, secondary and tertiary prevention strategies should be utilised to ensure early intervention. One example of a screening and referral system is The Healer Education Assessment and Referral (HEAR) programme. This encompassed a two-tiered programme involving educational models followed by anonymous screening using 9-item Patient Health Questionnaire (PHQ-9) to identify affective disorders and suicide risk in medical students (Simon et al., 2013). Students who were found to be at risk were then assessed further and referred for care if necessary (See Figure 3) ("The Patient Health Questionnaire (PHQ-9)", 1999). This study found that a significant number of 'at-risk' students were not in treatment (Downs et al., 2014). Programmes like this have the potential to identify, refer and treat 'at-risk' students with depression and increased suicide risk with the ultimate goal of reducing suicide behaviour, death from suicide, deliberate self-harm, education, treatment, screening, engagement, and follow-up. The Royal College of Psychiatrists actually endorses repeated assessments and screening, as they can actually increase engagement in treatment (Self-harm, suicide, and risk: a summary, 2010).

Screening for deliberate self-harm has proven more challenging due to aforementioned reasons of individual concealment and unwillingness to seek help. Despite this, the Columbia-Suicide Severity Rating Scale (C-SSRS) has been developed to assess suicidal ideation, lethality, and severity of suicide attempt as well as DSH without suicidal intent (Wasserman et al., 2011). The C-SSRS differs from the PHQ-9 in that it more thoroughly assesses suicidal intent, a key factor in differing suicide ideation and deliberate self-harm (Viguera et al., 2015). Unfortunately, neither the C-SSRS or the PHQ-9 have been evaluated for their sensitivity or specificity in identifying deliberate self-harm in medical students.

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Figure 3. 9-Item Patient Health Questionnaire (PHQ-9)
Source: Adapted from The Patient Health Questionnaire (PHQ-9, 1999)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or off hurting yourself in some way	0	1	2	3

Tertiary Prevention

Any acute, life-threatening incidences of suicide attempts or self-harm should be managed promptly by appropriately trained staff and acute psychiatric services (Carter et al., 2016; Hirschfeld & Russell, 1997). Ongoing treatment and follow up should be conducted by a health professional unrelated to the medical school to prevent any conflicts of interest. Any discussion between the medical school and treating team about a medical student's mental health should only be made with explicit consent of the patient.

According to the Royal College of Psychiatrists, there is insufficient evidence to clearly define the best therapy for those who have self-harmed or plan to self-harm (Bateman, 2014). This is further supported by the Royal Australian and New Zealand College of Psychiatrists, who define clinical practise guidelines for specific population sub-groups, none of which focus on medical student demographics (Carter et al., 2016). There is limited randomised controlled trial evidence to support pharmacological treatment for DSH, in fact, it has demonstrated an unfavourable risk-benefit ratio (Carter et al., 2016; Suarez & Saunders, 2012). Psychological or psychosocial interventions such as problem-solving therapy, cognitive-behavioural therapy and psychodynamic interpersonal therapy have been effective in reducing the number of recurrent DSH events (Carter et al., 2016). A health professional should make a tailored approach based on each individual's problems.

Suicidal behaviour is a serious psychiatric emergency with complex treatment. This treatment strategy serves as tertiary prevention to prevent progression of condition or a successful attempt. In acute cases, patients require evaluation and either inpatient or outpatient care (O'Connor, Gaynes, Burda, Soh, & Whitlock, 2013). The decision whether to admit patients to psychiatric ward is difficult due to the circumstances of each case, use of economic resources as well as negative effects of hospitalisation (Wasserman et al., 2011).

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In acute suicidal cases, the early phase is when patients are most at risk (Wasserman et al., 2011). An empathetic and supportive approach should be taken and encompass symptomatic, pharmacological treatment. Medications prescribed should be supervised by family or community services and given in small packages (Wasserman et al., 2011). Adequate monitoring and follow-up are of paramount importance as the risk of suicide increases in days and initial weeks after discharge (Hirschfeld & Russell, 1997).

Long-term management should be commenced immediately and include follow-up consultations e.g. active involvement of family members, telephone contacts, appointments and social network evaluation (Wasserman et al., 2011). Prevention of suicidal behaviours is achieved by treating underlying psychiatric disorders and symptoms. The treatment regime varies and depends largely on the specific cause which will not be discussed here as it is beyond the scope of this chapter.

Psychological treatment includes cognitive behavioural therapy (CBT) which is the evidence-based method of treatment, however this is not specific to medical students (O'Connor, Gaynes, Burda, Soh, & Whitlock, 2013). Other forms of psychological treatment which may be useful includes dialectical behaviour therapy, in-home interpersonal psychotherapy, family psychotherapy developmental group therapy and psycho dynamic therapy however further research is needed to confirm effectiveness of these treatment methods. Irrespective of psychotherapy employed, effective strategies require a good therapeutic relationship between patient and therapist, treatment fidelity, compliance, targeting identifiable skills and emphasis on personal responsibility (Wasserman et al., 2011).

Community resources are recommended as patients struggle with existential crises. These may involve support from family and friends, helplines, crisis centres, mental health centres, religious counsellor (Wasserman et al., 2011). The goal of elevating psychosocial support is to enhance sense of meaning in life. Such strategies can be implemented into medical school policies for both students and educators, as discussed in the following section.

Recommendations for Medical Schools and Educators

Implementation of prevention strategies to reduce suicide and deliberate self-harm amongst medical students requires an integrated and committed effort from both medical schools and educators (Hughes, Kent, & Bowman, 2008). Such entities have important roles in ensuring the success of intervention strategies and therefore reduce stigma and barriers seeking health services (Thornicroft et al., 2016).

Whilst no current literature supports any specific mental health interventions in medical students, a multitude of research has been conducted regarding guidelines for tertiary education institutions in support students with a mental illness. A 2013 Delphi consensus study conducted with 74 Australian professionals and 35 consumers supported 155 strategies that addressed mental illness in all students at tertiary institutions. These strategies encompassed generating policies in a variety of domains to assist students such as promotion, enhancement and accessibility of support services, education, and training of staff as well as funding, research and evaluation (Reavley, Ross, Killackey & Jorm, 2013). The authors will continue to discuss methods through which medical schools and educators can promote awareness and implement strategies in their institution, specifically with regards to university policy, support services and staff and student education.

University policies should address the promotion of mental health awareness, prevention of mental illness and provide the foundation for services for students with a mental illness (Reavley, Ross, Killackey & Jorm, 2013). Mental health awareness should be employed by leading executives and professors of the faculty in conjunction with student associations and representatives from external services. Most

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importantly, institutions should develop a plan for communicating this mental health policy to all staff and students. A report from the Australian Medical Students' Association in 2013 outlined several student-based initiatives such as mentoring programmes, wellbeing events including guest speakers on self-care, yoga and meditation as well as providing student-friendly external services such as general practitioners and psychologists. A collaborative approach from students and staff is essential in ensuring student participation (Australia Medical Students' Association Student Mental Health and Wellbeing Committee, 2013; Reavley, Ross, Killackey & Jorm, 2013).

Institution support services such as student counsellors, telephone counselling, online services and support groups should be made available to all staff and students. As discussed previously, barriers to seeking help play a large role in a medical student's decision and universities should adopt an easy access, non-judgemental approach to entry for assessment and treatment, a method that Hughes, Kent & Bowman address as the 'no wrong door' policy (Hughes, Kent, & Bowman, 2008).

As discussed in primary prevention, psychoeducational modules would be beneficial in conveying information to staff and students. This should clearly detail signs, symptoms, causes, treatment and the benefits of early intervention and prevention (Reavley, Ross, Killackey & Jorm, 2013). Staff should also be trained to use non-judgemental listening skills, respond appropriately when a student discloses a mental illness to them, techniques for motivating students and raising self-esteem and most importantly how to handle a mental health crisis (Reavley, Ross, Killackey & Jorm, 2013). These skills can be taught to staff over on-going professional development sessions and online training, to be accessible and thorough, yet not create a high burden of work. The university and staff should also provide 'reasonable adjustments' for assessments to encourage and assist students in coping with their mental illness and to ensure that high workload demands or expectations do not negatively impact an already stressed student (Hughes, Kent, & Bowman, 2008). Furthermore, this process should be made open and transparent for the fairness of all students.

Major limitations to these prevention strategies are due to lack of funding and resources. Despite this, medical schools should endeavour to allocate adequate funds and seek funding opportunities to enhance student mental health services to benefit their students. Additionally, these services should be followed up and evaluated in ongoing research to monitor the efficacy of such interventions.

The combination of university policy support services and staff and student education is a useful intervention strategy but an area that still requires further research in the medical school domain. As discussed in the sections above, implementation of intervention strategies is vital as they target all facets of prevention to ultimately reduce the risk of suicide and self-harm in this vulnerable population (Wasserman et al., 2011).

FUTURE RESEARCH DIRECTIONS

Deliberate self-harm and suicide ideology is an important, emerging issue amongst medical students. Current literature on this issue only scratches the surface of a deeper problem and requires further research to explore the depth and breadth of the issues. Future research is needed to quantify the severity and predisposing factors contributing to this issue, to ascertain student perspectives and engage students in finding solutions. Similarly, the perspectives and roles of medical educators and administrators in medical schools should also be examined. The downstream impact of deliberate self-harm and suicide ideology during medical school on well-being and performance in future clinical practise could also be

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explored. Implementation of the proposed solutions and recommendations can be a stepping stone to addressing deliberate self-harm and suicide in medical students and will also serve as future research opportunities to evaluate the usefulness and effectiveness of such strategies.

CONCLUSION

Deliberate self-harm and suicide ideology are pertinent issues amongst medical students. The relation between deliberate self-harm and suicide ideology is important and helpful for understanding the risk factors and preventative factors behind both diagnoses. Early screening assessment and intervention are evidence-based and often low-cost, meaning their implementation can be quick and effective.

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KEY TERMS AND DEFINITIONS

Deliberate Self-Harm: Direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent and that occurs in the absence of psychoses and/or organic intellectual impairment.

Primary Prevention: Intervention or action that aims to prevent disease or injury before it ever occurs.

Psycho-Educational Intervention: A broad range of activities, combining education, counselling and support interventions. These may be delivered individually or in groups, may be tailored or standardised.

Secondary Prevention: Intervention or action that aims to reduce the impact of a disease or injury that has already occurred through screening, early detection or halting.

Suicide: The act of deliberately killing oneself.

Suicide Ideology: Concerns, thoughts about or unusual preoccupation with suicide. Also known as suicide ideation.

Tertiary Prevention: Intervention, action or treatment for disease or injury that prevents complication and/or progression.

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