

Demoralization or clinical depression? Enhancing understandings of psychological distress in resettled refugees and migrants

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Abstract. *The concept of demoralization has always been controversial. Some question its value while others claim its usefulness in explaining non-specific psychological distress. This study used a set of standardised self-report scales including a Demoralisation Scale (DS) to examine the degree of psychological distress among a sample of 100 resettled refugees and migrant people from refugee-like backgrounds residing in Australia and New Zealand. A primary aim of the study was to determine whether demoralisation might offer a more relevant diagnosis than clinical depression for this population. A second aim was to explore whether clinical and non-clinical cohorts demonstrated similar rates of demoralization, and how other factors associated with forced migration and resettlement affected these rates. It was not possible to determine a clear distinction between symptoms of depression and demoralization, however, in cases of minimal or mild depression, it appears the DS may have applicability as a measure of non-specific distress that spans a spectrum from mild disheartenment through to total despondency.*

Keywords: demoralization, depressive disorder, somatic presentation, refugees, migrants, resettlement

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INTRODUCTION The international literature refers to immigration as a complex process and a stressful life event capable of putting an individual's mental health at risk (Bhugra, 2004; Claassen *et al*, 2005; Fazel *et al*, 2005). Hollifield (2002) notes that forced migration to a host country with a very different cultural environment magnifies this risk, as in the case of refugees who:

....owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, [are] outside the country of [their] nationality [are] unable or, owing to such fear, [are] unwilling to avail [themselves] of the protection of that country (United Nations High Commission for Refugees-UNHCR, 1996).

Both New Zealand and Australia have humanitarian response programmes, offering third country resettlement for refugees and 'migrants'¹. The New Zealand quota system allows for 750 such resettlements per year, which more realistically is approximately 1,250, including migrants entering under family sponsorship policies (New Zealand Immigration Service, Department of Labour, 2004). At the last census, these two groups contributed to the 22% of New Zealand's population born elsewhere (Statistics New Zealand, 2006).

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Australia's programme has onshore (asylum) and offshore components (Department of Immigration and Citizenship, 2009a), respectively offering protection to people in Australia who fit the above definition of refugees (UNHCR, 1996) and resettlement for people outside Australia who need humanitarian assistance. Australia accepted 10,800 such refugees for resettlement in 2007–2008 and approximately 11,600 in 2008–2009 (Department of Immigration and Citizenship, 2009b; 2010).

Refugees and migrants from non-English speaking cultures may have little preparation for their new English speaking environments, where limited English language skills can exacerbate resettlement problems regardless of previous economic and social status (Pahud, 2009). Whilst there is evidence that socio-economic position, with its associated risks of stress, impacts on mental distress in general populations, there is limited understanding of how these stressors' impact on refugee and migrant mental health (Fryers *et al*, 2003; Lindström *et al*, 2006). The literature tends to focus instead on the losses incurred through forced migration and later relocation; loss of homes, employment, income, mobility, primary and social supports, life roles, choices, autonomy, security, cultural environment and citizenship (Bhugra, 2005; Park & Bernstein, 2008).

Many refugee groups do not understand or accept the concept of mental ill health because this is not within their cultural understanding. Even if they are familiar with the concept, they tend to associate it with the more severe forms of psychopathology that require institutional care. Thus, all conditions are highly stigmatized and interventions are shunned (Gong-Guy *et al*, 1991). These different understandings add to the considerable adjustment required of refugees, migrants and their host societies, particularly during the post-migration period when adjustment begins (Nash *et al*, 2006). Mental health impact factors arising from resettlement include time to adjust to a different culture, severed ties from family and friends, acquisition of the host country language, employment, former role performance and resilience, individual or group perceptions of acceptance and aspirations for a new life, and the host society's socio-economic-political situation (Bhugra, 2005; Gong-Guy *et al*, 1991; Nash *et al*, 2006; Park & Bernstein, 2008). Disjunction between aspirations and achievements can leave individuals susceptible to low mood, and a sense of alienation and failure, which can trigger depression (Bhugra, 2004). The realities of this disjunction, combined with social isolation from extended family and friends, can result in existential distress leading to demoralization (Briggs *et al*, 2007).

Demoralization or depression?

Early references to demoralization describe feelings of loss of meaning and purpose in life, a sense of hopelessness and helplessness, symptoms and a sense of giving up or having given up, a persistent inability to cope, subjective incompetence and diminished self-esteem (Engel, 1967; Erikson, 1994; Frank, 1974). More recently, demoralization has been defined as 'a change in morale spanning a spectrum of mental attitudes from disheartenment (mild loss of confidence) through despondency (starting to give up) and despair (losing hope) to demoralization (having given up)' (Kissane *et al*, 2001). Depression and anxiety are symptoms often accompanying demoralization and despair. However, demoralization is more than a combination of these symptoms; it is about feelings of inability to 'cope' (usually voiced as 'giving up' or 'depression'), typically accompanied by 'hopelessness and helplessness' (Kissane *et al*, 2001).

The concept of demoralization has always been controversial. Some question its value while others claim its usefulness in explaining non-specific psychological distress (de Figueiredo, 1993). The main controversy centres on whether feelings of demoralization constitute a

syndrome of despair, distress and hopelessness separate from depression, or reflect clinical depression or a normal response to difficult circumstances. It has been argued that the critical feature distinguishing depression from demoralization is the presence or absence of anhedonia (a diminished ability to experience pleasure). A depressed person has lost the ability to experience pleasure generally, as well as motivation and drive, even when an appropriate direction of action is known. In contrast, a feeling of subjective incompetence and helplessness characterizes demoralization. A demoralized person, while unable to look forward with pleasant anticipation, may laugh and enjoy the present moment, but feels helpless, incompetent and inhibited in action by not knowing what to do (Clarke & Kissane, 2002; de Figueiredo, 1993; Klein *et al*, 1980). Research showing that suicidal ideation, or the wish to die, is differentially associated with hopelessness and depression (Beck *et al*, 1975), and that suicide intent in psychiatric inpatients correlates more strongly with hopelessness than with depression (Wetzel *et al*, 1980) further supports the argument for distinguishing demoralization from depression (Clarke & Kissane, 2002). This argument's supporters (Kissane *et al*, 2001) have advocated for the inclusion of demoralization as a separate syndrome in the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders (DSM)'.

The Psychiatric Epidemiology Research Interview Demoralization Scale (PERI-D), initially developed in 1980 (Dohrenwend *et al*, 1980), was designed to measure non-specific distress in the general population. It equates demoralization with global distress, and has been used to measure distress in immigrant and other populations (Jacobsen *et al*, 2006).

A new 24-item, 5-point, self-rating Demoralization Scale (DS) (Kissane *et al*, 2004) was developed almost a quarter of a century after introduction of the PERI-D. The DS captures the dimensions of demoralization in its subscales: dysphoria; disheartenment; loss of meaning; helplessness; and sense of failure. Research using this newer scale has enabled identification of a further distinction between anhedonic depression and depression with demoralization in that although demoralized patients were more distressed than patients with anhedonic depression, other factors such as a lack of family cohesiveness, quality of social supports and avoidance coping were uniquely associated with demoralization (Clarke *et al*, 2005). Other research using the DS with patients in the advanced stages of cancer found that demoralization symptoms could be identified and distinguished from depressive symptoms (Jacobsen *et al*, 2006).

Somatic complaints such as migraine headaches and stomach pain often occur in the context of hopelessness and helplessness (de Figueiredo, 1993). The tendency of refugee and migrant clients from non-Western cultural backgrounds to express psychological distress in somatic terms has been documented as a major reason for these clients presenting to mental health services (Briggs & Macleod, 2007).

As academic researchers and clinicians, the authors contend that while demoralization is commonly seen in people with serious physical illness or the elderly, it must be considered when working with refugee and migrant clients. It may also be a reason for some clients appearing not to achieve expected gains from traditional mental health interventions for depression.

The study

Clinical work with refugee or migrant clients presenting at a mental health service was the impetus for the three-year (2005–2008) quantitative study described in this paper. It aimed to explore the concept of demoralization with an Australasian sample (n=100) of refugees and migrants, examining their degree of psychological distress with the objective of determining

whether demoralization may provide a more relevant diagnosis than clinical depression for refugee and migrant clients with mental health conditions.

A secondary objective was to ascertain whether similar rates of demoralization were present among clinical and non-clinical cohorts in the study. It was important to determine whether factors with the potential to impact an individual's mental health, as well as create barriers to successful resettlement (for example, time in host country, loss of family and friends, lack of appropriate employment and language difficulties), could impact participants' demoralization scores. Similarly, other variables such as somatic complaints, diagnosis and response to antidepressant medication were explored to gain a better understanding of what contributed to the participants' demoralization scores. The next section describes the instruments used to collect these data.

MATERIALS AND METHODS

Recruitment and sample

Fifty participants — 25 from Australia (AUR) and 25 from New Zealand (CRS) — were recruited from two similar community-based multicultural resettlement services that people access for reasons varying from attending education programmes to receiving personal support and practical assistance with day-to-day living. Service workers made attendees aware of the study. Those interested in participating who met the inclusion criteria were given an appointment for an interview with one of the researchers.

In contrast, the other 50 participants were recruited through a refugee and migrant mainstream mental health service (MHS) in New Zealand that provides psychological interventions to people referred with mental health concerns and mental illness. Following normal admission procedures, every client attending this service and meeting the inclusion criteria was invited to participate in the study.

Data collection instruments

The attending clinician (MHS) or research interviewer (AUR and CRS) completed a short questionnaire with the participants to collect demographic and clinical data. The questionnaire was designed specifically for the study to capture factors found in the literature that may impact on eventual resettlement outcomes. It included questions about the presence of psychosomatic complaints, assignment of a DSM-IV diagnosis and participants' perceived response to any prescribed antidepressants. This information was additional to that kept on client service files.

All participants were asked to complete four self-rating scales. The BDI-II (Beck *et al*, 1996) was used to assess the level of subjective psychological distress because it contains items closely aligned with criteria for depression in the DSM-IV (American Psychiatric Association, 1994). BDI-II scores of 0–13 suggest minimal depression, 14–19 indicate mild depression, 20–28 indicate moderate depression, and 29 or greater suggest severe depression. Whilst these are arbitrary cut-off scores (Beck *et al*, 1996), a persistent score of 17 or above suggests professional treatment may be required. Researchers adhered to a cut-off point of 17 because participants were attending services. A mental health clinician scrutinized all the inventories to identify any participant at potential risk of suicide. Protocols were in place to respond quickly if necessary.

The 20-item BHS (Beck *et al*, 1974) was used to measure the sample's degree of hopelessness because it demonstrates a high degree of internal consistency (co-efficient alpha 0.85 and 0.93) and construct validity (for example, correlations between 0.62 and 0.74 with clinical ratings of

hopelessness). BHS cut-off scores suggest a score of 0–3 indicates minimal hopelessness, 4–8 mild hopelessness, 9–14 moderate hopelessness and greater than 14 severe hopelessness.

The 14-item SHAPS (Snaith *et al.*, 1995) containing four domains of pleasure response, was used to assess hedonic tone because psychometric evaluation has established the SHAPS can be used to distinguish between normal (score <2) or abnormal (score > 2) hedonic tone.

The newly developed 24-item DS, while not a standardized test, was used to determine the degree of demoralization among the sample because field trials have shown it correlates well with Beck's BDI-II and BHS scales, thus promising good psychometric properties (Kissane *et al.*, 2004). It was also found to have divergent validity, demonstrated through the differentiation of a sub-group of patients with high demoralization who did not meet DSM-IV categorization for a diagnosis of major depressive disorder. Although DS scoring is still being defined, the scale has a range of 0–96, with rising scores indicating increasing severity of the disorder.

The use of these Western instruments required modification in the way the questions were asked, including finding proper and consistent substitutes for words, symptoms and states of mind, which are part of linguistic and cultural idiosyncrasies, to make them suitable for use with the largely non-Western participants. Interpreters trained in working with people from the participants' cultures enabled all participants to give informed consent and understand the self-rating scales.

Following normal admission procedures and prior to completing the self-rating scales, the 50 MHS participants underwent a comprehensive psychiatric assessment. Whilst the self-rating scale scores formed the research base, the MHS participants' inventories were used as collateral information to aid diagnosis and treatment planning. These participants were followed up to repeat the self-rating scales after six months or on discharge from the service if earlier.

Statistical analysis

A preliminary analysis was undertaken of data collected from the first 50 participants recruited (25 AUR, 20 MHS, 5 CRS). The New Zealand cohorts were combined to achieve a more meaningful comparative analysis with the Australian sample. It was not possible to clearly ascertain whether depression and demoralization are the same syndrome or different constructs (Briggs *et al.*, 2007), therefore all 100 participant responses required analysis to achieve this aim. SPSS version 17 (SPSS INC., 2008) was used to analyse all data and to generate a reliability scale to allow comparisons using the mean total scores for the self-rating scales. Pearson correlations were used to assess the relationships between BDI-II, BHS, DS and SHAPS total scores. Analysis of variance (ANOVA) was undertaken, followed by a Less Significant Difference (LSD) post hoc test, to compare the differences between the MHS self-ratings and those of the resettlement services' groups (AUR and CRS) for all four measures. Cross tabulations and Kendall's tau-b (T^b) were computed to compare frequencies for depression with anhedonia and depression with demoralization among the four measures.

RESULTS

Demographic characteristics

Participants were of Asian (42%), African (25%), Middle Eastern (15%), European (11%), South American (5%) and Oceanic (2%) ethnicities. Afghanis (n=27) represented the largest single ethnic group (see **Table 1**).

Table 1 Frequency Distribution of Participant Defined Ethnicity (n=100)

DEMORALIZATION IN REFUGEES AND MIGRANTS

Global region	Ethnicity	Number (N)	Percent (%)
Africa	Ethiopian	9	
	Somali	3	
	Sudanese	8	
	Sierra Leonean	1	
	Egyptian	4	
			25
Middle East	Iraqi	1	
	Iranian	13	
	Israeli	1	
			15
Asia	Chinese/Taiwanese/Malaysian	3	
	Sri Lankan	2	
	Indian	6	
	Thai	1	
	Korean	1	
	Japanese	2	
	Afghani	27	
			42
Europe	Serbian	4	
	Maltese	1	
	Eastern European	5	
	Western European	1	
			11
Other	Chilean	5	
	Fijian	1	
	Filipino	1	
			7
Total		100	100%

The sample’s mean age was 34.5 years (SD=10.5; range 16–71 years). No pre-migratory aspects of participants’ mental health status or preparation for resettlement were known. Most reported living in refugee camps for many years before coming to Australia or New Zealand, and many reported experiencing severe trauma, torture and a range of untreated health problems. None reported being detained upon arrival in the host country or before resettlement. Immigration status was similar for participants in both host countries (61% refugees and 36% migrants), except for 3% asylum seekers in New Zealand (CRS=1, MHS=2).

Twenty percent of participants had lived in their host country for less than 12 months, 29% for 1–3years, 23% for 3–5years and 28% for more than 5 years, with 79% having family there and 71% able to speak English to a level not requiring an interpreter. Overall, 40% reported being employed full or part time, consisting of 68%, 36% and 28% of the AUR, CRS and MHS cohorts respectively. Twenty-four percent, 44% and 66% of the AUR, CRS and MHS cohorts respectively reported being enrolled in study.

Diagnosis

At entry to the study, 51% percent of the total sample reported experiencing somatic complaints and 50% (see **Table 2**), reported being diagnosed with a major depressive disorder (using the DSM-IV) in either Australia or New Zealand. Cross tabulations of diagnosis with service showed that 90% of the clients with a major depressive disorder, or adjustment disorder with depressive symptoms and/or anxiety, were attending the MHS. Forty percent of the CRS cohort reported a diagnosis of either of these disorders, and only one person (4%) in the AUR cohort had a diagnosed major depressive disorder.

Table 2: Cross Tabulation of Diagnosis with Service (N=100)

Diagnosis	MHS	CRS	AUR	Total
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Major Depressive Disorder	42	7	1	50
PTSD	1	0	0	1
Acculturation Problem	0	1	0	1
Bereavement	0	1	0	1
Adjustment disorder (with depressed mood/anxiety)	3	3	0	6
Dysthymia	1	0	0	1
Partner Relational Problem	1	1	0	2
Personality Disorder	1	0	0	1
No diagnosis	1	12	24	37
Total	50	25	25	100

Antidepressant intervention

Forty-seven participants from the total sample reported being prescribed antidepressant medication prior to the study. When asked how helpful the medication had been, 21% reported a perceived effective response and 36% a moderately effective response. Overall, 40% reported no benefit.

Further exploration showed that 26% of the 39 MHS clients medicated with antidepressants reported an effective response, while 74% reported limited or no effect on their depressive symptoms. None of the 8 participants from the resettlement services (CRS and AUR) who were taking antidepressant medication reported an effective response, indicating the medication had minimal or no effect on their depressive symptoms.

Comparison of data across measures

Demoralized or depressed?

A reliability scale analysis showed good internal consistency between all items in the DS questionnaire (Cronbach Alpha= 0.93), and between the DS, BDI-II, BHS and SHAPS total scores (Cronbach Alpha = 0.76).

The Pearson correlations used to assess the relationships between BDI-II, BHS, DS and SHAPS total scores showed high correlation between all measures ($p < 0.001$), as illustrated in

Table 3.

Table 3: Pearson Correlations between BDI-II, BHS, DS and SHAPS Total Scores (N=100)

	BDI Total Score	BHS Total score	DS Total Score	SHAPS Total Score
BDI Total Score	1	.629**	.772**	.628**
BHS Total Score	.629**	1	.754**	.599**
DS Total Score	.772**	.754**	1	.584**
SHAPS Total Score	.628**	.599**	.584**	1

** Correlation is significant at the 0.01 level (2-tailed)

The means and confidence levels across all measures for each service and the total sample (see **Table 4**) indicate many participants (52%) were in the moderate to severe range for severity level of depressive symptoms according to the BDI-II (mean=21.43; SD =13.35). The BHS (mean=6.89; SD=5.26) indicates that most were in the minimal to mild range (69%) for severity level of hopelessness.

Table 4 Comparisons and Confidence Levels of BDI-II, BHS, DS, and SHAPS Total Mean Scores for Each Service

Service	N	Mean	95% Confidence Interval for Mean			Upper bound	Min.	Max.
			Std. Dev.	Std.Error	Lower bound			
BDI-II Total Score	MHS	26.62	13.062	1.847	22.91	30.33	2	51
	CRS	18.80	13.115	2.623	13.39	24.21	0	46
	AUR	13.68	9.481	1.896	.977	17.59	1	30
Total	100	21.43	13.359	1.336	18.78	24.08	0	51
BHS Total Score	MHS	8.6	5.123	.724	7.14	10.06	0	18
	CRS	5.32	5.414	1.083	3.09	7.55	0	19
	AUR	5.04	4.363	.873	3.24	6.84	0	15
Total	100	6.89	5.261	.526	5.85	7.93	0	19
DS Total Score	MHS	47.76	17.749	2.510	42.72	52.80	10	84
	CRS	32.76	18.332	3.706	25.11	40.41	2	63
	AUR	29.76	17.057	3.411	22.72	36.80	0	66
Total	100	39.51	19.483	1.948	35.64	43.38	0	84
SHAPS Total Score	MHS	3.38	3.839	.543	2.49	4.87	0	12
	CRS	1.80	2.784	.557	.65	2.95	0	9
	AUR	1.00	2.415	.483	.00	2.00	0	10
Total	100	2.49	3.445	.345	1.81	3.17	0	12

According to the SHAPS (mean=2. 4; SD=3.44), 63% of participants were in the normal range for their ability to experience pleasure. Whilst scoring for the DS can range between 0–96, rising scores indicate an increased level of severity of the phenomena experienced (Kissane *et al*, 2004). Given the high correlation between all measures, similar cut-off points to determine the level of severity for demoralization could be estimated as <34 minimal, 35–59

moderate and >60 severe. Using these cut-off points, the mean total sample score on the DS (mean=39.51; SD=19.48) indicates that 84% of participants were experiencing a mild to moderate level of demoralization.

Table 4 shows the MHS cohort generally in the moderate (almost reaching severe) range for depression, with a mean BDI-II score of 26.62 (SD=13.06). The BHS score for this cohort was in the moderate range (mean score= 8.60; SD=5.12), the SHAPS score in the abnormal range (mean=3.58; SD=3.83) and the DS score (mean=47.76; SD=17.74) at the moderate level.

In this analysis, the resettlement services' total mean scores were lower than those for the MHS cohort. Scores across the CRS and AUR cohorts appeared similar, with all in the minimal or mild range except for the SHAPS, where the CRS participants still had abnormal hedonic tone (mean=1.80; SD=2.78) compared to the AUR cohort (mean=1.00; SD=2.41).

Analysis of variance (ANOVA), followed by a LSD post hoc test, was used for further comparison of differences between the MHS and the two resettlement services. There was a significant difference ($p<0.05$) between the resettlement services and MHS cohorts in all four measures, indicating that the MHS participants were more depressed and more demoralized than the resettlement services' participants.

Follow up

Forty-two (84%) of the 50 participants in the MHS cohort were contactable for follow up at six months or on discharge to repeat the self-rating scales. A comparison of baseline and follow up BDI-II mean scores showed no significant change in their depressive symptoms following intervention (baseline mean=26.62, SD=13.06; follow up mean=19.86, SD=15.67, $p=0.069$). This is consistent with the effective versus the limited or non-effective response rates already noted: clients did not achieve expected gains following a traditional intervention for a mood disorder. Much the same can be said of the DS mean scores (baseline mean=48.8; SD=18.2, follow up mean=38.3, SD=22.3, $p=0.265$).

Significant associations were found between the BHS baseline and follow up mean scores (BHS baseline mean=8.60, SD=5.12, follow up mean=6.86, SD= 5.61, $p<0.05$) and the SHAPS (baseline mean=3.58, SD=3.83; follow up mean=3.19, SD=3.66, $p<0.05$). This result indicated that while participants felt more hopeful and had slightly more hedonic tone, their depression scores had not changed.

Depression with anhedonia and depression with demoralization

The clinical cut-off points were used to recode the variables BDI-II, BHS, DS and SHAPS total scores into categories for further analysis to determine significant differences between depression with anhedonia and depression with demoralization.

Cross tabulations and Kendall's tau-b (T^b) were computed to compare these frequencies among the four measures. This analysis revealed a strong relationship between BDI-II and BHS categories ($T^b=6.603$, $p<0.001$). Nineteen of the 30 participants in the 'severely depressed group' were also in the moderate to severe level for hopelessness.

Comparison of the BDI-II and DS groups indicated a significant association ($T^b=9.503$, $p<0.001$) between the two. Twenty-five of the 30 participants in the severely depressed group were in the moderate to severe level for demoralization. Furthermore, comparison between the BDI-II and SHAPS categories was significant ($T^b=6.030$, $p<0.001$), with 22 of the 30 severely depressed participants having abnormal hedonic tone. All three measures (BHS, DS and SHAPS) were strongly associated with the depression categories, with severe depression

generally associated with more hopelessness, higher levels of demoralization and poorer SHAPS scores.

Analysis of factors known to impact mental health

Relatively small numbers in some of the variables with the potential to impact an individual's successful resettlement, mental health and participants' demoralization scores required re-coding of these variables to establish mean demoralization scores and levels for comparison among the differing groups to ensure more meaningful analysis. No significant associations were found between time in host country (0–12 months mean=44.52, SD=23.75; 1–3 years mean= 38.24, SD=17.62; 3-5 years mean=37.48; SD 19.72, p=0.619), family in host country (has family mean=39.42; SD=18.42; no family mean= 39.86; SD=23.56, p=0.927), language acquisition (speaks English mean=37.61; SD=20.21; no English mean= 44.17, SD=17.00, p=0.127) and enrolled in study (enrolled mean=40.22;SD=18.54; not enrolled mean=38.80;SD=20.54, p=0.718). The only significant association with 'other factors' was found between employment and demoralization (employed mean=33.18; SD=20.50; unemployed mean=43.73; SD=17.71, p<0.01).

Demoralization was associated strongly with 'other variables', including somatic complaints (mean=44.65; SD=17.74, p<0.001), diagnosis (mood/anxiety disorder mean = 48.89; SD=17.01; no mood/anxiety disorder mean=27.60; SD=15.94, p<0.001), antidepressant intervention (medicated mean= 48.72; SD =17.09; not medicated mean= 31.34; SD=17.87, p<0.001) and response to antidepressants (effective mean=36.40; SD=15.44, not fully effective mean=52.05, SD=16.12, p<0.001).

DISCUSSION The literature recognizes that psychological distress, depression, and psychosomatic illness are elevated in refugee and migrant populations (Bhugra, 2004; Claassen *et al*, 2005; Fazel *et al*, 2005). Clinical experience (Briggs & Macleod, 2006) suggests the concept of demoralization shows promise of being a more relevant diagnosis than major depressive disorder, as currently defined under the DSM-IV (American Psychiatric Association, 1994), for refugee and migrant people presenting at mental health services. However, while demoralization in immigrant and refugee populations is an intriguing and important concept it is also problematic due to the difficulties in categorizing it in clinical terms. That is, it raises questions in regard to whether demoralization is a symptom, a syndrome or a diagnosis or simply a descriptive term of psychological distress.

In order to address these questions, this study attempted to differentiate depression with anhedonia from depression with demoralization. Differentiation was not possible because the more depressed participants were also more demoralized. However, whilst it was not possible to differentiate between anhedonia and demoralization, there was a lower than anticipated positive response rate in participants who had been prescribed antidepressant medication, particularly among the MHS cohort, 74% of whom reported limited effective response rates. This is contrary to the findings of one of the largest studies to date, in which 47% of participants achieved complete remission of symptoms after an adequate trial with a single antidepressant, and up to 63% demonstrated improvement following a course of antidepressants (Thase *et al*, 2005).

Two other studies found that genetics may partially account for some variation in antidepressant treatment outcomes, with African-American patients responding differently from white patients to antidepressant medications, and psychosocial factors also playing a role

(Brown *et al*, 1999; McMahon *et al*, 2006). Therefore, genetics or psychosocial factors, as well as non-compliance with medication regimes may have influenced the results of the Australasian study. Nonetheless, the self-reported response rates for the use of antidepressants raise questions about appropriate conceptualization of the problems refugee and migrant clients may face, and imply difficulties with applying DSM-IV criteria to such clients presenting with mental health conditions.

Comparison of the mean baseline and follow up scores for the MHS participants indicated that the presence or absence of hedonic tone, and the degree of hopelessness, appear to be important indicators of demoralization, as significant differences were found when comparing the mean baseline and follow up scores of the BHS ($p < 0.05$) and SHAPS ($p < 0.05$). In contrast, no significant difference was found when comparing mean baseline and follow up BDI-II scores ($p = 0.069$). Therefore, demoralization may be helpful in predicting people at risk of suicide, because psychiatry has traditionally associated both depression and hopelessness with suicidal ideation (Beck *et al*, 1975; Wetzel *et al*, 1980).

Analysis and comparison of the clinical and non-clinical cohorts' overall responses to all four self-rating scales for subjective psychological distress, hopelessness, hedonic tone and demoralization to ascertain whether similar rates of demoralization were present in these two groups (AUR and CRS as one group; MHS as the other) found that all participants experienced some degree of demoralization. The MHS cohort were more depressed than other participants, as would be expected of clients admitted to a mental health service.

Findings in relation to other factors known to impact on successful resettlement indicate that for the study sample, contrary to the literature, time in the resettled environment did not appear to impact on the demoralization score. One explanation may be that the time taken for refugees or migrants to adjust culturally and emotionally to a new environment may be linked to whether or not they have family with them. As identified in the literature, depression and anxiety among refugees and migrants can be alleviated if they can maintain family ties (Bhugra, 2005; Gong-Guy *et al*, 1991; Nash *et al*, 2006; Park & Bernstein, 2008). The majority (79%) of participants in this sample had family in their host country.

This study agreed with the literature in relation to employment status. Getting appropriate employment is a key factor in resettlement (Pernice *et al*, 2009), and the significant association ($p < 0.01$) between employment and demoralization scores reflects the benefits of employment - access to an income, resultant acceptable standard of living and greater acceptance in the host society. Denial of this opportunity can affect an individual's mental well being. Gaining employment is often dependent on ability to communicate in the host country's major language. Almost two thirds (71%) of the participants could speak English to the extent that they did not require an interpreter, which would have enhanced their ability to gain employment. The finding that there was no significant association between language and the DS was expected due to the high rate of English language ability in the sample.

Comparison across Australian and New Zealand participants for the factors 'employment' and 'enrolled in study' showed unexpected variance. This may be attributed to differences in definitions of employment in each country and participants' understanding of enrolled in study meaning attending language classes. It was also more likely that employed participants had a limited opportunity to undertake study.

The association between somatic complaints (51% of the sample reported these) and demoralization was also consistent with the literature. Patterns of somatization are found among depressed patients from many ethnic groups, with depressive affect and disorder being common aspects of collective and personal experiences of loss and trauma among refugee populations (Kleinman, 2004).

Considering cultural differences in understanding concepts of mental illness and analyzing all results across all cohorts in the study, the DS may in future be a useful tool for identifying refugee and migrant people with moderate to severe demoralization scores. However, suggested cut-off points for the DS established for this study may not be useful in other samples.

There are limitations to the study as it leaves unanswered questions in regard to what interventions can decrease the distress of immigrants and refugees who experience depression and demoralization as yet, it is unknown as to what extent demoralization may decrease with time, appropriate employment and cultural integration in the host country.

CONCLUSION The literature details the complex relationship between the process of migration and the impact on an individual's development of psychological or psychiatric conditions. Successful resettlement requires considerable adaptation. If expectations are not met, an individual can become very distressed, disheartened and demoralized, leading to impaired mental health. Thus, any sample of refugee and migrant clients attending mental health or resettlement services is likely to have diagnosable psychiatric disorders.

This study has generated some unexpected results, in particular the seeming non-effectiveness of traditional antidepressant medication. Several unknown factors may have influenced this particular result. Little was known about the participants' personality, amount of social support and preparation for the process of migration prior to entry to the host countries because it was not possible to study the pre-migratory aspects of the participants' mental health. However, whilst it was not possible to differentiate depression with anhedonia from depression with demoralization, the overall results indicate that in cases of minimal or mild depression the DS may be an applicable measure of non-specific distress that spans a spectrum from mild disheartenment through to total despondency. It may also be useful for measuring change following intervention. These hypotheses require further exploration.

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The Upper South Regional Ethics Committee granted ethics approval for the study. Professor David Kissane also gave consent to use the DS with a sample of refugee and migrant people.

NOTES

¹ People migrating to New Zealand from refugee-like situations are officially termed 'migrants'. Hence, throughout this paper, 'migrants' refers specifically to migrants from refugee-like backgrounds.

REFERENCES

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (4th Ed) (DSM-IV)*. Washington (DC), American Psychiatric Association, 1994
- Beck AT, Weissman A, Lester D, Trexler L. The measurement of pessimism: the Beck Hopelessness Scale. *Journal of Consulting and Clinical Psychology*, 42: 861–865, 1974
- Beck AT, Kovacs M, Weissman A. Hopelessness and suicidal behaviour: an overview. *Journal of the American Medical Association*, 234: 1146–1149, 1975
- Beck AT, Steer RA, Brown GK. *Beck Depression Inventory-II Manual*. San Antonio (TX), The Psychological Corporation, 1996
- Bhugra D. Migration and mental health. *Acta Psychiatrica Scandinavica*, 109: 243–258, 2004
- Bhugra D. Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants. *Acta Psychiatrica Scandinavica*, 111: 84–93, 2005
- Briggs L, Macleod S. Demoralization - a useful conceptualisation of non-specific psychological distress among refugees attending mental health services. *International Journal of Social Psychiatry*, 52: 512–524, 2006
- Briggs L, Talbot C, Melvin K. An exploratory study of demoralization and migration experience. *International Review of Modern Sociology*, 33: 193–209, 2007
- Brown C, Schulberg HC, Sacco D, Perel JM, Houck PR. Effectiveness of treatments for major depression in primary medical care practice: a post hoc analysis of outcomes for African American and white patients. *Journal of Affective Disorders*, 53: 185–192, 1999
- Claassen D, Ascoli M, Berhe T, Priebe S. Research on mental disorders and their care in immigrant populations: a review of publications from Germany, Italy and the UK. *European Psychiatry*, 20: 540–549, 2005
- Clarke DM, Kissane DW. Demoralization: its phenomenology and importance. *Australian and New Zealand Journal of Psychiatry*, 36: 733–742, 2002
- Clarke DM, Kissane DW, Trauer T, Smith GC. Demoralization, anhedonia and grief in patients with severe physical illness. *World Psychiatry*, 4: 96–105, 2005
- de Figueiredo JM. Depression and demoralization: phenomenological differences and research perspectives. *Comprehensive Psychiatry*, 34: 308–311, 1993
- Department of Immigration and Citizenship. *Fact Sheet 60—Australia's Refugee and Humanitarian Program*, Australian Government, 2009a. <http://www.immi.gov.au/media/fact-sheets/> (Accessed October 22, 2010)
- Department of Immigration and Citizenship. *Fact Sheet 15—Population Projections*, Australian Government, 2009b. <http://www.immi.gov.au/media/fact-sheets/> (Accessed October 22, 2010)
- Department of Immigration and Citizenship. *Immigration update July to December 2009*. Canberra: Commonwealth of Australia, 8, 2010. <http://www.immi.gov.au/media/publications/statistics/> (Accessed October 22, 2010)
- Dohrenwend BP, Shrout PE, Egri G, Mendelsohn FS. Nonspecific psychological distress and other dimensions of psychopathology. Measures for use in the general population. *Archives of General Psychiatry*, 37:1229–1236, 1980
- Engel GL. A psychological setting of somatic disease: the 'Giving Up-Given Up' complex. *Proceedings of the Royal Society of Medicine*, 60: 553–555, 1967
- Erikson, EH. *Identity and the Life Cycle*. (re-issue 1959). New York, WW Norton & Company, 1994
- Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet* 365: 1309–1314, 2005
- Frank JD. Psychotherapy: the restoration of morale. *American Journal of Psychiatry*, 131: 271–274, 1974
- Fryers T, Melzer D, Jenkins R. Social inequalities and the common mental disorders: a systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology*, 38: 229–237, 2003
- Gong-Guy E, Cravens RB, Patterson TE. Clinical issues in mental health service delivery to refugees. *American Psychologist*, 46: 642–648, 1991
- Hollifield M, Warner TD, Lian N, Krakow B, Jenkins JH, Kesler J, Stevenson J, Westermeyer J. Measuring trauma and health status in refugees: a critical review. *Journal of the American Medical Association*, 288: 611–621, 2002
- Jacobsen JC, Vanderwerker LC, Block SD, Friedlander RJ, Maciejewski PK, Prigerson HG. Depression and demoralization as distinct syndromes: preliminary data from a cohort of advanced cancer patients. *Indian Journal of Palliative Care*, 12: 8–15, 2006

DEMORALIZATION IN REFUGEES AND MIGRANTS

- Kissane DW, Clarke DM, Street AF. Demoralization syndrome - a relevant psychiatric diagnosis for palliative care. *Journal of Palliative Care*, 17: 12–21, 2001
- Kissane DW, Wein S, Love A, Lee XQ, Kee PL, Clarke DM. The Demoralization Scale: a report of its development and preliminary validation. *Journal of Palliative Care*, 20: 269–276, 2004
- Klein DF, Gittelman R, Quitkin F, Rifkin A. *Diagnosis and drug treatment of psychiatric disorders: adults and children (2nd Ed)*. Baltimore (MD), Lippincott Williams & Wilkins, 248–249, 1980
- Kleinman A. Culture and depression. *New England Journal of Medicine*, 351: 951–953, 2004
- Lindström M, Moghaddassi M, Merlo J. Individual and contextual determinants of self-reported poor psychological health: a population-based multilevel analysis in southern Sweden. *Scandinavian Journal of Public Health*, 34: 397–405, 2006
- McMahon FJ, Buervenich S, Charney D, Lipsky R, Rush AJ, Wilson AF, Sorant AJM, Papanicolaou GJ, Laje G, Fava M, Trivedi MH, Wisniewski SR, Manji H. Variation in the gene encoding the serotonin 2A receptor is associated with outcome of antidepressant treatment. *American Journal of Human Genetics*, 78: 804–814, 2006
- Nash M, Wong J, Trlin A. Civic and social integration: a new field of social work practice with immigrants, refugees and asylum seekers. *International Social Work*, 49: 345–363, 2006
- New Zealand Immigration Service. *Refugee voices: a journey towards resettlement*. Wellington, Department of Labour, 44, 2004
- Pahud M. *The coping processes of adult refugees resettled in New Zealand*. Doctor of Philosophy Thesis, New Zealand, University of Canterbury, 19, 2009
- Park SY, Bernstein KS. Depression and Korean American immigrants. *Archives of Psychiatric Nursing*, 22: 12–19, 2008
- Pernice R, Trlin A, Henderson A, North N, Skinner M. Employment status, duration of residence and mental health among skilled migrants to New Zealand: results of a longitudinal study. *International Journal of Social Psychiatry*, 55: 272–287, 2009
- Snaith RP, Hamilton M, Morley S, Humayan A, Hargreaves D, Trigwell P. A scale for the assessment of hedonic tone: the Snaith-Hamilton Pleasure Scale. *British Journal of Psychiatry*, 167: 99–103, 1995
- SPSS INC. *SPSS for Windows*, 17 (August release), Chicago, 2008
- Statistics New Zealand. *QuickStats about culture and identity, 2006 Census*. New Zealand Government, 2006. <http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats> (Accessed October 22, 2010)
- Thase ME, Haight BR, Richard N, Rockett CB, Mitton M, Modell JG, VanMeter S, Harriett AE, Wang Y. Remission rates following antidepressant therapy with bupropion or selective serotonin reuptake inhibitors: a meta-analysis of original data from 7 randomized controlled trials. *Journal of Clinical Psychiatry*, 66: 974–981, 2005
- UNHCR. *Convention and 1967 Protocols Relating to the Status of Refugees*. Public Information Section, United Nations High Commissioner for Refugees, August 1996. www.unhcr.org/au/pdfs/convention.pdf (Accessed October 22, 2010)
- Wetzel RD, Margulies T, Davis R, Karam E. Hopelessness, depression, and suicide intent. *Journal of Clinical Psychiatry*, 41: 159–160, 1980