

The Impact of Cultural Values, Family Involvement and Health
Services on Mental Health and Mental Illness

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Abstract

This paper explores the impact of cultural values, the role of the family, access to and usage of culturally acceptable health services for three distinct Canadian cultural groups. Specifically the paper examines the mind/body/spirit connection, the cultural impact of formal or informal social support, as well as access and willingness to seek help in the context of mental health among Canadian Aboriginals, Chinese and Asian Indian cultures. Three diseases that have been documented only within Canadian Aboriginal, Chinese and Asian Indian cultures are also examined. Through using examples from three separate and very distinct cultures, this paper hopes to foster a greater cross-cultural understanding of mental health and mental illness.

Introduction

Awareness of culture has never been more important in Canada than now. There are hundreds of thousands of people who immigrate to this country every year from all over the world. The people who arrive in Canada come from distinct social, cultural and religious backgrounds. The adjustment to a new place of residence is often and can greatly impact the mental health of an individual or family. In Western culture and specifically in Canada, the difference between mental health and mental illness is rather sharply delineated, primarily based on the Diagnostic and Statistical Manual of Mental

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Disorders, Fourth Edition, Text Revision (APA, 2000). However, in certain cultures what defines good mental health or a severe mental illness is different (Chin & Kameoka, 2005). This paper examines the mind/body/spirit connection, the cultural impact of formal or informal social support, as well as access and willingness to seek help in the context of mental health of three distinct cultures. Three diseases that have been documented to occur within Canadian Aboriginal, Chinese and Asian Indian populations will also be briefly mentioned. Using examples from these three cultures, the paper is intended to foster a greater cross-cultural understanding of mental health and mental illness.

One positive outcome of greater awareness of different cultures would be that health care professionals, and specifically nurses, would be able to understand the needs of their patients better, allowing for more effective treatment. This paper will not provide a direct comparison between the three cultures and the majority so-called “Canadian” culture which is primarily European origin because it is intended to be only a beginning exploration of some relevant cultural concepts for nursing students. The cultures that will be outlined in this paper were chosen on the basis of our personal interests.

Cultural Values and Mental Health: An Analysis

The concept of the mind, body, and spirit connection is defined similarly by the three cultures. In the Canadian Aboriginal culture, it represents “interconnectedness of social, physical and spiritual environments” (Crowe-Salazar, 2007: 84), which is very important to the mental well-being of the people – so important, in fact, that a simple disruption can have serious repercussions. For example, outlawing certain cultural

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practices due to destruction of the environment, such as traditional hunting practices that were meant to maintain personal health, has had significant influence over the well being of individuals and families as well as the community (Kirmayer, Brass & Tait, 2000: 612). Outlawing traditional practices can certainly impact the self-image and the mental health of the affected community and its members. Traditional activities associated with these practices often involve family members in specific roles that contribute to their sense of belonging.

In the Chinese culture, similarly to the Canadian Aboriginals, there is a connection between the mind, body and spirit. This connection is referred to as yin and yang. The premise of yin/yang in traditional Chinese medicine is that both negative and positive forces act both positively and negatively on everything in life, including the body and the mind. For example, the inside of the body is considered yin and the outer surface is yang (Spector, 2004: 215). These positive and negative forces along with qi, which is vital energy circulating within the body, if maintained in balance, ensure a disease-free state of the mind and body (Leung, 1998: 122). On the other hand, “the loss of such a balance is the root cause of all emotional disorders” (Pan, 2003: 243). The need to integrate the entire body, mind, and relations with family, and society in the treatment of psychiatric disorders to maintain a balance of the forces of yin, yang and qi has been the basis for mental health treatment historically for millennia in Chinese culture (So, 2005). Health care providers in Canada need to have at least a rudimentary understanding of the elements that are considered to act on the health of an individual of the Chinese culture. This basic insight could potentially increase the efficacy of treatment.

The Asian Indian culture, as in the preceding two cultures, embodies the concept of interconnectedness of the mind, body and spirit. “Theories of ‘Ayurveda’ view the body, mind and soul as a system.” (Tewary, 2005: 12). These theories also identify that an “unbalance in any of these systems might lead to illness” (Tewary: 12) and that the family has a role in helping an individual to regain the balance (Kumar, Bhugra & Singh, 2005). Being able to maintain a balance in life can sometimes be challenging especially when that balance must include the mind, body and soul of an individual. It can also be challenging to deal specifically with mental health because the individual can “manifest both mental and physical symptoms” (Tewary: 12). These symptoms are a direct example of the belief that “the mind and body are a continuation of each other” (Tewary: 10). Keeping this connection in mind, it is important for the health care professional to be able to implement treatment that would meet the individual’s needs in terms of mind, body and spirit and that can involve the family in a supportive role.

To be able to address some of these needs some psychiatrists “regularly use religious teachings as a basis for the treatment of their patients” (Wig, 1999: 94). The use of religious teachings clearly shows a deeper cultural understanding of the well being of an individual. Knowledge and willingness of the health care provider to engage in such practices could help to ensure treatment that is more compatible with the personal beliefs of an affected individual. This is not to say, however, that health providers should compromise their own values in a way that distresses them, for this could harm their mental well being and their ability to promote the health of others. A basic understanding of the theories and concepts that the Asian Indians value along with referral to an appropriate chaplain may be the most fitting course of action in some situations.

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The involvement of family and the community in an individual's life is essential in the Canadian Aboriginal culture. In particular, "the well-being of the family, band or community is given central importance" (Kirmayer et al, 2000: 612). The involvement of the family to provide social support to individuals is critical during both the course of an illness and recovery process. Individuals affected by an illness and having an opportunity to be able to talk with someone about their feelings and fears have a much better state of overall well being, including a better state of mental health.

Family and community support are also crucial for people undergoing great changes in their lives, such as the effects that are still seen in Canadian Aboriginal populations due to colonization. Kirmayer et al (2000) indicated that high rates of depression among the Aboriginal people of Canada have been attributed to many factors, one such factor being cultural discontinuity as a side effect of colonization. The prevention and treatment of mental health problems as well as health promotion must then include not just the individual but the family and community in order to be successful (Kirmayer, Simpson & Cargo, 2003: 21). Involvement of the family and community in individual mental health promotion may be key to preventing some mental illnesses such as depression.

The concept of family and social support is immensely important in Chinese culture just as it is in the Canadian Aboriginal culture. The Chinese culture embodies very strong gender and family roles. Adherence to these roles is considered to be central to well being. "An individual is obligated to do whatever it takes to maintain a well-functioning family." (Hsiao, Klimidis, Minas & Tan, 2006: 999). There are some clear distinctions between Chinese and Western approaches to treating individual mental

illnesses. Treating a Chinese patient may not be successful if the whole family is not included due to the emphasis in the Chinese culture on interpersonal dynamics (Hsiao et al.: 999). The entire family is a unit as opposed to Western views of individuals, not families as units. The entire family, along with the general immersion into a community, contributes to the mental well being of the affected individual and, in fact, “social integration buffers stressors and contributes to more positive mental health status” (Mirowsky and Ross as cited in Mjelde-Mossey, Chi & Lou, 2006: 21). Understanding of family structure within the Chinese culture can improve the approach a health care professional would take in regards to treatment and inclusion of the entire family in the process of treatment and recovery. Keeping in mind the distinct roles within the Chinese community and family could potentially help the health care provider to be able to treat the individual and family appropriately.

The support of family and community for an individual with a mental illness is also crucial in the Asian Indian culture, in fact, the involvement of the family is so imperative, that sometimes it is not just encouraged but is often a prerequisite of seeking help for a psychiatric illness (Stanhope, 2002: 276). In Western medical treatment often just one family member or a friend is asked to be involved whereas in the Asian Indian culture the entire family may be expected to be involved in the treatment. In the rehabilitation process, the extent of family support for the affected individual has been cited as a major factor of success (Stanhope: 276). The existence of extended families is also a major contributing factor to the well being of the entire family and the individual with a psychiatric disorder. In particular, “the strain of caring for a person is absorbed by all clan members” (Chatterjee & Chatterjee, cited in Stanhope: p. 276). The clan then acts

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as “an important buffering mechanism for both the person with a mental illness and their caregivers” (Stanhope: 276). In this regard, family involvement and social support has a positive impact on the recovery of the affected individual while not overloading any one individual. The availability of a family support network influences the ultimate outcome of the disease process, while the presence of extended family support contributes to the well being of both the patient and the entire family.

Being able to have social support is extremely pertinent to recovery and prevention of mental illness. However, lack of access and unwillingness to seek help can dampen the effects of social support. The Canadian Aboriginal population is widely distributed throughout Canada. In the north many communities have very poor access to mental health care for several different reasons, including geographical problems for access such as lack of roads and long distances to travel for care (Kent-Wilkinson & Boyd, 2008), which would separate them from their families and community support systems. These are the physical barriers that Canadian Aboriginals must overcome to be able to have access to health care. There are also emotional barriers such as the desire or willingness to seek help for a mental disorder from persons of a different culture. A very small number of Native people have professional training in mental health and relatively little mental health information has been translated into Aboriginal dialects (Kirmayer et al., 2000: 613). The physical and emotional barriers may prevent many people from seeking formal help. This may have negative effects on the entire community because the individuals of Aboriginal communities are often interconnected.

With the Chinese, the issue of access to mental health care and willingness to seek help are completely different from the previously described Aboriginal Canadians. Many

in the Chinese culture tend to believe that their problems are insufficient to seek formal help (Chiu, 2004: 159). This limits the number of people who seek access to professional resources, such as crisis hotlines. This particular culture emphasizes informal to formal help due to the concept of self-reliance (Chiu: 156). Furthermore, it is even considered shameful to seek help in regards to personal matters (Shek, as cited in Chiu: 157). These limitations can greatly impede an individual's or a family's willingness to seek professional help or even to admit that a serious problem may be present that requires formal support.

The issues of access to mental health services and willingness to seek help are different for the Asian Indian culture. Despite a large proportion of Asian Indians in the Canadian population, "as a group they do not seem to utilize [a lot of] mental health services" (Das & Kemp, 1997: 30). The lack of people accessing mental health services may be related to their distinctive cultural beliefs. There are several reasons for this disparity, such as cultural beliefs that forbid talking about personal concerns outside of the family (Das & Kemp). Concerning mental illness, it has been noted that "in a study of 300 patients with psychiatric disorders, 55% attributed their psychiatric disorders to supernatural forces including ghosts, evil spirits, and witchcraft" (Jiloha & Kishore, as cited in Stanhope: 274). It is very difficult to attempt to seek help from a psychiatrist or a psychologist when a person genuinely believes that the mental disorder he or she possesses comes from a supernatural force. There is an element of fear of misinterpretation present and for some rural populations "up to 80% of people with a psychiatric disorder seek help from healers rather than physicians" (Jiloha and Kishore, as cited in Stanhope: 274). Health care providers need to be able to understand the

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presence of cultural barriers, such as specific cultural beliefs, and how those barriers may impact the willingness of an Asian Indian affected with a psychiatric disorder to seek formal help, such as the services of a psychologist, psychiatrist, or other health care provider.

How mental illnesses are manifested is, to a large extent, shaped by culture, so differences in culture could logically result in differences in disease presentation (Chin & Kameoka, 2005). There are several disorders known to occur within particular cultures. These diseases are not prevalent in Western medicine or in any other cultural group. Therefore, the diagnosis, treatment and even general understanding of these diseases can sometimes be challenging to health care workers who do not have prior knowledge of the existence of the disease or the means of treatment for it. This also presents barriers to access for persons of these cultures who experience the disorders and to their families.

In the Aboriginal Canadian population, the presence of unusual diseases that occur in their culture may be another reason for lack of use of the mental health care system. An example of one such disease is Uquamairineq, prevalent in the Inuit. This disease is described as “hypnotic states, disturbed sleep, sleep paralysis, dissociative episodes and occasional hallucinations” (Marsella as cited in Marsella & Yamada, 2007: 806). Another mental illness specific to Aboriginal people is Windigo. This particular illness is specific to the Cree population of the west coast and is characterized by “an individual’s belief that he or she [is] turning into a cannibal monster, as evidenced by a compulsive desire to eat human flesh” (Waldram, 2004: 192). Even though the above-mentioned illnesses are both extremely rare, the existence of these types of illnesses must

be acknowledged as part of greater understanding of culture of the Canadian Aboriginals and as a reason for hesitance to seek Western health services.

The Chinese culture also has some unusual, mental disorders which are not prevalent in other cultures and which are hard to distinguish from acute psychosis. The health care professional must be aware of the possibility of presence of certain types of mental illnesses within only the Chinese population. One such illness is Koro, which is a type of mental disorder in which there is “intense fear following perception that one’s genitalia (men/women) or breasts (women) are withdrawing into one’s body. Shame may also be present if perception is associated in time with immoral sexual activity” (Marsella as cited in Marsella & Yamada, 2007: 806). Awareness of culturally related disorders provides a wider base of knowledge for diagnosis and treatment of individuals of the Chinese culture. Awareness also helps health care professionals to provide more culturally sensitive care.

In the Asian Indian culture, as in the two previously mentioned cultures, there are also unusual, culturally related mental disorders. One such disorder, called Suchi-bai, is specific to Bengal, India and even more specifically to Hindu widows. The disorder manifests itself as “excessive concerns for cleanliness (changes street clothes, washes money, hops while walking to avoid dirt, washes furniture, remains immersed in holy river)” (Marsella as cited in Marsella & Yamada, 2007: 806). Another unusual, culturally related disorder evident in the Punjabi culture (which is seen both in India and Pakistan) is referred to as the “Sinking heart”. It is a condition of distress which manifests itself as “physical sensations in the heart or chest and is thought to be caused by excessive heat, exhaustion, worry, or social failure” (Matsumoto & Juang, 2004: 349).

Conclusion

Awareness of such disorders that may be found in particular cultures could immensely improve understanding of certain cultural groups and also improve the quality of health care provided to these groups. However, knowledge of all rare mental diseases is not practical. Openness to listen and record the client's or family members' descriptions of signs and symptoms without judgment or quick classification into Western medical categories could do much to improve cultural sensitivity, efficacy of treatment, and, in the long run, access to care for persons of non-dominant cultures such as these.

Three factors have been explored concerning their impacts on mental health. These are knowledge of cultural values, involvement of family in culturally acceptable ways, and increasing access to culturally acceptable health services. Having better knowledge of different cultural groups in Canada can greatly improve the quality and quantity of mental health services that people will utilize. The three cultural groups outlined in this paper all have distinct needs. Yet, values concerning the mind/body/spirit connection are similar and very important for all three. The belief systems of Canadian Aboriginal, Chinese, and Asian Indian persons are all based on the interconnectedness of the mind, body and spirit and that when there is a disruption in any one of these three, the body or the mind suffers. All of these cultures hold beliefs that when there is a balance of the three components, the body and the mind will be healthy.

Involvement of family and/or the community can greatly improve the health and recuperation from mental disease. Family members are a unit and everyone can contribute to the well-being of the individual with the mental illness. Access to health

care and the willingness of members of cultural groups to utilize formal resources or professional help is affected by unique barriers within the three cultures: such as geographical challenges, inadequate proportions of people within the cultural group with professional training in mental health, lack of translation of information into different dialects or languages with culturally appropriate contexts, and particular manifestations of illness that do not fit Western categories well. The cultural concepts related to self-reliance or the feeling of shame for seeking professional help also act as barriers to utilization of services for individuals and their families as do cultural ideas about supernatural causation of mental illness.

Increasing knowledge of the existing differences between beliefs and manifestation of illness could greatly improve the diagnosis and treatment of mental illnesses within these groups. This knowledge could also lead to a greater understanding of differences in other cultural groups from the Canadian culture which could lead to more culturally sensitive care for all.

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