CULTURAL COMPETENCE COLUMN

Family and Community Responses to Mental Illness

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Cultural groups respond differently to mental illness depending on the explanations of the cause, attitudes in the community toward mental illness and its treatment, and the social and community resources available to patients and their families. Our column last month explored these explanations and attitudes. This column focuses on family and community treatment of mental illness and the care of the mentally ill, especially those with severe mental illness.

In Western and developed countries, mental illness treatment may be highly organized and provided by mental health institutions and professionals. Ideally, supportive community resources, together with family and friend networks, facilitate effective coping with mental illness (US Department of Health and Human Services [USDHHS], 2001). Often, however, this ideal is not achieved in practice. For example, in Italy there is a general belief and acceptance of biomedical explanations, the use of psychotropic medications, and a community psychiatric treatment model accompanied, nevertheless, by a belief that those with severe mental illness should not have children (Magliano et al., 2004). In developed and resource-rich societies such as the US, social stigma, shame, and embarrassment associated with mental illness, distrust of the health care system, and fear of psychotropic drugs still exist and may lead to denial and a failure to seek treatment (Matthews et al., 2006). Some modern societies embrace both biomedical and traditional treatments — psychiatrists and psychopharmacologic medications coexisting with holy men, religious rituals, and pilgrimages to shrines in Morocco (Stein, 2000), with temple prayer and religious treatment in India (Saravanan et al., 2007), and with traditional healers/curandero(a)s, cleansing rituals, and psycho-spiritual healing among Mexicans (Magana et al., 2007; Zacharias, 2006).

In cultures in which family and harmonious communal living are emphasized, individual illness is considered family illness and brings shame and stigma to the family. These cultural groups believe that mental illness reflects poorly on the family and is an indication of poor guidance and discipline by the head (usually male) of the family (Burnard, Naiyapatana, & Lloyd, 2006; Lee & Bishop, 2001; Sanchez & Gau, 2007; Whittaker, Hardy, Lewis, & Buchanan, 2005). In these societies, the family may be subject to social rejection, community isolation, and an unwillingness of community members to marry into the family. Mental illness is often denied; the mentally ill family member is hidden from the community and cared for by the family. Professional help is a last resort and is not sought until caring for the family member becomes unbearable and mental illness is severe. Mental illness may be somatized allowing displacement of symptoms onto biologic conditions and allowing the family to seek medical treatment. When help is sought, it is a family decision and the family chooses the type of treatment that will be accepted.

Many of these beliefs and practices differ from those of Western psychiatry. However, mental illness treatment that is tailored to patient and family cultural practices is more likely to be accepted and to have better outcomes. Mental health professionals may be tempted to dismiss the efficacy of traditional treatments and to favor biomedical explanations of mental illness and neuropsychiatric treatments. Despite our belief that Western psychiatry offers the best treatment for serious mental illness, there is evidence to the contrary. The World Health Organization (1973) began the International Study of Schizophrenia in 1967 and has followed a cohort of patients diagnosed with schizophrenia for 30 years. Patients came from nine countries (Colombia, Czechoslovakia, Denmark, India, Nigeria, China, the USSR, the United Kingdom, and the US) representing the...
major contrasting cultures of the world with different levels of social and industrial development. The results have been consistent (Sartorius, Jablensky, & Shapiro, 1978; Leff et al., 1992; Vedantam, 2005). Schizophrenic patients in poorer countries (Nigeria, Columbia, and India) had, on average, a considerably better course and outcome than those in the developed countries: They spent fewer days in hospitals, were more likely to be employed, and were more socially connected. Between half and two-thirds became symptom-free, whereas only about a third of patients from developed countries recovered to the same degree. Nigerian, Colombian, and Indian patients also seemed less likely to suffer relapses and had longer periods of health between relapses.

Although diagnosis was standardized across countries, treatment differed appreciably among countries and cultures. For example, most people with schizophrenia in India lived with their families or other social networks—in sharp contrast to the United States, where many schizophrenic patients are homeless, in group homes, or on their own, in psychiatric facilities or in jail. Many Indian patients were given low-stress jobs by a culture that values social connectedness over productivity; patients in the United States are often excluded from regular workplaces. In countries such as Denmark, patients who are psychotic are on disability for life. Virtually no one who has schizophrenia has a job.

Doctors in poorer countries stopped drugs when patients became better—whereas doctors in rich countries often required patients to take medication all their lives. Psychiatrists in developing countries, unlike their Western counterparts, dispensed not only drugs but also spiritual advice, family counseling—even matchmaking services—and encouraged patients to complement their treatment with faith-healing techniques. Doctors were seen not only as medical experts, but also as wise authority figures.

The key to treating schizophrenia in these poorer countries lay in integrating cultural and social supports with medicine. But the current system in wealthy countries merely brings patients who are in crisis into hospitals, stabilizes them with drugs, and discharges them after a few days; an approach that seems doomed to end in the familiar "revolving door." Most US psychiatrists view schizophrenia as an organic brain disorder, whose origins and outcome depend on genes and brain chemistry. They acknowledge the psychosocial aspects of disease, but the challenges of connecting patients with jobs, schooling, and social networks are neglected—often because they fall outside the bounds of conventional medicine.

Mental health nurses have a real opportunity to provide the supportive psychosocial and cultural services that the seriously mentally ill require as part of their treatment. With our integrated background in biologic, behavioral, cultural, and environmental concepts, we are the ones to provide humane and sensible care to persons who are mentally ill and to support their families. We can do this while remaining centered in the nursing domain and maintaining our focus on caring and our sensitivity to the human condition (Flaskerud, 2000).

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REFERENCES


