Family, Culture and Mental Health
## Block 4

### FAMILY, CULTURE AND MENTAL HEALTH

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August, 2015

© Indira Gandhi National Open University, 2015
ISBN-978-81-266-6906-6

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Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by the Director, School of Social Sciences.

Laser Typeset by : Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sec.-2, Dwarka), N.Delhi-59
Printed at :
Block 4 of MPC-051 deals with the different influences of family and culture on the mental health of individuals. This block will give you details of how relationships and cultural influences can affect the mental health well-being.

**Unit 1** deals with “Developmental Theories”. In the first unit, you will be explained about the developmental theories which deals with the development of an individual in all aspects since childhood. It is interesting to know that human beings change with varied experiences of their life. Developmental theories attempts to understand; explain and predict behaviour that occurs throughout a person’s life span.

**Unit 2** describes “Family and Mental Health”. This unit will explain you about the role of family, care taker and related environments in dealing with mental illness of a child and other related aspects. The family’s part in mental health is inevitable and this unit will focus on understanding the role of family in mental health issues and its role in aspects of management.

**Unit 3** is on “Sociology of Mental Health”. In order to study social psychology and its relationship to mental health we need to understand social attitudes, social perception, attribution, social influence, communication patterns, leadership and social power, conformity and deviance, prejudice, group process and pro-social behaviour. The role of these aspects in mental health will be discussed in this section. Another aspect of understanding mental health from a sociological point of view is to understand the prevailing social conditions that influence psychological functioning.

**Unit 4** deals with “Culture and Mental Health”. In the last unit of this block, you will be introduced about the relevance of culture on the mental health of individuals. It is well known fact that, the differences in the way people think and behave may also be influenced by the culture to which he/she belongs and it has come to play a major role in the way mental health system is understood, developed and administered.
UNIT 1 DEVELOPMENTAL THEORIES

Structure

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1.0 INTRODUCTION

As reflected from the title, this block will deal with the influence of family environment and culture on the mental health of the individuals. The present unit will focus on the developmental theories which deal with the development of an individual in all aspects since childhood. It is interesting to know that human beings change with varied experiences of their life. Developmental theories attempt to understand; explain and predict behaviour that occurs throughout a person’s life span. Erikson’s and Piaget theories are two such theories.

1.1 OBJECTIVES

With the help of this unit, you will be able to:

- understand the stages of Psycho Social Development as propounded by Erik Erikson; and
- describe the stages of Piaget’s theory of Cognitive Development.
1.2 ERIK ERIKSON’S THEORY OF PSYCHOSOCIAL DEVELOPMENT

Erik Erikson has a significant contribution in the theories of personality development. The theory of psychosocial development is a well-known theory of Erikson which tries to explain the development of personality which takes place through a series of stages since childhood. The theory of Psycho social development describes the impact of social experience across the whole lifespan. In the process of social interaction, a person develops a sense of identity of oneself. *Ego identity* is one of the important concepts of Erikson’s theory. This is term given to the conscious sense of self that one develops through social interaction. According to Erikson, this sense of self changes, as one goes through the various stages of personality development. In every stage of life there is new information and experience that are present in one’s life. These are the challenges one faces to the sense of self or ego identity. The experience of facing these challenges determines one’s ego identity and shapes one’s perception of life. There are challenges which one faces in daily interactions in society and how one deals with it forms part of one’s personality. In addition to ego identity, Erikson also believed that a sense of competence motivates behaviors and actions. Each stage in Erikson’s theory is concerned with becoming competent in an area of life. If the stage is handled well, the person will feel a sense of mastery, which is sometimes referred to as *ego strength* or ego quality. If the stage is managed poorly, the person will emerge with a *sense of inadequacy*.

In each stage, Erikson believed people experience a conflict that serves as a turning point in development. In Erikson’s view, these conflicts are centered on either developing a psychological quality or failing to develop that quality. During these times, the potential for personal growth is high, but so is the potential for failure. The stages of psychosocial development have been discussed accordingly in the sub sections below:

### 1.2.1 Psychosocial Stage 1 - Trust vs. Mistrust (Approx. 0-2 yrs.)

This is the first stage of Erikson’s theory of psychosocial development. This stage occurs in between birth to two years of age of a child. It is a significant stage because at this phase of life, an infant is totally dependent on quality of care given. If the proper care is given a child will develop *trust*. This is considered important as this basic trust in the caregiver will make a child feel safe and secure in most of its future interactions. If care-giving is inconsistent, not dependable and rejecting in nature, the child develops a *sense of mistrust* which is carried over in future interactions.

Thus, when the child develops basic trust in the care-giver, a sense of hope and confidence in the world is developed. This would result in the child having an optimistic view of the world. The opposite is true for those children who fail to develop trust. Their sense of mistrust leads them to experience depression and they could be withdrawn from people and may even develop paranoia at a later point of time.
1.2.2 Psychosocial Stage 2 - Autonomy vs. Shame and Doubt (Approx. 2-4 yrs.)

The second stage of Erikson’s theory of psychosocial development occurs during early childhood. At this stage, children are focused on developing a greater sense of personal control. Erikson believed that toilet training was a vital part of this process. He believed that learning to control one’s bodily functions leads to a feeling of control and a sense of independence. Likewise developing control over the choice of food, toys or clothing is important in personality development. If a child is able to have a sense of personal control, he/she will feel secure and confident and if they do not succeed, then it might lead to a sense of inadequacy and self-doubt.

Thus, autonomy develops if a child is guided positively through praise, firmness, encouragement and gentleness to become independent. This will result in the child having a sense of will and good self esteem. If parents are too permissive, harsh, or demanding, the child can feel defeated, and experience extreme shame and doubt. This might result in maladaptive ways of gaining a feeling of control, power, or competence. For instance, following strict rules and regulations might give a false sense of competency. This could result in a form of obsessive behaviour. If the child is given no limits or guidance, the child can fail to gain any shame or doubt and be impulsive in its behaviour.

1.2.3 Psychosocial Stage 3 - Initiative vs. Guilt (Approx. 3-5 yrs.)

The third stage occurs during the preschool years, when a child starts asserting his/her power and is able to get a control over the world (his/her surroundings) through directing play and other social interactions. Children who are successful at this stage feel capable and able to lead others. Those who fail to acquire these skills are left with a sense of guilt, self-doubt, and lack of initiative.

Hence, if parents are understanding and supportive of a child’s efforts to show initiative, the child develops purpose, and sets goals and acts in ways to reach them whereas if children are punished for attempts to show initiative, they are likely to develop a sense of guilt, which in excess can lead to inhibition.

1.2.4 Psychosocial Stage 4 - Industry vs. Inferiority (Approx. 5-12 yrs.)

This stage covers the early school years and is a latency stage. At this stage of lifespan, a child starts developing a sense of pride in their accomplishments and abilities with the help social interactions. And if the child is encouraged and praised by parents and teachers then he/she develops a feeling of competence and belief in their skills. Those who receive little or no encouragement from parents, teachers, or peers will doubt their abilities to be successful. If caretakers do not support the child, feelings of inferiority are likely to develop and this might lead the child to become underachiever. Encouraging the child to feel over competent might make a child a shallow person not being able to reflect on personal deficits.
1.2.5 Psychosocial Stage 5 - Identity vs. Confusion
(Approx. 13-19 yrs.)

The fifth stage of development occurs at the stage of adolescence. At this stage, children explore their independence and develop a sense of self. Those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and a feeling of independence and control. Those who remain unsure of their beliefs and desires will feel insecure and confused about themselves and the future.

When an adolescent resolves this crisis, then a sense of *fidelity* would develop. This is described as a sense of identity regarding who they are and what is the objective of their life. If they are unable to resolve they develop *identity diffusion*. These adolescents may have an unstable sense of self and may need to belong to some group in order to develop a sense of identity. If this becomes a serious issue for the adolescent then they might have oppositional views and may join hate cults etc.

1.2.6 Psychosocial Stage 6 - Intimacy vs. Isolation
(Approx. 20-24 yrs. / 24-39 yrs.)

This stage covers the period of early adulthood. This is a stage in which people start exploring personal relationships. Erikson believed it was vital that people develop close, committed relationships with other people and have an ability to experience intimacy. Those who are successful at this stage will form relationships that are committed and secure. This will also depend on previous stages of development, such as developing a strong sense of personal identity. Persons with poor sense of self are observed to have a tendency to have less committed relationships and are more likely to suffer emotional isolation, loneliness, and depression.

1.2.7 Psychosocial Stage 7 - Generativity vs. Stagnation (Approx. 25-64/40-64 yrs.)

During middle adulthood, people continue to build their lives through various ways such as building a career and bringing up or caring for a family. Those who are successful during this phase will feel that they are contributing to the world by being active in their home and community. Those who fail to attain this skill will feel unproductive and uninvolved in the world. If a person has experienced a sense of creativity and success, then the person develops a sense of *generativity*. People who do not feel this develop a sense of *stagnation*. They become self absorbed, do not connect easily to others and do not offer much to society.

1.2.8 Psychosocial Stage 8 - Integrity vs. Despair
(65 yrs. till death)

This is a phase that occurs during late adulthood or old age and is focused on reflecting back on life. Those who face conflicts at this stage will feel that their life has been wasted and will experience many regrets. The individual will be left with feelings of bitterness and despair. Those who feel proud of their accomplishments will feel a sense of integrity. Successfully completing this phase means looking back with few regrets and a general feeling of satisfaction. These individuals will attain wisdom, even when confronting death.
This entails facing the ending of life, and accepting successes and failures, ageing, and loss. People develop *ego integrity* and accept their lives if they succeed, and develop a sense of wisdom and those who do not, feel a sense of *despair* and dread their death.

**Table: Psycho social Stages of Development by Erik Erikson**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Psycho-social crisis</th>
<th>Approximate age</th>
<th>Important relations at the stage</th>
<th>Criteria dominating the development at the stage</th>
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<tr>
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<td>Trust vs. Mistrust</td>
<td>0-2 years</td>
<td>Mother</td>
<td>Hope</td>
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<td>2</td>
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<td>Will</td>
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<td>Initiative vs. Guilt</td>
<td>3-5 years</td>
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<td>4</td>
<td>Industry vs. Inferiority</td>
<td>5-12 years</td>
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<td>13-19 years</td>
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<td>7</td>
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<td>25-64 years / 40-64 years</td>
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<td>8</td>
<td>Integrity vs. Despair</td>
<td>65 years till death</td>
<td>Humanity, mankind</td>
<td>Wisdom</td>
</tr>
</tbody>
</table>

**Self Assessment Questions 1**

State Whether the following statements are ‘True’ or ‘False’:

1) *Fidelity* is described as a sense of identity regarding who they are and what is the objective of their life ...................................... .

2) *Autonomy* develops if a child is guided negatively through blames, punishments and curse become independent .........................

3) If the proper care is given a child will develop *mistrust* towards the caretakes......................... .

4) Erikson believed it was vital that people develop close, committed relationships with other people and have an ability to experience intimacy......................... .

**1.3 PIAGET’S THEORY OF COGNITIVE DEVELOPMENT**

After knowing the theory of Erikson, it is important for you to know the significant contribution of Piaget. Piaget also tried to explain the development that takes place at different stages of development of child but from a
perspective of cognitive development. The Piaget’s theory of cognitive development focuses on the child thoughts, perception and acquisition of knowledge at each stage. The stages of cognitive development propounded by Piaget have been explained in the following sub sections:

1.3.1 Stage I: The Sensorimotor Stage (Birth to 2 years)

This stage of cognitive development takes place since birth to about two years of age. At this stage the child tries to make sense of the world through its senses and motor ability. Some abilities are innate behaviour which greatly assists the infant. Sucking, looking, grasping, crying and listening are such innate behaviours that enhance learning. In the beginning the infant uses only reflexes and innate behaviour. As they become mobile, their cognitive ability increases slowly. Towards the end of this stage, the child uses a range of complex sensori-motor skills.

According to Piaget there are two mental representations a child must develop. One is the concept of Object Permanence. This is an important accomplishment for an infant in this stage, as their memory power increases. This is the ability to understand that objects continue to exist even if they cannot be seen or heard. As the child matures towards the end of this stage, it develops the ability to mentally represent the object in their mind, leading to exploration for an object even if it is moved. Another concept that Piaget states is important to achieve in this stage is Deferred Imitation. This is simply the imitation of behaviour a child has seen before. As child can mentally represent behaviour they have seen, they are able to enact it through playing and in other situations. So a child might ‘talk’ into a toy telephone or ‘steer’ a toy car around the room.

1.3.2 Stage II: The Pre-operational Stage (2-7 years)

The pre operational stage occurs in between the age of two to seven years. During the age range of toddler hood to early child hood, there is a smooth transition from the previous stage. The major accomplishment during stage is language ability, memory and imagination power. A child is also able to symbolically use one object for representing another. For example, a child swinging their arms in a circular motion might represent the wheels on a train. This shows the relationships children can form between language, actions and objects at this stage.

A major characteristic of this stage is egocentrism. This is the ability to perceive the world only in relation to oneself and how the child perceives things. They find it difficult to see it from another person’s perspective. Another feature of this stage is conservation. Children struggle to understand the difference in quantity and measurements in different situations. For example, if a liquid in one container that is broad based is poured into taller and narrower container, the child is unable to see that the quantity of liquid is the same. They see the taller glass as containing more liquid.

1.3.3 Stage III: The Concrete Operational Stage (7-11 years)

This stage sees another shift in children’s cognitive thinking. It is aptly named “concrete” because children struggle to apply concepts to anything
which cannot physically be manipulated or seen. Children have difficulty in understanding hypothetical and abstract concepts. However, they now begin to understand that other people have different perspectives from them. For example, simple Maths, such as addition/subtraction becomes much easier but they struggle to apply any prior knowledge to abstract situations.

### 1.3.4 Stage IV: The Formal Operational Stage

(11 onwards)

Children at this stage acquire the ability to think hypothetically and think about abstract concepts. For example, children begin to have the ability to think about consequences and outcomes before taking an action. Verbal information becomes adequate for them to come to a decision or conclusion. They do not require “concrete” physical objects to do take a decision or act on something. When a problem is presented to them, they can think logically and consistently and solve the problem or come to a conclusion. Their thinking becomes more like an adult.

### 1.4 ASSIMILATION AND ACCOMMODATION

It is worth to mention that, Piaget basically focussed on two processes—assimilation and accommodation. Assimilation is a process in which with the help of experiences an individual assimilates or fits new thoughts and information in to an existing old thought or idea. It is a process of integrating external elements into definite structures through experience. It is process with the help of which an individual adapts new information. It leads to fitting of new information into pre-existing cognitive schemas. It gradually occurs when an individual faces new or unfamiliar information and then the individual refers to previously learned information in order to make sense of it. Accommodation is totally opposite of assimilation. In the process of accommodation, an individual takes new information in one’s environment and alters the pre-existing schemas in order to fit in the new information. That is, when the previously existing information or cognitive schema does not work then the individual needs to change the existing information in order to deal with the newer object, information or experience. Amongst the two, accommodation is more significant because with the help of accommodation only people will continue to interpret new concepts, schemas and frameworks. Although, he proposed that both the processes—assimilation and accommodation work together and go in hand by hand. In order to assimilate an object into an existing mental schema, one first needs to take into account or accommodate to the particularities of this object to a certain extent. For example, in order to recognize (assimilate) a car as a car, an individual first needs to focus (accommodate) on the boundaries of this object. To do this, one needs to roughly recognize the size of the object. Development increases the balance, or equilibration, between these two functions. When both assimilation and accommodation are well balanced then mental schemas of the operative intelligence takes place. When one process dominates over the other, they generate representations which belong to figurative intelligence.
1.5 LET US SUM UP

In this section we have discussed about two of the major theories of development - Erik Erikson’s theory of Psychosocial Development and Piaget’s theory of Cognitive Development. Erikson’s stages of psychosocial development as articulated by Erik Erikson explain eight stages through which a healthily developing human should pass from infancy to late adulthood. In each stage the person confronts, and hopefully masters, new challenges. Each stage builds on the successful completion of earlier stages. The challenges of stages not successfully completed may be expected to reappear as problems in the future.

However, mastery of a stage is not required to advance to the next stage. Erikson’s stage theory characterizes an individual advancing through the eight life stages as a function of negotiating his or her biological forces and sociocultural forces. Each stage is characterized by a psycho social crisis of these two conflicting forces (as shown in the table below). If an individual does indeed successfully reconcile these forces (favoring the first mentioned attribute in the crisis), he or she emerges from the stage with the corresponding virtue. For example, if an infant enters into the toddler stage (autonomy vs. shame & doubt) with more trust than mistrust, he or she carries the virtue of hope into the remaining life stages.

Piaget’s theory of cognitive development is a comprehensive theory about the nature and development of human intelligence. It deals with the nature of knowledge and how humans come gradually to acquire, construct, and use it. To Piaget, cognitive development was a progressive reorganization of mental processes as a result of biological maturation and environmental experience. Children construct an understanding of the world around them, then experience discrepancies between what they already know and what they discover in their environment. Moreover, Piaget claims the idea that cognitive development is at the center of human organism and language is contingent on cognitive development.
1.6 UNIT END QUESTIONS

1) What could be the consequences of developing a sense of mistrust in an infant?

2) How does an infant develop a sense of autonomy?

3) How does a sense of guild develop in a child?

4) How does developing a sense of intimacy help in future interactions?

5) What is meant by ego integrity according to this theory?

6) What are the major mental representations that children develop in the sensorimotor stage?

7) How do the mental representations in stage 1, help in the next stage or preoperational stage in Piaget’s theory of cognitive development?

8) How do young children’s ability to think in abstract terms help in problem solving tasks given to them?

1.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) True
2) False
3) False
4) True

Self Assessment Questions 2

1) experiences; thoughts and information
2) two to seven
3) Formal Operational
4) accommodation

1.8 REFERENCES


http://psychology.about.com/od/psychosocialtheories/a/psychosocial.htm accessed on 4/6/15

UNIT 2 FAMILY AND MENTAL HEALTH

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2.0 INTRODUCTION

In the previous unit, you were informed about how an individual’s psychosocial and cognitive development takes place since childhood. In the present unit, you will be informed about the role of family, caretaker and related environments in dealing with mental illness of a child and other related aspects. The term family has been derived from the Latin word ‘familia’ that indicates a household establishment, similar to ‘famulus’, which denoted a servant who came from that household establishment. Family has been defined in the Oxford dictionary as (i) The body of persons who live in one house or under one head, including parents, children, servants, (ii) The group consisting of parents and their children, whether living together or not; in wider sense, all those
who are nearly connected by blood or affinity. (iii) A person’s children reared collectively. (iv) Those have descended from a common ancestor.

In mental health, the term family denotes a group of individuals who live together during important phases of their life time and are bound to each other by biological and/or social and psychological relationship. It is a group defined by a sexual relationship sufficiently precise and enduring to provide for the procreation and upbringing of children.

Thus, the family’s part in mental health is inevitable and this unit will focus on understanding the role of family in mental health issues and its role in aspects of management.

### 2.1 OBJECTIVES

With the help of this unit, you will be able to:

- describe the nature and structure of family and their role in mental illness;
- explain the origin of family therapy;
- define family related approaches to wards illness;
- enlighten the importance of family in mental health and mental illness; and
- explicate the issues that influence management of mental illness.

### 2.2 HISTORICAL ASPECTS OF ROLE OF FAMILY IN MENTAL HEALTH CARE

There is no doubt that the significance of family, love and affection creates a healthy environment for the child to grow. In order to create a positive environment and well being of children, the movement of family therapy began way back in the 1950’s. One of the prominent names in the emergence of family therapy is Gregory Bateson. The central concept of family therapy stems from the understanding of how interpersonal issues affect mental health and also how resolving these issues can contribute in solving the problem of the individuals. Family therapist initially understood the limitations of individual focused interventions. The proponent of family therapy in United Kingdom was John Bowlby and in USA it was John Dell.

Family therapy came in to importance as a result of three movements:

- In the child guidance clinics, it was found that family intervention was essential for resolving child’s problems.
- In UK and USA, movement focused on marriage counseling eventually saw the need for family intervention and became centres for family therapy.
- Sex therapy movement which essentially was behavioural in approach in the 1970’s by Master’s and Johnson in the USA, later integrated with systemic marital therapy. Theoretically, Adler and Sullivan also at the same time pioneered the development of social psychiatry with emphasis on the ongoing family relationships. Banduras’s Social Learning theory also contributed to advent of family interventions (Carr, 2006).

In India, Dr. VidyaSagar in 1956 had pioneered the effort to involve family members in the treatment and management of mental illness. He was the first...
to demonstrate that patients improve and recovered sooner with family involvement. This approach was followed soon after in Christian Medical College, Velore by establishing family wards. The result of these was positive and faster recovery, lower relapse rates was noted. Family members also served as change agents in their community as they identified other patients and guided their family members to approach psychiatric centers for help (Avasthi, 2010).

2.3 FAMILY PERSPECTIVES OF MENTAL HEALTH ISSUES

There are various viewpoints towards the contribution of family in the child development and mental health related issues. Some of the perspectives have been discussed in the subsections below.

2.3.1 Multi-generational Transmission

Murray Bowen suggested that the attitude of parents towards children is influenced by how they themselves were treated as children. Family emotional process is considered to be transmitted from one generation to another. Bowen introduced the use of genogram which involves a pictorial representation of the client’s family tree, normally reaching as far back as the client’s grandparents. It is a format for drawing a family tree that records information about family members and their relationships, spanning at least three generations. This visual aid quickly points out the patterns and multi-generational transmission of the family system and it helps in planning treatment for a care-seeker.

A genogram helps in understanding several issues like:

- It helps in assessing the strength of relationship with other family members.
- It provides a complete history of the client’s significant relationships.
- It helps to identify family histories of significant health issues or mental disorders and disturbances.
- It also gives a clue of gender role expectations of that family.
- The influence of birth order and sibling relationships on the person can be understood.
- It helps to understand cultural and ethnic influences.
- It provides traces of specific problem issues (if any) in the family.
- It facilitates to examine the influence of traumatic events on the couple.

2.3.2 Nature of Family

The nature of the family has also been considered as a significant aspect in transmission of mental health as well as mental disturbances. It is a well known fact that, a family is universal, permanent and nucleus of all social relationships. It has an emotional basis, has an influence over its members, teaches its members about their social responsibility and the necessity for cooperation and follows a social regulation.
In India the family is the most important institution that has survived through the ages. India, like most other less industrialized, traditional, eastern societies is a collectivist (a sense of harmony, interdependence and concern for others) society that emphasizes family integrity, family loyalty, and family unity. More specifically, collectivism is reflected in greater readiness to cooperate with family members and extended kin on decisions affecting most aspects of life, including career choice, mate selection, and marriage.

2.3.3 Structure of Family

Salvador Minuchin gave the structural approach which puts forth the idea that in normal families every individual has specific functions to perform. The members of the family usually have fixed boundaries of relationship. Disturbances happen when family members are either too close or too distant from each other. Salvador Minuchin discovered two patterns common to troubled families: some are “enmeshed,” chaotic and tightly interconnected, while others are “disengaged,” isolated and seemingly unrelated.

The structure of a family has subsystems with boundaries separating them. A healthy structure of the family organism requires clear boundaries, particularly generational boundaries. Unclear boundaries create a dysfunctional family structure, one manifestation of which is a symptomatic family member. It is assumed that if the structural flaw is corrected, the family organism will return to health.

The theory of structural family has stated three essential components of family: structure, subsystems and boundaries.

- **Family structure** is the organized pattern in which family members interact. It is a deterministic concept, but it does not prescribe or legislate behaviour.

- Families are differentiated into **subsystems** of members who join to perform various functions. Every individual is a subsystem, and dyads or larger group make up other subsystems, determined by generation, gender, or common interests.

- Individuals, subsystems, and whole families are demarcated by interpersonal **boundaries**, invisible barriers that regulate the amount of contact with others.

Minuchin developed a theory of family process. This theory views pathology of the family as arising out of problematic interpersonal boundaries within the family. Interpersonal boundaries between family members can vary from rigid to diffuse. Rigid interpersonal boundaries are categorised as disengaged subsystems and diffuse boundaries are categorised as enmeshed/trapped subsystems. That is, enmeshed subsystems offer a heightened sense of mutual support, but at the expense of independence and autonomy. In disengaged families, boundaries are rigid, emotional distance is excessive, and the family fails to mobilize support when it is needed. Enmeshed parents create difficulties by hindering the development of more mature forms of behaviour in their children and by interfering with their ability to solve their own problems.

Adaptive changes in structure are required when the family or one of its members faces external stress and when transitional points of growth are
reached. Family dysfunction results from a combination of stress and failure to realign them to cope with it. The family’s failure to handle adversity may be due to inherent flaws in their structure or merely to their inability to adjust to changed circumstances.

In India for example, the concept of family is considered as strong, stable, close, resilient and enduring. Since ages, the ideal and desired family in India is the joint family. A joint family generally includes three to four living generations, including uncles, aunts, nieces, nephews, and grandparents living together in the same household.

Generally, when the elderly parents expire, a large joint family gets divided because there is no longer a single authority figure to hold the family together. However, after division, each new residential unit usually becomes a joint family when sons of the family marry and bring their wives to live in the family home. The lines of hierarchy and authority are clearly drawn, shaping structurally and psychologically complex family relationships.

The major principle of joint family is to create and maintain family harmony. Women are especially strongly socialized to accept a submissive position to males, to control their sexual impulses, and to subordinate their personal preferences to the needs of the family and kin group. However the conditions are changing in recent decades as women are getting good education and optimal exposure. Reciprocally, those in authority accept responsibility for meeting the needs of others in the family group. Psychologically, family members feel an intense emotional interdependence with each other and there is strong interpersonal empathy, closeness, loyalty, and interdependency.

2.3.3.1 Transition in Family Structure

There has been a shift in family structure with the change of time. For example, in Indian traditional joint family structures, where family members used to stay together with their spouses and children, have been significantly replaced in urban areas by nuclear families. More importantly, the family system has become a highly differentiated and heterogeneous social entity in terms of structure, pattern, role relationships, obligations and values.

2.3.3.2 Implication of Changes in Family Structure for Mental Health Professionals

As we have seen earlier, the strength of Indian families lie in their traditional nature. But the emerging urbanization and industrialization has lead to a transition. The trend to change has shifted persons from rural to urban settings and this has resulted families to turn to nuclear kind from joint families. Due to this they are subjected to stress more in terms of readjustments, reorientation and the making-breaking of human ties. The populations that are vulnerable to face this stress are elderly, children and adolescents, and women. The range of disorders and deviancies associated with urbanization are enormous and includes adjustment disorders, depression, sociopath, substance abuse, alcoholism, crime, delinquency, vandalism, family disintegration, and alienation. As a result of this, there is a worldwide emphasis on reducing the psychiatric hospital beds and reducing admission into the mental asylums.

2.3.4 Strategic Approach

Jay Haley proposed a strategic family approach. This is also known as the General system’s theory. This approach views that the main cause of disturbance
in an individual is the patterns and power structure in the family. Jay Haley stressed upon the importance of the rules of the hierarchical structured family. He believed that the cause of most behavioural problems lies in ineffective parenting hierarchies, that in a family if one parent is highly authoritative and does not allow the other parent or children to take part in any decision making, then this leads to psychological problems in the family. His approach towards these problems aimed to reorganize the family structures and make it more functional. He believed that if the boundaries of a family are clearly defined then there is clear cut clarity in the roles and positions of the parents and the children. The boundaries are designed primarily to help family members experience new ways of interacting so that they will have different experiences and feelings and therefore behave differently. For example, triangulation can occur in a family and that might lead to family conflicts.

Triangulation occurs when a dyadic relationship becomes too stressful or conflicted. A third person is involved as a way of diffusing the tension. This typically occurs in families, often with a husband and wife (or two partners) and one of the children. The more family members are differentiated, the less likely they are to triangulate.

Transgenerational therapy typically involves helping people learn to recognize emotional patterns that lead to triangulation, through more insight into how they learned these patterns through transgenerational transmission.

2.3.5 Experiential Family Approach

Virginia Satir, one of the few women family systems pioneers, believed that every human being had innate worth and that all individuals and families had the potential to grow and flourish. Her views towards humankind were very much similar to that of Carl Rogers’. She believed that any disturbance, problem or similar symptoms is a blockage towards growth of a person and for the family at large, and she was interested in what a family had to give up or sacrifice in order to maintain this kind of negative balance.

All individuals are born into a primary survival triad between themselves and their parents where they adopt survival stances to protect their self-worth from threats communicated by words and behaviors of their family members. Experiential therapists are interested in altering the overt and covert messages between family members that affect their body, mind and feelings in order to promote congruence and to validate each person’s inherent self-worth.

Self Assessment Questions 1
Fill in the Blanks

1) The major principle of joint family is to create and maintain .........

2) The theory of structural family has stated the following three essential components of family: .......................... , ............................and ..........................

3) Salvador Minuchin discovered two patterns common to troubled families: some are........................ while others are........................

4) The proponent of family therapy in United Kingdom was ......... ........................... and in US it was ...........................
2.4 ROLE OF FAMILY IN MENTAL HEALTH

The social aspect of mental health care has become increasingly important. Human behavior has to be understood in the context of interpersonal relationships and environmental factors. One’s immediate environment is the family and interaction with its members is an important influential factor in behavior. Sethi (1989) noted that for a mental health professional family denotes a group of individuals living together during important phases of their lives and that their relationship is bound by biological, social and psychological relationship. Therefore it provides scope for development of personality, behavior patterns, interpersonal responsibility and a context for emotional expression.

Robison, Rodgers & Butterworth (2009) mentioned that a family life provides positive and protective factors to its members. Social support and particularly the emotional support from a close relationship is one important protective factor for mental health problems. Anxiety and depression is higher with families that lack close supportive relationship. It has also been pointed out that families also influence quality of life in an important way. The potential of families in providing the earliest most enduring social relationships is a factor that influences feelings of competence, ability to be resilient and influence a sense of well being.

2.5 ROLE OF FAMILY IN MENTAL ILLNESS

In India, family is considered to be the key resource in the care of patients with mental illness. Families are considered to have the role of primary caregivers for two reasons: First, it is because of the Indian tradition of interdependence and concern for near and dear ones in adversities. Due to this most Indian families prefer to be meaningfully involved in all aspects of care of their relatives despite it being time-consuming. Second, there is a lack of trained mental health professionals and hence the clinicians depend on the family. Thus, having an adequate family support is the need of the patient, clinician and the healthcare administrators.

The traditional joint family is seen as a source of social and economic support and is known for its tolerance of deviant behavior and capacity to absorb additional roles in times of crisis, especially in Indian context. Leff et al (1990) have suggested that traditional joint families allow for diffusion of burden in families caring for the mentally ill and could be responsible for mediating the good course and outcome of major mental disorders. Reviews of the role of the family in relation to mental health have found that the nuclear family structure is more likely to be associated with psychiatric disorders than the joint family. Chandrashekar et al.(1991) reported that fewer patients from rural families sought hospitalization when compared to urban families because of the existing joint family structure.

2.5.1 Mental Illness and Family Therapists/Family Relationship Service Providers

Family relationships have been considered to be significant in the context of mental disorders. The therapists or the agencies that tries to provide family care services.
Those who seek help with regard to mental illness to the family therapist are dealt with the following problems:

- Mental disorders impact not just on the individuals affected but also on those around them—including immediate family and other relatives—and may be both a cause and a consequence of family/relationship difficulties.

- Although most common mental disorders are amenable to treatment, the majority go undiagnosed and untreated.

- Many disorders are chronic or recurrent and they often call for long-term management, not just acute care. A turnover role in trying to balance the relationship between the client and his/her family. The persons suffering from mental illness are taken care of at homes, but this leads to many difficulties for the care giver (family) and the care taker (person having mental disorder). Some

- Much of the care provided for people with mental disorders (even very serious disorders) is informal care provided by family members.

- Many of the “vulnerable” family groups that represent the clientele of family relationships services have a greater risk of mental health problems than the population average.

The role of the family therapist or family service providers helps in dealing with these problems as mentioned below in the following sub sections.

2.5.1.1 The Interpersonal Nature of Mental Health Problems

Mental health problems are often so deeply personal in nature that:

- They are often not visible to others;
- Most of the problems are characterised and identified by emotional and other subjective symptoms; and
- Many individuals experiencing problems attempt to conceal or downplay their difficulties.

At the same time, mental health problems have features that are fundamentally interpersonal. The clinical diagnosis of almost all mental disorders includes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The onset of illness can be identified by the immediate relatives and friends by observing the changes in a person’s behaviour. Mental disorders are also found to be linked with a range of adverse social outcomes, including marital dissatisfaction and the likelihood of marital breakdown.

An additional interpersonal feature of mental health problems is the importance of perceived stigma (when public endorsement of prejudice related to a stigmatized group occurs), and self-stigma (what stigmatized people may do to themselves, if the public stigma is internalized. Both types of stigma have impact on the likelihood of receiving help. Individuals may be particularly sensitive to the views or presumed views of relatives and friends about mental health problems and this can be a factor in their willingness to disclose their own problems or to seek professional help and then comes the vital role of family therapist.
2.5.1.2 Untreated Disorders

The lack of professional care for mental health problems has implications for family relationship service providers due to the following reasons:

- Untreated problems are likely to last longer and may worsen in terms of severity.

- Inappropriate forms of self-help, such as substance use, can lead to secondary problems (i.e. comorbidity).

- Clients with untreated disorders will be less likely to benefit from interventions provided by family relationship services.

2.5.1.3 Managing Chronic and Recurrent Disorders

Even though we have treatment available for common mental disorders, if the symptoms become ingrained before seeking treatment, the prognosis will be affected. The service providers help the client to care for self and also try to widen the role of interpersonal relationships and family responsibilities. For some therapies (e.g., behaviour marital therapy or family therapy) the importance of family relationships is an integral part of treatment.

This presents a challenge for both mental health services and for family relationship services to accommodate issues arising from mental health problems that can impact on families (just as chronic physical disease or disability affect families as a whole).

2.5.1.4 Informal Caregiving

The care that is provided by the family members to the person/member is considered as informal care giving. For those with mental disorders, a significant part of the care giving burden falls on family members. This role is often undertaken by parents when a young person or child is affected and when an adult is affected care-giving falls upon spouses, siblings or ageing parents. The important issues for care givers of people with severe mental disorders include access to specialist services and therapeutic support for themselves.

2.5.1.5 Vulnerable Families

The therapists have found that it is not only the client but the family members as whole becomes their target client group because of their susceptibility or vulnerability to some mental health problems. The research literature on risk and protective factors for adult mental disorders provides the evidence base for the characteristics of individuals and families that increase the likelihood of being affected by mental health problems. Some of research findings are as follows:

- Unlike the vast majority of physical disorders, mental disorders are more common in young and middle-aged adults, compared with older adults.

- Depression and anxiety disorders are more common in women than men, whereas substance use disorders are more prevalent in men.

- Family history of mental health problems, especially of parents or other first-degree relatives, is another important risk factor.

- The demographic and socio-economic factors that have the strongest association with depression and anxiety are lone parenthood and
unemployment (especially when the unemployment is long term). An underlying feature in both anxiety and depression is financial hardship. This is because of the dependence for essentials are on income alone.

- Adults with dependent children, especially mothers, are at increased risk for depression and anxiety, with the mothers of younger (pre-school) children having the highest risk.

- Past (own) relationship breakdown is also related to an increased risk of depression and anxiety (as seen in stepfamilies as well as lone parent families), as is parental separation in the family of origin even after many years.

- Occupational skill level as such is not strongly related to risk of mental health problems. Rather, work characteristics such as insecurity, high demands and low control are more pertinent, and having a combination of these poor characteristics may be worse than having no job at all.

- Stressful life events and transitions, whether expected or unexpected, or forms of longer-term disadvantage can influence the mental health status of one or more family members. Such life events and disadvantages include violence, death or serious illness of a family member, other relative or close friend, redundancy, financial crises, homelessness, incarceration, natural and other large-scale disasters, family breakdown, criminality in parents, and parental substance abuse.

2.5.1.5.1 Protective Factors

Social support and particularly the emotional support from a close relationship is one important protective factor for mental health problems. Often, this close relationship is with a spouse/partner or parent. People lacking such a close supportive relationship are at greater risk of anxiety and depression.

Additional protective factors are self-help strategies that aid recovery from mental health problems and may prevent difficulties progressing to diagnosable disorders. These include psychological strategies (e.g. increasing coping skills and cognitive approaches), behavioural strategies (e.g., exercise and relaxation techniques) and use of complementary therapies such as meditation and yoga groups.

**Self Assessment Question 2**

State whether the following statements are true or false-

1) Mental health problems are often so deeply personal in nature that they are often not visible to others ..........................................

2) Even though we have treatment available for common mental disorders, if the symptoms become ingrained before seeking treatment, the prognosis will be affected ..........................................

3) Mental disorders impact not just on the individuals affected but also on those around them ............................................................

4) Human behavior need not be understood in the context of interpersonal relationships and environmental factors..................

..........................................................
2.6 CAREGIVERS BURDEN

A sufferer is not only the person who needs care from his/her family members, but the family members who are providing care to those members also suffer a lot. Some of the problems faced by the family or the care givers have been mentioned in the subsections below.

2.6.1 Living with Someone who has a Mental Health Problem

Research in many countries has shown that mental illness in married couples co-occurs at a level far greater than expected by chance, i.e. that mental illness in one spouse is associated with mental illness in their partner.

A number of different explanations have been suggested for this co-occurrence (often called “spousal concordance”), including that:

- people marry partners who are similar to themselves, and this could apply either to mental health problems or to other characteristics which put people at risk of mental health problems in the future;
- spouses have similar environments and experiences (e.g., life events) after marriage and these contribute to the similarity in their mental health; and
- mental health problems in one spouse impact on the mental health of their partner, due to difficulties in their relationship, through any consequences on their economic or living conditions, or as a direct consequence of one spouse having to care for the other.

Such associations between mental health and marital relationships are reflected in the application of marital therapy in the treatment of depression and other mental health problems.

2.6.2 Children of Parents with a Mental Illness

There has been increasing recognition of the caring role that many children play in supporting a parent with a mental illness. The effects of having a parent with a mental illness may impact on children in different ways. Children may be affected in terms of their own direct care, or indirectly through impacts on their social and emotional health and wellbeing. Core attachment needs such as love, physical and emotional nurturing and security may be at risk.

For example, depressed mothers may provide less stimulation, support and responsiveness to children, which can affect children’s physical and psychological health, attachment and social problems. Children may be at an increased risk of developing mental health problems, either through genetic predisposition, parenting style or learned behaviour, with one study suggesting that approximately one-quarter of children living with a parent who has a mental illness are in situations of moderate, high or extreme risk of future mental health problems themselves. Poor relationships between parents and children may or may not result, but emotional safety and, particularly in cases of psychosis, physical safety may be compromised.
2.6.3 Caring for Someone with a Mental Health Problem

A “primary carer” is the person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities such as communication, mobility and self-care.

Two aspects of caregiving relate specifically to mental health—first, the care involved in looking after a person with a mental illness and the impact of caring on the mental health of the caregiver. The second type may occur in the caring of a person with a range of physical and intellectual disabilities, as well as mental illness.

One of the key aspects of caring that can impact on the mental health of carers is the level of burden involved in the caring role. Similarly to other caring roles, two types of burden associated with caring for a person with a mental illness are highlighted in the literature: objective burden and subjective burden. Objective burden relates to the specific tasks associated with caring, for example managing finances or doing housework, and subjective burden relates to the feelings and cognitive appraisals associated with caring, such as finding particular behaviours embarrassing, worrying about the future and dealing with excessive demands. The degree of burden is most often related to the degree of impairment or severity of the disability and symptoms associated with the illness of the care recipient.

It is important to state, however, that caring has positive elements for some caregivers and is not necessarily universally harmful to carers’ psychological wellbeing. Caregiving can be a source of achievement, bearing in mind that the experience of caregiving is not necessarily one-dimensional either—it can, for example, being difficult and rewarding or burdensome and gratifying.

2.6.4.1 Particular Needs of Carers

A recent report on people suffering from mental illness has identified the following needs from families and carers towards them:

- support, for dealing with issues such as challenging behaviours;
- education, particularly at the onset of an illness;
- understanding and empathy, for example, someone to listen to the difficulties they face; and
- kind of short break for exhausted families, who may also need assistance with feelings of guilt.

2.6.4.2 Stigma

Fear and stigma relating to mental health, in both professionals outside the mental health service system and in the community, cannot be underestimated. Many studies have indicated that stigma is the most prominent issue related to seeking help for mental health problems. As stated previously, family relationship services are in a good position to respond to mental health problems as they are not necessarily directly associated with mental health service delivery. A comprehensive discussion regarding stigma and responses to addressing stigma is dealt in another unit, it seems timely to consider the specific role that non-mental health services can play in ameliorating the damaging effects of stigma related to mental illness.
Self Assessment Questions 3

Answer the following questions in a single sentence-

1) Who is a ‘primary carer’?

..........................................................................................................

2) What is ‘spousal concordance’?

..........................................................................................................

3) Who is a care giver?

..........................................................................................................

2.7 LET US SUM UP

Throughout the discussions done in this unit, we can summarize that family is the basic unit of our society. Family teaches its members about the social responsibilities. Thus the interaction between the family members is important in mental health. Moreover, the changes which are taking place in the traditional family structure due to industrialization also have the impact on mental illness. Overall, in our country the mental healthcare needs are increasing but at same time one of our main resources which is the family, in the care of the mentally ill subjects is diminishing. Thus, it is important to take immediate steps to enrich the positive role of family in mental health care. Community mental health programs can be conducted to provide knowledge about the importance of family members in “well-being”, identifying the symptoms, and the availability of treatment.

It is important for the researchers to examine how the changing structure and functioning of the contemporary Indian family would impact care giving for people with major mental illness. Similarly, the contribution of family members who have played an all important role in the treatment and rehabilitation of psychiatric patients has to be recognized. Access to better treatment for patients, including medications, psychosocial interventions and rehabilitation services is to be ensured.

Moreover, caregivers need to be supported through active programs of support and guidance. Family interventions should focus on expanding training to patients and key relatives about wellness recovery, skills training, and task sharing of household and self-care chores. An improvement in these areas is likely to improve the quality of life of people with mental illness and their families. Researchers recommend that in addition to focusing on the symptoms of patients, more attention needs to be given to the mental health and well-being of family caregivers. Adequate information and support have to be extended to the family and caregivers.

The families need information, support, knowledge and specific suggestions for coping with mentally ill relatives. Caregivers must be encouraged to join such groups so that they can seek mutual help, learn from experience of others, can share their problems etc. Hence, the mental health professionals in India have an important role in promoting the preservation of family, if the needs of mentally ill subjects are to be cared for in a better way.
2.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) family harmony

2) structure, subsystems and boundaries

3) “enmeshed,” chaotic and tightly interconnected, while others are “disengaged,” isolated and seemingly unrelated

4) John Bowlby and in USA it was John Dell

Self Assessment Questions 2

1) True

2) True

3) True

4) False

Self Assessment Questions 3

1) A “primary carer” is the person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities.

2) A situation in which mental illness in one spouse is associated with mental illness in their partner.

3) A care giver is a person who takes care of the person suffering from mental illness in the family.

2.9 UNIT END QUESTIONS

1) Define family.

2) Explain the structure of family and effect of changes in family structure on mental illness.

3) Describe Bowen’s theory.

4) Explain the structural approach given by Salvador Minuchin.

5) What are the vulnerable factors and protective factors?

6) Describe about care givers’ burden.

2.10 REFERENCES


UNIT 3  SOCIOLOGY OF MENTAL HEALTH

Structure

3.0  Introduction

3.1  Objectives

3.2  Social Attitudes and Mental Health

3.3  Social Perception and Mental Health
   3.3.1  Communication

3.4  Attribution Theory
   3.4.1  Problems with Attribution
   3.4.2  Attributions in Clinical Setting

3.5  Social Influence
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3.6  Group Process
   3.6.1  Prejudice Towards Members of A Group
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3.7  Leadership and Social Power

3.8  Sociological Theories Related to Mental Health
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3.9  Let Us Sum Up

3.10  Answers To Self Assessment Questions

3.11  Unit End Questions

3.12  References

3.0  INTRODUCTION

You might wonder that what is the need of studying the aspects of sociology in this block? Let us first tell you that, sociology is a study of understanding social systems and relating various aspects of social structures to the pattern of human behaviour. The people who are part of the social system are
essentially interdependent for various reasons. This interdependence produces interaction between people. In the course of interaction influence is exerted on each other. Therefore social behaviour is a result of interdependence, interaction and influence and social psychology is a scientific study of this process.

Allport (1985) has defined social psychology as “the study of the way in which people’s thoughts, feelings, and behaviours are influenced by the real or imagined presence of other people.” This influence on a person’s thoughts, feelings and behaviour involves various processes. For example, the formation of attitudes is an important aspect that has to be understood. How these aspects are connected to mental health is the focus of this section.

In order to study social psychology and its relationship to mental health we need to understand social attitudes, social perception, attribution, social influence, communication patterns, leadership and social power, conformity and deviance, prejudice, group process and pro-social behaviour. The role of these aspects in mental health will be discussed in this section.

Another aspect of understanding mental health from a sociological point of view is to understand the prevailing social conditions that influence psychological functioning. In other words, it is connecting social experiences to mental health through psycho-social process that needs to be studied. The assumption that is made is based on the fact that social conditions that people live in influences their emotions, behaviour and thinking patterns. The social conditions are noted to vary across different social groups, societies and historical eras.

### 3.1 OBJECTIVES

With the help of this unit, you will be able to:

- understand the concept of social attitude in mental health;
- understand the concept of social perception and its influence in mental health;
- understand the role of group processes in mental health;
- understand the role the process of attribution and its role in mental health; and
- analyze the social situations that affect mental health process.

### 3.2 SOCIAL ATTITUDES AND MENTAL HEALTH

The formation of social attitudes is of great interest in the field of social psychology as it has a major role in how people behave in social situations. It is defined as a tendency to think, act and feel consistently in a favourable or unfavorable manner towards entities in the environment. These entities can be abstract ideas, one’s behaviour, ideologies, ideas or concrete objects. For example, one might have a favourable or unfavourable attitude towards immigrants, mentally ill people or alcohol drinking behaviour. These attitudes are learned. They are usually acquired from parents, family, friends and society, to some extent from cultural predispositions.
An attitude refers to a subjective judgment or evaluation of an entity made by an individual. For example, people may have a negative or positive attitude towards a condition or behaviour, such as all those who consume alcohol are irresponsible. It can be sometimes activated automatically and the processing may be at the preconscious level.

Attitudes are relatively persistent and stable and can be changed with effortful means. For example health promotions are aimed at changing people’s attitude towards exercising, smoking and drinking. However, two important areas pertaining to attitude change are cognitive dissonance and persuasive communication.

Cognitive dissonance is about inconsistencies in cognitions or beliefs and behaviour. It refers to two contradictory attitudes which leads to conflict in the mind of an individual by various means. Cognitive dissonance occurs when an individual holds two cognitions that are inconsistent with each other. For example, a smoker or a drinker generally holds two contradictory beliefs or cognitions which can contradict one against the other. One example is a person who consumes alcohol believes that alcohol relaxes his mind but at the same time knows that it is bad for his physical condition. This leads to an unpleasant state of mind or dissonance that has to be changed. Instead of changing the behavior (drinking), he tends to change the dissonance by either refusing to acknowledge the negative outcome of alcohol consumption or wanting to believe that consequence are not so severe that one cannot cope with.

Another way of changing attitude is through persuasion. This is a conscious attempt to change attitude through communication of some message with the help of power, language, expertise, creating likeability or appealing the individual or mass to change an existing attitude.

### 3.3 SOCIAL PERCEPTION AND MENTAL HEALTH

Social perception is the part of perception that allows people to understand how the other people think about themselves in their social world. This sort of perception is defined as a social cognition which is the ability of the brain to gain, store and process information. Social perception allows individuals to make judgments and impressions about other people. It is primarily based on observation, although pre-existing knowledge influences how we perceive an observation.

Social perception gives individuals the tools to recognize how others affect their personal lives. It helps individuals to form impressions of others by providing the necessary information about how people usually behave across situations. The social perception provides information needed for impression formation by approaching the behavior with an implicit personality theory outlook. Implicit personality theories state that, if an individual observes certain traits in another person, s/he tends to assume that his or her other personality traits are concurrent with the initial trait. These assumptions help us to make quick judgments about the character of an individual. It also helps us to “categorize” people so that we can infer additional information about them and predict their behavior. For example, if someone observes a drunken person being aggressive and violent towards people, then she/he generalizes such behaviour that most people in a drunken state would behave similarly.
Consequently, s/he avoids people who are drinking or would always perceive him to have other negative traits etc., such as being irresponsible, useless, good-for-nothing person.

Social perception is one of the initial stages of processing information in order to determine any other individual’s mind-set and intentions. It is combined with the cognitive ability to pay attention to and interpret a range of different social factors that may include: verbal messages, tone, non-verbal behavior, and knowledge of social relationships and an understanding of social goals. Any social interaction or social skill to deal with persons is influenced by social perception. A key aspect of social interaction is the process of figuring out what others are thinking and feeling which is also referred to as Theory of Mind (ToM). The Theory of Mind proposes that the ability of the mind to attribute mental states, such as beliefs, desires, emotions, perceptions, and intentions to self and others in order to understand and predict behavior. It involves making the distinction between the real world and mental representations of the world.

In the clinical setting. For example children with autism are assumed to have deficits in the theory of mind ability. That is, they lack the ability to understand that others have needs, intentions, desires that are different from their own. This is also true of some schizophrenic and some alcohol dependent persons.

### 3.3.1 Communication

As discussed earlier also, that our social perception influences our interaction with society and form an attitude. It must also be understood that social perception cannot take place without communication. In order for people to perceive one another, information must be transmitted. This happens with the process of communication. Communication serves as the basis for social relationships of all kinds. Infact, a social system may be considered as a set of positions interconnected with communication channels. Communication is referred to as a two way process of transmission and reception of all kinds of data. Most people would probably think of communication primarily in terms of what it does for them. In the process of communication information is exchanged, demands are made, and people understand that events have occurred, will occur or may occur.

Attempts at communication may be guided and oriented by feedback. This is the information available to the communicator that comes back to him through various channels. Our monitoring of our own behaviour also provides a kind of feedback that tells how we are responding to various situations. Feedback needs to be associated with empathy that is trying to understand why people behave in such a way is also part of the interaction process. People attribute various causes to their own and other’s behaviour. The next section discusses the theories based on attribution.

### 3.4 Attribution Theory

Attribution theory is concerned with how individuals interpret events and how this relates to their thinking and behavior. This theory explains the causes of our own behavior or the other people’s behavior. Attribution theory assumes that people try to determine the cause of an act. A person seeking to understand why another person did something may attribute one or more causes to that
behaviour. Seligman et al., in 1979 established several important dimensions of attribution, that is while attributing or analyzing an act of an individual we take certain dimensions into account. They are:

- **Locus** – Internal vs external: If we consider an individual responsible for an act or behavior, we are emphasizing on internal attributions, such as ability, effort, personality trait, mood, and so on. For example, depressed individuals believe that they have no control over what happens to them in their own lives. This concept is based on the learned helplessness model of depression put forth by Seligman, 1975). External attribution refers to causes outside the person, situational factors, actions of others, difficulty of the task etc.

- **Stability** – Stable vs unstable (permanent vs temporary) – stable causes are relatively permanent, unchanging and lasting, for example, people tend to attribute solely to genetic causes or personality traits for addiction; while unstable attributions are temporary and fluctuating, here people attribute the causes of drinking to the current stressor.

- **Generality** – Global vs Specific – global causes are perceived as applicable to most actions of the person for instance there is a belief that all girls are submissive and less assertive, whereas specific attributions pertain to those that are restricted to certain domains or situations for example a person may attribute his smoking behavior to peer pressure.

- **Controllability** – Controllable vs uncontrollable – attributions that are uncontrollable are perceived as beyond one’s effort, autonomous and independent (example-a person is depressed because he has a strong family history of depression), whereas controllable causations are seen as manageable and prone to containment or mastery (example – attributing depression to negative life events such as failure in examination).

These insights into attributional processes have been usefully applied to clinical situations, especially to depression. The best-known and most studied attributional phenomenon is that of learned helplessness.

### 3.4.1 Problems with Attribution

Attribution leads to a number of cognitive biases and errors. Our perceptions of events are often distorted by our past experiences, our expectations and our own needs.

There are many common types of errors in attribution: One is attributing causes for behaviour that serves a purpose to the self. The process of attributing their success to internal causes and attributing failures to external causes is known as Self-Serving Bias.

Examples for internal attribution: Attributing your success to internal factors “I did well because I am smart” or “I did well because I studied and was well-prepared” are two common explanations you might use to justify your test performance. The tendency of attributing causes to internal factors such as personality characteristics and ignore or minimize external variables when it comes to other people is called *fundamental attribution error*. 
3.4.2 Attributions in Clinical Setting

Person who accesses clinical facilities usually comes with certain complaints. These complaints are usually attributed to an underlying cause according to his/her belief system. They would have their own theories about the origin of the symptoms and go about making efforts to think and collect information in an attempt to make sense of their difficulties. Very often these attributions may not be expressed openly, however, it is essential for the clinicians to understand and bring it out in the open and discuss about it, thereby dealing with problems and misattributions. This process is called explanatory model. These beliefs profoundly influence care seeking behaviour and adherence to recommended interventions.

3.5 SOCIAL INFLUENCE

Social influence is a common tendency of people to behave differently when others are present than when they are on their own. In any social context there is a pervasive influence on behaviour when others are present. Studies in social psychology have demonstrated this. Social influence is said to occur when one’s emotions, opinions, or behaviors are affected by others. Social influence takes many forms and can be seen in conformity, socialization, peer pressure, obedience, leadership, and persuasion. Below, some of the more important social influences are mentioned.

3.5.1 Conformity and Deviance

Conformity is a kind of influence in which people change their behaviour or belief towards that of a group’s majority view or belief, as a result of real or imagined pressure from a group. Several explanations have been put forward to account for the process of conformity. They may be because of social comparison, avoidance of conflict and increased self awareness. Different mechanism may be operative in different situations.

For example, in any culture customs leads to conformity of behaviour. Customs are transmitted from generations to generations. Conformity reduces cause and increases outcomes and thus reduces deviation. In sociological terms, “conformity” simply means to not stray from social expectations, while “deviance” means to stray from social expectations. This can be positive or negative depending on the circumstance. Without conformity it would not be possible to form a social group. Conformity makes social cohesion possible. Deviance can cause an individual to suffer physical and/or emotional suffering from others. But within deviant sub-cultures there is also the opportunity for social ties, new identity formation, and high status.

3.5.2 Prosocial Behaviour

Prosocial behaviour is voluntary behaviour intended to benefit another. It consists of actions which benefit other people or society as a whole which an individual may involve in to even without getting any personal benefit. For example, helping, sharing, donating, co-operating, and volunteering behaviours are prosocial in nature. These actions may be motivated by empathy and by concern about the welfare and rights of others, as well as for egoistic or practical concerns. Empathy is a strong motive in eliciting prosocial behaviour.
Demonstrating such social norms is likely to get admiration from other people. There are factors that influence prosocial behaviour. People who are in a good mood are more likely to help others as they simply feel like doing so. So also with people who are feeling guilty, as a compensation for their guilt feelings. People in small towns are more likely to help than those who are together in cities.

<table>
<thead>
<tr>
<th>Self Assessment Questions 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>State whether the following statements are ‘true’ or ‘false’-</td>
</tr>
</tbody>
</table>

1) Conformity is a kind of influence in which people change their behaviour or belief towards that of a group’s majority view or belief, as a result of real or imagined pressure from a group ............ .........................

2) Attributions that are controllable are perceived as beyond one’s effort, autonomous and independent .......................................................... ........................... ............................ .............................

3) Social perception is one of the initial stages of processing information in order to determine any other individual’s mind-set and intentions ................................ ........................ .......................... ...........................

4) Social perception can take place without communication ........................ .......................... .......................... ............................ .........................

### 3.6 GROUP PROCESS

A group is a collection of two or more people, who are engaged in a functional relationship with each other and have a common goal. The members interact through communication process. They develop a structure as members occupy positions, acquire status, and play roles.

Group processes occur at least in three contexts: 1. **Interpersonal behaviour**, 2. **Intra group (within -group) behaviour** and 3. **Intergroup (between-group) behaviour**.

Group members interact over a period of time and therefore they go through a process of development that involves being accepted, resolving conflicts, attaining consensus and ultimately adjoining. During this process people form an identity, they perceive themselves as members of group and adopt a unique identity. They begin to get to know one another and form emotional bond. They usually have a sense of purpose and shared goals. Very often groups have standards of conduct such as rules that could be implicit or explicit.

The structure of the group varies such as–family members, friends, colleagues etc. group is based on the functions and specialties. Group members generally have a sense of loyalty towards the group. For a group to function together they need to be cohesive. Although there might be a difference in behaviour of group members towards their own group and how they behave towards the outer group.

There is evidence from studies that group behaviour is characterized by the following features:
- **Accentuation effect**: It refers to a tendency to magnify or overestimate the differences between groups in terms of their beliefs, preferences and behaviours. In spite of objective finding from studies showing that there are more differences in these aspects within the group than between groups, members tend to emphasize more on between group differences.

- **Intergroup competitiveness**: There is a tendency of groups to be more competitive than individuals.

- **Intergroup bias**: This refers to the tendency of group members to systematically evaluate their own group members more favorably than members from an outer group. They tend to discredit or derogate outer group members.

- **Out group homogeneity effect**: This is the tendency of groups to minimize differences between the members of the out-group and perceive them as homogenous and undifferentiated. This leads to higher chances of prejudice and discrimination.

### 3.6.1 Prejudice Towards Members of A Group

Prejudice is an attitude (usually negative) towards members of a specific group, based solely on their membership on that group. It is important to distinguish between prejudice and discrimination. Prejudice is a negative attitude directed towards people simply because they are members of a specific social group. Discrimination is a negative action towards members of a specific social group.

Prejudice is a judgment based on previous information or feelings and it is not based on present experience exclusively. It stands for an unfavorable attitude towards a person or group. The judgment is not based on adequate facts. Often based on stereotypes, it involves a certain amount of hostility against others. Sometimes it is shared by the group as a whole and therefore it is almost seems like a social norm. One of the conspicuous features of every society is prejudice towards minority. The minorities for example could be based on the race, creed or caste. The consequences of prejudice are discrimination and inequitable treatment.

Prejudice is most likely to develop under certain social conditions: firstly, Intergroup competition – this occurs when there are group conflicts especially when the resources are scarce. Another situation where it may occur is when there is unusual power distribution. Prejudice may even occur if a person or group of persons enhances their self identity and self esteem by having favourable opinion of their own group and putting down others. Apart from this, a person with authoritarian trait tends to be hostile and hold prejudices towards other groups. There is also a strong association between religion and prejudice.

#### 3.6.1.1 Types of Prejudice

Prejudice can be based upon a number of factors including sex, race, age, sexual orientations, nationality, socioeconomic status and religion. Some of the most well-known types of prejudice include:

- Racism
- Sexism
3.6.1.2 Prejudice and Stereotyping

Prejudice may further result in stereotyping and discrimination. In many cases, prejudices are based upon stereotypes. A stereotype is a simplified assumption about a group based on prior assumptions. Stereotypes can be both positive (“women are warm and nurturing”) or negative (“teenagers are lazy”). Stereotypes can lead to faulty beliefs, but they can also result in both prejudice and discrimination.

It has been found that prejudice and stereotypes occur simultaneously. In order to make sense of the world around us, it is important to sort information into mental categories. However, researchers have found that while when it comes to categorizing information about people, we tend to minimize the differences between people within groups and exaggerate the differences between groups. Some examples of stereotypes are ‘teenagers are irresponsible’. Stereotypes are resistant to change and persistent even though there could be evidence contrary to the current belief system and therefore it leads to discriminative behaviour or prejudiced mind set. Prejudice and stereotyping affect those who have mental illness equally.

3.6.2 Stigma

Mental illness has often the burden of stigma attached to it. The word stigma means ‘a mark placed on slaves so as to identify them.’ Earlier, when ever a person’s behavior was found to be different or deviated from normal then those persons were marked and were devalued or discriminated from the society. Mentally ill patient were assumed to be violent and people tried to avoid them and excluded them from main stream activities. The people suffering from mental illness lack insight, decision making and are dependent on others and therefore others need to take decision for the behavioural component of stigma by discrimination. This can take place by a tendency to avoid them in social interactions such as in a marriage. Maybe withheld from help such as, providing housing facility, or even showing lack of interest in providing professional help to mentally ill people when comparing to people with physical illness.

People come together in groups to satisfy both task and social needs. To able to satisfy these needs depends on several factors, which include an important aspect of the behaviour of leadership. The following section discusses the influence of leadership process in group changes or social activity.

3.7 LEADERSHIP AND SOCIAL POWER

Leadership is regarded as a crucial factor for success or failure of any social activity. Leadership may be defined as a process in which an individual influences a group of individuals to achieve a common goal. The importance
of leadership is that it can influence a reform in social norms or perceptions. It involves three main elements:

- **Power**: It refers to an ability to influence others and it specifically refers to ability of the leader to get others to adopt common goals. There are various types of power vested on a leader like providing rewards or punishment.

- **Persuasion**: This is the ability to motivate people to follow a certain goal.

- **Vision**: Leadership implies having a vision of future and leading the team accordingly.

Leadership arises only where there is group with norms striving to reach a goal. The main objective of leader is to make the followers act or behave accordingly in order to reach to a common goal. In such collectivism, leaders play a very important part in bringing about group cohesion. Irrespective of the size of the group, the essential feature is in the narrower sense of the team is that, there is group structure with status and role relationships and a hierarchic organization. The leader-follower relationship involves social interaction, face to face, as well as indirect, by means of communication.

Gibb (1969) has given the following list of seven aspects of leadership behaviour:

- Performing professional and technical specialty.
- Knowing subordinates and showing consideration for them.
- Getting channels of communication open.
- Accepting personal responsibilities and setting an example.
- Initiating and directing action.
- Training men as a team.
- Making decisions.

Thus a successful leader is persuasive, manipulative, charismatic and can easily influence others. A leader is desired to be an expert in problem solving, decision making. Based on the qualities of leadership, the leaders have been classified in to the following types:

- **The institutional leader**

  Such a leader may maintain authority, and build up a thoroughly coherent group. The danger with this group is that it inevitably tends to become rather narrowly self-contained and non-adaptable. If, by force of circumstances, it is thrown into close contact with groups of another type, it may show itself rigid and unfriendly. Nevertheless, to exalt the symbol is the only way in which the leader whose power is in his post rather than in himself can consolidate his authority. Such a leader, since he must emphasize rank, has to maintain an attitude of aloofness in general, so far as his followers are concerned.
• **The dominant leader**

  The dominant leader is one who impresses, commands, shapes, and sways his men, presents a number of extremely interesting psychological problems. It seems certain that the hereditary basis of this type of character is so strong, that nobody who does not possess it can by training learn to control men in the dominant manner. It is in reference to the second and third classes of leaders that it is more or less true to say that a leader is born and not made.

• **The persuasive leader**

  The persuasive type of leader is, in many respects, psychologically the most interesting of all. He is, as a rule, very much the most complex and subtle character. He has always played an important part in social life, but tends to come more and more to the front as society develops. This is the political type of leadership, the civil type, the administrative type.

In conclusion, studies have shown that effective leadership styles are situation specific. The most effective leaders are those who can develop a range of leadership styles and those who know when to apply each style.

### 3.8 SOCIOLOGICAL THEORIES RELATED TO MENTAL HEALTH

#### 3.8.1 Sociological Aspects of Mental Health

The sociological perspectives of mental health and illness are mainly based on theoretical. For example, mental disorder has been viewed to be related to the existing culture and the society to which the person belongs. The following sub sections briefly points out the various views of mental health and illness from a sociologically based perspective.

##### 3.8.1.1 Social Causation

Theories have been put forth to explain the role of socially derived stress in the etiology of mental illness. This social approach to understand the causes of mental illness puts emphasise on the relationship between social disadvantage and mental illness. Sociologists have considered low social class and/or poverty as the main indicator of disadvantage and study the relationship between mental health and social class. However, social class has not been the only variable investigated within this social causation perspective. Disadvantages related to race, gender and age have also been studied.

##### 3.8.1.2 Critical Theory

The relationship between socio-economic structure and the inner lives of individuals has been of interest for many writers during the twentieth century. For example, attempts have been made to understand people’s biography in relation to their social context and vice versa. Freud and his associates attempted to use insights which they had from an individual’s psychoanalytical process and extended this process to understand the societal processes. In the Frankfurt Institute of Social Research the members of the institute were known as the critical theorists. They explored the inter-relationships between the material environment of individuals and their cultural life and inner lives.
3.8.1.3 Social Constructionism

Social Constructionism is a branch of sociology that questions the prevailing commonly held views on the nature of reality. It touches upon the themes underlying what is considered as normality and abnormality in a particular society within the context of power and oppression in societal structures of that society. For example, the concept of a social construction of schizophrenia denotes that the label of ‘schizophrenia’ is one that has been socially constructed through ideological systems. These ideological systems are often not empirically defined as there is no definitive evidence for the causes of schizophrenia currently.

3.8.1.4 Social Realism

Social realism, in sociology, refers to the assumption that social reality, social structures and related social phenomena have an existence over and above the existence of individual members of society, and independent of our conception or perception of them.

The sociological perspectives of mental illness hold the view that it is essential to consider the social phenomena in contributing to the causal process of the illness.

3.8.2 Structural Strain Theory

Structural strain theory locates the origins of disorder in the broader organization of society. In order to prevent or reduce mental illness, society should be restructured to reduce levels of stressors or to enhance coping capacity. Some social structures that cause stress are the effects of poor neighborhoods on mental health and disaster situations.

3.8.2.1 Effects of Poor Neighbourhoods on Mental Health

In a study by Faris and Dunham in the mid 1930’s, in Chicago, previous residences of all patients admitted to hospitals for schizophrenia and other psychoses was recorded. They found that schizophrenic patients had lived in poor areas of the city, concentrated in the inner urban core, with high population turnover, a high percentage of rental apartments and boardinghouses, and a high percentage of foreign-born (probably immigrant) residents. Thus, they observed a pattern. Schizophrenic tended to live in neighborhoods in which few people knew one other or formed lasting ties. This study concluded that schizophrenia was caused, in part, by social disorganization and the prolonged or excessive social isolation that it produced.

This conclusion was later not acknowledged. In 1965 Dunham suggested that disorganized neighborhoods do not produce mental health problems in residents. Instead, disturbed persons selectively migrate into such neighborhoods because their poor mental health prevents them from having the jobs or money needed to live elsewhere. However, the bulk of the evidence from studies favors the causal influence of disorganized neighborhoods on mental health. This is because poor neighborhoods are characterized by high rates of racial segregation, unemployment, single-headed families, residential instability, crime, and physical decay, among an array of other disadvantages. These features of neighborhood organization have distressing and depressing influences in them selves. Neighborhoods, in short, are contexts or structures that generate chronic strain as well as magnify community members’ personal difficulties.
In 1976, a study was conducted by Kai Erickson on the survivors of a disaster. After a heavy rain fall, early one morning in 1972 in West Virginia, a dam constructed poorly by the Buffalo Mining Company crumbled and released tons of floodwater, which washed out 13 small coal mining communities in the valley below. Many were still fast asleep and were caught by surprise. Many were injured, 125 people were killed, and literally everything in the floodwater’s path was destroyed or swept away. The survivors were then taken by the federal to house them in scattered locations. Through in-depth interviews with survivors, Erikson and other researchers found that the shocks of destruction and damage caused by the flood were compounded by the sudden and permanent loss of community. Connections with kin and long-term neighbours and friends were cut by the survivors’ placements in haphazard emergency housing. Almost all of the survivors suffered from at least some symptoms of post traumatic stress disorder, which took years to dissipate.

Therefore, it can be noted that there are harmful consequences of social isolation or the lack of social integration. Social isolation can also take place at the individual level in terms of holding social roles.

3.8.2 Implications of Applying the Sociological Theories in the Field of Mental Illness

Studies have reflected that mental illness has been prevalent among those who are socially and economically disadvantaged or low in power and influence. The idea of the organisational role in the aetiology of mental illness is unique to this approach and may be neglected in other approaches to mental illness. In order to understand the complex and multiple causes of mental illness, it is necessary to study the stress caused by social systems, social institutions, and community contexts. Structural strain theory suggests that to prevent or reduce mental illness in society one must intervene in fairly large-scale ways, for example, by combating racial segregation, bolstering access to college education, buffering spikes in the unemployment rate, and expanding services for the elderly.

Self Assessment Questions 2

Fill in the blanks:

1) ........................................ refers to the assumption that social reality, social structures and related social phenomena have an existence over and above the existence of individual members of society.

2) ........................................ is one who impresses, commands, shapes, and sways his men, presents a number of extremely interesting psychological problems.

3) Prejudice is .......................................................... .

4) Social Constructionism is a branch of sociology that ................... .
3.9 LET US SUM UP

It can be summed up from the above discussion that social behaviour is a result of interdependence, interaction and influence exerted between the members of a particular society. Further, a person’s behavior is influenced by social attitudes, social perception, attribution style, social influence and group process. This is particularly applicable to the field of mental health. In addition sociological theories explain the causes and consequences of social structures and situations that affect mental health. Social attitude towards mental health maybe favorable or unfavorable as it involves evaluation of an entity. Therefore the understanding and management of mental health issues are affected by social attitude. Secondly, how people perceive themselves socially can explain certain conditions in mental health. Also, communication plays a significant role in the process of social perception. Social influence such as conformity, deviance and prosocial behaviour explains the way in which people behave and change behaviour in the presence of others. The factors that influence group membership and behaviour helps in understanding important issues such as prejudice, stereotyping and stigma. Leadership and social power allows us to predict how they can be used to change social behaviour and attitude. Finally, the sociological theories explain social phenomena in contributing to the causal processes of mental illness.

3.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1
1) True
2) False
3) True
4) False

Self Assessment Questions 2
1) Social realism
2) The dominant leader
3) an attitude (usually negative) towards members of a specific group, based solely on their membership on that group
4) touches upon the themes underlying what is considered as normality and abnormality in a particular society within the context of power and oppression in societal structures of that society.

3.11 UNIT END QUESTIONS

1) Write in detail about social attitudes and the ways to change them.
2) What is attribution?
3) What are all the dimensions of attribution?
4) What is attribution error?
5) How is attribution applicable in clinical setting?
6) Write about group process and the concept of prejudice in group members.

7) Describe Stigma.

8) Write about the concept leadership and its role in sociology of mental health.

### 3.12 REFERENCES


UNIT 4  CULTURE AND MENTAL HEALTH

Structure

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4.5 Let Us Sum Up

4.6 Answers to Self Assessment Questions

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4.8 References

4.0 INTRODUCTION

By now you must be well aware of the significance of family and environment on the mental well being of an individual. In the last unit of this block, you will be introduced about the relevance of culture on the mental health of individuals. It is well known fact, that the differences in the way people think and behave may also be influenced by the culture to which he/she belongs and it has come to play a major role in the way mental health system is understood, developed and administered. On basis of cultural differences, now individuals are differentiated on basis of people who belong to a culture which gives importance to belongingness to society (socio-centric cultures/collectivistic) and those cultures which give importance to individual independence (individualistic). This kind of categorizations helps in understanding the need of individual with mental health issues. It also helps in deciding what kind of mental health care facility is to be provided for people with such needs. For
example, if people come from collectivistic communities it is essential to incorporate the social support systems (e.g., family) in the treatment process. Specific behaviours that are considered to be deviant and classified as illness are dependent on cultural values and norms. Cultural beliefs about deviant behavior provide information to the cause of the illness, the views about cure and predict access to the nature care system. For example, if schizophrenic symptoms are believed to be caused by supernatural elements, the first choice of treatment would be a faith healer and an underlying hope of complete cure of the illness.

Culture formulates the expression and recognition of psychiatric problems. Culture influences the meanings that are given to symptoms. Culture also impacts the interaction between the patient and the health care system, as well as between the patient and the physician and other clinicians with whom the patient and family interact. Many people may not express their problems in front of clinicians as it would be shameful act in a particular culture.

### 4.1 OBJECTIVES

With the help of this unit, you will be able to:

- define the concept of culture;
- explain the cultural aspects of mental health and mental illness;
- describe the different types of culture bound syndromes; and
- point out the specific issues related to immigration and acculturation.

### 4.2 CULTURE AND MENTAL HEALTH

Before we try to explain you the impact of culture on mental health, it is necessary for you to understand the concept of culture. In the following subsections, you will be explained about the concept and role of culture in shaping up the mental health of individuals.

#### 4.2.1 Meaning of Culture

Culture refers to a set of meanings, norms, beliefs, values, and behavior patterns shared by a group of people. These values include social relationships, language, nonverbal expression of thoughts and emotions, moral and religious beliefs, rituals, technology, and economic beliefs and practices, among other items.

Culture has six essential components: (1) Culture is learned. (2) Culture can be passed on from one generation to the next. (3) Culture involves a set of meanings in which, words, behaviors, events, and symbols have meanings agreed upon by the cultural group. (4) Culture acts as a template to shape and orient future behaviors and perspectives within and between generations and to take account of novel situations encountered by the group. (5) Culture exists in a constant state of change. (6) Culture includes patterns of both subjective and objective components of human behaviour.
4.2.2 Role of Culture in Mental Health

Some of the role of culture towards mental health can be discussed as follows:

- **Defines mental health**: In any culture, in order to define mental health, it is vital to identify the state of physical, mental and social well being of an individual. Every culture has an ideal *type of role* an individual plays and *expectations* based on cultural norms that define a sense of well being. For example, cultural norms determine whether being submissive or assertive is associated to well being in women. Men who are competitive may be appreciated in one setting (e.g., corporate places) but not in other setting. Therefore, in order to define mental health, it is necessary to consider the context and cultural norms and values of the sub group to which the individual belongs.

- **Influences social competence**: A culture also influences the social competence among individuals. For instance, research indicates that cultural norms and values effect the development of social competence in children, particularly with respect to the meaning and evaluation of behaviors such as sociability, shyness-inhibition, cooperation-compliance, and aggression-defiance.

- **Influences emotional expression**: Culture can also have an impact on the way one expresses emotions. The manner in which one experiences depression and its expression is affected by the culture to which he/she belongs, for instance, women in India are known to express their depression through their body functions, such as headaches or body pains rather than verbally expressing it.

- **Influences behavior**: The way one explains one’s own actions is also influenced by culture. In fact, attribution of one’s own behavior is considered as an important factor in the field of mental health. For example, few cross cultural researches have shown that in cultures that stress upon interdependence on each other, people tend to explain others’ actions in terms of situational factors rather than internal or personal factors. Therefore, deviant behaviour among people suffering from mental illness may be attributed to external factors and less on individual factors. These cultural differences in attribution may have a positive or negative impact on individual’s responses to mental illness and different prognoses in various parts of the world.

- **Provides self identity**: An individual’s existence of self and identity is based on the culture one belongs to. Individual characteristics also interact with social roles in specific cultural contexts. Throughout the world, characteristics such as socioeconomic status, gender, age, color, ethnicity, religion, sexual orientation, minority status, or, in some places, tribal/caste status or immigration status affect not only role definitions but also self-evaluations, employment opportunities, and quality of life. These social perceptions clearly interact with the preexisting strains and stigmas of mental illness. In any culture abuse to one’s mental health may adversely affect an existing vulnerability or dysfunction.
4.2.3 Indian Family, Culture and Mental Health System

Keeping in view the present scenario, researches have emphasized on the need to preserve and strengthen family life in India as it provides support to the person suffering from mental illness. As discussed in the previous unit also, facts and findings have suggested that the traditional Indian joint families have helped the clinicians to deal with mental health issues of their family members. In Indian context, family is observed to be one of most important social institution that has survived through the ages. Indian society deeply values family integrity, family loyalty, and family unity. Further, in all the events of significant decision makings like career choice, mate selection and marriage are made by the family members collectively. Indian family is described to basically patriarchal in its ideology. The hierarchy, roles and the rules of conduct are clearly drawn. As discussed earlier also that the family members in traditional joint family kind have strong emotional bonding, interdependence, empathy, loyalty for each other. This is considered as the source strength for the family to cope with major life events. There has also been a long tradition of involving families in the treatment of mentally ill relatives. Therefore, the need to preserve and involve families in treatment of mental illness has been pointed out as being important.

4.3 CULTURAL CONTEXT OF UNDERSTANDING MENTAL ILLNESS

It is very interesting to know that even for same kind of mental illness the expression of deviant behaviour is not uniform across the various cultures. Therefore, even though the prevalence of syndromes such as schizophrenia is universal, the manifestations of the symptoms may differ and need to be understood in their cultural contexts. The interpretations of symptoms will differ based on their meaning, source, temporal nature, and curability. These symptoms may evoke different social reactions, which affects treatment seeking behaviour, compliance with treatment, functioning of the support system, stigma attached to the illness etc. The major mental illnesses are characterized by impairments of cognition and affection. Research findings show that there is an underlying vulnerability for many of the categories of mental illness. However, there are certain indicators to show that there may a relationship between stress and mental illness and mental health.

4.3.1 Culture and Mental Illness

Research and experience in the treatment of mental illness shows that culture affects mental health care and services in many ways. The significant influences of culture on mental illness have been discussed in the subsections below.

4.3.1.1 Cultural Identity

A clinician’s treatment process can be influenced by the characteristics of the person’s cultural group such as language use, religious belief, ethnicity, etc. Cultural identity emerges throughout the individual’s life and in social context. It is not a fixed trait of an individual or of the group of which the individual is part. An individual may have several cultural reference groups. The clinician needs to encourage the patient to describe the various elements like beliefs
of the culture to which he/she belongs. Evaluating the cultural identity of the patient allows identification of potential areas of strengths and supports that may enhance treatment effectiveness, as well as vulnerabilities that may obstruct the process of treatment.

With the help of the awareness of the patient’s cultural identity the clinician may be able to,

- Avoid the misconceptions based on inadequate background information or stereotypes related to race, ethnicity, and other aspects of cultural identity.
- Develop a better rapport with the patient, as it enables the clinician to understand the patient in a better way.
- Enhance effectiveness of treatment and
- Understand the vulnerabilities that can interfere with progress of treatment.

### 4.3.1.2 Cultural Explanation of Mental Illness

There may be a difference in the opinions of the clinician and the patient regarding the nature and causes of his/her illness and the treatment options they would consider. The explanatory model defines that such differences will occur due to the differences in their culturally acceptable means of expression of the symptoms of the illness and their behavioral response. Conflicts between the patient’s and the clinician’s explanatory models may lead to diminished rapport or treatment noncompliance. Conflicts between the patient’s and the family’s explanatory models of illness may result in lack of support from the family. Conflicts between the patient’s and the community’s explanatory models could lead to social isolation and stigmatization of the patient. Few examples of the more common explanatory models are as follows:

- The moral model implies that the patient’s illness is caused by a moral defect such as selfishness or moral weakness.
- The religious model suggests that the patient is being punished for a religious failing or transgression.
- The magical or supernatural explanatory model may involve attributions of sorcery or witchcraft as being the cause of the symptoms.
- The medical model attributes the patient’s illness primarily to a biological etiology.
- The psychosocial model infers that overwhelming psychosocial stressors cause or are primary contributors to the illness.

Culture has both direct and indirect effects on help-seeking behavior. In many cultural groups an individual and his or her family may minimize symptoms due to stigma associated with seeking assistance for psychiatric disorders. Thus, culture influences the patient’s expectations of treatment.

### 4.3.1.3 Psychosocial Environment and Level of Functioning

In order to understand the patient’s psychosocial environment, it is important to know about their family dynamics and cultural values. Even in the case of
immigrants, where one person moves out from his society, it is important to know how the individual and family perceive the openness of the host society toward people of their country and region of origin, their racial, ethnic, religious, and other attributes. For instance, when a person from India immigrates to a western country, how he views the perception of people from that particular country about Indians is important. The mental health also depends on how the individual identifies the cultural support of the host country when comparing to their region of origin. The patient and family may identify strongly or weakly or at the same gradient with communal sources of support in the host culture.

4.3.1.4 Cultural Elements of Relationship between the Individual and the Clinician

The cultural identity of the clinician and of the mental health team has an impact on patient care. Lack of recognition about patient’s cultural identity may lead to unintentionally biased treatment. Culture influences the relationship between the patient and the clinician. When the patient and clinician are of different genders, culturally ingrained role assumptions may create difficulties. For example, male patients from cultures where men are assumed to have higher status, the male patient may feel that expressing their emotional problems to a female therapist is evidence of weakness and is culturally humiliating. Conversely, females may view it as culturally inappropriate to discuss with male clinicians interpersonal issues and emotions that are only considered proper to talk about with females of their age group and within the setting of their extended family. Thus, it is important for the clinicians to examine their assumptions about other cultures in order to give better service.

4.3.1.5 Overall Cultural Assessment for Diagnosis and Care

In order to successfully deal with the patient, the clinician includes the use of culturally appropriate health care and social services. The clinician may include the family and social levels in their interventional plan. In making a psychiatric diagnosis the clinician should not use classification systems developed for one culture to another culture where its relevance may not be comparable. As discussed earlier also, many psychiatric disorders show cross-cultural variation. The evaluation of cultural factors on psychopathology can be a challenging task for the clinician.

4.3.2 Culture-Bound Syndromes

The cross-cultural literature has shown that certain disorders or psychotic behaviors are found only in specific cultural settings. Therefore the cultural and belief systems influence the presentation of illness. The following are examples of some of the culture-bound syndromes/symptoms:

Koro: More Prevalent in Southern China, Southeast Asia, India. This is a mental disturbance characterized by a man’s belief that his penis is shrinking into his abdomen. It is now considered an acute anxiety state associated with sexual dysfunction.

Windigo psychosis: Usually found among Cree Eskimos and Ojibwa of Canada. This disturbance is characterized by cannibalistic delusions. The victim believes he has been transformed into a giant monster that eats human flesh. This delusion is possibly derived from tribal mythology and reflects the survival struggle in the Arctic.
**Arctic hysteria**: Prevalent in Polar Eskimos. The person may scream for hours, imitating animal cries, while thrashing about on the snow in the nude or partially undressed. Some attribute the condition to diet, to hypo-calcemia, or hyper-vitaminosis-A.

**Latah**: Found among Southeast Asians. This syndrome appears most commonly among women who break into obscenities and echolalia after an event that startles them. They may also follow commands automatically or repetitively imitate another person. It has been suggested that latah is an arousal state (possibly located in the amygdala) that may have developed as an adaptive response to snakes. Seeing a snake is a common precipitant of the startle response in Malayan and Filipino cultures, where snake bite is a major cause of morbidity.

**Susto or Espanto**: Found among Latin American Indians. It is a fear state or sudden fright attributed to loss of soul by the action of spirits, the evil eye, or sorcery. Symptoms include weakness, loss of appetite, sleeplessness, nightmares, and trembling, and their frequency in this population has sometimes been attributed to hypoglycemia. Susto may be diagnosed as a brief reactive dissociative disorder, but it is unlikely to be healed by modern psychiatry. Its cure requires a traditional healer whose ministrations will influence the spirits to release the soul and return it to the host body.

### 4.3.3 Culture and Stress

According to the stress-diathesis hypothesis, stressful environmental events lead to biological vulnerability towards a specific condition. Many experts today tend to accept the diathesis-stress hypothesis in the case of major psychiatric diagnoses with known biological and genetic parameters, such as schizophrenia, bipolar disorder, or obsessive-compulsive disorder. Thus, it is important to know the interactions of the social and cultural environment of an individual before implying treatment towards mental disorders.

#### Self Assessment Questions 1

State whether the statements are ‘true’ or ‘false’

1) **Susto or Espanto** is a fear state or sudden fright attributed to loss of soul by the action of spirits, the evil eye, or sorcery ........................

2) Research and experience in the treatment of mental illness shows that culture affects mental health care and services in many ways ................................. .

3) The cultural identity of the clinician and of the mental health team does not have an impact on patient care .................................

4) In order to understand the clinician’s treatment, it is important to know about their family dynamics ................................. .

### 4.4 IMMIGRATION AND ACCULTURATION

The process of immigration and acculturation also has an impact on the mental health of individuals because it involves adaptation and adjustment towards
another culture. In order to make it more clear to you let us deal with both the processes and their outcome one by one:

### 4.4.1 Immigration

Refers to the movement of people into a country or region from their native place. Immigration is made for many reasons, including temperature, breeding, economic, political, family re-unification, natural disaster, poverty or the wish to change one’s surroundings voluntarily.

### 4.4.2 Acculturation

Refers to the process of cultural and psychological change that results following meeting between cultures. The effects of acculturation can be seen at multiple levels in both interacting cultures. At the group level, acculturation often results in changes to culture, customs, and social institutions. Noticeable group level effects of acculturation often include changes in food, clothing, and language. At the individual level, differences in the way individuals acculturate have been shown to be associated not just with changes in daily behavior, but with numerous measures of psychological and physical well-being. As enculturation is used to describe the process of first-culture learning, acculturation can be thought of as second-culture learning.

### 4.4.3 Fourfold Model

The four possible outcomes of immigration and acculturation are separation, integration, assimilation, and marginalization.

1) **Separation** - When an individual shifts to a new culture, then the individual may wish to maintain his/her cultural integrity, whether by actively resisting the incorporation of the values and social behavior patterns of another cultural group or groups with whom they have regular contact, or by disengaging themselves from contact with and the influence of those other cultural groups. Some religious cults are examples of separation.

2) **Integration** - It is an outcome of acculturative stress faced by an individual which is derived due to the desire to both maintain a firm sense of one’s cultural heritage and not abandon those values and behavioral characteristics that define the uniqueness of one’s culture of origin. At the same time, such individuals are able to incorporate enough of the value system and norms of behavior of the other cultural group with which they interact closely, to feel and behave like members of that cultural group, principally the majority host culture. Accordingly, the defining feature of integration is psychological: It is the gradual process of formulation of a bicultural identity, a sense of self that intertwines the unique characteristics of two cultures.

3) **Assimilation** is the psychological process of the conscious and unconscious giving up of the unique characteristics of one’s culture of origin in favor of the more or less complete incorporation of the values and behavioral characteristics of another cultural group, usually, but not always, the majority culture. Examples include involuntary migration, during war for survival purpose. However, there are many other life circumstances, including racial, ethnic, and religious discrimination, that motivate people to overlook, suppress, or deny aspects of their cultural
heritage in an attempt to have a seamless fit within another group. The price of such an effort, in terms of intrapsychic conflict, can be high.

4) *Marginalization* is defined by the psychological characteristics of rejection or the progressive loss of valuation of one’s cultural heritage, while at the same time rejecting, or being alienated from, the defining values and behavioral norms of another cultural group, usually that of the majority population. This is the psychological outcome of acculturative stress that is closest to the concept of identity diffusion. As such, it is most often exemplified by the angry, lost, and anguished youth and young adults of many groups, those whose intense intrapsychic conflicts are reflections of substantive intrafamilial, intergenerational, intracommunal, and intercommunal conflict. Part of their search for psychological meaning and self-esteem is reflected in their turmoil about their ethnic identity and in their formation of a negative identity.

The literature on acculturation and acculturative stress emphasizes the need for long-term study of the process. With the help of an understanding towards stress due to acculturation, clinicians can take account of its complex influence on the clinical presentation of the very large numbers of people affected by it and thereby improve the quality of their treatment.

Studies suggest that individuals’ respective acculturation strategy can differ between their private and public life spheres. For instance, an individual may reject the values and norms of the dominant culture in his private life (separation), whereas he might adapt to the dominant culture in public parts of his life (i.e., integration or assimilation).

### 4.4.4 Cultural Factors Related to Immigration and Mental Health

By now you must have understood that culture influences the health belief system and has an effect on the diagnosis and treatment of mental disorders. However, there is tremendous cultural variability among groups and heterogeneity within groups.

Several key cultural factors that are relevant to this process are as follows:

- **Language**: Language is one of the important factors influencing access to health care. When a person immigrates to another country/state wherein the language of communication is different, the communication between the clinician and the person could be problematic.

- **Level of acculturation**: Studies towards immigration in western countries have shown that generally it takes three generations for immigrants to fully adopt the lifestyle of the dominant culture. Therefore the feelings of alienation, disconnectedness would lead to mental health issues.

- **Age**: In general, the younger people can easily adapt to a different culture when they migrate than older people.

- **Gender**: There are higher chances for men to adapt to another culture than women because of exposure to the other culture.

- **Traditional beliefs about mental health**: The belief system about mental illness differs from one culture to the other. This can influence the access the mental health care; this in turn will affect the compliance with treatment and the prognosis.
These factors will have differing effects, depending on the individual’s degree of acculturation, socioeconomic status, and immigration status.

Many studies conducted among the immigrants at different countries showed that the immigrants showed above-average levels of admissions for schizophrenia to psychiatric hospitals. This could mean that immigrants face stressful situations while living in an alien country and culture. It might be suggested that for persons suffering from mental illness, appropriate education of caregivers or others in the person’s social network, can help in minimizing stress.

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<tr>
<td>State whether the statements are ‘true’ or ‘false’</td>
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<tr>
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</tr>
<tr>
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4.5 LET US SUM UP

It can be summed up from the above discussion that culture plays a significant impact on the mental health and belief system of individuals. The assumptions of role of culture in psychological processes and the application of this in understanding cultural issues in mental health and mental illness is significant. Culture is no more a stable unchanging aspect, as there are widespread political, demographic and economic changing taking place globally. Therefore, cultural aspects have become increasingly important in view of the diversity that exists in a given society, specifically in terms of mental health issues. It should also be understood that the therapists need to be sensitive to the cultural background of the clients. When dealing with clients from different backgrounds, treatment should incorporate three components: awareness, knowledge and skills. Further, immigration has also resulted in mental illness due to the process of acculturation with the change of time.

4.6 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) True
2) True
Self Assessment Questions 2

1) False
2) True
3) True
4) False

4.7 UNIT END QUESTIONS

1) Define culture. What are the components of culture?

2) Describe the important cultural factors that have to be considered by the therapist in the management.

3) Write briefly about culture-bound syndromes.

4) Write in detail about immigration and acculturation.

5) What is cultural identity?

6) What is cultural stress?

4.8 REFERENCES


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ISBN: 978-81-266-6906-6