

Short Communication

Redefining the Family in Mental Health: Understanding Norms and Improving Professional Practice

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ABSTRACT

The family as an institution and support unit has generated much discussion on its role for stress and mental health problems. Against this backdrop, this paper re-examines the family as a factor and as a locus of cultural norms and expectations derived from the society within which it exists. Using the cases of immigration, sexual minorities, and the intersection of mental health problems and coping mechanisms, I flesh out the social layers through which the family complexly improves and worsens mental health for its members. Finally, I identify

possible recommendations for improving communication in mental health treatment services: (1) recognizing the overlap of mental health problems; (2) developing culture-specific prompts to identify unreported problems and culture-specific solutions; (3) adopting a family-centred approach to mental health counselling; (4) improving mental health recognition and access.

MeSh Headings/ Keywords: Family; Culture; Norms; Mental health; Stress; Coping

Introduction

The subject of mental health in the family as an institution and support unit has generated interesting discussions on its role for stress and mental health problems. Discussions within this strand of thought have largely converged upon two themes: one that lauds the family for alleviating mental health problems through social support, caregiving, coping functions, particularly for children [1-3], and another that understands it as a context for aggravating these problems through abuse [4]. Yet, these themes paint a picture of the family as the only environment in which individuals are immersed, prescribing recourse to the family as the ultimate end for all mental health problems.

This is not entirely wrong. Families are an important indicator for understanding social change [5]. But instead, I will address how the family is a factor that affects mental health – one of many, amidst a field of experiences, processes, and norms weighing on the mental health of individuals who are part of society, no less than they are part of a family. The family, after all, is influenced by the society within which it exists, which, in turn, comes to effect tensions among its members.

Often, family members' identities can clash with society's norms, producing tensions that result in stress and other mental health problems. Keeping this in mind, three particular identities are useful for re-examining the complicated influence of the family on mental health: immigration, sexual minorities, and intersection of mental health problems and coping mechanisms. To this end, I will flesh out the layers of social processes through which the family can both improve and worsen mental health. Finally, I identify possible recommendations for improving communication in mental health treatment services.

Family, Immigration, and Acculturation

Immigration ushers in a swath of stressors that culminate

in externalizing mental health problems, including physical displacement, social isolation, socioeconomic status, language barriers, bureaucratic documentation, and locating and performing well at work. This section looks at how stress is a common predictor of mental health problems, and how the immigrant shows how complicated family can be in coping and worsening stress, and by extension, mental health problems in the process of acculturation, or the process of adapting to cultures unique to a host country. Little evidence suggests that immigrants have access to social support at work [6], forcing a heavier emphasis on the family and ethnic communities for social support for both second [7] and first-generation members [8-9] by helping to cope with, provide a sense of security from, and distract from acculturation challenges. Yet, against the backdrop of home country culture, family can also shield against acculturation and produce conflicts within the family, aggravating mental health problems – a level of detail largely ignored by mental health studies. Collectivistic cultures, for instance, are comparatively more resistant than non-collectivistic cultures to adopting values, norms, and routines [10]. For instance, mothers who immigrate to North America experience emotional problems when they are confined to a household role that no longer stimulates, in the wake of technology that renders household maintenance tasks easy, but boring [11]. Torn between personal desires for pleasure and family expectations for bored, confined servitude, these mothers experience heightened levels of stress with deleterious mental health consequences. Indeed, post-immigration, individuals become immersed in a new culture: rather than being expected to submit, they are encouraged to be autonomous, creating tensions within the family. As such, individuals become split between an East Asian traditional community and a mainstream host society, wherein the failure to adapt introduces a new range of stressors, anticipating helplessness, misplacement, and loss of identity [12].

These rifts paint an important picture for improving mental health professional practice. Professionals should be sensitized not only to the conflicts between patients and their families, but to the conflicts that split the patients themselves as they struggle to reconcile the need for family with their own personal desires.

Family, Sexual Minorities, and Coming Out

The stress that sexual minorities encounter is not only sourced from society, but is exacerbated by their families. This section provides further perspectives not only on how stress is a common predictor of mental health problems, but how the mental health of another type of individual, like the immigrant, can be improved or worsened by the family. Family norms, influenced by both religion and Conservative traditions, clash against sexual minorities across five types of values [13]: (1) the importance of religion; (2) the importance of marriage; (3) the importance of having children; (4) Conservative, unreligious stigma against sexuality minorities; (5) and the importance of gender norms.

The consequences of these five areas are well-documented in terms of shame, frustration, disappointment, and even harassment [14]. Disapproval from within the family towards sexual minority identity is compounded by disapproval from larger society and even from within the gay community, where discrimination and racism thrive [15].

Yet despite the variation in discrimination among these different areas of social life, and their equally damaging effects on mental health by precipitating stress, mental health disorders, and risky behaviour [16], they are all commonly dispelled by the social act of “coming out.” Defending one’s sexual identity affords a sense of dignity as a coping resource for mental health issues and a source of individual empowerment [17]. Being acknowledged by one’s social environment and by oneself provides a sense of control that encourages healthy self-esteem and positive response expectations, critical for good mental health [18]. Furthermore, coming out inspires others in similar circumstances to do the same within the sexual minority community. Empowerment, like repression, multiplies. Yet, whether one commits to the act of coming out hinges on the norms represented within the family, which come to affect and be affected by areas of social life beyond it.

Thus, where coming out normally constitutes a social process of alleviating stress and mental health, freeing the individual from the ambiguous judgment and rumours among others in larger society [19], and thereby eliminating two forms of non-event, chronic stressors, homophobia within the very household one resides in stifles this process. Because of homophobia at home, individuals become unable to address homophobia outside home, bound by fear of losing social capital, such as social isolation, oppression, harassment, homelessness, rejection [20].

These points are important for mental health practitioners to be aware of, in order to address in counselling sessions as causes of mental health problems for patients, especially those from cultures more reserved and less keen to discussing explicit

feelings. Moreover, it emerges that even within a single type of identity or circumstance (sexual minorities), the family can affect mental health in such complicated ways through its norms.

Intersectionality and Implications for Practice

Whatever social support the family provides is shaped by the very cultural norms embedded in its structure. Conversely, that family can aggravate mental health problems is because of these very norms as well. For instance, social support from family members within East Asian families is received under the expectation of conformity to their cultural norms and assigned roles [21]. Children experience more pressure to succeed in education for familial social status, and while this has been found to reduce their likelihood of developing externalizing problems [22], it also reduces the efficacy of mastery – the individual perception of ability to handle stress [23] – for everyone in the family. Thus, mastery and sense of control become eroded by obligations of complacency and submission to culturally assigned roles. Similarly, other mental health coping mechanisms can be ruled out by family norms. Changing the meaning of a situation, for example, is a common strategy, but would not work in the context of immigration or sexual minorities, given their urgency and sense of trauma as stressors. Avoidance or detachment from family itself as a source of distress is also common, but would also fail, because of the importance of family in non-Western, collectivistic cultures [24].

Furthermore, discussing mental health problems themselves with family or seeking professional help within these cultures is highly discouraged by stigma. Mental health disorders are perceived as curses to the family, rather than legitimate health issues [12], and emotional suppression is actually seen as maturity, rather than the mental health aggravator that it is [25].

Individuals who experience multiple identity problems – such as being both an immigrant and a sexual minority –, in fact, are likely to experience even greater stress than those who experience either one. More importantly, however, is how such circumstances that anticipate mental health problems are not just compounded in terms of stress, but also interact with each other. Take the case of a depression patient, but who also identifies as a sexual minority immigrating from a collectivistic culture. In this case, while he/she might be thankful for family providing a much-needed social support function, he/she could also be clandestinely suppressed “in the closet” and distressed by their attitude towards sexual minorities. Consequently, fear of upsetting the status quo eventually grows to become a stressor itself, at the same time it prevents the honest communication and resolution of other stressors. How does one navigate the ups and downs that a family is responsible for, if addressing the downs could potentially destroy the ups?

What, then, does this mean for practice? What recommendations can we garner from the complex nature of mental health and the family? (1) Physicians, practitioners, and officials should recognize the overlapping, accumulative nature of stigma across multiple dimensions – mental health, homosexuality – and their relationship with the family. Families

are often contacted in the event of risky or self-harm behaviours with roots in mental health. However, contacting family about such problems may often endanger an individual, if he/she comes from a cultural background that repudiates the legitimacy of mental health, risking social isolation and disappointment. Greater efforts should be made to culturally sensitize officials to such circumstances, and improve trust, confidentiality, and openness between practitioners and patients.

(2) In a similar vein, practitioners should be sensitized to the problems family could pose that patients themselves might be unable to recognize, and design culture-specific ways of communicating about such issues and developing their solutions. For instance, urging individuals to detach from family might normally be an adequate strategy, but would be a terrible way of communicating this strategy, likely inviting rejection.

Similarly, advising people to reinterpret the situation might be impossible, in face of the potential stressors they might be experiencing or masking. What patients do not say is just as important as what they do: particularly in collectivistic cultures, patients are accustomed to languages that draw upon metaphors and indirect, rather than direct, expressions of meaning. Practitioners should be aware of this circumstance, and develop prompts to sufficiently tease out and identify problems that patients do not overtly report.

(3) Services should adopt a family-oriented approach or component. Existing services also overburden counseling with the individual, often charging them with the task of confrontation and confession should the need arise, in spite of the aforementioned complications that family-relations pose. Keeping this in mind, bringing family in to particular sessions and addressing them with the patient in focus would be crucial for maximizing on long-term benefits – not only resolving individual problems, but also ensuring families are more educated, sensitive, and responsive to the causes and circumstances of mental health problems.

(4) Mental health itself also deserves greater access and recognition. Its stigma extends from hostility, where they are imagined as curses, to defamation, in which they are not recognized as health problems. Greater resources should be invested in raising public awareness of the depths and complexities within mental health and its problems, as well as in the mental health treatment practice, counselling programs, and services to connect individuals to such practitioners. In this regard, costs should be lowered and its coverage made a part of existing health coverage or insurance programs.

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