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PERCEPTIONS OF MENTAL ILLNESS IN AMERICA AND TANZANIA: COMBINING MODERN AND TRADITIONAL CULTURES

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ABSTRACT

Mental health has often been a neglected field of study, especially compared to physical health. However, more focus and attention on mental health is crucial, as mental illnesses are projected to increase dramatically, i.e. depression, in the nearing future worldwide. Mental illness varies globally; therefore culture plays a significant role in defining numerous mental disorders. It is imperative to understand other cultures in order to combat mental illness around the world and reach optimal health. In particular, modern and traditional cultures have differing views on what constitutes a mental illness and the appropriate treatments for the illness. In this thesis, cultural perceptions are analyzed and compared in the United States of America (a developed country representing modern cultures) and Tanzania (a developing country embodying traditional cultures). Through these conceptions of mental illness observed in both cultures, the apparent distinctiveness calls attention to the importance of recognizing other cultures, as well as combining modern and traditional cultures to attain optimum mental health. The presumption that developed nations can only help developing nations, rather than vice versa, is challenged here. Furthermore, to successfully and efficiently combine cultures, culturally appropriate interventions must be conducted. An example of one such intervention is demonstrated in this thesis, emphasizing the formation of trust and cultural communication. Cultural perceptions of mental health greatly impact mental disorders, creating both positive and negative health outcomes. As exemplified in this thesis, merging modern and traditional cultures, and essentially learning from one another, has the potential to reverse mental illness trends for the future.

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Chapter 1

Complexities of Mental Health

Where one thing stands, another thing must stand beside it. . . . This saying "there is only one way" is something which is new to my people.
-Chinua Achebe

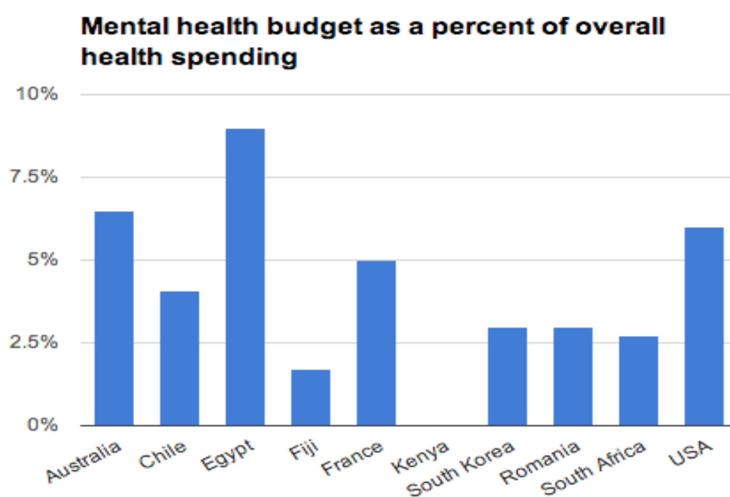
The mind and body are inseparable entities; mental health and physical health are dependent on one another to achieve optimal health. However, mental health is often underestimated and has been neglected throughout history, more so than physical health. Why is this? Defining mental health poses many challenges. "…What it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures" (DHHS, 1999). Furthermore, researchers discovered that mental illnesses are not like most other illnesses, which involve their own natural histories with similar symptoms, prevalence, forms, and outcomes. Rather, mental illnesses are recognized for their extreme variances across the world and "are inevitably sparked and shaped by the ethos of particular times and places" (Watters, 2010). While mental illness is exceedingly complex, it can no longer be disregarded and deserves equivalent attention as physical illness. Mental illness is a major global health concern today, as four of the top ten leading causes of disability in the world are mental illnesses: depression, alcohol-use disorders, schizophrenia, and bipolar disorder (NAMI, 2013). Perceptions of mental health differ principally across western and traditional cultures. Each culture's concepts of mental illness have both positive and negative outcomes for health, therefore we must learn from each other. In order to reach optimum mental health globally, it is imperative to have a unique understanding and balance of Western and traditional cultural practices, as there is not "only one way"—Ultimately, integration of these practices must be

achieved via culturally appropriate interventions. To illustrate this idea further, I discuss its application to mental illness in Tanzania and the United States of America.

General Impact of Mental Illness

The global health landscape has drastically changed over the past two decades. People are living longer, but not necessarily leading healthier lives. The leading causes of death globally have shifted from communicable diseases to non-communicable diseases, thereby increasingly accrediting disease burden to disability (IHME, 2010). Approximately 450 million people worldwide suffer from a mental disorder, and an estimated one in every four people will acquire a mental health condition in their lifetime (WHO, 2010). While the World Health Organization (WHO) approximates that the leading cause of illness and disability globally is attributed to mental disorders, "half of all countries in the world have no more than one psychiatrist per 100,000 people and a third of all countries have no mental health programmes at all" (Chambers, 2010). The gap between the need for treatment and available resources is startling; 44-70% of mentally ill individuals do not receive treatment in developed countries, while up to 90% do not receive treatment in developing countries. Mental illness is responsible for 14% of the global burden of disease, and most developing countries contribute only 2% of their government budget to mental health care (Gordon, 2011). On the contrary, the U.S. spends a total of $113 billion on mental health treatment, which accumulates to about 5.6% of the national-healthcare spending (Kliff, 2012). This places the United States within the same range as other developed nations, as displayed below in Figure 1-1:

Figure 1-1. Mental Health Budget as a Percent of Overall Health Spending



Source: Kliff (2012)

Mental health affects human development, social stability, quality of life, and is an overall determinant of well-being (WHO, 2010). That being said, mental health is one of the most critical, yet neglected, health issues today.

General Perceptions of Mental Health

Perceptions of mental illness have profoundly transformed since earliest civilizations, and will continue to alter as new revelations of the human mind persist. The earliest attempts to treat mental illness are traced back to 5,000 BCE, in which the use of "trepanning" initially occurred in Neolithic times (Froeschner, 2012). In order to cure the mentally ill patient, a hole was drilled into the patient's skull using crude stone instruments, thereby releasing what was considered to be the evil spirit that causes the illness. In ancient Mesopotamia, practices such as exorcisms, prayer, and atonement were conducted to rid the mentally ill patient's demonic possession (Froeschner, 2012). Ancient Egyptians suggested activities such as concerts, painting, and dance to those who suffered from a mental health condition in order to relieve symptoms and gain a sense of "normalcy" (Froeschner, 2012). These ancient civilizations primarily related mental illness to the

supernatural and personal punishment. Shortly after, Greek physician Hippocrates ascribed mental illness to the imbalance of the four essential fluids in the human body: blood, phlegm, bile, and black bile (PBS, 2002). Hippocrates was the first to attribute mental illness to physiology, rather than punishment from the gods or demonic possession.

The mentally ill were typically taken care of by their family during the ancient times (PBS, 2002). Abuse was common, though, as many mentally ill individuals were forced into unsanitary conditions such as dungeons, pigpens, or onto the streets. Until the mass establishment of asylums and institutions, humanistic physicians, medical astrologers, apothecaries, and folk/traditional healers offered treatment to the mentally ill throughout the Middle Ages (Froeschner, 2012). Treatments included prayers, exorcisms, charms, and other mystical techniques, as demonology (the belief that being possessed by a demon caused mental illness) peaked in the 1600s (Wiesner, 1993). In fact, historians believe an estimated 100,000 people were tried, tortured, and executed as witches throughout Europe and the U.S. Colonies (Wiesner, 1993). Beginning in the 16th century and onward, asylums were built around the world. However, treatment provided was not to better the mentally ill, but rather these institutions were used to relieve family members of the mentally ill individual. Therefore, inhumane treatment persisted as physical restraint, the use of straightjackets, and frequent threats were used, as well as the absence of food or clothing provided for the mentally ill (Ludovici, 2010). In the mid-16th century, the "gyrating chair" was invented as a means to shake up tissues and blood in a mentally ill patient's brain to restore balance. Similarly, in the 1700s and late 1800s, the "swinging chair" was used to spin around the mentally ill in a chair to induce vomit so as to improve the mental disorder (Ludovici, 2010).

Very few advances in psychological or theoretical concepts of mental illness arose after the mass establishments of institutions and asylums, until the advancement of psychoanalysis by Sigmund Freud in the early 1900s (PBS, 2002). The Psychoanalytic Theory describes the human

brain as having three elements: the id, ego, and superego. “Freud believed that anxiety arose as these three parts of the human mind battled each other, resulting in mental illness and that if the individual could only reveal and address the content of their unconscious, then their mental ailments would be cured” (Froeschner, 2012). Treatments offered by Freud included “talking cures,” or hypnosis. Freud believed that this treatment would allow the mentally ill to release repressed thoughts or memories from their unconscious state of mind. Other forms of treatment during this time period that were widespread included electroconvulsive therapy, psychosurgery, and psychopharmacology (PBS, 2002). These treatments were based on the idea that in order to cure a mental illness, one must restore the chemical imbalance in the brain. “The introduction of psychopharmacology is arguably one of the most significant and successful contributions to mental illness treatment, although it did lead to a movement that has been devastating to mental health care systems around the world, especially in the United States” (Froeschner, 2012). This movement of deinstitutionalization that is seen today will be discussed later.

A common contributor to the persistence and complexity of mental illness throughout history and up to today, in both developed and developing nations, is stigma. Mental illness probably entails more stigma than any other illness, as it affects more than just the patient (Sartorius, 2007). In many ways, the stigma surrounding mental illness acts as a rippling effect, touching every aspect related to the mentally ill. Stigma, therefore, is profoundly debilitating as patients are reluctant to seek help and become fearful, hopeless, ashamed, and even abused as society isolates them. Today, nearly two-thirds of all people with a diagnosable mental health condition do not seek treatment, and nine out of ten mentally ill patients believe stigma has negatively affected their lives (Jenkins & Mbatia, 2010). With a growing understanding of mental illness today, stigma is expected to decrease. However, that may not be the case, in which case the need for direct mental health attention throughout the world is accentuated even more.

Chapter 2

TANZANIA: Cultural Impacts

My Relative Experience

I had the opportunity to travel to a developing country, Tanzania, as part of the Penn State Global Health Program in the summer of 2013. Over a four-week period, I shadowed Tanzanian nurses in a rural village as they collected data on the mentally ill and conducted interventions on mental health. This first-hand experience enabled me to view a health setting very different than my own. In addition to my U.S. perspective, I gained an understanding of Tanzania's perspective on mental health and a greater understanding of the ways in which culture affects health outcomes. I believe it is absolutely crucial, especially of "Westerners" like myself, to open our minds and enhance our awareness of other cultures' lifestyles and beliefs. While many Westerners may not like to admit it, we tend to think our way is the best way, and as a result we become ignorant of the many cultures around us with their exceptional knowledge and resources they have to contribute. We must comprehend the role culture plays in one's life because "mental illness is an illness of the mind and cannot be understood without understanding the ideas, habits and predispositions--the idiosyncratic cultural trappings—of the mind that is its host" (Watters, 2010). It is essential to examine culture in both health settings in order to understand its significance, as I will now demonstrate using Tanzania and the U.S. as models.

Introduction

Tanzania is a developing country whose value is a combination of contemporary and traditional cultures. Tanzania is one of the poorest countries in Africa, with an estimated 36% of the population living under the poverty line and up to 80% living in rural areas (Jenkins & Mbatia, 2010). Many countries in Africa have been primarily focused on combating health issues such as malaria and HIV/AIDS, as well as political issues like war and economic issues like poverty; therefore they have not had the time or resources to effectively address mental health (Bednarz, 2013). As a result of limited focus on mental illness, most African countries do not have adequate mental health policies or programs (Alem & Gureje, 2000).

An estimated 2.5 million people in Tanzania suffer from a mental illness, and only 20% of them have access to mental health services (BasicNeeds, 2013). Mental health services are predominately funded by the government, but funding for mental health remains limited in Tanzania. Overall, Tanzania has a total of 900 psychiatric beds for a population of around 40 million, accumulating to about 20 beds per 1.5 million people in most regions (Jenkins & Mbatia, 2010). One mental health hospital exists in Tanzania, Mirembe Hospital, which holds 600 beds. The Lutindi Mental Hospital, used primarily as a rehabilitation center, is the only mission mental health clinic in Tanzania with 100 beds, and basic mental health services are also provided at Muhimbili University Hospital and in Mbeya, Tanzania (Jenkins & Mbatia, 2010). Additionally, two major NGOs called BasicNeeds and TUSPO offer mental health care as well. Eighteen psychiatrists were listed in 2009, of whom only four practice outside of Dar es Salaam, the most populated city in Tanzania. While 1,000 mental health nurses have been trained, only 460 mental health nurses actually work in mental health services. Lastly, adequate supply of treatment drugs for the mentally ill did not meet demand in 17 of the 20 regions in Tanzania (Jenkins & Mbatia, 2010).

A national mental health program is present in Tanzania, formulated in 1980 by the assistance of WHO and the Danish Development Agency. The National Mental Health Pilot Programme introduced mental health policy in Tanzania in 1990. This program strived to provide mental health services at all levels of primary care, as well as provide specialist psychiatric services, and to raise awareness of mental health in communities (Jenkins, Mbatia, & Shah, 2009). Unfortunately, the program was unable to sustain the implementation of this policy across Tanzania due to lack of government funding. In 2002-2003, however, "mental health has now been included in the national health sector strategic plan, enabling some continuing professional development for primary care to restart" (Jenkins et al., 2009).

Despite recent progress in Tanzania, there is much room for improvement. A simple example is that the language used to define mental health conditions in some African countries is not consistent across the region and may reflect a limited focus on mental health. For example, in Lesotho, there is no term equivalent to the English word "counseling". Similarly in Uganda, rather than using "depression", terms like "Yo'kwekyawa- hating oneself- and Okewkubagiza-pitying oneself" are used (Gordon, 2011). Furthermore, cultural environments, as well as how others describe the mentally ill, perceived manifestations and causes, and preferred treatment reflect the particular culture.

Economy

An economic condition that deeply affects Tanzania is poverty. Poverty and mental illness are perceived as interconnected, reflecting a parallel relationship as they are directly correlated. Gordon (2011) declares, "…People living in poverty are more vulnerable to mental illness, whilst those with pre-existing mental illness are more likely to become trapped in poverty

due to decreased capacity in everyday functions." Tanzania is one of the top twenty-five least developed countries in the nation, with a per capita annual income of $400 in 2008 (Jenkins & Mbatia, 2010). Those with levels of social and economical disadvantages have an increased risk for mental health problems. Even more, those who live in poverty are unable to afford mental health treatment, often leaving them hopeless with no means to improve.

Health

The widespread infectious diseases in Tanzania exacerbate socio-economic stressors as well. Harms, Jack, Kizza, & Sebunnya (2009) explore the mental health of orphaned adolescents due to the death of one or both parents from HIV-related illnesses in Uganda. In 2007, 12 million children between the ages of 0 and 17 were orphaned as a result of HIV-related illnesses. The findings expose internal and external symptoms of the orphaned youth that tend to formulate as indicators of poor mental health. Internal factors include depression, social withdrawal, and anxiety, while external factors involve aggressiveness, argumentative, and defiance. Overall, the HIV-related deaths of parents that result in orphaned youth entail negative effects on their mental health, posing future mental health problems (Harms et al., 2009). In Tanzania, 1.6 million people are HIV-positive, which is about 6% of the population (DW, 2013). More so, 84,000 Tanzanians die each year from AIDS-related diseases (DW, 2013). During my fieldwork in Tanzania, I visited the HIV clinic in the health center. About 300 people had been diagnosed with HIV in the village. The burden of infectious disease may impact mental health focus in Tanzania, essentially making mental illness a lower-priority health concern. As stressed previously, both physical health and mental health are dependent on each other, as the mind and body must be in balance together.

Communalism

Tanzania's communalism culture provides a supportive environment to cope with mental illness. Many Tanzanians rely on their community, family, and friends for support and treatment. Receiving care within one's community provides an immeasurable sense of belonging, and provides a home-based care system that is often more effective and beneficial than professional care in a hospital or institution (Bartlett, Jenkins, & Kiima, 2011). Traditional cultures profoundly value kinship and regard the self and one's kinship as an indissoluble bond, where one cannot survive without the other (Watters, 2010). This is often demonstrated in African families where relatives are referred to as brothers and sisters, where as in Western culture they would be referred to as nephews, nieces, and cousins. Airhihenbuwa (1995) argues that African forefathers and foremothers intentionally left out these distinctions because to distinguish between immediate family members and distant relatives only creates a "cognitive and affective distance" in the way one perceives them (pg. 18). Airhihenbuwa (1995) comments further, "Among the Edos of Nigeria, where children are familiar only with the concept of brothers and sisters, there is a type of closeness and reciprocal responsibility peculiar to the culture that is theirs to value" (pg. 18). This feeling of community support and immeasurable closeness present in African cultures is extremely valuable to the mentally ill. Rather than feeling isolated, those who suffer from a mental condition have people to lean on.

During my fieldwork in Tanzania, I immediately noticed small acts of kindness and the feeling of closeness in the village. As we walked throughout the village, everyone referred to the nurses, and even myself, as "dada" or "kaka", which mean sister or brother in Swahili. I think it is reverential and pleasant that these cultural phrases are part of everyday life, and they make Tanzania all the more welcoming. Tanzania emphasizes collectivism, meaning they work

together as a community rather than individually. However, every community member has their own beliefs and values, and how they perceive mental illness influences mental health outcomes.

Chapter 3

Perceptions of Mental Illness

Perceived Manifestations

The way people determine whether or not one has a mental illness affects mental health perceptions. Many Africans often affiliate a mental disorder with an individual depending on the level of destructive, outward behavior. During my fieldwork in Tanzania, we asked locals how they describe one with a mental illness. Many of them reported the mentally ill as talking to themselves and behaving inappropriately. For instance, during our home visits, we interacted with a man who suffers from schizophrenia. The man covered himself in black chalk and often pointed to the sky erratically. As the nurses approached him, he would only talk to a few because he believed the other nurses were police officers. This outward behavior is how many locals in the village view the mentally ill. Abubakar, Aliyu, Iliyasu, & Kabir (2004) conducted a study on mental illness in northern Nigeria, in a rural village called Karfi. In all, 250 adults in Karfi village were interviewed in a cross sectional study design. Table 2-1 displays findings of the participants' perceived manifestations of mental illness in the village:

Table 2-1. Perceived Manifestations of Mental Illness

Manifestation	**No.* (%)**	**Rank order**
Aggression/destructiveness	173 (22.0)	1
Talkativeness	167 (21.2)	2
Eccentric behavior	127 (16.1)	3
Wandering	105 (13.3)	4

Manifestation	**No.* (%)**	**Rank order**
Self-neglect	86 (10.9)	5
Nudity	56 (7.1)	6
Restlessness/anxiety	50 (6.4)	7
Insomnia	15 (1.9)	8
Loss of consciousness	8 (1.0)	9

Source: Abubakar et al. (2004)

Aggression/destructiveness, talkativeness, and eccentric behavior are seen as the most common perceived descriptions of those with a mental illness. This data suggests that in order to be recognized as having a mental illness, one must draw public attention and act in a socially disruptive way. In other words, one is believed to be mentally ill only when there is clinical manifestation. Likewise, the study mentioned prior by Harms et al. (2009) on the mental health of adolescents who have been orphaned due to HIV-related illnesses reflects these beliefs as well. The orphaned youth associate mental illness with terms such as “madness” and “insanity”, which indicates that the mentally ill display bizarre behaviors such as public nudity or eating food from trashcans (Harms et al., 2009).

Moreover, it appears that many frequently associate mental disorders to external, bizarre behavior rather than internal behavior, such as hallucinations and disturbed thinking. Therefore the limited focus on mental health in Tanzania could be explained as a focus on external behavior because it is more concrete (Abubakar et al., 2004). Thus if mental illness is internalized and not expressed, it may be overlooked in Tanzania.

Perceived Treatments

Treatment-seeking behavior is heavily associated with one's culture. Airhihenbuwa (1995) writes, "It is a commonly and easily observed fact that even the most 'detribalized' and 'modernized' Christians, scholars, scientists, and entrepreneurs among the African bourgeoisie today still consult African divinities, diviners, and healers when their health or other affairs are in serious trouble" (pg. 49). Africans traditionally turn to their roots and harbor their spiritual and cultural ways, searching for a healthy balance between the mind, body, and soul, as well as between themselves and the environment. This balance is a universal traditional healing modality (Airhihenbuwa, 1995). To restore balance, Tanzanians may seek help from traditional healers, religious leaders, and even Western professionals.

Traditional Healers

Traditional healers are a major source of treatment in African culture, as they are widely available, inexpensive, negotiable, user-friendly, and accessible (Abubakar et al., 2004). In modern Tanzania, traditional healers are referred to as "fundi," meaning engineers or technicians (Mann & Prince, 2003). They can be categorized into four groups: diviners, herbalists, herbalists-ritualists, and faith healers. Diviners call on spirits to heal mentally ill patients, while herbalists use plants and roots as healing techniques. Herbalists-ritualists use both herbs and rituals to treat the illness, and faith healers use phrases and prayers from the Koran or Bible for healing. A study carried out in Uganda analyzes stakeholder's perceptions on help-seeking behaviors of the mentally ill, and factors that influence these behaviors. The study was conducted over a six-month period, consisting of sixty-two interviews and six focus groups with stakeholders from both national and district levels (Cooper et al., 2011). According to the study, a traditional healer

asserts, "…most people here will try to help themselves… when they fail, the majority come to traditional healers…the biggest percentage of patients (65%) go to traditional healers and they are comfortable with that" (Cooper et al., 2011). The trust in traditional healers is so apparent and strong in this study that, when mentally ill patients are referred to hospitals simply because the healers cannot improve them, the patients inquire help from other traditional healers, putting conventional practices as an absolute last alternative.

Jenkins and Mbatia (2010) believe that compared to other medical conditions, the demand for traditional healing is higher among patients with a mentally ill condition. In a study conducted in Tanzania, authors concluded that, "the prevalence of common mental disorders recorded among those attending a traditional healer centre in Dar-es-Salaam (48%) was twice that recorded in those attending a primary health clinic (24%)" (Mann & Prince, 2003). In fact, approximately 60% of Tanzanian's population uses traditional care (Ministry of Health, 2003). However, while traditional healers' practices typically include herbal medicines and ritual practices, their treatments can also be dangerous to the patient. Therefore, in some cases, the healers may put their patients in risky situations, such as advising the patients to physically harm someone else in order to be 'cured'.

Western Medicine

On the contrary, there are also Tanzanians who prefer Western medicine to traditional medicine; it often depends on the history of colonization of the country, which may have resulted in the criminalization of certain traditional practices (Airhihenbuwa, 1995), as well as the state of urbanization. A cross-sectional design study in Ethiopia investigates the perceptions of mental illness among both rural and urban residents, involving 115 participants. The study examines treatment preferences between these two groups. The results are presented in Table 2-2:

Table 2-2. Mental Health Treatment Preferences for Urban & Rural Areas

	Preferred Modern Treatment	**Preferred Traditional Treatment**	**Preferred Both Types of Treatment**
Urban [N, (%)] N=82	34 (41.5)	12 (14.6)	31 (37.8)
Rural [N, (%)] N=33	18 (54.5)	7 (21.2)	8 (24.2)
Total Sample	48 (46.6)	16 (15.5)	34 (33)

Source: Balogun & Monteiro (2013)

While the overall consensus of preferred treatment for mental illness for both urban and rural inhabitants is modern medical care, Balogun and Monteiro (2013) note that "rural residents were more likely to endorse traditional treatment and urban residents were more likely to cite a combination of both traditional and modern treatments." In Tanzania, mental health nurses and general health workers provide primary mental health care, as mental health is part of the primary health care system (Jenkins & Mbatia, 2010).

Spirituality

In addition to traditional and Western care, many Tanzanians turn to their spirituality for treatment. They may seek religious leaders, say prayers, fast, or partake in spiritual rituals in order to be 'cured' from their mental illness (Cooper et al., 2004). A study on six South African Hindu psychologists' conceptions of mental illness analyzes the role of religion in treatment, revealing that prayer can be a strong source of healing (Laher & Padayachee, 2012). In addition, the experiment explored the evil eye as an aspect of Hinduism. The evil eye is stimulated by negative feelings such as hatred or jealousy, and inflicts adversity on others involuntarily in a manner as simple as wishing harm on another. Those who believe in the evil eye do not need a healer, and can expel the evil themselves by "using either water in a *chumboo* (small brass vase),

chilies, salt, alum or limes; rotating these items three (or seven) times around the persons head and then discarding the substance without looking at it" (Laher & Padayachee, 2012). While spirituality functions as form of treatment for some Tanzanians, reluctance to even seek treatment is also evident in Tanzania.

Perceived Treatment Barriers

Stigma

Since the concept of mental illness is stigmatized, mental illness persists in Tanzania, as well as other parts of the world. Many people typically react to the mentally ill with fear, isolation, and anger. A study carried out in Tanzania asked primary health care workers employed in four primary health care clinics to complete a questionnaire that inquires about knowledge and attitudes towards causes and treatments of depression. The results revealed that almost two-thirds of the primary health care workers associate depressed persons with poor stamina when dealing with life events (Jenkins, Mbatia, & Shah, 2009). In the study carried out by Abubakar et al. (2004), the participants demonstrated stigmatizing views towards those who suffer from a mental health condition. The results reveal that the two most common reactions towards the mentally ill are fear and avoidance, as shown in Table 2-3:

Table 2-3. How Others React to Mentally Ill

Attitude	**Male**	**Female**	**Total**
	No. (%)	No. (%)	
Fear	24 (20.8)	89 (79.2)	113
Avoidance	12 (14.4)	69 (85.6)	81

Attitude	Male	Female	Total
Anger	48 (96.8)	2 (3.2)	50
Suspicion	36 (90.4)	4 (9.6)	40
Hostility	32 (93.6)	3 (6.4)	35
Mistrust	28 (89.6)	4 (10.4)	32
Indifference	16 (96.0)	1 (4.0)	17
Sympathy	39 (33.6)	78 (66.4)	117
Kindness	17 (20.8)	62 (79.2)	79

Source: Abubakar et al. (2004)

Other demeaning attitudes directed at the mentally include anger, hostility, mistrust, and suspicion. While there are some positive feelings such as sympathy and kindness, the negative ones significantly dominate, and stigma essentially persists on these social attitudes and inequalities. In some cases, the stigma is even worse than the disease itself.

The study conducted by Cooper et al. (2011) discloses that high levels of stigma exist against both the patients and their families. The mentally ill are disgraced within the society and thought of as "stupid". Cooper et al. (2011) reveals one participant's statement: "…Unfortunately, people with mental illness are taken to be those who can not think for themselves; whatever they say they are mad, even if they improve… whatever they give…even if it's good, we say they are mad…there is that ideology that if you are mental, then you don't have any idea." In this sense, the mentally ill appear trapped and unable to improve due to societal perceptions of them.

Additionally, stigma is seen even within health facilities and psychiatric hospitals. The workers tend to laugh at the patients and call them "mulalu," or mad, essentially humiliating them (Cooper et al., 2011). As part of my Global Health fieldwork, we visited Mirembe Hospital, the

only in-patient mental health hospital in Tanzania. The nurses laughed at the patients, frequently calling them 'crazy'. Mirembe Hospital is stigmatized for the patients it cares for, because people refer to the hospital as a psych ward filled with insane people and therefore they do not want to go near the facility. The facility is fenced in a community and anyone can approach the fence and peer in to see the mentally ill patients. The patients ultimately lose hope in improving their health due to embarrassment of their condition that is stigmatized. Many people do not want to publicize that they have been "cursed," a common belief of the mentally ill, or even discuss the disease because they could potentially lose their friends, family, job, or even be physically harmed. Stigma of mental illness negatively affects health because it induces stress from the isolation and abandonment, as well as hesitancy to seek help due to shamefulness and fear. The isolation and abandonment may then lead to impaired resource access to food and shelter, essentially leading to a downward spiral and diminishing one's self worth. Stigma is extremely complex, as it is embedded in society. To reiterate, the intense stigma that envelops mental illness dissuades the mentally ill from seeking treatment. As a result, stigma perpetuates the negative energy, ultimately worsening mental illness. Within the African traditional healing context, "an understanding of social conflict is pivotal to curing a person who has become ill. This is where the healer deals with the *ultimate* cause of an illness: who or what caused it, and why" (Airhihenbuwa, 1995, pg. 51).

Perceived Causes

Supernatural

Non-Western cultures tend to hold very dissimilar psychological theories than Western cultures. Moreover, although African cultures are vastly diversified, there is a general belief that

the causes of mental illness are related to the supernatural, taboos, disturbances in social relations, or disharmony with the body. The study in Karfi village, Nigeria by Abubakar et al. (2004) also examined the perceived causes of mental illness, and the results are shown Table 2-4:

Table 2-4. Perceived Causes of Mental Illness

Perceived cause	**No.* (%)**	**Rank**
Misuse of drugs†	88 (34.3)	1
Divine punishment, God's will	48 (18.8)	2
Magic, spirit possession	46 (18.0)	3
Accidents/trauma	30 (11.7)	4
Heredity	27 (10.5)	5
Family conflicts/marital disharmony	14 (5.5)	6
Financial distress/poverty	3 (1.2)	7

Source: Abubakar et al. (2004)

The supernatural, meaning divine punishment, magic, and spiritual possession, are within the top three attributions of mental illness. Correspondingly, a study conducted in southeastern Nigeria depicts similar results. The study took place among the semi-urban Igbo community, involving 200 participants from schools, villages, markets, and corporate businesses establishments. The aim of the study was to investigate causal attributions to Schizophrenia. The collected data reveals that supernatural causes are the dominant belief, followed by biological causes and psychosocial causes (Galbraith et al., 2013). To illustrate further, during my fieldwork in Tanzania, I met a young girl with epilepsy who had continuous seizures. The family believes the grandmother bewitched the child so they went to a traditional healer; the healer told them that in order for the child to be cured, they must kill the grandmother. This belief is very common throughout the village, as well as other traditional cultures.

Reincarnation/Spirituality

Reincarnation is a popular belief among traditional cultures as well. When one is born, he or she already has a predetermined life planned out by an earlier agreement with God. If he or she deviates from this course, mental illness may be a consequence in the next life (Idemudia, 2004). Similarly, another common belief is when one strides away from traditional practices, mental illness can result as well. He or she must maintain their traditional lifestyle in order to be healed (Balogun & Monteiro, 2013). Otherwise, the breaking of taboos or disruptive behavior are punishable through ill-health (Idemudia, 2004). Religion is consistently expressed as a source of understanding of mental health in African cultures. Laher and Padayachee (2012) found that Hinduism associates mental illness with "magical, religious, and naturalistic elements." More so, all participants mentioned spiritual illnesses, one of them being the evil eye, as an underlying cause of mental illness (Laher & Padayachee, 2012). The impact of religion can be seen as both burdensome and supportive; supportive in the way that prayer can initiate healing as mentioned prior, and burdensome as religious guilt can contribute to mental illness.

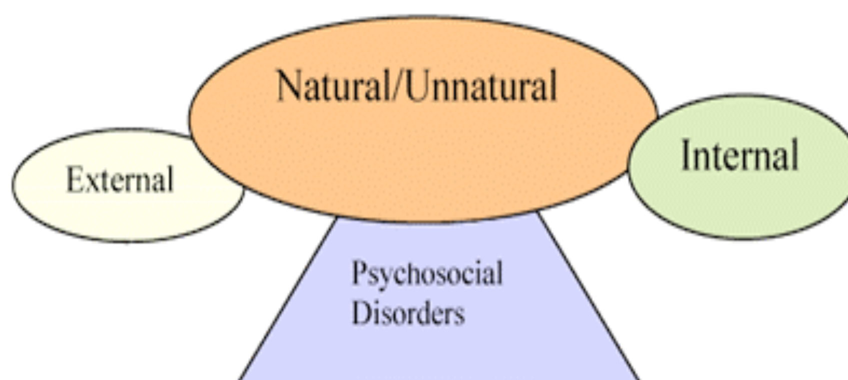
Biochemical

The Western biochemical concept as the cause of mental illness is present in Tanzania as well. The study conducted in Tanzania by Jenkins et al. (2009) discussed earlier revealed the vast majority of primary health care workers attribute severe depression to biochemical abnormalities. Additionally, a study conducted in Malawi consisting of 210 participants and a cross-sectional survey found that 92.8% of the participants believed mental illness is due to brain disease (Crabb et al., 2012). However, many traditional cultures in Tanzania typically do not associate mental illness exclusively to the biochemical model, as mind and body are viewed as interdependent.

Belief in Mind/Body Relationship

Tanzanians do not solely link illness to the biology of the body, but rather look at the individual as a spiritual being as well. That being said, the African cultural belief system involves the "living and nonliving, the natural and supernatural, material and immaterial, conscious and unconscious" (Idemudia, 2004). In other words, there are no distinctions in this way of thinking; rather their conceptions are interdependent. Contrary to this belief, Western societies tend to be suspicious of religion in medical context, and as a result become intolerant and rigid (Laher & Padayachee, 2012). It should be noted, however, that the earlier stigmatization of HIV in the U.S. was rooted in the belief that HIV/AIDS was a punishment from god, and this belief has fallen significantly (Fetsch, 2014). A paradigm of African spiritual belief system, shown in Figure 2-1, illustrates the natural and unnatural factors attributed to psychological disorders with the external and internal factors that result:

Figure 2-1. Diagram of Africa's belief system



Source: Idemudia (2004)

This paradigm shows that both mental and physical health affect each other. A reality is that culture considerably impacts the onset of mental disorders. Idemudia (2004) notes the influence of cultural conflicts, such as war, famine, and poverty, on mental health. These cultural conflicts provoke stressors, and therefore are expressed both physically and emotionally. This results in

disharmony with the body, or an "imbalance" as discussed previously. Idemudia (2004) writes, "The body is the mind and the mind the body; therefore, physical images are often used to describe feelings of the mind and dispositions of the external mind (as in witchcraft), which are frequently attributed to the body. As a result, complaints of ill health are always expressed physically, and the treatment is expected to be physical as well." This idea of mind and body as inter-reliant is one that the West has often lacked in the medical field.

Conclusion

As described thus far, Tanzanian culture strongly influences perceived manifestations, treatments, treatment barriers, and causes of mental illness. These cultural perceptions are intricately embedded in traditional societies, and are profoundly multifaceted. Tanzania's culture encompasses medical practices that have both positive and negative health outcomes for mental illness. For instance, Tanzania's limited definition of mental illness to be those with clinical manifestation also suggests why stigma may be very high. However, Tanzania's communalism culture provides immeasurable support for the mentally ill, ultimately improving mental health. As mentioned prior, some Africans believe that if they deviate from their ancestral ways, illness will result. But, culture is not static, and it is advantageous to have the ability to adapt in today's evolving global world. Additionally, "very often culture is blamed for certain ill-understood health practices, when in fact the culprit is the lofty interpretation of culture for the maintenance of imperial dominance and hegemony" (Airhihenbuwa, 1995, pg. xiv). That being said, it is imperative for the U.S. to understand Tanzania's cultural perceptions of mental illness in order to successfully incorporate them into Westernized practices.

Chapter 4

UNITED STATES OF AMERICA: Cultural Impacts

Introduction

The concept of mental health in America is not recent or unfamiliar due to more focus and attention on mental health over the years. While substantial research is still needed to analyze mental disorders further, as behavioral science remains a relatively new field and the human brain remains a complex specimen, mental health has been an ongoing debate for decades, even centuries, in America (Mantel, 2013). Over this extended period of time, shifts in treatment facilities, medication, and mental health policies have occurred, altering America's perceptions of mental health. America has learned a great deal of what is effective and what is not, and still has a great deal to learn. However, the path that has directed the way to today's progression and conception of mental health has been challenging. October 2013 marked the 50th anniversary of the Community Mental Health Act signed by President John F. Kennedy-- the Act ultimately aided in the transformation of how the mentally ill are cared for and treated (Smith, 2013). Historically, during the 1850s and early 1900s, the mentally ill were placed in state mental hospitals, where conditions were often overcrowded, understaffed, and atrocious (Mantel, 2013).

Kennedy's goals of deinstitutionalization involved millions of dollars to help build mental health centers within communities to provide services to the mentally ill, and also to attempt to prevent occurrence of new mental illnesses by aiding communities (Smith, 2013). The legislation, signed in 1963, was enacted in the midst of other changes and developments for the mentally ill that aided them in beneficial ways. For instance, chlorpromazine and thorazine, the first effective antipsychotic medicine for the mentally ill, were released in the 1950s. Secondly,

the establishment of Medicaid in 1965 accelerated the shift from institutionalized care to home-based and community-based care because states now had enticement to release those in state hospitals to the community, where the federal government could assist in funding. Shortly after, mental health policy changed, as involuntary hospitalization was no longer allowed without consent unless the person posed a threat to themselves or others (Smith, 2013).

While Kennedy's paramount vision was to see those suffering from a mental disorder to be able to work and live at home instead of in neglectful institutions, his goal was not achieved entirely. About half of the projected mental health centers were never built, and the ones that were built were not fully funded. An issue with the legislation was that it did not provide long-term funding for the centers, essentially abandoning them and leaving them to states and localities. "By the end of the 1970s, the mental health system was a decentralized, uncoordinated and bewildering array of institutions and practices: public and private psychiatric hospitals; nursing homes; residential care facilities; community mental health centers…" (Mantel, 2013). The services for mental health appeared to be stretched out too thin. Despite his good intentions, Kennedy's vision resulted in swelling the ranks of America's homeless, which will be discussed later. To change things around, various laws have been implemented ever since, including the Mental Health Systems Act in 1980, the 1984 Disability Benefits Reform Act, President George W. Bush's formation of the New Freedom Commission on Mental Health in 2002, and finally the 2010 Patient Protection and Affordable Care Act (Mantel, 2013). Additionally, a key informative report entitled *Mental Health: A Report of the Surgeon General*, presented profound perspectives on mental health in 1999. The report emphasized the fact that one in five Americans has a mental illness, but the majority of them do not seek treatment despite available resources. The Surgeon General stressed the need for those who may think they have a mental disorder to seek help immediately. The most crucial barriers to seeking treatment were described as the lack of insurance coverage and the stigma attached to mental disorders (DHHS, 1999). Another major

theme demonstrated in the report focused on how to reduce stigma. Besides educating the population, emphasizing the science of mental illnesses and viewing them as equivalent to physical illnesses is believed to reduce stigma. The Surgeon General believes a destigmatization campaign is needed to motivate the public and to reveal that mental disorders are treatable, enabling those who have a mental disorder to lead positive, productive lives. The Surgeon General's intention of this report was to "push the American people," and to pave the way towards improved access to treatment, enhanced mental health services, and reduced stigma (Martin, 2007).

America's history of mental health policy, treatment, and services contrasts with Tanzania's minimal and more recent response to this illness. The history of mental health in the U.S. proves this field to be complex and challenging. Kennedy's legislation laid the groundwork for the mentally ill, and hopefully the Obama Administration will continue to lead the challenging mental health movement forward, as "the opportunity to recover is much greater now than it was in 1963" (Smith, 2013). Today, approximately 58 million American adults, or one in four, suffer from a diagnosable mental illness, and of those adults, eleven million suffer from a severe mental disorder like schizophrenia, bipolar disorder or major depression (Mantel, 2013). Americans have access to various services and medication, which continue to expand. Why, then, does mental illness continue to progress in this country? Culture may be an explanation.

Consumerism and Individualism

The U.S., a highly developed, Westernized country, is known to execute matters in a "one directive" manner. Due to its power and wealth, the U.S. generally believes that its way is the right and *only* way. For this reason, as I have mentioned prior, it is extremely educational and beneficial for Westerners to delve into a different culture and broaden their horizons, so to say.

Ogden (2008) analyzes the ‘contemporary student’ and declares, “Recent decades have seen unprecedented growth in the number of U.S. students studying abroad for academic credit and an expansion of the field in such a way as to allow students to study virtually any subject in any part of the world and for any length of time.” Today, students are described as ‘customers’ within U.S. higher education due to their wishes and wants. They desire personal attention, top-notch facilities, immediate communication with their professors, easy Internet access, and specialized food services. This consumerism mentality now impacts students’ education abroad experiences. “Without hesitation, students (and their parents) are increasingly demanding familiar amenities and modern conveniences while abroad and seemingly with total disregard to host cultural norms or feasibility” (Ogden, 2008). Therefore, today’s “abroad student” has become the “colonial student.” Colonial students are more likely to choose English-based programs, not befriend local peers but rather stick with their student cohort, and often use their international home only as a base in order to travel to neighboring cities and countries. Moreover, “Learning the local language, developing meaningful relationships within the community or exploring the uniqueness of the host culture all become relatively less important” (Ogden, 2008). Westerners often inhibit their intellectual potential, and more or less their optimal health, by not “stepping off the veranda” and venturing into the unfamiliar. Even more, these materialistic views that emphasize the importance of money and personal possessions are actually associated with decreased happiness, depression, anxiety, anger, and isolation (Eckersley, 2006).

America’s consumerism mentality tends to run parallel to its individualistic culture, one quite the opposite of Tanzania’s communalism culture. Since the U.S. spends the most on healthcare by far, it should have a spectacular healthcare system and therefore have citizens living the longest. However, its healthcare system is not even ranked among the top twenty-five best health care systems in the world. In fact, in a study that analyzed seventeen countries including most of Western Europe, Japan, Canada, and Australia, the U.S. ranked the lowest in life

expectancy for men at 75.6 years, and second lowest in life expectancy for women at 80.7 years (Castillo, 2013). How can this be? Many researchers believe that the U.S. culture contributes to these statistics. In particular, America's individualism atmosphere plays an important role in health outcomes. Dr. Steven H. Woolf writes, "We have a culture in our country that, among many Americans, cherishes personal autonomy and wants to limit intrusion of government and other entities on our personal lives and also wants to encourage free enterprise and the success of business and industry. Some of those forces may act against the ability to achieve optimal health outcomes" (Castillo, 2013). Rather than looking out for each other's health and well-being, Americans typically fend for themselves. This individualistic outlook has damaging effects on mental health in particular. Mental illness is one that requires support, trust, and communication, more so than physical illnesses due to the attached stigma. An individualism culture essentially weakens social connectedness and support, and strengthens loneliness (Eckersley, 2006). While the U.S. prides itself on autonomy and freedom, these terms are frequently confused with independency. Eckersley (2006) writes, "Someone who holds collectivist values is behaving autonomously, but not independently, when acting in the interests of the group." Western individualism perceives independence as separate from the environment, as well as others. This essentially promotes isolation, and as a result, many people are tentative to offer support because they are accustomed to personal space and privacy (Eckersley, 2006). America's individualism culture, like consumerism, has a damaging impact on mental health.

An interesting study reveals the impact of social trends, rather than genes or family upbringing, on personality development (Eckersley, 2006). The study performed psychological tests on American children and college students over a 60-year time period. The findings showed increases in trait anxiety, self-esteem, and extraversion, as well as a decrease in one's sense of control over life. To illustrate the shifts in social trends, "the average American child in the 1980s reported more anxiety than child psychiatric patients in the 1950s, and the average college student

in 2002 felt less control of their lives than 80-90% of college students in 1962" (Eckersley, 2006). The researchers linked these results to rising individualism and freedom, as well as weakening social support and connectedness, rather than other factors such as poverty and unemployment. Personality characteristics of trait anxiety and a diminished sense of control over life have been associated with depression, suicide attempts, alcohol and drug abuse, lower well-being, and helplessness (Eckersley, 2006). In conclusion, evidence shows that America's individualism and consumerism culture influences mental health in detrimental ways.

Gun Violence and Media

As the U.S. does not rank high in life expectancy throughout the world, gun violence represents one contributor to our low ranking. In fact, the U.S. suffers from more violent deaths than other wealthy countries, with an estimated six violent deaths per 100,000 citizens (Castillo, 2013). Mantel (2013) affirms in 2010, more than 38,000 people took their own lives, nearly half with guns. More so, nine in ten people who commit suicide have a diagnosable mental disorder, most notably depression or substance abuse disorder. Even more interesting, in a cross-country analysis, researchers found positive correlations between national youth suicide rates and multiple national indicators of individualism, rather than between poverty or social disadvantages (Eckersley, 2005). But, the mentally ill account for only a tiny portion of gun crimes. Regardless, shortly after the massacre in Newtown, Connecticut in 2012 that left six adults and twnety children dead in a school, debates on gun violence and mental health care sharply arose (Mantel, 2013). Besides the Newtown shooting, various others have occurred throughout the nation that drew exceptional media attention, such as the Washington Navy Yard massacre this past year that left thirteen dead, and the 2012 Colorado massacre in a movie theatre that left twelve dead and seventy injured.

Unlike Tanzania, where only 11% of the population has Internet access and 45% has access to a telephone network (Jenkins & Mbatia, 2010), media is part of every day life in America. The deadly gun shootings make national news and portray the shooters as celebrities, stimulating public outcry. The media often impacts mental health negatively because it links the mentally ill to violence, resulting in people defying deinstitutionalization in order to lock up the "crazies" who shoot innocent people. It is challenging to gain positive awareness on mental health through media, more so than other diseases. Researchers believe that people will contribute twice as much to organizations that use captivating images, rather than written statistics and facts, to demonstrate a problem (Chambers, 2010). Unfortunately, it is hard to grasp what mental illness looks like in a single image, especially compared to issues such as anorexia or poverty. As a result, America's media-obsessed culture draws primarily damaging attention to the mentally ill by illuminating gun massacres.

Economy

The wealth of the U.S. has contributed to its mass media, but contrary to its negative impact, media influences mental health in a beneficial way as well because it brings awareness and calls for action. After the Newtown massacre, "while mental health advocates, researchers and scientists were wary about tying discussions about the fragmented mental health care system to the gun control debate, they welcomed the chance to advocate for better access to diagnosis, treatment and support services" (Mantel, 2013). Despite the context in which media attention is given to mental illness, attention is needed nonetheless in some circumstances.

While America's wealth and power have influenced the particular culture of communalism and individualism described above, it has also led this country to technological advancements and medical breakthroughs. Americans have opportunities and means that most

developing nations do not. They have instant access to high-speed Internet that can display mental illness symptoms and the diagnosis beside it, as well as risk factors and protective factors for mental health. This access is meaningful because it enables Americans to detect illnesses faster and more readily. Also, healthcare professionals have machinery that can decipher a chemical imbalance in one's brain activity, and media campaigns can broadcast awareness of available resources for mental health. In fact, the Obama Administration is strongly dedicated to enhancing its citizens' knowledge on mental disorders. The Administration hosted the National Conference on Mental Health as a daylong event in June 2013 at the White House in order to gather those who suffer from a mental illness, their families, mental health experts, policymakers, advocates, and treatment providers and educators. This day marked a pivotal step in mental health awareness.

America's advanced society offers a wealth of information and resources that have given mental health more attention and recognition. Recently, the Obama Administration enacted a new legislation that requires insurers to cover mental health, as well as addiction; equivalent to the way they cover physical health. Elizabeth Chuck, Staff Writer of *NBC News*, states, "The rule will guarantee that health plans' co-payments, limits on visits to providers, and deductibles for mental health benefits match those for medical and surgical benefits. It will also ensure that there is parity in residential treatment and outpatient services . . ." (2013). This new rule will provide more available screening, behavioral assessments, and access to treatment for Americans. The Obama Administration has also dedicated $55 million in 2014 to stimulate mental health awareness among the youth through programs within schools that identify signs of mental illness and methods of treatment (Mantel, 2013). With the support of its fundamental leader, the U.S. is making headway in the mental health arena, yet still with consistent controversy and debate. As in Tanzania, the way U.S. citizens perceive mental illness influences mental health outcomes.

Chapter 5

Perceptions of Mental Illness

Perceived Manifestations

Mental illnesses require a very different diagnostic procedure than physical illnesses; blood tests do not detect depression, and X-rays do not identify schizophrenia (Weir, 2012). Rather, mental illness involves subjective diagnoses because no laboratory tests currently exist. Therefore, Americans perceive mental illnesses as a particular label found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM).* Moreover, the nation relies on the *DSM* to define the manifestations of mental illnesses. The manual was first published in 1952, and lists mental disorders with detailed symptoms required for healthcare professionals to make a diagnosis. Since 1952, four more editions have been published; the *DSM-5* made available this past year by the American Psychiatric Association (APA). In the first four editions, the number of diagnosable mental disorders notably increased, beginning with 106 in the first edition and amassing to 297 in the fourth edition (Rosenberg, 2013). The *DSM* has received constant critique due to its influential expansion. Essentially, this manual determines who receives what treatment based on a list of symptoms observed through subjective judgment, inevitably resulting in misdiagnoses, discrepancies, over-diagnosis, and over-treatment. Based on the *DSM-4*, approximately 46.4% of Americans will have a diagnosable mental disorder in their lifetime (Rosenberg, 2013). That being said, the *DSM-5* will most likely make it "easier" for Americans to have a diagnosable mental disorder, as the definition of mental illness continues to broaden. Allen Frances, former chair of the task force for *DSM-4*, is not in favor of the most recent edition*, DSM-5*. Frances believes the task force which monitored the *DSM-5*, "gave their experts great freedom, and the

experts have used that freedom to do what experts always do, which is try to expand their area of interest" (Mantel, 2013). David Kupfer, the present chair of the *DSM-5* task force, specifically announced that this latest edition would not increase the total number of mental disorders, but rather, previous disorders will become subtypes of certain disorders. For instance, Asperger's syndrome was not in the *DSM-4,* and is now included in the *DSM-5* as a subtype of Autism Spectrum Disorders (Rosenberg, 2013). Dilip Jeste, APA president, proclaims his support of the latest edition: "We developed *DSM-5* by utilizing the best experts in the field and extensive reviews of the scientific literature and original research, and we have produced a manual that best represents the current science and will be useful to clinicians and the patients they serve" (Mantel, 2013). However, many people disagree with the legitimacy and effectiveness of the *DSM-5*, as recent additions and changes to the *DSM-5* have provoked criticizing and comical reactions.

A new mental disorder added to the *DSM-5* is Disruptive Mood Disregulation Disorder (DMDD), a diagnosis for irritable young children who have "severely recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation" (Mantel, 2013). These outbursts must appear three times per week, and have been ongoing for at least one year. Allen Frances, former chair of the task force for *DSM-4* mentioned prior, believes this new diagnosis will affect those with temper tantrums, a common characteristic of young children. While the intention of DMDD is to decrease the number of kids diagnosed with bipolar disorder and therefore decrease medication, Frances thinks the new diagnosis will do the contrary. He asserts, "If you want to attack the excessive diagnosis of bipolar disorder in children, you should have big warnings in the bipolar section that this is being terribly over-diagnosed in kids, explain why and explain what should be done" (Mantel, 2013). Furthermore, many diagnoses added to the *DSM-5* are medical conditions in nature. For example, a new disorder in the *DSM-5* is 'caffeine intoxication,' which is "characterized by at least five symptoms after consuming the equivalent of two to three cups of coffee: restlessness, gastrointestinal problems, difficulty sleeping,

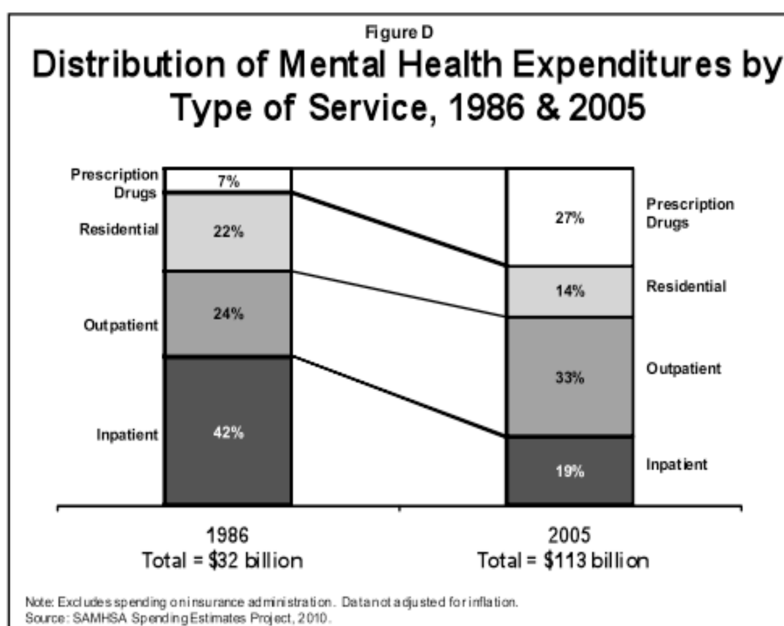
nervousness, and rapid heartbeat. To meet the diagnosis, the symptoms must impair functioning in some way" (Rosenberg, 2013). What if people are just drinking too much coffee? Although the *DSM-5* attempts to decrease over-diagnosis and over-treatment, it appears as though this edition has actually left Americans questioning themselves as to what defines normal and abnormal. In this case, whether or not the West should be spreading its knowledge of what constitutes a mental illness is a concern.

Perceived Treatments

Institutionalized/Home-Based Care

Due to deinstitutionalization, the number of people in state mental hospitals and institutions went from 500,000 in the 1950s to less than 40,000 in 2005 (Mantel, 2013). This resulted in the expansion of private nursing homes, private mental hospitals, and psychiatric units in general hospitals. Figure 5-1 illustrates the distribution of mental health expenditures by type of service in 1986 and 2005:

Figure 5-1. Distribution of Mental Health Expenditures by Type of Service, 1986 & 2005



Source: Kliff (2012)

The findings illustrate the decrease in inpatient care. Because of this massive decrease, specifically 90% of beds in state hospitals have been eliminated (Smith, 2013). Many experts believe that this has left the most severe mentally ill with nowhere to go, as there were not sufficient programs in place to provide support. Consequently, they end up on the streets, in prison, or abusing substances, eventually worsening the situation. “In the 1980s, it was estimated that one-third of all homeless individuals in America were considered severely mentally ill. Lack of support and guidance led to the incarceration of over 100,000 mentally ill individuals in America as well” (Foerschner, 2012). Currently, the three largest mental health providers in America are jails: Cook County in Illinois, Los Angeles County, and Rikers Island in New York (Smith, 2013).

Counselors

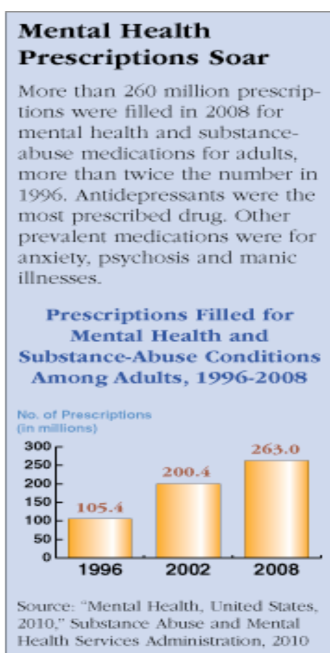
In 2010, The Bureau Labor of Statistics estimated a total of 156,300 mental health counselors in the U.S. (Kliff, 2012). It is very common for mentally ill patients to seek help from counselors, as well as psychiatrists. This form of treatment is where one can openly talk to another about their illness and emotions regarding their condition, as it is comforting to know the information will be confidential. There is also research that shows many mentally ill individuals may turn to clergy in search of help, first. According to Pillion, Reed, and Shetiman (2012), "Clergy have been described as a kind of 'gateway' to the health care system, particularly for persons from ethnic minority groups, who may be impeded by financial difficulties, be unfamiliar with local resources, or have concerns about stigma." Because Catholics represent the largest, single religious denomination in the U.S., Pillion et al. (2012) conducted a survey in North Carolina to analyze the capability of Catholic priests concerning treatment and diagnosis of mental illness. Out of the forty-right priests who completed the survey, 87% felt comfortable with recognizing a mental illness, and 87-92% sent certain patients to healthcare providers when conditions were severe (Pillion et al., 2012). Similar to traditional cultures, religion is seen as a source of healing by some people in western cultures, too.

Medicine

Additionally, Figure 5-1 above reveals the increase in prescription drugs. New prescription drugs were developed in the late 1980s and early 1990s, becoming a major source of treatment for the mentally ill in America. They are referred to as "atypical antipsychotic medications" because they are just as effective but also reduce the side effects associated with the older drugs. These drugs enabled the mentally ill to continue with their everyday activities. For

example, Prozac, a selective serotonin reuptake inhibitor (SSRIs), is believed to have "transformed the treatment of depression" (Mantel, 2013). Figure 5-2 displays the increase in mental health prescriptions since 1996:

Figure 5-2. Use of Mental Health Prescriptions in U.S. 1996-2008



Source: Mantel (2013)

"These drugs entered both the medical mainstream, through their widespread use by primary care providers, and the popular culture, with Peter Kramer's best-selling book in 1993, *Listening to Prozac*" (Mantel, 2013). Researchers have found that rate of successful treatment for depression—70%-80%, exceeds the rate of success compared to chronic diseases, such as heart disease—45-50% (NAMI, 2013). Yet with these effective treatments, almost half of all Americans who suffer from a mental illness do not seek treatment for various reasons (SoRelle, 2000).

Perceived Treatment Barriers

Access/Cost

Even though the U.S. provides extensive amounts of services and resources to the mentally ill, access to these mental health services is often worse than other medical services. More specifically, access to mental health professionals is not as easily attainable in comparison to other types of doctors, as "89.3 million Americans live in federally-designated Mental Health Professional Shortage Areas, compared to 55.3 million Americans living in similarly-designated primary-care shortage areas and 44.6 million in dental health shortage areas" (Kliff, 2012). Eleven million American adults that suffer from a serious mental illness face an average delay of 5 years for treatment (Mantel, 2013). Those five years pose great risk to the individual. However, even if mental health services no longer entailed shortages or delays in treatment, many Americans would still be disinclined to seek treatment due to financial reasons. That being said, the leading barrier to treatment for those suffering from a mental disorder in America is cost. Mantel (2013) demonstrates the varying reasoning behind reluctance to seek treatment, illustrating cost as the principal barrier in Figure 5-3:

Figure 5-3. Reasons for Not Receiving Mental Health Treatment, 2011

Source: Mantel (2013)

A survey conducted by the National Surveys on Drug and Health in 2005-2009 disclosed that a quarter of the 15.7 million Americans who received mental health services listed themselves as the primary payer (Kliff, 2012). Also, the majority of those who sought outpatient services accumulated out-of-pocket costs between $100 and $5,000 (Kliff, 2012). In addition to cost, the attitudinal barrier about the value of mental health care contributes to reluctance, as seen in Figure 5-3 as well. Rather than the mentally ill neglecting treatment due to embarrassment or shamefulness as seen primarily in Tanzania, many Americans simply believe they do not need help. A study conducted in 2007 questioned 303 mental health patients who had decided against seeing a doctor in the past year. The findings revealed that 66% of the patients believed the problem would improve on its own, and 71% of the patients wanted to handle the problem on their own (Kliff, 2012). Perhaps the attitude of solving the issue on one's own stems from

America's individualism culture discussed previously. The prevalence of the attitudinal barrier in the U.S. is similar to that of the stigma seen in Tanzania.

Stigma

While stigma plays a major role in Tanzania's perception of mental illness, stigma is not as strong and debilitating in the U.S. due to its heightened focus on mental health. The attention and recognition given to mental health over the past decades allows Americans to perceive mental illness with a sense of normalcy, at least more so than in Tanzania. However, that is not to say stigma does not exist, or that stigma is not significant in the U.S. Rather, stigma of mental illness continues to strongly persist even in a country like the U.S., which proves its significance as an exigent barrier to mental health. "In one study of 156 parents and spouses of first-admission patients, half reported making efforts to conceal the illness from others" (Byrne, 2000). Due to secrecy, the mentally ill are detached from social resources, dissimilar to physical illnesses in which these resources are organized, mobilized, and accommodated (Byrne, 2000). President Obama even addressed the "Three-S" factor (stigma, stereotypes, and shame) of mental illness at the National Conference on Mental Health by urging America "to end the shame and lift the veil of embarrassment associated with mental illness because 'the brain is a body part, too — we just know less about it'" (Repique, 2013). Yet, the U.S. may potentially be on the verge of a transformation through its extensive examination of the brain.

Perceived Causes

Social, Environmental, & Behavioral

Social, environmental, and behavioral factors are recognized as contributors, i.e. consumerism and individualism, to mental illness in Western cultures. Research today proves that an interaction of genetics, environment such as traumatic events, behavioral, and psychology, all influence mental illness (NAMI, 2013). Other perceptions of mental illness exist that associate the condition with personal attributes, or old age. A survey released by the APA shows that one-third of Americans believe personal or emotional weakness is a significant cause of mental illness, and almost as many believe mental illness is due to old age (NAMI 2013). However, despite these views, the West primarily emphasize the biological basis among mental disorders, dissimilar to Tanzania's mind and body relationship.

Biochemical

With the advancements in technology, research is enhancing and medical discoveries are accelerating. The Obama Administration recently launched the National Institute of Health's Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative on April 2, 2013. "Hopefully, for the first time in history — using far-more advanced and innovative neuro-imaging technologies — scientists will have the tools that they need to create a new dynamic image of the brain that can eventually lead us to the discovery of new treatments" (Repique, 2013). Because of new developments in genetic tools and neuro-imaging, scientists and researchers are able to examine more details of the underlying causes of mental illnesses. In recent years, researchers have identified more ways in which the brain functions, as well as abnormalities. "They [Scientists] have identified genes linked to schizophrenia and discovered

that certain brain abnormalities increase a person's risk of developing post-traumatic stress disorder after a distressing event. Others have zeroed in on anomalies associated with autism, including abnormal brain growth and underconnectivity among brain regions" (Weir, 2012). Furthermore, scientists have discovered a biological basis in depression as well, as they examined over-activity in a region of the brain, Brodmann area 25, in those who suffer from major depression.

Still, the prominence on biological factors draws considerable controversy. Eric Kandel, a Nobel Prize laureate and professor of brain science at Columbia University, claims, "All mental processes are brain processes, and therefore all disorders of mental functioning are biological diseases. . . The brain is the organ of the mind. Where else could [mental illness] be if not in the brain?" (Weir, 2012). Thomas Insel, director of the National Institute of Mental Health, supports Kandel's viewpoint. Insel believes that mental illnesses are equivalent to other chronic illnesses, with the same basic principles, but with a different focus on the brain rather than other organs. He actually compares mental disorders to cardiology and believes our understanding of the biological basis of mental illness today is where physicians were 100 years ago: "They [Doctors] could merely observe a patient's physical presentation and listen to the patient's subjective complaints. Today they can measure cholesterol levels, examine the heart's electrical impulses with EKG, and take detailed CT images of blood vessels and arteries to deliver a precise diagnosis" (Weir, 2012). Similarly, Insel predicts likewise medical breakthroughs in mental disorders through today's technological improvements, however it will take a very long time due to the intricacy of mental illness. It is known that multiple determinants of health affect one's overall well-being, not just biology, such as environmental, social, and political factors. "But for mental illnesses, we're a particularly long way from understanding the interplay among those factors," states Richard McNally, PhD, a clinical psychologist at Harvard University (Weir, 2012). Hence, many experts

question the emphasis on biological origins of mental illness and are reluctant to fully support the primary emphasis on the biological model.

Questioning the Americanization of Mental Illness

With the loosened criteria for mental disorders provided in the *DSM*, Americans perceive even the normal struggles of human life as mental illnesses. Consequently, "…providing a bigger tent for mental illness leaves us with an increasingly restricted definition of mental health and can make us all more likely to see mental illness even when it isn't there" (Rosenberg, 2013). As a result, simple differences in human characteristics, such as shyness, are seen as diagnosable mental disorders. Is "labeling" the mentally ill beneficial and effective, or have we defined mental illness too broadly? Allen Frances, mentioned earlier, states, "People don't change quickly, but labels do. Small changes in how disorders are defined can result in large changes in who gets labeled" (Mantel, 2013). Nevertheless, the U.S. tends to pride itself on its knowledge, research abilities, and medical discoveries of the human brain compared to other nations, especially developing ones. More so, "For more than a generation now, we in the West have aggressively spread our modern knowledge of mental illness around the world. We have done this in the name of science, believing that our approaches reveal the biological basis of psychic suffering and dispel pre-scientific myths and harmful stigma" (Watters, 2010). But, did providing a biological basis reduce stigma globally? Again, mental illness is not like other illnesses, as it is not universal in nature due to distinctive cultures. In the end, the "Americanization" of mental illness may not have stimulated the desired effect.

The notion to spread the West's biomedical explanation for mental disorders internationally stemmed from the idea that it would remove stigma associated with the mentally ill. The biological reasoning for the onset of mental illnesses would revoke other cultural

explanations such as demonic possession or wrongful behavior, thereby protecting the mentally ill from social isolation and blame. Professor Sheila Mehta from Auburn University Montgomery delved further into the rest of the world's impression of the West's enlightenment on brain diseases to detect if stigma actually diminished. Mehta conducted a study where one group of subjects were led to believe that a mentally ill individual's condition is due to psychosocial factors, and another group of subjects were told the condition is due to biological factors. The findings revealed that subjects reacted more callously to the biomedical rationalization of the mental illness (Watters, 2010). Mehta determined that a mental illness attributed to biology implies a permanent abnormality, more so than a mental illness attributed to a character flaw. Metha notes, "Viewing those with mental disorders as diseased sets them apart and may lead to our perceiving them as physically distinct" (Watters, 2010). More so, the biological explanation actually gave the mentally ill a new, separate image that characterizes them as a different species.

In fact, between 1950 and 1996, stigma steadily rose in America (Watters, 2010). Specifically, more people perceived the mentally ill as dangerous and aggressive. Researchers searching for the cause of this increase discovered the same results as Professor Sheila Mehta's findings. "It turns out that those who adopted biomedical/genetic beliefs about mental disorders were the same people who wanted less contact with the mentally ill and thought of them as more dangerous and unpredictable" (Watters, 2010). Studies from across the world in countries who have adopted America's biological description of mental illness, such as Germany, Russia, Mongolia, and Turkey, even reveal similar outcomes (Watters, 2010). Consequently, the mentally ill experience more social isolation and disconnect. Interestingly enough, mental health professionals believe the mentally ill are no more prone to violence than the general population, and linking violence to the mentally ill only encourages stigma and reluctance to seek help (Lindstrom, 2013). However, many people continue to tie the mentally ill to violence, especially

in America due to the heightened media attention to gun violence. As our understanding of mental illness has improved, stigma surrounding mental illness appears to have expanded.

Conclusion

America's cultural environments, as well as its citizens' perceptions of the mentally ill, deeply influence mental health. These cultural perceptions have both fruitful and detrimental health products. For example, America's wealth of knowledge and resources provides information for U.S. citizens to easily identify symptoms, causes, and preventative measures of mental illness. However, America's individualism culture creates an isolating atmosphere that is harmful to mental health. In the near future, research suggests the U.S. to be on the cusp of ranking number one in mental illness globally. To reemphasize the scope of mental illness in the U.S. at hand, "In any given year, 25 percent of the general population qualifies for a mental disorder; 50 percent will over their lifetime; and 20 percent take a psychotropic medicine. More people now die from overdoses caused by medicines prescribed by doctors than by street drugs sold by the cartels" (Mantel, 2013). These startling numbers prove that Western cultures, despite their wealth and power, cannot combat mental illness exclusively. Rather than always spreading our knowledge, we must learn from other cultures as well.

Chapter 6

Combining Forces

As one can see, traditional and modern cultures possess both negative and positive health outcomes as a result of cultural perceptions and practices distinctive to each culture. For instance, Tanzania traditionally associates mental illness with the supernatural, spiritual possession, and imbalance of the body, while America separates spirituality and healing, focusing on mechanical and chemical forces as the underlying causes of mental illnesses. Despite these differing perceptions, the end goals of mental health in both traditional and modern cultures are the same: to heal the illness. Furthermore, according to Global Mental Health Expert Vikram Patel, "traditional medicine already exists alongside biomedical treatment, and complementary healers should be working in a mutually respectful relationship with other health workers as part of the health system, sharing a common goal for helping people address their mental health problems" (Gordon 2011). With equivalent mental health outcomes in mind, it makes logical sense to combine the unique perceptions and practices of both cultures, effectively combating mental illness together and reaching optimum mental health worldwide. However, a perhaps unexpected factor exists: Africa may be one step ahead of modern cultures in attaining this goal.

Tanzania as a Model

Traditionally, mental health laws around the world were centered on institutionalized care and psychiatric hospitalization. "In this vision, the role of mental health law has been to ensure appropriate substantive and procedural standards prior to involuntary admission, and, more recently, to ensure standards of institutional care following admission" (Bartlett et al., 2011).

Currently, mental health law is on the edge of a remarkable revolution, as shifts from institutional-based care to community-based care have already begun, as seen in America's political history of mental health care. However, some countries in Africa, like Tanzania, are leading the way in this movement because the rates of institutionalized care are very low in comparison to international standards (Barlett et al., 2011). In highly developed countries, such as the U.S., the movement towards community-based care is being accomplished "through the development of decentralized community-based dedicated mental health care alternatives provided by specialist professionals in liaison with a strong primary care infrastructure" (Bartlett et al., 2011). Yet, countries in Africa are unable to development this type of specialist mental health care provision due to its lack of resources and trained staff. More specifically, per capita GDP in Africa is often less than US $2,000 per year, and generally one psychiatrist per one million people (Bartlett et al., 2011). Despite all of this, "people with schizophrenia in developing countries appear to fare better over time than those living in industrialized nations" (Watters, 2010). This startling fact was the result of three large international studies conducted by WHO over the course of thirty years beginning in the 1970s. How can this be?

Anthropologist Juli McGruder from the University of Puget Sound decided to uncover this perplexing finding. McGruder studied schizophrenia in families in Zanzibar, an island off of Tanzania, for years. The families, though predominantly Muslim, believe in the supernatural causes and spirit-possession of mental illness. McGruder actually discovered that these beliefs were helpful in various ways; in order to rid the demon away, their practices engaged the mentally ill individual with the family. Rather than casting out the demon through exorcism as seen in Christian practices in the U.S., the family provides the individual with food, song, and dance. Specifically, McGruder witnessed family members inscribe holy phrases from the Koran in a saffron paste on the rims of drinking bowls so the individual could literally absorb the words (Watters, 2010). "Besides keeping the sick individual in the social group, the religious beliefs in

Zanzibar also allowed for a type of calmness and acquiescence in the face of the illness that she [McGruder] had rarely witnessed in the West" (Watters, 2010). McGruder saw the advantages of Tanzania's communalism culture as discussed previously. In addition, one's health is strongly influenced by one's surroundings and his or her interactions with other people. With schizophrenia, existing evidence suggests a link between emotional reactions with family members and higher relapse rates (Watters, 2010). Here, McGruder identified a stark difference among Western and traditional cultures. Emotional reactions of family members are jointly referred to as "high expressed emotion (EE)," which envelops such emotions as criticism, hostility, and emotional over –involvement. In one study, about 67% of American families scored a "high EE" (Watters, 2010). This is not to say that Americans are cruel or feel no sympathy towards those who suffer from a mental disorder, however these findings have much to do with America's individualism culture. Many Americans believe they can resolve their issues on their own and do not need help because we value independence and personal accountability. These beliefs often leave people in isolation, with no support. On the contrary, traditional cultures regard the self in other terms that essentially involve lower levels of "high expressed emotion" and therefore help control the course of the illness. Watters (2010) describes the role of oneself in traditional cultures as "inseparable from your role in your kinship group, intertwined with the story of your ancestry and permeable to the spirit world." Western cultures have much to learn from traditional cultures in this regard. Tanzania, compared to most parts of the world, has less to do in the current transformation from institutionalized care to community-based care. In other words, Tanzania has less to "unlearn" and fewer institutions to scale down and decentralize (Bartlett et al., 2011). Although Tanzania does not have the resources that developed nations have, it encircles a sense of community that is harder to invest in and develop. In this sense, Tanzania should be used as a model for the U.S. in its vision of optimizing mental health.

As Tanzania is one step closer in reaching the mental health goal than Western cultures, it is beneficial to utilize Tanzania as a model in the U.S., as well as for both cultures to share and learn from one another. To reiterate, while Tanzania can profit from modern cultures' highly developed resources and vast knowledge, "the West also have much to learn from Africa in terms of collective spirit and collective support…" (Gordon 2011). Unfortunately, merging modern and traditional medicine is easier said than done. How can we merge our knowledge and resources with their communism culture to attain the best possible mental health? Culture is a vital force in health promotion and disease prevention, and is deeply rooted in societies. Introducing new health practices into any mainstream cultural system poses many obstacles, such as respecting the culture and proving the practices' worth. Is it possible, or even appropriate, to change the cultural norm? An important ethical issue arises when the possibility of influencing another culture comes into play. As such, the source and method of cultural intervention becomes critical. 'Helping' suggests a paternalistic attitude, and the assumption that the wealthier country is better than the poorer country. As Cody (2003) writes, "In paternalistic modes of relating, it is those persons more in need of assistance and less capable of autonomous decision-making upon whom paternalistic interventions are imposed" (p. 291). 'Sharing', on the other hand, implies the interaction and engagement of both the developed and developing country, as they work together to solve matters. Therefore, it is possible to transform cultural norms and values because culture is not immobile, but it must be conducted in a respectable and communicative manner.

Up until now, the foregoing attempted to substantiate that due to differing cultural perceptions and environments, integration of medical practices is required in order to stimulate and sustain optimal mental health, as well as to acquire valuable knowledge and lessons from both cultures. This assimilation must be achieved via culturally appropriate health interventions; a worthy, yet challenging and all-encompassing, route indeed. To illustrate this, I will use the

mental health intervention conducted by the Tanzanian nurses I shadowed in the rural village, which I will refer to as Village X.

Chapter 7

Village X

Village X, where I spent my fieldwork experience in Tanzania, is one out of fifty-six villages in the particular district. According to Kapologwe, Kjeldgaard, Lesangwa, & Mahano (2010), the total population of the district is estimated to be about 238,951. While the district has no district hospital, it has thirty-five health care facilities, of which six are health centers and twenty-nine are dispensaries. There are four ambulances for the entire district. Also, there are twenty-seven health care professionals who have been trained to manage mental illnesses. In the district, of those who are presenting with mental illnesses, "about 78% of patients …suffered from epilepsy, schizophrenia, and mental retardation and only 22% were suffering from stress related conditions" (Kapologwe et al., 2010). It was also found that about 60% of mentally ill patients in the district seek treatment initially from traditional healers.

According to the Nursing Community Assessment (2013), Village X has a population of approximately 11,220, whereby the community is homogenous. Village X only has one health center that is typically open Monday through Friday from 8am-2pm. The health center consists of a maternity ward, out-patient/receptionist building, CTC (care and treatment clinic), and laboratories. The services provided by the health center include:

1. Outpatient department services
2. Reproductive and Child Health care
3. Inpatient services
4. Laboratory services
5. Home based care for people living with HIV
6. Home based care for people living with mental health problems

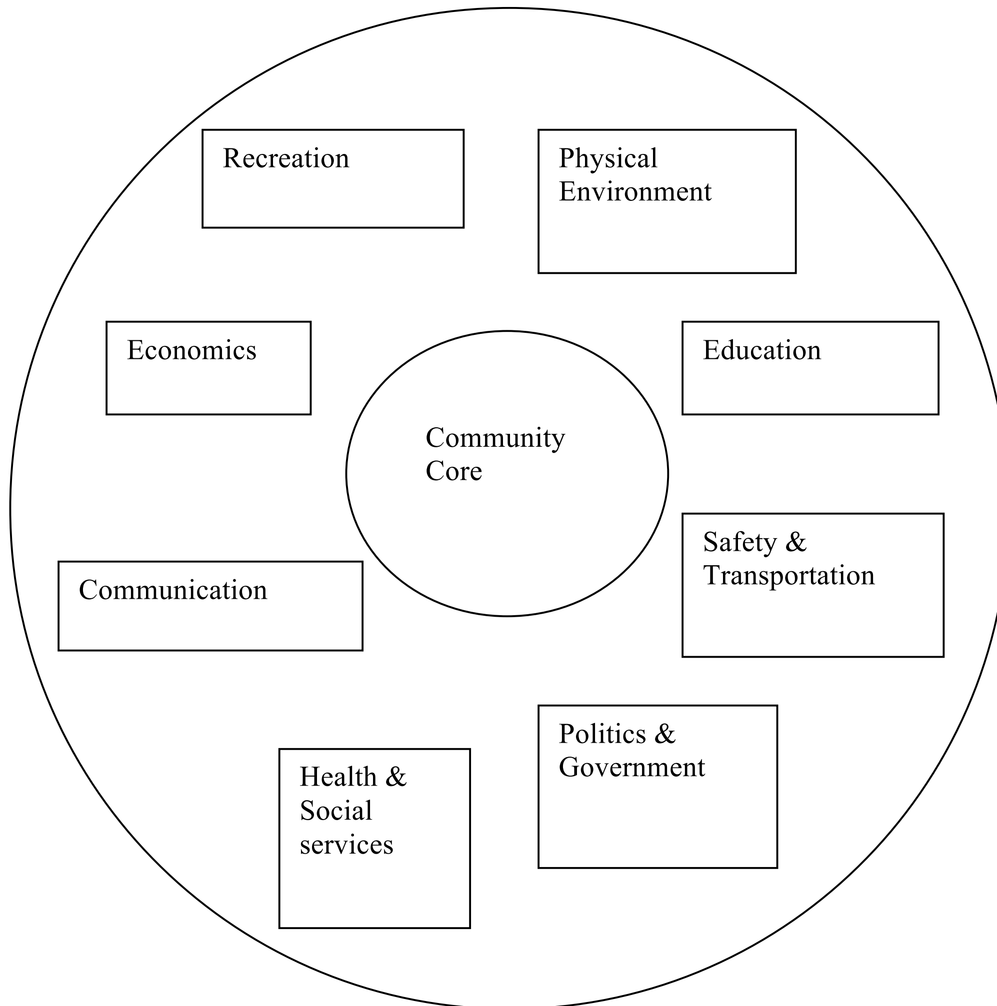
7. Outreach

However, the services provided are often inadequate, as the health center lacks trained staff, resources, and space. The health center has fifteen staff members, including nurses, doctors, and laboratory technicians. The attendance at the health center is about 20-50 patients per day. The most common mental illnesses seen at the health center in Village X since January 2013 include epilepsy induced psychosis, schizophrenia, and acute psychosis. Other mental illnesses observed were substance abuse, mental retardation, depression, and bipolar disorder. The health center provides free medication for mentally ill patients, and the common drugs provided are phenobarbitones for anti-convulsion and chlopromazines for anti-psychosis. In addition, the health center provides home-based treatment for the mentally ill by conducting household visits to all registered mentally ill patients in order to provide education and care.

Community as a Partner Model

I shadowed fifteen Tanzanian nurses as they executed assessment, diagnosis, planning, implementation, and evaluation on mental illness in Village X. The nurses used the "Community as a Partner Model," presented by Anderson & McFarlane (2004), to guide them throughout the process from May 18th, 2013 to June 14th, 2013. "The Community as a Partner Model" consists of three primary elements: the community core, the community subsystems, and perception. The Nursing Community Assessment (2013) illustrates this model in Figure 7-1:

Figure 7-1: Diagram of Community as a Partner Model



Source: Nursing Community Assessment (2013)

The Community Core

This factor of the model is described as "essential, basic, and enduring" (Nursing Community Assessment, 2013). The core of the community includes its people, their history, demographics, values and beliefs, and religion. In order to assess the community, one must first learn about its people.

The Community Subsystems

There are a total of eight subsystems, as demonstrated in Figure 7-1. They are recreation, health and social services, physical environment, education, safety and transport, politics and government, communication, and economic. The community subsystems inform the nurses of how Village X functions and how it is structured. It is essential to gain an understanding of these subsystems in order to effectively intervene.

Perception

Perception envelops the thoughts and concerns of both the residents of Village X and the nurses. Questions to the residents include: How do you feel about the community? What do you identify as strengths and weakness? Questions for the nurses involve general statements about the health of the community, as well as the problems and strengths they can identify.

The nurses extensively and thoroughly gathered the necessary data that fits into the "Community as a Partner Model". I followed them as they collected this data, and while the primary language used was Swahili, the nurses translated for me. They used interviews, discussions, and observations from sources such as government leaders, health committee leaders, community members, village leaders, traditional healers, teachers, and lastly records from government offices and the health center. After assessing the data, the nurses were able to identify the prominent health issues, and formulate the most effective way to conduct implementation of mental health education and care. Because they are familiar with Village X now, the nurses are able to relate to the residents more and adequately meet their concerns and needs. In addition, through collecting information throughout Village X, the nurses created interpersonal and working relationships with community members and leaders. The "Community as a Partner Model" emphasizes the importance of actually *knowing* the community and working with the residents to promote health.

Community Nursing Diagnosis

Once the nurses assessed the community, they gathered their information in order to describe the problems and identify the characteristics of the problems: the community nursing diagnosis. This step of the intervention requires critical thinking and decision making in order to develop an effective health program. For instance, through their assessment, the nurses discovered certain values and beliefs of the appropriate dress code in Village X. It is not acceptable for women to wear shorts, or even pants, because it suggests promiscuity. Therefore, I had to wear long skirts or dresses so as to not offend the residents. Another example involves communication. The nurses learned that the use of formal communication, such as newspaper, radio, television, and phones, is very low. Rather, dissemination of information by word of mouth is used. This is valuable information to know because the nurses can now determine the most effective way to execute their intervention. Lastly, during assessment, the nurses discovered a lack of knowledge among a large number of Village X residents regarding the mental disease process and symptoms. As a result, the nurses can prioritize the mental health information that must be delivered. The nurses formulated a diagnosis of the needs of Village X concerning mental health:

- Education concerning mental health- especially epilepsy and mental retardation
- Consistent mental health services including home based care services and medication supply at the health center
- Trained mental health personnel at the health center
- Education on mental health prevention and treatments

Planning

Planning is an essential aspect of the "Community as a Partner Model" used by the nurses because it can be defined as, "a systematic process completed in partnership with a community depending on the community nursing diagnosis" (Nursing Community Assessment, 2013). Because the community nursing diagnosis revealed that Village X holds long-term health beliefs, the nurses decided to address mental illness through health education in the home. The nurses created an "Action Plan Table" to organize their objectives and activities, and to ensure they fulfill each activity by the scheduled date, as they were only in Village X for four weeks.

Implementation

Implementation entails the process of executing the activities to successfully meet the planned objectives and goals. The planned activities were conducted at the school, community, and family levels in Village X.

School Level

Based on their assessment, the nurses decided to focus on one out of the three primary schools in Village X due to the needs of the school and priority setting. The primary school had many epileptic students compared to the other schools in the village. On May 31st, 2013, the nurses provided mental health education to a total of 60 students, with their main focus being epilepsy due to the high numbers in the school, and in Village X. Epilepsy poses as a risk for epileptic-induced psychosis. Swahili was used as the teaching language for the students to understand the content. I observed in the back of the classroom as the nurses defined epilepsy, described its causes and symptoms, explained how to help a patient who has an epileptic attack, how to prevent oneself from acquiring epilepsy, importance of drug compliance and early treatment, and lastly

where to receive treatment. After the sessions, which lasted about ninety minutes for each group, the students were given a chance to ask questions, which many participated.

Community Level

The nurses divided themselves into three groups in order to reach the many households in Village X. As I went from home to home with my assigned group, the residents came outside and we sat in a circle to interact and converse for hours at a time. The nurses would engage in interactive conversations with the residents, as they would inform the residents on general health information, as well as a concentration on mental health. The nurses clarified definitions of mental health and mental illness, prevention and causes of mental illness, and management of mental illness. For example, they described the causes of mental illness as altered neurotransmitters, biological factors, environmental factors, and lastly human development. I recall one home visit where nearby residents came on bikes and foot to listen to the nurses. I observed that many residents in Village X were unaware of causes and treatments for various health conditions, such as malaria, and believe mental illnesses are caused by witchcraft. The main form of intervention used was discussion, as the importance of oral tradition in African cultures is apparent.

Family Level

On June 3rd, 2013 the nurses visited selected families with known cases of mentally ill individuals determined by the assessment. The nurses visited these homes with a home-based care member as well, and their objective was to educate the families and patients on mental health and illness. Additionally, each nurse was assigned to a mentally ill client as an individual case study. I went on visits with one nurse as she assessed the client, a young man I will refer to as Patient X. The nurse examined the patient's health history and spoke with family members. Patient X has a health history of abusing alcohol, smoking, and cannabis. Patient X was well until 2012, but then began expressing abnormal behaviors characterized by aggressiveness, over talkativeness, beating

people, and using abusive language. Patient X tried traditional medicine for one month before being admitted to Mirembe Hospital on March 26, 2012, and has not been on any medication since released from Mirembe on May 21st, 2012. Patient X lives with his mother, and the mother and sister attribute the abnormal behaviors to witchcraft. From assessing her client, Patient X, the nurse discovered various symptoms and signs that lead her to diagnose Patient X's mental illness as Substance Induced Mood Disorder. The nurse then intervened at the family level by providing relative mental health education as demonstrated in the Nursing Community Assessment (2013):

1. Provided health education to family members on how to live with Patient X by understanding client's concerns, providing support, and instructing client to perform activities as part of gaining social skills.
2. Provided education to family members on disease process (how drugs lead to mental illness), and evident signs and symptoms once affected.
3. Provided education to family members on importance of sending Patient X to the health center for management and treatment.
4. Advised family members on importance of observing Patient X's behaviors frequently and closely, and to speak in low tones in order to find out what is making him angry.
5. Advised family members to avoid argument with Patient X and direct confrontation when Patient X changes behavior.
6. Provided education to Patient X on the effect of non-compliance to treatment after assessing the reasons for non-compliance to treatment.
7. Advised family members to allow Patient X to participate in daily activities at home.
8. Connected Patient X to the health center in order to receive other services (i.e. medication)
9. Connected Patient X to the District Coordinator of Mental Health, so that client can be used to educate other youth on the effect substance abuse on human health.

Each nurse conducted these interventions and formulated a diagnosis for each client. Many other nurses had case studies involving schizophrenia and epilepsy. The family level interventions created more personal and trusting relationships with patients.

A central strategy used by the nurses during implementation is coordination and collaboration with community members, as guided by the "Community as a Partner Model". As I observed each level of intervention conducted by the nurses, I noticed an active participation of the community, which is essential for any health change.

Evaluation

Evaluation is the last step in the nurses' intervention. Evaluation enables one to reflect on the implementations conducted. At each level of implementation, the nurses noted positive feedback and understanding of mental illness from community members and residents of Village X. All of the nurses compiled evaluation reports on their experience in Village X, and presented it to the District Medical Office, as well as at village offices and the health center. The report expressed challenges to mental illness in Village X, suggestions for improvements, and overall analysis of the intervention process. More so, evaluation consists of three components: relevancy, progress, and cost effectiveness. The intervention was relevant to Village X as mental health services are lacking, and limited focus and knowledge on mental illness is evident. The progress of the intervention is heading forward as effective coordination and collaboration were used between intervention group (mentally ill clients), health center workers, traditional healers, and community members. After expressing to community members the importance of seeking treatment at the health center, as well as collaborating with traditional healers to refer patients to the health center when necessary, the number of patients at the health center has increased since

the intervention (Nursing Community Assessment, 2013). Lastly, the intervention was cost effective because the intervention group work was voluntary.

While the nurses were only in Village X for four weeks, it is hard to measure its exact impact, however positive progress was made whether it was minor or major. The nurses were unable to conduct a thorough evaluation due to lack of funding and other reasons, but imagine what this model can do within long-term interventions? Furthermore, imagine what this model can do in developed countries that have the money and resources?

Reflection and Discussion

The "Community as a Partner Model" that I observed in Village X in Tanzania is an example of a culturally appropriate intervention that the U.S. should adopt. In my previous discussion on the Americanization of mental illness, spreading our Western knowledge of the biological model of mental illness appears to actually be increasing stigma globally. However, I do not intend to reject our knowledge, or to imply that we should not educate other cultures. In fact, as seen in Village X, the nurses spread the Western biological model to the residents. Education is key to mental health; without knowledge, one will not know how to treat a mental illness, or how to even prevent it from occurring. But, the *way* in which the nurses spread the model is impressive. In other words, their intervention envelops the culturally appropriate dissemination of the "American model" of mental illness.

The intervention of Village X emphasizes the crucial role of the community, as well as the importance of cultural communication. Cultural communication is necessary to successfully integrate modern and traditional health practices. As illustrated prior by American and Tanzanian cultures, each culture's perceptions of mental health differ. A culture's knowledge, beliefs, and values form those perceptions, and inevitably form its health practices and behavior. Therefore, in

order to combine health practices of modern and traditional cultures, one must first understand the culture's belief system of codes and symbols, as they provide substantial meaning. This is accomplished through effective cultural communication. By meaningfully engaging with the targeted culture, a trustful relationship develops. The nurses personally went from home to home and visited with each family for long periods of time. The families, by personally meeting the educators, are more inclined to listen and learn. Not only did the nurses meet with the mentally ill patients one-on-one, but they also interacted with their families, village leaders, schools, staff at the health center, and the District Medical Officer. They even met with traditional healers. Instead of criticizing the healers or pointing out their flaws, they engaged with them respectfully to understand their methods. They did not ask them to stop their practice, because their practice is part of the community's traditional lifestyle. Rather, they politely asked the healers to refer severe mentally ill patients to the health center when the healers know they cannot provide healing. This respectful manner and accepting engagement creates trust and diffuses any reluctance or fear that members of Village X may have towards an outside group.

The intervention in Village X is one that should be modeled in the America. As stated prior, this intervention is exigent, and requires immeasurable time and effort—but the outcome is rewarding. My proposed integrated route involves the developed country learning from the developing country, too; one not seen too often and offsets the typical paternalistic method that is seen too frequently. The U.S., with its wealth and power, must take the next step in reaching optimal mental health and diminishing stigma. We must not withhold our medical advances from other countries like Tanzania, but we must export them in a culturally appropriate manner as demonstrated by the Tanzanian nurses in Village X. "When we [the West] undermine local conceptions of the self and modes of healing, we may be speeding along the disorienting changes that are at the very heart of much of the world's mental distress" (Watters, 2010). To halt this from advancing further, we must bridge together intellect and trustful relationships. The

prominent barrier between traditional and western cultures is the fear of the unknown. To break this barrier, trust must be constructed and grounded, and then progress can be made. The U.S. has much to learn from Tanzania, and Tanzania has much to learn from the U.S. Together, these two forces have the potential reverse mental health trends globally.

Chapter 8

Conclusion

Mental health is often a neglected field, especially compared to physical health. However, mental health and physical health are interdependent. According to *Mental Health: A Report of the Surgeon General*, "Mental functions are carried out by the brain. Likewise, mental disorders are reflected in physical changes in the brain. Physical changes in the brain often trigger physical changes in other parts of the body too" (DHHS, 1999). Mental illness is extremely complex due to the many variations of definitions among cultures, as well as the attached stigma that continues to persist. Increased focus and attention on mental health is required immediately, as one in four people suffer from a diagnosable mental disorder in a given year (NAMI, 2013). Perceptions of mental illness, as well as cultural environments, have profound impacts on mental health. These vary particularly among western and traditional cultures, as exemplified through the cultures of the U.S. and Tanzania. However, each culture presents both promising and damaging outcomes for mental health. To attain optimum mental health, western and traditional cultures must learn from each other and integrate the promising mental health outcomes, such as America's knowledge and resources, and Tanzania's communalism culture. As demonstrated through my fieldwork experience in Village X, the intervention carried out by the nurses exemplifies a culturally appropriate way to spread the "Western model" of mental illness, one that the U.S. should embrace. It is one that, before providing education, encircles building relationships, learning about the target culture, and developing trust.

The West tend to educate other cultures of what it knows, which can indeed change mental health care globally for the future, but without learning from others. We preach our knowledge and then continue on our way, expecting other cultures to comprehend, adapt, and

practice our teachings without objection because we are right. Bednarz (2013) writes, "Oftentimes, rather than try to understand the cultural discrepancy, we'll immediately try to solve everything as if it is a Western problem requiring a Western solution." In this sense, it is no surprise that stigma has amplified throughout the world. Watters (2010) believes that Western cultures spread mental health concepts in ways that are not culturally neutral, but in ways that reflect the core components of Western culture that are not universal. In fact, "These ideas we [the West] export often have at their heart a particularly American brand of hyperintrospection—a penchant for 'psychologizing' daily existence. These ideas remain deeply influenced by the Cartesian split between the mind and the body, the Freudian duality between the conscious and unconscious, as well as the many self-help philosophies and schools of therapy that have encouraged Americans to separate the health of the individual from the health of the group" (Watters, 2010). These ideas contrast starkly with Tanzania's communalism culture and emphasis on the mind and body relationship. In Tanzania, the health of the individual is dependent on the health of the group, and the mind and body are viewed as inseparable. For mental health to reach its potential around the world, it is imperative that Tanzania [Traditional cultures] learns of the symptoms and causes of mental illness, just as much as it is for the U.S. [Western cultures] to learn of support and social-connectedness.

This is not to say that Americans know everything about mental illness and do not need to learn more about it. Stigma rose within the U.S., too, and in the survey conducted by the APA mentioned previously, almost 44% of Americans reported knowing little, or nearly nothing at all, about mental illnesses (NAMI 2013). This fear of the unknown, or fear of change, can be diminished with trust. If the U.S. should incorporate Tanzania's practices of communalism and mind/body relationship, the culturally appropriate dissemination of its knowledge on mental illness could then be successfully incorporated into Tanzanians' health practices, as well as into

Americans' practices—a possibility that may be more groundbreaking and valuable than any medical breakthrough on the brain.

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The Pennsylvania State University, The Schreyer Honors College, expected May 2014
Bachelor of Science in Biobehavioral Health, expected with honors
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Oakland Catholic High School, graduated 2010

HONORS AND AWARDS
Deans List, Penn State University, Fall 2010-Fall 2013
National Society of Leadership and Success, Spring 2012
Mel Douglass Honorable Mention Scholarship, Spring 2010

PROFESSIONAL EXPERIENCE
Mount Nittany Medical Center, January 2013-present
Volunteer in Patient Floor/Emergency Department

- Discharge patients
- Deliver patients to radiological services
- Deliver Doctor's notes
- Organize medical equipment
- Read patient trackers/codes
- Stock treatment rooms

Global Health Internship, Summer 2013
Shadowed Tanzanian nurses in Bahi Village, Tanzania

- Collected data from health center, government, schools, District Medical Officer
- Conducted home visits in village
- Administered infant weight at health center
- Developed educational pamphlets on mental health
- Observed mental health patients in psychiatric ward
- Observed malnutrition and diarrhea wards in pediatrics unit at Muhimbili Hospital

ACTIVITIES
Senior EXIT, member- Christian fellowship, Fall 2013-present
BBH Society, member, Fall 2012-present
Education First Program, Traveled Europe for 6 weeks, May 2012-July 2012
IM soccer, Co-captain, Spring 2012
Global Medical Club, Conference Committee, Fall 2011-Spring 2012
THON, OPP committee, Fall 2010-Spring 2011
Mukwano Club, Co-founder- Fundraise for orphanage in Uganda, Fall 2009- present