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CULTURE AND MENTAL HEALTH: CONSIDERING THE ROLE OF THE COMPLEX
CULTURAL HISTORY IN IRISH-AMERICAN POPULATION.

by

TIFFINIE PATRICIA SESKO

A master's thesis submitted to the Graduate Faculty in Liberal Studies in partial fulfillment of the
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ABSTRACT

Culture and Mental Health: Considering the Role of the Complex Cultural-History in
Irish-American Population.

by

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This study investigates the mental health of Irish immigrants and first generation Irish Americans. As the Irish-American population makes up such a large portion of the entire population of the United States, it is important we acknowledge its origin and take that into account where mental illness and treatment are concerned as the Irish culture has a pronounced effect on mental health. The intended audience of this review are expert and non-expert members of the clinical setting and community who may gain insight on helping a client or family member find a way to understand and express repressed feelings affectively. To fully understand Irish culture and acculturation, it was necessary to explore mental health cross-culturally with a researcher lens to gain anthropological, sociological, ecological, psychiatric, and psychological perspective. In literature of this nature, common variables were discussed as playing a part in the most typical behaviors and beliefs of various cultures. Those variables were documented and applied to Irish culture. A positivist approach was taken in the review of the material to summarize and synthesize the interpretation of Irish culture and mental health. It was concluded that socioeconomic status, religion, gender, and age commonly mold the traditions and characteristics of a culture which in turn, affect the status and perception of mental health and

illness, as well as the perception of and action taken towards treatment and healing. The history of the Irish culture in terms of religion, surviving imperialism, and socialization seem to be slowly losing its grip on the belief systems of the Irish and Irish-Americans today. However, due to the loyal-to-tradition nature of the Irish, many Irish-American families continue to have troubled relationships as traditional family roles encourage a cycle of problematic behaviors.

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Culture and Mental Health: Considering the Role of the Complex Cultural-History in the Irish American Population.

I. Introduction

The Irish have had the reputation of being witty, tough, heavy drinkers, not very affectionate towards their loved ones, private, cautious of what their neighbors think, to frown upon any “weaknesses” including recognizing and treating mental illness. In the United States, millions of Americans claim Irish ancestry, are Irish immigrants, and are children of Irish immigrants (United States Census, 2013). It is important to recognize this, the Irish tendency to stigmatize mental illness and treatment, and consider that as a vital factor in the stigma towards mental illness in America, overall. As the generations in Ireland and the United States grow more accepting of caring for mental disorder over time, there are still cultural and generational barriers faced in the Irish American household that hinder positive mental health. The multicultural therapist must be aware of Irish paradigms to assist the patient in recognizing what exactly is creating dissonance and with expression of the associated feelings. In this literature review, the positivist approach is taken to discuss my research and on my own synthesis of the sociological, anthropological, and ecological perspectives of various cultures and mental health; specifically, the ways culture is effected by religion, gender, socioeconomic status, age, and in turn, mental health. I place emphasis on the client-centered approach to therapy and how tying some aspects of universalism to the client as part of a culture that lives by a certain set of rules may be effective. To conclude, and on a personal note, I apply the research to the Irish culture. My objective is to remind the reader that in the present, a time of a rapid immigration of vast cultures, the secret, sullen suffering of the Irish, a highly claimed heritage in our country should

not be neglected. Starting at the community level, multicultural aware individuals can take part in creatively and culturally appropriately breaking the silence.

The guiding thoughts throughout choosing literature and developing research questions for this work are based on personal experiences of being of Irish-Catholic descent. After looking in to various selections on culture and mental health in general, along with what I have endured, to support the belief that the history of the Irish culture having long-lasting, negative effects on the mental health of Irish immigrants and first generation Irish-Americans, I formed questions regarding the roles religion, gender, age, social and economic status commonly play in culture, mental health, and seeking mental health treatment among various cultures. I propose possibilities of some therapeutic technique that may benefit the Irish-American population based on the literature reviewed.

II. THE MIND AND BODY ARE INSEPERABLE

In the first ever issued surgeon general's report on mental health and mental illness (David Satcher, 2000), two messages were conveyed regarding citizens of the United States and the world. First, mental health is fundamental to overall health, second, mental disorders are health related conditions that have an immense impact on individuals and families. In this report, Satcher (2000), defines mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, the ability to adapt to change, and to cope with adversity" (Satcher, 2000, p.4). It is indispensable to personal well-being and contribution to community or society. The surgeon general believes in educating organizations, experts, and individuals on the need for fresh approaches to research on mental

health and mental illness. Americans are bombarded with messages about success without recognition of the role that the foundation of mental health plays in that. What it means to be mentally healthy is subject to interpretation rooted in values that vary across cultures. Along the stages of life, the brain interacts with a person's mental status which reflects the sum of the individual's genetics along with life experiences. Satchel (2000) explains the importance of seeing children in the context of their everyday experiences, social environments as well as their larger physical and cultural surroundings as childhood mental health is expressed through this context while children develop. Mental illness which Satchel defines as health conditions characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning is influenced by age, gender, race, and culture (Satcher, 2000). Diagnosis and treatment must be tailored to all characteristics that shape a person's image and identity. "Culturally competent" (Satcher, 2000, p. 17) services blend the understanding of ethnicity, race, history, tradition, and values. The insufficient number of mental health service providers who are members of racial and ethnic minority groups must be redressed to ensure those individuals care from a professional of similar background should they have this preference.

Satcher argues that mental health should be part of the mainstream of health in the United States and that there is not a go-to treatment for mental disorders once the individual has made the decision to seek help (2000). Options for this help may include talk therapy, use of medications, raising questions about symptoms of mental health with a family doctor, family member, teacher, or school counselor. Despite these options, Satcher (2000) explains that nearly half of all Americans who have a mental illness do not seek treatment. The barrier resulting in the reluctance to seek assistance is the stigma that many in our society attach not only to mental illness, but to the people who have a mental illness. Satchel describes stigma as what "erodes

confidence that mental disorders are valid, treatable health conditions, leading people to “avoid socializing, employing or working with, renting to or living near persons with a mental disorder...” (Satcher, 2000, p. 2). As this stigma discourages individuals to seek proper treatment, it also deters our public from wanting to treat these conditions. Those in need then suffer from negative patterns of low self-esteem, isolation and hopelessness, depriving them from dignity. Stigma ultimately interferes with full participation in society which Satchel argues must come to an end (2000).

III. THERE IS NO MENTAL ILLNESS WITHOUT CULTURE

In the Sam and Moreira 2012 article “Revisiting the Mutual Embeddedness of Culture and Mental Illness” it is suggested that “Without a culture, we will not be in the position to determine what is bizarre, and the inability to determine what a bizarre is also makes it difficult to know how it can be treated” (Sam and Moreira, 2012, p. 5). The argument presented is that culture is an inherent part of mental illness and failure to understand this leads to a rather shortsighted view of the onset, expression, course, and prognosis of mental health problems.

Due to the dominant role medicine plays in the understanding of mental illness, the diagnosis and treatment is often kept in the biological realm. Sam and Moreira suggest the root of mental illness maybe the result of a clash of cultural beliefs (2012). By use of categorical positions of relativism and universalism, the authors tie those terms to depression, schizophrenia, and culture-bound syndrome. They defend the need to see mental illness and culture as mutually embedded by discussing limitations of cross cultural research.

The relativist position, rooted in anthropology, assumes that human behavior is culturally patterned (Sam & Moreira, 2012) and aims to avoid ethnocentrism by understanding people

without value judgements or preconceived ideas from an external cultural view point when a group is being described. In extreme forms of this, psychological reality is dependent on one's own understanding. "Moderate relativism" emphasizes that psychological processes are the outcome of interactions between the being and sociocultural contexts. In the article, universalism assumes basic human characteristics belong to all members of the species and that culture influences basic human processes. This suggests that the meaning of behavior depends on the cultural context in which it occurs while it can also be understood in common terms across various societies, objectively.

With these terms in mind, Sam and Moreira discuss cross-cultural research in depression, a common mental health problem affecting over 121 million people globally (Sam & Moreira, 2012).

When discussing the role of culture in mental health, depression and its universality are used for illustration. In a series of studies sponsored by World Health Organization (WHO) between 1973 and 1986 concluded that patients from Western countries expressed feelings (of guilt) differently than non-Westerners as the latter group reported more bodily complaints, more spontaneously. In a study carried nearly twenty years later, it was concluded in 1986 that 93 of these patients might be suffering from depression according to the DSM-III criteria. Yet, instead of reporting feelings of low spirits, these patients reported problems with sleeping, headaches, and dizziness. This finding raises questions about the universality of depression. For example, whether the Chinese suffer from that, body aches, or somatoform (as it would be called in the modern West) as the conditions lead the same symptoms (Sam & Moreira, 2012).

The notion of category fallacy becomes pertinent in this matter. This is the term used when researchers and clinicians impose illnesses of their culture on other cultures. The fallacy gives

emphasis using an outside perspective to label people while universalism becomes defrauded of validity (Sam & Moreira, 2012). In the WHO studies, a common belief was that similar symptoms of depression allowed cultures to recognize the disorder. As some aspects of it may differ cross culturally, it may be subjective, cultural experiences, economic or psychosocial oppression at the root of those differences, contributing to the perception of the disorder. This perception may be influenced by the reliance on biomedical advances in mental health studies which ultimately downsizes conclusions that can be drawn on the matter (Sam & Moreira, 2012).

Approaching this problem comes with challenges to our understanding of culture and mental health however, this must not become a barrier to understanding how the two are embedded. Reducing culture down to “casual occurrence” (Sam & Moreira, 2000, p. 11) allows social, political, and cultural contexts of unique individuals in need of mental health services to be overlooked. Assuming Western psychiatry is universal and having a pathoplastic (Sam & Moreira, 2012) view of cultural roots of mental illness (that culture is a precursor to the individual), according to Tatossian (1997), is an error of classic western cross-cultural psychiatry as is it is the West to choose psychiatry to regulate ‘disorders’ in the first place. Sam and Moreira suggest each culture having its own psychiatry, no better or worse than Western method (2000).

IV. APPLYING ANTHROPOLOGY, ECOLOGY, AND SOCIOLOGY TO INDIVIDUALIST UNDERSTANDING OF MENTAL ILLNESS

Like Sam and Moreira (2012), cultural psychiatrist Richard J. Castillo (1997) discusses the importance of an anthropological view of mental illness along with the role sociological forces play in structure, etiology, and the understanding and treatment of mental illness.

The holistic approach Castillo (1997) takes in understanding mental health is referred to as “client centered therapy”. “Culture determines aspects of learning” (Castillo, 1997, p. 5).

Because of that, cultural learning has been discovered to have a biological basis in the brain and therefore, mental disorders (Castillo, 1997). This is the basis of Castillo’s belief in his approach.

Treating clients as though they experience universal problems and symptoms as if they have a disease rather than an illness will not be entirely effective according to Castillo; treating a disease will only reduce symptoms (Castillo, 1997). One’s cultural identity thoughts, emotions, social context must be the center of diagnosis and treatment. Like cognitive schemas, cultural schemas cognitively construct a similar behavior as normal while another culture may call it a disorder. In phenomenology, a society’s cultural way of experiencing the world is known as a natural attitude (Castillo, 1997). Castillo argues this attitude is anything but natural as we experience the world culturally and in unique ways to that group of people.

Castillo defines culture as the sum of knowledge passed from generation to generation in a society that is composed of language, art, religion, economics, politics, social norms and views about behavior. This knowledge becomes what anthropologists call cultural meaning systems that structure cognitive reality for a society at large. Four functions of these brain systems occur in all societies, and can be conceived in certain patterns and sequences to provide rules for how to feel about mental illness.

The representational function enables the individual within a cultural group to represent the world symbolically to themselves and others. Symbol, coming the study of signs, are objects that represent something else. For a person raised within a certain symbolic system, the information contained in that system feel completely natural and true when in it is in fact, random. Outside of that system, meanings of objects will be different (Castillo, 1997).

The constructive function of cultural meaning systems is to create things that would not exist without the meaning system constructing them. Marriage is created by use of a symbol, the ring. Society begins to treat the couple as if they are married; as if something magical made them unmarried to married in an instant. There are no definitive descriptions of schizophrenia prior to 1800 or records of what resembles it, but “madness”. Interesting to note is the shortest courses of schizophrenia along with the best mental health outcome take place in the least modernized societies, most economically and culturally removed from the West. Castillo reveals the possibility of modern cultural meaning systems being not only related to the diagnosis of schizophrenia, but to the presence of it (Castillo, 1997).

The directive function of cultural meaning systems is to direct people’s behavior in the way that reflects how cultural entities have been created and have become part of a culture. The Caste system in India is a construct that directs people to behave according to the caste they were born in as this is an obligation (Castillo, 1997).

The evocative function triggers the emotions that cultural entities and behaviors create. This meaning system is a source of rules for how to feel as what a situation means to someone is defined. People may not be aware of how this function affects their lives as the things that bring passion and sadness to the conscious mind are cultural entities that cultural meaning systems constructed (Castillo, 1997).

Again, the example of depression can be used to explain how cultural meaning systems and cultural entities have ability to victimize. Ambitious students who devote their lives to studying become depressed from missing socializing, or because their significant others decide to leave them. This turns to a deeper depression and a decline in grades. As the depression worsens, one may become suicidal and decide to seek psychiatric help. The psychiatrist

prescribes medication for depression, a brain disease, and the students have even more difficulty going further with education (Castillo, 1997).

Castillo's feelings on depression are much like Satchel's in that there is much stigma attached to the illness. The stigma that is part of a culture, is in turn a part of an individual's choice in treatment. Clinical reality, the cognitive construction of reality in the clinical setting will vary among individuals as they apply cultural schemas. How culture affects this process is carried out in five ways; first, through culture-based subjective experience. The biomedical, perhaps pathoplastic model Americans are raised in helps to form opinions of ourselves. We construct our illnesses based on what we have systematically defined as illness and how we conceptualize ourselves. Second, culture affects clinical reality through culture-based idioms of distress; the ways people behave to express illness. A culture-based diagnosis, the third way of cognitively constructing reality in a clinical setting, involves indigenous clinicians assessing and diagnosing a problem in a way that is common for the local culture (Castillo, 1997). Fourth, culture-based treatment refers to the proper treatment for an illness as it is defined by the patient's meaning system or paradigm. For an American diagnosed with depression in the United States, appropriate treatment in the patient's clinical reality may be somatic treatments such as antidepressant medications. The fifth way culture affects the clinical reality of mental illness is in the culture-based outcome; the outcome that occurs because an illness has been cognitively constructed and treated in a way that reflects certain values. For example, the American medical subculture will most likely overlook the lives of medical students who are treated with antidepressant medications along with their emotional pain during the grieving process. Depression in this case is viewed as a chronic, internal problem; a brain disease which may further the progress of the patients/student's feelings of hopelessness. In turn, this notion has the

potential of ultimately holding medical students back or instilling a sense of reluctance in administrators to grant internship (Castillo, 1997).

Aside from anthropological views on culture and mental health, there have been sociological studies of mental illness analyzing frameworks of epochs; periods of time in history. In “Modernity Theories and Mental Illness: A Comparative Study of Selected Sociological Theorists”, Yawo Bessa, (2012) used four perspectives to explain how culture affects mental illness in societies; structural strain theory, anomie theory, the social stressor theory, and the labeling theory.

As Castillo stresses the importance of an anthropological view, Bessa (2012) discusses the influence of sociology on mental health problems. To begin, he explains the history and development of society in terms of how it is broken up into three periods: premodernity; prior to the modern era, modernity; a time of rejection of tradition (which is marked by industrial revolution in this work), and postmodernity; a reaction to modern era. Within the latter two periods, the perspectives used to explain mental illness have had influences on technology and knowledge leading to current thoughts about sociology, mathematics, physics, and moral of the modern and postmodern period. With logical reasoning behind them, these eras oppose religious force as a cause of social phenomena, a characteristic of the premodernity period.

A modern sociological theory associated with mental health is anomie theory formulated by Durkheim who in his book *Suicide*, expounded how the rate and typology of suicide, an indicator of depression, varies depending on one's level of social integration and collective regulation of desires and judgments. **Egotistic** suicide is connected to low social integration. Durkheim explains that low social integration is most likely correlated with an absence of strong moral value. This type opposes the next, **altruistic** suicide, which is connected to high social

integration, opposite of what is egotistical in nature. The third type, **anomic** suicide, is connected to a low degree of social constraint. Durkheim discusses that without a strong system of collective states of conscience, individuals are weakened by the things they imagine, including thoughts of taking one's own life; this is due to lack of social stability and order. In contrast, the fourth type of suicide, **fatalistic**, is attributable to an "excessive regulation", opposite of what is alienated.

Robert Merton (1957), proposed the structural strain theory to explain deviance and mental illness by focusing on cultural goals and institutional norms, proscribed (rejected) and prescribed (expected) behaviors, and anomie (the state of confusion). Merton explains that deviance depends on how the variation in cultural goals (purposes and interests held out as legitimate objectives) and institutionalized norms (acceptable social customs that regulate modes of reaching cultural goals). Merton explains that emphasizing cultural norms at the expense of institutional norms will lead to deviance. As for the United States, Merton argues that the emphasis of wealth as a symbol of success without a strong accentuation of how to earn that contributes to deviance in our society. Anomie is the result of the dissonance experienced in the making of and meeting financial goals. This value system results in what Merton (1957) describes as "marked anxiety" (Bessa, 2012, p. 33). This will lead to further mental health problems due to exposure of confusion between expectations and achievements.

Merton, like Durkheim, developed typologies resulting from varying levels between goals and how to reach them or rather, between levels of disequilibrium or equilibrium between cultural goals and institutionalized norms. First, the mode of conformity refers to the result of equilibrium between cultural goals and institutionalized norms. Second, innovation occurs when individuals score positively on cultural goals but not on institutionalized customs. Third,

ritualism. Ritualists score negatively on cultural goals, highly on institutionalized means. The fourth type known as retreatist, reject both types of goals while the fifth, rebellion simply score negatively on cultural as well as institutionalized norms.

Karl Marx's conflict theory (argues that the history of humanity is the history of class struggle between the oppressors and the oppressed. In greater detail, this means the oppressor owns channels of production and is economically, politically, and socially advantaged to the oppressed (Bessa, 2012). The perception of gender difference can be used in conflict theory as it would guide sociologists in understanding why women suffer mental illness more than their male counterparts. Bessa discusses studies in gender difference and power that highlight the phenomenon of male dominance; the dominant and the dominated, like the oppressors and the oppressed. Marx's theory suggests the dominated and the oppressed will suffer from greater mental health problems as these groups do not have the tendency to vent their dissatisfaction to the dominant group (2012).

Labeling Theory (Scheff, 1999) is a fourth, modern sociological theory of mental health which stems from the study of deviance. Scheff discusses the concept of deviance and how it relates to social norms as our society "spells out" acceptable and unacceptable norms of behavior. This arrangement allows for the rewarding of conformity and the punishment for not conforming. Stigmatizing is one way to "punish" these rule breakers by labeling the individual which Scheff argues will lead to more severe rule-breaking, contributing to the progression of deviance. Applying this theory to mental health, Scheff explains that mental health is deviance itself; non-conformity to residual rules that are not specifically prescribed or proscribed. For example, a mentally ill person in the United States who converses with the spirit world by a non-religious figure may be considered deviant (Bessa, 2012).

What these four theories have in common are structure, order, and universalism. Even those opposing each other (functionalism and conflict theory), share common ground in sociological thoughts on the modernity era. Bessa suggests the four frameworks lead to the likeness in approaching problem solving. He concludes that individual's mental health problems are ingrained in the structure of our society and argues the solution should be desired within the restructuring our welfare programs and our overdependency on medicating mental illness which is part of the aftermath of modernity in the United States (2012).

Medicating mental illness, treating universal symptoms rather than the client herself fails to treat the individual by understanding psychological adjustment. Israel Cuellar (2000) provides an ecological perspective to the roles of culture, cultural goals, and behavior in *The Handbook of Multicultural Mental Health* (Cuellar & Paniagua, 2007). He begins with a brief lesson in Darwinism. Ecological concepts initially formed by Darwin "maintain that all life has its province and is related to others in a web of life in which each struggle for existence" (Cuellar, 2000, p.45). The struggle requires adjustment of other organisms. It becomes competitive, requires cooperation and giving assistance that develops in acclimation; adjusting to an environment.

Anthony Marsella defines culture as shared, learned meanings and behaviors that are transmitted from within a social activity context for purposes of promoting individual/societal adjustment, growth, and development (Cuellar, 2000). If that changes, the ecological perspective occupies culture as an external and internal variable having influence on behavior.

Culture and cultural goals are powerful variables providing people a means of communication, a sense of belonging, meaningful systems of beliefs, views of self and others, means of commerce among many influences on what it takes to survive and reproduce (Cuellar,

2000). Acculturation, the process in which cultures and people change as a function of culture contact is a common phenomenon. It is defined by Redfield, Linton, and Herskovits (1936) as a process represented by all the changes that occur as result of individuals from two distinct cultures coming into continuous first-hand contact with one another; particularly those changes that result in transformation of the original cultural patterns of both or either groups (Cuellar, 2000).

The postindustrial technological revolution of the 20th century brought upon many changes in societies and cultures across the globe. Naturally, cultural conflicts have emerged. Most of all, this is the case between people of a nation where cultural beliefs are held most deeply, and those opposed to those beliefs. At a macrolevel, cultural conflicts have their individual significance in behavior, custom, and cognition. At a microlevel, the changes due to conflict are referred to as psychological acculturation changes. In this process, reaction, even violence in attempt to illuminate threatening cultural systems, is not uncommon.

Culture in this context has been viewed as having a possible impact on health, illness, and adaptation. It changes as result of interactions with others in different ecological categories including systems such as social, cultural, architectural, political, economic, and cognitive. These acculturative changes can take place in individuals or at a community level. Within the community, majority and minority groups are acculturating in different directions, at different speeds, while in diverse situations.

Depression is a strong example Cuellar uses as an example of illness that is affected by external factors such as contextual environment, culture and acculturation, and psychosocial positions as it is also defined clinically by DSM-IV criteria. Cuellar notes that culture forms the expression of many illnesses, including those of depressive disorders and determines the

individual's explanation of their illness (2000). Studies have proved ethnic identity, identity achievement, and affirmation and belonging to be inversely correlated with linear acculturation (Cuellar, 2000). Ethnic groups differ in rates of psychiatric illnesses suggesting higher risk for major depressive episodes (Burnam et al., 1987). Even when measured independently, empirical findings defend that acculturation is related to mental health. Cuellar explains the variance in these results are due to the complexity of acculturation and because of the factors involved that complicate the process. Context, determinants, phase, and mode of acculturation all alter adjustment. This is a unique experience to the individual.

What the chapter seems to suggest is how we experience change; the process of adaptation and conflict resolution are never ending progressions for all beings as Darwin (1859) suggested in the context of struggling to survive. Human abilities in creating and supporting the survival of culture while controlling those which act as a threat to their survival is essential to that survival (Cuéllar, 2000). Each culture in existence has developed traditions that have survival value or else that culture would have evolved. Those values must not be underestimated when mental health is examined. Culture conflict and acculturative stress have unique consequences for the people going through the process of acculturation as these components of mental health can heighten symptoms and add to stress to what the individual is currently experiencing. Cuellar suggests that by incorporating culture and ecological models to community psychology, a broader view of mental health will assist in finding solutions to mental health problems (2000). As an ecological perspective incorporates economic and political systems, socialization processes, and social problems related to individual functioning, applying it to the macro or individual level of mental health problems will expand the practice of psychology with more focus personal and cultural identity (Cuellar, 2000).

In chapter 13 of *The Handbook of The Sociology of Mental Health*, Brown, Donato, Laske, and Duncan (2013) reveal how individuals may differentially welcome their ethnic heritage in The United States. For example, among whites, ethnic groups such as Germans, Italians, Irish, have increasingly shared US influences on culture. Also, African Americans and whites living in the South share a Southern cultural influence despite their differences (Brown et al., 2013). Brown explains that ethnic groups within racial groups have a culture as well. Examples given are Somalians, Jamaicans, and African Americans; all three ethnic groups are distinct, but are referred to as black. An approach to unwinding race, nativity, ethnicity, and cultural influences in hierarchal divisions is a necessity for researchers to understand their effects on mental health.

As individuals tend to feel stress regarding their role or status, mental health researchers point out the lack of attention towards stress experienced because of culture and its unique attributes to the psyche. Brown et al., like Cuellar (2000), emphasize cultural beliefs about causes of mental illness and treatment can influence the outcome in that treatment as well as the expression of symptoms. Clinicians may not always be familiar with symptoms unique to a culture. This could result in misdiagnosis. As mentioned, Castillo (1997) discusses culture bound syndromes and mental illness in nonindustrial societies, explaining how mental illnesses in such societies are structured by indigenous cultural schemas and are at times, schemas of a culture. Only few of these culture-bound syndromes have been included in the DSM-IV. However, American culture-bound syndromes including anorexia, for example, are not. It is important to note that treatment for these nonwestern mental disorders do not require biomedical treatment yet according to Western standards, have demonstrated the capability of getting positive clinical results.

Brown et al. (2013) suggest sociologists of mental health embrace the chance to explore race, nativity, and cultural experiences more in depth as the United States is becoming more diverse as time goes on. Starting at the community level, multicultural aware individuals can take part in creatively and culturally appropriately breaking the silence. suggests sociologists of mental health embrace the chance to explore race, nativity, and cultural experiences more in depth as the United States is becoming more diverse as time goes on. It is predicted that by 2050, non-white groups will comprise 47.2% of the US population (Brown et al., 2013). It is time, according to Brown, to adjust to the “sociology of health’s research paradigm” to raise questions regarding diversity as the continued neglect of this will only cripple any valid studies in difference and inequality.

Race and ethnicity, discussed as socially created classifications in chapter 11 of the *Handbook of the Sociology of Mental Health* (2013), represent nationalism, colonialism, imperialism, and racism (Muntaner, Ng, Vanroelen, Christ & Eaton, 2013). In compliance with the Karlsen and Nazroo’s (2002) notion that race and ethnicity reflect the relation of individual identity to social structure and how they both influence one’s means of obtaining resources, Muntaner et al. list examples of these types of associations affect mental health. For example, African Americans are overrepresented in lower socioeconomic statuses because years of racism and discrimination have rejected the necessary opportunities necessary for mobility. Alas, racial minorities are more susceptible to mental disorder because they are more likely to not have access to adequate materials.

To understand the complicatedness of social inequality in terms of race and ethnicity, it is best to simultaneously test these factors for interactions (Muntaner et al., 2013). Almeida-Filho, Lessa, Magalhães, Araújo, Aquino, James, and Kawachi (2004) did so in a study on depressive

disorders in Uban Bahia, Brazil. A three-way interaction revealed that none of the racial/ethnic subgroups among upper middle class allowed a significant gender effect (which will be further discussed), women were more depressed in all racial/ethnic subgroups, and poor, working class black women were nine times more likely to be depressed than the men in the same social class. These findings clearly state the complexity in understanding mental health outcomes in terms of structural systems of stratification and inequality.

What Muntaner et al. (2013) seem to suggest is that the degree to which social inequality is experienced is a function of individual attributes one's culture may have shaped as well as social relations that constrain as well as regulate obtaining and distribution of resources. Social Stratification and social class complement one another and what remains usual in mental health and sociology because of the issue they confront, strength in theory, and the thoughts and work generated to date.

As this section has emphasized the importance of acknowledging the individual who experiences life culturally, steering clear of category mistakes, casual occurrence, and the stigma attached to mental health disorder, it consists of the research I began to form my research questions on. Brown et al. (2013) have encouraged the therapists understanding of symptoms, rules, and stressors unique to culture (and subcultures such as gender). As cultural meaning systems can victimize the individual, it is necessary for the clinician to understand the individual in terms of dissonance; expectations they have of themselves compared to their reality. It is crucial to the effectiveness of therapy to understand why this patient feels oppressed/not oppressed? Why does this patient feel/not feel like a victim? The answers to the questions may make more sense in the clinical setting if the patients connection to their culture and cultural background are also explored.

V. GENDER, CULTURE, & MENTAL HEALTH

Moving on from the emphasis on socioeconomic status, race, and ethnicity on mental health, understanding gender in terms of how men and women experience different types of psychiatric problems. Females are more likely to internalize depression and anxiety as white males tend to externalize aggression and antisocial traits. To understand men and mental health, studies primarily focus on mental health through paid work as men's work tends to involve a greater physical sense of risk as mental health of women is understood in work-life balance terms. As women are overrepresented in low paying occupations that offer little opportunity for advancement, the chance of psychological distress is likely. Women are more likely to take on household work, in addition all while having the least control over resources. Other common stressors among women themselves include being more likely to be a single parent leading to less access to resources, poorer mental health, and poorer mental health of her children (Muntaner et al., 2013).

In Cuellar and Paniagua's *Handbook of Multicultural Mental Health* (2007), gender is presented as "the first division of multicultural diversity" (Cuellar, 2007, p. 63) and works with culture to create cultural goals; knowledge of these goals is important in assessment and treatment of mental health issues with ethnic minority groups in terms of gender-role conflict and adjustment issues.

In the G. Canales chapter of the *Handbook of Multicultural Mental Health*, gender refers to the characteristics and behaviors that are typically accepted for one's sex; a social construct (Canales, 2000). Gender role, defined by O'neil (1990) is discussed as "behaviors, expectations, and role sets defined by society as masculine or feminine which are in the behavior of the individual man or woman and culturally regarded as appropriate to males or females." Gender-

role conflict occurs when negative effects on a person or other people occur as result of cultural rules learned during the process of learning to act in a socially acceptable manner. Canales illustrates gender-role conflict ethnic minorities experience at the subcultural level; as men or women who feel belonging to ethnic minority cultures (2000).

Expectations of the majority culture's gender role norms may bring upon gender-role conflict as the minority group adjusts to meet them. An engrossing example of this situation given in the text is what has been defined as "cool pose" (Majors & Billson, 1993). Since the days of slavery, oppression and discrimination towards black men has resulted in a rather defensive state of mind and way of life. This trait has been passed down from generation to generation as it has played a major role in surviving for centuries. Majors and Billson (1993) describe this as the façade used to hide true feelings of rage, fear and pain. Cool pose allows for the appearance of calm, detached, and dignity. This disguise however, has been studied (Bowman, 1992) and has the potential to reduce happiness in the home while family closeness and religion were found to be the resources that bring greater global family satisfaction (Canales, 2000).

Caretaking roles, gender-role conflict and stress maybe be typical of both majority and minority cultures but place higher degree of pressure to minority groups. Latinas face the pressures of being a "good girl" (Canales, 2000, p. 68) pressured to make motherhood the highest priority, live with parents until college or marriage, protect one's virginity, act like a "lady", and care for the children and elderly. This discourages these females from playing sports, being too loud, taking advantage of opportunities to be independent, and pressures the Latina into marriage to leave her childhood home guilt free, or find work outside of the home, as a mother.

Culture and gender together affect beliefs and behaviors groups endure. Respecting cultural rules is a necessity in assessing and effectively treating adjustment disorder with racial/ethnic groups. These beliefs stem from history of their political, economic, and social relationships with majority culture (Canales, 2000). Despite the diversity of those histories and relationships between minority cultures, it is important for therapists to know the value of extended family, interdependence, and religion in the lives of these groups while in the therapeutic setting in-order to embellish the client-therapist interaction and mental health outcome. Once these values are established, the therapist and the individual can explore how the values fit in to the individual's reality, and perhaps begin to work through any dissonance.

VI. AGE, CULTURE, & MENTAL HEALTH

Age also plays a role in the perception of mental health among cultures. Elderly, minority adults are a challenge in mental health care. As limited healthcare continues to be an issue in the United States, the need for suitable treatment and services are being researched. Not only must one's gender, social class, and race/ethnicity be considered in this treatment, but the factors that affect discrepancies among ethnicities and cultures, but also how aging takes part in that (Cuellar, 2007). In a 2013 study on ethnically diverse older adults in primary care Jimenez, Bartels, Cardenas, Daliwal, and Alegria (2013) attribute cultural influences on mental health to recognize the relationship between race/ethnicity and differences in beliefs on what causes mental illness, what treatments are preferred, and what the characteristics are of the provider. In a randomized trial known as The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E), two interventions were compared. First, an integrated model which provided mental health/substance services in the primary clinic by a mental health provider and

second, an enhanced referral model which provided those services in a separate, specialty mental health clinic. 2,244 patients tested positive for either depression, anxiety, or at-risk alcohol consumption, agreed to participate, and completed baseline interviews on cultural attitudes towards mental illness as well as completed questionnaires on stigma and cultural beliefs. This sample consisted of 1257 non-Latino Whites, 536 African Americans, 112 Asian Americans, and 303 Latinos and studies were conducted in native languages for those who did not speak English.

Using ANOVA, results confirmed that race/ethnicity among the elderly take part in feelings towards roles of health care providers in decision making regarding mental health treatment and characteristics of providers. African Americans viewed loss of loved ones and general and financial stress as immediate causes of mental illness and rely the care for that from the extended family. Although willing to speak with family and mental health professionals, African American elderly. This mistrust has been previously associated with perceived mistreatment, racism, stereotyping, and bias by mental health professionals (Jimenez et al., 2013).

Asian Americans believe that mental illness is caused by medical conditions, cultural differences, and family issues. In Canales's (2000) work on gender and minorities, it was revealed that Chinese Americans value the suppression of emotion which corresponds with Canales's work on gender and minority groups which highlights the Chinese traditional value of suppressing emotion. It is possible that Asian Americans do not wish to speak to anyone about mental health because of the value of social harmony and not disturbing their social network (Jimenez et al., 2013).

Latinos articulate the belief that mental illness is caused by loss of family, familial issues, and moving to a new place. Migration eventually changes traditional family systems as it alters

individual feelings, behaviors, and values (Jimenez, 2013). Latinos who were willing to fully participate in the study report willingness to speak to a psychologist and use medication which contrasts with prior research revealing the mistrust of mental health care professionals and psychotropic medications (Jimenez et al., 2013). The authors emphasize that these participants may not be representative of older patients who are unwilling mental to receive mental health services.

In this work, it is advised to review results with caution however, what can be taken from it is the insight that will inspire future research on how to address older patients with mental illness. It is indicated that diversity in health beliefs may require an understanding of why those beliefs, cultural rules exist. In honor of minority patients who feel belonging to groups known for having underutilized health services, Jimenez et al. predict not taking cultural values into account will perpetuate pre-existing mental health illnesses among racial/ethnic minority groups entering care facilities (2013).

Culture and age have some part in the perception and treatment of mental illness in the United States. What is not as clear in this research is what the distinct heritages are of the Asian, Hispanic, non-Latino whites, African-American, Native American, and Latino participants, and how in touch with their cultural roots they are, or which generation American the participants are. Older adults who have not fully acculturated to modern, American methods are more likely to remain part of the mental health illness epidemic in the country. Treating the elderly as elderly rather than who they are as individuals who have experienced life culturally will hinder the clinicians learning process of how to give more effective treatment.

VII. RELIGION, CULTURE, & MENTAL HEALTH

In K. Loewenthal's *Religion, Culture and Mental Health* (2007), some interesting questions are raised concerning the relations between culture, religion, and mental health. By considering disciplines in social and cultural psychology along with psychiatry, Loewenthal attempts to answer these questions by merging the material accordingly. Does religion cause, exacerbate or relieve mental disorder? And what role is played by cultural factors in the relation between mental health and religion? Are religion's roles in mental health similar in every culture? Do culturally carried religious beliefs and practices about illnesses and cures help, hinder or have no effect? (Loewenthal, 2007).

Loewenthal discusses four ways in which religion issues might be important to schizophrenia. I chose to explore this mental illness as it is a debilitating disease we as Americans see on the streets as well as in our homes and am interested in how approaching treatment for it in a culturally sensitive manner may improve chances of positive mental health outcome.

First, Loewenthal explores visions, voices, and delusions as symptoms of schizophrenia or as enlightenment. Loewenthal disagrees with these always indicating schizophrenia. Religious experiences share some characteristics with those that are psychotic (Loewenthal, 2007). People in the U.S. who claim to have visions of their recently deceased loved ones, perhaps on their way to the afterlife or somewhere in between, hearing them say goodnight one last time before they vanish into thin air are considered experiencing bereavement despite those same symptoms being positive signs of schizophrenia. In the section on schizophrenia, it is suggested that religion precipitates mania (bereavement in this case) rather than schizophrenia and that it is uncertain whether "insane" people were already in a susceptible state. Therefore, Loewenthal explores the notion of religious experiences as what bring mental illness to a peak. The Jerusalem syndrome

(Loewenthal, 2007) for example, occurring often with a devout Christian who has visions and dreams of traveling to Jerusalem, has led to the argument of it being an actual psychotic syndrome that includes a brief psychotic episode or a sign that psychotic illness is present. It is brought to a head by being in the place believed to be the holiest of all places.

It has been argued that some religious experiences and practices may be implicated in mood disorders. Burgha, (2002) after examining religious histories of first-onset schizophrenia in London, found that a high portion of these individuals switched religions and felt the desire to become more engaged in religion. This was true only for the ethnic minority patients. What Burgha took from this is that one's self-concept, self-esteem and self-acceptance are integral to the structuring of one's personal beliefs along with accepting or rejecting them. He suggests that being a minority in some way will likely lead to emotional or psychological disarray due to the disempowerment that goes along with discrimination. In turn, the need to self-improve may be satisfied by turning to religion which may offer a chance to feel a sense of rebirth.

As for the issue of the high incidence of Afro-Caribbean Schizophrenia in the UK and USA compared to other cultures, and to the incidence in West Indies and Africa, Loewenthal (2007) discusses two possibilities that may account for this. Importantly, religious beliefs and behaviors or culture-bound syndromes might be recognized as schizophrenia. Second, stress levels for Afro-Caribbeans in UK and USA are likely to cause schizophrenic breakdown.

Genetic predisposition may be a factor in the explanation of Afro-Caribbean schizophrenia, however, Sugarman & Crawford (1994) concluded that stress factors are most likely responsible. What this suggests is that stress leads to culture-specific disorder for Afro-Caribbeans perhaps due to social and economic status (Loewenthal, 2007).

The Process Evaluation Model (Butter & Pargament, 2003) predicts that general evaluation as well as religious evaluation of how helpful or harmful a religion depends on integration of the social system and religious means of coping (Loewenthal, 2007). Butter and Pargament's stance on religion is that there are no methods of religious coping that are positively correlated with positive outcomes where mental health is concerned. In their 2003 study, they defined three forms of poorly integrated coping. The "wrong road" where religious coping is inappropriate. For example, relying on faith alone to cure illness. The "wrong direction" involves religious coping directed towards poor integration. An example of this would be abandoning family and commitments to serve God. The "against the wind" form involves poor integration of goals for coping. This may take place when it is advised to stay in a situation because leaving it would be a sin. Integration in the case of religion and divorce should involve learning to accept that divorce is the most realistic option. Clinicians and clergy involved in the 2003 study distinguished the well-integrated from poorly-integrated coping which did not differ from each other in terms of religious or general methods suggesting judgements of both types of coping are just as good as each other's. Further, both groups were equally able to recognize religious red flags (Loewenthal, 2007).

What can be taken from Loewenthal's research thus far that is certain religions may contribute to culture specific disorders, more likely among minority groups. This research helped me connect the anthropological, sociological, and ecological works to my interests within the Irish culture. Researchers working with Irish American patients must take into consideration the long lasting acculturative stress the Irish Catholics experienced in a time of English Protestant rule. Besides the devastation of imperialism on the Emerald Isle, investigation of Irish Catholic guilt and tendency to go against the wind to avoid sinning would benefit the client-therapist

relationship. Understanding the personality differences between the older and younger Irish/Irish-American Catholic family members may help disclose feelings of guilt, anomie, and general emotion in the therapeutic setting.

VIII. CULTURE, DEPRESSION & ANXIETY

Moving on from Schizophrenia, Loewenthal discusses how religion plays a role in depression and anxiety. Religious coping beliefs and gender are two types of issues in the relation between religion, culture and depression. Loewenthal explains how religious factors have positive and negative effects on mood, possibly mood disorders by identifying two factors: social structures of religious groups and cognition.

Religious groups may satisfy the need to be social and involve rules that ultimately reduce the risk of becoming depressed (Loewenthal, 2007). It was noted that stressors such as divorce were linked to depression and were less likely in religious groups (Loewenthal, 2007). Kindness and social support are important in treating depression (Brown & Harris, 1978, Loewenthal, 1995, Leff, 2001) though it must be appropriate and may not be enough (Loewenthal, 2007).

Cognitive factors including religious beliefs can be used in coping with stress. These thoughts may be automatic, summoned from the pre-conscious collection of thoughts, or searched for, found and developed to meet the needs of the troubling situation which may or may not be helpful.

Religion can impact depression in both direct and indirect ways. A positive relationship with one's God and positive coping are associated with better mental health outcomes than "religious red flags" such as a belief in punishment. "Happy people may be less likely to suffer from depression" (Loewenthal, 2007, p. 73). In Chapter 5, Loewenthal discusses how religious

factors may reduce anxiety by offering spiritual or social support, or create anxiety of failure to carry out religious duty. Individuals suffering from distress may feel anxious and turn to religion for relief which would indicate a positive association between anxiety and religion. Religious coping can provide a sense of relief, however, leading to a negative association. In a study involving nearly a thousand adults by Luyten, Corveleyn & Fontaine (1998), it was implied that religious people may have guilt but this is not the cause of anxiety or other measures of mental illness, and was even related to empathy, a positive measure. It was also considered that religion may bring effects of shame to attention. Chinese victory of Korean soldiers along with the capturing and rape of Korean women and girls interfered with the association of Taoism and a shift towards individual success as a source of family honor. The defeat of these soldiers, women and girls lead to the choosing death and refusing contact with family to avoid the feelings of shame associated with failing to succeed. This failure would act as a bad omen for the failure of their entire families (Loewenthal, 2007). More recent study of this idea by Sica, Novara, and Sanavio (2002), involved three groups of Italians, high, medium and low in religious commitment. The highly religious group scored higher on obsessionality, overimportance of thoughts, control of thoughts, perfectionism and responsibility. This links to Lewis's conclusion (1998) that religion is associated with high levels of obsessive personality traits but not symptoms. This suggests religion may affect one's guilt associated with it but not to a point where the guilt effects behavior. The stereotype of the mental health of the religious is not entirely negative.

Loewenthal concludes that regarding religion, culture, and anxiety, some beliefs have calming effects. Shame has implications for psychopathology and is very important to some religious-cultural groups while there is still a need for more knowledge about whether and the

ways shame is related to religion, religion arouses guilt related to that which may influence the family's, community's and mental health providers in their interpretation of religious people's behavior as they are more likely to be thought of as suffering from psychosis than those who are less religiously active. With this noted, it would be helpful to understand religion in the Republic of Ireland and its history. What did and what does it mean to be an Irish Roman Catholic? Are there variances in the faithfulness between the generations? What is the relationship between older, Irish, Catholic adults and young, Irish Catholics, and how do these generations of Catholics view the very religious or even the mentally ill? Establishing the importance of religion and faithfulness in the lives of the young and the older Irish-American family members could help explain the existence of possible intergenerational, cultural barriers ailing family well-being. The possible predisposition of depression must also be examined in the process of treating Irish-Americans. The aftermath of hardship on an entire culture's psyche could have had detrimental effects on the ways the Irish viewed their own existence, their relationships with God, family members, friends, neighbors, and colleagues that have lasted throughout generations.

IX. CULTURE, ALCOHOL & SUBSTANCE ABUSE

In the *Handbook of Cultural Society* (Tseng, 2001), Alcoholism, a disease that effects the lives of over 15 million people and their families in the United States is discussed in a way that revolves around one's culture; it is explained that sociocultural dimensions cannot be ignored (Tseng, 2001). Dependence on alcohol may be a biologically related experience. However, social and cultural factors may play roles in the extensiveness of abuse. Alcohol has been consumed by humans for centuries, accepted into daily lives, associated with religion, ethnicity, and cultural

backgrounds in diverse ways. The anthropological view of the rate of alcoholism is distinguished by four different attitudes across cultural groups. **Complete abstinence** takes the view that it is wrong to take in alcohol or chemical substances as they will influence one's soul. This view is quite common for Muslims. A **ritual attitude** describes the case in which alcohol may only be used during religious ceremonies. To drink is considered a sacred ritual act of communion with sacred powers; common among Orthodox Jews. A **convivial** or "social" attitude, common of Americans, is symbolic of a social, emotional release to ensure social ease and positive attitude. A **utilitarian** attitude involves the medicinal use of alcohol, along with the intention to increase interest in the self. Known as solitary drinking, this way is often used as a way of coping with maladjustment. Drinking patterns also vary culturally. The amount of alcohol consumed among societies is associated with attitude towards drinking. Religious beliefs, again, like those of Muslims and Orthodox Jews, strictly prohibit taking a drink. The amount of alcohol consumed must be examined in terms of gender, age as these differences socially defined roles of men and women across cultures take part in that. In Euro-American, equal societies, female alcoholism tends to be less prevalent where in societies such as Muslim and Asian where women are expected to take on a conservative role, the degree of alcohol consumption among men and women varies greatly.

In the United States, patterns of life-long alcoholism among various ethnicities were suggested in a 1991 study (Tseng, 2001). Age groups subdivided into young adults (18-29), adults (30-44), middle aged adults (45-64) and aged adults (65+) it was found that the lifetime rates (by percentage) for the Caucasian-American male are high for young adults, but decrease with age. African American males start on a low scale for young adults, but drastically increase for adults and middle-aged adults. Hispanic-American males tend to consume a high amount of

alcohol which comes to a peak in adulthood, and decreases with age. Female rates, generally lower, also change over the lifespan, decreasing with age with exception of African-American females who begin to decline in prevalence rate as aged adults. Among African-Americans, both males and females consume the most alcohol during 45th and 64th years of life at 32.99% for males and 7.33% for females (Tseng, 2000).

Alcoholism is one social index of the condition of mental health. Tseng suggests the potential of regulating drinking problems through approaches that are social as well as cultural based on two common threads. One, culturally uprooted and economically challenged minority groups tend to reveal high prevalence rates of alcohol related problems which suggests that alcohol is a way to cope with stress. Second, drinking tends to increase as economic conditions improve. Although some societies tend to express a decrease in alcohol consumption after a peak of problems related to it, it is also clear in developed societies, drinking is being done more as time goes on which calls for attention as drinking leads to health complications. According to Tseng, very little attention has been given to the cultural perspectives in treating alcoholism. Now a world-wide practice, Alcoholics Anonymous is a United States born method of treating alcoholism that started in 1935 as a self-help program designed to help alcoholics become sober. By 1990, it had an estimated world-wide membership of two million. Throughout cultures, in AA meetings, the sociopsychological orientation including group confession and testimony are the foundation of practice. Social support and enforcement act as healing mechanisms. It is resorting to an alcohol-free life that feels normal that is the goal of this treatment (Tseng, 2001).

Abuse of a substance depends on availability of it as well as economic aspects, social control, and cultural attitudes. In Saudi Arabia, alcohol is forbidden, in Mormon culture, coffee;

heroin in the United States. Substances like these may take on meaning. Opium for example, was regarded as a symbol of national shame, a result of the Opium War.

Substance abuse in the United States increased around the era of the Vietnam War and the Hippie movement. Rebelling against conservative tradition, young people lived informal lifestyles, used marijuana, feared being drafted, protested the government. Along with these actions came a rise drug use. This included drug abuse of soldiers which led to an epidemic in the United States for over a decade upon their return (Tseng, 2001).

Tseng suggests that substance abuse must be understood as a disease that is attributed to social, cultural, psychological, and biological factors. These combined contribute to attitude towards and choice in whether to indulge as a means of coping with stress and social problems. Therapy for abusing substances as a means of relieving stress must be done so on a microscopic level (Tseng, 2001). This would ensure the individual and the group as well as the rehab program to take full part in mental health outcomes. With this, it is also integral to the healing process for the general population to have knowledge of the nature of sociocultural features and based on this information, create treatment policies and social prevention on a larger scale (Tseng, 2001).

Tseng discusses the limits and lack of systematic evaluation in the information available on this topic and lists descriptions of various communities. Among these communities, the factors that commonly affected practice included socioeconomic conditions including population size, food supply, health care provider availability, safety and stability of society. Political ideology and attitudes in autocratic political systems, under military dictatorship, in a government neglecting mental health needs of the community at large, the practice of psychotherapy becomes challenging. Medical systems, as they differ among various societies in terms of how it is characterized (primary or tertiary) and how that type of care is stressed, the ratio of caregivers to

population, how major or minor mental health disturbances are prioritized, how the society views capitalism vs. communism. Psychiatric orientation may be biological as it was in China in the past or professional as it is in Japan and Germany where psychotherapy is not strongly emphasized (Tseng, 2001).

In the United States, psychotherapy is the current most used method of service as it was tailored toward changes in psychiatry over half a century ago (Tseng, 2001). Laymen's perception and familiarity with psychotherapy is also influential in its practice. People's general psychological structure and culture-shaped personality will be decisive factors in whether psychotherapy will be utilized as well. Philosophical orientation impacts the acceptance of psychotherapy in many cultures. For example, cultures who believe that their lives are in the hands of God may not be so motivated to speak to a therapist about how to self-improve.

The implication of religion of culture on the use of substances here support the notion of culture and mental illness being embedded. In Tseng's (2001) work, little attention was given to the Irish despite the popular stereotype of the Irish having such a high tolerance for alcohol. Do the Irish put their lives in the hands of God? It is important the attitude taken towards drinking in Ireland is understood, along with how alcoholism is defined by the culture. The relationship between recognizing the abuse of alcohol and how to be healed in Irish families should be investigated. It may benefit the therapist to bring up the subject of alcohol and substance abuse in session to become familiar with the Irish patient's stance on and experience with the use of altering substances.

X. IRISH CULTURE AND MENTAL HEALTH

I'd like to now shift focus from my general findings on various cultures and aspects of mental health to a narrow one. I chose to research Irish culture, the Irish American individual, and how religion, spirituality, socialization, age, and gender shape the Irish heritage. I came to this decision for two reasons. One, because of my own heritage and curiosity about my Irish relatives, two, because of the percentage of Irish Americans living in the United States.

According to the United States Census, as of 2013, 34.5 million Americans list their heritage as Irish or partially Irish. That number is seven times larger than the entire Irish population (United States Census, 2013). What I found most intriguing about this is that based on my experience as someone with close relatives still living in Ireland, is how profound this statistic may be on Americans as the Irish are known to be loyal to old traditions (McGoldrick, 1996). I asked myself, "What does this mean for Americans?" "What does this mean for Irish immigrants and their children?" "What about Immigrants and their American born children?" I feel it is important to understand how to help the Irish as Irish, not just Caucasian-Americans when depression, anxiety, alcohol and substance abuse, and other mental illnesses such as schizophrenia for example, are being treated. The therapist must be aware of religious and spiritual beliefs as well as the possible reasons families hold on to traditions that may seem to be a hinder to positive well-being.

As I researched, I was surprised by how little information on Irish culture I found in the literature. Perhaps this is because I have lived to witness from my own home how very different the Irish and the Americans really are yet at the same time, are very similar when it comes to stigmatizing mental health disorder, particularly among the older generations. I will be discussing the ways Irish men, women, children and American men, women, and children differ in how emotions are expressed and what that means for Irish-American families. In line with

Satcher's (2000) and Sam and Moriera's (2012) arguments that the mind and body are inseparable just as culture and mental health are mutually embedded, this section will highlight the anthropology of Irish religion and spirituality, the sociology of Irish child rearing, gender, economic status, and mental illness, and the ecological view of Irish-American acculturation. I will be turning to depression, anxiety, alcohol and substance abuse, and schizophrenia, as I have previously, to portray these phenomena as I believe intergenerational and cultural barriers within the Irish-American family are the starting point of mental illness and negative well-being.

Two pieces of literature that acted as guides throughout my work on this section are *Saints, Scholars, and Schizophrenics* (Scheper-Hughes, 2001) and *Ethnicity and Family Therapy* (McGoldrick, Giordano & Pierce, 2005). In the Scheper-Hughes study on a small village in the West of Ireland "Ballybran" located on the Dingle Peninsula in County Kerry, the Republic of Ireland comes to life on paper.

Scheper-Hughes is an anthropologist which she describes as the product of a historical tradition and a moral commitment dedicated to seeing the bright side in every culture. She is partial to insights of Michael Foucault who has suggested that madness should be viewed as a "projection of cultural themes" (Scheper-Hughes, 2001, p. 73). With that said, Scheper-Hughes discusses the history of Ireland as a mold of a traditional culture. She explains that the history and present-day ecological experiences within family and community survival strategies are the result of English colonization and the economic and cultural submission to Great Britain. Overcoming starvation, its physical and emotional distress by drinking potato vodka, or to bring light to dark times by telling stories, reciting poems, singing songs and cracking jokes are the survival strategies that may have saved the Irish at one time, however, by now, have those strategies taught the Irish to live in denial of reality and to use humor and wit as a crutch when

faced with emotional challenges? Has a historical dependence on alcohol become embedded into the minds and bodies of the Irish today? These are the questions I have regarding these experiences as the root of the projection of Irish cultural themes and Irish mental illness. I am interested in how these strategies affected family life.

In one of Scheper-Hughes's weekly visits to mental hospitals, an Irish psychiatrist and director in County Cork summed up the general psychological problems he treated in his clinical practice including greed, envy, bitterness, frustration (including sexual), guilt, hatred, anger, a feeling of a lack of love often associated with a fear of love, fear of loss, high expectancy of and resignation to loss, with consequent fear and avoidance of tenderness and intimacy (Scheper-Hughes, 2001). Scheper-Hughes calls this state the "Irish Personality" (Scheper-Hughes, 2001, p. 203) which she believes the predisposition for is an unsatisfactory relationship to the first love object- the mother (which will be discussed further).

I'd like to discuss Rural, Irish socialization; the process through which children learn their cultures and the values, cognitive orientations, and rules for behavior associated with that. The author refers to Abram Kardiner's (1939) formulation of the **Basic Personality Structure**: the group of psychic and behavioral characteristics derived from contact with the same cultural institutions. How Scheper-Hughes gives meaning to this is by explaining that "like breeds like" and it was presumed that being exposed to similar culture would bring like personalities into existence (Scheper-Hughes, 2001, p. 225). With this notion in mind, Scheper-Hughes explored mental health in western Ireland in the context of shared experiences of social stress caused by cultural destruction, a decline in economy, and social confinement and the effects of these downfalls in parenting. Like John Bowlby, the author believes the very young infant's attachment to the mother is based on this instinct to be attached to another being (Scheper-

Hughes, 2001). Farming mothers and the division of labor in understaffed farm households are described as values to take pride in. Mothers who must work to complete agricultural tasks to make ends meet along with her household labor were more respected than those who took on the low-status work of child rearing (Scheper-Hughes, 2001). Breastfeeding and lullabies (even in the 1970's when the first edition of the book was released), a thing of the past, once provided time for physical closeness but as women took on more responsibility, were viewed as things that made children weak and overdependent on their mother (Scheper-Hughes, 2001). The Irish father is socialized to feel "inadequate and clumsy" around infants and the children are considered their mother's property until they are 4 or 5 years old (Scheper-Hughes, 2001). However, the author recites a fascinating folktale. After a mother shushes her husband for his concern for the crying baby, telling him the baby will simply cry himself to sleep, the father gets up to find the mother had no milk ready for the child, and after he made his walk back from getting some water from the well, fell dead. The moral of this story, women must always have water in the house, is interesting as it is the father who seems to be "maternal". This is a theme that the author found to occur regularly in patient's responses about their lives, in histories of the young villagers, as well the histories of their elders (Scheper-Hughes, 2001).

Child rearing in Western Ireland may be viewed as a reflection of the culture of religion. According to the author, the school of thought that dominates the rural Irish church has been considered monastic, ascetic, Augustinian, Jansenist, and puritanical (Scheper-Hughes, 2001). The emphasis of guilt, sin, and the natural weakness of humans, the need for purification, self-mortification, a distrust of reason, fear of sexual intimacy, and high regard for fasting and abstaining from sex are all characteristic of the Irish countryman in the literature. The moral education of the infant (Scheper-Hughes, 2001) begins at a very young age. The young child

learns he was born into original sin and possesses a tendency to do evil. These children are taught to control their bodies urges as well as the urges of their soul which include passions of greed, sloth, gluttony, anger, jealousy, and hate which baptism at birth will only reduce, not destroy. The devout, religious Irish mother ignores her infant's desires to be rocked and to suckle as these are unnecessary demands which will only contribute the child's self-indulgence. This concept is quite the opposite of the view the author takes in agreement with Bolby (1969, 1973), Harlow and Harlow (1958, 1965) that the infants and mothers need to be close to one another is natural and healthy.

Corporal Punishment was used both sexes and all age groups in the home and in school. Traditionalist parents explained to the author that beatings were the most effective form of discipline, best used in toddlerhood prior to stages of reasoning. Older residents of Ballybran reported broken spirits and fear of trying anything new when discussing the subject of corporal punishment. If home and school were housing for the encouragement of violence, this means children learned to be cruel to those who were who were not as strong, knowledgeable, or were more vulnerable as they were (Scheper-Hughes, 2001). It is this sort of learning that affects the generations to come.

I believe fear of intimacy, expressing feelings, and a lack in communication result from this upbringing which extends beyond family dynamics, into the relationships between friends, neighbors, colleagues, co-workers, men, women, husbands, and wives which Scheper-Hughes discusses in text. Feelings are then silently felt which is why I am so motivated to write this thesis as I can vouch for the truth in it. The author refers to what Erik Erikson's notion of basic trust in terms the lack of it in Irish relationships along with the caution of human nature. A villager explained his way to succeed in relationships: "Be courteous to all, have few friends, and

trust no one” (villager, p. 205). After the break-up of what the author believed to be a happy couple, a young village girl replied to her with “I guess we just talked ourselves out” (villager, p. 205). Trouble communicating, due to fear of intimacy or rejection may be the product of religion and its part in the socialization of boys and girls who apply the harsh lessons of an Irish Catholic upbringing into their everyday lives. Without the outward expression of emotion, the Irish tend to live in a “commonsense world” (Scheper-Hughes, xvii, 2001). The Ballybran double bind, common in the relationships between Irish boys and men, is the tendency to insult one another just to have a craic (or have some fun). It is considered weak for Irish males to reveal affection much like the American black men discussed in *Cool Pose* (Majors & Billson, 1993). A villager was teased for kissing his mother before he went to bed at night. When the villager denied this, he was teased for not kissing his mother before he went to bed at night. Not only in families does this double binding occur, but in social situations as well. During adolescence, the peak of Irish male double-binding, a time when the young male is sorting his identity and relationships, the consequences can be dramatic. Schizophrenia has even been linked to this shenanigan (Scheper-Hughes, 2001).

Irish masculinity and the double bind, following traditions of Irish-Catholic child rearing, and the division of labor for Irish mothers seem to result in fear of intimacy, shame and guilt, trouble with expression of emotion, and communication problems. Applying the work of Loewenthal on religion, culture, and mental health to Irish Catholic socialization, it becomes clear that the Irish may have the tendency to experience mental health disorders such as depression, anxiety, and schizophrenia.

Recently, depression has become the symptom commonly expressed by Irish young adults, also by young adults in the United States. Over the past twenty years, the stigma attached to

depression and suicide has been somewhat lifted and the rate of suicide has gone up from 2.2 to 28.6 percent for males, and from 2.3 to 29.9 percent for females (Scheper-Hughes, 2001). The Catholic church being involved in sexual scandals and the decline in religious practice correlate with one another in a meaningful manner. Without the strong influence of the church or a little voice telling depressed individuals that suicide is an unforgivable, mortal sin, Scheper- Hughes (2001) explains that young Irish men have allowed themselves to contemplate suicide as an acceptable problem solver for personal dilemma. This solution will only continue to be less of a heavy spiritual burden on the next generation according to the author (Scepher-Hughes, 2001). In this book, anxiety in Ireland is not given much space. What is mentioned about it is that “The composite picture for the Irish is one of tension, anxiety, and disequilibrium and this profile is intensified for the western region, where the highest rates for hospitalized alcoholism and mental illness originate” (Scheper-Hughes, 2001, p. 127). Also, it is mentioned how women in Ireland who claim to suffer from feeling overwhelmed or very nervous have been considered neurotic or hypochondriacs in the village. The village dispensary doctor would prescribe visits with neighbors and mild tranquilizers (Scheper-Hughes, 2001). Pregnant women who showed symptoms of anxiety and depression were taunted with making their unborn baby mentally retarded or insane.

Depression and anxiety play their parts in the anomie of the Ballybran villagers (Scheper-Hughes, 2001). The term anomie, meaning disintegration not of society as it used by Durkheim (Bessa, 2012), but of one’s self-esteem in Scheper-Hughes’ (2001) work, is applied to the section concerning Irish alcohol abuse and its negative effects on mental health. The role Gender has played in consumption of alcohol over the past decades and even now in agricultural areas of Ireland attributes to the variance in depression rates between men and women which could

contribute to the higher male suicide rate previously mentioned. The Ballybran males tend to sense anomie regarding life and farm work. Men do not wish to be home during the winter, as their wives remind them they have nothing to do. Village men who are expected to “shun the sick role” (including mentally ill) (Scheper-Hughes, 2001) take up the seats in the pubs in Ireland, which act as clubs, places of belonging for the men they cater to. Winter drinking patterns in Ireland leave the Irishman hospitalized for alcoholism twelve more times than the Englishman (Cooney, 1971, p. 123). It is the aged who make up the most depressed group of villagers, the widows, widowers, bachelors and spinsters who quietly drink alone in the pubs as the young men congregate and talk sports or politics; who contemplate suicide and beg God to spare them another cold and lonely winter. Alcoholism, a form of depression, slows down of all mental and bodily activities is an extremely common condition in the rural Irish population and is almost endemic among middle aged women in Ballybran (15% of whom have at one time sought to seek treatment for their problem) (Scheper-Hughes, 2001). What the author reports as a suicidal aspect of rural Irish anomie, is the absence of marriages not being replaced by death and emigration, or plan for a positive demographic result (Scheper-Hughes, 2001).

Scheper-Hughes also explores schizophrenia with an anthropological lens. Schizophrenia is the illness of 50.1% of psychiatric patients in the original edition; a time when married women in the United States were most likely to be diagnosed with the disease, Irish bachelors were most prone to it (Scheper-Hughes, 2001). Most rural Irish believed that aged people who experienced their first diagnosed episodes opposed to those who have the experience in their twenties or thirties, develop schizophrenia as result of postponed adulthood and the resulting identity crisis of the Irish bachelor, as Irish males will often live with their parents, free of financial responsibilities well into their thirties (Scheper-Hughes, 2001).

Like in Lowenthal's work on religion, religious beliefs correlate with rate of mental illness. Irish Catholicism correlates with not only the making of a gender, child rearing, socialization, alcoholism and its effects, but on Schizophrenia as well. Looking beyond the west of the Republic, Scheper-Hughes reveals the higher rate of schizophrenia treatment in Northern Ireland for the Catholic minority than the Irish Protestants. Catholic men and women are admitted twice as often as Protestants for Schizophrenia (three times as often for Alcoholism) (Scheper-Hughes, 2001). In addition to Irish studies, Canadian studies have found that Canadian Roman Catholics of Irish descent have schizophrenia more frequently than non-Catholic British descendants (Scheper-Hughes, 2001).

Attitudes toward recognizing and treating mental illness in western, rural Ireland have been greatly influenced by ancient laws of Ireland, known as the Brehon Laws. These laws demarcated the "madman" ("lunatic") from the "fool" (Scheper-Hughes, 2001, p. 153). The fool was viewed as a capable citizen as the madman was disjoined from the community, imprisoned or left to aimlessly wander the village, put to death if believed to be a violent threat. At the time of the author's research in the 1970's, it was suggested by the community that there was still a distinction between the fool and the lunatic, and believed the madness is effected by the phases of the moon. Fools include the mentally retarded, those who prefer their own company, and anyone who is unusual. What seemed to be considered abnormal for Irish villagers however, was also considered to be a normal part of everyday, village life as the tolerance for what was bizarre was quite high. "Just old Jack" would be used to describe an individual who behaved in a ludicrous way. Scheper-Hughes explains the individual's integration or lack of it, within a tight knit network determined how protected the individual was from the label of insane (Scheper-Hughes, 2001). The Irish belief in ancient myths may have a part in this protection of the

mentally ill, particularly for mentally ill family members. Family myths (a set of beliefs shared by all family members regarding each other and their unchallenged positions in the family despite reality), are commonly used. Schizophrenia and mental illness in this light is considered a social disease and a strategy for a troubled family. To explain this further, often a child will serve the family as the mentally ill scapegoat which places the disorder on him, releasing the family from the guilt of dysfunction (Scheper-Hughes, 2001). Of course, Schizophrenia is regarded as a medical condition; disease based. Scheper-Hughes brings to her readers attention, the interactionist perspective; a social process of the disease as one that culture and history, along with village and family dynamics, as well as the personal history of the individual provide the foundation to the Schizophrenics interpretation of their mental illness. Evoking factors in rural Ireland include traditional Irish family dynamics and their symptoms including the steady decline in marriage, birth rates, and the spread of consanguineal and independent nuclear households, poor communication with social networks, stress related to high social change, social disintegration, and death of culture due to rapid industrialization. Traditional areas such as the west of Ireland, stubborn to change, may have experienced feelings of internal disorganization that is known to manifest into symptoms of depression and anxiety or guilt (Scheper-Hughes, 2001). Scheper-Hughes explains that a predisposition to Schizophrenia may lead to more severe symptoms; hearing voices, hallucinations, feelings of persuasion. In non-western societies as we have learned from Loewenthal (2007), these symptoms are often viewed as positive, of prophets, shamans, medicine men. In European history, Catholic saints were given credibility for such symptoms, including Ireland's Saint Brendan (Scheper-Hughes, 2001). The author supports looking towards these individuals as valuable, like the Saints rather than locking them up may serve the community as these are the individuals who are quite in tune with the social problems

in their community. Scheper-Hughes reports witnessing “flashes of brilliant insight” (Scheper-Hughes, 2001, p. 302) on issues such as guilt from living by the rules of the Jansenist version of Irish Catholicism and sexual repression in Ireland, the scapegoating of children and lack of warmth of the mother towards her children since inventions such as the bottle cribs, or even central heat, the division of labor since the industrial revolution and how that as well began to change how a mother cared for her children, fear of further economic change, forced retirement and the death of meaning in tradition and traditional work. Scheper-Hughes forces the reader to imagine the lives of the Irish and how these sociocultural factors in mental illness are just as relevant as the biogenic and the psychodynamic, the individual’s family situations and patterns (Scheper-Hughes, 2001).

The 1970’s Irish clinic, a “cold, impersonal environment” (Scheper-Hughes, 2001, p. 163) offers drug therapy, modified shock therapy for depression and schizophrenia, social rehabilitation and inpatient employment and for “graduates”, jobs in the community are found. Scheper-Hughes reveals her thoughts on how an American psychiatrist would feel “struck” the lack of supporting personnel and therapies along with the lack of skill required of the few personnel employed. Catholic guilt of the psychiatric nurses in fear of disrespecting the doctor or of the patient opening-up to her and confessing sins enabled her to show compassion. Interestingly, despite the biases toward the biology of mental illnesses, it was believed that sexual repression and religious guilt contributed to the patient’s mental health conditions (Scheper-Hughes, 2001). The dependent and passive role in treatment encouraged the use of physical methods of cure. Families would rarely visit as the patients are then done away with once admitted into a mental hospital. Patients expressed their feelings of abandonment, or referred to themselves as the “dead” child (Scheper-Hughes, 2001).

The following information on mental health counseling in Ireland is based on the Irish O'Morain, McAuliffe, Conroy, Johnson, and Michel study (2012). Today, in the Republic of Ireland, mental illness and mental health care have become more accepted as the Catholic church plays less of a part in the younger generations lives, especially in sexuality. Prior to the acceptance of therapists providing counseling in Catholic Ireland, confession to the priest was the accepted form of counseling. As of 2012, Ireland has experienced much growth and the public has become positive regarding mental health counseling with the rise in secularization. Despite the lack of licensure, there are certified individuals attempting to provide qualified services in the Republic (O'Marin et al., 2012). Without third party payment however, it is problematic for the low-income families to receive care. At the time *Saints, Scholars, and Schizophrenics* was originally written, Ireland was paralleling some 1960's American approaches to mental health by confining mental illness in stigmatized, crowded and poorly funded mental hospitals (Scheper-Hughes, 2001). Towards the end of this decade, people's health and social needs became more recognized and the sexual scandals associated with the Catholic church lead the decline of the churches caliber. Marriage counseling in Catholic Ireland lead to the Protestant couples seeking help which eventually became a well-developed, non-denominational service which extended to the family. Those who provided this care became the independent counselors who helped to create the Irish Association for Counseling and Psychotherapy (IACP) which as of 2011, was the leading counseling organization in the country of Ireland. In the 1980's, career counseling, after its birth in the 1960's, was flourishing, preparing students to provide counseling outside of the church. At this point, counseling became a profession in its own right. The cases of sexual abuse by the 1990's lead to a deeper catastrophe of the church, a greater demand for mental health counseling which is now paid for

by the client with no reimbursement, unlike clients in the United States. This makes it difficult for the counselor to work full time, and for the person in need to be able to afford services.

Common Irish counseling services include a start with humanistic philosophy. This is correlative with conservative Irish values that past generations found to be challenged by modernization. This “person-centered” (or as Castillo would say, “client-centered”) therapy along with cognitive behavior therapy are the most widely accepted forms of mental health care in Ireland. The issue of substance abuse, (mainly alcohol abuse) is one that stands out in Irish therapy sessions, to this day. The Irish Association of Alcohol and Addiction Counsellors (IAAAC) as of 2011, had over 1,000 members. Counselors work with the public as team members and privately in private centers for addiction to assist the individuals who choose alcohol to deal with anxiety, anger, and depression. General mental health concerns and social issues are also the focus of many Irish counselors. It is suggested that aged Irish clients are less likely to confront personal issues compared with Americans and the younger generations of Irish who now have a new view on the usefulness and encouragement of negative feelings in achieving positive mental health. However, it is indicated that Irish clients will develop trust of a counselor at a slower rate than people in the U.S., so mental health counselors must be aware of the effort necessary in building rapport and trust and how comfortable the therapist is with the rate of that effort.

I looked further into Irish mental health care and explored the websites Mental Health America and Mental Health Ireland to compare. Some variance interested me. On the subject of self-help, lists were given to advise the readers. Number one on the American how-to self-help technique list is: “Work Toward Goals”; on the Irish list, “It’s not rocket science”. This is the “common sense world” view that Scheper-Hughes refers to (2001) while discussing her

experience working closely with rural Irish villagers over forty years ago. The Catholic church may longer be as strong and traditional a force in the lives of the Irish, young and aged, but, this “common sense world” way of life seems to remain an active part. It is this view that I feel takes away the validation of emotions and promotes the universalism that assumes we are all the same and emotionally, psychologically, and cognitively capable of the same. What I have found to be proof “the common-sense world” mentality is alive is right there on that self-help page and it is the Irish male who perpetually applies this way of thinking to life. This school of thought survives over space and time, emigration, and the generations.

In McGoldrick, Giordano, and Garcia-Preto’s *Ethnicity and Family Therapy* (2005), the Irish are portrayed much like they are in *Saints, Scholars, and Schizophrenics* in terms of how colonization, extreme poverty, mythology and religion, and economic change molded a culture. McGoldrick goes into detail about how these factors effected communication and conflict, use of humor and alcohol, family patterns in Ireland, and for Irish-American families in therapy.

McGoldrick writes about the paradoxes of the Irish; the pragmatic dreamers, the loyal yet fickle, the deniers yet fearers of shame. A culture of people who have given up a greater proportion (of single women and) immigrants to the United States than any other country in the world. Despite their power in numbers, Irish immigrants remained invisible to society at large (McGoldrick, 2005). In the United States, just as in Ireland, the Catholic Church was the primary unifier. Italians out the family first, Americans and the Irish put the church first. After the Vatican II brought the changes to the church that allowed Catholics to decide for themselves, the Irish experienced challenges coping with the associated guilt which McGoldrick explains as a prominent force in their anxiety about what others think of them. This anxiety effects their ways communication and handling of conflict. With the trouble of trusting the people around them,

McGoldrick explains the denial of this, the fantasy over the truth, a trait which was crucial to their survival for centuries as one that once saved them, but now harms them. Not being under the influence of alcohol and exploding in anger is considered toxic in the Irish household; wit, sarcasm, humor and emotional isolation, much like the isolation of their culture, is the true fight of the Irish (McGoldrick, 2005).

The ritual of alcohol use to achieve an altered state has been called “a good man’s weakness” (McGoldrick, 2005, p. 600). Once used to dull the pain of starvation, keep away a fever, keep out the cold, ease the grief, liven the party, cure a hangover, it has always been acceptable for the men to consume as much as they wanted, yet embarrassing the mothers to do so as they have had the responsibility to be the strength in the family. The alcoholic cycle in an Irish family may be in response to religion; guilt, shame, which allows for emotional contact without imposing on the distance maintained in the family. The Irish have been known to use the pub as a place to reveal inner thoughts to a drinking companion rather than a family member (McGoldrick, 2005).

Perhaps shame and fear of what a loved one would think of the family member showing weakness for having feelings is what keeps the Irishman in the pub with a companion rather than his family. Irish sense individual shame in such a way that makes them believe their pain is deserved. The myth of Irish badness, tied to the theme of original sin, engrains the belief that no matter how hard one strives to be good, they will forever fail as it is human nature to do evil and to sin (McGoldrick, 1996).

I found it interesting that McGoldrick revealed some test results on pain and ethnicity that is quite characteristic of my own Irish family, stating the Irish have a very high tolerance for it, and because of this, have trouble describing it. Therefore, the Irish will be much less likely to

seek medical help. This is the case even when they or their children need *medical* help; it is very difficult to communicate this which has negative effects on overall health as “the mind and body are inseparable” (Sathcher, 2000). Perhaps the Irishman is known for a heavy use of avoidance coping or denial of hardship. It would benefit the therapist to become familiar with McGoldrick’s position on Irish denial. “The Irish are not fond of the truth because they often fear it will reveal how bad they are” (McGoldrick, 1996). Using denial as a defense against the threat of starvation and death along with the burden of being born into original sin through the generations, has prohibited acceptance of what neighbors might perceive as disgraceful, what may reflect bad child rearing, or what would ignite a moment of weakness. This is often done with the help of alcohol, a means of reaching an altered state of consciousness which Tseng would describe as “utilitarian”, or “medicinal” (Tseng, 2001, p. 352). McGoldrick discusses the great impacts of alcohol use and the desire to experience alternate realities on the culture over time and how even the Irish families who do not indicate alcoholism being a problem should still be presented with the topic of heavy drinking to get a sense of how the individual (or family) tolerates heavy drinking as they tend to have “rigid emotional splits “between what is and is not acceptable behavior” (McGoldrick, 2005, p. 601). That said, the structure of Alcoholics Anonymous works very well with values of the Irish as it is spiritual and like the pub, social in nature, away from the family; AA is a place for sharing stories and feelings with a stranger opposed to family as discussed in *Saints, Scholars, and Schizophrenics* (Scheper-Hughes, 2001). In fact, in 1946, Ireland was the first European nation to accept the Message of Alcoholics Anonymous (www.aa.org).

Children are raised to be polite and respect their elders, regardless of any effects of alcoholism in the family, yet the bond between an Irish mother and her son will leave him

pampered and protected far longer than her daughter, or to be forever loyal to his mother than to his wife, as the daughter-in-law is expected to follow her demands (McGoldrick, 2008). Fathers were traditionally not at home very much, and dealt with the family by avoidance. In the United States, the Irish family began to strengthen however, as the fathers had more opportunities to work in the pubs, police work, and ultimately in politics after generations of men working on building bridges, roads, railroads, in factories, (as the women took domestic and servant jobs). The Irish father became the life of the party in America as he continued to be feared by his family (McGoldrick, 2008). The Irish mother who secretly held the reigns of the family, would never challenge her husband, was often tough on her children, refraining from praising her children in fear of swelling their heads (McGoldrick, 2008). The blame on the Irish mother for spoiling her sons that will never leave her, forcing her daughters to become cold, over-responsible, over-independent repeaters of cold child rearing may stem from the ancient roles of Irish women rulers combined with the 900-year history of Irish oppression which denied Irish men any sense of power who would turn to drink to alter the state of helplessness. Irish women struggled to keep their families alive and would turn to their sons to fulfill the purpose their drunken husbands were supposed to. Daughters learned to take care of the family in the home and to never ask for help. This signifies gender assumption as well as a culture-specific tendency to not articulate feelings and needs as it is assumed those who love you will know what you are feeling without a word spoken. Therapists from expressive cultures may experience some difficulty understanding the Irish patient and must be aware of what is really being said in the silence, here.

The Irish are likely to treat a session of therapy as a confession in which sins are confessed and forgiveness is desired. The basic belief that problems are private matters between the client

and God makes seeking help and self-assertion challenging. Therapy is an embarrassment and due to traditionally low expectations for happiness in life, a pessimistic view of change will more than likely be the case. The Irish believe in suffering alone, for sooner or later they will have no choice but to pay for their sins. A connection to the sentimental attachment to one's history in a genuine manner may benefit the therapeutic process. "Myth making is an ancient Irish industry in which legends and heroic tales of early and medieval Ireland are a characteristic product" (Moody, 1978). "The Fifth Province" model (McCarthy, Byrne, 2008) is a creative, merited way of treating Irish Americans (McGoldrick, 2005). This approach draws the attention away from clinical conversation and into "The Fifth Province", a place in Celtic mythology where contradictions can coexist. This province, a magic place of imagination and the containment of contradiction is where Celtic chieftains would come together to talk through their conflicts and resolve them through dialogue with help of druid priests. The documentation of the application of this approach describes the use of stories which offered metaphors, and Irish folklore as interventions to contradicting beliefs, narratives beyond logical discourse, and political metaphors of colonization as the framework for therapy, cautious of therapy itself becoming what "colonized" or oppressed the clients. If this alternative, story-telling like approach was is still not enjoyed by the Irish client, it may still be gratifying for the therapist to work with her due to the Irish sense of loyalty to the process. Like a priest, the therapist may become a figure of authority who is followed when she gives instructions. Despite the Irish patient's tendency to emotionally block and hesitance in giving feedback about the therapeutic progress from the family (when involved) the therapist may be surprised by the progress made in the end as result of what their deep sense of personal responsibility. The paradox of the Irish gift of gab and their inability to express their feelings may leave the therapist to question what exactly is troubling or

gratifying. Staying mindful of the respect the Irish have for personal boundaries, asking structured questions about assumed roles of men and women in the family with caution of making the client feel guilt, clear behavior modification plans, and using paradoxical and humorous techniques may be most effective along with finding ways to discuss the strengths of “being Irish” may be most effective when working with the Irish American patient.

In the *Handbook of Multicultural Mental Health* (Cuéllar, Paniagua, 2000), person-centered therapy is described as the turning point in the evolution of multicultural psychotherapy models. This type of model would be extremely useful when working with the Irish-American client while this type of approach is representative of an absolute, culture-centered view of the world that recognizes the crucial part culture plays in individuals as well as communities while not being restricted by culture-specific, universal references. The multi-cultural psychotherapist should strive to be a social engineer (Cuéllar & Panaguaia, 2000) in a transition toward an all-embracing, culture-centered society. The pioneers of community psychology have made contributions to the multicultural worldview who disclaimed the universal approach in psychology, and emphasized the importance of sociocultural factors, effects of minority status, and oppression on personality development. Although Irish Americans are part of the white, majority race, I believe the silent suffering of their culture enables the community to understand how Irish immigrants, their children, and even first generation Irish Americans are in many ways an American minority. Including this group in a multicultural worldview has the potential to enhance quality of lives, moving forward from traditional goals of helping individuals, toward helping individuals become participants and leaders in a pluralistic society. By combining the multicultural world view with community psychology, attention to family/intergroup relations, providing multicultural research studies in this area with the community in which data was

collected, and offering cost effective, culturally relevant activity, are small scale means of Irish American well-being.

An important part of the Irish American client achieving positive mental health, is for the multicultural psychotherapist to make use of assessment tools. For example, the measurement of with-in group variables acculturation status and acculturative stress as previously mentioned, allow the therapist to understand how individuals perceive themselves in relation to others in their daily lives which is information that can be applied to the development of a satisfying person-environment fit. Difficulty with acculturation may reveal itself in the Irish American family; generational barriers between Irish immigrant parents who were raised in a time of harsh childrearing and children who have started to rebel against the church along with cultural barriers between those Irish parents and their American children who are now exposed to children's rights and a Yankee tendency to smother children with affection. The encouragement of men to see their doctors on a regular basis and to care for their bodies as well as their psyches and for women to feel to care for their anxiety and depression with the help of therapist and medication should they choose, may also be stressors between the generations. I am most interested in Irish masculinity and fear the older generation may have of becoming emotionally expressive along with the younger generation's exposure and perhaps longing for more affection and/or sympathy from their fathers. This topic needs special attention in the United States. Living up to an Irish father's standards of "tough" not only becomes dangerous to his son's well-being as this involves the double-bind, but dangerous because these young sons may be left to wonder why their Irish fathers don't love them the way their friend's American fathers love them.

As community psychology studies the relationships of individuals to social environments (Nagayama-Hall, 2005) understanding Irish history and socialization tendencies is necessary in

examining the Irish individual and their immediate surroundings. Useful research questions may include how many Irish people live in this community, what is the economic status of this community, what extra-curricular activities are available and/or encouraged in this community, do you have to drive to these activities, how does this community view mental health and treatment, and most importantly, how do the individuals perceive themselves in the community?

As multicultural psychology has emphasized an internal perspective, community psychology focuses on a pluralistic one, combining paradigms developed in one context and applying them to others. What comes to mind here is “The Fifth Province” and another technique I learned about in the Cuellar (2000) handbook. Like the Irish, Puerto Rican clients and their families also benefit from the use folktales as a way for children to reduce anxiety, decrease aggression, and increase reading comprehension compared more traditional therapeutic methods. As we have learned from McCarthy and Byrne (2008), Irish mythology describes the fifth province in Ireland as a place where the four main provinces of the country would set aside their arms and seek counsel from the druids in the middle of the Island to resolve differences. Using this myth as a foundation for storytelling and role playing as a way of expressing one’s thoughts and feelings indirectly has had some success in Ireland. Perhaps if the United States, which numerically is dominated by Irish ancestry, incorporated opportunities for this type of alternative counseling in the Irish communities, specifically families encountering the generational and cultural barriers discussed throughout this section, will feel a sense of relief of tension, anxiety, aggression, and depression.

How does the claimed Irish ancestry in the United States contribute to the stigmatization of mental illness and treatment Satchel discusses? In the future, I would like to explore this and how the aged Irish Americans take part in that stigma versus the younger generation and first-

generation Americans. In addition, it would be useful to know what the relationships look like between those generations and in those families as a start to encouraging Irish Americans to understand each other and themselves in American society, along with the community to understand their silence, sarcasm, intolerance for weakness; the traits that continue to thrive throughout the generations, along with the co-dependence of mothers and sons, daughters who are overly independent, young men who have learned to turn to a drink when challenged just as his father did, and his grandfather did. How can the therapists, social workers, clinicians, teachers, and doctors spread their multicultural knowledge and research with the community, while encouraging accessible, culturally significant means of reducing symptoms of poor mental health like “The Fifth Province” method? Where would this take place? Who would act as “the druids” to provide counsel? Would they be compensated? It is important to remember the essence of Irish culture as it was the Irish who built many of our roads we travel today, ran households while earning a paycheck, and raising the children who grew to enforce the laws we follow to this day; most of who wouldn’t likely admit what they should be remembered for.

XI. A NARRATIVE

I must make it clear that I love my family with all my heart and without them, I would be a bit of a hermit. We certainly stick to our tribe because honestly and simply, we really do and see things differently. My brother and I were raised to do as we were told and to keep ourselves, occupied, away from the adults. We were never to speak of anything that happened in our house which didn’t become a challenge until we were old enough to understand a thing or two about how too much beer makes people act very different than they normally do. We were scolded for crying. Our friends would come over and my mother would occasionally get phone calls from

parents asking if there was anything they needed to know because their kids said they were a little scared at our house. As kids, my brother and I would get so defensive about this because nothing ever seemed out of the ordinary.

As the years went on and after some visits overseas, I knew my family was just a little different. The way they spoke, fought, their wit, how they'd say the cruelest things to each other, yet were always laughing. I didn't realize until I was in my early twenties that being in touch with my Irish-ness affected my life in so many ways. I was raised not only to keep family business just that but, to never depend on anyone, and that weak people did nothing for me. I had trouble keeping female friends and agreed to date any boys who seemed "soft." I would become distant and irritated when my girlfriends cried over losing a boyfriend. After chatting about life with someone from Ireland who had been living in the States for over twenty years, someone who was not part of my family, my eyes and ears perked. After some storytelling, a thing the Irish typically love to do, this person simply explained to me "you're an Irish woman, you're not supposed to be nice." This joke left me thinking about my entire family and marked a pivotal point in how I began to understand people on a much deeper level.

As the years went on and after some visits overseas, I knew my family was just a little different. The way they spoke, fought, their wit, how they'd say the cruelest things to each other, yet were always laughing. I didn't realize until I was in my early twenties that being in touch with my Irish-ness affected my life in so many ways. I was raised not only to keep family business just that but, to never depend on anyone, and that weak people did nothing for me. I had trouble keeping female friends and agreed to date any boys who seemed "soft." I would become distant and irritated when my girlfriends cried over losing a boyfriend. After chatting about life with someone from Ireland who had been living in the States for over twenty years, someone

who was not part of my family, my eyes and ears perked. After some storytelling, a thing the Irish typically love to do, this person simply explained to me “you’re an Irish woman, you’re not supposed to be nice.” This joke left me thinking about my entire family and marked a pivotal point in how I began to understand people on a much deeper level. This research reminds me of my family throughout its entirety. Cousin “L” is a thirty-five-year-old woman who suffers from being depressed after revealing her sexuality to her devout religious family. Her Irish elders first opposed her orientation and when “L” admitted she was then diagnosed with depression, her mother begged her not to tell anyone she was weak and depressed, and to pray harder so she could get closer to God so he could forgive her and grant her happiness.

I have also seen my uncles live with my Galway born grandmother until they were well into their thirties, just as my rural Irish father allows my brother; another reason I am encouraged to research. I live in fear for my brother’s future as his adolescent behavior as an adult has left him somewhat disabled. While his mental health is in decline after some severe motor vehicle accidents, my father denies the mental effects of his physical (brain) damage and blames my brother for acting like a child which appears to lead to negative affect. I can only hope the reason for what I suspect is denial is not the need for a family scapegoat (which I have wondered about in the past without tying Irish culture into my thoughts until doing this research).

A quote along that will remind me to explore the subject of alcohol with a patient (should I have the opportunity), comes from an Irish cousin of mine who once told me that the Irish aren’t drunks unless they beat their wives and children; otherwise, “you just drink like you breathe, you just do it” (P. Conneely, 2013). During my childhood years, drinking stout and whisky was what the adults did daily; in greater amounts when the family was altogether, which I began to realize as time went on it was then the nastiness of the double bind would lead to yelling, the shoving,

and bodies breaking furniture. This would occur just moments before the men would help each other up, shake hands, hug, and continue with their Sunday festivities as my grandmother would yell “Look what you did to my table! Now, get up and fix it, you bloody kids.” Now, that is not to say that all Irish families act this way, yet I do find the American stereotype of fighting Irishmen to be at times exaggerated, but, somewhat true and deserving of more attention.

The research I have done is fully supported by the characteristics of my family; my grandparents, my father and aunts and uncles, my brother, my mother, and myself. My Irish family is unlikely so unique. I am interested in those families who like mine, are very familiar with their ancestry, how that may create standards to live up to, and how that truly plays a drastic part in who we are and how we internalize and externalize love, fear, and pain. The challenge for the researcher, clinician, or family member which I will continue to focus on, is to fill the gap between repression, acceptance of mental illness, and starting to talk about feelings in a way that is not threatening in a clinical, community, or home setting. The history of the struggles of the Irish have imprinted the culture. The complete resilience that kept them moving has remained in the upbringing of Irish and Irish-American children. Despite the American, Yankee family tendency to smother our children with affection, there are still U.S. families we must not forget about. An important thing to remember for Irish families and clinicians is the possibility of depression and alcoholism being the result of generations of coping with unimaginable pain and suffering. Those family members who may have changed their nationality, but not their heritage, are those suffering in silence while contributing to the mental illness epidemic in America along with the stigmatization of mental health disorder and treatment. Like the cultures examined throughout this research, the huge population of Irish-American families, too are the ancestors of victims of manifest destiny.

Bibliography

- Bessa, Y. (2012). Modernity Theories and Mental Illness: A comparative Study of Selected Sociological Theorists. *International Journal of Humanities and Social Science*, 2 (17), 31-38.
- Brown, T.N., Donato, K.M., Laske, M.T. & Duncan, E.M. (2013). Race, Nativity, Ethnicity, and Cultural Differences in the Sociology of Mental Health. In Aneshensal et al. (Eds.), *Handbook of the Sociology of Mental Health, Second Edition* (pp.255-272). Nashville, TN: Springer Science and Business Media.
- Castillo, R.J. (1997). *Culture and Mental Illness: A Client Centered Approach*. Pacific Grove, CA: Brooks/Cole Publishing Company
- Canales, G. (2000). Gender as Subculture: The First Division of Multicultural Diversity. In I. Cuéllar & F.A. Paniagua (Eds), *Handbook of Multicultural Mental Health: Assessment of Diverse Populations* (pp.63-77). Cambridge, MA: Academic Press.
- Cuéllar, I. (2000). Acculturation and Mental Health: Ecological Transactional Relations of Multicultural Mental Health: An Assessment of Diverse Populations (pp.45-61). Cambridge, MA: Academic Press.
- Jiminez, D., Bartels, S.J., Cardenas, V., Daliwal, S.S. & Alegria, M. (2012). Cultural Beliefs and Mental Health Treatment Preferences of Ethnically Diverse Older

Adult Consumers in Primary Care. *American Journal of Geriatric Psychiatry* (6), 533-542.

McCarthy, I. C., O'Reilly-Byrne, N. (2008). A Fifth Province Approach to Intracultural Issues in an Irish Context: Marginal Illuminations. In M. McGoldrick & K.V. Hardy (Eds.), *Re-Visioning Family Therapy: Race, Culture, and Gender in Clinical Practice* (2nd ed.) (pp.327-343). New York, NY: The Guilford Press

McGoldrick, M. (2006). Irish Families. In M. McGoldrick, J. Giordano, N. Garcia-Preto (eds), *Ethnicity and Family Therapy* (3rd ed.). New York, NY: The Guilford Press.

McGoldrick, M. (1996). Irish Families in America. *Aisling Magazine*, 19. Retrieved from [http://www.aislingmagazine.com/aislingmagazine/articles/TAM2/Irish Families .Html](http://www.aislingmagazine.com/aislingmagazine/articles/TAM2/Irish%20Families.Html)

Mental Health America (2017). *Taking Good Care of Yourself*. Retrieved from <http://www.mentalhealthamerica.net/taking-good-care-yourself>.

Mental Health Ireland (2017). *Self-management - 10 tips*. Retrieved from <http://www.mentalhealthireland.ie/a-to-z/self-management-10-tips/>

Moody, T. W. (1978). Irish History and Mythology. *Hermathena* ,124, 6-24.

Muntaner, C., Ng, E., Vanroelen, C., Christ, S., Eaton, W.W. (2013). Social Stratification, Social Closure, and Social Class as Determinants of Mental Health Disparities. In C.S. Aneshensal, J.C. Phelan & A. Bierman (Eds.), *Handbook of Sociology of Mental Health* (pp. 205-227). Los Angeles, CA: Springer.

Nagayama Hall, G.C. (2005). Introduction to the Special Section on Multicultural and community Psychology: Clinical Psychology in Context. *Journal of counseling and Clinical Psychology*, 73(5), 787-789.

O'Marin, P., McAuliffe, G.J., Conroy, K., Johnson, J.M., & Michel, R.E. (2012).

Counseling in Ireland. *Journal of Counseling and Development*. 90. 371.

Sam, D.L. & Moreira, V. (2012). Revisiting the Mutual Embeddedness of Culture and Mental

Illness. *Online Readings in Psychology and Culture*, 10(2).

Satcher, D. (2000). Mental Health: A Report of the Surgeon General-Executive Summary.

reprint: Professional Psychology: Research, and Practice. 31(1), 5-13.

Schepher-Hughes, N. (2001). *Saints, Scholars, and Schizophrenics: Mental Illness in Rural*

Ireland. Berkely and Los Angeles, CA: University of California Press.

Tseng, W.S. (2001). *Handbook of Cultural Psychiatry*. San Diego, CA: Academic Press.