Health Care Professionals: A Synthesis and Integration of Select Concepts and Theories in the Study of Mental Illness through the Society, Culture, Personality (SCP) Model

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Abstract: The purpose of this article is to present select concepts and theories in the study of mental illness pertinent for health care professionals. The society-culture-personality (SCP) model is examined in relationship to mental illness so that health care professionals are well-informed on the severity of these disorders in order to provide quality care regardless of geographic location. The society-culture-personality (SCP) model is examined in relationship to some of the most severe forms of mental illness, namely, schizophrenia and major depressive disorder. Social meaningful interaction (SMI) is examined in the development of personality and how social and cultural norms affect the development of the individual. Psychoses are major mental disorders in the United States and in other parts of the world. It is important for health care providers to be knowledgeable about mental illness and the role social class, culture and family play in defining mental illness. By having a thorough understanding of the select concepts and theories involved in the study of mental illness we are hoping that the ingredients of quality, affordability, availability, accessibility, and continuity of care are extended to all members of society.

Keywords: Mental Illness, mental disorder, Health Care Professionals, Society-Culture-Personality, Social Meaningful Interaction.

INTRODUCTION

Mental illness, commonly referred to as mental disorder, has been with humanity for millennia (Hajar 2012) and continues to be a prevalent problem in our present society (Kobau *et al.* 2010). From a sociological viewpoint, mental illness involves the inability to discern and to act out one's social roles; implied is a blurring of statuses, for one's self and others. In a given social context, if an individual with a mental disorder is left untreated, there may be potentially unpredictable behavior that can make it difficult or impossible for others to maintain or to establish satisfactory reciprocal relationships. When a serious mental disorder is not properly managed and treated it can cause a strain on those experiencing the disorder as well as the family members who are caring for the patient (Drapalski Leith and Dixon 2009). The ramifications for individuals in the United States with a

mental disorder are readily apparent by considering the fact that "the absence of positive (flourishing) mental health increased the probability of all-cause mortality for men and women at all ages after adjustment for known causes of death" (Keyes and Eduardo 2012: 2170). The interrelationship between one's mental and physical health is therefore crucial for health care professionals to understand due to their foreseeable ability to affect one another. This point is further illustrated through systematic review of the literature which found it is common for an individual of any age with a mental disorder, irrespective of the specific diagnosis, to have "comorbid physical health conditions and/or poor physical health" (McCloughen *et al.* 2012: 283). Health professionals should not simply ignore the mental-physical relationship, considering that in the United States approximately 26.2 percent of the adult population ages 18 and older suffer from some form of mental disorder within a year period according to the criteria of DSM-IV/WMH-CIDI for diagnosing mental disorders (Kessler *et al.* 2005). When only considering those with a serious form of mental illness, these individuals are estimated to be about 5.5 percent of the

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contiguous United States' adult population (Hudson 2009). Given the prevalence of mental disorders, it is clear that health care professionals need to pay special attention to mental health of an individual as well as the patient's family during the diagnosis, treatment, and prognosis process.

Regardless of one's healthcare role or specialty, it is potentially advantageous for all health care professionals to have a general understanding of the classifications of mental illness. The purpose of this article, therefore, is to present select theories and concepts, within a conceptual model, for the study of mental illness with an emphasis on a few major disorders such as schizophrenia and major depressive disorder so that health care professionals can use them in their practices irrespective of locality. There are many different approaches toward making classifications of mental illness; however, elucidating a superior method is difficult given the complex nature of mental disorders (Goldberg 2012). When using the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) or the International Statistical Classification of Disease (ICD)-10 as a guide for criteria for diagnosis, there can be variation between these systems when applying them to a patient population, such as differences in the prevalence of schizophrenia (Lindström Widerlöv and von Knorring 1997). For the future DSM-V and ICD-11, there is a need for further consideration of the impact that society and culture have on the individual to be able to fully conceptualize all the factors that influence one's mental illness (Gureje and Stein. 2012). Mental disorders should never be studied compartmentalized from other disciplines, since doing so will result in a misconstrued understanding of the phenomena. Therefore, a simple conceptual model is introduced to aid in the understanding of mental disorders as an organizational device to teach the interrelationships of these select concepts.

SOCIETY, CULTURE, PERSONALITY (SCP), SOCIAL MEANINGFUL INTERACTION (SMI), AND THE DEVELOPMENT OF PERSONALITY IN RELATIONSHIP TO MENTAL ILLNESS

Society-culture-personality (SCP) form an interlocking social system, which one can view on the macroscopic (global village) or microscopic (group) level (Fredericks Mundy and Lennon 1969). To better understand the components of SCP, careful analysis of each of the subsystems individually is needed before comprehension of SCP as a functional interlocking

social system can occur. The first subsystem within the SCP social system to be dissected will be the personality subsystem. For the context of this paper, personality will be defined as "… the dynamic organization within the individual of those psychophysical systems that determine his [their] unique adjustments to his [their] environment" (Allport 1937: 48). Each person in the world has a unique personality that is philosophically unrepeatable. The personality is not only important to consider for potential personality disorders, but also certain propensities for developing other mental disorders an individual may possess. According to ICD-10, disorders of adult personality or behavior are of "…clinical significance which tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others" (World Health Organization, 2010). If certain types of personality disorders ("Specific personality disorders", "mixed and other personality disorders", and "enduring personality changes") are present then, "They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others" (World Health Organization, 2010). To better understand the concept of mental illness, it is important to bring the idea of culture into the discussion. Culture (C) can be viewed in a general overarching sense as simply a way of life. A more definitive way of viewing culture is essential to grasp the underpinning of this concept.

> *Culture is shared learned behavior and meanings that are socially transmitted for purposes of adjustment and adaptation. Culture is represented externally in [artifacts] (e.g., food, clothing, music), roles (e.g., the social formation), and institutions (e.g., family, government). It is represented internally (i.e., cognitively, emotionally) by values, attitudes, beliefs, epistemologies, cosmologies, consciousness patterns, and notions of personhood. Culture is coded in verbally, imagistically, proprioceptively, viscerally, and emotionally resulting in different experiential structures and processes* (Marsella and Yamada 2010: 105).

There is a clear relationship between one's culture and personality. During the process of internalizing one's culture through social interaction, a distinct personality is created within a specific society. In this

framework, society can be seen as "an ordered and dynamic system of all the social interactions involving the members (personalities) of a total population, which can be identified as sharing a culture distinct from that shared by other populations" (Zahn 1964: 34). A society's orientation may be viewed as being along a continuum between two ideal types, namely, *gemeinschaft* (G1) [rural] or *gesellschaft* (G2) [urban] (Figure **1**). The orientation of the society the individual lives in is paramount for health care professionals to fully appreciate all factors that bear upon an individual for proper diagnosis, given the societal context. Society-culture-personality (SCP) form an interlocking social system that necessitates consideration of all components when studying mental disorders. Current guidelines from DSM-IV or ICD-10 still do not adequately address the cultural and societal context of an individual in their criteria for diagnosis of mental disorders, especially in children and adolescence (Canino and Alegría. 2008). When considering one's potential to develop a mental disorder one must reflect upon the genetic basis of the individual (N_1) as well as the environment (N_2) in which they live. One's genetic basis merely provides the potentiality for developing a mental illness. The interaction an individual has with their social as well as physical environment impacts the overall potential for expression or lack of penetrance of the genetic basis for developing mental illness. Although, it is important to point out that the genetic basis for mental disorders is very real given that "studies of twins and adopted individuals show that most of the risk is carried by genes rather than family culture or environment" (Uher 2010: 105). A potential solution for counteracting a child's genetic risk (eg. Parent has a mental disorder) for developing mental illness, such as schizophrenia, can be to simply ensure the child is given "consistent, resourceful and stimulating parenting" (Uher 2010: 107). A proper history is imperative for health care professionals to ascertain during clinical encounters to recognize and address genetic risks their patients may inherently possess. A significant family history of mental illness will lead health care professionals to address concerns, as well as provide resources to aid in the fostering a positive environment for the child to thrive thereby reducing the propensity for expression of a mental disorder. The interaction between genetics and environment is a very real interrelationship, and should always be considered when addressing mental illness. Further development of a unique personality is formed through social meaningful interaction (SMI) with others, through which each person responds as actors and

reactors to a specific social situation. Social meaningful interaction (SMI), communication along with social contact allows for an avenue for positive growth and development of the individual's personality to potentially reduce the risk for the emergence of mental illness. The personality subsystem houses an important component, namely, the self-concept. "The self-concept involves the assumption that one's personality acts according to the way they perceive themselves (the self-concept) and according to the way they perceive the social situation" (Fredericks *et al.* 2003: 239). Social situations create opportunities for a person to participate in social meaningful interactions with others to allow for a socialization process to occur and foster the internalization of their value-attitude system (VAS) of their respective culture (Fredericks Mundy and Lennon 1969). It is imperative to realize that society-culture-personality (SCP) can only become a functional interlocking social system with the aid of an agent or catalyst: social meaningful interaction (SMI) (Fredericks Mundy and Lennon 1969). During the development of one's personality, the interaction between nature (genetics) and nurture (social [SMI] and physical environment) within the setting of a specific culture and society bear upon an individual's propensity toward development of a mental disorder.

One's developmental process, given the genetic-environmental interactions, may result in patterns of behavior which could be considered normal in one's respective culture; however, when viewed from the perspective of another culture and/ or society, it may be seen as abnormal or as a mental illness. In the next section, the issue of cultural differences in their perceptions of mental illness will be addressed.

CULTURAL DIFFERENCES, STATUS, ROLE TENSION AND CONFLICT

In a given society, there are specific statuses as well as roles that are achieved, assumed, or ascribed to an individual throughout their life. The process of transitioning from one role to the next may be a difficult one. Culture pressures may cause tension and/or conflict upon a specific individual as they undergo the process of socialization or professionalization. This may be seen when an immigrant or migrant individual attempts to balance two or more roles within a specific culture. The culture of origin as well as the current culture must be considered when analyzing mental illness to entirely recognize all the conflicts and/or tensions that bear upon an individual at a moment in time. Thus, one can appreciate if the roles are
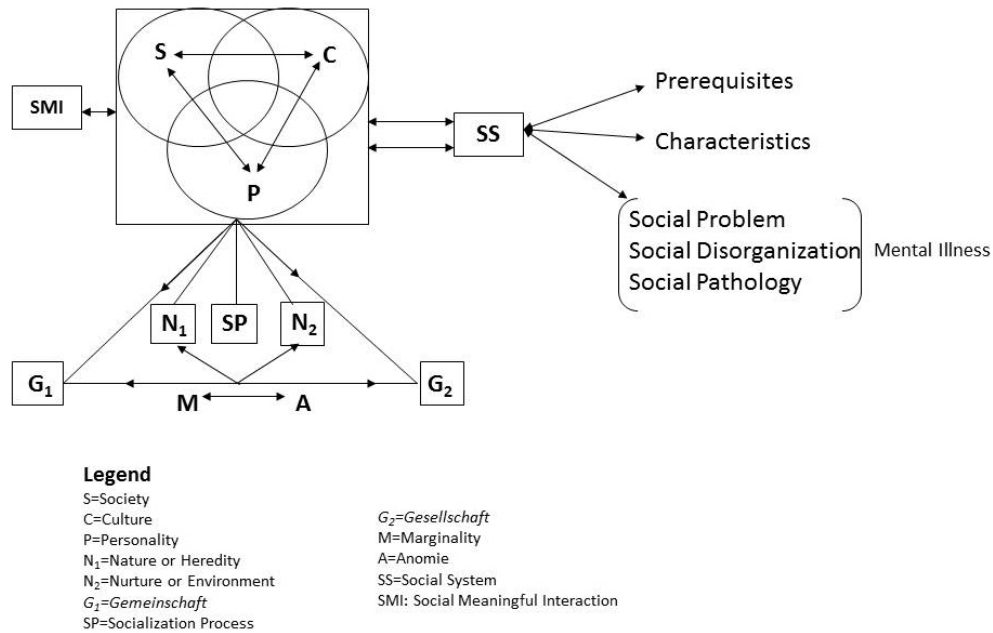
Figure 1: Society-culture-personality (SCP) the social system and social pathology.

synergistic or antagonistic. Conflicting roles may perhaps create undue social stresses upon an individual, which create the opportunity for a mental illness to develop. An important example of this interrelationship can be illustrated when examining first-generation Korean immigrant women who possess a greater probability compared to men of having *Hwa-Byung,* a "culture-bound anger syndrome" (Myunghan and Hye-A 2011: 227). These Korean women may develop or already have *Hwa-Byung* when immigrating to the U.S. whereby they suppress their distress due to their Korean cultural beliefs that stigmatizes mental health seekers. This may result in the suppression of compounding rage and/or anger from the tensions experienced overtime (Myunghan and Hye-A 2011). The marginality that first-generation Korean immigrants to the United States experience during acculturation process may potentially explain the reason that *Hwa-Byung* is more predominant in this group as compared to other second and subsequent generations. (Myunghan and Hye-A 2011). Accordingly, the stress immigrants' face when attempting to conform to the dominant culture in a new society can create opportunities for development or exacerbation of a mental illness. Understanding the cultural context of a mental disorder will better equip health care professionals in the diagnosis as well as treatment process to prevent misconceptions of the social situation during the time of a clinical encounter.

The socialization process for youth of immigrant parents can be a difficult one, due to potential conflict arising from the culture of their parents and that of the dominant environmental culture. This point is demonstrated when considering a study's findings about the role maternal influence plays on their child's development within a population of mostly "Spanish speaking, low-income, Mexican immigrant and Mexican American families" (Dumka Roosa and Jackson 1997: 309). This study found an important correlation when dealing with a Mexican-American family:

> *Higher levels of maternal acculturation were related to lower levels of inconsistent discipline practices and less depression in children…Higher maternal acculturation thus maybe a marker of a higher level of adaptive fit between the child and the family environment (i.e., the developmental niche of the child; Super & Harkness, 1986) and between the family and the immediate environment of the host society"* (Dumka Roosa and Jackson 1997: 309, 320).

If a healthcare professional lacks a sufficient understanding of the cultural differences affecting a family, this may cause an inability to help the family work towards positive mental health statuses for the parents as well as their children. It is clear acculturation must be valued in the diagnosis of mental disorders along with an unbiased analysis of the symptoms to prevent misdiagnosis through biased generalized assumptions about all ethic mental disorders as a

whole, with a disregard to the specific cultural context (Gonzales *et al.* 1997). Health care professionals should appreciate the cultural differences present in a specific individual in order to be able to be a patient's advocate toward a positive mental health. There are numerous potential dichotomous forces that may create additional mental stress upon an individual such as: old culture vs. new culture, parents vs. peers, and/or urban vs. rural. This list is not all inclusive of the major opposing forces within an individual's life pressures that exert themselves on a single person and/ or group. If an individual is unable to cope with the conflict arising from these opposing forces within his or her life, then it may create the possibility for developing a mental disorder, if left unresolved. Even though health care professionals may be aware of cultural and social pressures, they must be more cognizant of these forces to better appreciate the underpinning of the clinical picture, given the cultural and social contexts. The type of society is important when reflecting on how an immigrant or migrant person in a *gemeinschaft* (G1) [rural] might act and think differently when compared to another person in a *gesellschaft* (G2) [urban], regarding one's view of mental health. For example, a study found differences in views concerning mental health services among immigrant Latinos (ages 12-44) in a rural setting compared to those in an urban setting (García 2011). Some of the significant findings from the study indicated:

> *Urban respondents were over five times more likely than rural respondents to indicate knowing a place in the community that can help Latino adolescents with mental health problems such as depression or suicidal ideation (OR: 5.6, CI: 2.2–14.5, P<0.001)…Notably, urban respondents were over four times more likely to endorse the statement that "in my culture seeing a mental health professional is crazy" (OR: 4.2, CI: 1.9–9.5, P<0.001) and much less likely to indicate that "in my culture it is okay to seek help for depression" (OR: 0.2, CI: 0.1–0.4, P<0.0001)* (García 2011: 503-504).

It is important to consider these differences in beliefs among immigrant Latinos whether in a rural or urban clinic setting to better meet the needs of the patient at the point of care as well as provide proper implementation of public health programs. The type of society one lives in can largely impact one's mental

health beliefs and behaviors. Certain types of mental disorders could be more widespread in a rural population as compared to an urban population within the same region. A study on the rural and urban population of Canada demonstrated a difference in the 12-month prevalence of major depressive episode(s) (MDE) between these two societal orientations (Wang 2004). After taking into consideration the variables of "… working status, race, immigration status and marital status, it was found that participants in rural areas were less likely to have MDE than those in urban areas (OR = 0.80, 95 % C. I.: 0.62, 0.97)" (Wang 2004: 22). When considering this study, it is important to note that there were instances where the differences between urban and rural prevalence of major depressive episode(s) might vary upon the geographical region used for comparison (Wang 2004). Therefore, it may be difficult to make certain generalizations about Canada on the national level since there appears to be variance among Canadian regions. To superimpose this idea at the world at large, careful analysis must be made specific to a certain region and then to the societal orientation (urban or rural) to better reconcile differences of the prevalence of certain mental disorders. Also, health care professionals need to acknowledge the potential differences in attitudes and beliefs toward mental health services in these regions to provide quality care to diverse patient populations.

GENETIC SOCIOLOGY, MENTAL ILLNESS, AND THE HEALTH CARE INSTITUTION

Due to advancements in the field of genetics, studies have provided a better understanding of the gene-environment interaction concerning the development of a mental disorder. Some of the genetic factors contributing to the development of a few selected major mental disorders present throughout the world will be discussed, namely: schizophrenia and major depressive disorder. Schizophrenia is a psychotic mental disorder that approximately affects 26 million of the world population (Lora *et al.* 2012). Genomic testing from 51,695 patients was able to verify loci [6p21.32-p22.1, and 18q21.2] as well as discover new loci [1p21.3, 2q32.3, 8p23.2, 8q21.3, and 10q24.32-q24.33] that have shown a strong correlation with schizophrenia (Ripke *et al.* 2011). It is readily apparent genetics plays a role in an individual's propensity to develop schizophrenia. Another possible important genetic factor that plays a role in one's vulnerability to developing schizophrenia is a regulator allele of neural development called MIR137 (Cummings *et al.* 2013). It is essential to recognize gene-

environment as well as gene-gene interaction in the role of progression of schizophrenia. This gene-gene interaction is seen with MIR137 being associated with interacting with target genes that have been linked with schizophrenia such as: CSMDI, C10orf26, CACNAIC, TCF4 (Kwon Wang and Tsai 2013) and ZNF804 (Kim *et al.* 2012). The genetics of an individual provide the potential for a mental disorder to occur, like schizophrenia, but it does not necessitate one will inevitably develop a mental disorder since one's environment is a factor as well. A study taking into consideration the interaction between one's genetics and their environment showed that approximately 55% of the current known "schizophrenia candidate genes" were associated with "ischemia-hypoxia and/or vascular factors" (Schmidt-Kastner *et al.* 2012: 1194).

Depending upon when a certain environmental events occur in an individual's life could possibly determine the severity of the schizophrenia. Hypoxia in utero may contribute to the development of schizophrenia early in life (Schmidt-Kastner *et al.* 2012) and could potentially have a differing degree of severity when compared to another person who develops schizophrenia later in life. A study conducted in India was able to compare and contrast "schizophrenia with onset in childhood (COS), adolescence (AdOS) and adulthood (AOS)" by measuring the severity of the mental disorder by assessing any neurological abnormalities present, "Neurological soft signs [NSS]" (Biswas Malhotra Malhotra and Gupta. 2007: 295). The analysis of the three groups of onset of schizophrenia

indicated, "… NSS were seen in highest (100%) number of COS, followed by AdOS (90%) patients and then the AOS (55%) patients. … there was a clear relationship between age of onset and NSS in the form of a gradient of frequency as well as severity of NSS with COS occupying the highest level, AOS the lowest and AdOS as in between" (Biswas Malhotra Malhotra and Gupta. 2007: 299-300). The onset of schizophrenia in childhood has a higher severity of neurological abnormalities. This translates to the need for proper proactive interventions early on in the patient's life to offset this outcome. It is imperative that health care professionals fully comprehend the interrelationships between genetic potential in a given environmental situation whether viewing the situation from the perspective of the community, society, nation or global village at large.

Another common type of mental disorder seen in clinical practice is major depressive disorder. In a given calendar year, clinical depression affects more than 19 million Americans (Mental Health America.org, 2012). Major depressive disorder is a key problem in other countries as well, and it accounts for a prevalence of approximately 4.7% worldwide (Ferrari *et al.* 2013). A study conducted by pooling data from over 15 countries was able to show that women possess a greater lifetime risk developing major depressive disorder as compared to men (Seedat *et al.* 2009). During the screening process for a differential diagnosis for clinical depression, it is important to consider the sex of the patient to better assess the risk.
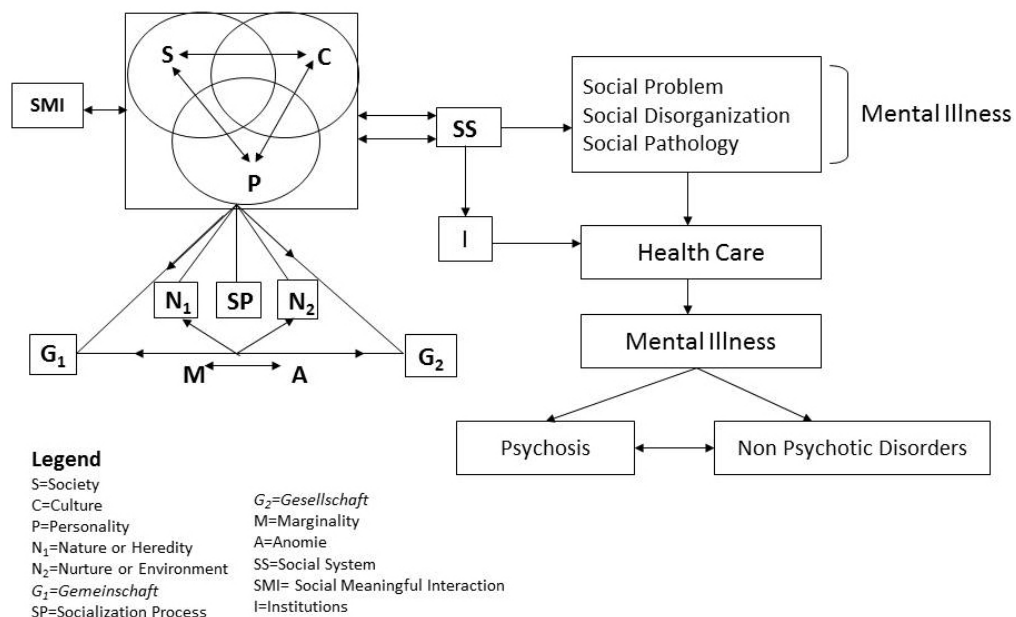

Figure 2: Society-culture-personality (SCP) and its relationship to mental illness.

Even if a country may have lower lifetime prevalence of major depressive disorder, which is the case for Taiwanese adults (1.20 %) as compared to other countries, there are still other obstacles to overcome (Liao *et al.* 2012). For example, Taiwanese individuals are less likely to seek treatment for their major depressive disorder when compared to U.S. individuals (Liao *et al.* 2012). This presents a unique situation for health care professionals who are treating Taiwanese patients because of their decreased willingness to seek treatment; this may cause a more retroactive rather than a proactive approach to medicine (Liao *et al.* 2012). The way in which an individual perceives a social situation can have a profound effect on how they act and think, which can both hinder or help, depending upon the perception. For example, a study conducted in the U.S., in the state of Texas, revealed that Hispanic pregnant women who experienced discrimination had a strong link to symptoms of depression (Walker *et al.* 2012). Therefore, the way society or a group view an individual may translate in some way to mental health ramifications down the line to a person or group who may be viewed through the lens of discrimination. If a child's parent(s) are undergoing major depressive disorder, then this places the child at risk for mental disorders and other issues as well. A small study in the U.S. showed promise for future research to aid in the prevention of major depressive disorder in adolescents who are placed at a higher risk for depression due to having parents with this same mental disorder (Mason *et al.* 2012). There are the genetic risk factors that parents pass on to their children that must be considered. From a genetic stand point, there are various "…biomarkers such as genetic mutations, neurotransmitters, and cytokines…" that may be used to aid in diagnosing depression (Tamatam Khanum, and Bawa 2012). Besides genetics, the environment of the family is important for contributing to the penetrance of these genetic risk factors. This idea is clearly seen in a research study pooling data about the families of twins which found:

> *Using a Children of Twins design (COT), we were able to determine whether these inter-generational associations are due to the direct of impact of the family environment, a shared genetic liability, or both. We have found that parental depression has a direct environmental impact on both children's depression and conduct problems. Although there are*

juvenile-specific genetic effects not associated with the genes for adult depression, the genes for childhood conduct problems appear to be early indicators of genetic risk to adult depression. (Silberg 2010: 742).

Thus, potentially a vicious cycle of depression can occur from parent-to-child if there is not proper prevention as well as intervention to aid in offsetting this phenomenon. If depression is allowed to escalade and become a chronic condition in a person, it has been shown that these individuals "… were socioeconomically and educationally disadvantaged, tended to be older, report loss of spouse or history of divorce, live in rural areas, have public assistance, low self esteem, worse overall health…" as compared to non-chronic MDD individuals (Rubio 2011: 622). All these factors must be considered when developing a treatment regimen to offset some of the risk factors that may make this condition more difficult to control.

The family is an important factor when considering major depressive disorder. A dysfunctional support system can cause undue stress while a strong support system can aid in recovery and treatment (Gallagher 2012). According to the social stress theory, the onset of mental illness is triggered by social and cultural factors. Stress can be induced by various socio-cultural elements including unemployment, natural disasters, limited access to quality health care, a dysfunctional family unit and even war. Research also indicates that individuals that belong to lower socioeconomic classes not only lead more stressful lives, but also have higher rates of mental disorders (Gallagher 2012).

When considering a sensitive section of the population that has undergone considerable stress throughout their life, one must bring to mind the veterans of war. In the United States, mental illness accounts for thirty percent of discharge diagnoses from an inpatient clinical setting in 2008, which is tied for second for most common diagnoses within that period (Maynard and Fihn. 2010). The stress induced by war, the death of comrades, and separation from the family (among other factors) has led to an increase in suicide among U.S. troops. While military veterans make-up only 10 percent of the U.S. adult population, they do, however, make-up 20 percent of all suicides in the U.S. (Thompson and Gibbs, 2012). The lack of trained professionals to provide quality mental health care has contributed to this alarming trend.
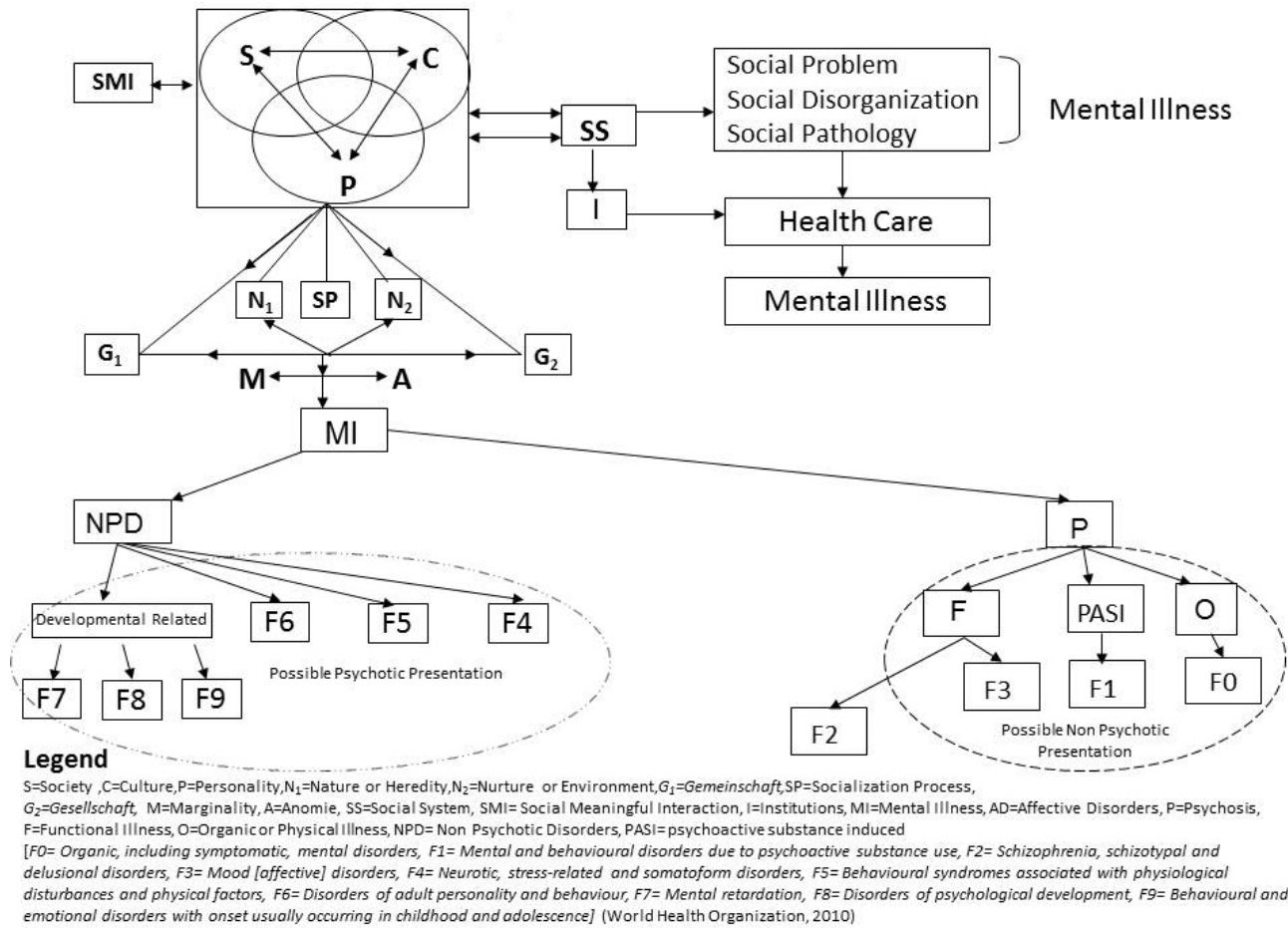
Figure 3: Mental illness in society.

Since 2009, the Pentagon's ranks of mental-health professionals have grown by 35%, nearing 10,000. But there is a national shortage of such personnel, which means the Army is competing with the VA and other services—not to mention the civilian world—to hire the people it needs. The Army has only 80% of the psychiatrists and 88% of the social workers and behavioral-health nurses recommended by the VA. Frequent moves from post to post mean that soldiers change therapists often, if they can find one, and mental-health records are not always transferred (Thompson and Gibbs, 2012).

CONCLUSION

This discussion examined some select theories and concepts of mental illness. Mental disorders, as explained throughout this paper, are very significant health problems within the *gemeinschaft* (G1) and

gesselschaft (G2) dichotomy. It is important for health care providers to be knowledgeable about the various kinds of mental illness and how culture and social class affect the development of the individual and the definition of normal and abnormal behavior. The cultural meanings associated with "normal" and "abnormal" behavior are especially important in the study of mental health and mental illness. Some particular attention was given to immigrants to illustrate the shaping influences of society and culture on the behavioral aspects of personality. Possible causal links exist between culture on the one hand and mental illness on the other.

A patient's social class status is directly linked to the type of treatment and care received. Additionally, socioeconomic indicators (for example, occupation and social class) need to be considered when diagnosing, as well as treating mental disorders. The quality, availability, accessibility, affordability and the continuity of health care has a significant impact upon the outcomes of genetic diseases and social behaviors affecting mental illness.

CONFLICTS OF INTEREST

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