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Cultural Context of Human Development and Mental Health: Implications for Community that Care (CTC) Programme for Development of Mental Health Amongst Adolescents and Youths

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Abstract: The present article offers an overview of a cultural context of human development and its relationship to the mental health of youths and adolescents. The article traces the context of human development by comparing collectivist and individualistic social patterns and how theses affect human development in terms of values, autonomy, responsibility, achievement and self-reliance. These cultural developmental patterns are underpinned by an integrative perspective of human development in a cultural context. The article brings to light current trends and prevalence of mental health amongst adolescents and youths from a global perspective. By so doing, the articles posits a strong relationship between culture and mental health. Accordingly evidence points to the fact that cultural factors are critical determinants of mental health. Hence there are cultural criteria for determining mental illness in relation to dysfunction, distress, deviance and disorder. The paper concludes by recommending the Community That Care (CTC) approach in mitigating mental problems amongst adolescents and youths. In this regard, CTC is an evidence-based, comprehensive, multi-tiered system of support that encourages the collection and systematic use of community-level data to identify areas of strength and need and to guide plans for preventive strategies based on a community's specific profile.

Keywords: Culture; Human Development; Mental Health; Community That Care

Introduction

Mental-health conditions have a significant impact on the development of over a billion youth and their social and economic integration, including employability (United Nations, 2014). Yet, it is also critical that attention to global mental health moves beyond treatment-oriented programs in health-care settings to include broader approaches inspired by home, school and community based programs focused on psychosocial inclusion considerations. Specific models that are likely to prove effective in low- and middle-income countries include nurse home-visitation programs, which benefit youths, in the short and long term. Multi-tiered prevention models for addressing behavioral and mental-health needs have also demonstrated promise in several countries by targeting parents and the community. A number of school-based programs focused on promoting competencies – such as emotion-regulation, social skills, behavioral inhibition and conflict resolution. Community-wide frameworks that draw upon community partnerships and are guided by local data have also demonstrated significant impacts on a range of mental-health outcomes (United Nations, 2014).

Culture encompasses the values, traditions, art, language and beliefs that mediate a given social group's behavior (Parsons, 2003). Berry and Dasen (1994) described six uses of culture: descriptively to characterize a culture, historically to describe the traditions of a group, normatively to express rules and norms of a group, psychologically to emphasize how a group learns and solves problems, structurally to emphasize the organizational elements of a culture, and genetically to describe cultural origins. Children grow and acquire culturally acceptable knowledge through the process of socialization. Each society and culture has different ways by which it socializes children into what is considered as intelligent and socially acceptable behaviors.

The aim of the present paper is to examine the cultural context of human development that has an impact on mental health of adolescents and youths. By so doing, the paper exposes an integrative theoretical framework for cultural human development (Dasen, 2003). The paper then goes further to analyse the relationship between mental health and culture. Based on this strong relationship, the paper proposed the Community That Care (CTC) (Hawkins and Catalano, 2004), approach to handling mental health issues amongst adolescents and youths.

Conceptual considerations

Cultural context of human development

Cultures differ in their social orientations (independence vs. interdependence). Cultures that endorse and afford independent social orientation tend to emphasize self-direction, autonomy, and self-expression. Cultures that endorse and afford interdependent social orientation tend to emphasize harmony, relatedness, and connection. Independently oriented cultures tend to view the self as bounded and separate from social others, whereas interdependently oriented cultures tend to view the self as interconnected and as encompassing important relationships (Markus & Kitayama, 1991; Triandis, 1989). In independently oriented cultural contexts, happiness is most often experienced as a socially disengaging emotion (i.e. pride), whereas in interdependently oriented cultural contexts, happiness is most often experienced as a socially engaging emotion that is sense of closeness to others (Kitayama, Mesquita & Karasawa, 2006). Finally, in cultures that have an independent social orientation, people are more motivated to symbolically enhance the self at the expense of others; this tendency is not as common in interdependently oriented cultures (Kitayama, Ishii, Imada, Takemura, & Ramaswamy, 2006; Kitayama, Mesquita & Karasawa, 2006). As can be seen in the table 1, cultures with collective vs independent social pattern possess the following characteristics in relation to values, autonomy, responsibility, achievement and self-reliance.

Table 1: Collective Vs Individualistic Social Pattern

ITEMS	COLLECTIVE SOCIAL PATTERN	INDIVIDUAL SOCIAL PATTERN
Values	Supremacy of group or collective over individual	Supremacy of individual over group
	Collective development and actualization (roads, houses, bridges, harvesting of crops)	Self-actualization
	Uniformity and model emulation	Individuality and uniqueness of the individual
	Collective identity, defined by group membership.	Individual identity defined by personal attributes
Autonomy/ Conformity	Conformity to societal and group norms	Individual makes self- judgments and decisions
	Little right of privacy. One's business is also the business of the community	Right to privacy and people should mind their own business
	Preference for the company of others	Prefers to be alone
Responsibility	Collective ethical/legal responsibility. Group responsible for its individual members	Individual responsibility. Individual alone is held responsible.
	Consequences of one's actions affect the whole group.	The individual alone is affected
Achievement	Collective effort in achievement of projects	Individual initiative and do things by one's personal effort
	Cooperation and unity rather than competition	Attainment of excellence through competition.
Self-Reliance/ Interdependence	Mutual help. Individual's wellbeing depends on the group	Self-reliance and individual responsibility for well-being

	Actions guided by group rather than self interest	Actions guided by self-interest.
	Security found in group solidarity	Security to be sought in individual strength.
	Public and communal ownership of property and sharing	Private ownership of property.
	Political system meant to preserve collective values	Political system meant to satisfy the individual needs
	Religious collectivism and membership in religious groups is essential.	Religious needs are personal and personal relationship with the divine

Source: Adapted from Bayne (2000)

Western societies tend to be more independent and more analytic, while African and East Asian societies tend to be more interdependent and holistic (Nisbett et al., 2001).

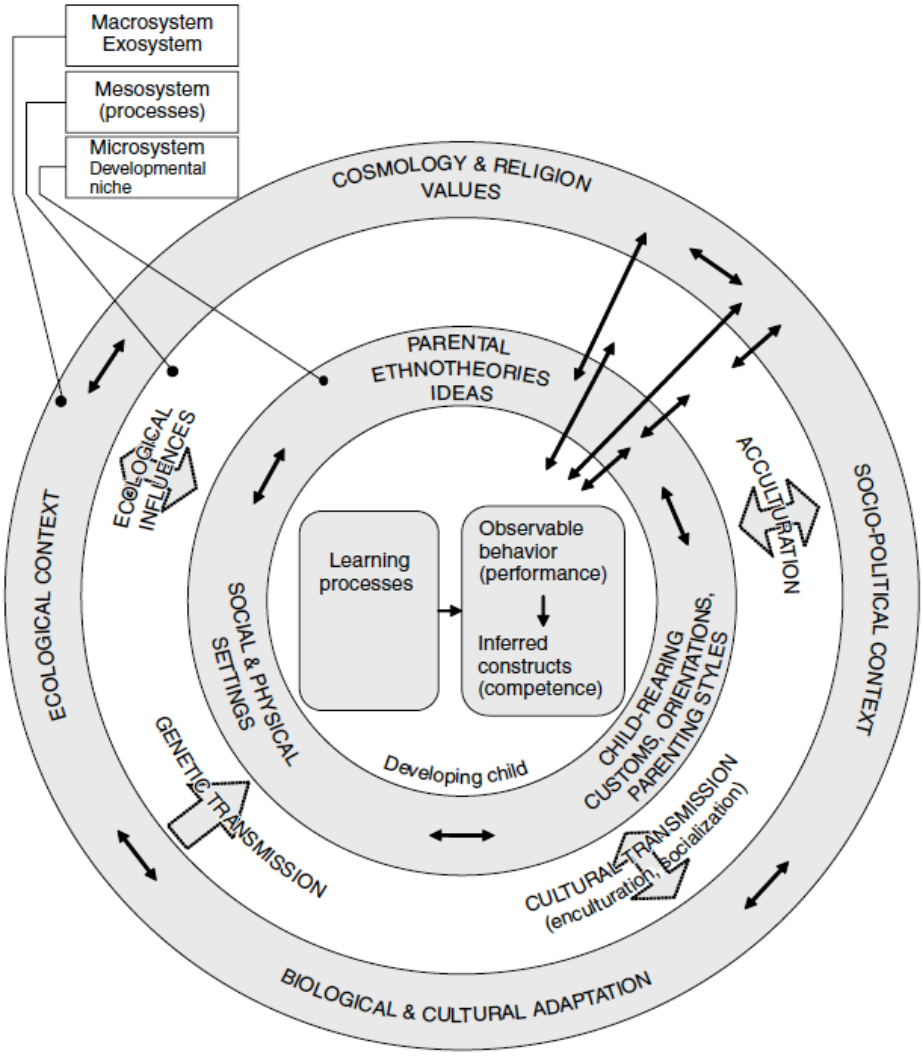
Integrated theoretical framework for cultural human development

The theoretical framework is a combination of various frameworks useful in a variety of contexts (Dasen, 2003). At the centre of the framework is the individual child, with his or her particular set of inherited and acquired dispositions. Surrounding the child, there is the micro context in which development occurs, also called the "developmental niche", a concept first formulated by Super and Harkness (1997) on the basis of their research carried out in Kenya. The niche has three components:

1. The settings, or physical and social contexts in which the child lives;
2. The customs, or culturally-determined rearing and educational practices;
3. The social representations or parental "ethno-theories" of child development.

These are the ideas parents or other caretakers, or indeed all adults have about what they consider to be important in the development of their children (to be illustrated below). The developmental niche is a system in which the component parts interact and function in coordinated fashion. Typically there is consonance among the elements of the niche, especially under conditions of stability in the society, but sometimes there are also inconsistencies, especially under the impact of social change and acculturation. Moreover, it is an open system where each component is linked with other aspects of the more general environment. The latter is represented in the outer circle of the macro-system, which includes the ecological and socio-historical contexts to which each society adapts both biologically and culturally. The processes that link the phenomena at the group level to those at the individual level are shown in the meso-system. Among these, as educators, we are most interested in the processes of cultural transmission, notably enculturation and socialization. In fact, this is how we can define education, not only as schooling but as the totality of cultural transmission (Dasen, 2003). These interactions are represented in figure 1.

Figure 1: Integrated Theoretical Framework for Cultural Human Development



Source: Theoretical frameworks in cross-cultural developmental psychology: An attempt at integration. Dasen (2011)

The framework points out the importance of situating the child's development and education in a wider macro-context, which contains, for example, the cosmologies, religions and values that prevail in any particular society. These in turn are linked to the particular ethno-theories or social representations that caretakers, teachers and parents tend to share in particular social groups.

Mental health amongst adolescents and youths

On a global level, it is estimated that approximately 20 per cent of youth, namely, well over one billion youth, experience a mental-health condition each year (Patel et al, 2007; United Nations Children's Fund, 2012). In fact, young people are at the greatest risk of a range of mental-health conditions during their transition from childhood to adulthood (Kessler et al, 2005), due, in large part, to the host of physical, psychological and emotional changes which occur during this vulnerable period. Epidemiological research suggests that the majority of individuals with mental-health conditions first experience symptoms prior to age 24 (Kessler et al, 2005). Mental and behavioral conditions are the leading causes of ill-health in young people in both high- and low-resource countries, accounting for one third of all years lost in productivity due to disability (World Health Organization, 2008). Suicide is the fifth highest cause of death in this age group globally and second highest in high-income countries (Blum & Nelson, 2004). Among youth between the ages of 15-24, 17 per cent of all disability-adjusted life years are due to mental and behavioral disorders, with an additional 4.5 per cent due to self-harm and 5 per cent due to other neurological disorders (Murray et al, 2012).

Mental-health conditions have a significant impact across a wide range of developmental outcomes, limiting opportunities for social integration. One area that can be impacted by mental-health conditions during adolescence and young adulthood is the development of safe and healthy relationships with peers, parents, teachers and romantic partners. In fact, adolescence is the developmental period that is critical for identity formation and taking on roles, especially with peers. Many mental-health conditions negatively affect a youths' ability to successfully form supportive and healthy relationships and manage conflict within these relationships. For example, at least one in four adolescents experiences symptoms of depression (Kessler et al, 2005), which commonly includes irritability, anger and avoidance of social interaction. These symptoms can lead youth to withdraw from others as well as be rejected by their peers, which can exacerbate depressive symptoms further and limit opportunities for social skills development. Similar social challenges occur for youth with anxiety, whereby they tend to avoid social interaction and may be rejected by their peers because of their anxious behavior.

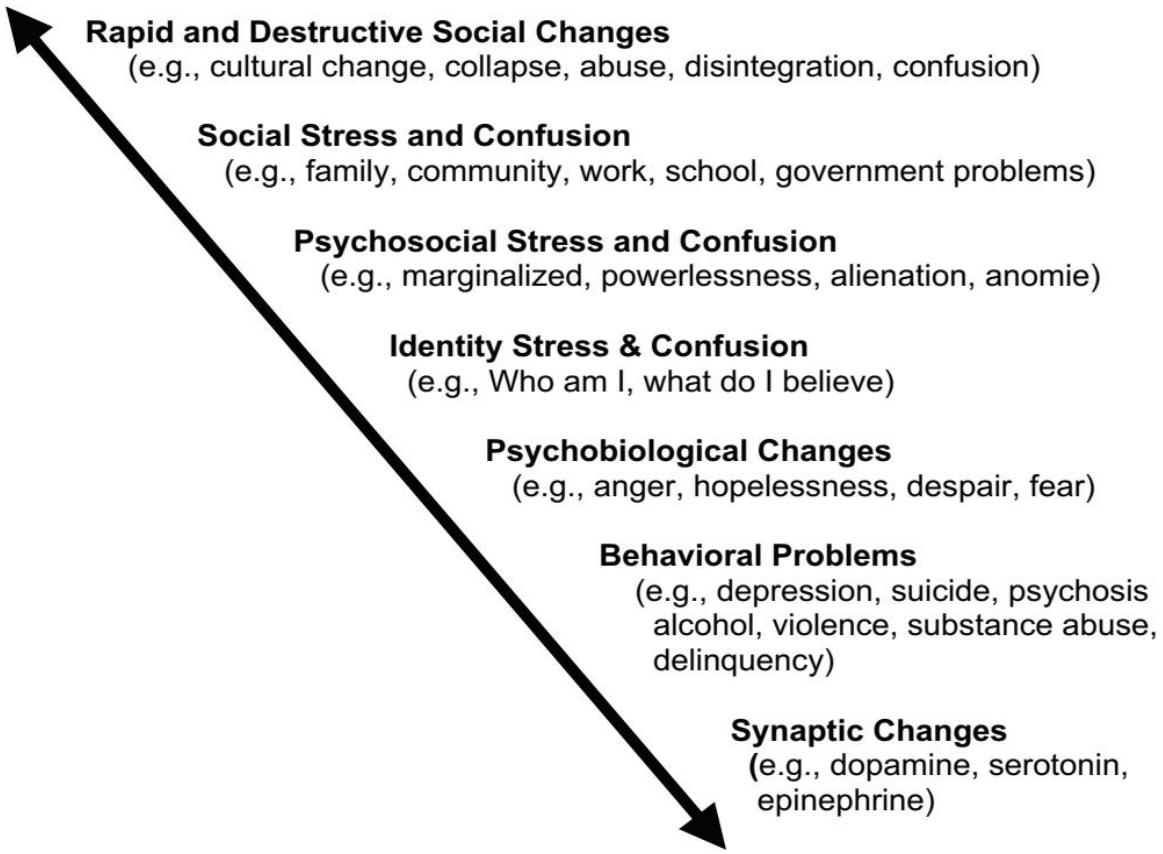
Aggressive youth and those with attention deficit disorder/hyperactivity problems often experience rejection by peers because their behaviour is perceived as aversive by pro-social peers (Stormshak et al, 1999). This often results in a cascade process, whereby the rejected aggressive youth spend time with delinquent peers and become disengaged from the academic process, which exacerbates their behavioural and mental-health conditions (Lynne-Landsman, Bradshaw & Ialongo, 2010). Another common mental-health concern among youth is substance use. A recent study of students attending the eighth to the tenth grade in South Africa (Reddy et al, 2010) indicated that 10 per cent of youth who had tried cannabis were introduced before they were 13 years old, with roughly 30 per cent smoking daily. It was found that substance use was strongly correlated with repeating a school grade and a range of other negative outcomes, such as physical injury, crime, sexual violence and risky sexual behaviour (Reddy et al, 2010). Mental-health conditions affect youths' self-esteem, social interaction, and even, their chances of personal injury and harming themselves and others (Bradshaw et al, 2012).

Youth with untreated mental health conditions struggle to succeed in school. Academic problems include low engagement, poor academic performance, learning disabilities, discipline problems (e.g. suspension), poor attendance and, eventually, school dropout (Bradshaw, O'Brennan and McNeely, 2008). This trajectory of poor academic engagement leads to diminished workforce readiness and inability to transition to work and employment which, in turn, impacts independent living and social integration negatively (Bradshaw et al, 2010). As they near, and enter, adulthood, youth with mental health conditions face poor transition outcomes, especially into the world of work. Integration into society, including the workplace, is key to their successful transition to working life (Bradshaw et al, 2012).

Relationship between culture and mental health

Evidence points to the fact that cultural factors are critical determinants of mental health (e.g., Leighton & Murphy, 1961; Marsella, 1982). For example, consider the following cultural processes in the etiology of mental health: Culture determines: (1) the patterns physical and psychosocial stressors, (2) the types and parameters of coping mechanisms and resources used to mediate stressors, (3) basic personality patterns including, but not limited to, self-structure, self-concept, and need/motivational systems, (4) the language system of an individual, especially as this mediates the perception, classification, and organisation of responses to reality, (5) standards of normality, deviance, and health, (6) treatment orientations and practices, (7) classification patterns for various disorders and diseases, (8) patterns of experience and expression of psychopathology, including such factors as onset, manifestation, course, and outcome (Marsella & Yamada, 2007).

Figure 2: Sociocultural pathways to distress, deviance and disorder



Source: Adapted from Marsella & Yamada, 2007.

In an effort to increase sensitivity to cultural variations, the DSM further offers a series of criteria for the cultural formulation of a case and a listing of 'culturebound syndromes'. The criteria include determining the (1) cultural identity of the individual, (2) cultural explanations of the individual's illness, (3) cultural factors related to the psychosocial environment and levels of functioning, (4) cultural elements of the relationship between the individual and clinician, and (5) overall cultural assessment for diagnosis and care. Theoretically, these criteria should be used in each and every case since each case is a 'cultural' encounter between the different cultures of the patient and professional.

The Community That Care (CTC) programme for development of mental health amongst adolescents and youths

Often, at the community level, large-scale interventions are required to affect prevalence rates of adverse behavior. Some community-based programs, such as youth-mentoring initiatives, emphasize outcome improvements for a specific age group. The Communities That Care (CTC) approach (Hawkins and Catalano, 2004) is an evidence-based, comprehensive, multi-tiered system of support that encourages the collection and systematic use of community-level data to identify areas of strength and need and to guide plans for preventive strategies based on a community's specific profile. Emphasis is placed on areas of greatest need, not those with the largest populations and, because schools typically are included, CTC frequently targets school-aged children and adolescents explicitly. The program is built on the tenets underlying both social control and social-learning theories, which hold that individuals' behavior is influenced by the groups to which they belong. Interventions based on these theories aim to create pro-social norms and community bonds, both by providing opportunities, teaching the skills to be involved with a group and by creating a system of recognition for positive behavior (Hawkins, Catalano, & Arthur, 2002).

The CTC approach accomplishes those goals by increasing communication among community members, guiding community mobilization and providing training. It involves being trained in a five-

phase, data-driven, analytic, problem-solving approach, forming an action plan, selecting evidence-based interventions and implementing them. The approach has been implemented in Australia, the Netherlands, the United Kingdom and the United States of America. The end goal is to ensure healthy outcomes by having the involved community take ownership of the process. Studies of Communities That Care in the United States of America have documented consistently that – even with limited funding – communities can implement such an approach. Compared with non-CTC sites, CTC communities were more likely to select evidence based prevention programs for implementation (Fagan et al, 2011).

Educators, peers, parents, counsellors and other stakeholders engaged in the youth mental-health support system should have respectful and caring attitudes to all youth. These supportive adults should be open-minded and non-judgmental, and focus on developing trusting relationships and maintaining awareness of the importance of diversity and youth culture, when working with youth at risk of developing, or with, mental-health conditions. Any system that supports youth with mental-health conditions should be able to recognize and address the need for intervention, advocate for, motivate, recruit and engage youth, understand youth disability and culture, and communicate with youth with physical, sensory, psychiatric or cognitive disabilities (United Nations, 2014).

Conclusion

Mental-health conditions during adolescence and young adulthood can have a significantly negative impact on the development of safe and healthy relationships with peers, parents, teachers, and romantic partners. Many mental-health conditions negatively affect youths' ability to successfully form supportive and healthy relationships and manage conflict in relationships, which is particularly disconcerting given that adolescence is a critical time for identity formation and taking on roles, especially with peers. Disruptions in the ability to form and sustain interpersonal relationships can have lasting impacts on youths' social and emotional functioning. Mental-health conditions are associated with behavioral health risks such as substance use, unsafe sexual behavior and violence, injury and all-cause mortality. Mental-health conditions perpetuate a negative cycle of poverty and social exclusion. They impact work-related performance negatively, including employability, work performance, hours worked and overall work-related productivity. Taken together, these data illustrate the significant impairment, disability and disease burden associated with mental-health conditions. Therefore, the prevention of mental-health conditions must be a global public-health priority.

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