

Case Report

Reflecting on Transcultural Care; Culture Care Theory and Mental Health Nursing

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Received: September 09, 2014; **Accepted:** October 06, 2014; **Published:** October 08, 2014

Abstract

This intrinsic case study explores the mental health nursing care of a consumer that was born in mainland China and who had migrated to Australia. The perception and understanding of mental illness from a Chinese migrant perspective can differ from the western cultural view. These differences can provide challenges for Chinese migrants and the health services that deliver care.

The case study occurred at a 20-bed inpatient unit which admits people suffering from mental illness or severe behavioral disturbances from within the metropolitan suburbs of Sydney, Australia.

Using Leininger's 'Culture Care Theory', the consumers nursing care is explored from the key parts of the theory which include; culture care preservation and or maintenance, culture care accommodation and or negotiation and culture care restructuring and or repatterning. Implications for the consumer's mental health care are discussed and recommendations for the mental health nursing care of Chinese migrants from a culture care perspective are suggested.

Keywords: Culture Care Theory; Mental health nursing; Mental health; Migrants; Mental illness

Introduction

There have been increases in migration to Australia from mainland China in recent years. Census of population and housing data in 2012 showed that 206,588 people in Australia were born in China, representing the third largest overseas-born nationality in Australia [1]. This growing increase has created challenges to health services in delivering appropriate culturally competent care. The perception and understanding of mental illness from a Chinese migrant perspective can differ from the western cultural view [2]. These cultural differences can create barriers to mental health service utilization [3].

Several studies have attempted to understand the influence of Chinese culture on a person's mental health and their access to health services [4,5]. Blignault et al [3] in a qualitative study, interviewed nine Chinese born migrants with a mental illness, identifying low levels of mental health literacy, communication difficulties, stigma, confidentiality concerns, service constraints and discriminations as barriers to accessing mental healthcare. Chinese born migrants in New South Wales, Australia, have lower rates for hospitalization for mental disorders and a 25% higher proportion of involuntary hospital admissions compared to Australian born consumers [6]. In an Australian study by Hsiao et al [7], twenty eight Chinese born Australian consumers and careers were interviewed to understand popular concepts of mental illness and their social and cultural knowledge about mental illnesses influences. Hsiao et al [7] found that they combined traditional knowledge of western medicine to develop their own label for various kinds of mental disorders, including mental illness, physical illness, and normal problems of living and psychological problems. A consistent theme within the

Australian literature is one of difficulty in accessing health services for the newly arrived immigrant. The combining of beliefs about western medicine and traditional Chinese medicine further complicates this for individuals and also the western trained healthcare staff they see [8]. The international literature reflects similar issues to the Australian studies, reporting the stressors of migration and the differing health beliefs systems amongst migrant populations, for example: Abbot et al [8] (New Zealand); Chen and Kazanjian [9] and Tang et al [10] (Canada).

Challenges for mental health nursing may lie in our understanding of the cultural attribution of mental health suffering in Chinese societies [11]. Mental health nurses are in key roles to enable the care and provision of culturally competent care to consumers with a mental illness. Increased knowledge, a critical understanding and consideration of theoretical approaches to the 'how' of providing culturally competent care could improve the mental health nursing of consumers from culturally and linguistically diverse backgrounds. There are a number of models and assessment tools within nursing that can be used as frameworks to provide care to immigrants such as; Leininger's Sunrise Model [12], Purnell's Model for Cultural Competence [13], Campinha-Bacote's Model of Cultural Competence, and Giger and Davidhizar's Transcultural Assessment Model [14]. Leininger's model is used in this case study because it includes the concept of care as central to nursing and seeks to understand people in terms of their cultural values and beliefs, symbols, material and nonmaterial forms, and living contexts [12]. Leininger work on the Sunrise Model has been implemented for over 30 years by nurses worldwide for use with various cultural groups [16-18].

Aim

This case study reviews the mental health nursing care of a migrant consumer born in mainland China within an inpatient mental health unit.

Method

The case study occurred at a 20-bed inpatient unit which admits people suffering from mental illness or severe behavioural disturbances from within the metropolitan suburbs of Sydney, Australia. A qualitative case study approach was taken as it is an exploratory method of enabling understanding of complex care issues, where detailed presentation of real-life experiences are preferred to quantifiable methods. After the consumers discharge the primary nurse reflected on her care within the context of a clinical supervision group [19]. From this process, a critical reflection of how the consumers care was provided; in terms of culture care theory will be examined [12]. Upon discharge from the unit, the consumer was approached to discuss publishing the work within a health related journal. Although the consumer has a good understanding of the English language, it is her second language and for the purpose of informed consent for the case study, an interpreter was used and supervised the signing of the consent letter. Demographics have been changed to further protect the patient's anonymity. Leininger's model of Culture Care Theory is used as a framework to understand the delivery of care in this case [12].

Case Study

The consumer immigrated to Australia from China in 1998. Aged 37 years old she had four previous admissions to various mental health inpatient units, due to relapses of her schizoaffective illness in Australia. On presentation to the unit for the admission being reported here, there was evidence of a significant deterioration in her mental state, non compliance with prescribed medication and financial difficulties. She had a history of symptom related aggressive behaviour during previous admissions, and posed a sexual safety risk evidenced by sexually disinhibited behaviour with others when unwell. She had a diagnosis of diabetes mellitus type 1 insulin dependent and was treated pharmacologically with the following: antipsychotics, mood stabilizers and anti diabetics. She spent the first twenty six years of her life living in mainland China where her extended family lives. She regards herself as Chinese-Australian and is proud to be a permanent resident. She reports that she has adopted a westernized medical view of her mental illness. Her family lives in China with a limited understanding of her illness. Her mother has more traditional Chinese view of her illness, believing it to be caused by evil spirits or a curse. She reports that her family is ashamed of her because of her mental illness. This has meant that she has felt isolated from her family, with them offering little in the way of support.

Before she was diagnosed with a schizoaffective disorder, she had some success in her educational studies at school level in China. She attended university in Australia (accountancy), but was unable to finish her studies due to her illness. This was a source of high anxiety and low self esteem to her family, Chinese culture places a high level of emphasis on educational achievement. Before the development of mental illness the consumer was able to work various part time jobs to supplement income. At present she is unable to work and receives

a disability support pension of approximately \$520 each fortnight. She lives by herself in a one bedroom department of housing flat. She has never married, has no children or dependants and currently has no partner. She also received money from her family in China occasionally to help her with her financial strain. On discussion with her was revealed that she continually received financial assistance from her family, which was a source of much frustration for her leading her to believe she has failed her family. Her original plan was to send financial assistance to her parents in China, once she finished her studies. Traditional Chinese immigrants are sent abroad to earn money for their families at home in China, this reverse in role for her and her family is a significant contributor to stress and a possible contributing reason for her to relapse.

The consumer is a devout Christian and regularly attends a Chinese Christian church. Although she occasionally displays some traditional Chinese views of her illness, the majority of her belief system is grounded in Christianity. As she has no family in Australia, the church has proven a good source of support, comfort and introduced her to other people from her culture with similar religious beliefs. The main factors affecting her mental state are the management of diabetes type 1, risk of cultural isolation and loss and cultural identity. She states that at her current age, "I should have had children at this stage of my life" and "I should have been married many years ago". The possibility of never having children is a source of distress and anxiety for her, her psychiatric symptomatology possibly reflects some of this, where she has been sexually disinhibited and has had delusional beliefs that she has several husbands.

Mental health nursing and culture are theory

A dominant theory in the nursing care of people from the diverse cultural backgrounds is known as 'Culture Care Theory'. Culture Care Theory (CCT) has emerged as a theoretical approach for which nurses can base their practice on when nursing people of differing cultural backgrounds [12]. Leininger [12] divide CCT into three parts that help assist, support, facilitate or enable acts that help cultures; 1. Culture care preservation and or maintenance (retain, preserve or maintain beneficial care beliefs and values), 2. Culture care accommodation and or negotiation, (act of helping cultures adapt to or negotiate with others for culturally congruent, safe, effective care for their health and well being) 3. Culture care restructuring and or repatterning (acts that help reorder, change, modify, or restructure institutions for better health care outcomes). Leininger [12] who developed the theory suggest it provides a mode of ensuring safe, competent, and congruent transcultural nursing care.

Culture care preservation and or maintenance

Involved in this part of the theory are the processes that "assist, support, facilitate and enable professional acts or decisions that help cultures retain, preserve or maintain beneficial care beliefs and values or to face handicaps or death".^{20p51}In an attempt to preserve and maintain some of her religious beliefs and values she was encouraged to link back in to her church group and encourage members to visit whilst she was in hospital. She was given opportunities each week to contact her mother in China, by doing this she able to help preserve the family links with the intent of decreasing the isolation that she feels from her family unit. The concept of losing 'face' or ones reputation is a strongly held belief in Chinese culture. Maintaining a

good reputation or 'face' for the entire family is considered a primary consideration as to whether once engage in certain behaviours or not. 'Face' can be lost with an entire family due to the behaviour of one family member [21,22]. Losing one's reputation can lead to influences on help seeking behaviours of individuals. Disclosure outside one's own family within Chinese culture can result in shame for the whole family.

Culture care accommodation and or negotiation

This mode includes those "assistive, supportive, facilitative, or enabling acts or decisions that help cultures adopt to or negotiate with others for culturally congruent, safe, and effective care for their health, well being, or to deal with illness or dying"^{20, p51}. To improve her support network of carers and friends she requested that nursing staff and her community case manager educate them on the signs and symptoms of her illness and her current medications regime. The aim was to give the consumer, a better understanding of her illness and aid in her medication compliance before discharge. The intent is to empower her carers with the ability to recognize the early warning signs of relapse and hopefully become more accepting of her illness [23]. Acceptance is said to decrease stigma and give consumers a sense of belonging within their community, in turn promoting better health outcomes [24]. Assistance with her housing and income was provided by the social work department, whom also developed a rapport with her friends and contact with family overseas to ensure they understand her living and financial situation.

Culture care restructuring and or repatterning

This mode includes the "assistive, supportive, facilitative or enabling acts or decisions that help people reorder, change, modify, or restructure their life ways and institutions for better (or beneficial) healthcare patterns, practices, or outcomes"^{20p51}. A nurses understanding of a consumer's cultural background and their attitudes towards western concepts of mental health is important in the effective delivery of mental health care. This understanding enables appropriate and culturally sensitive treatment [11]. Consumers of a Chinese-Australian origin may view failure to fulfill cultural expectations of their roles in the family and to demonstrate appropriate behaviour as 'losing face'. Understanding the culturally sensitive issues will enable the nurse to engage more empathically with consumers [11]. The psychiatric hospitalization of a member of family in Chinese culture can have a negative emotional response for the whole family [25]. The consumer in this case was concerned that she has not fulfilled her obligations to her family by failing in her educational endeavors and not being married or having children. Through a process of empathic restructuring, these anxieties were addressed and ultimately became less invasive.

Study limitations and future research

This case study was limited by an in-depth investigation of a single persons care delivered at one hospital site, discussed within a single theoretical framework. Future research should consider transcultural care more widely, across a variety of settings and within a variety of culturally and linguistically diverse populations. Organizations need to consider strategies that enhance cultural competency within healthcare settings. Healthcare organizations need to invest in the development of policy initiatives around: interpreter use; multilingual hospital signage; patient information; discharge protocols of patients

from different backgrounds, and the development of new models of care for vulnerable migrant groups. These strategies need to be evaluated for their relevance and effectiveness in engaging differing cultural groups.

Conclusion

By reflecting on her care from a culture care theory position the primary treating nurse was able to gain a deeper understanding of some the reasons for her presentation and difficulty in accessing services and treatments. Positioning nursing care within a theoretical framework enables the nurse to develop reasoning and rationale for a direction in care. Critically reflecting on her care using culture care theory enabled the nurse to improve their knowledge and therefore enhance their ability to predict similarities and differences that are required in future care of like consumers. CCT allowed the nurse to discover caring and healing values, beliefs and practices that are used by individuals from culturally and linguistically diverse backgrounds. The ability for nurses to provide culturally competent care is dependent upon a nurse's ability to understand cultural differences and diversity [26]. To establish effective rapport, to accurately assess and develop care, cultural competence amongst nursing staff needs to be further developed.

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