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LETTER TO EDITOR

Additional Thoughts on the Individualism–Collectivism Paradigm: Familial Co-aggregation, the Treatment Gap, Structural Competency, and Social Suffering

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In their article "Applying a mental health recovery approach for people from diverse backgrounds: the case of collectivism and individual paradigms," Tse and Ng [16] point out that the individualistic and collectivistic (I–C) paradigm can shape how people understand and pursue recovery. As stated in their article, two orientations constitute the I–C paradigm: (1) The first is the individualistic value orientation (IVO), which celebrates loose relationships, independence, and autonomy, prizing personal goals over group goals; (2) The second, in contrast, is the collectivistic value orientation (CVO), which emphasizes one's obligation to the family or community, subordinating personal goals to group interests. The authors acknowledge that these are not necessarily mutually exclusive orientations, and then discuss major ways in which IVO and CVO each carries the potential to help or hinder recovery. As suggested in their article, person-centeredness and social connectedness are both important components of recovery, yet there is some debate about how to resolve the tension that sometimes emerges between them. The authors conclude by pointing out the need for the mental health workforce to acquire skills for working with families according to the I–C paradigm. I would like to offer four additional insights in response to their article.

First, I think the I–C paradigm is particularly important given the tendency for mental illnesses to co-aggregate within families (e.g., [2]. In other words, it is not uncommon for more than one person in a family to have a mental illness. When only one members of a family has mental illness, interventions typically aim to teach the other family members how to best support the individual in recovery, usually by way of communication skills and coping strategies. But when more than one member of a family has mental illness, the task becomes all the more intricate, in that the family must accommodate multiple, simultaneous, and sometimes conflicting recovery processes. I believe a skill that mental health professionals should develop is the ability to facilitate dialogue within families to negotiate the needs and goals of each individual member while honoring the wishes of the family as a whole (for practical ideas, see Open Dialogue studies by [15]. This will require a strong awareness of the I–C paradigm, as culture can inform which members of the family will assume new roles and shoulder the caretaker burden. Further, IVO concepts such as autonomy, independence, and person-centeredness need to be reconciled with CVO principles such as filial piety, obedience, and other collectivistic virtues.

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Case Scenario: Multiple Recovery Processes within a Family can Lead to Conflict

Jimmy's mother is recently widowed and lives with major depression. Since Jimmy is the eldest child, he has been charged with the responsibility of caring for his mother. As is customary in Korean culture, his mother moves into his home. Jimmy's wife lives with general anxiety disorder, and the new living arrangement has caused her significant distress that places a strain on their marriage. Jimmy struggles to find a way to be both a dutiful son and a loving husband.

Second, fostering a greater understanding of the I–C paradigm is a step toward providing culturally responsive treatment, which can potentially address the underutilization of professional services among people of color in the United States. Historically, mental health providers have overlooked the importance of culture in service provision, causing racial and ethnic minorities to distrust professional services (the literature is extensive, but a couple of examples include: [17, 18]. Indeed studies have found that people of color feel judged, mishandled, and coerced (e.g., [3, 11]. Providers have since made efforts to reduce the treatment gap, tailoring culturally specific outreaches and interventions to engage those individuals who have been alienated from mental health institutions [5], with the hope that honoring the unique cultural needs of people in recovery will reduce negative attitudes about treatment. There are several social and cultural factors that influence the pathways into formal treatment [14], and Tse and Ng call our attention to the I–C paradigm as yet another factor.

Third, beyond cross-cultural understandings of individual patients, the I–C paradigm points to greater need for training around structural competency, which is an awareness of macro-level forces that shape physical and mental health outcomes, such as neighborhood effects (e.g., exposure to violence), discrimination (e.g., being denied a loan), access to resources (e.g., affordable health care), strength and availability of social institutions (e.g., presence of civic groups), and so forth. Metzl and Hansen [12] posit key aspects of structural competency, which include: recognizing the structures that shape clinical interactions, developing extra-clinical language of structure, rearticulating cultural formulations in structural terms, observing and imagining structural interventions, and developing structural humility. And so before we attribute behaviors and attitudes to the I–C paradigm, we must first acknowledge that allocentric tendencies can arise in response to oppression or exclusion from the mainstream society. For instance, in the United States and in Europe, people of color continue to face economic, social/cultural, and political exclusion [9], forcing them to depend on one another for the resources that are systematically denied to them by the mainstream institutions and markets [4]. Some scholars have even regarded ethnic enclave models as a viable means of achieving recovery in a society that is unreceptive of people with mental illness (examples of enclave models in practice include therapeutic communities, Fairweather lodges, and clubhouses) [10]. And so, in addition to greater understanding of the I–C paradigm, practitioners need greater structural humility to discern how much of a person's behavior is attributable to culture (which can be appreciated), and how much is attributable to social inequality (which must be rectified so that recovery can take place) [13].

Finally, one additional way in which collectivism can help recovery is by giving rise to social action. Tse and Ng rightly point out that CVO is also conducive to shame and stigma; however, they also note that collectivism can nurture social capital in local community in order to support recovery. A recent illustration of this point can be found in the US, where many Christian communities tend to place a strong emphasis on charity, compassion, community life, and activism [1]. In 2013, a prominent evangelical pastor lost his son to suicide, prompting his church to organize a mental health conference in partnership with the Catholic Archdiocese and the National Association of Mental Illness. This conference aimed to educate the public about mental illnesses, to dispel stigma, and to inspire greater support for people in recovery. In this instance, the CVO engendered a sense of shared responsibility to experience hardships together, to respond to each other's suffering, and to attempt to rectify the underlying causes that give rise to the suffering in the first place [8].

I am encouraged to see that this topic has received attention in the larger discussion about promoting recovery-oriented services across the globe, and I look forward to having further discussions about how to incorporate the I–C paradigm into training curricula.

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