OKINAWAN SPIRITUAL AND CULTURAL BELIEFS:
DERIVING IMPLICATIONS FOR MENTAL HEALTH NURSING CARE

by

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ABSTRACT

I examine traditional Okinawan cultural beliefs regarding mental health care, and how these differ from Western approaches used in Okinawa, often hindering treatment outcomes. Identifying Okinawan mental health beliefs and their differences and commonalities with Western health care practices can begin a dialogue leading to an integrated approach that more fully considers the limitations and benefits inherent in both systems. Such examinations can be a starting point towards adapting the Western approach to the Okinawan environment, rather than fitting the Okinawan population into a Western paradigm of treatment, and culturally empower the patient to participate more actively in their mental health care process. Thus, this paper seeks to begin identification of the cultural perspectives that can lead to the development of a uniquely Okinawan mental health care system that is optimized to meet the cultural and social needs of the patient, with special attention to the role of nurses.
Introduction

Mental health care providers have increasingly realized over the last few decades that socio-cultural factors affect patient perceptions of mental health conditions, and that this can impact treatment outcomes. Marsella & White (1984) stated that “since cultures condition different concepts of the self, and since self is inextricably linked to the definition, experience, and expression of mental disorder, it is clear that cultural factors are closely related to mental disorders.” (p. 362). Devos (1976) also noted that “values are always involved in the sense of malaise as it is subjectively experienced by an individual suffering some disorder,” and that therefore “the objectives of therapy cannot avoid being determined, at least partially, by the shared values of a culture” (p. 293). In the current mental health care environment, Western-derived practices and often values that they contain are practiced across a great diversity of cultural and social environments, where human values and worldviews may vary considerably.

This paper examines and acknowledges the unique nature of Okinawan cultural beliefs and society as they pertain to the local mental health care practice community, and in particular nurses. Enhanced understanding and integration of the mental health beliefs of diverse cultures and societies leading to integration with current mental health treatments would be of benefit to nurses across many populations and cultures.

A discussion examines possible starting points for new perspectives in care that would more fully address important cultural factors that nurses can integrate into their practice to provide the best possible mental health care treatment for Okinawans. It is suggested that nurses, as direct care providers, are optimally positioned in the Okinawan health care system to implement such new services. Some nursing theorists have already addressed factors that would
be helpful in understanding Okinawan (and other Eastern) mental health care concepts. Unitary Transformative (UT) theory in particular contains many views that would be useful in framing the Okinawan condition. The Okinawan example carries potential implications for mental health care across diverse cultures in general.

Background and Significance of the Problem

As a result of cultural and societal differences, Western paradigm-based mental health care practitioners as practiced in non-Western societies often fails to adequately address underlying cultural or societal contexts in the patient’s illness profile. (Kleinman & Sung, 1979; Marsella & White, 1984; Polaschek, 1998; White, 1984). Consequently, the uniform application of Western mental health care methods may hinder the provision of optimal, culturally congruent mental health care (Berg, 2003). In fact, in a society such as that in Okinawa, where traditional belief systems still dominate worldview and perceptions of mental health problems, the efficacy of adopted Western practices can be profoundly compromised (Allen, 2002a; Allen, Naka, & Ishizu, 2004; Lebra, 1969; Naka, Toguchi, Takaishi, Ishizu, & Sasaki, 1985; Shimoji & Miyakawa, 2000). For example, Okinawan patients who hold their view on traditional beliefs system have been observed to continue seeing indigenous practitioners after being discharged from hospital, and often stop taking medications due to side effects and conflict with traditional beliefs (Allen, 2002b; S. Kouchi, personal communication, July, 2007). Some researchers have suggested the combining of traditional healers and treatments with modern treatment modalities as an optimal approach to provision of treatment in populations having traditional health care beliefs that differ from current Western mental health models (Allen, 2002b; Berg, 2003; Helman, 2007).
Despite having among the longest life spans in the world (Cockerham & Yamori, 2001; Sered, 1999; Willcox, Willcox, He, Curb, & Suzuki, 2006), Okinawans have a relatively high rate of mental illness. Allen (2002b) has noted that “the occurrence of schizophrenia in Okinawa has been documented as being consistently higher than the national Japanese average” (p. 222). Some attribute this partially to the lingering trauma of the battle of Okinawa in World War II, during which by some estimates nearly one-quarter of the civilian population of Okinawa perished (Cook & Cook, 1992). As one author has noted, with the wide-scale destruction of family, the environment, and ancestral tombs, the “People whose emotional health had been nourished by the security of ancient family roots could neither pay tribute to their ancestors nor complete their own lives by joining them” (Feifer, 2001, p. 448). Further, Okinawans are an indigenous population apart from that of mainland Japan, much as the Native American population is unique compared to most other American groups, differing considerably in their culture and society. As a result of its uniqueness, Okinawa is especially lacking in a focus on the mental health needs of its population, and this is a situation that requires careful consideration of the traditional beliefs and the culture of the Okinawan population in looking for solutions.

The author (a native Okinawan) has had extensive contact with Okinawan patients during nursing practice in Okinawa, and has heard many patients’ impressions concerning their mental health care treatment. These patients have indicated that while they found parts of current Western methods of treatment helpful, they still felt that many aspects of their cultural beliefs concerning their experiences of illness and healing were being ignored. This led them to experience feelings of disconnection or isolation during the treatment process. This observation is similar to Shimoji & Miyakawa’s (2000) report on Okinawan patients. Further, Okinawan
patients have described modern psychiatric care in terms such as “depersonalizing” (Allen, 2002b, p. 234). In the view of many Okinawans, the modern mental health care system is seen to emphasize the patient’s physical disease and use of professional language, to scientifically “distance” the patient, to see the patient’s role as passive during the healing process, focus on the perceived side effects of medications, and to be less sympathetic and more authoritative (Allen, 2002b; Allen, Naka & Ishizu, 2004).

Allen (2002a) and Naka et al. (1985) observed that Okinawan patients who suffer from mental health problems commonly seek Yuta (traditional Okinawan healers), usually accompanied by their family, for help; they also found that “before (patients) are admitted to hospital the families of the patients have conducted some rituals to appease their ancestors” (Allen, 2002a, p. 156). Allen’s study found that two thirds of patients diagnosed as suffering from schizophrenia consulted a Yuta prior to visiting a psychiatrist, and had been diagnosed by the yuta as either experiencing “kami-darri” or as being a “saa-daka- nmari” (Allen, 2002a). As Sakihara (2006) explains, “kami-darri” means “divine retribution” and a “saa-daka- nmari” is a person born with strong spiritual power (p. 143). Allen (2002b) expressed concern that, from a Western psychiatrist’s perspective, such help sought prior to visiting a psychiatrist is “potentially a damaging situation” if it delays seeking other forms of treatment.

Most psychiatrists in Okinawa have been educated in the Western biomedical paradigm, and may not be fully aware of or desensitized to the impact of Okinawan patients’ cultural beliefs on their illness experience, resulting in a ‘disconnect’ between mental health professionals and their patients. (Allen, 2002a; S. Kouchi, personal communication, July, 2007). In fact, Naka et al. (1985) found that Western-trained Asian psychiatrists working in their own
culture must unlearn much of what they have studied and actually need to relearn the cultural values that will enable them to best treat patients (p. 271).

Nurses in Okinawa are increasingly using Western methods of patient care, and increasingly neglecting the spiritual aspects of patient care. The author has observed there to be no significant formal education within the academic or clinical setting in Okinawa regarding the integration of cultural care. However, at an individual, unorganized level, many nurses and doctors in Okinawa practice some degree of cultural care, showing at least an inherent recognition for the need of such care.

Okinawan People and Cultural Beliefs

Okinawans are the historical inhabitants of the Ryukyu islands, which are located approximately 400 miles south of the main Japanese islands. “Okinawans” refers to the group of indigenous persons whose ancestors have been situated on the Ryukyu island chain for thousands of years, falling under Japanese rule at the end of the 19th century, and undergoing cultural influences most heavily during the mid to late 20th century, while retaining a unique cultural and societal identity. The total indigenous population of Okinawa is approximately one million.

The Okinawan culture is deeply spiritual, with emphasis on strong connections to and unity with family, nature, and earth and life cycles. In the traditional Okinawan belief system, it is a deeply held belief that the “self” is not entirely distinguishable from one’s family, ancestors, and nature. Within this view, nature is a nurturing presence that all of the family members and the community remain solidly connected to, something to be respected. Most Okinawans have ancestral altars or shrines in their house dedicated to their ancestors, and perform rituals that include thankful prayers to their ancestors for protecting and maintaining family members’
health, as well as praying for inner peace in both their ancestor’s and their current family members’ spiritual being which are intertwined and inseparable. The term “ancestor reverence” is used to describe the Okinawan tradition of honoring and respecting one’s ancestors (Berg, 2003). Most rituals, including those conducted for ancestors, usually follow cycles of nature, such as the seasons.

In Okinawa, one looks to their ancestors to better understand their current situation in life, seeking guidance and comfort. This is not necessarily seen as a religion, but instead as a form of introspection, where one examines their roots, heritage, and strong spiritual connection with their ancestors. As Berg (2003) notes, “ancestor reverence is a way of seeing and understanding the world; it is not a religious system” (p. 196). This philosophy differs considerably in many ways from the individualistic concept of self that is commonly seen in modern Western societies.

Based on the author’s observations, the inner strength of the individual and by extension the family is sometimes felt by Okinawans to be weakened by modern society, which seems to emphasize the material over the spiritual. Whereas in older traditions and cultural practice one could look to their family or spiritual interpretation for support during the course of an illness, the task now increasingly falls on the individual and their clinical reality and biological state. As Kleinman (1988) notes, “increasingly, in contemporary Western society, the process of modernization has weakened… older forms of dealing with trouble” (p. 70). As a result, there has been a reduction of the role of family, spiritual, and societal structure in supporting the individual through adversity.
Traditional Healer (Yuta)

In Okinawa’s past, indigenous healers commonly called “Yuta,” “Kami-nchu” or “Saadaka-nchu,” a person with strong spiritual awareness (Sakihara, 2006), have played a significant role in medical practice (Sered, 1999). In many regards, the yuta is a reflection of the historical beliefs of Okinawans regarding mental health care practices and perceptions. Yuta are usually elderly women or middle aged women who are considered to be sensitive to a person’s spiritual, psychological and family interactions, and who usually have had an experience that could be described as experiencing insightful modes of thoughts and perception that transcend the norm. While not translating precisely, this is in some ways being similar to Watson’s statement concerning transcendence, where “one’s higher sense of mind and soul transcends time and space” (Fawcett, 2005, p. 559). Okinawans frequently refer to yuta as saadaka-‘nmari (of high spirit birth/ gifted as higher sense of awareness) (Sakihara, 2006), and use their skills to help people by mediating spiritual and physical awareness. Okinawans consult a yuta for not only mental health concerns, but also physical health issues and personal matters such as marriage, death, births, property issues and so forth (Allen, 2002b).

As a note, in the Western literature Yuta has been referred to as “Shaman.” This is an unfortunate misnomer, as the term carries historical connotations that do not accurately represent the yuta. Berg (2003) notes a similar negative meaning in the usage of “witchdoctor” to describe traditional African healers.

Possible reasons for the popularity of indigenous practitioners are described in various studies. In Okinawa, the yuta shares familiar concepts of mental illness and health with the patients such as external causes (Ancestor spirits, imbalance with environment). Their healing
practice focuses more on relationships (such as with other people, or with supernatural entities) than on processes that are internal to the individual (Marsella & White, 1984). Importantly, seeing a yuta carries less of a social stigma of shame than does seeing a psychiatrist. For example, the signs and symptoms of schizophrenia such as hearing voices are normalized by the yuta’s spiritual interpretation. As a result, the patient will usually be able to receive family support during the healing process (including the performance of shared rituals). A yuta practices within the context of a culturally familiar setting, including the use of familiar language and the shared understanding of the importance of ancestral connections (munchu) (Allen, 2002a; Ohashi, 1994).

Regarding treatment in other non-Western cultures, Devos (1976) observed that “in …the practices of native healers, it seems clear that most do not work with the concept of effecting an actual change in personality structure. That is a Western goal in psychotherapy” (p. 293). In a particularly notable observation on the yuta as a reflection of traditional Okinawan perceptions of mental health, Devos (1976) found that a mental health condition may also be seen as an indication that the patient may possess spiritual talent particularly suitable for the role of yuta. Devos (1976) also noted that “…the particular symptoms of (the person’s) illness are thus channelized in such a manner that the behavior becomes more controllable, hence, socially useful. The personality structure may not change, but a socially positive climate fosters adaptation rather than alienation” (p. 284). The Yuta plays a central part in facilitating this process.
General Beliefs on Mental Health and Practice in Okinawa

Although geographically Japanese, Okinawans have a unique perspective on health care perceptions and practice, composing an indigenous population having its own belief system (Allen, 2002a; Naka et al., 1985; Shimoji, Eugchi, Ishizuka, Cho & Miyakawa, 1998). If a family member complains of a mental or physical health problem, they may consult with a yuta, or they may see a doctor in a modern clinic. As an adaptation, Okinawans frequently utilize both healing practices; this is often referred to as “Isha hanbun, yuta hanbun,” which means a patient half following a yuta, half following a physician. It is estimated that the majority of Okinawan patients initially consult indigenous healers for their mental health problems, and tend to use modern psychiatric care as a “last resort” (Allen, 2002; Shimoji et al., 2000; S. Kouchi, personal communication, July, 2007). One study found that more than 70 percent of patients follow this pattern (Allen, 2002b).

Modern mental health professionals and patients in Okinawa have varying perceptions of mental health, its causes, and its treatment. Shimoji and Miyakawa (2000) and Naka et al. (1985) found that while Okinawan patients were suffering from symptoms that the attending psychiatrist attributed to schizophrenia, the patients and their families believed that the symptoms reflected “kami-darri”, which means shirase/messages from the patient’s ancestors or spiritual cause. Allen (2002b) notes that, “in today’s modern Okinawa some are cynical about the perceived value of shamans (Yuta), particularly medical and scientific personnel” (p. 225). As a result of such differences of opinion, patients admitted to psychiatric hospital may still hold their views on the causes of mental distress, and may not accept a psychiatrist’s assessment. (Shimoji & Miyakawa, 2000). Often, Okinawan patients who adhere to their traditional belief system will
continue to see indigenous practitioners after being discharged from hospital, and sometimes they stop taking medications due to side effects and their beliefs (Allen, 2002b).

In clinical psychiatric treatment, the patient is treated with a combination of medications and behavioral therapies. In the traditional Okinawan belief system, the negative energy cycle that is causing one’s soul distress or spiritual affliction must be stopped for the sake of the individual’s (and family’s) well-being. The family participates in rituals for the healing process, providing emotional and spiritual support. Such practices are based on traditional Okinawan belief concepts such as “Chiji-uri manikata” (Urasaki, 2004) and “Ninnu-migui.” Chiji-uri manikata” is a type of “karmic carryover” from one’s ancestors, both positive and negative in nature, and varying in intensity and focus among family members. Ninnu-migui roughly translates in ancient Okinawan language to a “year-cycle.” If a negative incident impedes this cycle, the individual and the family pray for the patient to heal and resume a “healthy” (both mental and physical) ancestral life cycle.

The possible effectiveness of performing rituals in protecting against anxiety and uncertainty related to unknown mental illness for the patient has been indicated in the literature (Helman, 2007). In Okinawan ritual, a return to an appreciation of nature and its cycles, and cultural traditions including oneness with family and nature is usually emphasized in order to rebuild spiritual and inner strength. As a matter of preventive practice, a family member, usually the eldest female, may consult with a yuta yearly for family spiritual guidance, or “hachi-unchi” (Allen, 2002a; Sered, 1999).
Western Nursing Theorists: Application in Okinawan Context

Western and Eastern mental health and treatment concepts and theory do not necessarily need to be exclusive of each other. In fact, different Western nursing theorists have sought to reinterpret mental health care practice and nursing theory, sometimes in reflection of their experiences in Asia. Some theorists come from a background of Western treatment theory and systems, and yet seek to address issues of spirituality and culture that hold relevance to Eastern cultures such as that of Okinawa. Such theorists have recognized the importance of a holistic approach for the patient that includes elements such as spirituality and cultural context, and have cautioned the profession against becoming too impersonal in an age of new technologies and complex health care systems; additionally, they suggest that the basic humanity of the patient must not be forgotten and should be incorporated into new practice, research and theory (Leininger & McFarland, 2002; Newman, 2002; Rogers, 1994; Watson, 1988, 1990; Watson & Smith, 2002).

The theorists reviewed in this paper are typically categorized as having a unitary-transformative (UT) perspective. Here, it would be useful to briefly overview the UT perspective in the Okinawan context. For example, the UT concept of the “whole,” where all elements of the environment impact on each other is a concept that also follows many elements of traditional Okinawan beliefs, where nature is an integral part of the individual. Other aspects of UT theory hold both parallels and differences, such as the concept of a “universal self-evolving, energy system” (McEwen & Wills, 2006, p. 123). In Okinawan belief systems, this is to some degree displaced by a more structuralized concept of a family and social relations that has a heavy impact on what defines the individual.
Nursing theorists such as Watson (1988), Rogers (1986), Newman (1994) and Parse (1992) frequently refer to holistic elements that include the importance of interconnectedness between human beings, nature and the universe (Laustsen, 2006; Leddy, 2006; Malinski, 2002; Mitchell & Cody, 1992). In this worldview, when an element of an individual’s environment—their family, society, air, water, and work surroundings is negatively impacted, then the individual’s internal balance can be compromised, affecting that person’s health. As a result, it would be impossible to fully understand a patient’s needs without understanding to some degree their cultural and/or socioeconomic background; part of understanding the patient’s health is consideration of the circumstances that arise from their unique interaction with their environment. And this holds especially true for Okinawan and other Asian patients. Marsella and White (1984) note that “many traditional Asian healing systems are based on concepts of health which view man as a microcosm, a reflection of the process at work in the cosmos” (p. 366).

Watson (1988) and Rogers (1986) hold many views that are particularly similar and relevant to Okinawan concepts of mental and spiritual health; below, some of these points are compared to Okinawan beliefs to highlight their relevancy. Leininger (2002) and Kleinmans’ (1988) concepts of care as practiced within varying cultural contexts are also discussed as they relate to Okinawan mental health care practice.

*Watson’s Theory of Human Caring*

The values, claims, and assumptions of Watson’s (1988) theory are seen as a philosophy that holds particular applicability for Okinawan mental health nursing practice. Sarter (1988) notes that Watson is a unique theorist in that she “support(s) the concept of soul and (emphasizes) the spiritual dimension of human existence” (p. 55). Watson’s Theory of Human
Caring describes the nursing profession and practice as a human science that is based upon “an epistemology that can include metaphysics as well as aesthetics, the humanities, art, and empirics” (Watson, 1988, p. 17). While this may still be somewhat unique from a current Western viewpoint, much of Watson’s approach adapts well to aspects of Okinawan beliefs as they relate to the person, their surroundings, and their traditional beliefs.

Watson (1988) points out the value that “Eastern ideas and philosophies” can hold in nursing practice (p. 40), and cautions against the lack of attention to the spiritual in healing, warning of the consequences of doing so (p. 37). In a strong reflection of the UT approach, Watson considers external factors such as the environment and a patient’s connection to nature and the universe as being important for an individual’s well-being; the human being is seen as not merely a biological organism or being, but also a spiritual being, a part of nature (p. 55). As Fawcett (2005) notes, “Watson sees the human being as a “unity of mind-body-spirit-nature” (p. 558).

Relating strongly to this UT perspective, In Okinawa both a person and their family are spiritually connected to nature and the cosmos, and a positive balance in these connections is needed for well-being. In the Okinawan ethos, the traditional Okinawan concept of spiritual being, or soul, is called in old Okinawan “mabui,” and this is deeply tied to how Okinawans perceive mental health, which is almost indistinguishable from their spiritual health. While the word mabui may not be known by many younger Okinawans, the tradition of associating the soul to illness continues (Sered, 1999; Urasaki, 2004). As in Watson’s (1988) concept of well-being, in Okinawans generally regard mental health well-being as being dependent on the spiritual health of a person and their family and their connection to nature.
Illness is not seen by Watson as necessarily being disease in the purely biological or clinical sense, but also attributable to lack of “harmony” or imbalance in the soul, or with the greater environment or nature (Watson, 1988). Watson indicates that illness and disease cannot be separated from the soul or the “essence” of what constitutes a person (Watson, 1988). In this view a person’s health is subjective and to a large degree dependent on their perceived reality, and their “… inner world can transcend time past, present, future, through introspection, creative imagination, meditation, visualization, and the projection of the self in a series of experiences, as well as in sleep, dreaming, and fantasizing…” (Watson, 1988, p. 48). As a result, a person may have an illness that is “completely hidden from our eyes,” or “not related to the external world.” (Watson, 1988 p. 51). Watson describes health as being a subjective experience, where a person’s situation may not be related to the external world as much as to the person’s inner world as he or she experiences it, or their perspective.

Watson’s view of health parallels traditional Okinawan thinking, where an illness may be a manifestation of an ancestors’ (and thus the patient’s) karmic imbalance, which is in turn connected to the greater physical and spiritual environment; one needs to address these imbalances in order to re-attain a desirable health state. In this perspective, the Okinawan sees their family and ancestors as a part of their spiritual and physical environment, along with their natural surroundings. Similar to Watson’s (1988) account, these factors play a role in “hidden” mental illness, which can be the result of many unseen causes: family, ancestors, or an imbalance in nature. This is a connection that transcends time and space limitations, in that the events of the ancestors’ past are reflected in the health state of their descendents. The Okinawan indigenous practitioner will seek to find these hidden “meanings” for their clients in order to identify the
cause of their ailment (Fawcett, 2005). For the Okinawan, these underlying causes require introspection, often guided by the yuta, to discover.

In treatment, Watson’s (1988) concept of the “transpersonal caring relationship” emphasizes the importance of assessing recognizing the state of the other person’s “soul” in caring for them, and establishing empathic connections through verbal and non-verbal actions and shared realities (Watson, 1988). According to Watson, transpersonal caring is “a means of progress where an individual moves toward a higher sense of self and harmony with his or her mind, body, and soul” (Watson, 1988, p. 70). The caregiver seeks to empower the individual, as seen by self-healing, self-knowledge, and self-control.

In Okinawa, during patient treatment the psychiatric nurse encounters a relatively high degree of patient contact in comparison to many other healthcare professionals, a level of contact that emphasizes the importance and uniqueness of the human-to-human relationship for nurses in Okinawa. This is similar to Watson’s (1988) concept of recognizing the state of the other’s soul in a transpersonal caring relationship, although it may be more of an inherent approach that comes very naturally to the Okinawan caregiver. In the Okinawan culture, persons refer to deep interpersonal communications with other as “chimu-kukuru” (Sakihara, 2006), which means “from the heart,” or communication that is spiritual and natural, rather than business-like or socially indicated.

Watson (1988) emphasizes that caring is based on an ontological view of oneness and unity, as she sees the human being as a “unity of mind-body-spirit-nature” (Fawcett, 2005, p. 558). Watson’s theory recognizes the “essence of the person and emphasis on its care and treatment.” Watson addresses this issue specifically, referring to the concept of “spiritual
evolution” and “potentiating instances of transcendence and self-healing” (Fawcett, 2005, p. 559).

The sense of a soul’s ability to transcend and evolve is also very strong in Okinawan culture. There is a higher sense of mind and soul transcends time and physical reality. This follows what Watson refers to as collective unconscious, causal past, mystical experiences, a higher sense of power, and the spiritual evolution of human beings (Fawcett, 2005). The author would suggest that in this respect, the Okinawans have a level of awareness that is very developed, and should be respected and acknowledged, rather than accommodated.

*Rogers’ Science of Unitary Human Beings*

Much as with Watson’s (1988) view of “oneness,” Rogers (1986) is a UT theorist who forwards the concept of the “whole” where all elements of the environment have an impact on each other and are seen as “a manifestation of an interaction process” where each element is not isolated, but “an integrated part of the whole” (Malinski, 1986, p. 17). Rogers views human beings as being “unitary, irreducible” (Rogers, 1986), and states that they and their “environment are constantly exchanging matter and energy with each other” (McEwen & Wills, 2006, p. 203).

Rogers’ (1986) concept of the relation of person with their environment is particularly relevant to traditional Okinawan cultural concepts, where the mind and the essence of the person (soul) is connected to a wider spiritual reality (universe). Much as with Watson’s (1988) ideas on oneness and unity, this view follows elements of Okinawan belief in which family members, ancestors and nature are an integral of the individual. In the Okinawan worldview, the family is an extension of their connection with the environment. Traditional Okinawan people practice
rituals involving praying for the family’s health to both their ancestors and the spirits (deities) of nature that provide the environment that sustains human beings (Sered, 1999; Urasaki, 2004).

*Leininger’s Theory of Cultural Care*

Leininger’s “Culture Care Diversity and Universality Theory” emphasizes the importance of nurses’ “knowledge of patients’ cultures and worldview” (Leininger et al., 2002). She addresses the importance of the “humanistic dimensions (of) people in their cultural life context… (and the) incorporation of social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living and geo-environmental factors, as potential influencers of cultural care” (Leininger, 2007, p. 9). While Watson’s (1988) concept of the transpersonal caring relationship seems to focus more on spiritual and intuitive aspects of understanding and communicating with others, Leininger’s approach towards patient understanding and communication places emphasis on the need to incorporate observable and measurable cultural beliefs into nursing practice in order to “promote quality of life and health, and to help cultures survive and maintain their health” (Leininger, 2007, p. 9). Leininger’s assertion is not only that the patient is a “person” whose unique values and beliefs affect their life experiences including health and illness perspectives and practices, but that cultures are also an entity that needs to kept healthy.

While not addressing all the important spiritual aspects of Okinawan culture, Leininger’s views still hold relevance to the practice of mental health care in Okinawa. As mentioned above, in Okinawans the concept of health and illness is deeply embedded in traditional cultural beliefs. The health of the ancestors, the spiritual, and the physical are interconnected. Mental health is particularly seen as being affected by this connection, at least in contemporary Okinawans.
While understanding the spiritual aspects of Okinawan beliefs is critical in providing optimal care, nurses also need to understand the cultural history that accompanies these spiritual beliefs. Further, the Okinawan nurse needs to understand the importance of supporting the role of their native culture in the mental health care process, which also entails supporting the health of the culture itself. Related to the concept of the nurse’s role in maintaining cultural health, Leininger & McFarland (2002) describes the importance of nurses recognizing and being aware of their own values and biases in caring for others: “Nurses may be acculturated to another culture and unable to see and know their own traditional and current culture” (p. 122). Okinawan nurses have in many cases fallen out of considering their own traditional cultural beliefs and practice regarding health and mental health care. While, as mentioned above, Okinawan nurses may unconsciously provide culturally sensitive care, in most cases there is little cognizance of actually providing such care, much less of teaching it to others or formally recognizing it.

**Kleinman’s Explanatory Theory**

Kleinman’s (1988) theory is similar to Leininger’s in that it examines the effect of cultural awareness on treatment; however, it also provides an interesting psychiatric perspective regarding the disconnect between clinical and personal conceptions of illness. Kleinman’s “Explanatory Model” describes the importance of understanding how patients’ cultural and social backgrounds can affect how they perceive and react to their disorder and respond to its treatment (Kleinman, 1988; Kleinman, Eisenberg & Good, 1978). He points to the differences between “egocentric Western culture and sociocentric non-Western cultures, and disclose that culture exerts a powerful effect on care” (Kleinman, 1988, p. 117). Kleinman indicates that the psychiatric practitioner needs to look beyond purely biological causes of mental illness, and
follow a “patient model” of negotiation with the patient to determine the patient’s treatment goals, with attention to patient perception of illness that involves traditional belief systems (Kleinman et al., 1978, p. 256). He noted “how a patient’s explanatory model and view of clinical reality can be quite discordant with the professional medical model, producing misunderstanding and problems in clinical management” (Kleinman et al., 1978, p. 254).

One clinical management difficulty for Okinawans has already been mentioned in this paper, that of the patient uncertainly alternating between the traditional family or yuta-based therapies and Westernized treatment, often resulting in a delay of one modality. Improved patient discussions with attention to traditional beliefs could help to alleviate such concerns. Whereas in Western or modern practice a mental health professional may see a mental illness as the result of a disturbance of brain neurotransmitters, the Okinawan patient and their family might attribute an affliction to “shirase” (signs) manifested by their ancestors or to “kamiddari” (attack) by deities (Shimoji et al., 2000). If the communication regarding such differences in concepts of mental health is poor, then patient confidence and certainty will suffer.
FIGURE 1. Relevancies of Okinawan Mental Health Beliefs and Western Theory Concepts

With some basis in observation of Asian society, it isn’t surprising that both Watson (1988) and Rogers’ (1986) concepts of spirituality and Kleinman (1988) and Leininger’s (2002) concepts of cultural awareness and health in care hold applicability to Okinawan issues in mental health care. Through examination of relevancies and applicability, it is hoped that these theories can help in the developing of new perspectives in mental health treatment in Okinawa.

Views on Care Across Societal and Cultural Contexts

Providing care that understands spiritual, cultural and societal contexts has been acknowledged to be an important concept, one that has over time assumed an important role in nursing practice and education. Research studies indicate that “culturally congruent” care
“improves patient information, compliance and satisfaction with services, with significant consequences for physical and psychological health outcomes” (Ayonrinde, 2003, p. 246; Majumdar, Browne, Roberts, & Carpio, 2004). The literature has described the collaboration of modern health care systems and indigenous practitioners across a number of societies including African, Asian, Middle-Eastern, and Western countries including the U.S. An examination of observations across cultures reveals patterns that hold relevance to the Okinawan example.

Kleinman and Sung’s (1979) study described the comparison of treatment approaches between indigenous practitioners and modern health care in Taiwan. The primary difference seen between modern and traditional practice was that modern clinical care focused on treating and curing biological disease, whereas an indigenous practitioner placed more emphasis on the psychosocial context and cultural beliefs that might play a role in the patient’s illness experience. The researchers observed that the connection between the patient’s social and cultural factors and the patient’s concept of “healing” and treatment satisfaction was especially strong in the case of psychological problems. They concluded that socio-cultural factors and illness experience of a patient can be integrated into the treatment process to optimize patient’s care in modern health care system (Kleinman & Sung, 1979).

Barnard’s (2007) describes her unique experience working with Native American patients during her psychiatric mental health practice. Barnard found that Native American patients’ worldview and values are different from Western cultural perspective, and that this affected their mental health beliefs and treatment practices. For example, Barnard describes the difficulties in treating her Native American patients with what she refers to as an “Eurocentric” approach that focuses on the individual, rather than the family or community. One Native American client
related to her illness as follows: “if my husband is not happy, then I am not happy. If my children are not happy, then I am not happy” (Barnard, 2007, p. 32). Barnard noticed that this greater involvement of the mental healing process extended to the patient’s community, a contrast to the Western approach of focus on “self-mastery.”

Barnard (2007) also had difficulties in eliciting a chronological history, as her patients did not tend to relate their course of mental illness in terms of chronology, but through “their worldview of connectedness to their total environment” (p. 34). The concept of time extended to their keeping appointments not on the basis of chronology but on need and convenience, which she found that she also had to adapt to.

Further, Barnard (2007) also observed that respecting the Native American patient’s traditional healing ceremonies and rituals are necessary for the non-Native American practitioner in providing optimal services. Barnard’s overall observation of her experiences was that there were many family and cultural dynamics that she was not familiar with, and that these needed to be understood in order to provide good treatment. Attempting to force the patient to fit the Western model of modern psychiatric care was not a viable option.

Berg (2003) became concerned with the importance of understanding traditional African cultural perspectives and worldviews as the result of her interactions with her African clients. Berg had noted that many of her patients were seeking out “traditional healers” and sought to explore this phenomena further. She observed that traditional healers in South Africa share the same worldview and perspectives with their clients; this appealed to African patients’ deeper psychological needs, or “fundamental human needs” by performing traditional rituals in order to re-connect “the individual, the family and the community, (the) body and mind, and…"
conscious and unconscious of (the) psyche” (p. 202). Berg found that indigenous South African tribe people’s mental health care practices are deeply embedded in their “belief system which reveres the ancestors, who in turn act as intermediaries to a higher being” (Berg, 2003, p. 205), which could be another way to promote their mental health as some way similar to Western psychotherapy. Berg suggests that it is important for mental health professionals to widen their perspectives and respect other cultural beliefs.

Watson (1988) also draws upon her observation of the healing processes of diverse cultures; for example, she has observed the funeral rites of aborigine tribes in Australia, looking for “psychological-nursing-human care relevance” (Watson, 1988, p. 83). Based on this experience, she described the aborigines’ healing process as it ties into their religious and cultural beliefs. Watson has related the role of the aborigine comforter of the bereaved to the nursing process by virtue of “healing” through empathy/sympathy and shared pain (Watson, 1988).

Hussain and Cochrane (2004) reviewed evidence concerning the treatment of depression in women of South Asian origin (primarily Pakistani and Bengali) living in the UK. They found that South Asian women in living the UK underutilized mental health services in comparison to Caucasian women, observing that the unique cultural and religious needs of this group was inadequately met by the mental health services available (Hussain & Cochrane, 2004). The researchers identified several cultural and social factors that impacted the mental health of these patients that differed from typical Western patients, or “culturally specific vulnerability factors” that included “social isolation, living with extended family, unhappy marriage and inter-generational conflicts” and “gender of offspring” (Hussain & Cochrane, 2004, p. 257).
Hussain and Cochrane (2004) further note that Asian people tend to utilize traditional healers for mental health care due to their beliefs for mental illness as “spiritual problems,” and that such treatment usually accompanies rather than displaces Western treatment (2004, p. 261). They suggest that patients are most comfortable when dealing with traditional healers who share the same background and community, and that for “spiritual problems, the appropriate helpers may be spiritual healers” (Hussain & Cochrane, 2004, p. 261).

Saravanan, Jacob, Deepak, Prince, David, and Bhugra (2008) qualitative study of patients and their families in India found that many felt psychosis to be the result of fate, love, “family problems,” or “karmic deeds” (p. 233). Patients indicated that they frequently consult “traditional healers and shamans” and visited temples seeking treatment (Saravanan et al., 2008). Further, study participants including patients and family members were more likely to regard mental illness as a spiritual affliction rather than a disease (Saravanan et al.). The researchers indicate that since Western systems of treatment may not address cultural belief systems adequately, “an intensive Western oriented (patient) education programme in non-Western countries may not be effective ” (Saravanan et al., 2008, p. 236). They suggest that there is an “urgent need” to re-evaluate these Western-based systems in place in India, and that a patient education program that “an education programme that shares patients and relatives health belief models may be more effective in this population” (Saravanan et al., 2008, p. 236).

As seen in the above examples, patient care that addresses cultural, societal, and spiritual contexts has been studied across many societies and countries. Consistencies can be observed that hold true across very different cultures and appear to be universal. One is that the importance of traditional beliefs in the healing process is very important to recognize and
integrate into “modern” health practices as they are implemented within a culture. Another is that in Western mental health care models the individual is emphasized, while in Eastern beliefs the group or family, including ancestors, receives more emphasis in mental health care belief systems. In Eastern and other non-Western belief systems, there is a very strong spiritual involvement in the perception of mental illness, and this is more frequently and directly applied in traditional mental health care practices, often involving care and consultation from traditional healers. Interestingly, in some cases the caregiver was made directly aware of the importance of traditional treatment by patient need and practice circumstance, such as in Barnard’s (2007) and Berg’s (2003) examples. Further studies of diverse cultures and societies in mental health care practices should help to further illuminate important issues in providing optimal care that addresses cultural and spiritual contexts.

Discussion

As we have seen, researchers have observed that across non-Western cultures the connection between patients’ social, spiritual, and cultural factors and patients’ concept of “healing” and treatment satisfaction can be especially strong in the case of psychological problems. Improved mental health care practice in Okinawa would be greatly aided by the development of new perspectives that receive grounding in traditional and spiritual aspects of the culture. As has been mentioned, although a Western-derived care system is in place many Okinawans persist in seeking traditional methods of mental health care. This behavior is not limited to Okinawans, and would appear to be common across many nations and cultures, suggesting that there is an inherent need in times of illness and distress to seek treatment in comforting and familiar ways. Even if such care is not actively sought, traditional beliefs
concerning mental health are still deeply embedded within the culture, affecting the patient experience despite the best intentions of health care providers.

The traditional beliefs of Okinawans are strongly spiritual, and UT Theorists and researchers such as Watson (1988) and Rogers (1986) have stressed the importance of spiritual beliefs in optimal care of the patient. Any serious consideration of Okinawan mental health needs to include such concepts, especially in the context of the unique and highly developed traditional belief and spiritual values system of the Okinawan population. Nursing theory is especially relevant, as Okinawan nurses have extensive interaction and contact with patients, and thus nurses must play a key role in implementation. Such theory provides a strong starting point for bridging cultural gaps in mental health care provision.

While the spiritual aspect of care is critical, the other aspect of developing perspectives from which to base new mental health care measures would include an understanding of the cultural history of the population, following Leininger (2002) and Kleinman (1988). In Okinawa, the cultural history and spiritual beliefs are intertwined. For example, traditional Okinawan mental health care practice reflects a culture of accommodation and acceptance, as compared to Western methods that “fight” the symptoms. In some ways, this reflects Watson’s (1988) concept of transcendence, where a spiritual approach takes priority. In other ways, this is a uniquely Okinawan approach that reflects the locally specific connections between tradition, customs, and spirituality in mental health perceptions and treatment. Western mental health treatments seem to address this type of unique and very direct connection in a very limited fashion.
While some Western authors have identified perceived moves towards Western values or practice as “progress” in Okinawa, such moves eliminate a very complex and beneficial system of checks and balances between the spiritual and the physical in the Okinawan belief system. In fact, approaches to mental health care that are based in Western traditions which seek to “accommodate” the Okinawan culture will simply not be able to address the complexity of the culture.

Considerations for Nursing

Nurses play a central role in the provision of health care to the Okinawan patient. In cultural and spiritual aspects, formal and informal nursing education needs to carefully consider the context of the Okinawan patient. Through nursing education and practice, what is learned can be transformed into improved patient care. Kleinman (1978) emphasizes the importance of teaching medical professionals the necessity of understanding patients’ and family’s worldviews to help avoid “the danger of pedagogic isolation” (Kleinman et al., 1978, p. 257).

Okinawan traditions and beliefs regarding mental health are unique, and the nurse practicing in Okinawa needs to be aware of these beliefs. In one regard, this means consideration of observable, empirical observations regarding societal practices such as the consultation of the yuta and family support systems. However, perhaps more importantly, this also means understanding spirituality and worldviews concerning one’s place in society and the universe. For example, the Okinawan patient will most likely consider themselves to be part of a larger whole, and less as a separate individual as in the West. In provision of empathic care, the nurse has to take into account the family and environment (the “whole”) of the patient and how these impact the patient’s mental health. For example, flexibility in understanding the need for family
to visit when they are able, and in allowing the patient to attend events such as visiting an ancestral site ("ushi-mi") is important towards maintaining the mental comfort and stability that contributes to the healing environment. It is impossible to adequately provide patient care without this knowledge and understanding.

Nurses in Okinawa, although primarily native, are trained and educated in the Western practice and philosophy of health care. Nurses in Okinawa practicing Western medicine can be enabled to practice increased culturally integrated care by raising Okinawan cultural awareness within the self (Leininger & McFarland, 2002). The native Okinawan nurse is in an optimal position to enhance their own existing cultural values towards provision of empathic care. Nurses in Okinawa have a very high level of contact and interaction with their patients, with a role that involves many more tasks than would be common in the US. As such, the culturally empowered nurse would be in a better position to empathically facilitate care that considers both traditional Okinawan and Western methods of treatment. One example of the benefit of an enhanced understanding of Okinawan culture would be the acknowledgement of Okinawans’ health practice of integrating Western and Okinawan mental health care treatment, or “Ishahanhun and yuta-hanhun.” The nurse who communicates openly and effectively regarding a patient’s desire to consult a yuta, and understands the patient’s need to do so, can arrange for the patient to concurrently see the yuta and begin therapies in the clinic, rather than delay treatment or delay the comfort of familiar traditional practices.

The nurse can also develop greater awareness of the strengths of the culture. For example, Okinawans have a philosophy of “ikigai,” where they develop a sense of purpose, and look forward to a task or the next day; this frequently involves family or societal rituals and
interactions. In Okinawa, cohesiveness, social network, family support, and an active societal role for elderly people all contribute to their being among the longest-lived people on earth (Willcox et al., 2006; Goto, Yasumura, Nishise & Sakihara, 2003; Cockerham & Yamori, 2001). Other concepts such as the aforementioned “chimu-kukuru” are aspects of Okinawan empathy that can lead to improved patient outcomes. The nurse needs to understand how these types of cultural strengths can be acknowledged and integrated into care of the patient, and be aware of the detrimental effects of neglecting the role of these cultural strengths as they concern the overall well-being of the patient. In consideration of the preceding discussion, the table below outlines a few examples of ways in which traditional Okinawan concepts that relate to cultural and mental health can provide starting points for a native system that uses Western treatment methods. An Okinawan cultural concept is followed with how that would relate to concepts and considerations in nursing care:

**TABLE 1. Relation of Okinawan Cultural Concepts to Nursing Implications**

<table>
<thead>
<tr>
<th>Okinawan Cultural Concept</th>
<th>Related Nursing Implications</th>
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<tbody>
<tr>
<td>Nuchi-du takara - Spiritual value over material value</td>
<td>Nurse awareness of cultural strengths that can contribute to mental health</td>
</tr>
<tr>
<td>Nankuru-naisa - Let things go, don’t hold onto worry</td>
<td></td>
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<tr>
<td>Ikigai - Having a sense of purpose, looking forward to the next day, a task, providing a social function</td>
<td></td>
</tr>
<tr>
<td>Isha Hanbun, Yuta Hanbun – Half Yuta, half “modern” treatment</td>
<td>Integration of traditional and Western practice in nursing practice</td>
</tr>
<tr>
<td>Chimu-kukuru - Communication of the spirit, from the heart, that is pure</td>
<td>Empathy and communication in nursing practice</td>
</tr>
</tbody>
</table>
This builds on the relating of Western theory to Okinawan mental health concepts as discussed earlier in this paper, from an Okinawan viewpoint. The influence of the theorists discussed in this paper is apparent in the relation between the above cultural concepts and the nursing considerations. For example, chimu-kukuru has parallels to Watson’s concepts transpersonal care, Leininger’s views on cultural awareness and health relate the importance of cultural views such as nankuru-naisha and ikigai, and so forth. The inclusion of the work of UT theorists such as Watson and Rogers is particularly important, as the spiritual and metaphysical concepts that are so valuable to Okinawan culture are an integral part of their theories. Such aspects should relate well to concepts such as Ninnu-migui and Chiji-uri manikata, which contain elements of karma, ancestral connections, and the cycles of nature. Further, investigation into the utilization of their theory by others in the nursing field can yield findings that could tie back into care solutions applicable to Okinawans.

Looking more closely at the reasons for building a model of mental health nursing care based on the target culture’s belief systems, the culture’s perspectives on mental well-being must be understood on its own terms and not interpreted through Western or even Japanese philosophy or presumptions. Even the usage of Western medical terms and language clouds the interpretation and understanding of mental health status in the Okinawan culture. Therefore, a treatment based on Western-derived concepts is by its very nature bound to have biases that will present difficulties to the mental health care process. In other words, the base set of assumptions upon which mental health care practices are built must come from the culture itself and not the reverse. It also helps to promote what Leininger (2007) describes as “cultural health,” which in
the UT and Okinawan system ties directly back into the individuals’ health. This will help the nurse to empower rather than alienate the patient.

Conclusion

There are many aspects of nursing practice in Okinawa, and by extension Japan and other Eastern countries, that need to be strengthened by introducing new directions in education and professional activities. Here, Western nursing practice can make a significant contribution, with Western nursing theory being an important contributor to progress in increasing the professional profile of nursing in Okinawa. Another issue to address is that nurses in Japan and Okinawa need to expand their role in research and professional capacity. For example, there is no equivalent of a nurse practitioner in Okinawa. In nursing education, the spiritual aspects of care and self consciousness of own culture, historical, social and cultural considerations for care of Okinawans should be better addressed in training and within nursing curriculum.

By examining the similarities and differences between Okinawan and Western mental health care beliefs and practices, we can frame how mental health care practices are brought to the Okinawan culture, and by extension to other cultures. This would be a good starting point towards improving the quality of mental health care that has been derived from one philosophy and culture and then implemented across other cultures. Nurses serve as a primary contact point through which patient-health care provider interactions occur. Nurses can be at the forefront of health-care transition, using the works of nursing theorists to set a starting point from which to frame meaningful change.

In the Okinawan case, as in other cultures, the goal of the Western-trained health care provider, including nurses, should be to use the belief systems of the Okinawan culture as a
starting point from which to build a care model, rather than adjusting the Western-based system to accommodate the culture. Polaschek (1998) noted that “nursing practice involves actions which recognize, respect and nurture the unique cultural identity” (p. 453). It is the unique culture that makes Okinawans who they are. Having a native system that inherently “understands” and has a basis in the Okinawan culture and it’s strong belief connection between mental health and spirituality is critical in providing optimal mental health care. Through a process of introspection and comparison, it is hoped that a dialogue can occur that will lead to new perspectives on care, greater understanding, and ultimately the implementation of a changed mental health care system that is Okinawan in its core.
REFERENCES


