This is the published version:


Available from Deakin Research Online:

http://hdl.handle.net/10536/DRO/DU:30057399

Every reasonable effort has been made to ensure that permission has been obtained for items included in Deakin Research Online. If you believe that your rights have been infringed by this repository, please contact drosupport@deakin.edu.au

Copyright: 2012, David Lovell Publishing
BEREAVEMENT ANXIETIES AND HEALTH AMONG THE AUSTRALIAN-ITALIAN CATHOLIC COMMUNITY

ABE W. ATA

Introduction

RELIGIOUS AND CULTURAL DIVERSITY in Australia have been overlooked by many religious, educational, and health care institutions where practices and attitudes to death and bereavement are concerned. The formulation of culturally appropriate treatment plans necessitates a radical turnabout, namely adjusting one's perception and awareness to different cultural and religious values. Likewise the need to develop new investigative instrumentation and culturally diverse health services is not to be underestimated. This paper reveals the shortcomings of the mental health model of western cultures such as in Australia where members of the community are no longer homogeneous in their cultural and religious background. In a multicultural society, where the basis of understanding trauma and stress is interconnected with religious and cultural undercurrents, myopic psychiatry and health approaches are rendered ineffective. We offer some suggestions on what needs to be done to better address the needs of people from culturally and linguistically diverse backgrounds.

Western psychiatry has developed as an ethnocentric discipline with illness as a basis for its model – a rationale which took precedence over anthropological considerations. In disregarding the presence of other racial and cultural perspectives, western health care institutions, of which psychiatry is a front-runner, failed to rid themselves of culturally distorted perspectives and sensitivities regarding non-European, non-American communities (Fernando, 1991). What constitutes the foundations of western
psychiatry and its rational scientific approach are cultural assumptions where individual, material and non-religious interests dominate. The result is a hierarchical order of human values which is fundamentally at odds with non-western psychiatry.

In the case of mourning rituals and ceremonies surrounding death, one finds vast differences between the two systems in terms of overall diagnosis and healing assumptions. Where rituals involving a dynamic relationship between the grieving and support-providers are used as healing powers in traditional spiritually-oriented societies, western psychiatry dismisses them as something irrelevant to its biomedical treatment methods. For example, culturally sanctioned expressions that are considered by many migrant communities as coping strategies, including passivity, euphoria, aggression, submissiveness, extroversion, self-flagellation, non-assertiveness, psychological martyrdom, hierarchical dependence, hearing voices, masculinity and femininity, are often described by western psychiatry as pathologies.

This study draws on the emotional experiences of a group of bereaved Italians, and presents them as the bereaved themselves interpret them. Often their reactions and impressions told us of things we were not looking for, or would have dismissed as peripheral. The result is a text that is experience-based in content yet within a theoretical framework, and is stimulating, readable and provides a moment's reflection on one's life. Because of this, this paper has avoided many drawbacks of remote abstraction and theoretical irrelevance.

**Aims and significance of this research**

The study specifically examines the health, religious, ethnic, gender, age and psychological dimensions of bereavement.

It provides mechanisms for health care workers which might open communication between the bereaved and the dying, the family and staff members, and which might encourage them to view death in a less negative way so that feelings of adjustment will ensue. It also promotes the understanding of the dynamic of cross-religious and cross-cultural grief.

**Method**

A sample size of 300 households in Shepparton, Albury-Wodonga, and Melbourne was set as a target for the survey research. The number, though it could be considered small for an elaborate study, was chosen as being sufficiently flexible to permit statistical reliability, cross tabulation of variables and meas-
urement of mean scores. Seven other religious and ethnic groups consisting of 239 households took part in the survey for the purpose of cross comparative analysis. The distribution of these categories is set out in Table 1:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian-born Christians (self and parents)</td>
<td>62</td>
<td>23.1%</td>
</tr>
<tr>
<td>Italian-born Catholics</td>
<td>28</td>
<td>10.4%</td>
</tr>
<tr>
<td>Arab-born Muslims</td>
<td>30</td>
<td>11.2%</td>
</tr>
<tr>
<td>Vietnamese-born Buddhists</td>
<td>27</td>
<td>10.0%</td>
</tr>
<tr>
<td>Indian-born Hindus/Sikhs</td>
<td>31</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other Christian migrants</td>
<td>66</td>
<td>24.5%</td>
</tr>
<tr>
<td>Other minor religions</td>
<td>18</td>
<td>6.7%</td>
</tr>
<tr>
<td>Non-religious affiliates</td>
<td>7</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>269</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

The Privacy Act did not allow selecting addresses from funeral directors and the Registry of Births, Deaths and Marriages was tried but did not lead to a desirable outcome. Addresses of the participants were canvassed from selected ethnic and religious leaders. Participants of the study were 18 years and older. Where possible the closest person to the deceased was requested to participate; alternatively any other member of the family. For a person to be interviewed, the period of loss should not have exceeded five years. The interview was conducted in English so as to avoid potential discrepancies in meaning between languages.

**Findings**

*Emotions of grief*

The impact of religious affiliation and cultural upbringing on bereavement and health vary in intensity and form as the findings unfold in subsequent chapters. For example, findings in Figure 1 (see p. 168) show that unrestrained emotional expression is encouraged in one community group but is strongly discouraged in another. The level of significance (.003) indicates that a strong variation exists among the various groups on 'feeling ashamed at public expressions of grief', with the Italian Catholics ranking fifth highest and Australian-born fourth; Other Minor Religions, Buddhists and Non-Religious Affiliates lowest.

For comparative purposes, other possible differences of significance on the issue of 'feeling of shame at public expression of grief' were examined on
the variables pertaining to gender, age and education (Figure 2). Measures of significance on the Chi Square Test did not reveal statistical difference among the three age groups (0.5) nor between different levels of education (0.7). However, a strong relationship was found on the gender variable (level of significance .002), showing that the proportion of males (23%) experiencing feelings of shame at a public expression of grief was almost three times higher than females (9%).

Figure 2. Feelings of shame at public expression of grief, by gender, age and education.
The resolution of grief of first generation Italian migrants, i.e. those born outside Australia, is interconnected with their adaptive and acculturation process as much as to the affiliation to their ethnic community. Clearly, their emotional ties with their old home town and the relatives they left behind have not been totally severed. Not being able to view the body of a deceased relative or to participate in deeply-cherished elaborate mourning ceremonies as occur in the old country are both painful and guilt evoking. Their guilt feelings are further multiplied in believing that they have let down the mourner relatives in their home country by not being around during the funeral.

It is also reasoned that because first generation immigrants descend from certain ethnic or religious backgrounds their grief behavior is immediately expected to fit into specific patterns that have been transplanted by leaders of ethnic communities in a multicultural society like Australia (Ata, 1988, 1989, 1990).

Kleinman (1984) believes that first generation immigrants are particularly vulnerable to burdensome grief emotions. On the one hand, they may have not brought with them supportive resources for their grieving periods in the host country. A case in point is a bereaved migrant family which became quite distressed over not being able to afford to go to view the body of its deceased person in the old country.

Religious affiliation, death anxiety and access to health services

The relationship between a culture such as Italian and death and death-anxiety is a strong one. Perspectives on the implications of such a relationship have been discussed by several theorists, from which several arguments have been derived (Leming, 1989; Milanowski, 1965).

First, certain religious and cultural backgrounds function as a unifying force for many disrupting, disorganising and upsetting events that interfere with routine life-events and their continuity. In making worshippers aware of human anxieties, of which death-anxiety is a major one, religious institutions serve as a unifying force in providing a sense of cohesion and common concern.

Tests of significance on the strength of these relationships were carried out. They indicate, for example, that the relationship between the length of grieving reported by the various sample groups and their belonging to their ethnic/religious communities is strong, according to Chi-Square and Lambda tests (Figure 3 – see p. 170).

The overall response of self-assessed anxiety is high, the lowest provided
by Non-religious Affiliates and the highest by Arab born-Muslims. Australian Italians ranked almost in the middle at a slightly lower ranking than Australian born.

Figure 3. Length of grieving, by religion and culture

For the majority of the bereaved families, the length and nature of grief are conditional on the relationship and level of intimacy. The following statements were chosen from a range of responses to the question: Does the length of your mourning period change depending on the relationship with the deceased? If YES explain:

'Mourning lasts for a few weeks to a few months, depending on the closeness of the relationship.'

'About a fortnight for a blood relative.'

'Exactly three months and ten days.'

'It was very hard losing my father; I was very close to him. I would feel this way with anybody who was very close to me.'

'If one is a blood relative, one is expected to mourn; thus the mourning period is prolonged, especially being from an Italian family.'

Various disorders have been detected; they can be found in the immune systems, such as cardiovascular, respiratory, muscular, neuro-endocrine, muscular and dermatological (Shuchter, 1986). The resulting stresses can lead metaphorically to a broken heart and literally to various psychiatric and psycho-somatic illnesses (Parkes, 1964; Reich et al, 1981; Hofer et al, 1972).
According to Freud (1957), the grief symptoms identified above may be found both in groups who are 'pathologically' and 'normally' bereaved. What brings about a pathological manifestation is the individual's sense of worthlessness and poor self-image: the implication being that it is the bereaving individual and not the relationship or involvement with the deceased that is pathological.

Recommendations in these studies signal that the bereaved should be relieved from all sorts of occupational and other social responsibilities. Behaviour of the bereaved at the death of someone close (brother, sister, father, mother) is not dissimilar from that of people on serious sick leave. Not only are they on the margin of coherent conscious functioning, but periodic lapses can occur. Of course the intensity and duration of this reaction varies with the kind of relationship and its intensity with the deceased. The realities of the contemporary, highly regulated, 'me'-centred society that is ours, however, are at odds with what is to be desired.

Results in this survey show that, apart from the Italian and Arab-born groups, a higher percentage of the bereaved took less than seven days time off work after the death of their beloved ones. Australian-born groups ranked higher (27%) than any other group in not taking any days off work after loss, followed by Italian-born Catholics (22%), and an equal percentage (13%) of Other Christian Migrants and Other Minor Religions.

Access to health care services by bereaved members of various community groups is an issue that is raised in other health-related research. The question of whether the use of health services by the bereaved is culturally and religiously determined, whether it is bound by the knowledge of such services, or if it is related to institutional barriers, is not quite apparent.

One way of finding out whether inequality of access is the main factor is to see whether the rates of bereavement-related consultations by Australian and non-Australian groups are dissimilar. Another is their awareness of the existence of counselling services, despite differences of morbidity patterns and the need for these services (Garrett & Lin, 1990).

Examining these issues is of paramount importance, even though it is not the aim of this project to provide a historical overview of health formulation policies.

The results reflected in this survey confirm the expectation that the majority of people across the seven religious/culture groups reported lack of awareness of grief counselling services. Almost 59% of Australian-born provided this response, compared with 98% Vietnamese-born Buddhists, and an equally high percentage, 96%, among the Italian-born and Indian-born.
According to the Lambda measure of significance, there was no statistical variations within the groups; the Chi-Square Test validates a strong relationship (.0001) between the independent variable (lack of awareness of grief counselling services) and the dependent variable (religion/culture).

The point to be made here to specialists in this field is to adapt and sensitise their stance away from a mono-cultural treatment of a mainstream community. Caregivers who attempt to comfort and treat migrant families should be aware of the deep subtleties and variations within cultural and religious subgroupings. Traditions in the Muslim religion, for example, do not allow room for bereavement therapy or counseling for its adherents.

Several bereaved people in this study reported experiencing and being medically diagnosed with symptoms such as asthma, weight loss, compulsive eating, hormone imbalance, back shingles, bronchitis, heart trouble, addiction to alcohol and various kinds of depression. The volume of such somatic expressions was observed to change with variables including age of both the deceased and the bereaved, gender, suddenness of death, feelings of how much one has contributed to the death of their loved ones, emotional investment and relationship to the deceased.

The implications for health care providers are obvious. Not only can bereavement cause mental illness, such as neurotic disorders, phobias and obsessions, but it may cause in addition social and personal problems with lasting effects.

Measures of significance also revealed statistical differences among the various community groups on the question of being aware of the existence of health-based grief counselling services. Almost 59% of Australian-born reported being unaware of their existence, rising to 98% for Vietnamese-born and 96% for Italian and Indian-born people.

Lack of awareness of the existence of these services relative to other kinds of health care services prompts several explanations. One could say that this is primarily related to institutional barriers set by the host society. It could also be that such services are not as prominent or as widespread as say, marriage counseling services. It is also possible that migrant communities may rely heavily on support provided by their community networks, as is the case in their home country. Understandably the effectiveness of such support depends on the size, cohesiveness and structure of the community, as well as the length of its establishment in this country.

Findings in Figure 4 show a diversity of responses with regard to experiencing more manageable grieving conditions because of the respondents' affiliation to their own religious or ethnic community. According to the T-
Test, the relationship between religious/ethnic affiliation and a feeling of an improved grieving condition is not the result of a chance factor; it indicates causality (although the statistical differences between the various religious/cultural groups was weak; i.e. lower than 20% according to the Lambda measure of significance). Leading in the response that religious/cultural affiliation creates a better grieving condition are Australian Italians and Australian Indians ranking at similar levels to the Muslim group (96.7%), followed by Other Minor Religions (83.3%) and Vietnamese-born Buddhists (65.4%).

Figure 4. Grieving conditions, by religious and cultural affiliation

Cultural differences in funeral practices and emotional expressions
Every culture has deeply entrenched customs of handling death. As grief ensues, societal-based reactions become more pronounced in the form of funer al practices.

Variations in the intensity of response among the seven groups emerged on the issue of Australia's burial instructions conflicting with one's own ethnic, cultural or religious background (Figure 5 - see p. 175).

The Australian-born group aside, almost one quarter of the remaining sample reported one or more conflicting instructions of one nature or another. The following comments may shed some light on the nature of the interviewees' grievances:

'Many Italians prefer concrete around and inside the burial hole; they do not like dirt burial holes.'
'Cremation. I feel bodies should be used for donating organs that can help others."

'I do not agree with some Italian rituals such as throwing oneself on the coffin or the ground; wearing black for long periods; pulling one's hair; isolating oneself from society.'

Practices and laws pertaining to the disposal of the body have long concerned humankind, irrespective of the religiosity and sophistication of cultures. For centuries the Christian church was against the cremation of the body, arguing that it was an old Greco-Roman ritual. The objection was further endorsed early in the 19th century by the opinion that Christian discipline is counter to such practice. Not until the 1960s did the Catholic Church allow such practices, made possible by changing attitudes of clergy, increasing burial costs, shortage of land in the cities, and health reasons.

The occurrence of religiously or ethnically-based practices and laws permitting cremation of the body reveals a significance according to the Lambda Test (.38095 or 38% of the cases). The percentages were, 76.0% Hindus/Sikhs; 69.2% Buddhists; 60.0% Non-Religious Affiliates; 30.8% Italian Born Catholics; 19.6% Other Christian Migrants; 17.6% Other Minor Religions; 8.8% Australian-born; and 0% Muslims.

Cremating the deceased arguably has many psychological benefits for the survivors. Some relatives may feel comforted that the ashes are united with the main ingredients of nature (Rando, 1984). Others have argued that cremation may cause anguish for relatives whose relationship with the deceased was not a healthy one. It is thus suggested that it may become symbolic for relatives to act out their feelings of hostility (Irion, 1974).

There were various responses showing the occurrence of religious or ethno-specific practices and laws within the communities. A high loading is shown with regards to washing the body, clothing it, facing it in a certain direction and placing it in a coffin. Refrigerating the body or donating parts show a small loading.

Of interest are the Hindu and Italian communities registering the highest response (80%) of reported differences between their country of birth and Australia's funeral practices, even though the differences are almost as great as those reported by the other five groups.

No statistical difference emerged between the gender groups (.55); education groups (.15), or among the three age groups (.66) in the Chi-Square T-Test (Figure 3). Comments and reactions by individuals were unique and in ample supply. The following direct quotes were selected from a bereaved father:
Figure 5. Reported differences between country of birth and Australian funeral practices, by religion and culture

<table>
<thead>
<tr>
<th>Country of Birth &amp; Religion/Culture</th>
<th>Percentage of people reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian Born Catholic</td>
<td></td>
</tr>
<tr>
<td>Arab Born</td>
<td></td>
</tr>
<tr>
<td>Vietnamese Born Buddhist</td>
<td></td>
</tr>
<tr>
<td>Indian Born</td>
<td></td>
</tr>
<tr>
<td>Other Christian</td>
<td></td>
</tr>
<tr>
<td>Other Minor</td>
<td></td>
</tr>
</tbody>
</table>

Where I come from there are no funeral directors. It is at the family's level with all the near and dear ones. They have become more formal in Australia—a really very tense time ... Expenses here are greater. We hire cars to take us to the cemetery; in Italy we walk carrying the coffin on our shoulder. The body would be kept at home for 24 hours while the relatives stayed and grieved ... In Australia funerals are more ostentatious; people go to the pub instead of having supper together ... People here wear lively colours and patterns to funerals, and women don't wear veils. There is less respect shown ... Funeral directors telling people who attend the funeral to leave the cemetery after the service.

Participants indicated a range of physical and emotional expressions they recall having experienced in public at the funeral.

Reactions such as beating the breast, pulling hair, slapping one's head, wailing in unison, fainting and injuring oneself registered a smaller response than weeping and restraining oneself from showing emotions.

Weeping in particular drew the largest reported emotional expression by all groups except the Arab-born Muslims. The disproportionate representation of male and female may have contributed to this, particularly as weeping in public by males is discordant with cultural values.

With restraining oneself from showing emotions, the Australian-born group registered the highest response (74%), followed by Indian-born Sikhs and Hindus (61%). Other Minor Religions registered the lowest response (2%).
Communicating with the deceased

The need for communication is universal among human beings. On many occasions this need becomes intense when getting together with others is not possible. In normal circumstances, one becomes conditioned to expect to be able to communicate at will with those who are alive. It is an event that is by and large taken for granted. The intensified passion of attempting to talk to the dead is partly precipitated by this kind of conditioning.

To many of the bereaved, opting to be comforted by the illusions of the presence of the deceased is a lesser trauma than facing the pain of the unbearable reality of death. It provides an escape from the anguish of finality; the hope of permanence overrides the despair of extinction.

The dynamics of the continuing psychological and emotional ties are often powerful enough to sustain the relationship and confirm the reality of life thereafter. The belief in the survival of the spirit is further strengthened by community rituals and related cultural and religious beliefs (Shuchter, 1986; Kalish, 1981; Lifton, 1977).

Lack of religion or casual attendance at religious institutions appears to be no barrier to faith in the afterlife. Given that 20.1% of the sample said they had no religion and 28.8% attended religious institutions very infrequently (Chapter 3, Table 1), the number of those confessing a belief that the soul went to nothing (5.6%) is surprisingly very small (Table 1).

The variety of responses to the question *What do you think happens to the soul after death?* were aggregated into five categories. For the Muslim group, the belief in heaven and hell was unanimous (100%). Almost three-quarters of the Australian-born respondents said a soul went to heaven or hell, 8.1% believed in reincarnation, and 6.5% said that the soul remained with the living.

Another interesting finding was the relatively small number of Buddhists and Hindu/Sikhs who indicated that the soul reincarnated. With approximately 40% believing in some form of reincarnation, the remaining respondents can be regarded as being at odds with fundamental aspects of their background. The extent to which co-existence in a pluralistic Australian society has contributed to integrating 'other' values and beliefs into one's own may be considered as one possible explanation for such an outcome.

The response from the Italian Catholic group is particularly interesting. In comparison to the other seven groups it is the least polarised in response. It may have been expected that Italian Catholics would commonly endorse the belief that the soul goes to heaven or hell. However only 35.7% endorsed this option. In fact 34.3% of responses could be considered as 'irreligious'. 
There were beliefs that after death nothing follows, and that the soul remains in the world of the living. One possible explanation of the fact that Italian Catholics did not conform to expectations is that the group may have acculturated towards the beliefs and values of Australian culture, given that they are not a recently arrived group. Another 21.4% indicated that nothing happens to the soul – it simply dies away – which is further evidence for this explanation.

The point here is that religion has traditionally provided the basis for beliefs in the afterlife or in the immortality of the soul. It would seem that lacking in faith does perpetuate a heightened level of anxiety and despair in modern day living (Ata, 1988, 1989, 1990).

Differences across religious and cultural groups with regards to the appearance of the deceased are shown in Figure 6. A high percentage of Muslims (63.3%) and Hindu/Sikhs (40.9%) reported seeing their dead loved ones at some stage after the funeral. A smaller percentage from the other groups also reported a similar experience, excluding those without any religion.

**Figure 6. Communication with the deceased**

![Communication with the Deceased](chart)

Figure 6 shows an aggregate response of three modes of communication with the deceased. When analysed separately a sharper difference emerges. For example, the response to hearing voices of their dead ones is slightly different although a similar pattern is observed across the seven religious com-
munities. Some 50.0% of Muslims and 36.0% of Italian Catholics reported hearing the voices of their dead ones.

Statistical differences among the various groups on the variables of 'attempting to talk to, or, hearing voices' were non-significant. However, a high level of statistical difference (0.01) was found to exist amongst the various groups on the variable 'appearing to you', with Australian-born respondents ranking lowest (13.5%) and Arab-born Muslims ranking highest (63.3%).

Significantly, some psychiatrists believe that speaking to the dead is not the same as seeing ghosts or hearing voices; and that many people may speak to the dead even though they may believe no one is actually listening. In the analysis, such argument holds as much weight as its opposite. If one continues to speak to the dead in the same manner as if they were not, the boundaries to hallucination ipso facto are not significantly different from hearing or seeing 'ghosts'.

Almost half of the female sample (49.7%) and just over one third of the males (39%) reported having attempted to talk to their deceased. A similar discrepancy emerged with regard to hearing their voices and the deceased appearing to them. However, the differences between the gender groups are significant (0.04) only in the first communication category.

The gender issue is interesting in that it evokes a number of possible explanations. First, the volume of emotional investment and depth of feelings in relationships is known to be more characteristic for females than males. It is also suggested that women view an intimate close relationship as more important for good mental health and high morale than occupational or social status. The small body of literature in psychology is filled with studies on the relatively marked intensity of relationships and depth of introspection as expressed by women (Gething et al, 1989).

**Summary and conclusions**

The general picture that emerges from analysis of the data in this project is somewhat daunting and yet provides information that is relevant to mental and other health care providers in considering the relationship between well-being, health and bereavement.

Findings in this work provide us with a clear picture of the bereavement experience and suggest strategies to approach it as a process with several observable and manageable parts.

First, pre-migration experiences, particularly cultural and religious, appear to have a great influence on people's susceptibility to emotional and mental strains and their eventual adjustment and response to the healing
process. Formation of culturally appropriate treatment plans necessitates adjusting one's perception and awareness to different cultural and religious values. Likewise the need to develop new investigative instruments and culturally diverse health-services is not to be underestimated.

Several in-depth interviews have revealed how certain aetiologies - the cause of bereavement anxieties - may be differently interpreted by health care providers and the bereaved from contrasting cultural backgrounds.

Second, cultural background and religious affiliation have been found to be strong indicators of the individual's health and well-being. Religious and cultural diversity in Australia have been overlooked by many of the religious, medical, legal, educational, health care and other institutions where practices and attitudes in relation to death and bereavement are concerned. For example, in Muslim and Indian community groups, unrestrained emotional expressions in public towards loss are strongly encouraged, as compared to Australian-born, Italian-born, Vietnamese-born and other Christian migrants (sig = .003).

Clearly, the resolution of grief of first generation Italian, and other migrants, is interconnected with their adaptive and acculturative process as much as to the degree of affiliation with their ethnic community. Their emotional ties with their home country and relatives they have left behind have not been totally severed.

The relationship between religious affiliation and death-anxiety was found to be a strong one. It was found, for example, that a relationship between the length of grieving as reported by the various groups in this study and their belonging to their ethnic or religious communities is statistically high.

A similar relationship was found between experiencing better grieving conditions and strong affiliation. Leading in these responses is the Muslim group (96.7%), followed by Other Minor Religions (83.35%) and Buddhist Vietnamese (65.4%). The Australian-born group is fairly equally divided with just over 50% indicating an improved grieving condition. In contrast, the data [not shown on table] indicated that 56% of Italian-born Catholics and 54% of Indian-born Hindus and Sikhs indicated that their affiliation made their grieving condition neither better nor worse.

The findings strongly indicate that bereaved individuals who are more religiously oriented exhibit lower anxiety symptoms than other groups. Affiliation to a religion seem to charge the bereaved with great strength and sustenance in their dealing with death.

These findings however should in no way suggest psychological deprivation or absence of well-being for those who do not believe. For, whatever their
orientation, funeral rituals and associated bereavement behaviour embody a universal holistic outlook, and continue to promote a communal sense of destiny and togetherness.

Cultural background and religious affiliation have been found to be strong indicators of the individual’s health and overall well-being. Significant differences were revealed between the sexes on such matters as health problems, grief expressions, psychosomatic manifestations, communication with the dead, beliefs in the afterlife and interpretation of the meaning of loss.

One of the strong differences between the sexes related to the feeling of shame at public expression of grief (sig. = .002). The findings reveal that the proportion of males (23%) was almost three times higher in experiencing feelings of shame at public expression of grief than females (9%).

Another finding showed that almost half of the female sample (49.7%), compared just over one third of the males (39%), reported having attempted to talk to their deceased. A similar discrepancy emerged with regard to hearing their voices and the deceased appearing to them.

The gender issue is interesting in that it raises a number of possible explanations. Firstly, the volume of emotional investment and depth of feeling in relationships is known to be more characteristic for females than males. It is also suggested that women view an intimate relationship to be more important for good mental health and high morale than occupational or social status.

To western psychiatry, the model of mental health may be considered beneficial in direct proportion to the extent to which it is influenced by members of the culture it hopes to treat. That is, it can be considered as useful as it is sensitive and open to diverse cultures. However, in a multicultural society, where the basis of understanding trauma and stress is interconnected with religious and spiritual undercurrents, western-style psychiatry is rendered ineffective as far as it is in-itself and for-itself. In other words, because it carries with it the assumption of superiority, it will not be open to integrating approaches which others regard as effective.

The assumption that what is diagnosed in Anglo-Celtic cultures as psychopathological must by necessity be universal, is not only indicative of myopic vision but also evokes dissatisfaction among other cultures. Western psychiatry cannot assume a universally established context from which it can deal with culturally conditioned fears, or a variety of other feelings and behaviours. Western psychiatry has a duty to grow within our postmodern world to a maturity in which difference and otherness are encountered with wisdom, service, and a heart.
It is recommended that the relationship between the treatment of bereavement associated pathologies and the bereaved pre-migration experience and cultural upbringing should be further explored. This will provide mechanisms for health care providers to open communication between the patient, the family and staff members. It will also provide information for specialised counselling and correct intervention as required.

The ability to recognise or interpret expressions of bereavement specific to Italian and other migrant communities may result in tremendous cost-effective management within family, community and health services.

References


