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PSYCHIATRIC REHABILITATION :
THE ASIAN EXPERIENCE

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Veronica Pearson, Nancy Rhind, Lindsay Barker,
John Bacon-Shone, Michael Phillips

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CONFERENCE ORGANIZING COMMITTEE

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Dr. Veronica Pearson	Senior Lecturer Department of Social Work and Social Administration The University of Hong Kong
Mrs. Nancy Rhind	Fieldwork Instructor Department of Social Work and Social Administration The University of Hong Kong
Dr. Ines Dias	Consultant Psychiatrist Department of Health Services Macau
Ms. Nobuko Kobayashi	Association For Better Mental Health Tokyo, Japan
Dr. Michael Phillips	Research Director National Training Centre for Mental Health Workers Shashi Psychiatric Hospital Shashi, Hubei Province People's Republic of China

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LIST OF CONTRIBUTORS

(in alphabetical order)

Ms. Theresa ALCANTARA	Occupational Therapist Department of Psychiatry Department of Health Services

Macau

Dr. Kunihiko ASAI
Vice-Director
Asai Hospital
38-1 Katoku
Togane City
Chiba Prefecture
Japan

Ms. Kai Fong CHAN
Senior Lecturer
Department of Social Work
Baptist College
Princess Margaret Road
Kowloon Tong
Hong Kong

Mr. K.H. CHAN
Officer-in-Charge
Yum Yuen Half Way House
Richmond Fellowship of Hong Kong

Professor C.N. CHEN
Department of Psychiatry
Chinese University of Hong Kong
Sha Tin
Hong Kong

Mrs. J.M. CHOUDARY
Research Scholar
Department of Social Work
Punjabi University
Patiala 147002
India

Mr. Allan CHOW
Commissioner for Rehabilitation
14/F Harbour Building
38 Pier Road Central
Hong Kong

Ms. Teresa COELHO
Occupational Therapist
Department of Psychiatry
Department of Health Services
Macau

Dr. Ines DIAS
Consultant Psychiatrist
Department of Psychiatry
Department of Health Services
Macau

Dr. Jose FLORES
Psychiatrist
Department of Psychiatry
Department of Health Services
Macau

Ms. Irene LAW
Officer-in-Charge
Wan Tsui Half Way House

	Richmond Fellowship of Hong Kong
Professor Julian LEFF	Department of Social and Community Psychiatry Institute of Psychiatry De Crespigny Park London SE5 8EF
Mrs. Mary LEUNG	Director Baptist Oi Kwan Social Services Oi Kwan Road Wanchai Hong Kong
Professor Felice LIEH-MAK	Department of Psychiatry The University of Hong Kong Pokfulam Road Hong Kong
Dr. Estefania Aldaba LIM	Regional Vice-President for Asia World Federation For Mental Health 9H Legaspi Towers 300 Roxas Boulevard Manila Phillipines
Ms. Nobuko KOBAYASHI	Co-ordinator Association for Better Mental Health Park Side Daikan 3F 7-9-7 Nishi Shinjuku Shinjuku-Ku Tokyo Japan
Ms. Joyce L.C. MA	Lecturer Department of Social Work Chinese University of Hong Kong Sha Tin Hong Kong
Dr. Elisabeth MARX	Lecturer Department of Social Work and Psychology National University of Singapore 10, Kent Ridge Road Crescent Singapore 8511
Dr. Vijay NAGASWAMI	Deputy Director Schizophrenia Research Foundation (India) Vice-President World Association for Psychosocial Rehabilitation

	C 46, 13th Street East Annanagar Madras 600 102 India
Ms. Tomoko KIMURA	Association For Better Mental Health Park Side Daikan 3F 7-9-7 Nishi Shinjuku Shinjuku-Ku Tokyo
Dr. Rosaleen OW	Lecturer Department of Social Work and Psychology National University of Singapore 10 Kent Ridge Road Crescent Singapore 8511
Dr. Veronica PEARSON	Senior Lecturer Department of Social Work and Social Administration The University of Hong Kong Pokfulam Road Hong Kong
Ms. Maria PINTO	Social Worker Department of Psychiatry Department of Health Services Macau

Ms. Urmil SHARMA
Senior Research Investigator
Ministry of Welfare
Government of India
West Block No.viii
2/F Wing 2
R.K. Puram
New Delhi
India

Ms. Vivian SIU
Social Worker
Baptist Oi Kwan Social Services
Oi Kwan Road
Wanchai
Hong Kong

Mrs. Christine TAYLOR
President
Richmond Fellowship of New Zealand
28 Awarama Crescent
Orakei
Auckland
New Zealand

Mr. R.M. VARMA
Head
Department of Social Work
University of Delhi
Delhi 110 007
India

Mrs. Elizabeth WONG, I.S.O., J.P.
Secretary for Health and Welfare
Hong Kong Government Secretariat
Lower Albert Road
Hong Kong

Ms. Jenny WONG
Social Worker
Baptist Oi Kwan Social Services
Oi Kwan Road
Wanchai
Hong Kong

Mr.K.S. YIP
Senior Lecturer
Department of Applied Social Studies
Hong Kong Polytechnic
Hung Hom
Hong Kong

Ms. Rose W.M. Yu Fieldwork Instructor
Department of Social Work
Chinese University of Hong Kong
Sha Tin
Hong Kong

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INTRODUCTION

Veronica Pearson

The title of the conference, Psychiatric Rehabilitation; The Asian Experience, expresses the conviction of the organizers that while mental disorders are a universal phenomena, approaches to care are affected by culture, resource availability, and notions about what is a `normal' life in any given society. Thus the form that rehabilitative efforts take cannot be assumed to follow Western ideas of what is effective the world over. Rehabilitation needs to develop organically in ways which are culturally coherent, rather than using frameworks based on alien cultures.

It was the aim of the conference organizers to provide an opportunity for mental health professionals in Asia to have a chance to examine issues of relevance and importance to them without being constantly over-shadowed by the hegemonistic tendencies of Western ideas; a common experience at international conferences. This is not to suggest that all Asian cultures are the same. As Professor Lieh-Mak pointed out in her opening address, there is great cultural and economic variety in Asia, partially stemming from the different major religious traditions of Bhuddism, Islam, Taoism and Hinduism. Nor is it to say that Asian cultures are totally different from those in the West. The centrality of family care, the experience of stigma and discrimination are common features of the care of the mentally ill the world over. But there are specific issues that those working in Asian countries have to address. Many, like China and India, are largely agricultural societies. Asian cultures tend to be arranged on more hierarchical principles than Western ones, with age and sex frequently used as a means to rank and structure social relationships and confer social status.

Almost all countries in Asia, with the exception of Burma, Laos and Cambodia, were represented at the conference. About 280 delegates attended and nearly 50 papers were presented in English speaking workshops and 10 in Putonghua speaking ones. The organizers were particularly pleased that there was a very large delegation at the conference from China and twelve papers from that country were presented in English. These papers were given by the prizewinners of a competition that was held in China specifically to select scholars and practitioners to attend the conference. Through this means, we hoped to encourage some of the younger academics and professional workers in China, and give exposure to the best of the work that is going on there. These twelve papers have now been accepted for publication by the British Journal of Psychiatry and will form the basis of a supplement on psychosocial rehabilitation for the mentally ill in the P.R.C. Thus none of them appear here.

Not all workshop presentations were `worked up' by their authors into full papers. The contributions to this volume were selected from those that were and represent both the research concerns of academics and the practice experience of those engaged in day to day work with mentally ill people and their families. It seemed important to us to include both perspectives because, in an ideal world, they should work hand in hand. Both are a valuable source of knowledge and ideas for future directions and improvements.

So what issues and concerns are reflected in the papers gathered in this volume? The most important theme is the centrality and the dominance of families in the care of the mentally ill, an influence which is frequently positive and occasionally negative. Professor Leff's talk on expressed emotion posed the question of whether his research findings will also have relevance for Asian cultures. His paper touched on the importance of providing families with greater understanding and knowledge of mental illness in order to increase empathy with the afflicted family member and efficacy in dealing with manifestations of the problem. Dr. Nagaswami looked at the issue of the best use of scarce professional time in an under-resourced society, and the necessity of moving from the direct provider rôle to that of being a resource/training person for others, including families. This is a theme that Sharma also explores in her paper.

Varma, too, emphasizes the need for greater knowledge and information both for the general public and for the mentally ill and their families. He suggests that to achieve this more use should be made of the very popular medium of television. In another stimulating suggestion about case finding, he describes a project that was targetted at children. Street theatre was designed to illustrate typical problems and symptoms experienced by mentally ill people, to enable children to recognize people in their families or neighbours who were sufferers. This enabled medical workers to identify patients who were being hidden away by relatives, and offer them treatment.

Dr. Aldaba-Lim points out that, despite their traditional cohesion and caring functions, Asian families are under stress having to adapt to and cope with a changing world. In such circumstances, while governments cannot be expected to take on the traditional caring rôle, ways can be explored to support families as they attempt to take care of their family members. Chan's paper explores what `caring' entails from the perspectives of both the carer and the cared for. Both Ma and Wong et al. discuss the suitability and importance of self-help groups for relatives and patients as a means of harnessing their own strengths and increasing their sense of efficacy and control over their own lives.

The paper by Dias et al. demonstrates that the desire of relatives to have their family members hospitalized on a long term basis can be reduced by a service which is community oriented, responsive to crises and easily accessible both in the home and in an out-patients' clinic. Taylor poses the question of what services we would appreciate if we or our loved ones suffered a mental illness. This, surely, should be the guiding principle in much of the work we do.

Other papers, particularly those by Kobayashi and Kimura, and Choudary highlighted some of the drawbacks to the dominance of the family as the major resource for care. Kobayashi and Kimura rightly point out that it cannot be assumed that families have the patients' best interests at heart. In Japan families may be happier when patients are institutionalized and actively resist discharge, leading to the phenomenon of over 50 per cent of psychiatric patients having been detained for more than five years in hospital (Asai, this volume). Choudary highlights the problems of daughters-in-law in India, particularly the domination of the mother-in-law within a family and the psychiatric distress to which this can lead. It is, however, generally the woman's natal family who have to pick up the pieces.

The papers by Ow, Marx and Yip at al. are all, in their different ways, concerned with if and how models of intervention developed in Western countries could be useful in Asian contexts. Ow deals with the general issue of how the values of professionals (in this instance, caseworkers), influenced by Western ideas and training can differ markedly from those of clients. In Singapore, this issue is complicated further by the culturally heterogeneous nature of the society. More specifically, Marx examines the problem-solving approach to counselling and concludes that there are cultural incompatibilities in implementing it in the Singapore context. Although many of the papers were concerned with non-institutional contexts, that by Yip at al. shared experiences gained over eight years of trying to implement the therapeutic community concept in half-way houses in Hong Kong. They found that despite the cultural differences in expectations of staff and services, the model could be usefully modified while retaining most of its distinctive characteristics.

The overwhelming impression gained from attendance at this conference is that the experience of mental illness is similar all over the region, and probably all over the world. On the whole, the mentally ill are not a group who provoke sympathy. Even in comparatively wealthy societies, like Hong Kong and Japan, fewer resources are spent on them than other vulnerable groups. Fear and stigma are also shared experiences. However, while problems are held in common, solutions are likely to be more variable. Our aim, through the conference, is to encourage people to devise their own solutions and to be selective in their choice of models from other places. Some of that variety is expressed in this volume and we hope that our readers will find much to stimulate their interest and concern.

OPENING SPEECH AT THE CONFERENCE "PSYCHIATRIC REHABILITATION: THE ASIAN EXPERIENCE"

by

Felice Lieh Mak, M.D., F.R.C. Psych., OBE, J.P.

Professor and Head, Department of Psychiatry,
Faculty of Medicine, University of Hong Kong
President, World Psychiatric Association

I must congratulate the Richmond Fellowship of Hong Kong and the Social Sciences Research Centre for this ambitious conference. In many ways, it is a courageous attempt to tackle a complex problem in a complex continent.

When Lindsay Barker asked me to give the opening address she very generously allowed me to choose any topic relevant to the conference content, but she was less generous with the allocation of time. So you need not worry too much about the danger of my boring you all with things that will most likely be discussed in greater detail in the next few days. I will therefore take this opportunity to highlight a few areas relating to differences and commonalities.

We Asians do not usually view ourselves as being such except in a very general geographic sense of the word engendered by the shift of tectonic plates. However, there is a tendency for persons living outside this region to lump Asians together. Thus, we have terms like Asian-American, Asian migrants, Asian culture. The truth is Asians are an ethnic mosaic made up of many colours and cultures. There is no single theme of culture linking the magnificent Taj Majal to the great wall of China. Unlike Europe which shares a common bond of Christianity, there is no single philosophical or religious thread to tie Buddhism in the same knot with Hinduism, Confucianism and Islam.

In terms of government, Asia has the greatest diversities. Brunei is an absolute monarchy; the People's Republic of China (PRC) is communist; Burma is militarist; Hong Kong is a colony; the Philippines is a democracy; Thailand is a constitutial monarchy and tribalism is still rampant in Papua New Guinea.

The state of economic development is also varied. We have an economic behemoth that is Japan, the first generation of "little dragons" consisting of Hong Kong, South Korea, Taiwan and Singapore, the second generation little dragons like Thailand, Malaysia and Indonesia and perhaps the third generation in the form of Vietnam. While the world's attention is riveted by these economically successful countries and territories, we must also remember that some countries still exist at a subsistence level. The per capita GNP ranges from a low of US$110 in Cambodia to a high of US$24,000 in Japan. There exists an imbalance in this region with Asia's poor vastly outnumbering Asia's rich.

The sizes of various countries contained in the Continent are also different. The smallest country, the Maldives, is a mere chain of islands in the vastness of the Indian Ocean. It has a population of only 200,000. The largest and most populated country is the PRC with a population of 1.1 billion.

Whatever the differences may be it is evident that Asia's population is substantial. By the year 2,000 Asia's population will grow to 3.75 billion which when translated into in a more manageable perspective means that six out of every ten people on this planet will be from Asia.

The religious tapestry of Asia is rich and colourful. The dominant religions are Islam, Buddhism and Hinduism. There are also a multitude of other sects and variations including animism and folk beliefs peculiar to specific classes or villages in each country. In addition there is the common philosophical thread of Confucianism that links Japan, China, Singapore and Korea.

It would not be right at this point to disregard what Asia has in common. One of the most precious things that we have is the closeness of the family. Go to any Asian home and you will still see the traditional value of respect for one's parents and elders. Parents still feel responsible for their children. Extended families, though living apart, still maintain links. Children continue to look after their parents in their old age. Throughout Asia, from mudwall villages where Afghan toddlers gather to learn the Koran to the high-tech private schools in Tokyo, education is a serious affair. Even the poorest peasant dreams of giving their children some form of education. Because for so many Asians life has been and is still so hard, the work ethic remains strong. The strong desire to be self reliant is evident at all levels. In most Asian countries women still suffer from discrimination. Women are accorded lower social status. In terms of job and educational opportunies women are at a disadvantage.

Despite the diversities, we share many commonalities relating to the mentally ill.

1. Low priority is accorded to the mentally ill. In the less developed countries high priority is given to the control of infectious disease, reducing infant mortality and

improving nutritional status. In the developed countries funds are being diverted to cancer, cardiovascular diseases and a host of high-tech, high profile specialties.

2. The rights of the mentally ill are not safeguarded. In many countries mental health legislation is yet to be enacted. In some that have legislation enforcement leaves a lot to be desired.

3. Stigma, often called the great compassion killer, is prevalent. In the hierarchy of disabilities the mentally ill are invariably allotted the lowest status. Through a halo effect, stigma also clings to those who work with the mentally ill.

Earlier in my talk I constructed a mosaic of Asia. This was not with the aim of conducting you through a guided tour but to remind us that while the object of this conference is to look for Asian models of psychiatric rehabilitation, this does not automatically imply that a successful programme developed by one country can be transferred in toto to another. Indeed, it may not even be applicable to different groups in the same country.

To enable technology to be transferable we need several conditions:

1. A clear definition of the socio-cultural context in which the programme was developed.

2. Resources needed to implement a programme must be clearly stated. Given the differences in availability this is an important consideration.

3. An agreed system of communication, "a common language", which will allow mental health workers to convey their findings and compare them with those of others. The WHO has been instrumental in developing such a language in the form of the ICD-10.

   This system has the following characteristics:

   a. Classification of disease not of people
   b. In so far as possible it is open ended and flexible
   c. It is descriptive and based on clinical observation
   d. Related documents, one of which is a separate classification of disabilities and handicaps

4. Proper instruments for function, behaviour and outcome assessment.

Looking at the various headings for the workshops and the titles of the keynote speeches, I am sure that all of the issues mentioned will be thoroughly discussed.

OPENING SPEECH AT THE CONFERENCE "PSYCHIATRIC REHABILITATION: THE ASIAN EXPERIENCE"

by

Elizabeth Wong, I.S.O., J.P.

Secretary for Health and Welfare
Hong Kong Government

It is my honour to be present at this opening ceremony of the Conference on "Psychiatric Rehabilitation: The Asian Experience". Please allow me to welcome you all and to congratulate the Richmond Fellowship of Hong Kong and the Social Sciences Research Centre for giving us this excellent opportunity to focus our minds on the subject of psychiatric rehabilitation. Culture obviously has an important bearing on the extent to which certain models can be adopted and developed. I am sure that all participants will be able to share experiences, exchange ideas and stimulate new thinking in this field.

I would now like to share with you the Hong Kong experience and our vision for psychiatric rehabilitation in the future. You may ask: what factors contribute to a successful psychiatric rehabilitation programme? I would like to highlight the importance of community support and self-awareness.

An essential factor in the effective operation of the various social rehabilitation services for persons who have recovered, or are recovering, from mental illness is community support. In Hong Kong, since 1985, public education on rehabilitation has been given a major status in the publicity campaigns of the Government. A key aim of our public education programmes is to promote public understanding of mental health and community acceptance of persons with mental illness. This task, though difficult, is important and we continue to work on this with a view to removing any misconception about mental illness and to inculcate community support for persons so afflicted.

In my view, another important factor is the clients' own awareness of the illness and readiness to seek psychiatric help. Very often symptoms of illness and of relapses are not recognized by patients themselves or their family members. Symptoms are often swept aside or misinterpreted. Ignorance of the subject gives rise to prejudice which in turn gives rise to discrimination. The 'stigma' attached to mental illness leads many patients and their families to hide the symptoms to avoid discrimination by neighbours or isolation by friends. Early recognition of the symptoms of mental illness, particularly by family members of the patients, is important for early treatment and prevention of the onset of residual disability.

Traditionally, the psychiatric in-patient service has been mainly hospital-centred and institution-oriented, while the out-patient service is district-based. The geographical separation of these related services in Hong Kong has limited the extent of interaction and communication between relevant parties in the treatment and rehabilitation process. Such inadequacies are even more pronounced when it comes to aftercare services; for example, half-way houses provided by non-governmental organizations.

The flow of patient information between hospitals, out-patient clinics, day hospitals, the community psychiatric nursing service, and welfare service units is far from adequate. The unsatisfactory state of communication and co-ordination has led to a common lack of long term care planning and consistency in rehabilitation programmes for individual patients. This has given rise to the so-called 'revolving door' phenomenon which is most undesirable. Many patients are repeatedly admitted into and discharged from mental hospitals without ever being able to be genuinely re-integrated into the community. In our hospitals many of our patients/clients are ignored and forgotten by their family members, with the result that these members of our society are not given the warmth of reception that they deserve when they leave the institutional setting. These patients would eventually end up having significant, irreversible, residual disabilities or, not uncommonly, chronic institutionalization.

To tackle the problem we have adopted a new approach in the delivery of psychiatric rehabilitation services in Hong Kong. The objective aims at restoring the functional capacity of the patients to its maximum potential and helping them live and function in the community. Hence, the link with the community is closely maintained while long term institutionalization is avoided.

Our Mental Health Service was reorganized in 1990. Instead of being facility-based, the service is now team-based. The executive arm consists of consultant-led, multi-disciplinary teams each providing a similar scope of service, including hospital beds in psychiatric hospitals, psychiatric support to general hospitals, district-based psychiatric out-patient clinics and day hospitals, as well as a team of occupational therapists and community psychiatric nurses. Patients are managed by the same team of staff regardless of their destination. This has enhanced continuity of care through better co-ordinated multi-disciplinary efforts.

Consideration will be given to the development of two sub-specialities, namely psycho-geriatrics and community psychiatry, both of which are heavily rehabilitation-oriented.

To improve the patient information system for mentally ill patients, we are considering the establishment of a database for individual patients containing relevant information regarding their mental illness. Such an information system will link up with the existing information system in social welfare organizations.

In order to promote mutual communication with and early participation of the welfare service providers, we have recently started to invite their participation in meetings of the Community Work and Aftercare Units of the major psychiatric hospitals. The aim is to effect better assessment and devise well-tailored and comprehensive rehabilitation plans for the patients. The exact mode of operation of such an arrangement will be decided according to the working experience gained.

Our present policy on rehabilitation for disabled persons is based on a White Paper entitled "Integrating the Disabled into the Community: A United Effort". It was published in 1977. Many services have been set up or improved since its publication. In retrospect, however, while such services might have contributed to the well-being of disabled persons, few of them appear to have benefited from the concept of integration as promulgated in the 1977 White Paper. For example, mentally ill persons are, as I have mentioned earlier, neither understood nor, for the most part, accepted by many in the community.

A Working Party comprising mainly `non-officials' was set up in January 1991 under my chairmanship. It is charged with reviewing policies and services for disabled persons and with producing a Green Paper which sets out proposals for the way ahead. The Green Paper will be released early in 1992. As regards psychiatric rehabilitation, a number of improvement measures have been recommended. With our twin goals of full participation and equalization of opportunities, we hope to build up a better tomorrow not just for disabled persons but for all in Hong Kong.

Rehabilitation of mentally ill persons has never been an easy task. To achieve success requires the concerted efforts of Government, concerned non-governmental organizations and the dedicated members of the various professions in this field. In Hong Kong we face manpower difficulties as well as the need to gain greater community acceptance of mentally ill persons. Nevertheless, we are determined to continue to improve services for mentally ill persons and explore new initiatives. I would appeal to your generosity to share your views and knowledge with us. We will, I am sure, all gain from the experience of this Conference and return to our work with new insights.

I wish the Conference every success.

Thank you.

CLOSING SPEECH AT THE CONFERENCE "PSYCHIATRIC REHABILITATION: THE ASIAN EXPERIENCE"

by

Char-Nie Chen

Professor and Chairman
Department of Psychiatry, Faculty of Medicine
The Chinese University of Hong Kong

To be invited here to say a few words at the closing of this conference is indeed a pleasure and an honour. However, you might forgive me for not attending this meeting until now as I have just spent two long weeks organizing another meeting on the other side of the Victoria harbour.

I have heard that most of you have for the past three days had a very active and successful exchange of views and ideas. I hope you all have enjoyed this meeting, which is gracefully organized by the Social Sciences Research Centre, University of Hong Kong, and the Richmond Fellowship of Hong Kong. It is a pity that you do not have more time to dwell on this very complicated but important subject. But as usual all good things have to come to an end, and I expect you will have made enough contacts for future communications after leaving here.

The central theme of this conference is: psychiatric rehabilitation - the Asian experience. The word rehabilitation, according to the Dorland's Medical Dictionary, is the 'restoration of an ill or injured patient to self-sufficiency or to gainful employment at his highest attainable skill in the shortest possible time'. Psychiatric rehabilitation poses additional problems because of the chronic nature of psychiatric illnesses. The theme is therefore set for discussion about the different approaches required for each individual patient in separate cultural settings in the Asian countries.

But when does rehabilitation begin? Does it begin only after the patient is out of the hospital? To use an analogy of a barbershop in Hong Kong, are we asking the psychiatrist to trim the hair, the psychiatric nurse to shampoo the hair, and the social worker to set the hair? If so, this is a multi-disciplinary team working in sequence and not in parallel. Mrs.Elizabeth Wong, our Secretary for Health and Welfare, talked about the inadequate links between hospitals and aftercare services when she came to the Opening Ceremony of this conference. My personal experiences at the Professorial Unit of the Prince of Wales Hospital are that there are only 1.5 to 2 social workers for 6 clinical teams with 72 in-patients, 50 day-patients and many outpatients, and that it is impossible for a social worker to be available in my own ward round every week. Where then are the social workers in Hong Kong? Many of them are working in the voluntary organizations for psychiatric patients in the community, but most of them are working in the non-medical areas in the community. Is tertiary prevention more important than the secondary or even the primary prevention? Are we promoting tertiary care at the expense of secondary care? Or simply because we think psychiatric rehabilitation only starts when the patients are out of the hospital? Otherwise, why is it that the provision of qualified psychiatric social workers in our general hospital psychiatric unit is so inadequate?

Ladies and gentlement, I did not share your caviar during the meeting, but hope that you do not mind me offering some pepper and salt. In any case, especially for those of you who come from afar, you may already know that Hong Kong is famous for its superb cuisine as well as the glittering lights in Victoria harbour and the Tsimshatsui area during this time of the year. I sincerely hope that you will have time to look around this bustling city that we love so dearly. Finally, for every one of you, may I wish a Merry Christmas and a very Happy New Year.

Thank you very much.

CLOSING SPEECH AT THE CONFERENCE "PSYCHIATRIC REHABILITATION: THE ASIAN EXPERIENCE"

by

Mr. Allan Chow

Commissioner for Rehabilitation
Hong Kong Government

It is indeed my honour and pleasure to be invited to the closing ceremony of the Conference on "Psychiatric Rehabilitation: The Asian Experience". Let me join you all here to thank the Richmond Fellowship of Hong Kong and the Social Sciences Research Centre, University of Hong Kong, for taking the initiative in organizing this Conference. I am sure participants have benefited from their discussions as well as exchange of views and experiences at workshop sessions over the last few days.

You may recall that Mrs. Elizabeth Wong, Secretary for Health and Welfare, talked about our twin goals of full participation and equalization of opportunities for disabled persons in HongKong at the opening ceremony a few days ago. I would now like to elaborate on how we move towards the goal of full participation for discharged psychiatric patients.

It is through residential services, amongst others, that we achieve the re-integration of discharged psychiatric patients into the community. Our services are designed in such a way that they are helped to develop their physical, mental and social capabilities to the fullest extent their disabilities permit.

Half-way houses are provided to those who are able to return to their families or live independently after receiving treatment in hospitals, but who require a transitional period of residential care to adjust to normal and independent life. Through small group living and professional supervision, the residents are able to maintain a stable frame of mind and develop a sense of self and group identity for work and community life.

We also offer compassionate rehousing, supported housing and supported hostels to those discharged psychiatric patients who are homeless, or have little family support, or who have been rejected by their families but who can live independently or semi-independently requiring limited supervision in daily living. In the spirit of supported housing, a non-governmental organization has introduced a 'community residence' service for ex-mentally ill persons. It is expected that additional supported housing or hostels will be set up when more discharged psychiatric patients with such functioning levels are identified.

To improve our residential services for mentally ill persons we have, since 1989, established two new types of facilities: the purpose-built half-way house and the long stay care home. The purpose-built half-way house serves not only those who are under conditional discharge from mental hospitals or those with a history of criminal violence or assessed disposition to violence, but also discharged psychiatric patients without such a background. Instead of placing those requiring enhanced supervision in one residential facility on their own, a dispersal model has been adopted in that they are rehabilitated together with other discharged psychiatric patients in the purpose-built half-way house. The assumption behind this dispersal model is that violent behaviour could become mutually reinforcing if people exhibiting similar characteristics are all housed in isolation under the same roof.

The experience of the United Kingdom has demonstrated that the chance of successful rehabilitation will be smaller if all those requiring intensive care and supervision are segregated into an isolated and exclusive group. In a purpose-built half-way house, through the provision of a small group living environment, coupled with professional support, the residents are assisted to develop a sense of self identity to help effect positive adjustments to their social skills, work habits, values of life and decision-making abilities. In this way the half-way house serves as a transitional venue for reajustment back into the normal routine of daily life in the community.

The long stay care home was set up in Hong Kong in early 1990 to cater to the needs of another group of mentally ill persons, those with a chronic psychiatric disability who are stable and do not require active treatment except minimal nursing care. The long stay care home, which provides rehabilitation outside a hospital environment, constitutes accommodation coupled with care and training. The aim is for residents to progress from a state of dependency to semi-dependency through social support, appropriate stimulation and supervision. Some, indeed, can be expected to progress to independent living and eventual return to the community. Three types of programmes are provided in the long stay care home: a nursing care programme to maintain and improve the health conditions of the residents; a domestic care programme to train them in personal hygiene and independent living; and a social rehabilitation programme to help them to acquire the necessary skills in communication, socialization and adjustment in the community. Two more long stay care homes will be built in the near future.

I turn now to recent changes in Hong Kong legislation. Our Mental Health Ordinance was amended in 1988 to reinforce the protection of the rights of mentally ill persons. In particular, two new provisions of major significance were introduced, namely the Guardianship Scheme and the Mental Health Review Tribunal.

The purpose of the Guardianship Scheme is to safeguard the welfare of mentally ill persons aged 18 and above and at the same time to protect others in the community. An application for guardianship can be made to the Director of Social Welfare by a relative or friend or any other person on the endorsement of two psychiatrists. If no suitable friend or relative is available, the Director of Social Welfare will be the guardian. The guardian is required to take all reasonable steps to ensure the safety and welfare of the person received into guardianship. The guardianship order expires after two years, unless renewed.

The purpose of the Mental Health Review Tribunal is to review the cases of patients liable to detention in a mental hospital or Correctional Services Department Psychiatric Centre, a patient permitted to be absent on trial or conditionally discharged, or a person admitted into guardianship. An application to the tribunal can be made by the patient or his relative, and if this right is not exercised within 12 months after the right first becomes available, the medical superintendent, or the Commissioner for Correctional Services (as appropriate) must refer the patient's case to the tribunal for an automatic review. The establishment of the Mental Health Review Tribunal, therefore, strengthens the protection of the rights of mentally ill persons.

Mental illness grows beneath a wide variety of problems - physical, emotional, social or economic; the individual himself may be unaware of his own condition. It is, therefore, important to educate those in the public service and non-governmental organizations who are in daily contact with the public about possible psychiatric symptoms and problems. The general public also requires education not only about the illness but also about what and where treatment services are available. They should learn how to assist in the rehabilitation of those who are mentally ill with a view to helping them to re-integrate into the community and participate fully in our daily activities.

I hope you will enjoy your visits to psychiatric rehabilitation facilities in the Territory and would like to take the opportunity to wish you all merry Christmas and happy New Year.

Thank you.

THE IMPLICATIONS OF THE RESEARCH ON EXPRESSED EMOTION FOR ASIAN CULTURES

by

Julian Leff

(Keynote Speech)

Families East and West

All societies are organized around the family unit of mother, father and children, but there are numerous variations on this theme. Joint or extended families may have as many as 30 people living in one household, or more than 100 people can share the same living space, as in the long houses in Borneo. At the other extreme the nuclear family has been the norm in Western Europe and the USA for the past 50 years at least. The average family in Britain today consists of two parents and two children, but even this basic unit is shrinking as one-third of marriages end in divorce. In the USA there are currently one million fathers bringing up children on their own. Given these enormous differences in family size, could research in families which has developed in the West have any relevance to Asia, where families for the most part retain their traditional structures? Certainly one could not make this assumption without careful pilot studies; however, there are indications that where cities develop on western lines, such as Hong Kong and Tokyo, family structures begin to resemble those in the West.

There is a problem of a different kind concerning the applicability of the measurement technique for Expressed Emotion across cultures, but that will be explored after the technique has been described.

Measuring expressed emotion

This technique was originally introduced by Brown and Rutter (1966) but had begun as a more global measure some years previously (Brown et al., 1962). The refined measure was termed Expressed Emotion (EE) and was based on a semi-structured interview, the Camberwell Family Interview (CFI), which originally took four to six hours to administer. Vaughn and Leff (1976a) showed that it could be shortened to an hour and a half or less without losing any of its ability to differentiate between families of different types. The interview is conducted with a relative of the patient under study, usually just after the patient has been admitted to hospital or has made contact with the psychiatric services. This point in time is chosen for a number of reasons: emotions are likely to be running high as this represents a crisis in the family's life; the relatives are more likely to accept being interviewed because they are anxious to talk about their problems and difficulties; and the patients can be compared at an equivalent stage in their illness.

The interview focuses on the patient's symptoms and behaviour in the previous three months, so makes sense to the relative. The whole interview is audiotaped and ratings are made later from the tape. There are five rating scales, but only four of them have been found to be associated with the course of psychiatric disorders, so we will confine our description to these. They are: critical comments, hostility, over-involvement and warmth. Ratings on these scales depend both on the content of the relative's remarks and on the way the relative expresses them. A heavy emphasis is placed on the rate, volume and tone of speech. These vocal aspects of speech are used in English to express a range of emotions. It is necessary to ask whether these characteristics of speech are used in the same way in other languages, particularly those such as Chinese in which tone has the additional function of altering the meaning of words. We will return to this question later.

Critical comments are negative remarks made about the patient's behaviour which are critical in content and usually in tone as well. The predominant emotion expressed by critical comments is anger, which is considered to be one of the basic emotions common to all humankind (Ekman and Friesen, 1971). The number of critical comments made during the interview is counted, and has been found to range from none to as many as 60.

Hostility is related to critical comments conceptually. It is rated as present in two forms: (1) a series of critical comments made by the relative without prompting by the interviewer, which concern unrelated areas of the patient's activity, e.g. "He stays in bed till the afternoon, and when he does get up he makes a terrible mess in the kitchen. He shows no consideration for the other members of the family"; (2) criticism of the patient as a person rather than just his behaviour, e.g. "He's the laziest person I've ever come across".

Over-involvement is a composite measure with four different aspects, each of which could lead to a high rating by itself: excessive display of emotion during the interview; over-protectiveness (behaving towards the patient as though he were much younger than his actual age); excessive self-sacrifice (giving up too much to look after the patient); and symbiosis (being unable to see the patient as a separate individual). This scale is a global one which is rated from 0 to 5. The main emotions that fuel over-involvement are guilt and anxiety.

Whereas anxiety is a variant of fear, one of the basic emotions, guilt is considered to be strongly influenced by culture (e.g. Binitie, 1972).

Warmth is conveyed by appreciative remarks made in a warm tone of voice. It is also rated on a global scale ranging from 0 to 5. Tone is particularly important in rating warmth.

EE and the outcome of illness

In the first studies to use the CFI (Brown et al., 1972; Vaughn and Leff, 1976b) critical comments, hostility and over-involvement were each related to the outcome of schizophrenia over a nine-month period after the patient left hospital. A higher rate of relapse was observed if a relative made six or more critical comments, or showed any hostility, or scored three or above on over-involvement. It was noted in these samples of relatives from London that when hostility was present there was always a high level of criticism. If the relatives scored low in these negative emotions but high on warmth (rating of four or five), the patient's relapse rate was significantly lower.

These findings led to the construction of a dichotomous scale. Relatives scoring above threshold on critical comments, hostility and/or over-involvement were assigned to a high EE category, the others to a low EE category. Where there were two adult relatives in the household, if one was high EE and the other low EE the household was designated as high EE on the asumption that high EE attitudes affect the patient even if a more benign relative is present.

A series of studies in a variety of cultures has shown that patients living in high EE households relapse with schizophrenia about three times as often as patients in low EE households. Relatives' EE has been measured in a large variety of conditions including schizophrenia, neurotic depression, dementia, eating disorders, child abuse, Parkinson's disease, diabetes and inflammatory bowel disease. High EE attitudes have been found in all these conditions, although shown by varying proportions of relatives. Outcome data have only been published for schizophrenia, neurotic depression, eating disorders and Parkinson's disease. Relatives' critical comments are related to the outcome of neurotic depression and eating disorders, but the threshold for high criticism is two for these conditions (Vaughn and Leff, 1976b, Hooley et al., 1986; Fischmann-Havstad and Marston, 1984; Van Furth, 1991) instead of six as in schizophrenia. In Parkinson's disease no association has been found between any EE component and the course of the neurological symptoms, although there is a link between relatives' critical comments and the patients' performance on cognitive tests. The only published research in an Asian country has been on EE and schizophrenia, so we will concentrate on this condition, while bearing in mind that the association between EE and outcome is not unique to schizophrenia.

Measuring EE in an Asian culture

The Asian centre for research on EE was established in Chandigarh, north India, as part of the Determinants of Outcome Project run by the World Health Organisation (WHO). This was a successor to the International Pilot Study of Schizophrenia (IPSS). One major finding of the IPSS was that schizophrenic patients in the developing centres, including Delhi, had a better outcome than those in the developed centres at two-year follow-up (WHO, 1979) and at five-year follow-up (Leff et al., in press). This was not explained by any of the factors in the patients known to determine outcome in schizophrenia (e.g. acuteness of onset, male sex, marital status). However, the IPSS samples were not epidemiologically-based and this could have explained the difference in outcome between developing and developed centres. These considerations led to the setting up of the Determinants of Outcome Project, in which the centres attempted to collect epidemiologically-based samples of patients making a first contact with psychiatric facilities. Unfortunately, this ambitious study only met with success in one centre in a developing country, Chandigarh. However, this was the centre selected to conduct a sub-study of EE which would be integrated with the first contact study of schizophrenia. The EE study was mounted because of the success of this measure in predicting the outcome of schizophrenia in a variety of developed countries. It was hypothesized that differences in family attitudes might account for the better outcome of patients in an Indian setting.

The first problem to be tackled was whether the technique could be transferred from English to Hindi. This is not simply a matter of accurate translation of the schedule. It involves a much more fundamental issue of the transfer of the concepts of the EE components from one language to another. Hindi belongs to the same family of languages as English and is not a tonal language, so the gap to be bridged is not as wide as between, say, English and Cantonese. The strategy we used was to employ a bilingual rater who was trained in the EE techniques in English and who then had to rate the tapes made in Hindi by the Chandigarh field workers. The field workers had achieved acceptable inter-rater reliability between themselves in Hindi, but we had no way of knowing whether their rating techniques in Hindi were the same as they had been taught in English. It was quite possible that they had modified the techniques considerably during their field experiences. The best way to check on this is to employ a bilingual rater who has had no experience in the field in Hindi and therefore has to transfer the techniques from English to Hindi in his head (Wig et al., 1987a).

This strategy revealed that the field workers were rating critical comments and hostility in Hindi much as they had been taught to do in English. On the over-involvement scale, however, they were both under-rating significantly. This appeared to be due to a drift away from the original rating convention rather than a problem of cross-cultural transfer. Unfortunately, we could not check on the ratings of warmth in Hindi because the bilingual rater did not manage to become reliable on this scale in English, an unusual problem.

The transferability of the EE ratings between English and Hindi is really rather surprising. It indicates both the universality of the emotions underlying the EE scales, and the robustness of the rating techniques. Having gained some confidence in the EE ratings in Hindi, we can compare their distribution with those for a sample of British relatives. First, however, it is important to describe the population in the Chandigarh centre.

Cultural influences on EE

Chandigarh is a modern city, built in the 1950s to designs by European architects. It has attracted professional people from all over India. As a consequence, the life-style in the city shows a western influence. By contrast, the rural population in the surrounding areas continues to follow the traditional life-style of the peasant farmer. To cite one index of the differences between the city-dwellers and the rural farmers, the literacy rate is 70% for the former but only 30% for the latter. Hence it can be appreciated that it is advisable to conduct separate analyses for the urban and rural relatives. This has been done for the components of EE and the findings are shown in Table 1.

Table 1

A COMPARISON OF EE RATINGS OF RELATIVES IN LONDON AND CHANDIGARH

	London (Vaughn & Leff 1976b)	Chandigarh (Wig et al. 1987b)		
		Urban	Rural	P (Urban *vs* rural)
Mean critical comments	7.49	2.42	0.58	<0.01
Hostility	18%	24%	3%	<0.01

Over-involvement in parents	36%	2%	7%	
Mean warmth	2.32	2.34	1.23	<0.001

It can be seen that far fewer critical comments are made by Indian than by British relatives, and that within the Indian sample rural relatives are significantly less critical than urban relatives (Wig et al., 1987b). It is of great interest that the ratings of urban Indian relatives on hostility and warmth are very similar to those of British relatives, whereas once again the rural Indian relatives rate significantly lower. Over-involvement was virtually absent in the Indian sample but, as noted above, this may be a rating artefact. It is of great interest that the city-dwellers in Chandigarh show a shift towards western patterns of EE compared with the rural farmers. This could be a consequence of education or the life-style in the city, or a combination of the two.

This finding can be put in context by comparing the prevalence of high EE attitudes in samples of relatives from a large variety of cultures.

Table 2

PROPORTION OF HIGH EE RELATIVES ACROSS CULTURES

Country	City	Group	%
Italy	Milan	Italian	70
UK	Salford	British	69
Poland	Cracow	Polish	69
USA	Los Angeles	Anglo-American	67
Spain	Madrid	Spanish	58
Denmark	Åarhus	Danish	54
UK	London	British	52
USA	Los Angeles	Mexican	41
Spain	Galicia	Spanish (rural)	34
India	Chandigarh	Hindi (urban)	30
		Hindi (rural)	8

It can be seen from Table 2 that there is a spectrum of frequency of high EE attitudes extending from the most westernized and industrialized cultures to the least. The samples with less than half of the relatives rated as high EE are Mexican Americans in Los Angeles, who retain a traditional family organization despite living in a city, Spanish relatives living in a rural area in north-west Spain, and the Indian relatives. It would add strength to our speculations to have more rural cultures investigated, but it appears that a shift to industrialized, city-based societies reduces people's tolerance of the disabilities associated with schizophrenia. We can guess at some of the factors involved. Industrialized societies emphasize competition and disadvantage people who are slow or inefficient due to psychiatric illness or the effects of maintenance drugs. Furthermore, jobs are relatively specialized, whereas an unspecialized task can usually be found in an agrarian economy for a handicapped person. The philosophy of western societies holds a person responsible for failure and even illness. By contrast, the general attitude to illness in a developing country is to look for causes external to the sufferer; for instance, supernatural influences, fate or the evil intentions of others. As we noted above, family structure and function are altered by western life-styles. The extended or joint family shrinks to a small nucleus of people; for instance, it is not unusual to find a single elderly relative, usually the mother, looking after a middle-aged schizophrenic patient. Consequently, the whole burden of care falls on one or two individuals instead of being shared among a whole network of supportive people. Another consideration stems from the size of the household. If there are only two carers, one or both of whom are high EE, it is difficult for the patient to avoid exposure to high EE attitudes. If only one or two relatives out of a household of 20 or so are high EE, it is likely that the effect is diluted. A further point is the traditional sense of duty that families have in the developing world towards a sick or disabled member, leading them to undertake the care of a patient without question. This has progressively weakened in the West. Clearly, further research is needed to determine the relative influence of these factors on the development of high EE attitudes.

Returning to the Chandigarh material, there are two interesting differences from western samples in the patterns of EE components. It has already been noted that hostility was closely linked with critical comments in previous research. However, Chandigarh relatives expressed hostility at relatively low levels of criticism. In fact 6 of the eleven hostile relatives made less than 6 critical comments and 1 hostile relative expressed only a single critical remark. This indicates that, unlike western relatives, Chandigarh relatives can express a rejecting attitude towards the patient without being particularly critical.

The other intriguing difference lies in the relationship between critical comments and warmth. In western samples there is a consistently negative relationship between these components; for example, in three studies the correlation coefficient was -.44, -.45, and -.46 (Vaughn and Leff, 1976b; Leff et al., 1982; Szmukler et al., 1985). There is a dramatic difference in the Chandigarh sample, in which the correlation was close to zero (+.10). This indicates that western relatives are unlikely to express warmth if they are highly critical, while in Chandigarh relatives can often be warm and critical at the same time. There is a suggestion from these findings of a cultural difference in the patterns of emotions, but more studies are needed from non-western cultures before giving these results greater weight.

EE and the outcome of schizophrenia in Chandigarh

We have seen that the EE ratings in Chandigarh relatives are different in many respects from those of western relatives. A key question is whether they still relate to the outcome of schizophrenia. A one-year follow-up of 70 first contact schizophrenic patients found a significant relationship between EE and the relapse rate. Of the 16 patients in high EE homes, 11 (31%) relapsed, compared with 5 (9%) of the 54 in low EE homes ($p = 0.035$). Thus the relapse rate in high EE homes was about three times that in low EE homes, as had been found in studies in the West. However, where we came to look at the individual components of the EE index, only hostility was significantly related to the relapse rate (Leff et al., 1987). This is an important difference from all other studies. Furthermore, a two-year follow-up showed that hostility expressed at the initial interview was still associated with relapse, the rates being 67% when hostility was present and 31% when it was absent ($p = 0.045$). It is noteworthy that hostility was the only component of the EE index which was as common in the Chandigarh relatives as in British relatives.

The relevance of family interventions for Asia

Over the past 15 years there have been six studies published on the effectiveness of working with the families of schizophrenic patients in conjunction with maintenance medication. All the studies have focused on high EE families, and all have shown a statistically and clinically significant reduction in relapse rates over nine months and two years.

Table 3

SCHIZOPHRENIA FAMILY TREATMENT TRIALS

	RELAPSE RATES	
	Short-Term F.U. (6-12 months)	2 Year F.U.

	Control	Exp.	Control	Exp.
Goldstein (1978)	48%	0%		
Falloon (1982)	44%	6%	83%	12%
Leff (1982)	50%	8%	78%	20%
Hogarty (1986)	41%	0%	67%	25%
Tarrier (1987)	53%	12%	59%	33%
Leff (1989)		8%		33%
		17%		36%

* Family sessions and relatives' group attenders

Although the different programmes have been given a variety of names, they contain very similar components (Leff, 1985). Furthermore, the success of our own interventions has been shown to be dependent on our effectiveness in altering the family environment in the desired direction (Leff, 1989). With this evidence for the value of family interventions and the association between EE and relapse of schizophrenia in Chandigarh, should we be considering such work with Asian families? I do not feel able to give a definite answer to this question at the moment. It is obviously necessary to have the findings of EE studies in other Asian cultures rather than pinning everything on a single study in one part of India. There is also the issue of the relevance of the particular techniques of family work that have been developed to Asian family structure and function. These techniques were designed to tackle all three components of the EE index: critical comments, hostility and over-involvement. Should they be modified to target only hostility, since this was the single component of statistical importance in the Chandigarh study? Again, questions of this kind must await further research findings. In the meantime, I think it is worth considering the intervention components one by one to speculate on their appropriateness for Asian families, with the proviso that people familiar with family life in Asia are in a much better position to do this than myself.

The components of family work as used in the western intervention studies are shown in Table 4. In general there is a tradition of Asian families being involved in the hospital care of the patient, so family work should be acceptable.

Table 4

THE COMPONENTS OF FAMILY WORK

Education about schizophrenia

Problem solving

Improving communication

Dealing with expressed emotion

Reducing contact

Expanding social networks

Lowering expectations

Education about schizophrenia

This begins the programme and consists of two sessions with the relatives which are held in their own home. This venue was chosen to put relatives at their ease. They are more likely to take in information on their home ground than in the formal surroundings of a hospital. The patient is not included in these education sessions since they tend to dominate them with discussions about their experiences and arguments about diagnosis. Instead, education about schizophrenia is given to the patient on the ward by the nursing staff.

The sessions with the relatives are structured around the causes of schizophrenia, the symptoms, the prognosis, and the treatment and management. We stress the fact that there is no evidence that families cause the illness. This is aimed at relieving any sense of guilt felt by the relatives, but this emotion is much less likely to be encountered in an Asian context. We place a lot of emphasis on the negative symptoms, stating that they are part of the illness and not under the patient's control. This seems to modify critical attitudes and may also soften hostility.   We inform the family that one in four people who develop schizophrenia recover completely and remain well for years. Judging from the findings of the IPSS, we could greatly increase this proportion to one in two for Asian countries. The aim is to increase the family's optimism. We tell the relatives that the illness makes patients very sensitive to stress, which should be reduced where possible, which will benefit both patient and relatives. We emphasize the value of drug treatment in the long term, but add that the atmosphere should be calm and predictable. It may be that less emphasis should be placed on maintenance medication in the Asian context as it is less commonly used than in the West for a variety of reasons.

It is my opinion that education is always appropriate when family members are expected to care for a sick member, and particularly in the case of schizophrenia which has such puzzling and sometimes frightening manifestations.

Problem solving

This component involves a behavioural approach to helping the family solve the daily problems that arise with a schizophrenic member. The family are asked to identify the various problems, each member is encouraged to give their own point of view, and then they are requested to choose the problem they want to work on first. The chosen problem is broken down into small steps. Solutions are invited to achieve the first step and the therapists help the family to decide on the optimum solution to attempt. The whole family is encouraged to co-operate in attempting to implement the solution, to avoid sabotage by one member. The therapists tell the family that they will ask for a report on their progress the next time they come.

This set of techniques would seem to be appropriate whatever the culture of the family.

Improving communication

Some families in the West with a schizophrenic member communicate in a chaotic way, members interrupting each other and speaking over each other. Often the patient gets left out of the conversation because he or she lacks the social skills to assert themselves. The therapists attempt to restore order by asking only one person to speak at a time, and ensuring that each member gets a fair share of the conversation. An additional convention to be established is that if a family member is talking about a person present in the session they should address them directly.

I suspect that these interventions may violate the hierarchical rules of traditional family systems, in which the head of the household is expected to dominate the conversation, and direct communication between higher and lower members of the hierarchy is discouraged. However, I am open to correction on this.

Dealing with expressed emotion

The techniques for reducing criticism and hostility are to reframe negative statements made by relatives in a positive way, to prevent the escalation of conflict by stopping it rapidly and encouraging the resolution of differences by discussion, and to help relatives to understand the patient's problems. These would all seem to be relevant in the Asian context, particularly given the important influence of hostility in the Chandigarh data.

By contrast, techniques for dealing with over-involvement may be of little relevance. These aim to reduce relatives' over-anxiety and over-protectiveness and to encourage autonomy and independence in the patient. This may conflict with cultural norms concerning mutual interdependence of parents and children throughout their lives.

Reducing contact

In some, but not all, western studies patients have been able to reduce their risk of relapse by keeping out of the way of high EE relatives. However, this was not a significant factor in the Chandigarh study, so that techniques of reducing contact between patients and relatives are probably irrelevant.

Expanding social networks

This is aimed at increasing social support for isolated relatives and patients. Social isolation of families is probably rare in the Asian context, though patients may be confined to the house, sometimes through shame and embarrassment on the part of the relatives. Patients are encouraged to make contact with their peer group outside of the home and to take up leisure activities.

Lowering expectation

In the West, relatives often hold high expectations for the patients to return to studying or to a job after a schizophrenic illness. The therapists stress that although the delusions and hallucinations usually resolve with hospital care, the patient is left with apathy, inertia and problems of concentration which can persist for one to two years. Thus, the relatives are led to expect a prolonged convalescent period. As discussed above, relatives in developing countries generally have lower expectations for patients. Furthermore, there are many more opportunities for non-competitive and undemanding jobs. As an illustration of this, the social outcome for patients in the IPSS was significantly better in Agra, India and Ibadan, Nigeria than in the western centres both at two years (WHO,1979) and at five years follow-up (Leff et al., in press).

Our review of the techniques used in family work in the West suggests that a number of them are likely to be of relevance to Asian families, in particular education about schizophrenia, teaching problem-solving and dealing with Expressed Emotion. What about the resources required for this work, considering that trained personnel are scarce in developing countries? In fact, we have a similar problem in Britain because there are not enough psychiatrists to work with all the families who are in need of help. Our solution has been to set up training courses for psychiatric nurses. These take up two hours per week for nine months and we are able to train ten nurses at a time. We have been very encouraged to find that the trainees are quite capable of learning the necessary skills in the time available.

In conclusion, the research on EE and the clinical application of it seem to be of considerable relevance in the Asian setting. Although only a small minority of families with a schizophrenic member are likely to need this form of help directly, it should be recognized that with increasing urbanization and industrialization the proportion of high EE families will inevitably increase. In ending, I would like to make a plea that intact, traditional families are viewed as a valuable resource in developing societies and that every effort is made to preserve them. This may be a naive appeal, but once family structures have fragmented they cannot be rebuilt, and it is very expensive to replace them with professional carers.

REFERENCES

Binitie, A. (1972) 'A study of depression in Benin, Nigeria'. M.D.Thesis

Brown, G.W., Birley, J.L.T. and Wing, J.K. (1972) 'Influence of family life on the course of schizophrenic disorders: a replication. *British Journal of Psychiatry*, Vol. 121, 241-258.

Brown, G.W., Monck, E.M., Carstairs, G.M. and Wing, J.K. (1962) 'Influence of family life on the course of schizophrenic illness'. *British Journal of Preventive and Social Medicine*, Vol. 16, 55-68.

Brown, G.W. and Rutter, M. (1966) 'The measurement of family activities and relationships: a methodological study'. *Human Relations*, Vol. 19, 241-263.

Ekman, P. and Friesen, W.V. (1971) 'Constants across cultures in the face and emotion'. *Journal of Personal and Social Psychology*, Vol. 17, 124-129.

Fischmann-Havstad, L. and Marston, A.R. (1984) 'Weight loss maintenance as an aspect of family emotion and process'. *British Journal of Clinical Psychology*, Vol. 23, 265-271.

Hooley, J.M., Orley, J. and Teasdale, J.D. (1986) 'Levels of expressed emotion and relapse in depressed patients'. *British Journal of Psychiatry*, Vol. 148, 642-647.

Leff, J.P. (1985) 'Social factors and maintenance neuroleptics in schizophrenic relapse: an integrative model'. *Integrative Psychiatry,* Vol.3, 72-88.

Leff, J.P. (1989) 'Controversial issues and growing points in research on relatives' expressed emotion'. *International Journal of Social Psychiatry*, Vol. 35, 133-145.

Leff, J.P. et al. (in press) 'The IPSS: five year follow-up findings'. *Psychological Medicine*.

Leff, J.P., Kuipers, L., Berkowitz, R., Eberlein-Fries, R. and Sturgeon, D. (1982) 'A controlled trial of social intervention in schizophrenic families'. *British Journal of Psychiatry*, Vol. 141, 121-134.

Leff, J.P., Wig, N., Ghosh, A., Bedi, H., Menon, D.K., Kuipers, L., Korten,A., Ernberg, G., Day, R., Sartorius, N. and Jablensky, A. (1987) 'Influence of relatives' expressed emotion on the course of schizophrenia in Chandigarh'. *British Journal of Psychiatry*, Vol. 151, 166-173.

Szmukler, G.I., Eisler, I., Russell, G.F.M. and Dare, C. (1985) 'Anorexia nervosa, parental 'expressed emotion' and dropping out of treatment'. *British Journal of Psychiatry*, Vol. 147, 265-271.

Van Furth, E.F. (1991) *Parental expressed emotion and eating disorders*. The Haag: CIP-Gegevens Koninklijke Bibliotheek.

Vaughn, C.E. and Leff, J.P. (1976a) 'The measurement of expressed emotion in the families of psychiatric patients. *British Journal of Clinical and Social Psychology*, Vol. 15, 157-165.

Vaughn, C.E. and Leff, J.P. (1976b) 'The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic and depressed neurotic patients'. *British Journal of Psychiatry*, Vol. 129, 125-137.

Wig, N.N., Menon, D.K., Bedi, H., Ghosh, A., Kuipers, L., Leff, J., Korten,A., Day, R., Sartorius, N., Ernberg, G., and Jablensky, A. (1987a) 'Expressed emotion and schizophrenia in North India. I. Cross-cultural transfer of rating of relatives' expressed emotion'. *British Journal of Psychiatry*, Vol. 151, 156-160.

Wig, N.N., Menon, D.K., Bedi, H., Leff, J., Kuipers, L., Ghosh, A., Day,R., Korten, A., Ernberg, G., Sartorius, N. and Jablensky, A. (1987b) 'Expressed emotion and schizophrenia in North India. II. Distribution of expressed emotion components among relatives of schizophrenic patients in Aarhus and Chandigarh'. *British Journal of Psychiatry*, Vol. 151, 160-165.

World Health Organisation (1979) *Schizophrenia: an international follow-up study*. Chichester: John Wiley & Sons.

THE INFLUENCE OF EXPLANATORY MODELS OF MENTAL DISORDERS ON CONCEPTS AND PRACTICE OF PSYCHOSOCIAL REHABILITATION

by

Vijay Nagaswami

(Keynote Speech)

Mental disorders are as old as the hills. Although Hare (1990), scanning the English literature, observed that documented descriptions of severe mental disorders such as schizophrenia made their appearance only around the 18th century, graphic descriptions of a condition called *Unmada* (what we now refer to as schizophrenia) can be found in an ancient Indian medical treatise, *Charaka Samhitha*, published circa 600 BC (Namboodiri, 1986). This, I suspect, would also be the experience in other ancient Oriental civilizations. Communities over the centuries have responded to the existence of such mental disorders in a variety of ways, dictated in the main by socio-cultural norms prevailing at the time. The northern hemisphere has over the last two centuries seen several paradigm shifts *vis à vis* perceptions and understanding of mental disorders, ranging from magico-religious models through humoral models to a classic disease model of mental disorder, and these have largely determined the nature of care and services offered to persons with mental disorders - from the community to the institution and back again to the community. The southern hemisphere has, however, adopted a different process. While the pattern of services available in the last two centuries or so has kept reasonable pace with developments in the northern hemisphere (a process owing its origins almost entirely to the dictates of colonial overlords), perceptions and explanatory models have changed little over the centuries except, perhaps, in areas of high industrialization, high urbanization, and therefore high *westernization*. Also, the development of institutional facilities has not really been proportional to the number of 'service seekers'.

It would, at this time, be politic to seriously examine the issues faced by practitioners of psychosocial rehabilitation (PSR) in the context of an international process that seeks to universalize the methods and practise of PSR. The obvious question facing the practitioner is whether models of PSR developed in the West and, therefore, necessarily tailored both in concept and method to the needs of the Western client and his socio-cultural milieu, would be appropriate in Eastern cultures, a question which the organisers of this Conference have squarely posed. I would like, in the course of my presentation, to address precisely this issue.

This paper does not seek, as its esoteric title may indicate, to provide a marvellously complicated academic treatise on explanatory models, nor does it seek to establish the relative superiority of one model over the other. Rather, it aims to develop a conceptual framework of PSR derived from practical realities in the field against the background of an understanding of the essential cultural differences between the hemispheres with respect to explanatory models of mental disorders. In doing so it will make the following assumptions:

1. The term *explanatory model* will be used to refer to the ways communities identify, assign meaning to and handle mental disorders.

2. There is a distinct difference between explanatory models held by communities in the northern and southern hemispheres - the former being more principally medical/biological and the latter being more traditional (magico-religious) with two important caveats: that this does not mean that all communities in either hemisphere are culturally identical but that they do, in the main, share attitudes and perceptions *vis à vis* mental disorders; and that in urbanized regions in the southern hemisphere the explanatory model more closely approximates the one held in the northern hemisphere.

3. Explanatory models have a definite bearing on the nature of the service to be provided and this would also include the content of a PSR programme.

4. Even if a given explanatory model is considered 'undesirable' in the face of scientific evidence, changing such a model cannot be effected by a *culture-unfriendly* service. Social change is a painfully slow process.

5. Cultural diversity notwithstanding, most countries in the southern hemisphere, by virtue of leaning towards *traditional* or *indigenous* explanatory models, can be considered together as a unit, and therefore the observations made in this paper, while drawn from experiences in South India, can be generalized to other Asian cultures as well.

6. The positive spin-offs of delivering a culturally-sensitive PSR programme cannot be over-emphasized.

7. Asian countries are at a critical stage of their development, especially in the area of mental health service delivery, and they can least afford to repeat the mistakes made by the West.

I request, therefore, that the paper be interpreted against the above background.

Conceptual and definitional issues - a starting point

A more detailed discussion of conceptual and definitional issues pertaining to PSR has been discussed elsewhere (Nagaswami, 1989), but for the purpose of this paper an appropriate starting point would be the framework proposed by the *International Classification of Impairments, Disabilities and Handicaps (ICIDH)* (WHO, 1980), according to which *illness* gives rise to *impairments* (residual disorders of structure or function), which cause *disabilities* (difficulty in performing rôles or tasks expected of the individual), which then result in a *handicap* (a position of disadvantage in which the disabled individual is placed), all arising in the context of a diagnosable mental disorder.

In terms of intervention, it is assumed that medical treatment would be required at the level of illness; impairments can be corrected by the institution of skills training (both vocational and social); disabilities can be corrected by environmental restructuring (providing housing alternatives, intervening with families, etc.); and handicap can be prevented by effective advocacy, provision of welfare support and initiating social change. This sequence, described graphically in Appendices 1 and 2, implies that PSR can be directed at two levels: the client and the environment, a position elegantly and consistently articulated by the Boston group (eg. Anthony, 1977). Definitions of PSR have been developed by several authors (e.g. Bennet, 1983) and have ranged from 'normalization' definitions to more pragmatic ones. Based on practical realities obtaining in the field and elucidated elsewhere (Nagaswami, 1990), I would like to offer the following as a starting point definition of PSR for the purpose of this paper:

> *Psychosocial Rehabilitation can be conceptualized as a PROCESS initiated by a health or mental health professional in collaboration with the patient's family and community and supported by the policy planner, focussed on developing and implementing an individualized intervention programme seeking to* ***maximize the patient's assets and minimize his disabilities in the area of socio-occupational functioning****, centering around the philosophy of mobilizing and utilizing resources available to the community, with the final objective of* ***mainstreaming*** *the patient.*

From the foregoing definition it becomes apparent that the professional is the primary agent of PSR and in implementing programmes he/she assesses the patient, the family, the social network, the community, and higher order supra systems, including national policy makers as illustrated in Appendix 3. The following sections will attempt to validate the starting point framework developed above.

Persons with severe mental disorders in Asia: the bad news and the good news

A recent issue of the *Psychosocial Rehabilitation Journal* (July 1990), devoted to a comparative analysis of PSR in several countries including some in the Asian region, revealed that, although precise numbers differ, the situation of persons with severe mental disorders (SMD) in most Asian countries is quite similar: large numbers of untreated and unserviced patients; dearth of professionals; dearth of basic mental health services; lack of PSR facilities; and the absence of disablement/welfare benefits for persons disabled by SMD. The equation in India can be cited as a representative example: *about 3,000 mental health professionals (Psychiatrists, Psychologists and Psychiatric Social Workers); about 25,000 hospital beds; about 5-8 million persons disabled by SMD out of a total of about 25 million service seekers; about 10 PSR facilities concentrated in the southern states; and the absence of any form of disablement/welfare benefits for persons with SMD.*

An appalling equation by any standards but representative, I imagine, of any developing economy. While many may consider this bad news, I am inclined to consider this as good news because it puts the Asian policy planner in a position of advantage. With contemporary psychiatric thought favouring a movement from the institution to the community, the Asian planner can obviate the need for mass deinstitutionalization and its attendant problems by not building any more institutions and taking a fresh look at the alternatives available in the community.

The macro-planner does not have to deal with problems such as homelessness, developing community support systems or delivering a bewildering array of services targeted at 'promoting functional autonomy' (when all they do, paradoxically enough, is foster dependence on the service), for precisely the reason that mental health services in Asia are by and large not yet completely institutionalized. Add to this the facts that Asian cultures on the whole have *strong family ties, strong support from a cohesive community, extensive primary health care networks that are begging to have a mental health component integrated in them, and extensive albeit distressingly under-utilized traditional healing networks,* and you get the heady and exciting possibility of working with an *as-yet-uninstitutionalized* PSR process.

This does not, of course, imply that the situation in Asian countries is in any way Utopian. Individual problems and exceptions do indeed exist, but at the macro level it is apparent that Asian rehabilitators need not repeat the mistakes made in the West and are, therefore, in the potentially advantageous position of taking a quantum leap in the field by studying, understanding, augmenting and supporting the existing natural PSR process that operates within the social systems of a given community. There is, of course, no room for complacency; but for optimism, certainly.

A FEW CRITICAL ISSUES

Before attempting to develop a revised framework for PSR, it would be prudent to examine a few critical issues that professionals in the region must address.

Explanatory models and community expectations

By and large, most rural communities (and a few urban ones as well) in the Asian region adopt traditional or magico-religious explanatory models of mental disorders. An explanatory study of this subject, undertaken by the author in a defined rural catchment area of 100,000 population about 60 kms away from Madras in South India, has thrown up a few interesting findings. These, although of a preliminary nature, are worthy of consideration as a few general directions do emerge.

Most persons, regardless of their socio-economic or occupational background, subscribe essentially to supernatural explanations of mental disorders. When presented with a checklist of behavioural descriptions covering what professionals would recognize as registers of psychopathology, members of the community respond best and most readily to those descriptions referring to *violent, bizarre, socially disruptive or alcohol-related behaviours*. Descriptions related to epilepsy and mental retardation are explained as definitely medical problems requiring the services of a doctor. All other behaviours referring to psychoses, depression and other disorders are explained as arising out of the complex interplay between supernatural phenomena and socio-economic problems (mainly poverty and unemployment).

Only some of the more educated respondents were willing to consider a medical explanation for the problem. While recognizing that some of the more aggressive/violent problems can be effectively dealt with in a *mental hospital*, most respondents also felt that the traditional healing centres in the region (a mosque and Hindu temple) could also serve the purpose, thereby indicating that they were responding, in the main, to the essential common feature between the two facilities: *restraint*. The method of restraint (physical in the one and chemical in the other) was not considered germane to the issue. Expectedly, respondents living in areas of greater accessibility to public transport, and therefore to the city of Madras, were more amenable to adopting medical models of causation of mental disorders. Despite this confused scenario, most respondents appeared to agree that the traditional healing network was the principal, and often final, court of justice on such matters. Regardless of medical interventions being sought or provided, the Gods had to be propitiated, a clear reflection of the overpowering influence of the philosophy of *karma*.

Interestingly enough, the respondents were not averse to changing explanatory models, but only in the face of credible service availability. This can be evidenced by the fact that many long years of providing anti-convulsant medication through primary care facilities has served to change the explanatory model of epilepsy to a *medical-disease* one.

The locus of control of mental disorders is usually placed outside of the sufferer (rarely, if ever, do communities feel that a person displays abnormal behaviour because he/she wants to). Therefore the community is remarkably tolerant of bizarre/eccentric behaviour. Their main expectation of the 'patient' is that he/she should be economically productive if a breadwinner, or attend to domestic chores if that is what is expected of the individual, and that he/she should not be socially disruptive (aggressive, violent, suicidal, etc.). As mentioned earlier, most respondents are reluctant to shift systems of care even if their explanatory models are amenable to change.

The experience in urban communities is not quite the same but not remarkably dissimilar either. Urban communities, while recognizing the need for medical intervention for 'insane' persons, are still not quite decided as to how to explain the phenomenon. An enduring belief in astrology, performance of certain rituals to ward off the *evil eye*, and the fatalistic acceptance of the phenomenon of mental illness, comfortably coexists with the need for hospitalization and asylum for persons with severe mental disorders.

It is evident that the community has adopted a natural process of providing care for persons with mental disorders, although they do find the task quite difficult and are quite agreeable to the idea of being supported in this by institutions / professionals.

Family expectations

Families of persons with SMD are usually the primary care givers in Eastern cultures. A recent study undertaken at Madras (Shankar and Menon, 1991) of needs and expectations of families of persons disabled by SMD revealed that the situation was quite different from the one that obtains in the West. The primary issues that families in Madras addressed themselves to was *cure vs care*. Most persons expressed very little need for the provision of care based services. They were more preoccupied with the issue of cure as care was something they were already providing and would certainly continue to do, despite perceiving the care giving process as substantially burdensome. Their primary need was for economic support either in the form of 'curing' the patient so he could go back to work, or arranging for employment opportunities for the patient or someone else in the family so that the home fires could be kept burning. Most families, especially those belonging to the lower income groups and those of rural origin, were not particularly enthusiastic about receiving information about the illness or emotional support. Their expectation of the professional was very clear: cure my ill family member or, if you cannot do that, tell me what else I can do.

Rural and urban differences were found to exist, as were differences between the educated and illiterate. The higher the socioeconomic group the family member belonged to the more were the expressed needs for care rather than cure, while in the lower socioeconomic groups the converse was the case. This can be understood as a function of the different kind of pressures faced by the two groups: social for the former and economic for the latter. Also, the families interviewed displayed remarkably high tolerance of the negative symptoms of the illness and were mainly disturbed by positive, disruptive symptoms as detailed in the preceding section. It does become fairly clear that families have very definite expectations of professionals regarding persons with SMD. The professionals are not expected to take on the kind of tasks that their counterparts in the West have to do. The family is coping and is willing to continue to do so. What they appear to need is support as evidenced by the fact that family support groups do seem to help families to 'accept their lot' as it were. Support is essential but information is not.

Mental health service delivery systems

It is an inescapable fact that mental health services in Asian countries have to initially concentrate on reaching the unreached. Given the lack of fiscal and manpower resources and the need to provide services at the consumer's doorstep, the most effective strategy would be the integration of a mental health component in the existing primary care infrastructure, by training and supporting primary health care personnel to deliver basic mental health care services. The feasibility and efficiency of this approach has been demonstrated in several countries in the Asia Pacific region. In India, the National Mental Health Programme (NMHP, 1982) adopts this approach of deprofessionalization, demystification and decentralization with not inconsiderable success. The consequence of offering a mental health service in an area where none previously existed is the problem of the long term management of hitherto undetected persons with SMD, who were receiving the care and support of the community but who, in the wake of increased expectations of the newly developed service, now require more substantial inputs from the service facility: in short, PSR.

In developing PSR programmes, certain facts must be borne in mind. Integration with all sectors (health, development, education, etc.) should be the touchstone. The situation that exists in some Western countries in which different state departments offer different kinds of services such as medical care, housing, recreational facilities, disablement benefits, etc., with the bewildered client requiring the services of a case manager to guide him through all the services, should, if possible, be avoided. Additionally, good programmes should *utilise minimal professional inputs, not dislocate the individual from his/her natural environment; harness the valuable resource potential of the family and community, not alienate the individual from the social environment by according him/her privileged status (by providing special benefits such as employment benefits, etc. which the rest of the able-bodied though no less needy persons in the community cannot avail themselves of); be low cost and grassroot dependent; and in general be community intensive rather than client intensive.* All these criteria are satisfied by the community-based rehabilitation (CBR) model developed by the WHO and practised, with telling success, for persons with physical handicaps. A similar approach has been used by this author in a rural catchment area in South India (Nagaswami, 1990), using trained volunteer workers who perform the function of rehabilitators and serve as an effective bridge between the patient and, on the one hand, the rest of the community and, on the other, the health, development and educational infrastructures.

Common elements in PSR programmes the world over

Despite the intrinsic differences in conceptual orientation, resource availability, needs and infrastructural facilities, PSR programmes in all parts of the world have four common elements. All programmes integrate their approach with the need for clinical recovery, thereby providing clinical support for patients with SMD. By offering opportunities for patients to share their problems individually or in groups, engage in shared activities, and by taking up the process of promoting attitudinal change, the professional also provides social support. In taking care of the information and/or emotional needs of family members, family support is offered, and economic/welfare support is provided by sheltered workshops, transitional employment programmes, vocational training, and provision of disablement compensation, etc. In essence, most PSR programmes offer support in one form or the other, the areas of support being offered depending on fiscal and manpower resources available to the programme planner.

The major difference between the two hemispheres is in the providers of support. In the northern hemisphere, usually the *mental health professional provides clinical support, social support, and family support, with the state stepping in to offer economic/welfare support.* *In most of the southern hemisphere, the mental health professional is primarily concerned with providing clinical support and, to a very limited extent, social support.* *Usually the family and the community, including the traditional healing network, provides the social support, other families and the community provide family support, and the community provides economic support.* This means that, in the southern hemisphere, the natural support systems are untouched although unsupported. More important, this also means that PSR in the northern hemisphere has become *institutionalized.*

A revised and more Asian framework of PSR

Based on the issues discussed in the earlier sections, I have attempted to develop a revised framework within which PSR in the Asian region can operate. In doing so I have also tried to be as pragmatic as possible and have provided for the resource problem that most developing countries face.

The central feature of the revised framework is that the primary agents of PSR are the family and community, with the mental health professional taking on the rôle of a resource person. As detailed in Appendix 4, the professional's primary intervention is at the level of illness leading to disability. This can be achieved by instituting appropriate medical interventions, skilled training and other treatments to prevent disabilities, e.g. family interventions, etc. If disability does set in, or already exists at the time of detection, the natural processes of PSR that the family and the community resort to should not be disturbed, and the professional should support and try to augment the resources available to the community to handle socio-occupational problems, coping problems and economic problems faced by the family. This would mean that the professional would be a part of the process, a member in the networks of the patient, the family, the extended network, and the community, aside from supra systems up to the level of the policy planner (Appendix 5), and would **not** be a primary care provider. What rôle, then, does the professional play? I would like to submit that the professional would mainly be a *resource person and an agent of social change.* *He/she would be a trainer of other potential rehabilitators (families, volunteers, etc.), be an advocate for the person with severe mental disorder, be a valuable support figure, and an educator.*

If the above is considered acceptable, a revised definition of PSR becomes necessary.

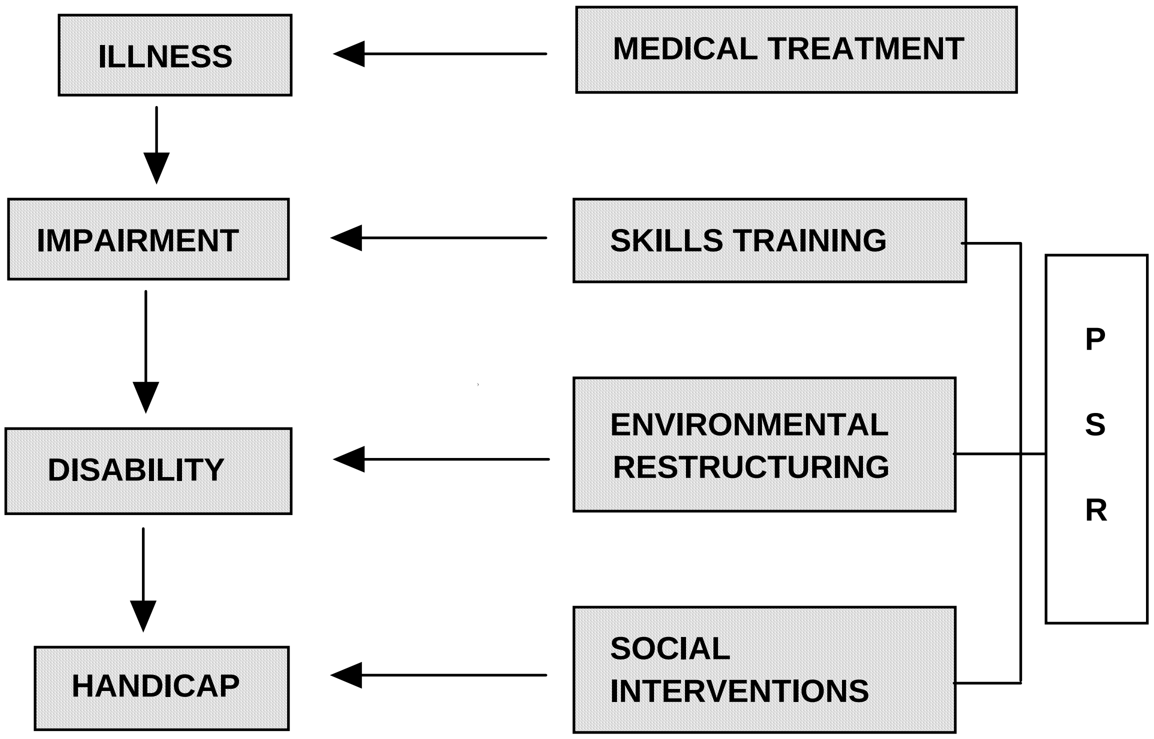
> *Psychosocial rehabilitation is a process initiated by the family of a person with a severe mental disorder, in collaboration with the community's natural support systems* ***which includes the mental health professional****, that seeks to* ***maximise the socio-occupational functioning*** *of the patient with the final objective of* ***preventing marginalization****.*

A last word

Fourteen years ago a persuasive argument was put forth by Anthony (1977) that psychosocial rehabilitation was a concept in need of a method. Today, psychosocial rehabilitation is dangerously on the verge of becoming **methods in need of a concept.** It is, indeed, a cause for celebration that Asian planners are today in a position of advantage given them by the communities for which they are planning services. The time is, therefore, ripe for a process of stock-taking of PSR strategies and programmes, concretizing our objectives, concerns and expectations regarding services for persons disabled by mental disorders, and **empowering the community** to participate in the planning process, either directly or indirectly, by studying their perceptions and processes. I would conclude with a strong and earnest appeal to *deinstitutionalize Psychosocial Rehabilitation*.

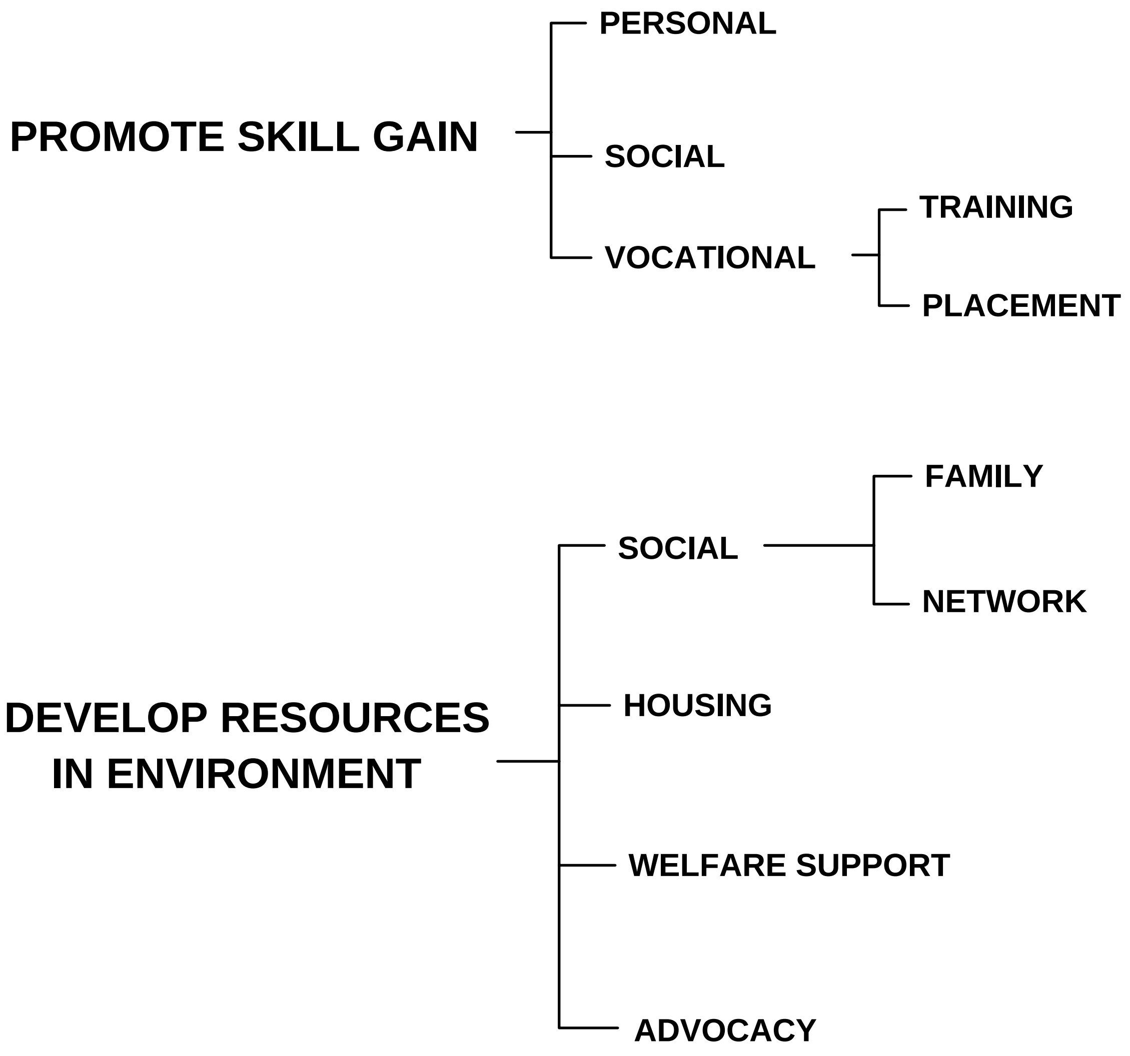
APPENDIX 1

A WORKING CONCEPTUAL FRAMEWORK



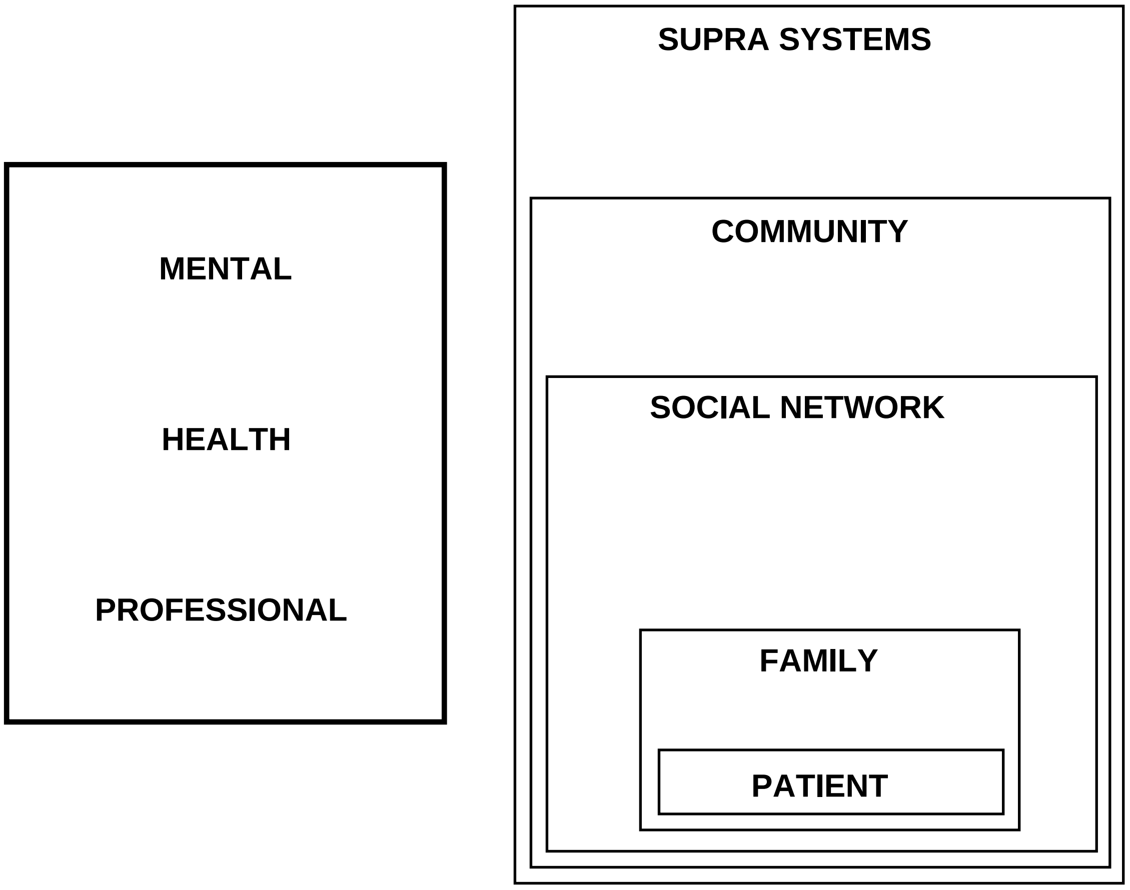
APPENDIX 2

ELEMENTS OF REHABILITATION



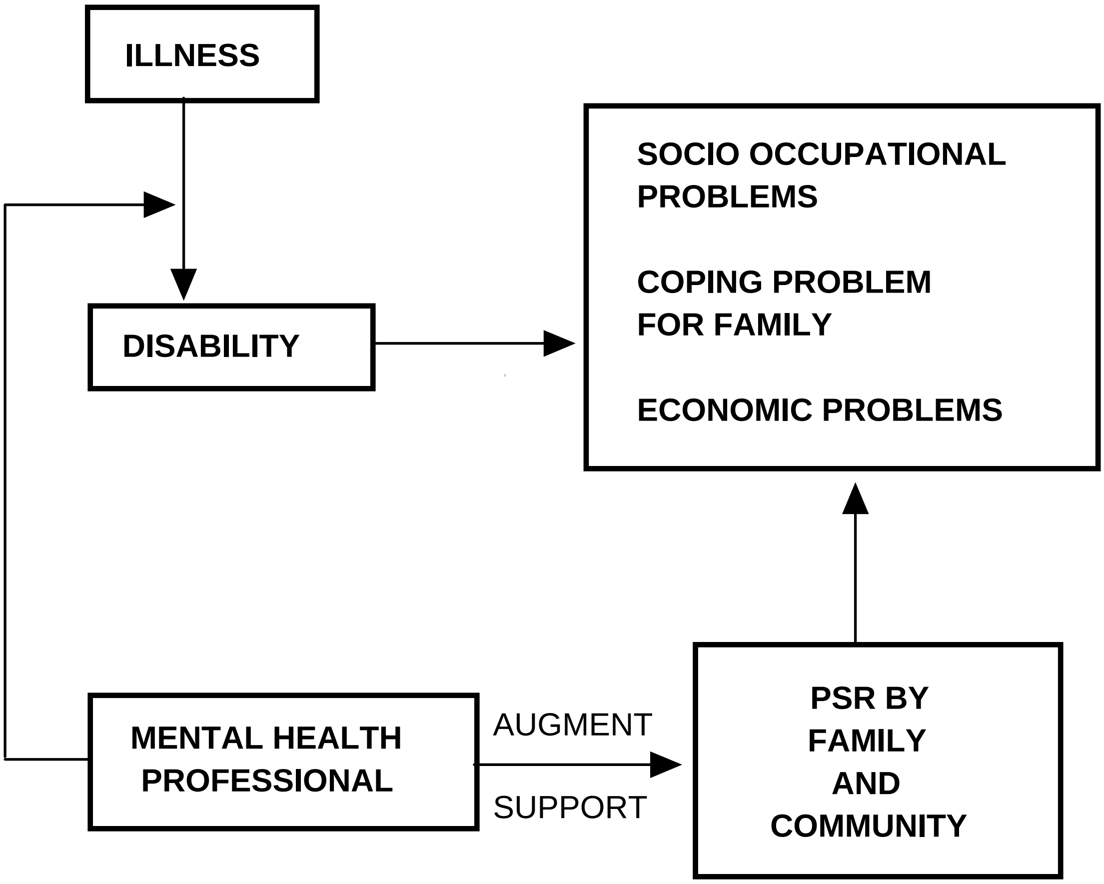
APPENDIX 3

SOCIAL SYSTEMS IN THE PSR PROCESS



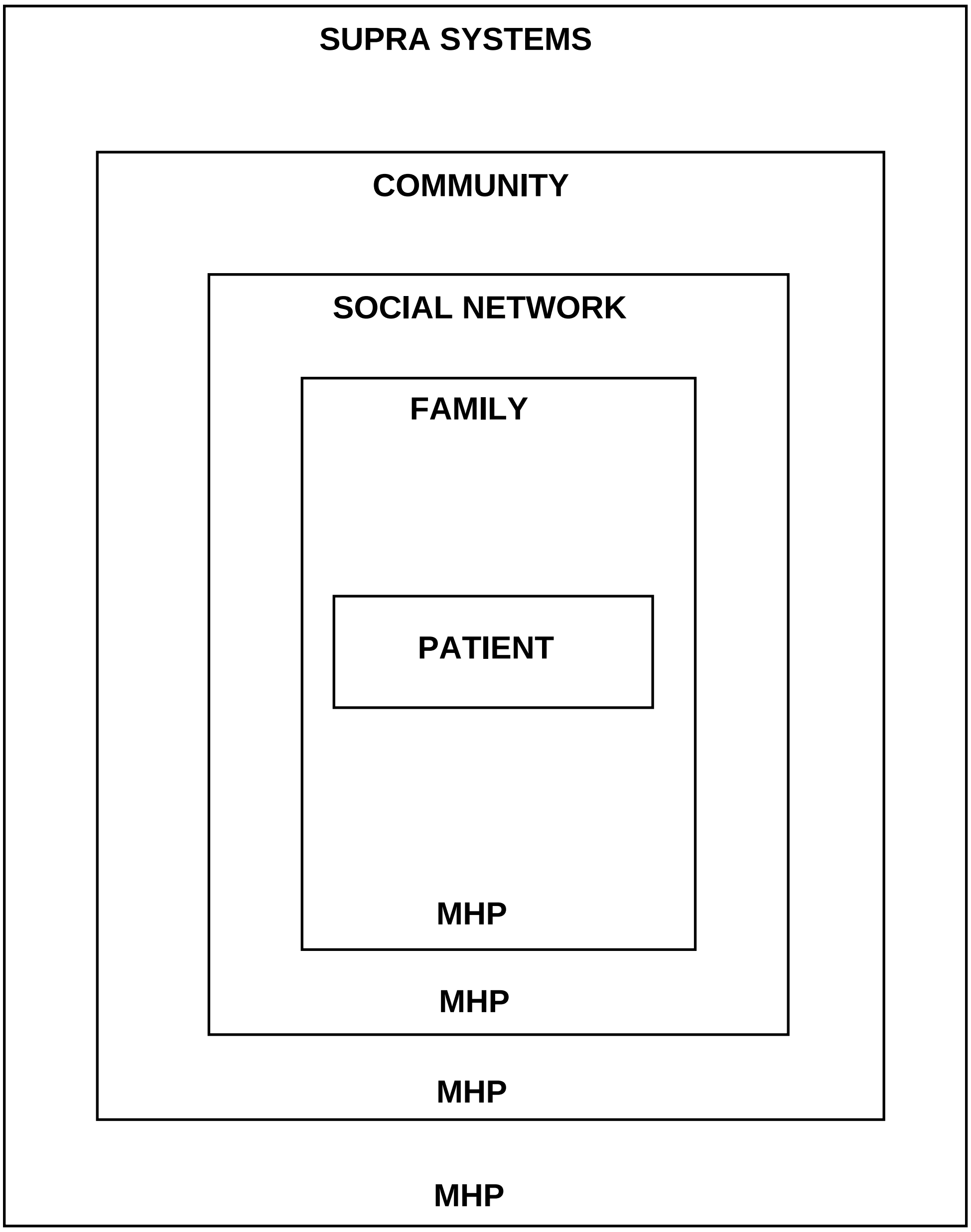
APPENDIX 4

REVISED CONCEPTUAL FRAMEWORK



APPENDIX 5

SOCIAL PROCESSES IN ASIAN PSR



REFERENCES

Anthony, W.A. (1977) 'Psychiatric rehabilitation - a concept in need of a method'. *American Psychologist*, Vol. 32, 658-667.

Bennet, D.H. (1983) 'The historical development of rehabilitation services'. In Watts, F.N. and Bennet, D.H. (eds) *Theory and Practice of Psychiatric Rehabilitation*, pp3-14. London: John Wiley & Sons.

Hare, E.H. (1990) 'Schizophrenia: a recent disease'. Key paper presented at *Schizophrenia 1990: Poised for Discovery*, Vancouver, Canada.

Nagaswami, V. (1989) 'Impairments and disabilities: concepts and applications'. In Rajkumar, S., Thara, R. and Nagaswami, V. (eds) *Natural History of Schizophrenia*. Madras: SCARF publications.

Nagaswami, V. (1990) 'Integration of psychosocial rehabilitation in national health care programmes'. *Psychosocial Rehabilitation*, Vol. 14, 53-65.

Namboodiri, V.M.D. (1986) 'Indian medical systems'. In Menon, M.S. and Das, U.G. (eds) *Schizophrenia: Historical Trends*. Madras: SCARF publications.

'National Mental Health Programme for India (1982). Director General of Health Services. New Delhi: Government of India.

Shankar, R. and Menon, M.S. (1991) (submitted for publication) 'Perception of needs by mental health professionals and families of persons with schizophrenia'. Paper presented at *World Congress of Psychosocial Rehabilitation*, Montreal, Canada.

World Health Organisation (1980) *International Classification of Impairments, Disabilities and Handicaps*. Switzerland: WHO

THE REHABILITATION OF LONG-TERM PSYCHIATRIC PATIENTS IN THE COMMUNITY

by

Julian Leff

(Keynote Speech)

Introduction

Over the past 40 years changes have taken place in the provision of long term psychiatric care which have affected hundreds of thousands of patients. The decline of the mental hospital has been most dramatic in England and Wales, the USA, and Italy, although it has also occurred in some other European countries. It is important to note that there are countries, for example Japan, in which the mental hospital population is continuing to expand. It is a remarkable fact that very little research has been directed at the evaluation of this revolution in the care of the chronic mentally ill. In particular, apart from a few small-scale follow-up studies, e.g. Jones (1985), we know of no attempt other than the TAPS Project to determine whether the new mode of care actually benefits the patients involved. We can speculate on the reasons for this neglect (reluctance to treat government policies as experiments, low scientific status of health services research) but the first priority is to remedy it. Important issues arise with respect to the design of such a study, and to the choice of research instruments.

Design issues

Ideally one would want to set up a randomized, controlled trial in which experimental patients were discharged to community facilities, while control patients remained in the institution for a specified period of time. In practice, this design is most unlikely to be adopted anywhere since research workers do not normally have sufficient control over the discharge process to insist on randomization. This point is well illustrated by the situation that the Team for the Assessment of Psychiatric Services (TAPS) was faced with when setting up its central project. The North East Thames Regional Health Authority (NETRHA) made a decision in July 1983 to close two of the six large mental hospitals in the region over the course of ten years. This was seen as an opportunity to evaluate the closure policy, and after a period of negotiation NETRHA set up TAPS to undertake this task. As the magnitude of the project became evident, TAPS grew in size and currently comprises seven full time research workers with an honorary director. Funding is partly NETRHA and partly from the Department of Health.

The two hospitals to be closed are Friern and Claybury, which between them serve nine health districts with a total population of one million. In response to the closure decision the health districts set up Core Teams whose remit was to select long-term patients for discharge and to prepare them for life in the community. The Core Teams were multi-disciplinary and in almost every case led by non-psychiatrists. Thus the discharge decisions were not generally under the control of hospital-based personnel. This made it extremely unlikely that randomization of discharges would be acceptable to the Core Teams. Another local factor rules out this design entirely.

In announcing the closure decision, NETRHA laid down only three guidelines for community facilities, preferring to delegate detailed planning to the district health authorities. One was that facilities should be domestic in scale with a maximum of 24 places. In retrospect this limit appears too high as reprovision facilities for the long-stay have so far rarely exceeded 8 places. The other two stipulations have had a major impact on the evaluation. One was that patients should be relocated in the community together with their friends, effectively nullifying the possibility of randomized discharges. The final policy statement was that the acute admission facilities should be the last service to be transferred from the mental hospitals. This was an enlightened decision intended to prevent stagnation in the declining institutions. It meant that TAPS would give priority to the evalution of the long-stay non-demented, since these would be discharged first.

With randomization ruled out, the next choice is a matched case-control design. This had already been successfully employed in the evaluation of the closure of Darenth Park Hospital for the mentally handicapped, by Dr. Lorna Wing. The strategy is to match each patient who is due for discharge with a patient who is likely to remain in hospital for a further year, and then to follow up both members of the pair a year later. There are a number of problems with this design. First, there is the choice of variables on which to match the mover and stayer. One wants to select the factors that determine the ability to remain out of hospital. But this is a Catch 22 situation since we will only be able to identify those at an advanced stage of the follow-up study. We can only make educated guesses at the beginning of the study about the factors likely to emerge as important from the data analysis. The variables we selected for matching on were: hospital (Friern or Claybury), age, sex, length of stay, diagnosis, and social disability. Whereas the first four variables are obtainable from hospital records, the latter two necessitate interviews with the patient and/or staff. Thus it was not possible to match accurately on all six factors until we had completed a baseline assessment on all eligible patients.

Unfortuntely, as will be recounted below, it took two years to complete the baseline assessments on the 770 patients in the two hospitals who met the criteria for the study. Consequently, when we began on 1 August 1985 to look for matches for patients to be discharged, we could only match accurately on the first four variables and approximately on diagnosis. We were unable to match on social disability, and much later, when the data became available, we found that the first year cohort of discharges was significantly less disabled in social behaviour than their matches. By the time the second year cohort of discharges needed matching we not only had the data we required but had also written a computer program that completed the matching process automatically.

We have been able to find close matches for the great majority of the patients discharged in the first five years of the project. However, the pool of patients available for matching is shrinking as more and more are discharged. We are now into the sixth year of discharges and matching is no longer a viable strategy. However, as we have found relative stability in the mental state and social behaviour of patients remaining in hospital, it is justifiable to use the subsequent leavers as their own controls. The assumption is that any changes detected between the baseline assessment in hospital and follow-up in the community are attributable to life in the community since, had they remained in hospital, the measures would have been unchanged.

Assessment measures

In selecting a batch of assessment instruments, we had to consider carefully the outcome criteria of greatest relevance to the question which initiated the research: does the policy of hospital closure benefit the patients? It was obvious that we needed to assess the mental state and social disabilities of the patients. We also felt that we should measure their physical ill-health for the following reasons. Firstly, we knew this to be an elderly population with a mean age close to 60. Secondly, their physical health had been closely monitored by the nursing staff and by junior psychiatrists who acted as their general practitioners. We were concerned that, once in the community, patients might not receive the same careful attention to their physical health. Our anxieties had been raised by several preventable deaths from physical illness of discharged long-stay patients.

In addressing the issue of quality of life, we saw the imperative need to ask patients their opinion about the care they received, and to assess the degree of restrictiveness of their environment. Finally, we were concerned to chart the social networks of patients, partly to check whether they were indeed being placed in the community in company with their friends, and partly to determine whether they would develop social links with individuals in the community.

We will describe the instruments chosen for each of these areas of personal enquiry.

Personal data and psychiatric history schedule (PDPH)

This schedule was designed to collect basic data on patients' demographic characters, including ethnicity, and factual information about length of stay and previous admissions. The data were collected partly from case notes and partly from staff. Each patient's primary diagnosis was derived, wherever possible, from the case notes. However, this had often changed several times in the course of a long admission. Where there was doubt, the patient's consultant was asked to provide a definitive diagnosis.

Present state examination (PSE)

In view of the prominent negative symptoms to be expected in this population, we first used the Krawiecka scale (Krawiecka et al., 1977) in a pilot study. However, in our hands this did not yield satisfactory levels of inter-rater reliability. We therefore chose to use the PSE, particularly as it has been employed in so many studies, both national and international. We were conscious of the problem posed by patients who deny psychotic symptoms in response to the PSE, but are well known by nursing staff to harbour florid delusions and/or to regularly converse with auditory hallucinations. To accommodate this, we added two items to the PSE which record information from the nursing staff about active psychotic symptoms when the patient denies them.

Physical health index (PH)

We did not have enough medically qualified research staff to examine each patient physically. Instead we derived information from case notes and ward staff. The information was collected with respect to seven bodily systems, for each of which two rates were made: the level of disability and the level of medical and/or nursing care received. In addition, problems with incontinence, immobility and dyskinesia were noted as these are likely to hinder community placement.

Social behaviour schedule (SBS)

We used this schedule, developed in the Unit by Wykes and Sturt (1986) and of established reliability. However, when we began interviewing discharged patients with it, we became aware of some gaps in the schedule. These were mostly to do with areas of self-care, which patients were allowed little or no opportunity to exercise in hospital. We needed to develop a supplementary schedule to cover these areas, but this could not be given to all patients in the hospital cohort because of the stage at which the deficiency in the SBS was noticed. The additional schedule is known as the Basic Everyday Living Skills (BELS) and is now in a final form after piloting, having undergone reliability tests. Both schedules rely on information given by staff.

Environmental index (EI)

This schedule was developed from instruments existing in the Unit and measures the degree of restrictiveness of the patient's environment. In that respect it reflects institutional practices. We added some questions on the accessibility of a variety of amenities which would be important for patients in the community. These include shops, launderettes, pubs, parks and day centres or day hospitals.

Patient attitude questionnaire (PAO)

Patients are asked what they like or dislike about their current caring environment. There are also questions about their desire to leave hospital or to stay, and about where they would prefer to live.

Social network schedule (SNS)

We constructed this questionnaire from scratch as nothing suitable existed. The enquiry begins with the completion of a time budget that provides the context of activity within which social contacts are made. All the people named by the patient constitute his social universe. Within this he is asked to identify which individuals he talks to regularly, who would be missed if not seen, whom he would visit if they were separated, who is considered to be a friend, and in whom he would confide (Leff et al., 1990).

Initially we employed two versions of this schedule, one for patients and one for staff to give information about patients. It soon became evident that staff overestimated the number of friends patients had on the ward and knew little or nothing about social contacts off the ward. Consequently we stopped collecting these data from staff, even though it meant having no SNS information for patients who refused or were unable to complete the interview.

Use of community facilities

Information on the use of community facilities, such as day centres, CPNs and GPs, was collected for discharged patients to enable the economists to calculate the cost of all the services which were provided to replace the psychiatric hospital.

Collection of the full batch of information occupied about half a day per patient. We began by drawing up a list of patients in the two hospitals who met the criteria for inclusion in the cohort, namely a continuous stay in hospital of more than one year, and no evidence of dementia if aged over 65. We included all patients under 65 even if they had dementia since they would be considered for reprovision alongside the non-demented. The cohort comprised about 900 patients at the start of assessments in August 1985, but attrition occurred through the death of more than 100 of the older patients before they could be interviewed. Assessments were carried out on a total of 770 patients, of which 373 were in Friern (F) and 397 in Claybury (C), and took two years to complete.

Sociological study

In addition to the central project, which is essentially clinical in nature, a sociological study is being conducted of the processes of decision-making which lead to implementation of new services and facilities (Tomlinson, 1988). The sociologists involved in this research attend planning meetings as observers but make no contribution to the meetings themselves. However, they do interview key participants before or afterwards to clarify issues about decision-making. They cover the whole hierarchy of meetings from the regional management down to case conferences about individual patients.

The value of this work lies in its comparative nature. It is possible to compare health districts with different political leadership, with differing styles of management, and with varying success rates in achieving the goals of implementation. This is likely to identify those management structures and policies which lead to success in providing alternative facilities to the mental hospital.

Economic study

In these times of financial stringency it is clearly of great importance to calculate the cost of community services designed to replace the mental hospitals. This is no easy matter since patients are being discharged to a wide variety of facilities, statutory, voluntary and private. Furthermore, there are many different sources of money used to support patients discharged into the community. One crucial innovation in the Friern-Claybury reprovision is to attach to each discharged patient the annual revenue that it costs to maintain the patient in hospital. This currently amounts to about £14,000 per annum. This revenue goes to the district health authority which accepts responsibility for the discharged patients and remains in the authority's budget even after a patient has died. Since many of the Friern and Claybury long-stay patients are elderly, this represents a strong incentive for district health authorities to make provisions for them and to ensure that they remain in the district's care.

The commonest form of community provision for these patients also represents an innovation. It consists of an ordinary house bought by the health authority or a voluntary organization, and converted for the use of between three and twelve patients. Nursing staff and other professionals may be present in the house for up to 24 hours a day, depending on the level of disability of the patients. The most intensive staffing levels to date represent a staff-patient ratio of 1:1, comparable with an acute admission ward. The costs of staffing such homes are, of course included in the economic calculations. As a result accommodation and living expenses occupy over 80% of the cost of community care for these patients.

The cost of hospital care is also not simple to estimate since an average derived by dividing the total annual budget by the number of patients fails to take into account the great variation in costs incurred by different groups of patients. For example, the cost of an acute admission ward with a high staffing level will be much greater than those of a long-stay ward with small numbers of staff, and patients who may be contributing to the income of the hospital by their work in industrial therapy. In order to take due account of this variation it is necessary to desegregate hospital costs down to ward level.

In the TAPS Project, the team of economists has worked very closely with the clinical research workers so that the characteristics and service usage of individual patients in each cohort can be related. It then becomes possible to make predictions about the cost of community care for patients who are still in hospital but will eventually be discharged

(Knapp et al., 1990). This kind of calculation showed that it was possible to account for 36% of the variance in the cost of community care for discharged patients using their characteristics at baseline assessment while they were still inpatients. This is a surprisingly high proportion and lends some confidence to the notion of prediction of future costs for patients not yet discharged.

Specific problems in the Friern-Claybury reprovision

accumulation of the new long-stay

We began our census of the long-stay non-demented patients in the two hospitals on 31 August 1985. Any patient whose stay in hospital exceeded one year after that date and who qualified in other ways for our study joined the study population. However, we made a distinction between the patients qualifying on the census date (the base population) and those entering the study thereafter (accumulation patients). We monitor the accumulation rates on a monthly basis since they have a vital bearing on the rundown of the hospitals. It soon became evident that the two hospitals, although containing very similar populations of patients in many respects, had quite different accumulation rates. Although Claybury services a larger catchment area than Friern (550,000 as opposed to 450,000), its accumulation rate was much lower. Over the three years between August 1985 and August 1988 the total number of accumulation patients at Friern was 164 (Margolius, 1988) compared with 69 at Claybury.

This was a puzzling difference which we thought initially might be attributable to the higher number of homeless patients and patients from outside the catchment area admitted to Friern. However, very few such individuals were found among either the Claybury or Friern accumulation. Another line of enquiry was pursued by comparing the accumulation rate for each health district with its Jarman Index. The latter figure is the relative ranking of an area in terms of a composite of measures of social deprivation. A Working Party of the Royal College of Psychiatrists (1988) had already established that there was a close relationship between the use of psychiatric beds as a whole and the Jarman Index. Table 1 displays the rates of accumulation and Jarman Index ranking for the health districts served by Friern and Claybury.

Table 1

ACCUMULATION RATES AND JARMAN INDEX RANKING FOR NINE HEALTH DISTRICTS

Health district	Accumulation rate	Jarman Index

	per 100,000	
	FRIERN HOSPITAL	
Hampstead	2.5	18
Bloomsbury	3.8	9
Islington	4.3	8
West Haringey	3.4	55
	CLAYBURY HOSPITAL	
Waltham Forest	1.5	40
Redbridge	0.7	161
East Haringey	1.9	15
Enfield/Edmonton	0.5	104
West Essex	0.8	178

Spearman's rank order correlation between
accumulation rate and Jarman Index = 0.82

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It can be seen that the accumulation rate for each of the Friern districts is higher than that for any of the Claybury districts. There is a strikingly high association between the accumulation rates and the Jarman Index rankings (R = 0.82). This suggests that social deprivation in the catchment population is a major determinant of the accumulation rate.

This has obvious importance for reprovision since the higher the rate of accumulation of new long-stay, the slower will be the run-down of long-stay beds in the hospital. Furthermore, we have found that the accumulation patients take up a disproportionate amount of the discharges from long-stay beds at Friern. Thus, in the first three years of discharges from Friern, accumulation patients occupied 22%, 46% and 49% respectively of the cohorts, while the corresponding proportions for Claybury were 0%, 6% and 14%. As a result there has been a smaller reduction in the number of the base population at Friern than at Claybury; 20% compared with 31%. Furthermore, different types of community provision are required by the accumulation patients since they are significantly younger than baseline patients, have a much shorter cumulative length of hospital stay, and are significantly less likely to carry a diagnosis of schizophrenia.

Although this may be a local peculiarity, the link between long-stay accumulation and social deprivation suggests that it is likely to be an important factor in any attempt to close psychiatric hospitals serving inner city areas, and in the evaluation of such a process.

Creaming-off

It is understandable that the teams selecting patients for discharge should choose the least disabled first. However, this practice has profound consequences both for the process of reprovision and for the evaluation of it. The way in which creaming-off has affected the discharges from Claybury is shown in Table 2.

For the first three years of discharges from Claybury there is a progressive increase in the mean age, duration of stay, and number of problems in social behaviour from year to year. This is interrupted in year four due to the high proportion of accumulation patients discharged in that cohort. In year five, however, the progression continues, with the result that the patients in this cohort begin to closely resemble the patients still remaining in hospital.

The consequences for reprovision include escalating difficulties for hospital staff as they try to rehabilitate an increasingly disabled group of remaining patients, and the need for community planners to develop new types of facilities for these patients. Facilities that work reasonably well for the first few cohorts of discharges may be inappropriate for the most disabled patients still in hospital. Many of the remainder appear from our SNS data to be completely asocial, and we have grave doubts as to their ability to form cohesive social groups when placed in homes in the community.

Table 2

CHARACTERISTICS OF FIVE CONSECUTIVE COHORTS OF DISCHARGES AND THE REMAINING PATIENTS

CLAYBURY

Year	N (Accumulation) %	Mean age	Mean years in hospital	Median SBS score
1	12 (0)	54.2	17.5	0
2	48 (6)	55.5	20.1	2.5
3	62 (15)	56.9	22.7	4.0
4	34 (32)	47.6	19.5	5.2
5	51 (10)	63.7	29.7	5.0
Remaining 219		63.0	29.6	7.0

The effects of creaming-off on evaluative research are equally momentous. It can be seen from Table 2 that for the first four years of discharges the patients in the cohorts are less disadvantaged on each measure than those remaining in hospital. As a result neither the results of the clinical follow-up of these cohorts nor of the economic analysis can be extrapolated to the patients still to be discharged. However, the findings for the fifth year of discharges, which are currently being analysed, may well be applicable to the remaining inpatients.

Preliminary findings of the TAPS project

The baseline assessments were completed after two years and comprised 397 patients at Claybury and 373 at Friern. A comparison of the samples from the two hospitals revealed very few significant differences on any of the schedules, suggesting that patients with similar characteristics have been left behind in psychiatric hospitals after four decades of an active discharge policy (NETRHA, 1988). The one year follow-up of the first three cohorts has been completed and the data analysed. Of the 278 discharged patients there were no more deaths than in the matched group who stayed in hospital, although there was one suicide in the community and none in the hospital. The leavers had little contact with the police and only one person went to prison, from where he was soon transferred back to hospital. Six patients were lost to follow-up and were presumed to have become vagrants. Three had formerly been vagrants before hospital admission, but three others were new to this way of life. All three of them were placed in bed and breakfast accommodation. No patient was lost from a staffed group home and this remains true for the one year follow-up of the first five cohorts comprising nearly 500 patients.

Analysis of the data derived from the follow-up interviews revealed very few significant changes over time affecting discharged patients differentially from their matches. The three main effects over time were that the leavers were living in a much less restrictive environment than previously, that they were more content with their living situation than they had been in hospital, and that there was a significant increase in the size of their social networks. However, there were no significant changes in the patients' mental state, or social disabilities. The surprising finding from the economic analysis was that community care for the first three cohorts of discharges was less costly than care in hospital. We have already cautioned against extrapolating these findings to the more disabled patients remaining in hospital.

Conclusions

An enormous expenditure of time and effort has been invested in the TAPS Project. This is appropriate because no previous study has attempted a comprehensive evaluation of the policy of closing psychiatric hospitals.

The results to date are favourable to the policy of deinstitutionalization, provided that the programme is well planned and adequately funded. However, it remains to be seen what will happen to the most disabled patients still left in hospital.

REFERENCES

Jones, K. (1985) *After Hospital: A Study of Long-Term Psychiatric Patients in York*. York: University of York/
York Health Authority.

Knapp, M., Beecham, J., Anderson, J., Dayson, D., O'Driscoll,C., Leff, J., Margolius, O., Wills, W. and TAPS (1990) 'The TAPS project 3: Predicting the costs of closing psychiatric hospitals'. *British Journal of Psychiatry*, Vol.157, 661-670.

Leff, J., O'Driscoll, C., Dayson, D., Wills, W. and Anderson,J. (1990) 'The TAPS project 5: The structure of social network data obtained from long-stay patients'. *British Journal of Psychiatry*, Vol. 157, 848-852

Margolius, O. (1988) 'Friern Hospital 1985-1988: Movement and accumulation of the long-stay population'. North East Thames Regional Health Authority.

North East Thames Regional Health Authority (1988) 'Team for the assessment of psychiatric services: preliminary report on baseline data from Friern and Claybury Hospitals'.

Tomlinson, D. (1988) 'The administrative process of Claybury and Friern reprovision'. North East Thames Regional Health Authority.

Working Party of the Royal College of Psychiatrists (1988) *Psychiatric Beds and Resources: Factors Influencing Bed Use and Service Planning*. London: Gaskell

THE ASIAN FAMILY UNDER STRESS

by

Estefania Aldaba-Lim

(Keynote Speech)

The psychology of the family is a clue to a nation's psychology. As we watch and study the changing trends of family life in the world arena one can better understand the nature of the strife and harmony that characterize our society.

Changes in the social, economic and technological life of the country not only influence family changes but family changes affect national changes. In a sense a family is like a barometer indicating not only what is going on in the society today but also tomorrow's trends that have not yet become generally visible. I believe this concept is basic to our appreciation of psychiatric rehabilitation processes in our part of the world.

There are many who understand this dominant rôle of the family in social change and have boldly experimented with using the family as the tool for creating dramatic changes in a nation's life. In the 1920s the newly established communist states, in creating a new culture instituted a program aimed at abolishing the family as it existed in Western civilization. From the stand-point of the revolutionaries, the family and the church were hopeless, for it is their very nature to preserve tradition. Further, as Frederick Engels, Marx's collaborator, theorized the family was another vestige of the iniquitous capitalist system and therefore it has ceased to be a necessity both for its members and for the state. Thus it was the deliberate communist plan to destroy the stable character of marital relations, e.g. severing its bond with religion, dropping incest, bigamy, abortion and adultery from the list of criminal offenses. Children were made to denounce loyalty to their parents. It is through the breaking of the Confucian family, said the Communists that a new pattern of human interdependence must be created.

For a decade the anti-family policy seemed to succeed until the detrimental effects (e.g. dissolution of communities, increase in juvenile delinquency and unlimited freedom in sexual relationships etc.) were found to endanger the very stability of the new society.

In 1934, the great experiment had to be stopped and the government had no other choice but to reinforce that pillar of society - the family. The pendulum swung to the other extreme and a reversal of all the edicts and laws followed, aimed at stabilizing the family. We now know that if the family must change the change must start from the family. The change must first be accepted.

If this, as a principle, be so, we may well learn a lesson and take good notice of the changes in family structure in Asian societies and analyze their implications for us in the field of mental health and specifically in the field of rehabilitation.

A good starting point for this task of analyzing the Asian family would be to take a look at the social / economic environment in which the family functions today, after which we may look into how we can maximize our rôle in furthering human development in our own countries.

Pressures on the Asian families

For the initial step I would like to share with you the most recent survey of the Asian Regional Social Situation prepared by United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). This report was considered at the fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development attended by 32 countries from the region. This was held in Manila October 7-11, 1991. The opening statement of the Survey summed it all up. "Despite several years of fast-paced economic growth, the Asia Pacific region maintains a poor record in social development". Poverty, inequality, oppression, inadequate social infrastructure and related circumstances making for social distress continue to exist throughout much of the ESCAP region despite economic development. After decades of development efforts, joblessness, homelessness, illiteracy, family violence, family disintegration, street crime, suicides, drug and alcohol abuse, and prostitution, have increased. The Survey estimates that almost three fourths of the world's poor, or about 800 million, live in the region, with the majority being in South Asia. The number of those who cannot read or write has also increased, now comprising three fourths of the world's illiterate population estimated at about one billion. Furthermore, more than 60 million primary school-age children have no access to basic education.

"Social deficiencies breed social discontentment," the Survey says. Pessimism concerning the prospects for improvement in the situation have added to the high levels of dissension and civil strife that exist in various countries in the region.

The Survey blames a lack of policy focus on specific social objectives for the problems. Instead of organizing a frontal attack on the social issues for example: the swelling of age-dependent population, rapid urbanization, unemployment and family breakdown, policy makers have relied primarily on economic growth to boost social progress. As a result, social development in most countries of the region lacks consistency and sustained pace.

In his paper "A Human Development Agenda" in Asia, delivered at the same conference, Mr. Mahbub ul Haq, Special Adviser to the UNDP Administrator, restates the Survey's findings and suggests a priority agenda for the year 2000. "The human profile of Asia presents great contrasts," he avers. On the one hand, significant human progress has been made in the last three decades. Average life expectancy has increased by 18 years - from 46 years in 1960 to 64 years in 1990. On the other hand, there is a distressing and lengthening agenda of human deprivation; over 700 million people in absolute poverty, over 600 million people who cannot read or write, two thirds of them women, about half the population with no access to safe drinking water.

More disturbing are the wide disparities within Asia. South Asia, containing over one billion people, has a life expectancy 10 years lower than East and Southeast Asia, and a literacy rate of 42% compared to *72%*. In fact, South Asia has the lowest literacy rate of all the regions of the world. Three-quarters of the world's illiterates live in the five most populous Asian States -- China, India, Pakistan, Bangladesh and Indonesia. If the poor, the unemployed, disabled persons, refugees and other disadvantaged groups were added to the age-dependent population, the burden on the region's developing countries would be almost unbearable.

Urban population is also increasing rapidly. Economic and Social Commission for Asia and the Pacific (ESCAP) estimates that by the year 2000 one third of Asians and two thirds of Pacific islanders will be living in urban areas. Poverty and lack of opportunities have caused many young rural workers to migrate to the cities in search of a better life. The result is a transference of rural poverty to the urban setting, a replacement of rural squalor by urban slums.

Equally a developing cause for grave mental health concern is the traditional extended family in the region which has become smaller, while the number of single-parent households is on the rise. At the same time, more cases of divorce, separation, widowhood, teen-age pregnancy, and unmarried parenthood have contributed to the increasing numbers of single-parent households, particularly those headed by women.

The Survey pinpoints the factors causing changes in the family structure in the region: l) rural to urban migration 2) the governments population control policy 3) changing values (lure of the city) 4) growing numbers of women entering the labour force and 5) the high cost of maintaining dependents. The extended family has traditionally provided economic, social and physical security to its members and care for the young and the aged. The Survey likewise reports that drug and alcohol abuse and AIDS afflictions have spread at an alarming rate, posing new deadly health hazards to the region. While virtually every country is affected, drug abuse is reaching an epidemic proportion in many parts of the region. The problem, to quote the Survey "is emerging as a dangerous symptom of rapid social change," resulting from "frustrations and anxieties of individuals caught up in development processes beyond their understanding and control". Alcohol abuse has caused family violence and family breakdown.

Other global conferences like the 20th World Conference of the Society for International Development held in May 1991 on the theme "Putting People First", the "World Summit for Children" attended by 71 heads of states who committed themselves to implementing the Convention on the Rights of the Child to insure the survival, protection and development of children, the World Conference on "Education for All" in March 1990 (Jomtien in Thailand), critically reviewed national and international development policies and priorities, each one emphasizing the social development concerns of developing countries at the macro and sector levels.

Primary prevention - the best hope for dealing with Asia's mental health problems

Why this emphasis on the human and social development situations in Asia today? Needless to say as providers of psychiatric and social services, as family therapists, as guardians and purveyors of supportive security for the endangered family, as volunteers for mental health in the community, we desperately need new prevention programs to stem the unprecedented mental health problems spawned by the vast social and economic upheavals in our region. The gloomy statistics on joblessness, homelessness, hunger, family violence, single parenthood, family disintegration, street crime, suicides, drug abuse, street children are taking a devastating toll on the mental health of people, children, women, youth, including the aging of Asia.

With dramatic increases in the sheer numbers of mental - psychiatric problems in Asia today, individual therapy is a hopeless effort. Further, the numbers of psychiatrists, psychologists, social workers, counsellors, will never be enough to meet the multiplying demands for psychiatric services. The only real hope to do anything significant is through primary prevention. Prevention, not costly "high tech" treatment holds the best hope for dealing with mind boggling problems in our region.

Dr. Morton Kramer, Professor Emeritus of the Johns Hopkins University School of Hygiene and Public Health, in a paper read at the 16th annual meeting of the Vermont Conference on the Primary Prevention of Psychopathology (VCPPP) held at the University of Vermont, June 25-30, 1990, pointed to spiraling population growth among groups at high risk for mental, neurological and psychosocial (MNP) disorders in Third World children. "The size of the problems that exist currently and those predicted to occur as a result of such growth will out-distance by far our current capabilities of dealing with them," Kramer said.

Another barrier to prevention, Kramer said, is the flight from the rural areas to hoped-for jobs in the cities. This migration has created slums and squatter neighborhoods where 25 to 50 per cent of Third World city dwellers now reside. Children living in these slums are at high risk for mental disorders.

As Special Representative for the UN during the International Year of the Child (IYC) in 1977-1979, it was my pleasant duty to visit countries, both developed and developing, including Eastern Europe, as the child's advocate. I remember traveling to approximately 70 countries meeting heads of state, government ministers, professionals and volunteers involved in the welfare of children. I was often asked about the nature of problems of children and adolescents in countries I had visited. Did I find or observe any trend in problems of children specific to developing countries? What about problems specific to developed countries? Were there any differences?

I used to say then that in developing countries in Asia, Africa, and most of Latin America, the problems of children, for the most part had a physical basis, the offshoots of poverty and inequitable distribution of the country's resources i.e. hunger, malnutrition, high infant mortality, early deaths due to diarrhea, bronchial disorders, lack of water, shelter, clothing, food, simple health services. UN and UNICEF statistics bear this out. For example, of the 150 million children who were born during the International Year of the Child, one in ten would die before their first year. Twelve million could have been saved if they had been born in the developed world.

And what about children's problems in developed countries? I was asked. Mostly I have learned from briefings that their problems are mental and behavioral difficulties which stem from emotional deficits such as drug abuse, teen age pregnancies, delinquency, suicide, violence, children who are abused, "latch key" children. This does not mean that the rich and developed countries did not have problems of poverty, hunger and neglect. They do exist in the inner cities of the big capitals in Europe and North America.

That was in 1977. Today, as mentioned earlier, the migration from rural to urban areas and uncontrolled population explosion have spawned a new breed of vulnerable children and youth in Asia: drug dependents, child prostitutes of both sexes, teenage pregnancy and millions of street children or "abandonados" as they are called in Latin America.

Who are these street children?

Street children are those who find themselves in a state of material helplessness, lovelessness, deprived of care and protection. They are subject to abuse, exploitation (child labor) and other material and moral dangers. They have lost the basic support mechanisms of their families as they come face to face with the daily needs to survive. They are generally found sleeping alone or in groups in empty market stalls, in public parks, side walks or shopping centers, under the bridges near squatter colonies. Various estimates have placed their numbers in the cities of Asia at about 20 million.

The Foundation for Children, a non-profit group in Thailand, estimates there are as many as 800,000 child prostitutes under the age of 15 working in some 60,000 brothels across the country. These sexually abused children of both sexes are at high risk for HIV infection. This picture of child abuse is repeated in Pakistan, Malaysia, India, Indonesia, Sri Lanka etc.

Refugees, also a high-risk group for mental illness, now total 10 to 15 million, half of them children - and are increasing by about 3,000 a day. And HIV infection is causing increasing stress and neurological problems in developing nations. Even assuming a conservative 12% MNP rate for children, the total number of cases of mental disorders in children under 18 will be 200 million in the less developed regions and will increase to 223 million by the year 2000.

Concluding statement

The human development agenda for the Asian family in the 90s is a compelling challenge to all of us here. The essential problems have already been identified and politically endorsed by the Asian Ministers of Social Welfare at their recent meeting in Manila October 7-11, 1991, and prior to that, by a number of international conferences spearheaded by several UN agencies and concerned NGOs.

The magnitude of the problems facing us today is predicted to increase a hundred fold unless the tide is stemmed. There is no lack of knowledge and experiences in formulating concrete plans of action for implementing a primary preventive program. These range from government and NGOs adopting specific measures to stimulate nation wide awareness of such evils, (child prostitution, drugs, exploitation of child labor), to the reviewing of statutory provisions to introduce suitable amendments and regulatory controls to protect the welfare of people. At the highest level of government, does the political will exist to give the highest priority for the welfare of children by separate and distinct allocations of funds for social development?

I have no doubt that this meeting on "psychiatric rehabilitation" will open new windows of opportunity in the 90s and the years to come to develop more effective ways to achieve our common goals in mental health.

REFERENCES

1. *Social Progress No Match for Economic Growth in Asia Pacific*. (1991) UN/ESCAP Report for the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development. PICC, Manila, Philippines.

2. Tarumizu, K. (1991). Address before the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development. PICC, Manila, Philippines.

3. Mahbub ul Haq, (1991) `A Human Development Agenda for Asia'. Address to the inaugural session of ESCAP's Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development. PICC, Manila, Philippines.

4. Grant, James P. (1991) `New Momentum for Social Development in Asia and the Pacific'. Statement before the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development. PICC, Manila, Philippines.

5. Conclusions and Recommendations of the Meeting of Experts on *The Exploitation of the Child; Child Labor and Child Prostitution* organized by the LAWASIA Human Rights Standing Committee, November 12-13, 1984, Singapore and Feb. 21-23, 86 Kuala Lumpur, Malaysia.

6. Phillips, M. `Investment in people'. *The UNESCO Courier*, October 1964

7. Lin, Tsungyi. (1958) *Reality and Vision - a report of the First Asian Seminar on Mental Health and Family Life*, Baguio City, Philippines.

8. *Report of the UN Secretary General Economic and Social Council* E 1327 Add. 1 and Add. 2.

9. Engels, Frederick. *The Origin Of The Family, Private Property, And The State.*

10. Kluckhohn, Florence R. (1958) `Family diagnosis: variations in the basic value of family systems' *Social Casework* XXXIX.

11. Lim, E. Aldaba. (1962) `To be individualistic yet secure.' *Sunday Times Magazine*, April 29.

12. Lim, E. Aldaba. (1957) *Report on the First National Conference on Filipino Family Life*, Manila.

13. Lim, E. Aldaba. (1961) `Social and psychological changes consequent upon rapid economic development and its implication for family life'. Council on World Tensions Meeting, *Tensions of Socio-Economic Development in Southeast Asia*, Bombay - Allied Publisher Private Ltd.

14. Lim, E. Aldaba. (1961) `New frontiers in the understanding of Filipino family life.' Keynote address at the 15th annual convention of CAP.

CARING AND ITS MEANING: VIEWS FROM SCHIZOPHRENIC PATIENTS AND THEIR CARERS IN HONG KONG

by

Kai-Fong Chan

Much has been written about the profound effect of schizophrenia on the patient and his/her family. Schizophrenia usually occurs in young adults and produces a severe psychological, social and vocational disability which adversely affects them in their productive years. Deterioration and recurrent relapses may happen to most patients and they may need treatment and care at various later stages of life.

Over the past two decades, there has been an increasing trend all over the world for schizophrenics to be discharged from mental hospitals into their community and families as soon as possible, in order to avoid chronicity and institutionalized behaviour. As a result of this deinstitutionalization and the community care movement, together with the advances in psycho-pharmacology, many schizophrenics in Hong Kong, after a brief stay in hospital, return to their families. Then the families are expected to take up the primary care responsibility to rehabilitate the patients. However, with a paucity of community-based resources, the burden of care inevitably falls on families. It is well-documented in English and American literature that prolonged care responsibilities impose on families a formidable burden and emotional strain (Creer & Wing, 1974; Hatfield, 1978; Thompson & Doll, 1982); Gibbons et al., 1984; Fadden, Bennington & Kuipers, 1987; Lefley, 1989).

But what is the situation of such families living with schizophrenics in Hong Kong? Little has been done in Hong Kong to study the impact of schizophrenia on families or the burden of mental illness on families or carers. Before tackling this broad question which involves a wide range of areas for investigation, we have to answer some fundamental questions. Is the caring responsibility shared by family members? Who are the primary carers in most of the families? Will those whose names were recorded in the hospital files as the next of kin of patients be the major carers? What is the meaning of caring? Is there any discrepancy between the views of patients and of their relatives over the meaning of caring? What do they perceive the caring responsibilities to be?

This survey attempts to address these questions by obtaining views from both schizophrenic patients and their primary carers. A sampling frame was developed in two out-patient clinics and day hospitals of a government hospital and a government-assisted hospital with the following criteria:

(1) active cases with a diagnosis of schizophrenia receiving psychiatric services from the day hospital or out-patient clinic in the period from mid-December, 1989 to mid-March, 1990 and opened as cases between 1984 to 1990;

(2) the patients are living with at least one relative;

(3) the patients are over 18 and under 65 years old;

Based on these criteria, 163 cases were selected. From this sampling frame, 50 patients and their relatives were selected by quota sampling. In this instance relatives means those whose names were first registered as the next of kin when the patients became known to the two hospitals. Both the patients and their next of kin were asked ten identical short questions, separately, either through face-to-face contact or telephone (see Appendix I and II for the questions). The questions were asked in an open-ended manner and the number of responses from each subject was not restricted. However, the majority of subjects in either group gave one answer to each question. For example, in answer to question #1 "Who sees the mental health professional in connection with xxx's illness?", most respondents named one person, saying either the mother or the patient. Some named two such as the mother and the patient, and some even named three such as the patient, the mother and the father. On the whole, not more than three answers from each individual subject were given for each question. The total responses of the views of patients and their relatives for one question range from 55 to 72.

To qualify for inclusion a case had to include both parties: the patient and his or her next of kin. In other words, where one party, either the patient or the relative, refused to answer the questions, the case was discarded even though the other party might have answered.

The 50 schizophrenic patients included 24 (48%) males and 26 (52%) females. They ranged in age from 18 to 64 (x=29.5). 50% were aged 25-34, 30% aged 15-24, 16%aged35-44, 2% aged 45-54 and 2% aged 55-64. 54% were employed and 46% unemployed. The relationship of relatives to patients is shown in Table 1.

Table 1

RELATIONSHIP WITH PATIENTS

Different groups of carers		N	%
Parents		29	58%
	Mothers	20	40%
	Fathers	9	18%
Spouse		14	28%
	Wives	4	8%
	Husbands	10	20%
Siblings		7	14%
	Sisters	4	8%
	Brothers	3	6%
Total		50	100%

Results and discussion

Despite the small number in the sample, the percentage in different groups of carers generated in my survey is comparable to that in a local burden study of schizophrenia on the family conducted by the Department of Psychiatry of Hong Kong University (1987). In that study, a sample of 652 was drawn from three psychiatric out-patient clinics. The relatives included parents, 51.5% (36.4% mothers and 25.1% fathers), spouse, 25% (husbands and wives were not differentiated) and siblings, 13.6% (7.7% sisters and 5.9% brothers). The sample may not be representative of the whole population of schizophrenics in Hong Kong, but this survey seems to be the only local reference for burden studies to date.

Generally speaking, the findings of my survey indicate that the views of patients and their next of kin are very close in terms of naming the carers, defining the meaning of caring and also in their perception of the responsibilities of caring. The results of each question of the survey will be discussed more specifically in the following sections.

The carers named by patients and relatives

One of the important findings from the question (Question #7) "Who are the carers named by the patients and their relatives?" is an 80% consistency between the views of the individual subjects in two groups: the patients and their relatives. When the answers of patients are compared with these of their relatives in this question, 31 out of 50 responses (62%) were exactly the same irrespective of the number of responses an individual subject gave, and 7 out of 50 responses (18%) have at least one identical response. Only 10 out of 50 responses (20%) were totally different.

Table 2 shows the percentage frequency of patients' and carers' views on naming the carers. About 75% of subjects from both groups named someone from their family as the carer and about 25% of patients and their relatives named the patients as the carers. In this case, one-fourth of the patients seemed to be in a stage of remission and their condition stable. To some extent they are able to take care of themselves despite the fact that they still need regular follow up at the psychiatric out-patient clinic, and chemotherapy.

Table 2

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO IS THE CARER

	Patients' views %	Carers' views %
Patients themselves	25.4	23.6
Mothers	40.0	41.8
Fathers	9.0	7.2
Sisters	5.4	1.8
Brothers	3.6	3.6
Wives	5.4	5.4
Husbands	9.0	10.9
Everybody	1.8	3.6
Others	0.0	1.8

The next of kin recorded in the patient's file tends to be the primary carer.

As expected, the findings suggested that the next of kin of the patients tends to be the primary carer. 64% of the patients perceived their next of kin as their carer and 62% of the next of kin perceived themselves as the carers. The remaining 36% or 38% fell into other categories of relatives. The percentage data in Table 3 shows that the figures for mothers registered as the next of kin are almost the same as perceived to be the carers by both patients and the mothers themselves. Besides the mothers, the number of other relatives perceived as carers by both groups is much lower than was registered as the next of kin. The reasons for the discrepancy are as follows:

(1) As pointed out earlier, about one-fourth of the patients and their next of kin perceived the patient as his or her own carer.

(2) The gender differences may cause a discrepancy. It seemed that the husbands and fathers, who were most likely to be breadwinners, were the closest kin to the patients and their names were usually given to the clinics. But they may be busy with their jobs and can not afford time to accompany the patients to see doctors. Thus, the patients and even the next of kin perceived patients and/or other relatives in the families as carers.

(3) Some patients and/or their relatives named everybody in the family as carers. In other words, the caring responsibilities were probably shared by everybody in the family. In that case, the one registered as the next of kin was one of the carers. He or she might or might not accompany the patient to the hospital or the clinic on the first occasion when the patient became known to the hospital.

(4) Siblings were given as the next of kin because they have received more education than their parents, especially in comparison with the mothers who may be illiterate. In these cases, the brothers or sisters may be concerned about the patients but the primary carers are actually the mothers.

(5) In some cases, the sisters and brothers of the patients have a closer relationship with the patient than the parents. Thus, their names were given as the next of kin because they were willing to be responsible for caring for the patient.

(6) The relatives' names may have been recorded as the next of kin simply because they were available when the patient was first known to the hospital or the clinic. They may or may not be the primary carers of the patients.

Table 3

PERCENTAGE OF NEXT OF KIN AND CARERS NAMED BY BOTH PARTIES

	Next of Kin	Carers named by patients	Carers named by relatives
	%	%	%
Mothers	40	40.0	41.8
Fathers	18	9.0	7.2
Sisters	8	5.4	1.8
Brothers	6	3.6	3.6
Wives	8	5.4	5.4
Husbands	20	9.0	10.9
Patients	-	25.4	23.6
Everybody	-	1.8	3.6
Others	-	0.0	1.8

A general conclusion may be drawn from the data that the next of kin of the patient tends to be the primary carer for the patient. Although the information about next of kin can be obtained from the patients' files, more understanding of the family structure, rôles of the next of kin in the families, their relationship with patients and the health conditions of the patients, etc. needed to be considered in identifying the carers.

The data in Table 4 (findings of question #9) suggests that the next of kin are the ones who have the closest kinship with the patients and also the ones who see the doctors or professionals with the patients in connection with the patients' illness. The two items, namely "closest kinship with the patient" and "see doctors with the patient" constituted over 50% for both groups. For other items there is no significant difference between the views of the two groups except on the item "Most concerned for the patient" which is slightly different (8.6% vs 1.7% for patients and their relatives) as compared with other items. This means that the patients perceive the next of kin as the ones who are concerned about them more often than did the relatives.

Table 4

REASONS FOR NAMING A RELATIVE AS THE NEXT OF KIN WHEN ADMITTED TO THE PSYCHIATRIC WARD OR REGISTERED FOR THE OUT-PATIENT SERVICE

Reasons	Patients' views %	Carers' views %
Closest kinship with the patient	31.0	33.3
See doctors with the patient	24.1	29.8
Was available at the time	8.6	5.2
Most concerned for the patient	8.6	1.7
The responsible person for the patient	3.4	5.2
Understand the patient	3.4	3.5
The head of the family	1.7	3.4
Living together	5.2	1.7
Don't know	3.4	8.8
Signature needed	0.0	3.5
Others	6.8	5.2

The meaning of caring as perceived by patients and their carers

Both groups - patients and their next of kin - held very similar views in defining the meaning of caring (Question #8). The first three items according to the highest percentages for both groups were the same. The most popular answer from both groups was "caring for the patients' daily living", followed by "reminding or supervising patients to take drugs" and "giving patients emotional or psychological support". The percentage of other definitions are listed in Table 5. Although the views of patients and their carers are not significantly different in general, more patients defined the meaning of caring as "something related to daily living" than did the carers (11% difference), and more carers defined caring as "keeping an eye on patients" than did the patients (7% difference). It seems to suggest that patients see caring primarily as helping, while relatives identify a controlling function in caring.

Table 5

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHAT IS MEANT BY CARING

Meaning	Patients' Views %	Carers' Views %

Care for the patients' daily living	49.1	38.0
Remind/supervise patients to take drugs	13.7	16.0
Give patients emotional or psychological support	12.2	12.0
Offer patients help if needed	8.7	4.4
Keep an eye on patients	1.7	8.8
Give advice to patients	1.7	5.8
Supervise patients for follow-up at the clinic	1.7	2.9
Give money to patients	1.7	2.9
Don't know	3.5	1.4
Help patients solve problem	3.5	0.0
Others	2.5	6.3

Caring responsibilities perceived by the patients and their carers

The caring responsibilities of the carers were explored in six areas in the survey. They are: (a) seeing doctors and/or other professionals in connection with the patients' illness; (b) supervising and/or reminding patients in taking drugs; (c) giving financial support to patients; (d) giving emotional support to patients; (e) waking the patients up in the morning for work or for training, etc.; (f) doing the cooking, washing and shopping for the patients. The relevant questions are the questions #1 to #6 in the questionnaire (see appendix I and II).

On the whole, the patients and their carers held similar views in these six areas. Greater variations between the views of patients and their relatives were found in question #2 and #4 "Who makes sure that the patient takes drugs?" and "Who gives the patient psychological or emotional support?". The findings and discussion of questions #1 to #6 are presented in Tables 6-11.

(a) seeing doctors and/or other professionals in connection with the patients' illness

In Table 6 the figures suggest that both groups view patients themselves as taking more responsibility for seeing professionals than did the carers. Over half of the patients (53%) thought that they were the ones who were responsible. 45% of relatives held the same view.

Table 6

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO SEES THE MENTAL HEALTH PROFESSIONALS IN CONNECTION WITH THE PATIENTS'S ILLNESS

	Patients' Views %	Carers' Views %
Patients themselves	53.0	44.6
Mothers	23.0	29.0
Fathers	6.2	9.2
Sisters	3.0	1.5
Brothers	3.0	1.5
Wives	4.6	4.6
Husbands	6.2	9.2

(b) reminding and/or supervising the patient in taking drugs

Like the previous question, over half of the patients (64%) thought that they were themselves responsible for supervising their drug taking, while of their carers a little over one-third did (64% vs 36%). However, the carers perceived themselves taking more responsibility in making sure that the patient took drugs (48% vs 52%). Comparing the two groups there was a significant difference (16%) between patients and their carers. Patients perceived more fathers taking this job than did the fathers. Husbands thought they did this more than was perceived by their wives (see Table 7).

Table 7

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO MAKES SURE THAT THE PATIENT TAKES DRUGS

	Patients' Views %	Carers' Views %
Patients themselves	64.0	48.0
Mothers	20.0	21.8
Fathers	9.0	4.6
Sisters	0.0	1.5
Brothers	3.6	1.5
Wives	0.0	1.5

Husbands	1.8	9.3
Grandmother	1.8	3.1
Everybody in family	0.0	3.1
Friend	0.0	3.1
Others	0.0	3.1

(c) giving financial support to the patients

The data in Table 8 suggested that less than 50% from both groups thought that the daily expenses were supplied by patients themselves. This may be due to the fact that 46% patients in the sample were unemployed. Apart from getting money from family members, 10% of patients and 11% of carers viewed the patients as financially supported by disability allowance or public assistance.

Both the wives and their carers - husbands - held the same views. The spouse carers, predominantly husbands, are the main persons to give financial support to the patients.

Table 8

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO GIVES THE PATIENT MONEY FOR DAILY EXPENSES

	Patients' Views %	Carers' Views %
Patients themselves	44.8	38.1
Mothers	17.2	21.8
Fathers	5.1	3.6
Sisters	0.0	1.8
Brothers	5.1	3.6
Wives	0.0	0.0
Husbands	15.5	18.1
Grandmother	0.0	1.8
Everybody in family	0.0	1.8
Public Assistance/Disability Allowance	10.3	11.0
Others	1.7	0.0

(d) giving the patients psychological or emotional support

Question #4 "Who gives the patient psychological or emotional support?" has a connotation that the family members take an active or initiative rôle in giving emotional support to the patients. But in the Chinese version, the translation is like this: "whom would the patient talk to or share with when the patient needs emotional or psychological support?", implying the patient takes the active rôle in getting support from people. Therefore the results may be different from what was originally planned. However, the findings were quite interesting. Some variations between the views of both groups over some items were found (see Table 9).

Table 9

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO GIVES THE PATIENT PSYCHOLOGICAL OR EMOTIONAL SUPPORT

	Patients' Views %	Carers' Views %
Mothers	16.6	16.6
Fathers	4.5	3.0
Sisters	9.0	12.0
Brothers	6.0	9.0
Wives	4.5	4.5
Husbands	10.6	12.1
Nobody	24.2	13.6
Friends	18.0	3.0
Seldom talk/share	4.5	21.2
Grandmother	0.0	1.5
Everybody in family	1.5	1.5
Professionals	0.0	1.5
Others	1.7	0.0

From Table 9 we can see that more patients, almost twice the number of carers, thought that the patients had nobody to talk to or share their problems with (24.2% vs 13.6%). Some of the patients (18%) thought that they could talk to their friends whereas the carers did not think that way (3.0%). On the contrary, the carers said that 21.2% of patients seldom talked while at home. Only 4.5% of the patients held this view.

The views from patients and carers about mothers and wives giving emotional support to the patients, or sharing with the patients, were exactly the same. Wives were viewed by both groups as the carers giving emotional support to their husbands.

(e) waking the patient up for work or for training

Patients thought of themselves (58%) as taking on this job more often than their carers did. If 10.9% in the item of being woken up by "the alarm clock" was added into the item of "the patients", then the percentage increases to 69%. The carers held similar views (68.9%). Interestingly, fathers were not perceived as taking on the job of waking patients up by either party. Nor were husbands seen as the ones to wake the patients up. Perhaps wives are perceived as housewives and so may not need to get up at a certain time in the morning. The findings are presented in Table 10.

Table 10

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO WAKES UP THE PATIENT

	Patients' Views %	Carers' Views %
Patients themselves	58.0	62.0
Mothers	20.0	15.5
Fathers	0.0	0.0
Sisters	1.8	1.7
Brothers	1.8	5.1
Wives	1.8	5.1
Husbands	1.8	0.0
Grandmother	0.0	1.7
Friend	1.8	0.0
Alarm clock	10.9	6.9

(f) cooking, washing and shopping for the patients

The patients themselves as well as the mothers are seen to do the cooking, washing and shopping for the patients. Siblings of the patients are not perceived by either party as taking on the caring responsibility of doing the housework (see Table 11). It seems that there is a gender difference between the rôle of carers in carrying out the household chores.

Table 11

PERCENTAGE OF PATIENTS' AND CARERS' VIEWS ON WHO DOES THE COOKING, WASHING AND SHOPPING FOR THE PATIENT

	Patients' Views %	Carers' Views %
Patients themselves	34.2	31.9
Mothers	38.5	40.3
Fathers	8.5	6.9
Sisters	0.0	1.3
Brothers	0.0	0.0
Wives	5.7	5.5
Husbands	4.2	5.5
Grandmother	1.4	1.3
Others	7.1	5.4

Conclusion

This is a small scale survey of a sample of 50 patients and their closest kin whose names appeared in the patients' files. It was found that the next of kin tend to be primary carers. However, other variables such as the structure of the family, relationship of the patient with the relative, rôle of the carer in the family and also the degree of remission of the patient have to be taken into consideration when we identify the carer of a patient.

By and large, the views of patients and their carers are very close in the perception of who the carers are, and the nature of the caring responsibility. As far as the caring responsibility is concerned, there are some differences between parental and spouse carers and also between male and female carers.

The findings of this survey can pave the way for further research to study the burden on carers living with or caring for people diagnosed as schizophrenic. In-depth interviews can be used to further explore the perceptions, feelings, meanings and experiences of different categories of the carers. To what extent do they experience a burden? Will it be more an objective than a subjective burden? How do they cope? What are the differences between parental and non-parental carers, male and female carers etc.? In order to address these questions, it is recommended that further research be conducted.

REFERENCES

Creer, C. and Wing, J.K. (1974) *Schizophrenics At Home*. London: Institute of Psychiatry.

Department of Psychiatry (1987) *Burden of schizophrenia on the family*. Unpublished paper. Hong Kong University.

Fadden, G., Bebbington, P. and Kuipers, L. (1987) 'The burden of care: the impact of functional psychiatric illness on the patient's family'. *British Journal of Psychiatry*, Vol. 150, 285-292.

Gibbons, J.S., Horn, S.H., Powell, J.M. and Gibbons, J.L. (1984) 'Schizophrenic patients and their families - a survey in a psychiatric service based on a DGH unit'. *British Journal of Psychiatry*, Vol. 144, 70-77.

Hatfield, A. (1978) 'Psychological costs of schizophrenia to the family'. *Social Work*, Vol. 23, 355-359.

Lefley, H.P. (1989) 'Family burden and family stigma in major mental illness'. *American Psychologist*, Vol. 44, 556-560.

Thompson, E.H. and Doll, W. (1982) 'The burden of families coping with the mentally ill: an invisible crisis'. *Family Relations*, Vol. 31, 379-388.

APPENDIX I

BRIEF INTERVIEW WITH THE PATIENT

Patient's
Name______________________ Sex/Age_____ Employed: Yes/No

Patient's File No. _____________

1. Who sees the mental health professional, e.g. doctor, social worker, etc. in connection with your illness (medical and social needs)?

2. Who makes sure that you take your drugs?

3. Who gives you money for daily expenses?

4. Who gives you psychological or emotional support?

5. Who wakes you up? (for work or for DTC or half-way house?)

6. Who does the cooking, washing and shopping for you?

7. Whom would you name as your care-giver?

8. What do you mean by caring?

9. Why did you name xxx as your next of kin as admitted to hospital or registered for out-patient service?

10. What do you mean by next of kin?

Interview conducted by telephone/face to face

Date of Contact____

APPENDIX II

BRIEF INTERVIEW WITH PATIENT'S NEXT OF KIN

Patient's Name______________________________________ Sex/Age__________

Patient's File No.______________________ Relationship with patient________ ___

1. Who sees the mental health professional, e.g. doctor, social worker, etc. in connection with xxx's illness (medical and social needs)?
2. Who makes sure that xxx takes drugs?
3. Who gives xxx money for daily expenses?
4. Who gives xxx psychological or emotional support?
5. Who wakes xxx up? (for work or for DTC or half-way house?)
6. Who does the cooking, washing and shopping for xxx?
7. Whom would you name as xxx's care-giver?
8. What do you mean by caring?
9. Why were you named as next of kin of xxx as he/she was admitted to hospital or registered for out-patient service?
10. What do you mean by next of kin?

Interview conducted by telephone/face to face

Date of Contact____

THE EMERGENCE OF A SELF-HELP ASSOCIATION FOR RELATIVES OF THE MENTALLY DISTURBED IN HONG KONG

(BAPTIST OI KWAN SOCIAL SERVICE)

by

Mary T. Leung, Jenny Wong and Vivian Siu

HISTORY

Baptist Oi Kwan Social Service is a multi-service social work agency which has served the Hong Kong district of Wanchai and Causeway Bay since 1982. The Lok Kwan female halfway house is one form of community based mental health service for the mentally disturbed. It was subvented by the Social Welfare Department of Hong Kong in 1982 and has a capacity of 35 beds for female mental patients. After two years of frontline service experience in the house and with the ex-residents in the local community, we have come to realize the importance of involving the relatives and friends of our clients in the aftercare programme for the goal of optimal rehabilitation and community integration. Thus, educational and social recreational programmes involving relatives and friends of the residents or ex-residents of the half-way house have been emphasized by the social workers. Regular meetings and contacts with the relatives were maintained and managed by the aftercare workers of the Lok Kwan halfway house with the intention of building up a self-support, self-help group or association for the relatives of the ex-mentally ill in the future.

In April 1988 another service unit, the Lai Kwan Day Training Centre, became a fully subvented centre for ex-mentally ill people. Due to the nature of its service, the staff found that involving relatives of our clients was all the more indispensable if continuity of treatment was to be achieved. Thus, the day centre prepared and paved the way for the establishment of the first Relative Resource and Service Centre for the mentally ill in Hong Kong.

The Relative Resource and Service Centre received financial support from the Community Chest and the Rotary Club of Victoria of Hong Kong early in 1989. The addition of new staff has given fresh impetus to the self-help movement of the relatives which had been developing informally and steadily in the rehabilitative service units of the agency. In December 1991, the elected officers (committee members) of this self-help group decided to apply for formal registration with the Hong Kong Government to become an official self-help organization for the relatives of mentally ill people in Hong Kong.

REASONS FOR INVOLVING FAMILY MEMBERS IN PSYCHIATRIC REHABILITATION

Enlisting the family members as partners and supporters in rehabilitation

From the beginning of our service operation, Oi Kwan sensed the importance of involving the relatives of the mentally ill in patient rehabilitation plans. Family members are people who have to face patients every day and they can exert direct influence on the latter throughout their rehabilitation process.

A number of authors have pointed out that family interaction may be the cause of its member's mental illness (Leiderman, Bimbaum & Dazzo, 1988). However, we prefer to agree with Anderson, Hogarty and Reiss (1986) that families are extremely influential forces in the lives of patients, and are powerful agents of change. Families can be unmined assets to be mobilized for the benefit of the patients. In order to truly benefit the clients, professionals have to be prepared to learn to respect, to understand and work with family members in an effort to mobilize them as partners for the clients' rehabilitation.

Prevention of further breakdown of a potentially at-risk group - the relatives themselves

Research by Professor Lieh Mak of The University of Hong Kong (1987) illustrated the great stress that the relatives of the mentally ill faced: of the relatives interviewed, 80% felt heavily burdened in respect to emotional health, sleeping, and family finances. 60% of those interviewed suggested that they were stricken by the fear of relapse. Thus, the relatives themselves faced greater risk of developing mental breakdown.

Furthermore, as the literature suggests, lack of information regarding mental illness and ways to cope with the patients' behaviour may leave family members fearful, anxious and confused (Leiderman, Bimbaum & Dazzo, 1988). We, therefore, felt that this at-risk group urgently needed support and concern and services to help them counteract their feelings of hopelessness and helplessness. The major goal of our service was to help them to maintain their own mental health so that more energies could be freed to be better used for coping with their family members' illness.

Maximizing self help and mutual help principles in service development

We emphasized developing a self help group for the relatives because we believe self help groups, as mentioned by Gartner and Riessman, "...have two unique preventive features: they provide social support to their members through the creation of a caring community, and they empower members' autonomy and coping skills through the provision of information and the sharing of experiences and solutions to problems." (Brown, 1985, pp 318-319).

In a group where all members have similar problems, relatives know that they are 'in the same boat'. Thus they can easily learn to give mutual support and to help one another. In exercising the helper rôle, the relative's self-esteem is enhanced. They may develop more confidence and independence in problem solving.

We were prepared to provide more substantial staff input in the formative stage of group development. We hoped that, as it matured, the self help group would become a fairly independent organization with the clear service objectives of reaching out to other relatives of the mentally ill in need.

DEVELOPMENT OF THE SELF HELP GROUP ASSOCIATION FOR RELATIVES

When we got started in 1989, our relatives' Resource and Service Centre had the following objectives:

a) to increase the relatives' knowledge about mental health and mental illness so that they knew how to enhance their own health and at the same time to cope with their disturbed members' problems;
b) to serve the relatives by providing educational, social and recreational programmes;

c) to promote mutual help amongst members; and
d) to train potential leaders to lead their self-help groups.

The following annual programme cycle was developed to reach the above objectives.

ANNUAL PROGRAMMES FOR THE RELATIVES

	Objectives	Contents	Month	Division of Labour
Educational Seminars	annual recruitment of members	nature of mental illness, etc	summer months	staff of agency and elected officers are co-organizers
Closed-end Workshops	provide therapeutic support	sharing & practical problem solving techniques	1. Sept. to November (4 to 6 sessions) 2. Jan.to March	professional social worker as leader, experienced relative serves as co-leader
Group Activities	cultivate group togetherness	sharing and discussion of personal concerns and frustrations	on-going (monthly meetings)	the elected group leader leads the group meeting; professionals act as consultants only
Leadership Training	training, advocacy	press interviews, workshop	Feb, April and July (irregular)	professional serves as resource person and co-trainer
Annual Election	election of new officers	election, initiation ceremony	end of March	co-ordinated by new and old office bearers of association

With the psycho-educational approach, we stressed the importance of providing information to relatives especially to those who were newly registered. The provision of information and support to relatives will help them to reduce fear, anxiety and unrealistic expectations towards mental illness (Anderson, Hogarty and Reiss 1986, Leiderman, Bimbaum & Dazzo, 1988). From our experience, relatives usually come to seek help because they know little about mental illness and are unable to find effective methods of coping with the illness. Thus, they welcome very much the educational programmes organized by our Centre. These seminars were organized on an annual basis to serve as an outreach programme to extend our relatives' group service to new members of the public.

a) Pre-group period: summer months

The educational programmes or seminars were held in the summer months (July or August). These were usually well attended with nearly 100 participants. Topics such as the nature of mental illness, its symptoms; treatment and process of rehabilitation; resources available for clients and their families, etc. were arranged to meet their needs. Guest speakers (psychiatrists, medical social workers and clinical psychologists) were invited, while some of the experienced and trained relatives whose family members were also mentally ill were invited to share with the participants. As a result, we were able to recruit at least 20-30 new members after each educational programme.

b) Group formation period:

A closed group model was applied since it helped to facilitate cohesion and trust between group members. After the pre-group interview, 20-30 group members were selected. The group was led by professional social workers with experienced relatives to serve as co-leaders. Within the group, therapeutic support was provided and group members also shared their common experiences of coping with mental illness.

We found that our co-leaders were influential at this stage because they were more accepted by group members as compared with the professional social workers. Moreover, the co-leaders who had experienced different methods of dealing with various difficult situations in the past, were in a better position to challenge and confront group members' present method of handling their relatives. Professional input at this stage focused on preventing the groups from "griping" about personal issues and focusing on superstitious/ignorant concepts. After 4-6 sessions, members began to experience a strong sense of identification with each other, were more at ease with their problems and experienced an increased sense of self esteem and control.

At this stage, many of the members were eager to continue the sharing process by joining a self help group. Potential leaders were identified and approached by our workers and an invitation was extended to all members to join our relatives association.

c) Group development period:

Regular group activities were organized on a monthly basis aimed at cultivating group togetherness and decreasing members' sense of isolation. Social activities like picnicking, tea parties, home visits among members were encouraged. They might also hold informal seminars discussing issues such as how to communicate with the mentally ill; how to deal with emotional outbursts and how to maintain their own mental health, etc. At this stage, professional workers in the group acted as consultants and the group members, led by group leaders who were experienced relatives and office bearers of the association, planned and organized activities themselves. In fact, most of the activities arranged fulfilled the emotional as well as the educational needs of our members. At the same time, getting more information increased their confidence to get on with their own lives despite the fact that they had to face their family problems.

d) Leadership training programme and other staff support:

Leadership training programmes were organized several times a year by our professional staff to enable the new group leaders to assume a leadership position in the self help association. Programmes included lectures and sharing sessions on the skills of programme planning, evaluation, group dynamics and organization, etc. As a result, the relatives' confidence and knowledge base increased and their commitment to the association deepened. They became better suited to take up the official positions for the association. Besides leading the therapeutic workshops and the leadership programmes, our professional staff operated the Resource and Service Centre to lend support to the development of the self help organization. Services included a hot line service to answer relatives' enquiries, visits, a short-term counselling service for relatives in crisis, and a small resource library with audio visual material available for loan.

e) Summary of progress to date

The annual plan as presented in the previous section has evolved from our work with relatives over the last three years. Thus, it represents a fairly regular cycle for the relatives' association. The annual election, held around April of each year, allows the association to renew its membership. It also enables the association to absorb new blood, via elections, in forming its central committee. Each year, the chairperson, vice chairpersons, and other officials are elected to provide leadership for the various self help groups and the association as a whole.

At present, the association operates several self help groups with monthly meetings in various regions of Hong Kong and Kowloon. These "chapters" of the association are organized along geographical lines for the purpose of providing an easily available support network for members. In order to facilitate co-ordination, the group leader of each regional chapter represents the group in the central committee.

The self help association is now in the process of applying to the Government for registration as a formal independent organization. Should it be successful, this association will face new challenges in furthering its mission and developing additional community support.

DIFFICULTIES ENCOUNTERED IN GROUP DEVELOPMENT

The ex-mentally ill people are a group which is highly stigmatized in this fast-moving, highly competitive society of Hong Kong. Working with the relatives of such a socially deprived group reveals many unmet needs and stresses, thus, we have been constantly complimented for our courage in launching this project. On the other hand, one can easily understand the many difficulties that a self help group faces in various stages of its development. The following is an attempt to outline the major problems of our project to date. Attempts are made to be specific regarding problem areas which have a tendency to present themselves throughout the group development process and, as much as possible, relevant experiences from literature are used to help us reflect and evaluate our difficulties.

a) Diverse background and expectation of the relatives

The attached appendix indicates that our existing members differ greatly with respect to age, sex, educational attainment, occupational status and even their relationship with the ex-mentally ill family member. Other important differences between them include the length of their family member's illness, their length of joining our group, and their level of acceptance of and adjustment to their problems. All these factors have to be carefully weighed so as to allow for the right amount of homogeneity and heterogeneity for maximizing mutual care and self help in the leadership structure and the various support groups of the self help association. Our concerns have been openly shared with the elected office bearers in recent years so that they also worked with us in using these differences carefully to foster the overall development and cohesiveness of the association.

b) The limitation of "available time" for the relatives

The problem of "available time" to participate in various activities of the association remains an issue which recurs time and again. The high inflation rate, and the busy working schedule of most Hong Kong residents contribute to the problem. "Only a small proportion of those in need find access to a group and are then willing to remain members and engage their energies over a long enough period. Estimates vary between one and five per cent depending on the field." (Matzat et al., 1990, p.252). Thus it is no surprise to us, that every time we organize a publicity drive for the relatives' association, a stream of "would be members" rush in to register, but few become active enough to be elected officers in the future.

c) The problem of leadership

A problem that is partially linked with the above one of available time is that of leadership. We have often found that the group members with leadership potential are those who are better educated and are slightly younger in age. But these people are likely to be already heavily occupied in their own career or family life. Many of these people are only interested to "help out" the group for a short period of time before they resume a more passive rôle as a group member. Then there are usually several members who are keenly interested to get involved as they have experienced great distress in the handling of their relative. Other members, however, are more hesitant about such involvement as real doubts are expressed regarding whether such keen participants can objectively differentiate between their own needs and the needs of other members of the group. The importance of locating indigenous leaders becomes crucial as the relatives' association gains recognition gradually with the media. The association loses important opportunities to fulfil an advocacy rôle for the mentally ill if the appropriate leaders are not available for interview. In whatever shape or form, the cultivation of mature leaders, who would serve the association in a continuous manner, is likely to remain an ongoing challenge.

d) Limitation in staff and resources for future development

With the recent emphasis on achieving "savings" from the already stringent budget for the welfare sector, our work with the relatives is unlikely to gain permanent Government support. Relatives of the mentally ill are considered secondary targets in welfare planning. In addition, it is difficult to use existing staff of the halfway houses or other services for this type of project on a permanent basis as these staff already have heavy workloads and shift duties. Experience in other countries (Lazar 1988) suggests that it is important to find staff who are willing to work with relatives as "partners" in designing and implementing the programmes if self help concepts are to be actualized. Thus, developing and supporting this special type of staff who would work with the association without ever feeling in competition or threatened by the latter is certainly another important task for future development.

e) Balance between providing a self-help group and establishing a self-help association

> This problem has come out every step of the way in our development. At each stage, we feel the "pushes and pulls" of various members to develop the cosy, spontaneous, tightly bonded small group as well as to establish the sophisticated, procedure oriented, formally elected self-help association. How to establish a delicate balance to serve the real needs of our members in both directions is a most challenging task. Our tentative solution to the problem involves a careful division of labour between professional staff and the volunteer leaders of the association, as suggested by Toseland et al. (1989). The former would be mainly responsible for planning and implementing the yearly therapeutic workshops and the latter would be responsible for the overall planning of the other activities of the association. Close co-ordination is necessary between the two groups before and after each major programme. The results, so far, have been encouraging.

CHALLENGES AHEAD

The relatives' association is now waiting to obtain registration thus achieving autonomous status. Baptist Oi Kwan Social Service is also prepared to give the association the necessary support to achieve independence in decision making and future development. We understand that, even at this stage of development, the struggle to achieve a proper balance of power and the division of labour between Oi Kwan as a professional social service agency and the newly-established Self Help Association is by no means over. We look forward to trying out new rules and breaking new ground in our partnership with the relatives for the benefit of our clients and the association itself.

Another challenge which we have planned for ourselves in the near future, is to conduct an effectiveness research on our work with the relatives. This type of study would certainly enable more people, including Government officials and the "unreached relatives" themselves, to be informed of the importance of relatives' involvement in rehabilitation.

REFERENCES

Anderson, C.M., Hogarty, G. and Reiss, D. (1986) *Schizophrenia and the Family*. New York: Guilford Press

Gartner, A. and Reissman, K. (1985) 'Self help and mental health'. In Brown, P. (ed) *Mental Health Care and Social Policy*, pp 316-327. U.S.A.: Routledge and Kegan Paul.

Gitterman, A. (1989) 'Building mutual support in groups'. *Social Work With Groups*, Vol. 12, No. 2, 5-21.

Lazar, M. (1988) 'Working with families of chronically mentally ill individuals: A psychoeducational approach to families featuring family and professional partnerships'. In Leiderman, L., Bimbaum, M.L. and Dazzo, B. (eds) *Roots and New Frontiers in Social Group Work*. London: Haworth Press.

Leiderman, M., Bimbaum, M.L. and Dazzo, B. (1988) *Roots and New Frontiers in Social Group Work*. London: Haworth Press

Ma, J. (1986) 'Mutual Aid Group as a practice model in working with the family members of psychotic patients'. *The Hong Kong Journal of Social Work*, Vol. xx, No. 1, 40-46.

Matzat, J. (1990) 'Self-help group as basic care in psychotherapy and social work'. *Groupwork*, Vol. 2, No. 3, 248-256.

Toseland, R.W., et al. (1989) 'The effectiveness of two kinds of support groups for caregivers'. *Social Service Review*, Vol. 63, No. 3, 415-432.

MUTUAL AID GROUPS FOR THE MENTALLY ILL IN A FAMILY SERVICE CENTRE

by

Joyce L.C. Ma

Introduction

Psychiatric rehabilitation is a process which enables psychiatric patients to make the best use of their residual capacities (Watts and Bennett, 1983). Its focus is on developing psychiatric patients' strength and assets, with the ultimate goal of enhancing their ability to live independently in the community. Traditionally, rehabilitation has been mainly carried out for psychotic patients, which is understandable in view of the severity of their disability. The confinement of rehabilitation work to a particular group, nevertheless, is unnecessary. The positive orientation and the emphasis on psychiatric patients' strength should be equally applicable to patients suffering from milder mental problems such as neurosis, depression and adjustment difficulties, since these patients also struggle to live a better life in society.

The mutual aid group has shown its promise for providing a supportive context to tap the unmined resources of the mentally ill, to create a genuine community support system, to increase members' personal independence and to discourage their over-dependence on mental health professionals and the service system, and last but not least, to serve as an alternative to traditional care for the mentally ill (Salem, Seidman and Rappaport, 1988). The theoretical orientation and the underlying assumptions of the mutual aid group and psychiatric rehabilitation are compatible with each other. The mutual aid group has been regarded as one of the viable means through which the goal of psychiatric rehabilitation can be achieved.

Professional experience of running mutual aid groups in Hong Kong has been, hitherto, largely restricted to a hospital setting or to a social welfare agency with psychiatric rehabilitation experience (Ma, 1986; Yiu and Ng, 1989). In 1988 an innovative mental health project was started by the Hong Kong Family Welfare Society, a well-established welfare agency with its professional expertize in running family services in Hong Kong. This paper documents the experience of the agency in using mutual aid groups to help people suffering from milder mental health problems cope with their problems. The contributions of this practice model, as well as the difficulties faced by the social workers in practice will be discussed.

Mutual aid groups in mental health services

Mutual aid groups refer to voluntary associations among individuals who share a common need or problem and who seek to use the group as a means of dealing with that need or problem (Gartner and Reissman, 1977). They are either initiated by professionals for those with a common problem, or formed by the afflicted people themselves, who come together for mutual support in satisfying a common need, overcoming a common handicap or life-disrupting problem, and striving for improvement in their quality of life.

The emergence of mutual aid groups in mental health services can be attributed to the unavailability of needed mental health services, an erosion of traditional family support, bureaucratization and alienation of the mental health professionals from the patients, the dehumanization of patient care, and the more ready acceptance of social support in maintaining one's psychosocial well-being (Jacobs and Goodman, 1989; Robinson and Henry, 1977).

The mutual aid group has dual functions to play in mental health services. It provides social support to members by creating a caring community; at the same time it increases members' coping skills by providing a social context for information exchange and emotional sharing (Gartner and Reissman, 1985).

The harmful impact of social disorganization on mental health has been discussed by the epidemiologist John Cassel (1974), and developed by the social psychiatrist Gerald Caplan (1974), who reminded mental health professionals of the contribution of the informal support provided by primary groups in preventing mental illness. Thereafter, much empirical work has explored the impact of social support on mental and physical health (Cohen and Syme, 1985; Gottlieb, 1981; Ganster and Victor, 1988; Sherbourne, 1988). No definite conclusion has been reached regarding the causal relationship between stress and health, or between stress and mental health outcome. Nevertheless, the results from Sherbourne's study (1988) indicate that, when social support is defined in terms of social resources, the more support one has from one's immediate social network, the less likely one is to use mental health services.

The increase of coping skills, through the provision of information and shared solutions to the problem in mutual aid groups, can be conceptualized as coping assistance for an individual in response to external stressors. By participating in the groups, afflicted people learn to change the meaning of the problem, as well as to change their emotional reaction to the problem (Thoits, 1986).

As an intervention model, the mutual aid group is characterized by seven features: common experience of members, mutual help and support, the helper principle, differential association, collective will power and belief, importance of information, and constructive action towards shared goals (Killilea, 1976). Although there is still debate about the mechanism of change provided by the mutual aid group, four kinds of influence have been identified in its process of interaction:

(1) The leaders' influence:
The leaders of mutual aid groups are life models who have gone through similar experiences and have attempted to cope with the problem, even though they may not have a full mastery of the problem. Their similarity to the participants, their warmth and concern, their valuable personal experiences are influential enough to instill a sense of self-efficacy in the participants.

(2) The unique properties of small face-to-face groups:
The power of a small group lies in its capacity to provide a context for social comparison, to fulfil members' needs for affiliation through the creation of a strong sense of group cohesiveness, and to induce powerful affective states in the participants (Silverman, 1980).

(3) Effect of affliction and societal norms on the helping process:
The afflicted members' perception of their deviant status in society frequently leads to the creation of a feeling of 'we-ness', that is, we are 'in the same boat'. It helps to soften the defence mechanism of the participants, and to enable them to have a free emotional cartharsis. The group encounter widens the participants' scope of perception by introducing them to a new perspective in viewing their problem.

(4) Ideology:
A mature mutual aid group has its own belief system, which embraces a new system of ideas that promises relief or comfort. It operates as a subtle form of indoctrination that enables the participants to deal with the unsatisfactory reality.

It is hoped that the project selected for presentation here, as an illustration of the potential contribution of the family service agency in the community care for the mentally ill, will encourage social workers in the welfare field to participate actively in mutual aid groups, and to take more active rôles in the community care for the mentally ill in Hong Kong.

The Mutual Aid Groups (MAGS) run by the Hong Kong Family Welfare Society: A case study[1]

The Mental Health Group Work Project and the mutual aid groups (MAGS) are special projects of the Hong Kong Family Welfare Society, which was founded in 1949 with the mission to assist destitute families who had left their homes in Mainland China to escape the plague of wars (HongKong Family Welfare Society, 1989). After forty years of development, the Hong Kong Family Welfare Society has expanded into eleven centres, providing a counselling service, home help service, school social work service, family life education service, clinical psychological service, and foster care service (Hong Kong Family Welfare Society, 1990).

The MAGS is a follow-up service of the Mental Health Group Work Project, which was started in May 1986 for individuals between the ages of 18-45 with mental health problems ranging from mild to moderate impairment of psychological, social and familial functioning. The Mental Health Group Work Project offers a package of 12-week structured therapeutic training programmes, adopting the cognitive-behavioural approach to promote members' mental health and to enhance their coping capacity (Hong Kong Family Welfare Society, 1989). In the course of the project, these group participants voiced their strong desire to form an alumni or a self-programming group. The agency responded to their request enthusiastically, taking into consideration the fact that these group members did not have much social support from their immediate social network and that there was no other suitable service available in the community. Subsequently, two mutual aid groups were formed at the end of 1987, with one in Cheung Shan Centre, located in a housing estate in Tsuen Wan, and the other in Western Centre, located in Sai Ying Poon, Hong Kong Island[2].

The ultimate goal of MAGS is to promote mental health among group members and to foster members' independence. Specifically, there are three service objectives: (1) to maintain the emotional stability of those members who are not under psychiatric treatment, in order to reduce the incidence of mental breakdown; (2) to provide a source of community support and activities so as to reduce the risk of relapse on the part of those members who have been under psychiatric treatment, and the rate of residual defect-chronicity subsequent to mental illness; and (3) to sustain what has been learnt from the cognitive-behavioural group programme through the reinforcement of such a sub-culture in the mutual aid group.

Based on the experience of other mutual aid groups, the social workers planned to develop the MAGS according to four phases: (1) the establishment of relationship; (2) the development of the group cohesiveness; (3) leadership training; (4) consolidation and expansion of group activities. The two mutual aid groups, with more than 90 members, have grown steadily in the past two years. Members of the MAGS were graduates of the cognitive-behavioural groups. The majority (over 90%) suffered from neurosis, depression, adjustment difficulty, personality problems and only 8 per cent suffered from psychosis. The genders were evenly distributed (female to male = 4 : 6), with the mean age at 29 years old. Most of the problems they encountered were related to interpersonal relationships in the family and at work, failure to handle stresses arising from their daily lives, and low self-esteem.

Members of the MAGS met at least twice per month. Their activities included picnics, teas, small group sharing, talks, camping and parties. Apart from that, some active members would either telephone the needy members or visit them from time to time. Most of these activities were organized by the core members of the groups, while the social workers took up the rôles of facilitators, advisors, consultants, trainers, and brokers according to the need of the groups.

A small study conducted in October 1991 among all the core members revealed that in joining the MAGS they expected to know some friends, to relax, to do something constructive and collectively, and to consolidate what they had learned from the cognitive behavioural group. After joining the group, they found that most of their expectations were fulfilled. Among all the group activities they ranked picnics, group sharing, talks and teas as their favourite activities. What they treasured most was group members' genuine concern and the spontaneous support given by one member to another. For example, every meeting a member of the Cheung Shan Group would take a bowl of nutritious soup to give to another member who had no family. They viewed the rapid turnover of the social workers, especially in Western Centre, the lack of strong leaders, and the busy working schedule among members as three predominant factors impeding the future development of the groups. Despite all these constraints, they still regarded the group as an important source of social support in their personal life.

Strength of running the MAGS in the family service agency and problems faced by the project

In Hong Kong, psychiatric patients have been stigmatized as social deviants with no hope and no future. It is not surprising that even psychiatric patients refused to associate with the other psychiatric patients to avoid the labelling effect. Running mutual aid groups in a family service setting has a number of advantages. To most of the group members, going to attend a meeting in a family service setting is more acceptable than going back to the hospital for a similar purpose, since they are less likely to be stigmatized.

Mutual aid groups can realize the principle of caring for the people in the community, for these groups have a proclivity for quietly blending into the ordinary life of communities and are grounded in the collective wisdom of powerless people (Jacobs and Goodman, 1989; Salem et al., 1988). As the centre is located in the community, it will be relatively easy for group members to join the activities.

In running mutual aid groups for people with mental problems, social workers had to provide crisis intervention for some members from time to time as their stress tolerance level is low and they are not competent to deal with daily stress. A family service agency like the Hong Kong Family Welfare Society runs a whole range of social services for people in the community, which provide back-up services for the group members as well as the social workers. For instance, the project social workers can refer the members with such a need to the counselling service, or call for the help of the agency clinical psychologist without going through any inter-agency bureaucracy.

Continuity of service is one of the ingredients essential for the community care of mentally ill people. In this case, mutual aid groups provide follow-up service for the cognitive-behavioural groups. It fills in the service gap of our community since most of the rehabilitation services are channelled to serve the psychotic patients, so that the needs of those with milder mental health problems are often neglected.

Despite these strengths, running the MAGS in a family service agency suffers from three limitations. First, the working hours of a family service agency are usually from 9.00 a.m to

5.00 p.m. In view of the nature of the project, the agency has already lengthened its working hours until late evening at least once or twice per week. However, administratively it would be impossible for the agency to open the centre every day until late evening because of the heavy overhead cost. Given such constraints, the agency cannot provide a place for the members to drop in, hence reducing their chance for informal interaction and consolidation of the group cohesiveness.

The most serious problem is the rapid turn-over of the project social workers. Take as an example the MAG in the Western Centre, Hong Kong Island, which has been run by four different social workers since its inception in autumn 1987. The rapid turn-over of social workers is a problem common to many welfare agencies in Hong Kong, as many social workers are emigrating on account of the 1997 issue and the transfer of sovereignty from the British Government to Mainland China. The group was impeded from developing into a more mature stage. It also affects the morale of the group members.

Since all members are graduates of the cognitive behavioural treatment group, they are already used to the rôle of the social worker as an expert. They have a strong tendency to depend on the social workers. The project social workers had to put extra effort into changing their perception of the rôle of the social worker from an expert to a facilitator. This demands the social worker spends more time and energy in the project. As the agency can only allow the social workers to spend not more than eight hours per week in this project, the social workers had to struggle between the limited time and the enormous organization work. The situation was particularly harsh for a new social worker, who had to win the trust of the core members and at the same time establish his or her professional credibility among them.

Conclusion

Mutual aid group is not an infallible approach. It operates with limitations and dangers. For instance, it seems to attract highly motivated clients, and has the danger of preaching to the already 'converted'. Mutual sharing, one of its characteristics, does not necessarily mean constructive learning. It may be a sharing of misconceptions, prejudices and personal bias, if not properly guided by professionals. The dilemma is how much control the professionals should exert, to what goals the professionals should guide them, and in what ways the professionals can reach a compromise between practical constraints and the ideal operation.

The case study of the MAGS run by the Hong Kong Family Welfare Society further confirms the indispensable rôle played by a family service agency in the community care for people with milder mental health problems. The constraints faced by this project are not insurmountable. They can be overcome if the policy makers start to appreciate the contribution of mutual aid groups in mental health services and to channel the needed resources to support their development.

Mutual aid groups, which include leadership training and deliberate efforts to cultivate independence and democracy, tend to be associated with community development service in Hong Kong, while the mental health service is usually associated with status, hierarchy and the expectation of helplessness on the part of the clients. It is high time for mental health professionals to show their faith in the abilities and strength of psychiatric patients. Mental health professionals need to show a willingness to take risks in extending the commonly accepted boundaries of professional behaviour and cease to hide behind the defence that "clients would not like it and cannot do that". The greatest enemy is not the conservatism of the mental patients but the conservatism of the mental health professionals.

ENDNOTES

1. This case study is based on the author's two years of regular contact with the two mutual aid groups (MAGS) run for people suffering from milder mental health problems such as schizophrenia in remission, neurosis, adjustment difficulties, depression and personality problems. In August 1989 the author was appointed as the professional consultant of this project and was responsible for providing ongoing professional supervision to the project social workers, with contacts at two-monthly intervals. The two project social workers provided a summary of the group activities and audio-tapes of the group sessions to the author before every supervision session.

   A small study was also carried out in October 1991 among the core members of the mutual aid groups, with the aim of understanding their personal perception of the usefulness of the group in helping them resolve their personal problems, and on the future direction of the groups. Open-ended questions were used in this study (Appendix A), on the assumption that they would provide a richer source of information for analysis.

2. The group operated in the Western Centre and moved to Southorn Centre in Wan Chai in the summer, 1991.

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APPENDIX A

Questions used in the study carried out in October 1991

(1) What did you expect to get out of this group when you joined this group?

(2) In what way do you feel this group is helpful to you?

(3) Which group activities do you like most?

(4) Which group activities do you feel most disappointed in?

(5) Which part of the group experience do you think helps you most in resolving your personal problems and fulfilling your personal needs?

(6) What are the difficulties affecting the development of this group?

(7) Why do you participate in this group enthusiastically?

REFERENCES

Caplan, G. (1974) 'Support system'. In Caplan, G. (ed.) *Social Support and Mental Health*. New York: Basic Books.

Cassel, J. (1974) 'Psychosocial processes and "stress": theoretical formulations'. *International Journal of Health Services*, Vol. 4, 471-482.

Cohen, S. and Syme, S.L. (eds.) (1985) *Social Support and Health*. New York: Academic Press.

Gartner, A. and Reissman, K. (1977) *Self help in the Human Services*. San Francisco: Jossey-Bass.

Gartner, A. and Reissman, K. (1985) 'Self-help and mental health'. In Brown, P. (ed.), *Mental health and Social Policy*, pp. 316-327. London: Routledge and Kegan Paul Plc.

Ganster, D.C. and Victor, B. (1988) 'The impact of social support on mental and physical health'. *British Journal of Medical Psychology*, Vol. 61, pp. 17-36.

Gottlieb, B.H. (1981) 'Social networks and social support in community mental health'. In Gottlieb, B.H. (ed.), *Social Networks and Social Support*, pp. 11-39. London: Sage Publications.

Hong Kong Family Welfare Society (1989) *A Research Report On Cognitive-Behavioral Group Therapy for Adults With Mental Health Problems*. Hong Kong: Hong Kong Family Welfare Society.

Hong Kong Family Welfare Society (1989) *Hong Kong Family Welfare Society - 40th Anniversary Commemorative Issue 1949-1989*. Hong Kong: Hong Kong Family Welfare Society.

Hong Kong Family Welfare Society (1990) *Annual Report 1989-1990*. Hong Kong: Hong Kong Family Welfare Society.

Jacobs, M.K. and Goodman, G. (1989) 'Psychology and self-help groups'. *American Psychologist*, Vol. 44, No. 3, 536-545.

Killilea, M. (1976) 'Mutual help organizations: interpretation in the literature'. In Caplan, G. and Killilea, M. (eds.), *Support Systems and Mutual Help - Multidisciplinary Exploration*. Grunne and Stratton, Inc.

Ma, J.L.C. (1986) 'Mutual aid group as a practice model in working with the family members of psychotic patients'. *The Hong Kong Journal of Social Work*, Vol. 20, No. 1, 40-46.

Robinson, D. and Henry, S. (1977) *Self-help and Health: Mutual Aid and Modern Problems*. London: Martin Robertson.

Salem, D.A., Seidman, E. and Rappaport, J. (1988) 'Community treatment of the mentally ill: the promise of mutual-help organizations'. *Social Work*, Vol. 37, 403-408.

Sherbourne, C.D. (1988) 'The rôle of social support and life stress events in the use of mental health services'. *Social Science and Medicine*, Vol. 27, No. 12, 1393-1400.

Silverman, P.R. (1980) *Mutual Help Groups - Organization and Development*. Great Britain: Sage Publication.

Thoits, P.A. (1986) 'Social support as coping assistance'. *Journal of Consulting and Clinical Psychology*, Vol. 54, No. 4, 416-423.

Watts, F. and Bennett, D. (1983) 'Introduction: the concept of rehabilitation'. In Watts, F.N. and Bennett, D.H. (eds.), *Theory and Practice of Psychiatric Rehabilitation*, pp 3-14. New York: John Wiley and Sons, Ltd.

Yiu, L.S.W. and Ng, C.P.Y. (1989) 'An outlet? Ex-mental patients in a mutual help organization in the community'. In Chan, C. and Yeung , A. (eds.), *Community Work - The Practice of Community Care*, 111-125. Hong Kong: The Hong Kong Social Workers' Association (in Chinese).

THE THERAPEUTIC COMMUNITY: IMPLICATIONS FOR THE MANAGEMENT OF HALFWAY HOUSES IN THE RICHMOND FELLOWSHIP OF HONG KONG

by

K.S. Yip, Rose Yu, Irene Law and K.H. Chan

INTRODUCTION

This paper attempts to evaluate the implications of the therapeutic community model for the management of halfway houses in the Richmond Fellowship of Hong Kong. The Richmond Fellowship of Hong Kong (RFHK) was established in 1984 as a non-profit-making registered charity. It is affiliated to the Richmond Fellowship International which was founded in the United Kingdom in 1959 with a clear mission to implement rehabilitation services for the ex-mentally ill based on the therapeutic community model. The Richmond Fellowship of Hong Kong now operates four service units: Yum Yuen House (YYH), a small halfway house for 14 ex-patients; Wan Tsui House (WTH), a standard halfway house for 40 ex-patients; Ping Shan House (PSH), a special halfway house for 22 ex-patients, some of whom have criminal or violent records; and New Jade Manufacturing Centre (NJMC), a sheltered workshop for 140 ex-patients.

The concept of the therapeutic community is still a rather new one to use in halfway houses for ex-mentally ill people in Hong Kong. To begin our discussion, let us start with a brief review of the original concept and practice of the therapeutic community.

Rapoport (1963), in his analysis of Maxwell Jones's experiences at Belmont, described the ideology of the therapeutic community thus:

1. Democratization: every person has a vote; everyone's opinion - nurse, doctor or patient - was as good as the next.

2. Permissiveness: the members were expected to tolerate disturbed behaviour; discussion was better than discipline.

3. Communalism: equality and sharing were valuable; everyone should express their thoughts and share them with others.

4. Reality confrontation: all were expected to face their problems, and interpretations were vigorously forced on them (Rapoport, 1963, 105)

Clark tried to summarize the practice of the therapeutic community into the following eight components:

1. Size: it is small enough for each member to know the others and for community meetings of all involved.

2. The community meeting: all the people in the community - patients, nurses, doctors, social workers, domestic staff etc. - meet for a period regularly to consider common problems.

3. Its underlying philosophy is the psychodynamic hypothesis: all problems and difficulties in relations with other people can be discussed, understood and remedied.

4. Social analysis of events: happenings in the unit are discussed in the community group meetings and an attempt should be made to understand them.

5. Freeing of communication: attention is given to improving the flow of information upward and downward.

6. Flattening of the authority pyramid: this happens inevitably but is regarded as important in itself and is in marked contrast to the traditional hospital ward.

7. Provision of learning experiences: protected situations are fostered where patients can try out their ego strength and learn new ways of coping with difficulties.

8. Rôle examination: this applies to all but especially to the staff; as they examine their work they are able to change to a more effective and helpful way of functioning (Clark, 1965, 950).

The concepts and practice of the therapeutic community model have flourished in the past 30 years in different settings and with different groups of clients. In the course of development, different interpretations of the therapeutic community have evolved. Some may use the operational model developed by Maxwell Jones as the standard, while others may follow the therapeutic community principles without adhering to the standard `activities'. Kennard (1986) differentiates these two orientations as the `therapeutic community proper' and the `therapeutic community approach'. For the purpose of the present paper, therapeutic community refers to an `approach' rather than a specific operational model.

THE PRACTICE OF THE THERAPEUTIC COMMUNITY IN THE HONG KONG CONTEXT

The practice of the therapeutic community in Hong Kong is actually limited by two important factors: the Chinese cultural context and the mental health service in Hong Kong.

A. HONG KONG CHINESE CULTURE

Our education teaches us fragmented bodies of knowledge which makes very sharp distinctions between `Eastern' and `Western' culture and ideas. This sometimes clouds our understanding of human interactions and may lead to gross differentiation of certain behaviour or modes of interaction as predominantly `Western' or `Eastern'.

Social work practice is based mostly on concepts borrowed from psychology, largely a product of Euro-American tradition. Challenges must be faced when these concepts are applied to a group of people who have experienced very different socialization processes and probably perceive the world differently. Some may argue that since one's culture significantly determines the way one perceives and conceptualizes psychological phenomena, psychological knowledge should be developed indigenously. Notwithstanding a certain degree of truth in this statement, one must be careful not to draw a crude conclusion by dismissing Western psychology and technology derived from it as irrelevant and inappropriate to Asian cultures.

How can we then evaluate the applicability of a certain model in a different cultural context? Kluckhohn and Murray stated, "Every man is, in some respects, (a) like all other men, (b) like some other men, and (c) like no other man" (Paranjpe et al., 1988. p.14). If we accept this statement as able to describe one's psychological functioning in relation to others accurately, it is then important for us to delineate the level at which we are dealing. We are, in fact, dealing with a much more complicated issue than just the casual comment of `That's a fine model but it's too Western; we Chinese are different' could legitimately dismiss. We do not know what exactly is in common in the psychological makeup of humankind.

When we talk about 'the Chinese', we are referring to about one-quarter of the world's population consisting of different groups of people. Chinese culture is not a single entity with clear and definable characteristics. In Hong Kong the situation is further complicated. Hong Kong has been a British colony since 1842 and is now a cosmopolitan city and an important financial centre. Over 99 per cent of people in Hong Kong are Chinese who have emigrated from the southern part of China. Many of the older generation were born and brought up in China and still hold a rather strong Chinese tradition. The younger generation have had many opportunities to be exposed to Western ideas and ways of thinking. This mixture - East and West, old and new - has created a rather special blend: a Hong Kong culture. Hong Kong Chinese cannot be understood purely from a `traditional' Chinese perspective.

Generally speaking, there are five important factors that may influence the practice of the therapeutic community within the Hong Kong Chinese culture. They are: the communication pattern, expression of feelings, tolerance of uncertainty, issue of authority and rôle of family.

1. **Communication pattern**

The therapeutic community emphasizes change arising from conflict as illustrated in the use of reality confrontation and the importance of open communication. For each member to be able to contribute to the treatment of others, it is required that they should be able to give and receive honest feedback.

For Chinese, the maintenance of an harmonious relationship is considered very important in interpersonal relationships. Conflict is best avoided even at the cost of denying one's own idea. Under this norm, people prefer to remain quiet or are more ready to compromise should there be a difference in opinion. Putting this in a group situation, the group would probably be dominated by the more vocal members, especially in an unstructured situation. It has also been found that Asians are characterized by verbal non-assertiveness, a low level of emotional and behaviourial expressiveness, and reluctance to disclose themselves to strangers (Leong, 1986). Anxiety rises when no clear guidelines are given as to how they are expected to behave. This may have particular significance among the ex-mentally ill who are already characterized by social withdrawal.

Another important aspect is the family/group orientation. One's rôle in society is very much defined by one's rôle in the family or in a social group. In order to preserve one's rôle or identity it is important that one remains friendly with others. Friendliness relates to how much `face' you give to others. 'Face' is the degree of respect you receive in front of a group of people. This varies from the number of guests you can invite for a banquet, whether your mistake is pointed out or whether your opinion is challenged in public, etc. 'Face' only has meaning in a group context. It is the recognition and response others give that could possibly make you feel publicly shamed. To cause a person to lose face in a public disagreement, or not to give a man face, is considered to be very rude. Hence, it is usually safer not to express one's idea openly. It is more common for one to hear genuine feelings in informal sub-groups than in formal meetings.

Face giving is also mutual. It is something you give and take as an exchange of goodwill. Negative feedback, if given at all, is expected to be expressed informally - over a cup of tea, a meal, or even through another person.

The tendency to maintain a harmonious relationship and the importance of face in inter-personal relationships colours the perception of open communication. What is considered to be therapeutic could be taken as highly inappropriate in a different cultural context.

2. **Expression of feelings**

Expression of feelings, either in itself or as a means to achieve other goals, is considered to be highly therapeutic in many intervention models. In the therapeutic community approach it is utilized structurally in groups where members are encouraged to express their feelings about themselves or towards others so as to enable members to realize the effect of their actions on others and to allow others to give feedback. `Natural' interaction is taken as valuable in providing information for therapeutic intervention. In addition, free expression of feelings is essential in materializing principles such as reality confrontation and permissiveness.

In accordance with a harmonious world view and the avoidance of conflict, Chinese are usually brought up in an environment where strong feelings are expected to be avoided or controlled. Ability to control one's emotion is a sign of stability, maturity and even one's `manhood'. Emotions, should they become out of control and upset the equilibrium, tend to be expressed via somatization rather than psychological symptoms. The Chinese vocabulary is also very limited in expressing feelings and emotions as compared with the English language. If we ask our clients to express how they feel verbally, we may encounter a frustrating condition for both parties in not finding the correct words to use.

3. **Tolerance of uncertainty**

The Maxwell Jones-type therapeutic community approach entails a lot of uncertainty and grey areas. The rôle of the staff is not usually clearly defined. Members in a community may find themselves in a situation where re-definition of boundaries and rôles is a constant process. Rules and regulation are minimal and the principle of permissiveness allows tolerance of the more `bizarre' behaviour. All these are considered therapeutic as members are expected to use all the available resources in the community to help each other. Boundaries are fluid enough and the tolerance level high enough to allow a high level of participation and a high level of control by members.

To strike a balance between tolerance for therapeutic purposes and anarchism is very difficult. Members, both staff and residents, must feel secure enough to confront inappropriate behaviour, or else a feeling of apathy may develop.

Though well-known for their ability to stand stressful situations, Chinese people have a low tolerance for uncertainty. They expect the staff to provide clear guidelines as to how they should behave and expect clear boundaries between helper and helpee. The idea that each member is able to be a therapist and the belief in community life as a learning process for both the worker and the client is alien to them. They expect the worker to be a directive, paternalistic and authoritative person who knows better. They should be able to give guidance while they would receive help and `become better'. They expect that they are told what is expected of them and are given clear guidelines about what contributes to unacceptable behaviour. It is the staff's responsibility to get rid of `trouble-makers'. Should they be expected to have a say and the power to decide what sort of behaviour is acceptable in the community, it is easy for them to withdraw and adopt an apathetic attitude.

4. Issue of authority

A key principle, in fact one of the most important contributions of the therapeutic community approach, is a totally different perception of the staff-client relationship. Staff should lose their authoritative image: all should be on first name terms, wear casual clothes, listen and respect what the client has to say and involve clients in the decision-making process. Many of these principles are still used in therapeutic communities. This kind of environment seems to be very much welcomed by people in a Euro-American culture and fits in with their cultural expectations.

For Chinese, with the more rigid lines of hierarchy in the socialization process and societal norms, these ways of interaction are perceived as disrespectful. It is not uncommon to find situations where clients feel uncomfortable in addressing the staff by their first names and feel insecure and unsafe to say what they really think in front of the staff.

5. Rôle of family

The therapeutic community emphasizes the use of the community itself and the development of individuality. Historically, it is developed within a hospital setting with a psychodynamic undertone. The primary focus of intervention has been the individual. The rôle of family in the therapeutic community concept is minimal. Locally, families still play an important part as a social or economic supportive system. Clients still see living with the family as one of the signs of `being normal'. It is, therefore, important to take families into consideration in the whole rehabilitation programme. The boundary of `community' in this context is expanded. One's self-esteem cannot be assessed solely on an individual level; rather, it is dependent on successfully meeting the rôle expectations of family life.

B. ISSUES IN MENTAL HEALTH SERVICES IN HONG KONG

Mental illness is a serious problem for an industrialized, densely populated and rapidly changing society such as Hong Kong. Statistically speaking, one in every six persons in Hong Kong suffers from a certain degree of mental imbalance. Also, three persons in a thousand are diagnosed as suffering from schizophrenia. It is estimated that over 20,000 mental patients and outpatients are under the care of the medical and social services in Hong Kong (Hong Kong Government, 1987, 60). To rehabilitate such a large number of mental patients and outpatients, high quality and sufficient quantity of community-based services are necessary.

Unfortunately, although there are a variety of community care services provided by the Social Welfare Department and the voluntary sector, both the quality and quantity are far from satisfactory. Firstly, very few resources are allocated to support the community mental health services. Most of the professionals in the mental health services are under the pressure of heavy caseload. Fatigue and burnout are common in daily practice (Yip, 1991, 105) and would certainly affect service effectiveness. Secondly, the case management system for psychiatric patients and outpatients in Hong Kong is loose and fragmented. Thirdly, public attitudes towards the psychiatric patients and outpatients are extremely negative (Yip, 1991, 23). Under such conditions, mental patients and outpatients face many difficulties in the process of rehabilitation. Without proper support from the professionals and the community it is very hard for a patient to maintain employment, to have acceptable accommodation and to establish satisfactory interpersonal relationships. Consequently, he/she may relapse and be sent back to the hospital.

Under such a fragmented case management system and poor mental health services and policies, residential care is inevitably affected. According to the government criterion, a `standard' halfway house should house 40 residents with only one qualified social work graduate as the centre-in-charge, one enrolled nurse, one cook, several untrained welfare workers and one untrained senior welfare worker as the assistant centre-in-charge. Such a large group of residents and untrained staff create a burden for the implementation of the therapeutic community. Experiences in the Richmond Fellowship of Hong Kong do reflect that practice constraints in halfway house management are always in conflict with the values and practice of a therapeutic community. It imposes pressures and tension in leadership, staff communication, staff supervision, power and authority, decision making, client-worker relationships, and use of resources.

1. **Leadership**

To facilitate democratization and communalism in a therapeutic community, democratic leadership is of paramount importance. Nevertheless, leadership in a period of high staff turnover (Oskam & Gilhuis, 1991, 13), and within a destructive staff dynamic (Janzing, 1991, 5) can hardly be purely democratic. Within the Hong Kong context, both the untrained staff and the residents have a tendency to expect a more autocratic leadership style with clear guidelines, or a charismatic leadership with high influential power, so that specific advice is given. When a less directive rôle is adopted by the team leader, some staff and residents may feel apprehensive. During such periods of uncertainty, members may respond with anxiety or, at most, apathy. Some staff may take up the leadership rôle in a more autocratic way by pushing others to follow. Very destructive dynamics of `pseudo representation' may develop. To resolve such situations and dilemmas, very often the leader has to make sure that a more democratic process has been gone through and elements of the therapeutic community approach have been enforced. Many staff will interpret such autocratically democratic leadership as no different from pure autocratic leadership. They tend to follow the suggested elements of the therapeutic community rigidly as the `commands' from the team leader rather than internalizing the values and the philosophy of the therapeutic community.

2. **Staff communication**

Communalism, democratization, and flattening of authority may imply strengthening of horizontal and vertical communication among staff. Staff dynamic sessions further facilitate such informal communication. For a small number of staff and residents this kind of sharing and communication are, in fact, very nurturing and facilitate personal growth. However, with 11 staff and 40 residents who come from very different backgrounds and do not necessarily share the same ideology, the dynamic created can also be rather destructive. Some degree of formal communication and clarity of boundary is unavoidable. Unchannelled horizontal and informal communication may threaten healthy and formal communication. Staff may confuse whether the team leader is using information shared informally for evaluative purposes. Similarly, residents may be confused as to whether staff are formally disciplining them or informally advising them to do something. They may have a feeling that the welfare workers or the team leader are cunning, hypocritical and having double standards. It is not uncommon to see the staff team as having a mixture of apathetic and very committed workers. The committed ones may feel betrayed when the sharing of deep feelings is responded to with apathy, particularly in staff dynamics sessions. They are easily burnt out and frustrated. High turnover rates can be predicted. Under this circumstance, those who are apathetic are more likely to survive and stay. Subsequently, it becomes even harder for the more committed ones to tune in to the spirit of the therapeutic community.

3. **Supervision**

The therapeutic community approach favours the staff- centred style of supervision. This type of supervision, on the one hand, is very nurturing to the staff and to the organization. Staff concerned are allowed to learn from mistakes. Through sharing with the supervisor, he/she can gradually develop into a mature and experienced worker. On the other hand, this type of supervision is very consuming in terms of time and manpower. The supervisor needs to contact the staff frequently and intensively. For a halfway house with 11 staff and 40 residents, frequent intensive individual supervision is unrealistic. Very often limitations in time and resources may force the supervisor to use a monitoring type of supervision, which is highly task, organization-maintenance and client-oriented. In addition, this type of supervision may, to a certain extent, conflict with the values and ideologies promoted by the therapeutic community. If the supervisor tries to insist on using a staff-centred style of supervision, he/she may fall into the trap of poor time management. Staff may also be apprehensive about the supervision style. Infrequent deep sharing is worse than frequent but short communication.

4. **Power and authority**

The therapeutic community stress on flattening the power pyramid results in the delegation and decentralization of power to staff and residents. For a large group of staff and residents, the team leader may face a serious problem of how to delegate and decentralize his/her power, especially when the staff team and the residents are submissive, unable to face uncertainty and are looking for direction. On the one hand, the team leader may be aware of the aversive consequences of delegation and decentralization to immature and apathetic staff and residents. On the other hand, it is only through participation and delegation of power that the staff and residents can realize and internalize the ideologies and values of a therapeutic community. There are a lot of grey and ambivalent areas in exercising and sharing power and authority within a residential setting, especially for the large halfway houses that typify Hong Kong.

5. **Decision-making**

Democratization is actually a process of collective decision-making. Community meetings and staff meetings in a therapeutic community are mechanisms to facilitate such a decision-making process. When a small number of residents and a small number of staff are involved collective decision-making is easy. However, when a large number of staff and residents are involved, decision-making through negotiation becomes a much more complicated manoeuvre. However, if the decisions are only made by some residents, by some staff, or by some staff and some residents, should we call such decision-making process a democratization process? Sometimes the majority view may be in contrast to the ethos of the therapeutic community; for example, the `community' would have a tendency to expel `trouble makers'. The team leader will try to work against the will of the majority in order to preserve the spirit of permissiveness but may violate the spirit of democratization.

6. **Client-worker relationship**

Communalization as described by Rapoport makes a less sharp distinction between helper and helpee. In actual practice, the helpee's submissiveness and feelings of insecurity may force the worker to take a more directive rôle. Both tend to favour a clear distinction between helpers and helpees in the helping process. Instead of treating residential life as a learning process for both the residents and the workers, workers like to perceive themselves as `helpers' to the residents. As helpers they expect to give advice, to solve the residents' problems. Inmates assume that they, as helpees, should follow staff's advice closely. Workers may juggle among various interpretations of client-worker relationship in terms of for the good of the staff, for the good of the client, for the good of the organization and for the good of the community.

7. **Use of resources**

Meetings are one of the important channels in practising the therapeutic community approach. Community meetings, staff dynamics sharing, 'think days', staff meetings, case conferences and other working groups seem to be a must in the traditional practice of the therapeutic community. With a large group of residents and staff, the manpower involved in such meetings is immense. Staff always get a strong feeling that too much staff time is being spent on meetings, particularly for those meetings which involve the attendance of all staff and all residents.

Furthermore, as too many people are involved in the meeting, discussion of individual topics is inadequate and shallow. As the staff team and the team leader try to re-adjust the time allocation for various types of meeting, they may face difficulty in setting priorities among, say, sharing of intervention methods in a case conference; sharing feelings in the staff dynamics meeting; task and information sharing in the staff meeting; and staff development and reflection at the 'think day'. All of them are equally important elements in the practice of the therapeutic community approach.

A THERAPEUTIC COMMUNITY MODEL FOR HONG KONG

In the light of the previous discussion, adaptation of the traditional model of a therapeutic community is needed. Below is an adjusted model of practice deriving from our working experience. This adjusted model mainly consists of five elements: dormitory orientation, structured group decision- making, staff development, client leadership training and linkage with the community.

1. Dormitory orientation

To have better communication among 40 residents, the idea of dormitory groups was initiated and implemented. The weekly meeting is divided into a business session which involves the whole community and is then followed by individual dormitory meetings. Eight residents are the maximum capacity. Two workers, one nurse and one social worker are assigned to work with the dormitory groups. They work with untrained welfare workers as a small team. Within each dormitory group residents are encouraged to share their views and feelings about tasks such as cleaning, food purchase and leisure activities. Emphasis is on participation and taking control of one's own life rather than the more psychodynamic orientation of the Maxwell Jones type of therapeutic community. Follow-up discussion and sharing after the large community meeting are also facilitated in each dormitory group. Each dormitory now becomes a `mini therapeutic community'. Results of this attempt are encouraging as residents are more relaxed and willing to share their views and opinions within a small group. The problems of ineffective communication in the large community diminishes. Of course, there are still some other problems in achieving open and free communication; for instance, the linkage between the small dormitory group and the large community in terms of decision-making and information sharing, the issue of gender, etc. All these should be handled carefully in further development.

2. Structured group decision-making

A collective decision-making process may not be possible for all kinds of decision for all staff and all residents. Structured group decision-making is implemented. According to Delbecq (Delbecq, 1967, 334), there are three types of decision-making, namely routine decisions, creative decisions and negotiated decisions. For routine decisions such as the structured routines in the halfway house, discussion is not so necessary. For negotiated decisions such as handling behavioural problems of some residents, full discussion among staff and residents will be a must to reach an important consensus. For creative decisions such as designing programmes and activities, it may be better for some responsible residents and staff to design an initial proposal before seeking the opinions of other staff and residents. Furthermore, creative and negotiated decisions can become routine decisions if thorough discussion has taken place. Different levels of staff may have different capacities. Professional staff may be better equipped for decisions of treatment plans for individual residents. Untrained frontline staff may be more in touch with everyday events of the hostel and be in a better position to make decisions in these aspects. Dormitory groups can be more focused on decisions concerning the daily routines of the dormitory. Community meetings should be more focused on issues concerning the whole hostel. Sometimes representatives may be selected to allow a more in-depth discussion. Of course, being an open system, keeping an open ear to others' opinions is of paramount importance.

3. Staff development and client leadership training

To facilitate better understanding of the rationale, philosophy, concept and practice of the therapeutic community, staff development and training is essential. In-service training for all levels of staff should be conducted. This enables the staff to have better awareness and knowledge in implementing the therapeutic community.

Apart from ongoing in-service training, all senior staff are sponsored by the agency to have a three months study trip to the U.K. to learn and experience the therapeutic community as practised by the mother organization. No attempts have been made to follow the operational tradition rigidly. Rather, they are expected to use their experience to make valid adjustments in setting up a similar service in Hong Kong.

Furthermore, untrained welfare workers are encouraged to participate in the general in-service training organized by the Social Welfare Department so as to enrich their knowledge and practice methods in the rehabilitation service.

To promote mutual understanding among staff, team building exercises are also stressed. By means of games and designed programmes, staff become more aware of their personality, and their attitudes towards other staff and residents. It is hoped that staff are able to increase their sensitivity towards others' feelings and facilitate mutual support among themselves. Also, by means of team building exercises, staff become more alert to the impact of the culture and norms on community dynamics. Finally, team consensus and team spirit are enhanced.

As the spirit of client participation is highly stressed in the practice of the therapeutic community, client leadership training should be encouraged to achieve their full participation. Self-help groups and local support networks are formed for dischargees so that their potential can be fully developed. As the residents become more accustomed to participating in programme planning and implementation, they will be more assertive in voicing their views and opinions in the hostel. Further formal leadership and assertiveness training for the residents should be carried out to strengthen their assertiveness in practising the concepts of a therapeutic community constructively.

4. Realistic democratic leadership

To be effective within so many constraints, the team leaders of the halfway houses have to assume that not every staff and resident is ready to practice democratization, decentralization of power and resources, and freeing of communication. Thus, power and authority will be allocated and decentralized to those who are mature enough to use them constructively. Also, some of the staff and residents may need a longer time for training and orientation so as to understand and practise the relevant concepts. For some critical issues the team leader may still need to maintain a certain degree of control and manipulation. Formal and vertical communication may still be needed on occasion for the maintenance of the organization. Some staff, especially the unmotivated ones, may still need to be evaluated and supervised closely for the sake of the team spirit. Some of the residents who are too destructive to the house may still have to face immature discharge in order to maintain a healthy and therapeutic atmosphere.

5. Linkage and support from the community

Integration and rehabilitation is never completed without the linkage and support from the community at large. To prepare for the discharge of the residents in the halfway house, integration with the community is crucial. Also, as the Chinese are so family oriented, the rôle of the family in psychiatric rehabilitation is crucial. The original concept and practice of the therapeutic community is limited by its confinement to residential and institutional life. Under the concept of community care and integration, residents are encouraged to contact members of the community by means of programmes and joint activities with nearby churches and welfare agencies. Furthermore, family activities and programmes are organized in each house to strengthen the family support of the residents in the process of rehabilitation (Yip, 1991). In other words, the `community' within the concept of the therapeutic community should be widened to include the community outside the four walls of the institution.

Conclusion

In conclusion, this paper is an initial attempt to evaluate the implication of the therapeutic community approach for the management of halfway houses in the Richmond Fellowship of Hong Kong. In facing the Hong Kong Chinese cultural context and the problems of mental health service in Hong Kong, the writers try to suggest an adjusted model of practice. Certainly, the issues raised in this paper are neither exhaustive nor conclusive. Further research and implementation should be done to strengthen the application of this adjusted model of practice. Furthermore, in practising the adjusted model, the staff should always bear in mind that too much structure may suffocate free communication and hinder individuality. It is always a matter of degree and extent. We believe that the adaptation of any operation model in a different culture is a highly complicated issue. Dynamic and spontaneous reflection is necessary to put it into a realistic context. In terms of the international movement and philosophy, the concepts and practice of the therapeutic community approach should be reviewed constantly for better application and implementation within various settings and cultural contexts.

REFERENCES

Clark, D.H. (1965) 'The therapeutic community: concept, practice and future'. *British Journal of Psychiatry*, 947-954.

Delbecq, A.L. (1967) 'The management of decision making within the firm: three types of decision making'. *Academy of Management Journal*, 329-339.

Kennard, D. (1986) 'From a movement to a method'. *International Journal of Therapeutic Community*, 207-209.

Hong Kong Government (1983) *Report of the Working Group on ex-mentally ill patients with a history of criminal violence or assessed disposition to violence.*

Hong Kong Government (1987) *Hong Kong 1987: Review of the rehabilitation programme plan*.

Hong Kong Government (1991) *Hong Kong 1990: Review of the rehabilitation programme plan.*

Janzing, C. (1991) 'One foot in Hell: on self-destructive staff dynamics'. *International Journal of Therapeutic Community*, 5-11.

Jones, M. (1952) *Social Psychiatry*. London: Tavistock Publications.

Leong, T.L. (1986) 'Counselling and psychotherapy with Asian-Americans: a review of the literature'. *Journal of Counselling Psychology,* Vol. 33, 196-206.

Oskam, B. and Gilhuis, H. (1991) 'Leadership in a period of turn-over in staff'. *International Journal of Therapeutic Community*, 13-20.

Paranjpe, A.C., Ho, Y.F. and Rieber, R.W. (eds) (1988) *Asian Contributions to Psychology*, p.14. New York: Praeger Publishers.

Rapoport, R.N. (1960) *Community as Doctor*. London: Tavistock Publications.

World Health Organisation (1953) *Expert Committee on Mental Health 3rd Report*. Geneva: WHO.

Yip, K.S. (1991) *Controversial Issues on Hong Kong Mental Health Services* (in Chinese). Kam Ling Publishers.

Yip, K.S. (1991) 'A brief report of the integrative aftercare project implemented in the Richmond Fellowship of Hong Kong'. Paper presented at the conference *Psychiatric Rehabilitation: The Asian Experience*.

THE RôLE OF FAMILY IN THE REHABILITATION OF MARRIED WOMEN PATIENTS IN RURAL PUNJAB, INDIA

by

J.M. Choudary

Introduction

Families are simultaneously a resource in the care of the mentally ill (Falloon, 1986) and a source for the aggravation of psychological distress (Laing, 1972; 1976). In a society such as India's where families are fundamental to the social structure and government-provided resources for caring for the weak and vulnerable are scarce, understanding of the relationship between family interaction and psychological distress is even more important.

The most vulnerable members of Indian families tend to be young daughters-in-law. Discrimination against women begins before birth with selective female foeticide (Lingam, 1991). Female children are frequently considered to be a liability rather than an asset, and will receive fewer of the families' available resources, on the whole, than sons.

Marriages tend to be arranged, so that a young bride must leave the house of her parents and everything familiar to live with strangers, and adapt to a new pattern of norms and values in an atmosphere that is frequently highly critical. Often, she will be blamed for misfortunes that befall the family and little credit will be given to her, however well she performs her household tasks and looks after her children.

Her most formidable foe within the family is likely to be her mother-in-law. Although there are exceptions, mothers-in-law tend to be dominating and very much 'queens' of household matters. Sons are used to being controlled by their mothers and submissive to their wishes, with little consideration for their wives and the harsh treatment they receive.

The nature of the ties to both families, of birth and marriage, are essential in understanding family reactions to prolonged psychological distress. Ties of affection within their natal families, particularly among the female members, are important to women even after marriage and consistitute a 'pull' factor when care and support are needed. The behaviour of mothers-in-law, the greed for bigger and better dowries, the expectation of bearing male children, and the demand for unlimited labour are all 'push' factors away from the family of marriage in times of personal distress. Thus the functions and needs of the individual cannot be separated from those of the family where expectations about 'proper' rôles, behaviour and attitudes are socially approved and culturally determined.

The problem

The research started from the premise that women from rural areas in the Punjab suffer from psychological disorders as a consequence of social discrimination. The discrimination that begins before a female child is born continues to be hammered into her at different stages of her life. This differential treatment and discriminatory behaviour, combined with attitudes of society in general and those of the family of marriage in particular, have a cumulative effect resulting in various stresses, a situation which encourages psychological disorders. Recovery and rehabilitation have to take place quite often without the assistance of the family of marriage. Instead, the woman must turn for care to her own parents. Consequently, it is important to know more about the part that a woman's family of origin play in her treatment and rehabilitation.

The rural areas of Punjab (India) around Patiala constituted a catchment area from where all cases in this study were drawn. Women patients suffering from psychological disorders and who visited psychiatric institutions for treatment were selected[1]. Those who had a prolonged illness and had been visiting the doctor for some time were taken up for intensive investigation. The psychiatrist diagnosed the disorders and illness initially and administered drug therapy. Simultaneously the patient was referred to the psychiatric social worker for counselling. Repeated interviews, discussion and counselling of the patients and their relatives and in-laws was undertaken and a continuous liaison among all of them was maintained. An attempt was made to re-establish the disrupted communication among various members within the family, and between families. Work focussed on those who could play a significant rôle in the environmental modification and rehabilitation of the patient. Factors were also identified that thwarted attempts to repair the network of broken relationships and interaction among them. Both intensive case work and group work methods were followed during diagnosis, investigation, environment modification and rehabilitation. The extent to which these efforts were successful was ascertained through a follow-up interview obtained at a later stage.

The data

The data comprise information obtained from and about a number of clients over a period of more than one year. Three cases have been selected to highlight the major findings of the study.

Case A:

> Mrs. A. was a 24-year-old married woman hailing from an economically-medium rural agricultural joint family who was brought to the psychiatric nursing home by her parents. She was suffering from depressive neurosis with the diagnosed symptoms of abnormal behaviour, insecurity, sleeplessness, restlessness, reduced appetite and sudden bouts of crying without any apparent reason.
>
> Due to the mental illness of her father during her childhood and later, all her needs were met by her four elder brothers, giving others the impression that she was over-protected.
>
> Mrs. A. was married into a joint family consisting of her husband, his parents, brothers and married sisters. They lived in an urban area combining farming and business as means of livelihood. The mother-in-law was the most powerful and dominating person in the family, commanding respect and taking all the decisions. She was active, good-looking, well-dressed, sociable and busy in keeping herself, as well as the house, tidy and in order. She was considered to be the life line of the house, filling the house-gatherings with joy and making her presence felt on all occasions. She expected these qualities and skills in her daughter-in-law also.
>
> Everything went smoothly for about two years until the birth of a girl to Mrs. A. and then the problems began taking a toll upon the health and behaviour of Mrs. A. Eventually Mrs. A. was despatched to her parents' home on the pretext that a change in the environment might help her return to normal. However, this did not happen and she was admitted to a psychiatric nursing home by her parents. During the total period of treatment all the expenses for board, lodging and medicines were met by her parents and brothers. They stayed with her all the time. Her husband and his parents paid occasional visits but did not stay with her. All the responsibility for care and support was borne by her parents and brothers. This is in keeping with the Indian situation where even after marriage a daughter remains the liability of her parents, a situation continuing into old age.

The discussions and interviews with her husband, mother-in-law, other members of the family, their friends, Mrs. A.'s mother and brothers revealed a gamut of factors associated with the problem.

It was observed that during her childhood the harmony of family relationships was disturbed due to the illness of her father and over-spending on his treatment. Thus economic strains became apparent and she received insufficient guidance and care for healthy personality development. She could not cope with the work demands and needs of the house of her husband.

In interviews, Mrs. A. appeared dull and was introverted in her behaviour. Others said that she did not participate in the household activities and decisions. She preferred seclusion and did not participate in social functions in the house. Her husband and mother-in-law tried in vain to persuade her to join friends in discussions and to present herself in a happy way. However, when the mother-in-law joined the company she became the centre of attention because of her attractive personality and the charm that she added to the parties. Mrs. A. found this intolerable. The mere presence of her mother-in-law irritated her. She seemed to be envious of her. While all the activities in the house continued, Mrs. A. started receding into her self and communicated with others very rarely. She appreciated her father-in-law and husband, but condemned her mother-in-law and sister-in-law. She found it easier to relate to members of the opposite sex.

Members of both the families were involved in the treatment plan and rehabilitation of Mrs. A. Her brothers and parents provided emotional support and met costs for medical treatment and other expenses. Through their persuasion, involvement of other relatives and mediation they were able to restore Mrs. A. to her husband and his household. Repeated counselling of her husband and mother-in-law proved fruitful. A task-oriented social case work model was used in which both Mrs. A. and her mother-in-law were assigned some tasks that ensured a close interaction between both of them as well as other members of the family. Mrs. A. was associated with decision-making processes, household and recreational activities; she participated in domestic work and the household's social and religious functions, and was able to meet the requirements and expectations which earlier she had not been able to fulfil. Thus, the counselling and the involvement of different members of both families helped in Mrs. A.'s rehabilitation biologically, psychologically and socially.

One of the major tasks faced by the social worker was to co-ordinate the interaction between Mrs. A. and her husband, Mrs. A. and her mother-in-law, and the two families. The initial and major problem was to resume the disrupted communication channels between the two families that paved the way for further action. During their visits to Mrs. A. both families were contacted, discussions were held, counselling was done and both families were brought together around the discussion table. According to traditions, and in terms of relationships, the in-laws of girls are considered superior and under such circumstances they have an inflated ego. The mother-in-law, particularly when she is in charge of all the decisions and family affairs, is the most difficult person to communicate with and convince. Such traditions and values provide her with a special place in the family. Within the framework of such traditions, the uphill task of re-establishing the interactional channels was achieved.

Case B:

Mrs. B. was a 23-year-old married woman who was brought to the psychiatric ward of the government hospital by her parents. She complained of body aches, depression, numbness of limbs, sadness, sudden weeping without any apparent reason, and poor appetite. She had suffered disturbed sleep as well as having fits for about six months.

Mrs. B. was married into a joint urban business family and shared a household with her husband, his parents, married and unmarried brothers and sisters. She was the youngest child in her family and was married to the eldest boy of the in-law's family. Before marriage she had no problems. In her own family she was well looked after and had a pleasant personality. She gave birth to a son after about two years of marriage.

In the family of her in-laws, her husband, his younger brother and father looked after the business. At home, her mother-in-law dominated the scene and took decisions in almost all family affairs. She decided what to spend money on and who would spend it. She had the last word regarding decisions about food and clothing for different members.

As Mrs. B.'s son was her first issue, she wanted to bring him up very well with every care in every way. She wanted to feed him properly. She herself wanted to eat properly, wear good clothes and jewellery, desired to go out with her husband and participate actively in home affairs. But all this was not acceptable to her mother-in-law. The mother-in-law did not allow Mrs. B. to have a nutritious diet, nor to give milk and good food to her small son. She did not permit Mrs. B. to go out with her husband. All the clothes and jewellery given to Mrs. B. by her own parents were kept under lock and key by her mother-in-law.

Anxiety and tension started brewing in the mind of Mrs.B. She was being denied the kind of life she desired to lead. Her emotions and desires were being suppressed. The last straw came when Mrs. B.'s husband attempted suicide over family and business problems. This led to psychological disturbances resulting in fits which further aggravated sleeplessness, sadness, sudden crying and numbness of limbs. Initially her husband and in-laws consulted doctors but finally, after a few months, she was sent to her parents' place along with her son. Her parents accepted the responsibility and brought her to the psychiatric wing of the government hospital. Her parents paid for everything needed during her hospitalization. Her elder sister stayed with her to look after the child. They thought that if the child was to be with her it might help in her cure. Her in-laws came very rarely and were not prepared to contribute to the costs of treatment. Mrs. B. knew of this and even thought of committing suicide, often telling her parents to look after the child if she died.

Though the psychiatrist administered drug therapy, the social worker was responsible for intervening in Mrs.B.'s social and family environment. It became necessary to understand the structure and expectations in both families; to know the areas and aspects of personalities of different people who could be or already were involved in treatment, and how modifications could be brought about.

Many facts were gathered from the parents and sister of Mrs. B. who were readily available. An opportunity to make contact was seized during visits by her husband and mother-in-law. They were interviewed and discussions were held. It was observed that there was a clash of egos and a communication gap between Mrs. B. and her mother-in-law. Mrs. B. over-reacted to her mother-in-law and refused to submit to her authority. Gradually this had resulted in strained relationhips between different members of the family, who blamed one another for the aggravated situation.

A number of sessions were needed to bring about the change in the attitudes of different members of both families and mediation was attempted to try and bring them closer. Different members were counselled separately and were encouraged to re-establish the positive communications between them that had existed before the crisis situation arose. Mrs. B.'s husband and mother-in-law co-operated in the rehabilitation. Much persuasion was needed to bring about a modification in the behaviour of Mrs. B. and long-term support was needed to increase and maintain her self-confidence but Mrs. B. was restored to her husband and in-laws where they accepted her and were helpful in her rehabilitation.

Case C:

Mrs. C. was brought to the psychiatric wing of the government hospital by her mother. She had been deserted by her husband and had emotional and psychological disturbances. As a result she suffered from physical ailments also. She hailed from a rural background where her parents had a general shop. She was in her late thirties with three children and lived with her parents.

Even before marriage her husband had gambled and drunk alcohol excessively. His parents thought that he would change his behaviour after marriage. However, after marriage his drinking and gambling increased. As a consequence he could not concentrate on his family business and it started suffering losses, causing strained relationships with other members of the family. In the meantime he had three children.

As the conflicts in the family increased her husband rented a separate house and all of them started living there. As he did not work, he took money and jewellery from his wife and left for Delhi to start a business. He did not pay the rent and expenses for the family. Eventually his visits home ceased. The resulting shock and economic problems led to the development of psychiatric symptoms.

Her parents took her and her children to their house and started looking after them. Mrs. C. suffered from body aches, depression and started sleeping more and more, becoming indifferent to all activities and people.

Mrs. C.'s in-laws never came to see her and the children and showed no care or concern for them. Her parents were the only ones to look after them. She received medication for depression. Whenever she visited the hospital she was accompanied by her mother. During our interviews she expressed concern about the welfare of her children but was not in a position physically, psychologically or economically to do anything about it. Through counselling, her self-confidence gradually began to return and she started coming to the hospital alone. Prolonged counselling proved fruitful. She started conversing with her family members, started discussing her own and her children's problems, and accepted advice. She began to work, taking in sewing at home, to earn money with which she could meet minor expenses for her children and the household. She developed more confidence and could even contemplate the possibility of leading an independent life without becoming a burden on anybody.

In this case there was no problem of co-ordination between the two families as the client did not expect anything from the family of her husband. More attention had to be paid to helping the client develop confidence in her own capabilities, helping her to shed fear and become economically independent. Encouraging her to be responsible for her children and their welfare evoked a positive response that helped in her rehabilitation, emotionally and economically. Socially, she started communicating more frequently with people around her.

Discussions and conclusions

All the clients in the study who reported to the psychiatric institutions suffered from depressive neurosis. The causative factors identified during investigation were predominantly social and cultural rather than constitutional and hereditary.

All the clients hailed from rural areas where the traditional character of values, attitudes and relationships played a crucial rôle. These women were unaware of (a) the structure of the family where they were to be married, (b) the habits and attitudes of their prospective mates, (c) the total environment of the family of their in-laws, and (d) the situations they were to face after marriage. Transplanted into completely alien environments they confronted entirely different situations than prevailed in their parents' homes. The most hostile person was the mother-in-law who dominated all decisions and family affairs. She did not allow her daughter-in-law to be an equal partner in decision-making processes. This resulted in reduced interaction and disruption of communication between the clients and other members of the family. The outcome in all the cases was psychological disorders manifested in various forms. One of the main causes was that the mother-in-law had an inflated ego which was difficult for the daughter-in-law to satisfy.

In the above situations, it was not only the patients who were put under treatment but also the members of both families (natal and marriage) who were actively involved in the environmental modification. Therefore the treatment was a multi-dimensional process. The parents' rôle emerged as more effective and forthcoming. They played a more constructive and crucial rôle in helping to restore the patients to their normal selves through their supportive rôle in treatment and rehabilitation. Both families and society consider the presence of a psychologically disturbed person among them as a social stigma. Thus, the rôle of the family is both clear and important, not only in overcoming the stressful situations arising out of the behavioural disorders of an individual, but also as an agency of tension management and rehabilitation.

ENDNOTES

1. Twenty cases were included in the present study. All of them were married women drawn from rural areas.

   These twenty women suffered from the following psychological disorders:

Psychological disorder	No.	%
Depressive neurosis	6	30
Anxiety	4	20
Psychosomatic illness	4	20
Behavioural and adjustment problems	6	30

Most of them had suffered from these disorders from between six months to two years.

All of the subjects in this research were treated as psychiatric in-patients for a period ranging between three and four months. They were brought to the clinic only when the illness became acute.

REFERENCES

Coleman, J.C. (1976) *Abnormal Psychology and Modern Life*. LosAngeles: Scott, Foreman & Co.

Desai, Murli and Shalini Bharat (1989) 'Research on families with problems in India' (seminar report). April 17-20, 1989, Tata Institute of Social Science, Bombay. *Indian Journal of Social Work*, Vol. L, No. 4, 531-543.

Falloon, I., et al. (1986) 'Family support versus family pathology'. *Journal of Family Therapy*, Vol. 8, 351-369

Johnson, L.C. (1989) *Social Work Practice - A Generalistic Approach* (3rd ed.) Boston; Allyn and Bacon.

Laing, R.D. (1972) *Series and Nexus in the Family*. London: Penguin Books

Laing, R.D. (1976) *The Politics of Family*. London: Penguin Books.

Lingam, L. (1981) 'Sex-detection tests and female foeticide: discrimation before birth'. *Indian Journal of Social Work*, Vol. LII, No. 1, 13-19.

Pearson, V. and Jin, Dezhen. (1992) 'The view from below: the experience of psychiatric service consumers in China'. *Asia Pacific Journal of Social Work*, Vol. 2, No. 1, 45-55.

DEVELOPMENT OF A NEW PERSPECTIVE ON THE RôLE OF THE SOCIAL WORK AND NURSING PROFESSIONS IN PSYCHIATRIC REHABILITATION IN THE INDIAN CONTEXT

by

Urmil Sharma

Being a signatory to the Alma Ata Declaration, India is committed to the attainment of 'Health for All' (HFA) by the year 2,000 AD. In moving towards this objective, the Government of India initiated Rural Health Programmes during the Fifth Five Year Plan (1974-1979). Later, according to the National Health Policy 1983, a network of comprehensive primary health services, linked to an extension and health education approach, was also to be established.

The Alma Ata Conference strongly reaffirmed that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The deliberations also viewed health as a fundamental human right and that the attainment of the highest possible level of health is a most important goal worldwide, whose realization requires the action of many other social and economic sectors in addition to the health sector.

To achieve a complete state of health, mental health components need to be integrated with general health care services. The International Conference on Primary Health Care has included promotion of mental health as one of the components of Primary Health Care. The Conference Report recommends that primary health care should include at least:

> "Education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases;

> prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of *Mental Health* (emphasis supplied); and provision of essential drugs." (1978, p.73)

Since the individual needs to be taken care of as a totality, physical and mental health cannot be dealt with independently. In other words, mental health has to be an integrated part of the health delivery system and also a part of the developmental services rendered by various sectors of development.

Over the years the major attributes of the changing socio-economic scenario have been greater industrialization and urbanization, leading to break-up of the joint family system, migration, housing shortages, over-crowding, unemployment, poverty and the growing number of slums. The unbridled pursuit of material wealth and stark individualism further compound the problem, making it very hard for the individual, family and the community at large to cope with the resultant tensions, leading to increasing incidence of mental health problems.

No precise estimates are available about the extent of these problems for the country as a whole. The Bhore Committee (Health Survey and Development Committee, 1946), considered problems of mental patients as two per thousand. Some other surveys in India reveal that 2-3% of the population suffers from a major mental illness such as schizophrenia, severe depression or mental retardation, whilst another 10-15% suffer from other minor psychiatric problems and emotional disturbances in their lifetime, and these illnesses can be grouped under neuroses (Sethi et al., 1967, 1972; Verghese et al., 1973). Thus, about 125 million of the population suffers from one or other mental illness and this is likely to be a matter of concern if the goal of 'health for all' is to be attained by 2,000 AD.

The existing institutionalized system in the form of 45 mental hospitals (20,651 beds), general hospitals' psychiatric units having 30-50 beds (about 2,000 beds in all) and Child Guidance Centres in a few urban pockets is totally inadequate to cope with this vast population's mental health problems. (Health Information for India, 1990). There are in all only 1,500 psychiatrists in the country, and 400-500 clinical psychologists. The number of psychiatric social workers is estimated to be between 200-300, and psychiatric nurses to be about 500. These figures come from the National Mental Health Programme, 1990 and D'Souza and D'Souza, 1984.

The above is beside the fact that the existing mental hospitals do not cover all the states, one-third of them being located in one single state, Maharashtra. Maharashtra has played a leading rôle in the development of health and welfare services from the period when India was under British rule and subsequently ofter India's Independence. The total admission to these mental hospitals in a year during 1989 amounted to 45,140 (data in regard to 30 hospitals). These cases were diagnosed as: Psychoses - 38,330; Neuroses - 5,942 and Mental Retardation - 868.

It is obvious that only a small percentage of cases approach these hospitals. In fact, hospitals are usually approached only in cases of a more severe nature, the large number of neurotics rarely going for treatment at these institutions because of a variety of reasons. In addition, the existing facilities, being mainly urban based, are beyond the reach of the rural population. It would be more appropriate to bring the mental health facilities to the people in rural areas by integrating the mental health component in the existing health service model: providing services through sub-centres, Primary Health Centres (PHCs) and social welfare organizations such as *Anganwadis*, *Mahila Mandals*, educational institutions, etc.

Clearly, the existing infra-structure cannot do justice to the needs of the country in the area of mental health. The answer, therefore, lies in developing a community-based approach wherein the existing primary health care and social welfare network can be empowered to cope more effectively with the problem. This, to my mind, can be done by educating and re-training the existing personnel who can then take care of people's needs within the community. Operationally, this will mean close involvement of the social work and health professionals, particularly those working at the grass roots level as well as those responsible for their learning.

Realizing the gravity of the situation, some efforts are underway in fostering community mental health prorammes. Specifically, this includes the Government's National Mental Health Programme (NMHP) launched in 1982. The objective of the NMHP is to ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population. Still in its infancy, the NMHP has developed programmes of an *ad hoc* nature, particularly for physicians and para-medical personnel.

The present paper attempts to highlight the limitations of the existing institutional model for providing psychiatric rehabilitation. It also tries to identify the key rôles that need to be played by the social work and nursing professionals in improving the scope of the existing services. In addition, it presents some vital areas which need to be attempted in the reorientation of both the professions.

THE RôLE OF THE SOCIAL WORK AND NURSING PROFESSIONS IN PSYCHIATRIC REHABILITATION

Social work

Psychiatric social work plays a crucial rôle in the institutional setting as well as in the prevention and rehabilitation of mental illness. Unfortunately, however, the psychiatric personnel are far short of the required numbers and their existing workload makes it impossible to undertake preventive functions.

The psychiatric social workers in the hospital setting deal primarily with cases of social maladjustment, including personality problems, neurosis or psychosis in the initial stages. The areas of work may involve social case work, group work, family therapy, educational work, administration and executive activies. *Vis à vis* the emerging needs, it is obvious that the psychiatric social worker's rôle needs to be extended to the broader front of community-based services.

It is relevant to mention here that it is not only the trained psychiatric social workers but practically all the social workers who must equip themselves with the knowledge of mental health problems. This is an ideal way to strengthen the area of preventive mental health practice as well as the rehabilitative aspects.

The main rôles which are expected from social workers are as follows:

1. educating the community about mental health and thus preventing mental illness;
2. creating awareness of mental health problems and their association with physical health;
3. helping in early detection of mental illness and timely intervention to institute remedial measures, preferably at the community level;
4. helping the family and the community to take care of the mentally sick in the family;
5. utilizing community resources and helping people to accept and rehabilitate the mentally ill in order to help them to lead a healthy life;
6. involving the community in instituting various mental health programmes;
7. training the social work professionals and other functionaries in the broad field of social development to promote mental health amongst the masses;
8. working in co-ordination and collaboration with various community-level agencies engaged in health, welfare and other developmental tasks.

The nursing profession

Nurses are key functionaries of the health delivery system both in the rural and urban sectors. At present their rôle is by and large confined to providing curative services to the mentally sick in mental hospitals and psychiatric units. With the adoption of a primary health care approach, this limited rôle needs to change.

Currently, the nursing professionals perform administrative as well as direct-service functions at various levels. A close look at their job responsibilities reveals that these do not include the functions related to mental health. Experience has shown that the health workers and health assistants are engaged mainly in Maternal and Child Health and Family Planning activities. Health education is an important area entrusted to them but it does not receive the importance which it deserves. As far as nurses working in hospitals at district and sub-district levels are concerned, they rarely extend services in the field of mental health and mental illness.

Being a key component in providing services at all levels of primary health care, the nursing profession needs to be optimally utilized to promote both physical as well as mental health amongst the rural masses. The rôle may vary at different levels but broadly it should include the following:

1. Prevention of mental illness in the community by creating community awareness and educating people about mental health in general.

2. Involving the community in organizing various mental health care activities. This will include educating the family and the community about the association between mental and physical illness and providing holistic health care to the people.

3. Early detection of cases of mental illness and their referral.

4. Providing domiciliary care to the mentally ill.

5. Seeking the family's co-operation and preparing the family to take care of the mentally ill within the family itself.

6. Actively seeking the co-operation of other professionals in the rehabilitation of the mentally ill.

7. Training of nursing professionals (including re-training of the existing staff) responsible for providing primary health care and supervising their

activities. Here, training of functionaries engaged in other health-related and developmental tasks is equally important.

TRAINING OF PROFESSIONAL SOCIAL WORKERS AND NURSES IN MENTAL HEALTH AND PSYCHIATRIC CARE

Professional social workers

Health is a concern of social workers working in any field of social work. Whether working as trainers, administrators, researchers, policy makers or at the direct service level, health is one of the prime issues which all these functionaries need to look after, with mental health as one of its vital components. With the adoption of the primary health care approach, it behoves social workers to deal with health issues through a community approach. In view of this, every social worker needs to have the knowledge and skill to take care of the physical and mental health of the community.

Elementary information about Medical and Psychiatric Social Work as an area of social work practice is included in the Master's Degree curriculum of most of the schools of social work. Some schools also offer this subject as an 'elective' or as a 'field of special interest' to about 10-13 students each year. The course curriculum at the undergraduate level provides a still more scanty exposure to the medical and psychiatric settings to students which hardly equips them to deal with psychiatric cases. Besides a few schools of social work, the National Institute of Mental Health and Neuro Sciences (NIMHANS) is the only institution which provides an M.Phil. degree in Psychiatric Social Work to about ten students each year.

With regard to the above, it is essential that students opting for Medical and Psychiatric Social Work must also have greater inputs of medical and psychiatric aspects of various ailments. Different aspects of diseases need to be stressed, such as epidemiology, its origin, cause, effect on body and mind, treatment of various types, prognosis, rehabilitation, etc. It is only when these components are strengthened that the social workers may be able to do justice to their function as Counsellors *vis à vis* psychiatric illness. Students with a background in psychology, especially clinical psychology, should be encouraged to take the elective paper in Medical and Psychiatric Social Work.

With only about 200-300 trained psychiatric social workers in the country, it is not possible to do justice to the needs of the mentally ill. One of the reasons for this is that these social workers are more or less confined to the institutions where they are employed. Often their case load is so high as to make it virtually impossible for them to extend their services to the community at large; nor have they been trained to function in the mental health field at the community level.

A beginning can be made to tackle the issue more effectively by initiating an Orientation Course in Psychiatric Rehabilitation covering various aspects of Mental Health and Psychiatry in the community setting (see Appendix I). Designed to develop basic knowledge of and skills in functioning in the area of mental health and psychiatric disorders, the course may enable the learner to provide: (a) 'on the spot' assistance to the mentally ill and their families, and (b) the development of preventive mental health and rehabilitative programmes with community involvement.

The course may initially concentrate on training of trainers of such health and social welfare functionaries who are working at the grass roots level. Schools of social work as well as colleges of nursing and other training institutions can take a lead in imparting such training to the existing functionaries as well as for new entrants charged with the implementation of community health programmes.

Nurses

Training of nursing professionals is carried out through colleges and schools of nursing attached to hospitals and rural health training centres (see Appendix II). The figures in Appendix II clearly reveal that the training facilities and trained nursing manpower is far too inadequate to cater for the vast needs of providing primary health care for a country such as India. *As far as training in psychiatric nursing is concerned, from 1950 to 1985 only 632 nurses have undergone a Diploma course in Psychiatric Nursing.* In contrast, the Diploma in Public Health Nursing was awarded to 2,388 nurses during the same period. Obviously, the number of nurses trained in psychiatric care is merely a drop in the ocean. Only two institutions provide training in psychiatric nursing and the number of psychiatric nurses is estimated to be around 500 only. (National Convention of Nurses, 1988, p.16)

Training of graduate nurses

The syllabus and regulations suggested for the training of B.Sc.Nursing by the Indian Nursing Council (1981) includes a paper on Mental Health Nursing during the 3rd year, and a total of only 3 hours are devoted to cover topics such as historical perspective, community mental health, trends in mental health, communication skills, principles and nursing care of the mentally ill patients, legal aspects, community acceptance and rehabilitation of the mentally ill, etc. For practical experience, students are placed in psychiatric wards for a period ranging from 15 days to one month, spending 4-5 hours a day, 4 days a week.

The syllabus needs a revision in the light of the emerging rôle that nurses are expected to play with the launching of the NMHP. In terms of practice, the existing course gives only a brief exposure to the student to provide care to the mentally ill within the hospital. During their field training no emphasis is placed on the importance of mental health and care of the mentally ill within the community. This is in spite of the fact that training does include subjects such as community health, topics on communication, health education and the basics of sociology and psychology.

In sum, institutionalized care is stressed all along. Students of the nursing profession are hardly attuned to the socio-cultural diversities prevailing in different sections of society and the importance in caring for the mentally ill through primary health care network. The trainees are not even aware of various developmental programmes and people engaged in the delivery of different services with whom they need to cooperate to make the programme more effective. Psychiatric nursing at the community level has no place in the training.

Training of diploma nurses, health assistants and health workers

The syllabus for courses in general nursing and midwifery devote in all 30 hours to psychiatric nursing for instructions and supervised practicals out of a total course duration of 3,265 hours *(less than 1%)*. For examination purposes there is a combined paper covering paediatric nursing, mental health and psychiatric nursing both in theory and practicals. This combination does not appear to be appropriate to foster mental health programmes. The topics covered under psychiatric nursing include definition, aetiology, legal aspects, community responsibility, diagnosis, management, physical and psychotherapy, and the rôle of nursing. Topics on rehabilitation cover acceptance in the family, re-employment and follow-up.

Health workers or the ANMs undergo a course of 18 months' duration (1,260 instructional hours). The course content consists of topics such as normal/abnormal behaviour, causative and predisposing factors of mental illness and use of various family and community resources. It also covers topics on human relations and communication, prevention of mental illness, early detection of mental disorders, and responsibilities of health workers, individual, family and community for prevention, early detection, care and acceptance of the mentally ill. Behaviour problems such as psychosomatic diseases, drug dependence/addiction and personality disorders are also included. Basic therapies, psychiatric emergencies and legal aspects, etc. are also a part of the theory sections. Here as well one cannot fail to observe that *mental diseases are covered through theory sessions of only 15 hours out of 1,260 instructional hours*.

After acquiring some experience, the health workers (female) become eligible for promotion and are required to undergo a Health Supervisor's course (promotional training of ANM) of six months' duration. Even this course does not mention mental illness and the NMHP, nor the rôle of the Lady Health Visitors (Health Worker - Female) in the prevention, detection, care and rehabilitation of patients with mental illness or drug dependence. These topics need to be included and the concept of total health needs to be inculcated amongst mental health workers.

The suggested syllabus for the Nurses' Diploma does not cover the mental health components of domiciliary care of the mentally ill. It lays no emphasis on prevention of mental illness, has no mention of socio-cultural diversities, communication skills required for the care of the mentally ill, and the rôle of nurses specifically in the NMHP. In the syllabus the paper on Health Education and Communication Skills needs to cover topics such as the rôle of the media, mass communication, essentials of communication, and research and evaluation of the impact of the messages delivered.

The trainers need to be made aware of the existing community level development programmes and the rôle of the various functionaries in promoting the health/mental health of the people. They should learn to channel the various resources and people's involvement in promoting mental health in the community. Their changing rôle with the launching of the NMHP should also be emphasized. During their summer duties, nursing of the mentally ill within the community should be made a compulsory assignment in the courses at graduation level and that of the general nurses' level. Extensive training should be given in developing skills for identifying vulnerable sections of society who are prone to mental illness and others having psychosomatic problems who frequently present themselves at the PHCs or sub-centres with physical illness. Association between physical and mental health needs to be stressed during the training period. Emphasis also needs to be placed on socio-cultural diversities. A similar orientation, to meet the needs of the Health Assistants and ANMs for dealing with the mentally ill, needs to be worked out.

Clearly, to achieve the goal of mental health, a small fraction of the available psychiatric nurses is not the answer. Instead, the nursing community as a whole should be equipped to provide community-level services or primary health care services. The foregoing analysis of nurses' training at various levels underscores that serious thought needs to be given to equip the nursing professionals in imparting an integrated health service at the community level. As suggested, training and reorientation of both categories of professionals can be jointly undertaken by the schools of social work as well as by those institutions currently training nurses.

APPENDIX I

SUGGESTED CURRICULUM FOR AN ORIENTATION COURSE IN PSYCHIATRIC REHABILITATION

Duration	Two months (45 working days)
Teaching Span42	
Teaching Hours	42 x 7 = 294 hours

Objective:

To develop community-based preventive, promotive and rehabilitative services for the psychiatrically ill, and to integrate these within the broad framework of Community Health Services.

Course participants:

Staff members in the psychiatric settings with extension units in the community;
Child guidance centre staff;
Child Development Project Officers, supervisors and the grass roots level *Anganwadi* workers in the Integrated Child Development Service Scheme;
Block Development Officers under the Rural Community Development programme;
Welfare Officers in the State Sector, prisons and children's institutions;
Teachers in schools of social work;
Urban and Rural Community Organizers/Workers;
Functionaries of voluntary agencies engaged in health and related activities in the community;
Public Health Nurses, Health Assistants, trainers from the colleges and schools of nursing.

The course is intended to equip participants with the appropriate knowledge and skills for the promotion of psychiatric rehabilitation at the macro-level.

Suggested topics

1. The human body and its composition. Relationship between mind and body.

2. Physical and mental health and ill health: concept, process and relationship. Concept of normal and abnormal behaviour. Abnormal behaviour: causes, intrinsic, extrinsic, predisposing and precipitating factors.
3. Historic developments in the field of mental health, with particular reference to community mental health. Incidence of mental illness in India.
4. Contemporary approaches to the study of mental illness, mental hygiene, social psychiatry and community health.
5. Psychosomatic medicine: concept, etiology and treatment.
6. Socio-cultural and environmental factors influencing medical care, with special reference to mental health.
7. Personality: concept and theories of personality.
8. Prevention of mental illness: (a) psychological and social needs at various stages of development; (b) basic skills - human relations and communication skills; (c) awareness building and educating the family/community about mental health/mental illness; (d) caring for people with childhood problems; problems associated with adolescence and adulthood; problems of the elderly.
9. Identification and assessment of the mentally ill: implications for institutional and community management.
10. Mental illness and mental retardation.
11. Review of the health care delivery system: organization and administration of programmes for the mentally ill.
12. Social/welfare services at the community level. Domiciliary care of the mentally ill.
13. Institutional care of the mentally ill: mental hospitals, psychiatric departments of general hospitals; child guidance clinics, etc.
14. Management of the mentally ill in the community through PHCs/community-level welfare network.
15. Mental health as a component of primary health care. National Health policy and programmes. Mental Health Act 1981, and emerging rôle of health and social welfare professionals in promoting mental health.
16. Interaction of family and the mentally ill: implications, ignorance about mental illness and consequences, social stigma. Value of family care and support for the mentally ill.
17. Identification of the community's perception of and attitude towards mental illness. Creation of a positive attitude in dealing with the mentally ill.
18. Assessment of the rôle of health and social welfare functionaries in prevention, care, cure and rehabilitation of the mentally ill.
19. Rôle of indigenous systems of medicines in coping with the mentally ill. Need for co-operation and co-ordination.
20. Identification of the rôle of an integrated approach for health care and the place of mental health care in the overall service delivery system.

21. Rôle of vocational rehabilitation in managing the mentally ill.
22. Rôle of research in identification, care and rehabilitation of the mentally ill and facilities for their care.

APPENDIX II

SOME FACTS AND FIGURES ABOUT NURSING PROFESSIONALS' TRAINING IN INDIA

No. of Registered General Nurses and Midwives*	24,500
No. of Training Institutions for Diploma/ Certificate holders*	421
Annual turnover*	10,092
No. of Institutions Training Graduate Nurses	19
Annual turnover**	454
No. of Postgraduate Nursing Training Institutions**	8
Annual turnover**	47
Auxiliary Nurse/Midwife/Health Workers' Training Centres*	490
Annual turnover	15,538
No. of Registered Auxiliary Nurse Midwives/ Health Workers*	132,923
Health Supervisors Training Institutions	13
Institutions for training Health Visitors to be promoted to the position of Public Health Nurses	2
No. of Registered Health Visitors/ Health Assistants	15,817

** Figures for 1986

* Figures for 1988

Sources', Government of India; Health Information of India, 1990, pp.65-71
Government of India; National Convention of Nurses, 1988, p.12

APPENDIX III

AN OVERVIEW OF THE EXISTING HEALTH AND WELFARE SERVICES

Agency*	Staff	Coverage
Sub-centre	1 male health worker	5,000 population
Primary Health Centre	1 Medical Officer Block Extension Educator 1 Male Health Assistant 1 Female Health Assistant	30,000 "
Community Health Centre	Medical Specialists Nurses Para-medical staff	1 Block with 100,000 population
I.C.D.S. Projects**	Project Officer Supervisors *Anganwadi* Workers	

District-level Health Centres and sub-divisional health centres with more specialised services and wider coverage.

* By 1.4.90 the number of sub-centres and PHCs functioning was 130,390 and 20,530 respectively. Community Health Centres numbered 1,852. Based on an estimated population of 822 million (638.69 rural and 183.31 urban), each sub-centre covered nearly 6,300 population and each PHC 40,000.

** Integrated Child Development Service scheme, providing services to children and mothers. About 2,529 projects in operation by March 1989. The key person is the *Anganwadi* worker numbering about 1.89 million.

Other agencies functioning at the community level include *GramMahila Kendras*, Youth Welfare Centres, *Balwadis*, and voluntary agencies.

With this infra-structure set out for the countryside, delivery of health services is to be rendered to meet the challenges facing 77.7% of the rural population, i.e. approximately 600 million+ persons.

REFERENCES

D'Souza, A. and D'Souza, D.A. (1984) *Psychiatry in India*, Bombay: Bhalani Book Depot.

Sharma, U. (1991) *Annual Report 1990-91*. Dept. of Women and Child Development, Ministry of Human Resources Development. New Delhi: Government of India.

Sharma, U. (1991) *Annual Report 1990-91*. Ministry of Health & Family Welfare. New Delhi: Government of India.

Anon. (1985) *Compendium of Recommendations of various Committees on Health Development 1943-1975*. Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health & Family Welfare. New Delhi: Government of India.

Sharma, U. (1980) *Curricula for Training of Staff of Primary Health Centers 1980*. Ministry of Health & Family Welfare. New Delhi: Government of India.

Sharma, U. (1987) *Encyclopaedia of Social Work in India, Vol.III*. Ministry of Welfare. Government of India.

Sharma, U. (1986) *Handbook on Social Welfare Statistics*. Ministry of Welfare. Government of India.

Sharma, U. (1990) *Health Information of India, 1990*. Central Bureau of Health Intelligence, DGHS, Ministry of Health & Family Welfare. New Delhi: Government of India.

Sharma, U. (1988) *National Convention of Nurses*. Ministry of Health & Family Welfare. Government of India.

Sharma, U. (1984) *National Health Policy, 1983*. Ministry of Health & Family Welfare. Government of India.

Sharma, U. (1989) *National Mental Health Programmes for India - Progress Report for 1982-88*. Ministry of Health & Family Welfare. New Delhi: Government of India.

Sharma, U. (1980) *Primary Health Care Training Guide, Part II, Training of Community Health Volunteers*. Ministry of Health & Welfare. New Delhi: Government of India.

Sharma, U. (1981) *Report of the Working Group on Health for All by 2,000 A.D.* Ministry of Health & Family Welfare. NewDelhi: Government of India.

Sharma, U. (1991) *Survey of Causes of Death (Rural) Annual Report, 1989*. Office of the Registrar General, Ministry of Home Affairs. New Delhi: Government of India.

Sharma, U. (1977) *Syllabi and Regulations for Courses of Studies for Auxiliary Nurse Midwife*. New Delhi: Indian Nursing Council.

Sharma, U. (1985) *Syllabi and Regulations for Health Supervisors' (Female) Course, Revised Curriculum for Promotional Training for ANMs*. (Mimeo.) Indian Nursing Council

Sharma, U. (1986) *Syllabi and Regulations for the Courses in General Nursing.* New Delhi: Indian Nursing Council.

Sharma, U. (1981) *Syllabus for B.Sc. Nursing and Basic Regulations*. New Delhi: Indian Nursing Council.

Sharma, U. (1990) *Annual Report, 1989-90*. Bangalore: National Institute of Mental Health & Neuro Sciences.

Park, J.E. and Park, E. (1983) *Textbook of Preventive & Social Medicine*. Jabalpur: Banarsidas Bhanot.

Sharma, U. (1978) *Primary Health Care - Report of the International Conference on Primary Health Care,* Alma-Ata, USSR. WHO & UNICEF.

Glossary of Hindi Terms

Anganwadi

Akin to a tiny-tots' playground within the home. *Angan* refers to a small open compound within the home, while *Wadi* means a place of nurture, e.g. *Phulwadi* meaning a place where flowers grow (*Phul* = flower).

Balwadis

Bal = children. Hence *Balwadi* is a place where children can grow or flourish. A kind of nursery for children.

Gram Mahila Kendra

Rural Women's Centre. *Gram* = village, *Mahila* = woman, *Kendra* = Centre

Mahila Mandal

A women's Council (*Mandal* = Council)

A MODEL FOR CREATING COMMUNITY AWARENESS FOR EFFECTIVE REHABILITATION OF PSYCHIATRIC PATIENTS

by

R.M. Varma

Introduction

There is increasing realization worldwide of the serious lacunae in the existing industrial-urban model for ushering in rapid economic development. Unfortunately, however, practical efforts to tilt the scales in favour of corresponding social development continue to play second fiddle. In fact, measures for developing a just social order seem confined to the domain of intellectual exchanges and the production of attractive slogans as a part of political gimmickry in most cases.

Even a casual look vividly brings out the contradictions inherent in the so-called developed countries. Amongst their positive attributes are: low infant and maternal mortality, better nutritional standards, better health care facilities, longer life span, greater opportunities for upward mobility and higher income levels. All along, however, they also suffer from crass materialism, weakening family ties and resultant unbridled individualism, an ever-increasing pace of life, rising incidence of crime and violence and drug abuse, to name a few. It goes without saying that a major consequence of the *status quo* is a steady increase in the incidence of mental health problems.

Factors affecting resolution of mental health problems in India

The foregoing should offer no consolation to the developing nations which, having opted to follow the same model of economic development, are increasingly facing similar problems. Being no exception to this, India is also facing a spurt in the incidence of mental illness. Some idea of the magnitude of the problem can be had from the fact that over 100 million people in India need psychiatric care at one time or another,[1] while nearly two persons per thousand population (about 2 million) need active psychiatric care during their life span.[2]

The institutional infrastructure to cope with these vast numbers comprises 45 mental hospitals, 60 psychiatric units in teaching hospitals and only 25 out of a total of 380 district hospitals having psychiatric services.[3,4] In terms of geographic distribution, one-third of the mental hospitals are in one state. The state of Maharashtra has been in the forefront in terms of the provision of medical and psychiatric services. It also has the distinction of being in the vanguard of developing social reform and welfare services throughout the nineteenth and early twentieth centuries. To a considerable extent, this has come about because its capital, Bombay, has been known as the Gateway of India and has had maximum exposure to the Western way of thinking. Run mostly with Government funding, mental hospitals appear more like mental asylums. Most of them still administer somatic treatment.

While investment in health in India's national plans has gone up nearly 10 times, only about 7 per cent of it is earmarked for mental health services.[5] Consequently, with just one psychiatric bed per 7,000+ population, the existing system cannot serve even 10% of those requiring mental health care.[6] Further, since patients in hospitals are drawn from far off places, follow-up is rarely possible.

Even though nearly 100 psychiatrists are trained each year, a substantial section is lost to the country due to brain drain.[7] This apart, while 75 per cent of their patients live in rural areas, a majority of psychiatrists are located in urban areas with the rural population depending largely upon indigenous systems of health care.

One also comes across a high rate of wastage of psychiatric services due to financial difficulties, lack of time, physical incovenience, ignorance about the illness and public prejudice about psychiatric treatment. Doubts are often raised about the efficacy of psychotherapy in the Indian context. According to an authority, the average Indian is not interested in intra-psychic conflicts. Rather, he expects immediate relief from symptoms which can be achieved through administration of drugs and other physical methods.[8]

All these apart, there is another section of the population which continues to be neglected. Specifically, the reference here is towards those having learning difficulties or the so-called mentally retarded. In the absence of precise estimates one can, at best, make a guess about their numbers. According to one source, 0.5 per cent of the population falls in this category. Using this yardstick, their number can be anywhere around five million.[9]

A most unfortunate part of the situation is that families having persons from either category run from pillar to post, often spending their precious earnings in the hope of some kind of a cure. While relief may probably come about in some cases of the psychiatrically ill, there is no chance of having any succour for the mentally retarded. Yet the quest continues for sheer want of knowledge and information on the part of the parents and relatives.

As far as the mentally retarded are concerned, facilities for their care are conspicuous by their absence. While a few metropolitan cities have day-care centres to entertain those who are not yet adult, there is hardly any provision worth the name for the adult mentally retarded. All this is beside the fact that this category of people, especially during childhood, frequently gets either over-protected or treated very harshly. Outside the home they are often the subject of mockery by the neighbourhood. The process of ill-treatment continues even when some of them are admitted to a school. Since they find it difficult to cope with the requirements, even at the elementary levels, they are prone to be treated with disdain by many of their teachers who fail to recognize their learning disabilities. Continued failure at a given level further makes them the subject of ridicule by each new batch until such time as they are compelled to leave the school.

In a study of the 'Level of Development of Social Welfare in Delhi' spanning 20 years (1951-1971), the author found that not one person from this category was reported to be gainfully rehabilitated as far as the governmental statistics were concerned. (The few whom the author had seen to be gainfully employed were those whose relatives had taken pity on them and engaged them in some occupation suited to their capability.)[10] This is beside the fact that all kinds of attempts were made to 'cure' them. This included continuing medication of one type or another (allopathy, homeopathy, naturopathy, Ayurvedic and Unani); taking them to holy men 'renowned' for their miracle cures; getting them 'treated' by witch doctors who may beat them with brooms or sometimes even with a piece of hot iron to rid them of the evil spirit haunting them; getting them married (often with disastrous results), and so on.

Who, then, cares for the patients requiring psychiatric care as well as those with learning disabilities? The obvious answer still is *the family*. With their symptoms being frequently attributed to external factors such as demons, evil spirits, etc., the mentally ill are not held responsible for their condition and are, therefore, viewed as objects of care and sympathy. For the same reason, whether in a rural area or urban, mental illness is regarded as a problem of the family and not of the individual. Since it is thought of as a misfortune, it is not strongly stigmatized. This is unlike in the West where the mentally ill are prone to be stigmatized, alienated, devalued and even feared.

In the Indian culture, less severe types of illness such as hysteria, depression, neurosis, etc., are not even recognized as mental illness. Such individuals are usually expected to overcome their emotional problems on their own or through the family's co-operation. The family helps not only in retaining the integration of the mentally ill but also provides the necessary physical care, sympathy and support. For the same reason, hospitalization is avoided if possible because of the stigma it brings on the family and hence is considered as a last resort. Hospitals are usually approached only in the case of dangerous, unmanageable patients. Consequently, hospitals tend to be loaded with psychotic cases.

The existing infra-structure for the care of the mentally ill, while concentrated in urban areas, is, nevertheless, far too inadequate to cope with the rising incidence of mental health problems. This is beside the fact that, even in urban areas, only the elite can afford to utilize the psychiatrists' services. And the situation is becoming worse with the breakdown of the joint family, overcrowding, increasingly less dwelling space for the family, under-employment, unemployment and poverty. Consequently, the family's potential for the care of the mentally ill is consistently being eroded.

The position of the mentally retarded is in no way better. On the one hand, over-protection by the family creates a serious hurdle which prevents them from having access to the opportunities whereby they can learn to perform various chores suited to their physical and mental capability. This is beside the fact that a lot of parents express shock when their child is asked to perform tasks which they regard as menial. On the other hand, such individuals may also be severely ill-treated even by the family members who, unaware of their intellectual potential, have high expectations. Not infrequently the performance of such persons is compared with that of the other siblings, making the former resentful or even hostile.

Need for developing community awareness

In the emerging scenario, it is vital that the community at large is enabled to:

(a) acquire elementary knowledge whereby people can have at least some inkling whether an individual is having psychiatric problems or suffering from learning disabilities;

(b) reduce (if not totally do away with) the ignorance and prejudice surrounding the psychiatrically ill and those having learning disabilities;

(c) acquire basic know-how for the care of such persons;

(d) identify various factors within and outside the family which may aggravate the condition of the persons in either category;

(e) accept the need for proper treatment of the psychiatrically ill, and proper assessment of the potential of the mentally retarded, to evolve appropriate plans for their training and rehabilitation;

(f) create opportunities for the socio-economic rehabilitation of the psychiatrically ill and the mentally retarded, preferably within or near the neighbourhood where they live;

(g) institute community-level programmes to promote mental health;

(h) experiment and innovate, through non-Governmental agencies in the field, various measures for the care and rehabilitation of persons from both categories; and

(i) marshal public opinion through various forums to put pressure on the authorities to expand the preventive, remedial and rehabilitative infra-structure for such persons.

The underpinnings of effective rehabilitation comprise:

i) early identification of mental illness/retardation;

ii) acceptance of the person and his/her limitations by the family/society;

iii) provision of necessary care and support within the family and knowledge of avenues from where effective care, treatment and/or training may be obtained; and

iv) willingness on the part of the community to provide opportunities to such individuals to contribute their bit. In part, this will also mean that the families of persons with psychiatric problems learn to avoid creating situations which may create tension.

In the case of the mentally retarded, likewise, this will mean appropriate reduction of one's expectations from such individuals and, thereafter, providing opportunities for undertaking activities which they can gainfully pursue.

In regard to the foregoing, some months earlier a small field-level experiment was conducted in Delhi by the Department of Social Work, University of Delhi, in collaboration with the psychiatric unit of a large general hospital. In this experiment an attempt was made to create community awareness of the psychiatrically ill. The objective was to draw people's attention to the need for seeking proper medical advice for the psychiatrically ill in the village.

In attaining this objective, the Department's student (who was placed for her field work training in that village) decided to make personal enquiries from the villagers about the existence of such persons by going from door to door. The student social worker not only felt the process to be rather slow but also found considerable reluctance on the part of the families to volunteer details of such members who (possibly) had some psychiatric ailment.

To overcome the problem she organized street plays which depicted the psychiatrically ill, highlighting their behaviour and the implications of the behaviour for the rest of the family with the ill person. The street plays also highlighted the rôle of referral of such persons to the hospital, giving a ray of hope both to the patients as well as to their families. This was followed by the organization of small group discussions which were attended by the village women, the student social worker and the psychiatric social worker from the hospital.

This had the result of bringing the social worker closer to the majority of families. The worker also found to her delight that not only adults but even youngsters started coming to her to tell her about the presence of 'so-and-so' in a given family who behaved in the same way as was shown in the street play. The worker could thus locate such patients in a much shorter time. By discussing the cases with the psychiatric social worker, the student social worker could also offer 'on the spot' guidance to many families besides prompting them to seek the necessary medical advice from the doctors and the psychiatric social worker at the hospital.

Over a period of time the result was that the patients were brought regularly by their relatives to the doctors for consultation. It also ensured a gradual improvement in the home environment so that tension-producing situations were increasingly lessened. The author's interaction with the persons visiting a couple of Child Guidance Centres further confirms that it is possible to educate a community about the problems of the psychiatrically ill and those having learning difficulties.

To bring about community awareness on a large scale it is hoped to utilize both mass and folk media. The objective at all times has been to make people aware of the value of early identification of both mental illness as well as mental retardation, to know how to make the home environment more congenial and responsive to the needs of such individuals, to seek expert advice *vis-à-vis* care and rehabilitation and to ensure that the family and/or the neighbourhood collaborate in making rehabilitation an operational reality.

In the above context, because of its almost hypnotic audio-visual potential, television is expected to play a primary rôle in providing basic knowledge to the community on these aspects. As well as specially designed skits/plays, etc., depicting such individuals and the problems faced by them, discussions conducted by a team comprising a psychiatrist, a psychologist, a professional social worker and an occupational therapist can be televised. Using creatively presented visuals, such a team can not only educate the masses about various kinds of psychiatric ailments but also highlight how popular notions, fallacies, myths and fears can erode the chances of rehabilitation of such individuals.

Such a team can pursue a specific time schedule *vis à vis* various sections of the population in a city. For example, after making a series of presentations, the residents of various municipal wards can be informed of the dates and times when a particular team will visit their area. An appeal can, thereafter, be made to the residents of the intended area to write brief letters, preferably postcards, about the presence of such persons in their families and the problems faced. Such information can then be processed to find out the common queries and the cases requiring specialized attention.

Whilst the common answers can be televised and/or answered in the scheduled community meeting, cases requiring specialized attention and care can be informed of where help can be obtained. The effectiveness of the community-level meetings can be further enhanced by linking them to other audio-visual presentations, including short skits or street plays.

It is also worthwhile to consider the organization of such meetings for more captive audiences, e.g. in various educational institutions. The advantage of these meetings is that the exposure of such information is likely to be more readily absorbed by those audiences. In fact, meetings can be planned so that appropriate rôle play and similar other participatory sessions can be organized using some of the students themselves from the institutions.

A living example of the success of this approach can be seen in the manner in which the World Health Organization is attempting to propagate basic information about AIDS. The warm and spontaneous response which has been forthcoming in these sessions makes the author feel confident that problems associated with the rehabilitation of the psychiatrically ill can indeed be more effectively resolved through such an approach. All that is needed is a concerted drive and a willingness to innovate.

While one can argue that such an approach can be more readily adopted by a non-Governmental agency, the fact remains that even a governmental body should not hesitate to come forward to implement a project with such a *modus operandi*. The rationale for this statement lies in the fact that greater awareness on the part of the community will mean more effective rehabilitation of such persons within the community and by the community. It will also make possible more effective utilization of the existing institutional infra-structure by the people. An indirect but very vital benefit of all this can be the preservation of the family ties instead of straining the inter-personal relations on the issue of the care and rehabilitation of the psychiatrically ill and the mentally retarded. In the long run such an approach is also likely to be conducive to better utilization of the productivity of such individuals, with enhanced social adjustment.

ENDNOTES

(1) Interview with Dr. P.B. Buckshey, National Professor of Psychiatry and neurosciences, also Honorary Physician to the President of India. Former President, Indian Psychiatrists' Association, Dr. Buckshey House, NDSE -I, New Delhi 110 049.

(2) Government of India, *Compendium of Recommendations of various Committees on Health Development - 1943 - 1975*, (1985) Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health & Family Welfare, New Delhi.

(3) Government of India, *Health Information of India*, (1990) Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi.

(4) Verma, Ratna, *Psychiatric Social Work in India*, (1991) New Delhi; Sage Publications.

(5) Neki, J.S., `Psychiatry in South East Asia', *British Journal of Psychiatry,* quoted in Verma, Ratna, ibid.

(6) *Health Information of India*, 1990, op. cit.

(7) Government of India, INDIA, 1988-89, Ministry of Information and Broadcasting, New Delhi.

(8) Verma, Ratna, op. cit.

(9) Taylor W.W. & Taylor, I.W., *Services for the Handicapped in India*, International Society for the Rehabilitation of the Disabled, New York, 1970.

(10) Yadava, A.K.S. & Varma, R.M., *Level of Development of Social Welfare in the Union Territory of Delhi*, (1975) Dept. of Social Work, University of Delhi (Study sponsored by the Govt. of India), New Delhi.

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PSYCHIATRIC REHABILITATION IN JAPAN

by

Kunihiko Asai

Current policy developments

Until recently, Japanese psychiatry emphasized hospitalization where "treating and protecting mental patients" was regarded as the overriding objective. However, now the philosphy of community psychiatry has become as important as hospitalization.

Although the importance of community psychiatry has long been acknowledged in Japan, implementation has been relatively slow. For one thing, even today, the social rehabilitation of those with psychiatric disabilities is not supported by the government's welfare policy; this is still left to the goodwill of psychiatric hospitals or the patients' family associations. While many non-governmental psychiatric hospitals have begun rehabilitation services, their goodwill and effort alone are not sufficient.

The number of long-term patients in psychiatric hospitals is increasing every year. Now more than 50 per cent of residential patients have been in hospital for more than five years. The age of hospitalized patients, becoming older every year, has reached a peak of between 45 to 55 years old. Patients over 65 years old accounted for 22 per cent of all psychiatric patients in 1989.

According to the Statistics of the Ministry of Health and Welfare in 1990, out of 349,000 hospitalized patients, schizophrenic psychoses was the leading diagnosis (61%), affective psychoses (4.6%), senile and pre-senile organic psychotic conditions (9.3%), alcoholic and drug psychoses (6%), neurosis (6.2%), epilepsy (3.5%), and mental retardation (4.4%).

Figure 1

ESTIMATED NUMBERS OF MENTALLY DISORDERED PERSONS

Psychotic persons	1,600,000
Mentally retarded persons	400,000
Senile dementia	1,000,000
Persons drinking more than 150ml alcohol per day	2,000,000

Ministry of Health and Welfare, 1990

In 20 years' time it is estimated that the number of people with senile dementia will have doubled. Currently, 25 per cent of these patients are being treated in hospitals or other facilities.

In Japan there are neither special hospitals nor security units for mentally disordered offenders and refractory patients. Most of them are hospitalized in either public or private mental hospitals. With the progress of community care and open door treatment for hospitalized persons, the problems presented by mentally disordered offenders have become more important. The government is developing new policies to address this issue.

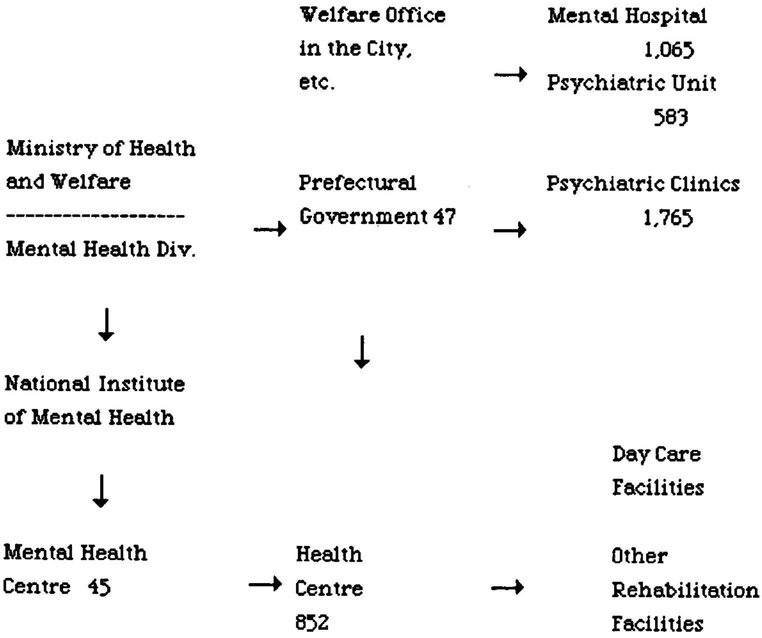
Current organization

The Mental Health Law is under the jurisdiction of the Mental Health Division of the Health Service Bureau of the Ministry of Health and Welfare. In each Prefecture government Departments of Public Health are in charge of mental health services. Most prefectures have a Mental Health Centre which has responsibility for promoting public mental health services and for information dissemination at the prefectural level through consultation services, training, education, research and surveys.

In local districts, consultations, supportive visits and other mental health activities are carried out mainly by mental health counsellors or public health nurses who belong to the Public Health Centres.

Figure 2

THE RELATIONSHIP BETWEEN ADMINISTRATIVE DEPARTMENTS AND INSTITUTIONS



There are 47 Prefectural Mental Health Centres and 852 Health Centres which co-ordinate the delivery of public mental health services including counselling, day care programmes, information dissemination and other services.

Figure 3

INSTITUTIONAL CARE	
Number of Institutions	1,655
Number of Psychiatric Beds	358,128
Psychiatric Beds per 10,000 population	28.4
Percentage of Beds Occupied	90%
Number of Outpatient Clinics	1,765
(18% of total psychiatric hospitals are public ones and 12% of beds are public)	

Ministry of Health & Welfare, 1990

Figure 4

TYPE OF ADMISSION	N	%
Total Number of Inpatients	349,400	
Voluntary admissions	184,503	52.9
Involuntary admissions for medical care and custody	139,123	39.8
Involuntary admissions by the Prefectural Governor	12,566	3.6
Free admissions	12,818	3.7

Ministry of Health & Welfare, 1990

At the end of June 1988 the medical personnel employed in mental hospitals was as follows:

Figure 5

MENTAL HEALTH PERSONNEL

Psychiatrists		8,725
(Designated Physician of Mental Health		7,815)
Nurses		37,087
Assistant Nurses		36,402
Nurse Aids		20,342
Occupational Therapists (qualified)		469
Psychiatric Social Workers		1,235
Clinical Psychologists	about	1,000
Mental Health Workers (in Public Health Centres)		1,656
Public Health Nurses		8,749

(Among para-medical staff, only occupational therapists
meet national standards of qualification)

Ministry of Health & Welfare, 1990

There is a nationwide shortage of labour both in medical and other professional fields. Mental hospitals also suffer because of a shortage of nurses and other professionals.

There are 1,765 outpatient facilities and clinics taking care of 700,000 patients. They deliver medical services including case management and counselling for recovering patients.

Theoretically speaking, mental health facilities and services fall into the public domain. The Mental Health Law, amended in 1988, refers to the social rehabilitation needs of the mentally ill, but states that only "municipalities and medical juridical persons may establish social rehabilitation facilities for persons with mental disorders". Consequently, although non-governmental hospitals are aware of the importance of community psychiatry, many of them find it extremely difficult to start loss-producing rehabilitation services without government subsidies.

In Japan, since 1970, community care programmes have been gradually developed for psychiatric patients. However, they have not developed enough to become a major site of treatment.

Figure 6

SOCIAL RESOURCES FOR ACTIVITIES

1990

		facilities	clients	N.B.
1. the sheltered workshop with subsidy		25	500	by mental health law
2. small scale sheltered workshops		529 *(209)	9,500	not by MHL *subsidized by the local government, etc.
	sub total:	**554**	**10,000**	
3. day care facilities (in hospitals and clinics)		186	4,000	
4. day care services		20	-	
community care programme (in public health centre)		665	21,885	
5. patient club, etc.		209	-	
	sub total:	**1,080**	**25,885**	
6. system for foster employers of ex-mental patients		1,438	2,300	by government subsidy for employers
7. foster employer system (for inpatients and outpatients)		999 (related to 280 mental hospitals)	about 2,000	non-subsidized by hospital, etc.

Social resources for activities in 1990

Sheltered workshops were first introduced in the 1960s for the physically handicapped, the mentally retarded and the mentally disordered. As of October 1, 1990 there were 2,231 such workshops, of which 554 served mainly those with mental disorders. These sheltered workshops are run by families or voluntary mental health personnel. Only 25 sheltered workshops are officially subsidized. There are 186 approved day care facilities, but only 42% of them are public. Among 852 public health centres, 665 centres have community care programmes.

In 1982 the Ministry of Health and Welfare launched a Rehabilitation Programme for Outpatients in close collaboration with prefectural governments. Central government allocates funds to prefectural governments who make contact with companies designated and registered as "vocational parents". We now have 1,438 companies who are "vocational parents" but they only provide work for 2,300 patients. In Japan there is no protected employment system for mentally disabled persons.

In the near future we should have well-organized vocational rehabilitation systems for the mentally disabled persons in the same way as for the physically handicapped or mentally retarded.

Social resources for living in 1990

We have poor community residential facilities in Japan (Figure7). The amended Mental Health Law in 1988 set forth the legal framework for the two types of residential facilities, which may be established and operated by prefectural governments, municipal governments, social welfare juridical persons and others.

As at June 1990 there were only 33 hostels - mental health facilities for social adjustment and 32 care homes. The number of such residential facilities has not grown much in these two years, largely because of problems of finance.

We now have only 95 group homes with room for a total of 916 persons all over Japan. Most of these group homes are established by private hospitals and self-help groups without financial support from the government. We hope that in future the number of group homes will be increased but subsidies from the government will be indispensable.

Figure 7

SOCIAL RESOURCES FOR LIVING

Residential Facilities 1990	facilities	inmates	N.B.
1. hostel mental health facilities for social adjustment	33 ↓ [4,000]	995 ↓ [8,000]	with government subsidy by MHL capacity : 20
2. care home	32 ↓ [500]	320 ↓ [5,000]	subsidized by MHL capacity : 10
3. group home	95 ↓ [2,000]	916 ↓ [9,000]	by private hospital and self-help group
4. independent apartment		[10,000]	
sub total	**160** ↓ [2,900]	**2,231** ↓ [32,000]	under MHL, etc.
5. urgent care institutions	171	15,428 *(6,171)	subsidized by welfare law *40% of them are the mentally disordered
6. institutions for rehabilitations	18	1,768	
7. geriatric nursing home	-	[13,000]	
sub total	**189**	**[20,939]**	under welfare law
Total:	3,000<	50,000<	

Figures in brackets [ ] represent estimated need.

Urgent care institutions were established in a subsidiary welfare law. According to study reports in 1990, out of a total of 15,500 persons living in the urgent care institutions, 6,000 (38%) were mentally disordered, including epileptics and alcoholics.

Unfortunately, most communities resist the construction of psychiatric facilities and related settlements in their area. It is very difficult to obtain agreement to build a new living facility for mentally disordered persons. The gap between supply and demand is very great.

Facilities needed for social rehabilitation of the mentally disordered in Japan still face many problems. And yet Japan has obviously started making serious efforts to expand its resources in this regard. In order to solve problems in the future, the national government, municipal governments and other parties involved in psychiatric care must work closely and energetically together to develop social rehabilitation strategies based on the new Mental Health Law.

According to a 1983 fact-finding survey on mental health by the Ministry of Health and Welfare, more than 30 per cent of hospitalized patients could leave hospital if only there were enough social support systems in the community. 60 per cent of the patients' families said that they could not look after discharged patients.

In Japan deinstitutionalization has not yet advanced. Psychiatric hospitals in Japan play a rôle which intermediate facilities should play. Therefore, psychiatric hospitals provide hospital functions such as security, emergency services, acute, sub-acute and chronic services, for which the same base charge is applied. Simultaneously, psychiatric hospitals, again for the same base charge, have to serve as nursing homes or sometimes as board and care facilities as well. Mentally ill people living on the street are rarely seen.

Conclusions and discussion

To further develop community psychiatry in Japan, there needs to be: first, an ability to generate an appreciation about mental health among the general public and to obtain the support of society; second, the establishment of strong networks among public health centres, welfare bureau and child consultation centres, and the ability to provide crisis intervention if necessary; third, and most important, a good working relationship must be developed with public health nurses, who regularly visit homes where there are potential health problems, and they must be helped to remedy those problems. More importantly, psychiatric hospitals should not isolate themselves from the rest of society. Psychiatric hospitals must be open, so that residents in the community will feel comfortable about admission to one.

While public education and public understanding about mental illness is fostered, the country also needs to develop a variety of facilities: day care and night care services, supported dormitories, half-way houses, sheltered workshops for vocational opportunities, and other appropriate programmes. With a variety of facilities and services, people with mental disabilities will be able to try, according to their ability, to adapt to a new environment and eventually participate in society as independent individuals. However, psychiatric hospitals should continue to offer prompt medical intervention, if necessary, so as not to arouse unnecessary misgivings in the community. Rehabilitation services for the mentally ill should not be at the expense of psychiatric hospitals.

Today Japan needs a community psychiatric system suitable for our culture and our social needs. Japan also needs a policy which does not impose a financial burden on those willing to undertake community psychiatry. Without financial support from the government to cover deficits almost inevitably incurred by rehabilitation services for former patients, and with the social stigma still remaining in this society, hospitals have been forced to withdraw from rehabilitation services in some cases.

The Mental Health Law has this to say:

> "The National, Prefectural and Local Governments shall endeavour to enable mentally disordered persons, etc. to adapt themselves to social life, by expanding and improving the facilities needed for medical care and social rehabilitation."

Requests need to be made for more subsidies and legal support to promote the rehabilitation and community care of mentally ill people in Japan.

REFERENCES

Asai, K., Takahashi, T. and Lin, T-Y. (1991) *Mental Hospital as a base for community mental health in Asian cultures.* Tokyo: Keimei Publishing.

Ministry of Health and Welfare (1988) *National Health Administration in Japan*, Vol. II. Tokyo: Koken Shuppan.

Ministry of Health and Welfare (1988) *The Mental Health Law*. Tokyo: Koken Shuppan.

HUMAN RIGHTS FOR PSYCHIATRIC PATIENTS IN JAPAN: RECENT DEVELOPMENTS

by

Nobuko Kobayashi and Tomoko Kimura

The first-named author is the co-ordinator of a grass-roots organization called the Association for Better Mental Health (ABMH), a member of the World Federation of Mental Health. The purpose of ABMH is to contribute to the civil movement to reform Japan's hospital-centred mental health system towards a comprehensive community-based system.

This advocacy organization particularly emphasizes empowerment of mental health service users. It has contact with overseas users on behalf of Japanese users. Unfortunately, however, there is neither enough money nor staff to carry out many activities so it often collaborates with other groups working for the same purpose. The Tokyo Centre for Mental Health and Human Rights is ABMH's legal advocacy section concerned with mental health. ABMH challenges hospital practices and laws, visiting whoever wants help, and preparing legal representation if it is needed. Lawyer members have a crucial rôle in the activities. ABMH has a network of centres in Japan. Of course, members work on a voluntary basis.

The concern of this paper is to discuss three issues linked to the amended Mental Health Act which came into force in 1988: the power of the family, the protection of the human rights of patients, and the need for rehabilitation. Before this Act, psychiatric care was largely institutional and associated with confinement and control. Psychiatric hospitals were hot-beds of all kinds of abuses against patients.

The power of the family

The law prior to 1988 emphasized family needs in the case of a family member's admission to a mental hospital rather than the patient's needs, and there were few people who recognized that a mentally disturbed person's interests did not always coincide with the family's interests. It is of concern that this emphasis can still be seen in the 1988 Act.

There are many ex-patients who use the help-line provided by ABMH to talk about their resentment and anger towards their families and mental hospitals. One of them told ABMH that one day his family had taken him to the mental hospital against his will; someone gave him an injection and later he found that he was locked in a seclusion room. He wanted to sue his family for human rights abuse and asked for legal advice.

Another case was a woman who could have been discharged. The psychiatrist said that she was ready to be discharged whenever her family agreed to accept her or prepared some place for her to go. But her family did not want her to return home. She is still in hospital and has asked ABMH for help. ABMH feels very sorry for these people but practically can do nothing except listen.

ABMH has come across many families that have been trying to detain the mentally disturbed member in the mental hospital as long as possible by using their power of consent as a person responsible for custody (Hogo-Gimusha) for involuntary admission under Article 33 of the Mental Health Act of 1988. This power is very arguable and it is not only abused by some families but also very often destroys the relationship between the patient and the family, which is vital for the rehabilitation of the patient. It is inevitable that many mentally disturbed people think that their families are their enemies. At the same time, ABMH realizes that many families also have felt guilty regarding their mentally disturbed member.

The stated chapter of Medical Care and Custody in the Act forces enormous burdens on a person responsible for custody (Hogo-Gimusha), i.e. a spouse of a mentally disturbed person can be a Hogo-Gimusha with no formal appointment. A Hogo-Gimusha has a duty to obey a physician's order for the sake of so-called 'effective treatment'. A Hogo-Gimusha has a duty to prevent a mentally disturbed person from committing a crime! As a result, fearing litigation by a victim of any possible violence of a mentally disturbed person, a Hogo-Gimusha tends to commit his/her family member to a mental hospital when sometimes it does not seem to be necessary. Statistically this causes high rates of involuntary admissions. According to official figures this was about 47 per cent last year in Japan but it is considered that the figure is an under-estimation.

It is true that the family is a very important resource but it does not do much for the mentally disturbed member on a daily basis in this rapidly changing society. Some conservative people admire this system which they claim is unique and traditional. They stress that individualism and human rights would not easily be accepted in Japanese culture. ABMH disagrees with this. Moreover it believes that this is plainly a pretext in order that the government does not have to take responsibility for the mental health care services on the basis of public policies.

From ABMH's experience as a "watch dog", it believes that Article 33, "involuntary admission with family consent" should be abolished at the time of review of the Mental Health Act in 1993. ABMH will continue to challenge this system because it feels that this is a fundamentally wrong concept to maintain and which reinforces cheap and low quality mental health services in Japan.

The protection of human rights

The new law has created a 'wind of change', and hospital directors and staff generally appear to have become very conscious of the law[1]. For example, since 1989 ABMH have not been refused access to or communication with an inpatient who has sought the help of ABMH. However, under the old Mental Health Act, sometimes even lawyers were not allowed to meet their prospective clients. This was typical of the hospitals' attitude.

Such changes may only be the icing on the cake, and ABMH are interested in changing the cake itself.

The new Mental Health Act has two principal pillars[2] which were not referred to in the old law: protection of human rights and rehabilitation. With regard to the protection of human rights, the government has set up Psychiatric Review Boards (PRBs). The PRBs provide the opportunity for inpatients to have their detention reviewed and give a right of appeal should they object to being kept in the hospital, or have a complaint about their treatment.

It is said that the government wanted to bring in Great Britain's system, the Mental Health Review Tribunal (MHRT)[3]. Stealing the name (or almost) has not made the system the same. PRB members are appointed by the Governor of each prefecture, through an unclear selection process. However, the constitution of the PRB is rather a problem: the law requires that each PRB consists of between one and three collegiate bodies, each consisting of three psychiatrists, one legal person and one lay person. Obviously, the absolute majority of the members of each collegiate body are psychiatrists, most of whom are directors or senior psychiatrists of private mental hospitals. It is questionable whether they are impartial, given their background. Also, no allowance is made for the number of psychiatric beds or the population in each prefecture.

Another problem is that the Ministry of Health does not provide any funding for the PRBs; their budgets are dependent on local governments. This is inconsistent with the Ministry's assurances that the PRBs would serve as a "court" according to the criteria of I.C.C.P.R.[4]

There is great diversity in the implementation of the PRBs in each prefecture since there is no formal code of practice. According to one survey, there is much diversity in the procedure of hearing and in the length of time between patients' requests and interviews with patients, and other aspects of the PRB system. On the other hand, the survey found a similarity on the most crucial point: the number of applications to the PRBs. For each prefecture the survey calculated the percentage of all inpatients who submitted applications to their PRB for review of their hospitalization or treatment. Of these the highest percentage was 1 per cent (0.96) of inpatients, and the lowest was 0.02 per cent from April 1989 to March 1990[5]. This is devastatingly few applications, which gives rise to some thought. Table 1 gives precise data from Tokyo-To for the first years that the PRBs functioned.

Table 1

TOKYO-TO: NUMBER OF APPLICATIONS TO PSYCHIATRIC REVIEW BOARD

Period covered	Total number of applications	Applications approved
July 1988 - March 1989[6]	75	3
April 1989 - March 1990[5]	164 (0.7%)	5 (2 discharged)
April 1990 - March 1991[7]	106 (0.3%)	3 (0 discharged)

As these statistics show, most inpatients do not seem to understand how the PRB can work for them. ABMH are concerned about the very small number of applications. Inpatients are not clearly informed about the PRB's function, and at the same time they do not trust it because of their past negative experiences. To break through this conflict the ABMH have suggested the necessity of an advocate to advise patients of their rights.

It is known that currently the PRBs do not discharge applicants unless they have a place to go with their families' consent, even if they are clinically suitable for discharge. This is a controversial subject, as is the problem of psychiatric patients who become homeless because they have no place to go, a subject that Dr. Asai discusses in his paper in this volume. From April 1989 to March 1990 there were only 22 PRB approvals[5] for discharge among a total of approximately 350,000 psychiatric inpatients in Japan. This provides a distressingly small opportunity for applicants to be discharged. The ABMH are convinced that the PRBs should be more closely linked with social work and other resources to allow former patients to function in the community. Unless the PRBs undertake a broader rôle, it is certain that the PRB system will be a dog without teeth. In this regard, the ABMH is forced to take up welfare rehabilitation matters.

Rehabilitation

This term has many meanings and it is used here in the context of community care. The government does not seem very eager to have a policy for disabled persons and it is a matter for some despair. There is a serious lack of adequate policies and an insufficiency of money devoted to community care for disabled people. Mental health service users, in particular, are unable to take advantage of their welfare rights because of the especially convoluted government bureaucracy in this area. This means that mentally distressed people have been discriminated against among other disabilities.

Actual rehabilitation policies are structured according to the medical model. As at August 1990, 33 hostels had been established under the new Mental Health Act[8] but 27 of them were run by private mental hospitals. These hospitals are trying to extend their business into community care. However, they seem to find that the community care business is not as lucrative as the hospital business at the moment. The Ministry of Health officially estimates that one-third of psychiatric inpatients could be discharged immediately if the community was able to provide the necessary resources. Almost all private mental hospitals ignore this and still manage inpatients like real-estate property, a strategy with which the Ministry of Health concurs. Rehabilitation and community care policies have developed very slowly.

It costs approximately 7,800 yen (US$58) per day to keep a person in a psychiatric hospital in Japan; much cheaper than a single hotel room in Tokyo. This is an outrageously small amount to spend on the care of psychiatric inpatients, considering that Japan is one of the richest countries in the world.

Compared with the national government, Tokyo-To has a different, more progressive, attitude towards community support[9]. It provides large amounts of money to subsidize workshops, more than 130 of which are now operating[10], and which are mostly welcomed by their users. Also Tokyo-To has some pilot projects to subsidize group homes in which five or six residents may live independently. But it is not clear that Tokyo-To has plans to establish any further policy regarding community care.

Also affecting community care is a little-discussed phenomenon concerning the attitudes of hospital medical staff. In many hospitals medical staff are not prepared to do multi-disciplinary work at all, still keeping to a traditional doctor-led pyramidal hierarchy. This raises other issues, such as training and specialization of medical professionals. The government has promised to review the current Mental Health Act in 1993.

Conclusion

Professionals, users, users' family groups and advocacy groups, etc. are working very hard to take part in the process of improving the lot of psychiatric patients. There have been significant improvements in the last five years. But there are still detectable echoes of the old practices and much remains to be achieved.

REFERENCES

1. *Annual Report of the Tokyo Center for Mental Health and Human Rights, 1989-1990.*

2. *The Mental Health Law* (1988) Ministry of Health and Welfare of Japan. Kosei-Shuppan.

3. Bluglass, R. *A Guide to The Mental Health Act 1983 London;* Churchill Livingstone.

4. *Commentary on Mental Health Law* (1990) Ministry of Health and Welfare of Japan. Chuo-Houki.

5. *National Statistics of PRBs, April 1989 - March 1990*.

6. *Statistics of PRBs in Tokyo, July 1988 - March 1989*.

7. *Statistics of PRBs in Tokyo, April 1990 - March 1991*.

8. *Report on Mental Health Rehabilitation Setting, October 1990.* The Council of Mental Health Rehabilitation Network of Japan.

9. *Mental Health Policy Committee of Tokyo-To, July 1991*.

10. *Report on Mental Health Practice in Tokyo-To, March 1990*.

PSYCHIATRIC REHABILITATION IN MACAU; A WESTERN TEAM WORKING WITH CHINESE PATIENTS

by

Inês Dias, José Flores, Maria Pinto,
Teresa Coelho and Teresa Alcantara

Macau, a territory located in the southern part of China, in Guandong province, is a small peninsula and two islands with a total area of 16 sq.km. Since the 16th Century it has been under Portuguese administration, as it will remain until December 29th, 1999. The total population is about 500,000, the majority of them living in the city of Macau. The population is predominantly ethnic Chinese, with the Cantonese in the majority. In the past 20 years the population has increased almost 100 per cent, 50 per cent of the population being recent immigrants to the Territory, attracted by the opportunities of work and business created by rapid industrialization (toys, textiles, electronics), gambling and tourism. The culture of this population is that of an urban society consumption-oriented, with rapidly changing values and ways of life .

Figure 1

POPULATION (31st December)	thousands	1986	1988
Men		423,3	443,5
Women		219,0	227,5
Population	**percentage**		
Less than 15 years old		22.0	21.8
From 15 to 64 years old		72.1	72.3
Above 65 years old		5.9	5.9

In Macau there are two hospitals: one is a Chinese privately-owned hospital and the other is the Macau Government Hospital, which is the only one that provides psychiatric care in the Territory. The Psychiatric Department is integrated into the general hospital and has the following units:

a) One outpatient unit
b) Two inpatient units - one acute unit with a total of 32 beds, one chronic unit with a total population of 100
c) Day Hospital
d) Psychiatric emergency unit, integrated into the general emergency unit of the hospital.

The Department also provides training programmes, mainly:

a) Nursing training in co-operation with the Government Nursing School
b) G.P. training in the field of Psychiatry and Mental Health
c) Psychiatric Internship

The work of the Department is based on teamwork involving professionals from different backgrounds and training: psychiatrists, nurses, occupational therapists, a social worker, a psychologist, and auxiliary staff, undertaking different kinds of therapeutic intervention: biological, psychological and social. A music therapist works with the Department on a sessional basis.

The senior staff of the psychiatric department are Western people who do not speak Cantonese and use Western models of intervention in different areas ranging from psycho-pharmacology to psychiatric rehabilitation.

The majority of the nursing staff have no specific training in psychiatry and present strong resistance to changes in the models of intervention. Their position is crucial as they form the bridge of communication between the senior staff and the patients. However, some of them have shown themselves to be willing to try new ways of working.

Until 1985 the Department provided a model of care which was institutionalized and custodial in nature and centred on the hospital, with a shortage of properly trained staff. There was a lack of other facilities in the Territory, except for some religious institutions providing shelter for the long-term mentally ill.

Figure 2

STAFF MEMBERS	
Psychiatrists	4
Psychiatrists in training	1
Social Worker	1
and	
Social Worker Aid	1
Occupational Therapists	2
and	
Occupational Therapists' Aids	4
Psychologist	1
Nurses	24
Auxiliary Staff	25
Others	3

-

In 1985 the situation was as follows:

- an overcrowded inpatient ward;
- poor compliance with outpatient follow-up;
- absence of clear criteria for admissions;
- no clear distinction between social, chronic and acute cases;
- social and family pressure on the Department of Psychiatry for long-term admissions;
- lack of response from the social institutions under religious ownership;
- no updated therapeutic schedules;
- shortage of properly trained staff.

After 1985 the Department was reformulated. The main aim of the reformulation was to switch the model of care provided to a community-oriented model. To fulfil this aim several goals had to be achieved, including: the improvement of diagnostic skills and update of therapeutic schedules; the improvement of the basic training of the staff; the establishment of clear criteria for admissions; the establishment of clear distinctions between social, chronic and acute cases; and the improvement of compliance with outpatient follow-up. We also wished to ease the social and family pressure on the Department for long-term admissions.

The achievement of these goals entailed the establishment of an intermediate structure, the Day Hospital, to serve the large number of cases with frequent relapses and with lack of social and community support. Initially the families' response was not so enthusiastic and they still asked for inpatient care and long-term admissions. As the day hospital developed and the results were seen, we could detect a change in the patients' and families' attitudes towards the day hospital. Now we have a waiting list. As a natural outcome of this strategy, the Department presented to the government a programme for a half-way house, a day centre and workshops for the mentally ill. This programme is meant to be undertaken in co-operation with the Social Welfare Department and other organizations with experience in this field.

Since 1987 we have regularly had several doctors in our department for training in Psychiatry and Mental Health, integrated into a general programme of G.P. training. This is very important to the improvement of the awareness of mental health problems and the development of a close and co-operative relationship between the department and primary care providers.

All the above-mentioned achievements were possible due to the motivation and dedication of some staff members who promoted the improvement of the basic training of nurses and other staff and began to work with patients, their families and neighbours, both in hospital and in their homes. The enthusiastic support and hard work of the social worker integrating the team of the Department was extremely important in the involvement and commitment of the relatives in the treatment process and the acceptance of the patient within the family.

To strengthen the links with the community, in 1989 we organized an exhibition, "Psychiatry in Macau: A Prospect For The Community", which took place in the Chinese pavillion of one of the most popular parks in Macau. The event was a team effort involving not only the staff but also both outpatients and chronic patients. This event was extremely important because it was possible for the patients to participate in the organization and activities undertaken at the exhibition, contributing to an increased awareness and acceptance of mental illness and the mentally ill. The large number of visitors shows the impact this initiative had on the community and there was considerable interest from the media.

As previously mentioned, the social institutions under religious ownership play an important rôle in the support of the mentally ill. However, in the beginning, this rôle was more a charity approach than a therapeutic one. We wanted to change this perspective to make them aware of the real needs of the population under their supervision. First, we tried to introduce criteria for new admissions. Secondly, we gave medical support to all the cases with psychiatric pathology at our outpatients clinic and also we admitted them to our acute ward whenever necessary. Pursuing our community-oriented policy, we also established contact with other government departments such as social welfare, labour, housing and education. This policy reduced the inappropriate use of hospital resources and strengthened our links with the community.

The implementation and strengthening of this strategy had as its outcome the improvement of compliance with outpatient follow-up and an increase in the number of new cases as shown by the steady increase in the number of consultations per year (Figure 3). It also led to a decrease in the number and length of admissions to the inpatient ward (Figures 4 and 5).

Figure 3

MEDICAL APPOINTMENTS

Year	Appointments
1985	3,000
1986	4,100
1987	3,100
1988	3,300
1989	4,100
1990	5,800
1991	5,700

Figure 4

HOSPITALIZATIONS

Year	Patients
1985	296
1986	215
1987	200
1988	180
1989	180
1990	180
1991	291

Figure 5

AVERAGE LENGTH OF HOSPITALIZATION

Year	Days
1986	25
1987	22
1988	23
1989	18
1990	21
1991	21

-

There was an improvement in the referral rates from the primary care network. Rehabilitation activities developed through the establishment of O.T. workshops in the two psychiatric units. Pressure from families on the department was eased, and a co-operative programme with the religious institutions was developed. The goal was to prevent new admissions that did not meet proper criteria, and improve the standard of care of those already admitted[1].

The results obtained, after these six years of experience, are:

1. Early detection of psychiatric disturbances has greatly increased.

2. There has been an improvement in follow-up standards.

3. The number of relapses has decreased.

4. There has been an improvement in the attitude of the community towards mental illness and the mentally ill.

We conclude from our experience that Western psychiatric rehabilitation based on a bio-psycho-social model, emphasising teamwork, family care and support and brief hospitalizations is appropriate for and welcomed by the Chinese community of Macau.

ENDNOTES

1.

PSYCHIATRIC PATHOLOGY

Sample of 400 consultations
(monthly average)
of our outpatients department

n = 400

	%
Schizophrenia	48.4
Paranoid Psychoses	3
Affective Psychoses	5.2
Organic Psychoses	4.9
Other Psychoses	3
Neurotic Disturbances	16.8
Adjustment reactions	3.1
Drug addiction	3.95
Alcoholism	2.35
Mental Retardation	4.45
Personality Disturbances	1
Epilepsy	2.5
Others	1.35

WHERE WOULD YOU GO FOR HELP?

Five success factors in effective neighbourhood services

by

Christine Taylor

Introduction

This paper examines some elements of successful and effective neighbourhood mental health services[1]. They were found in several countries. I was told that their practices were good, and when I visited them and talked to staff and to service users and local neighbours, I found that this was so. My work as a practitioner in counselling and in service planning and development has convinced me that intangibles are as important as physical resources, and the purpose of this paper is to share impressions of the factors that go into successful projects.

Where would you wish to go for help, if you could choose, once you were over the acute treatment phase of an episode of serious mental disorder? Where would you go for basic knowledge and information if you found a friend or colleague or family member was, to your way of thinking, becoming psychologically disturbed? You would use your professional contacts and network of relationships, of course.

But for those who do not know about these things, those who do have the duty of seeing that preventative and rehabilitative mental health services are readily available. Indeed, not only available but in such a form that we ourselves would wish to use them if necessary. None of us is immune from the possibility that, despite social class or economic status, we may be among the ten per cent of any population in any society who will at some time require formal psychiatric services. I shall not speak of treatment modes, which vary from place to place and country to country, and are adequately reported elsewhere. I have found that success depends equally on the structural and functional form of the service system: the means of ensuring that a person who becomes affected by mental disorder has every chance of remaining a person, and of returning after acute treatment to the prospect of leading an ordinary life; those are the common goals of rehabilitation.

Agreement on a common position

Let us begin from a common position. Let us remind ourselves of Article 5 of the Luxor Declaration, the Declaration of Human Rights and Mental Health adopted in 1989 by the World Federation for Mental Health: Article 5 builds on the definition of health set forth by the World Health Organisation, not merely the absence of disease or infirmity but "a state of complete physical, mental, social and moral well-being".

> **Article 5**
>
> All mentally ill persons have the right to be treated under the same professional and ethical standards as other ill persons. This must include efforts to promote the greatest degree of self-determination and personal responsibility on their part. Treatment shall be in settings valued and accepted by the community, in the least intrusive manner, and under the least restrictive circumstances possible. It shall be beneficent in the sense of being carried out in the patient's best interest, not that of the family, community, professionals or the state. Treatment for persons whose capacities for self-management have been impaired by illness shall include psychosocial rehabilitation aimed at reinstating skills for living and shall take account of their needs for housing, employment, transportation, income, information and continuing care after hospital discharge.

Surely there can be no-one today who could in clear conscience deny this right, accepting that the rubric "least restrictive circumstances" includes "having regard to the safety of the individual, the family and the public".

Article 5 leads us straight to neighbourhood mental health services. Neighbourhoods are settings valued by the community - that's where we live. So if someone is safe to live there, let us ensure that that person, even if disabled or impaired for the time being from the aftermath of mental disorder, can live in our neighbourhood. If we truly value the amenities of life in our neighbourhood we will wish to enrich it by making it the best place for all its citizens. It will have a range of services that, for people with disabilities, offer the best hope for reinstating their fullest capacity for self-management.

Here are the five characteristics that I found common to all good community-based mental health rehabilitation services. Others may add to the list, but this is mine:

A value system
Community involvement
Ease and equity of access
Power-sharing management
Continuity of sufficient resources

The operating conditions of any neighbourhood services, in health or any other arena, are never static and are often frustrating. Living means changing and changing brings its own tensions. Strategies to ensure that these five success factors are built right into the structure and fabric of the services will have political and educational aspects as well as demographic and economic aspects. Each service needs its own place, its known place, so that each can be readily understood as part of a comprehensive network, essential threads in the neighbourhood pattern of life. Now we will look at these in practice.

A value system

Intangibles are the key to mental health. What is it worth to have the best physical surroundings in the world if you have no personal integrity, no-one who cares what you think or believe, no-one to trust in or be trusted by, no-one who is your good neighbour?

Having a sense of values, and stating these openly, ensures that **attitudes** and **behaviour** of staff and neighbours is understandable, given the purpose of the service. The foremost value is **respect for individual dignity**. If you think about it, that is the means to acknowledging the skills of colleagues, to treating the person who comes to the service as a human being of worth, and the family as people to be listened to with attention.

The result of working out a value system, and requiring that it be openly acknowledged, is an enhancement of mental health. It enhances the capacity of all to receive and exchange information and to take full account of the needs and wishes of participants in the service. In the community mental health centre, it means that colleagues work as a team, respecting the therapeutic and administrative skills each has and needs to see demonstrated in daily practice. In the work skills centre, it means there are choices and options available for consideration. In the area of accommodation, it means that individual needs for sharing or for privacy can be met. As to supervision and care, the value of respect for individual dignity ensures good manners and encouragement to co-operate for the benefit and comfort of all in the enterprise. To state, discuss and re-state the **values** which are held in common by all concerned with the neighbourhood service ensures the health of the collective soul as well as ensuring pathways that lead to healing the mind.

Community involvement

The aim of all rehabilitative services is "an ordinary life". For the person who has residual difficulties or problems of mental health, services must be available in the community so that that individual can be part of the community, leading, as far as possible, an ordinary life.

It must go without saying that to be a welcoming neighbourhood, the neighbours need from the very outset to be involved in the planning and development of community-based services. The success pointers here are that you are offering a resource. If a mental health facility is 'dumped' in a residential location with no open process of forward planning and consultation, the community will resent it and set up fearful bogeys based on prejudice and tales of terror. You can stop all that very easily by inviting the loudest of the potential critics to join the management committee whose task is to ensure that legal requirements are met and standards of service high. Make them part of the monitoring procedure. They will thus have a share in responsibility for ensuring that all goes well. In six months they will develop a sense of ownership of the facility and will become your staunchest supporters.

Then come the real chances for community outreach. Your facility needs to have, as one of its functions, positive mental health education by schools, and other local group visits. Make resource kits, sponsored by local businessmen. Teach that good mental health means you can think clearly, speak effectively, listen well, you can concentrate to the end of your task, you can keep a balanced outlook and enjoy your life, laughing at the absurd, marvelling at the sublime.

In establishing your new facility, build in the employment of local people into every part of the staff team. Your aim is to see that people using the service have the chance of an ordinary life. I have seen the effectiveness of West Indian health workers employed in Paddington in London, a largely Afro-West Indian neighbourhood, people recruited and retrained who were previously employed in the markets or little shops. Their talent was a strong sense of community and supportive involvement with the families and life of the neighbourhood. Everyone knew who were the resourceful people, so they were recruited for the mental health team. In-service training later gave professional status to several who had never had career opportunities before. Building a staff team compatible with the ethnic mix of your clients and the host neighbourhood is the best investment in time and training you can make, whether the staff are paid or not. In my country, a New Zealand-born Chinese mental health worker borrowed from our Maori people the concept of "kohanga reo", the language nest where young families nurture their indigenous culture and receive health and nutrition information along the way. The Chinese worker established family support networks as a resource for recent Chinese immigrants. I am convinced that ethnic recruitment is the quickest entry to effective rehabilitation for those who, for whatever reason, have developed problems of mental health. The re-establishment of personal integrity depends upon cultural sensitivity combined with professional knowledge.

Soon your neighbourhood facility is known as an employment resource. Volunteer local community members can become actively involved too, planning open days for visitors, festival events, forays into local factories for work practice, mutual assistance for the elderly in shopping and household maintenance. Your neighbourhood mental health facility can become a local feature which enhances self-respect, pride in mutual self-help, and is a genuinely normalizing context for its users.

Ease and equity of access

The third success factor is equity of access. The facility must be culturally acceptable, the service must be affordable to those who need it, and the venue, the physical buildings and location, must be tolerable to the users and to the host community. Where would you wish to see your best friend referred, who needed to recover from a mental breakdown? The mental health service network should be known locally so that the starting point for any question is well undrstood both inside the health profession and outside in the wider society. A community mental health centre for crisis assessment and referral? A doctor's office for maintenance medication? A multi-purpose bureau? A school clinic? A day-centre which accepts self-referral? Whatever is the range your area service development scheme has planned, be very prepared to work on ease and equity of access. Everyone deserves a chance to have problems taken seriously, assessed thoroughly and at once, and any recurrence treated not with blame but with acceptance at an open door. It is both therapeutically effective and cost-effective to have a comprehensive, well-organized and well-known service.

Power-sharing management

Here is a concept foreign to the traditional hierarchical professional structure. In the neighbourhood setting, however, our object is *an ordinary life*. Most rehabilitation facilities for people with psychiatric difficulties are provided by non-statutory groups, since most medical personnel are more interested in the intellectual problems of diagnosis than the long aftermath of healing and restoration. For safety and acceptance, the non-statutory groups must respond to the quality assurance standards of the official health system. So the success factor here is a *foundation legal document or service agreement* setting out very clearly the partnership aspects involved. Rights and responsibilities are reciprocal and complementary, giving adequate coverage of all duty areas. Each neighbourhood mental health facility should have its own clearly specified model of the structural relationships **within** the facility and the means by which it is linked to other parts of the whole mental health service provision in the region. Who does what, when, to whom, where, and how often? The purpose of the action is to achieve what aim? Very clear specifications bring a sense of certainty and security, and provide an excellent basis from which to advocate for completion of any gaps and omissions in the service spectrum.

Power-sharing working relationships are health-promoting. If there is common understanding and respect, acknowledgement (back to our value system again) of language, lifestyle, belief, knowledge and skill, beneficial interaction will be the result of daily service in the facility. All the groups which have, or ought to have, an involvement with health care need strong links: personal contact, allowing time for visits to people previously unknown; introductions by someone who knows both parties to act as an initial social and professional 'interpreter'. Whatever therapies are practised, whatever guidelines are followed in the neighbourhood clinic or facility, you should be able to go to any person there and say, "tell me what you do - what is **your** area of responsibility, what is the objective of **your** work effort?" and that person in giving a clear answer will have pride in a professional outlook and satisfaction in the work effort. All this derives from sound knowledge and a solid legal basis that sets out the rationale for the facility.

Continuity of sufficient resources

The first step in successful and effective management of resources is to count what you have. These resources include time and the exercise of human skills, as well as the obvious one, finance. Planning to do what you think best with what you have, and then stating clear limits as to what you will not attempt to do, makes plain how far the resources will stretch.

Effective resource management requires setting objectives: statements of what you expect to achieve in your rehabilitation programme. Are these objectives indeed gained by what you do? The quality of service and its results - its effect on the health and social competence of the people who come to the service - need to be kept under scrutiny. Monitoring is a planned process too, requiring the perspectives of the users, their families, the neighbours, as well as peer colleagues and service seniors who hold hierarchical responsibilities. Comparing service activities with the achievement of service goals demonstrates accountability in practice. The increased health and social function visible in the daily life of the service users demonstrates the effectiveness of your management of resources. More than annual reports and published statistics, neighbourhood and service user satisfaction will ensure that there will continue a demand for your service to continue, along with strong advocacy for resources to match. And your effective management of resources will be enhanced many times by ensuring strong, well-maintained links with the other parts of the service spectrum. Thorough assessment of clinical state and capacity for social function, an individual rehabilitation plan, good case management for advocacy and continuity, well-documented follow-up will ensure that service users can rely on you. Staff and volunteer satisfaction from being involved, consulted and extended in the service effort will ensure maximum use of scarce resources and effective capacity to adapt to changing circumstances and to plan for the future. One thing we are sure of: there is always a need for good mental health services since, in an imperfect world, the customers keep coming.

I hope to have shown in this paper that in addition to fulfilling their primary function, good neighbourhood mental health services also make for an enriched life of the general community and bring the additional benefits of social cohesion and the uplifting of positive mental health in a resourceful, vibrant, orderly and creative society.

Envoi: the wider social context

My starting point is the progress that has been made in psychiatric knowledge since the 1960s, and the effect of spreading that knowledge. Couple this spread of knowledge with the social revolutions, peaceful and otherwise, of changing attitudes and rising expectations amongst the citizens of every country, and you can discern a distinct personal shift in individual perceptions as to what life may reasonably be expected to bring. Many people today expect that in the course of their life they may go some way towards realizing their potential, that life is more than mere existence.

Requirements for an orderly society

A society can expect to be healthy, peaceful and productive only if it pays attention to the fundamental needs of its people. Good government and orderly development depend, in the end, upon the consent of the governed. So it was inevitable that the civil rights movements of the 1960s, the excesses of individual abandon of the 70s, the changing economic groupings of the 80s, and the demand for certainty and protection from future shock now facing all governments should by osmosis affect social institutions in all countries. We are none of us immune from the information flood that surges and eddies about us. Health systems have been changing along with everything else. Today, government policy-makers and mental health professionals have agreed that large ghetto-like hospitals are unsuitable for effective therapy or humane care. After crisis intervention, once the symptoms of distress have been treated and the person is psychiatrically stabilized, what then? If scandal is to be avoided, good care systems must play their part.

In this paper I have tried to show that it is not only possible but mentally healthy and socially cohesive to have neighbourhood mental health services that work well, and that assist in enabling the host society to be peaceful, orderly and productive.

ENDNOTES

1. The author was awarded a Winston Churchill Memorial Trust Travelling Scholarship in 1989. These scholarships are awarded for projects "that would be of benefit to New Zealand as well as advancing the profession, business or occupation of the Fellow". This paper is based on visits to various community-based rehabilitation programmes, especially in the U.K., undertaken as a Travelling Scholar in 1990.

PROBLEM-SOLVING THERAPY IN THE ASIAN CONTEXT

by

Elisabeth Marx

Problem-solving therapy has been successfully used as part of a family programme to reduce relapse in patients with schizophrenia (Falloon, Boyd and McGill, 1984). According to Falloon, et al., (1984), four treatment components should be available to patients in remission living with their families: maintenance of neuroleptic medication, education of the family about the nature of schizophrenia, family training in effective verbal and non-verbal communication of emotions (*cf.*Vaughn and Leff, 1976), and family training in problem-solving skills. The problem-solving component aims at training the patients and their families in problem-solving heuristics that can be used in a wide range of stressful situations. The rationale is that more effective problem-solving skills may reduce the stress-level for patients and families, thereby diminishing the risk of relapse.

Problem-solving therapy is characterized by two main features (Marx, 1988):

1. the training of generalizable strategies (as opposed to the training of discrete behavioural skills in classic behaviour therapy);

2. the aim is for the patients and families to become 'their own therapist' (the therapy does not focus exclusively on solutions to patients' present problems, as in many traditional therapies, but intends to enhance their coping skills for future problems, i.e. self-help is the primary aim).

Therapy programmes follow closely the model of social problem-solving as developed by D'Zurilla and Goldfried (1971) and D'Zurilla and Nezu (1982). This model conceptualized problem-solving as consisting of five consecutive stages:

1. Problem-orientation (acceptance of problems as a normal part of life)

2. Problem definition (differentiation between relevant and irrelevant stimuli; the aim is a realistic and adequate definition of the problem)

3. Generation of alternatives (brainstorming; listing of all possible solutions)

4. Decision-making (establishing criteria for effective solutions; selection of the most promising strategy)

5. Implementation (behavioural implementation and feedback.

The training follows exactly these stages in a graded-task approach, i.e. the cognitive operations of each stage have to be successfully managed before proceeding to the next stage. The therapist explains and models the strategies of each stage and subsequently helps and corrects the patients' attempts. The approach is very structured and includes behavioural techniques like rôle-plays, modelling, reinforcement, etc. Regular homework assignments are usually included in order to facilitate the generalization of the training programme.

The major question in this paper is: can this therapeutic approach, which was developed and implemented in the West, be successfully applied in a different culture such as Asia? Recent work on cross-cultural psychology and psychiatry stresses the urgency of investigating the universal applicability of Western therapeutic approaches (Lin, 1985). It is generally assumed that cultural beliefs and conceptions of mental illness have to be taken into consideration if therapies are to be carried out successfully. Ultimately, what one is looking for is whether there is a fit between the treatment model and the patient's conceptualization of illness and treatment, i.e. the patients' "explanatory model of illness" (Kleinman, 1980). However, so far, very little theoretical and empirical work on this issue is available.

Since direct evidence in the form of therapy-outcome studies of problem-solving therapy with Asian patients is not yet available, the aim of the present paper is to investigate whether there is any indirect evidence for the general applicability of this therapy with Asian patients and their families.

This topic will be addressed in two ways: first, the underlying assumptions of the problem-solving approach will be outlined and potential differences between Western and Asian cultures will be highlighted. The 'Asian' culture will be restricted to the Chinese population because this is the main ethnic group in Singapore where the research was carried out. Second, the results of an empirical study on the conceptualization of mental illness and help-seeking behaviour, including Singaporean Chinese subjects, will be analysed within the above framework.

In order to illustrate the theoretical assumptions of problem-solving therapy, Table 1 gives a brief outline of the cultural, social and personal assumptions of the problem-solving model.

Table 1: Assumptions of the problem-solving approach

Cultural	Social	Personal
Conceptualization of mental illness (diathesis-stress-model)	Family's preparedness to help patient	Internal LC
Prevalent values: personal control and rationality		Patient accepts idea of self-help
Egalitarian relationship between patient and therapist		Independence from therapist

LC = Locus of Control

One of the main assumptions of problem-solving therapy is the conceptualization of mental illness as a diathesis-stress-model, i.e. the assumption that besides a diathesis (predisposition), stress factors are important and that these can be reduced by better problem-solving skills. A further assumption is that personal control over events/problems is possible and desirable. This aspect is mirrored at the individual level in the concept of internal locus of control (LC), the belief that one has some influence over events in one's life. Other characteristics of the problem-solving approach are: an egalitarian relationship between patient and therapist, and the ultimate aim of self-help.

Do these assumptions fit into the concept of mental illness in Chinese cultures? Only if the treatment model and the cultural explanatory model of illness match, can we expect a treatment to work. If we look at the concept of mental illness in Chinese cultures, as described by the research literature and summarized in Table 2, we find many discrepancies between the Western treatment model and the Chinese concept of mental illness, making the applicability of the problem-solving model questionable.

Table 2: Conceptualization of mental illness in Chinese cultures

Cultural	Social	Personal
Conceptualization of mental illness: ideas of spirit possession (Tsoi, 1985)	Reaction of family: love, denial, rejection (scape-goating) (Lin and Lin, 1981)	External LC (Hsieh et al., 1969)
Prevalent values: fatalism (Lee, 1982)		Patient expects advice from expert (Hsu, 1985)
Focus on hierarchical relationships (Hsu, 1985)		Dependence on therapist

LC = Locus of Control

The Chinese have been described in the research literature as fatalistic, dependent on the therapist, demonstrating an external locus of control, etc. - all aspects that are inconsistent with the theoretical assumptions of the problem-solving model. Of interest is the reaction of the Chinese family towards the mentally ill person (Lin and Lin, 1981): from the initial stages of love and denial, the family later often rejects the mental patient, especially once a psychiatric diagnosis has been formulated.

Most of the studies on which the summary in Table 2 is based were conducted in the People's Republic of China, Taiwan or Hong Kong. We cannot assume that these findings are universally valid for all Chinese. In order to obtain some information as to how Chinese people in Singapore conceptualize mental illness, with special reference to schizophrenia, an empirical study was carried out.

Empirical study in Singapore

Eighty-one Singaporean Chinese (covering an age range from 16 to 65 years, mostly from the lower middle-class) were presented with a scenario that described a 40-year-old man (called "Mr.Wong") who experienced psychotic symptoms. The scenario was:

> "Mr. Wong is a 40-year-old manager in an accounting firm. During the last two months, Mr. Wong has been acting strangely. He has been hearing a voice describing everything he does, sometimes even with critical comments. He cannot control his behaviour and feels compelled to do whatever the voice suggests. Mr. Wong is unable to work, feels threatened by people, and prefers being alone."

Subjects were asked to answer a series of qustions, such as "what do you think is the main problem of Mr. Wong?", "what do you think caused his problem?", "what could/should Mr. Wong do about the problem?", "whom should he ask for help?", "how could his family help?", "how could the problem be treated?".

The open answers were content analysed by two psychologists in a common scoring process and the main results are presented in Table 3 (there was no difference between age groups). Only the results of the major content categories are presented here.

Table 3: Summary of main findings

1.	Conceptualization of the main problem		
		Definition:	- stress (49%)
			- mental/intrapsychic problem (34%)
		Cause:	- stress (70%)
			- intrapsychic (11%)
2.	Strategies to deal with the problem		
			- seeking professional help (37%)
			- relaxation/distraction (35%)
3.	Target of help-seeking		
			- professional help (58%)
			- friends (24%)
			- family (14%)
4.	Help that the family could provide		
			- care, moral support (52%)
			- direct help with the problem (17%)
5.	Treatment of the problem		
			- professional help (26%)
			- distraction/relaxation (20%)
			- problem-solving (12%)

The main findings were: (a) the conceptualization of the problem as being stress-related; (b) the seeking of professional help or relaxation/distraction as the main strategies to cope with the problem; (c) professionals (and not the family) as the main target of help-seeking; and (d) the lack of active problem-solving strategies to deal with the problem.

What are the implications of these findings with regard to the applicability of the problem-solving model with this group of Singaporean Chinese? As Table 4 illustrates, there are several advantages and disadvantages concerning the applicability of the problem-solving model that the results of the present study indicate. The first two of these aspects could be interpreted as both positive and negative, and need further investigation in future studies.

Table 4: Implications of the findings for the applicability of the problem-solving model

Advantages	Disadvantages
Problem conceptualized as stress (*cf.* diathesis-stress-model)	If seen as external problem (externalization of distress)
Seeking of professional help (instant access)	Dependence on expert
	Very few active problem-solving strategies
	Family is not seen as a target of help-seeking
	Family is not perceived as providing direct help with the problem

At first sight, the fact that most subjects saw the psychological problem in the scenario as being stress-related seems to be consistent with the diathesis-stress-model of the problem-solving approach. However, an alternative interpretation is that the psychological problem may be externalized as being stress-related (external cause), implying that it has very little to do with the individual himself (internal cause). Similarly, the interpretation of the tendency to seek professional help is ambiguous. On the one hand, this result can be interpreted as being positive (as in instant access to professional resources); on the other hand, it could indicate an inability to engage in more active self-help and a dependence on experts. Both aspects have to be followed up in future research. Nevertheless, the findings indicate several potential difficulties in using problem-solving therapy with Chinese patients and families;

these are: the lack of active problem-solving strategies and the fact that the family is not seen as a major target of help-seeking.

It is important to note that these findings were obtained from a lower middle-class group of Singaporean Chinese. The findings may be different for other groups of Singaporean Chinese from different social classes/educational backgrounds, or different for specific groups, such as people who seek help from temple mediums. More in-depth research and the inclusion of different types of group will be addressed in future. Similarly, an extension of the study to include actual patients and their families is underway.

Nevertheless, the study indicated several aspects that might make the application of family problem-solving therapy with Singaporean Chinese difficult. The potential externalization of the problem, the lack of active problem-solving strategies, and the reluctance to approach and involve the family for help may require a re-orientation of patients and families towards active self-help strategies and towards the family sharing the patient's problems before problem-solving therapy can be successfully applied with this group.

REFERENCES

D'Zurilla, T.J. and Goldfried, M.R. (1971) 'Problem-solving and behavior modification. *Journal of Abnormal Psychology*, Vol.78, 107-126.

D'Zurilla, T.J. and Nezu, A. (1982) 'Social problem-solving in adults'. In Kendall, P.C. (ed.) *Advances in Cognitive-Behavioral Research and Therapy*. New York: Academic Press.

Falloon, I.R.H., Boyd, J.L. and McGill, C.W. (1984) *Family Care of Schizophrenia*. New York: Guilford Press.

Hsieh, T., Shybut, T. and Lotsof, E. (1969) 'Internal versus external control and ethnic group membership: a cross-cultural comparison'. *Journal of Consulting and Clinical Psychology*, Vol. 33, 122-124.

Hsu, J. (1985) 'The Chinese family: relations, problems, therapy'. In Tseng, W.S. and Wu, D.Y.H. (eds.) *Chinese Culture and Mental Health*. Orlando, Fla.: Academic Press.

Kleinman, A. (1980) *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Lee, R.P.L. (1982) 'Social science and indigenous concepts: with "yuan" in medical care as an example'. In Yang, K.S. and Wen, C.I. (eds.) *The Sinicization of Social and Behavioral Science Research in China*. Taipei: Institute of Ethnology, Academia Sinica.

Lin, T.Y. (1985) 'Mental disorders and psychiatry in Chinese culture: characteristic features and major issues'. In Tseng, W.S. and Wu, D.Y.H. (eds.) *Chinese Culture and Mental Health*. Orlando, Fla.: Academic Press.

Lin, T.Y. and Lin, M.C. (1981) 'Love, denial and rejection: responses of Chinese families to mental illness'. In Kleinman, A. and Lin, T.S. (eds.) *Normal and Abnormal Behavior in Chinese Culture*. Dordrecht: D. Reidel.

Marx, E. (1988) 'Problem solving therapy'. In Watts, F. (ed.) *New Developments in Clinical Psychology Vol. II*. Chichester: Wiley

Tsoi, W.F. (1985) 'Singapore: mental health and Chinese culture'. In Tseng, W.S. and Wu, D.Y.H. (eds.) *Chinese Culture and Mental Health*. Orlando, Fla.: Academic Press.

Vaughn, C.E. and Leff, J.P. (1976) 'The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic and depressed neurotic patients'. *British Journal of Psychiatry*, Vol. 129, 125-137.

ASIAN BEHAVIOURAL CONCEPTS IN COUNSELLING

by

Rosaleen Ow

Introduction

Much has been written about the Asian concept of personhood and social behaviour (Ho, 1981; Tham, 1979; Li, 1989; Mehta, 1989). The general picture which emerges is that the Asian individual exists in an interdependent relationship between the self, the family and the universe. Such accepted interdependence has resulted in the need for the individual to function within the framework of expectations laid down by the family and community. Current literature suggest that the Asian worldview on personhood and behaviour conforms closely to the concept of 'fit' between the demands and fulfilment of rôles as in the systems and ecological perspectives of human functioning.

However, the perception of personhood and behaviour between the client and the professional helper may be different because of differences in the 'stock of knowledge'. Lay knowledge and professional knowledge is said to vary in content and the nature of their organization and application. Lay knowledge is acquired in a slow, unsystematic and random manner, tested and confirmed through personal experiences. Professional knowledge, on the other hand, is acquired in a highly formal and systematic manner from specialized rather than socially comprehensive sources.

While it is recognized that an individual's worldview may consist of many different aspects, the nature of the sample in this study is such that the data is exclusively related to parent/child difficulties. This fact has influenced the selection of the aspects of worldviews described in this paper.

A. Sources of data

The data is derived from a larger study related to the client and caseworker perceptions of the casework process in two family service agencies in Singapore. Altogether 34 clients and the 10 social workers who worked with them were interviewed. The sample was representative of the Chinese, Indian and Malay mix in the Singapore population. Data was collected in two stages. The first interview was conducted after the initial contact between the client and the caseworker, and the second interview between six to nine months later. This paper is based on their responses to questions regarding their perception of family rôles and responsibilities, their problems and the nature of the help provided.

B. Sources of respondents' worldviews

The data confirmed that while there might be some overlap, the worldviews of the clients and caseworkers were generally derived from different sources. Most of the knowledge which the clients said influenced their worldview on human behaviour in the family was acquired from such informal sources as the family, personal observation and spiritual beliefs. The caseworkers, on the other hand, attributed their knowledge primarily to the process of personal observation and formal education. Since the caseworkers, by virtue of differences in socio-economic status, were likely to interact in a different social environment from that of their clients, the personal experiences which influenced their worldviews were also likely to be different. This strengthens the assumption that an inevitable discrepancy in perception in many aspects of their worldviews will occur as a result. (Ow, 1991)

C. Worldviews on personhood and social behaviour

The following discussion concerns the respondents' worldview on the concept of 'place'; the concept of 'face'; the principle of self-control and the concept of social influences in the context of familial behaviour. These aspects are selected for analysis because family myths and family rules are reflections of the underlying rationale for human behaviour within the family system. They may also influence the individual's relationship with other social systems in the relevant life space (Germain and Gitterman, 1980) such as in a counselling context.

Since family myths and family rules are the main regulators of human behaviour in the Asian context, they are also said to be the main sources of conflict within the family in situations where there is a lack of congruency or consensus regarding the appropriateness of such myths and rules (Sue and Moreshima, 1982).

1. The concept of 'place'

The concept of 'place' is very significant in Asian cultures. 'Place' for an individual is given according to the circumstance of birth and the rules of succession within the given culture and not according to personal merit. Embodied in the 'place' ascribed to an individual is a distinctive range of duties and responsibilities. Such duties and responsibilities identify the rôle and authority the individual possesses in the family and society. As long as the family exists, the individual is assured of his or her social identity. Among the clients in the research sample, hierarchy in social relationships as a consequence of the concept of 'place' was emphasized across all ethnic groups. This emphasis on hierarchy defined the age and sex rôle differentiation in the clients' perception about familial behaviour.

a) The clients

Gender-related rôles

First, there is a myth or general belief that a man exhibits his sense of manhood primarily through the rôle of provider. Most of the clients described this rôle as "the husband should go out to work" or "to earn money". The rôle of the woman as provider was thought to be of secondary importance compared with her rôle as nurturer and home-maker. This is consistent with the religious teachings and philosophies of the major Asian cultures. Hinduism, for example, stresses that the primary rôle of the adult man is that of the householder (Michael, 1979: 113-116). The Quran clearly exhorts the father to provide for the material necessities and the mother for the bodily welfare of the family (Hammudah Abd el Ati, 1977: 199). In the Confucian tradition, among the range of responsibilities the Chinese father holds, as a senior member of the family hierarchy, is that of providing for physical and material needs.

Age-related rôles

(i) Behavioural rules of parents vis-à-vis the child:

There appeared to be no marked cross-cultural differences among the clients in their belief that parents possess a superior position vis-à-vis their children. The superior 'place' of parents rests on the fact that parents as adults have more experience in life and therefore have more wisdom. The parents' rôles include that of being disciplinarian and provider.

(ii) Behavioural rules of the child vis-à-vis the parents:

Regardless of ethnicity, the clients believed that children must "listen" to their parents. The operational definition of "listening" appeared to be "do as you are told" (Henderson and Cohen, 1984: 112). In addition, obedience was also reflected in the rule of non-autonomous behaviour. Some variation existed across cultures in the manner in which these behavioural rules were perceived. The Chinese clients appeared more autocratic in comparison with the Malay clients who were more democratic in their approach. The Indian clients were in between, depending on their experiential knowledge and observation of what was true or feasible.

b) The caseworkers

In contast to their clients, the caseworkers have a less definite view about the concept of 'place' in interpersonal familial interaction. They generally had a more egalitarian outlook and perceived relationships on a horizontal rather than a hierarchical or vertical level.

Gender-related rôles

With the exception of the rôle of provider, the caseworkers did not emphasize rôle differentiation between spouses. Gender was not perceived as a major factor in determining the nature of spousal rôles and responsibilities. The rôle of the husband was expanded to include a greater involvement in the social and emotional nurturing of the children. The expectation of a more qualitative involvement of the man in the home is expressed by caseworkers across educational, religious and ethnic backgrounds.

Age-related rôles

Age was perceived by the caseworkers as a relevant factor in determining the nature of social relationships. There appeared to be a greater degree of congruence between the clients and caseworkers in their perception of age-related rôles as in the vertical relationship between parents and their children. There was similarity in their emphasis that children should exercise respect in their behaviour towards their parents. However, the caseworkers differed from their clients in their perception of how such respectful childhood attitudes and behaviours could be developed. While the caseworkers believed that the 'place' of elders was assured by virtue of birth, being respected was not a prerogative of 'place'. It must be earned rather than prescribed. The development of respect and filial piety was viewed as a transactional activity. Heavy emphasis was placed on the parents being positive rôle models. Learning from observation and guided participation was believed to be more effective in producing desired behaviour than didactic teaching.

In addition, fostering a child's respect for parents requires an open communication system between them. Implied in this is the right and the responsibility of both parties to be open and trustworthy in the exchange and processing of information. The onus for providing a conducive environment for communication, however, lies with the parents. The parents must ensure that their children are treated as individuals with the potential to develop even without the direct intervention of adults.

The views expressed by the caseworkers on age-related rôles and responsibilities are in many ways antithetical to those expressed by their clients. A clear preference by the caseworkers for a child-centred approach in the concept of 'place' contrasted sharply with those of their clients. The respondents' worldview of the concept of 'place' may have several implications for family counselling, especially if the helper's preferred approach to problem-solving is systemic rather than linear, involving the family as targets for change.

First, there may be a discrepancy in the recognition of behaviours as "problematic". Autonomous behaviour among individuals may be viewed as developmental by the helpers. On the other hand, these same behaviours may be interpreted as troublesome and non-conforming by the clients.

Second, there may be a discrepancy in the perception of the helper and client rôle and behaviour in the helping process in the context of sex and age. The concept of 'place' defines to some extent the nature of interaction between males and females, the younger person with an older one. Among Indian working class clients, for example, gender is an important factor in the counselling relationship. According to an Indian caseworker in the research sample,

> "the Indian men are generally very defensive when they work with female caseworkers. It could be said that we don't talk to each other as one human being to another .... the fact that we are females standing in front of a male already presents a rôle differentiation which we have to break down even before we can talk. The Indian culture, it is quite stereotyped. They expect women to be like this and men to be like that. It hurts their pride a lot if a woman comes in and tells them that they are wrong .... you have to ask indirectly ....".

Thirdly, in the eyes of traditional Asian clients, making the parents the major cause of childhood problems may imply that the professionals are not only most unfilial but are also ignorant about the concept of 'place' in society. The caseworkers in the study also reported the need to be concerned with behavioural rules associated with the age hierarchy. Very often indirect counselling using illustrations and examples from other similar situations would be more appropriate when working with older clients. Direct reference to mistakes and inappropriate client behaviour would result in the client feeling uncomfortable and the likelihood of withdrawal from the counselling context.

2. The concept of 'face'

'Face-saving' is not an exclusively Asian phenomena, although it has been written about most extensively in the context of Asian, especially Chinese and Japanese, inter-personal behaviour. 'Face-saving' is a universal commonsense approach to human relationships which recognizes that a person whose self-esteem is threatened is probably more difficult to deal with. In the Asian context, the unique element in the concept of 'face' is the inclusion of group as well as individual considerations in 'face-saving' behaviour. Theories of 'face work' in Western societies are derived from observation of face-to-face behaviour between individuals in largely anonymous and mobile populations (Goffman, 1955; 1967). In Asian cultures, the understanding of 'face' also takes into consideration the hierarchical structure of Asian society with its permanency of statuses and group orientation.

Hu (1944) made two important distinctions in the Chinese concept of 'face': 'lien' and 'mianzi'. 'Mianzi' is said to be similar to the kind of prestige emphasized in American society, a reputation achieved through getting on in life as a result of success and ostentation. 'Lien', on the other hand, represents the confidence of society in the integrity of the individual's moral character, the loss of which will make it impossible for that individual to function properly within the community. In the realm of Chinese inter-personal behaviour, six categories of 'face' behaviour are said to exist (Bond and Hwang, 1988: 243-249). These categories are: enhancing one's own 'face', enhancing other's 'face', losing one's own 'face', hurting other's 'face', saving one's own 'face', and saving other's 'face'.

a) The clients

For the Chinese respondents, 'face' was largely defined by 'mianzi'. It was linked in a holistic manner to educational achievement, economic worth, social security and prestige. Therefore, an individual's behaviour was often associated with how much that particular behaviour would lead to better prospects in the future. Success in life was usually measured in terms of the individual's ability to achieve in a material sense. The fear that an individual would end up with "no future" was one of the primary causes of anxiety among the Chinese respondents.

Losing 'face' or 'lien' was said to occur when certain behavioural rules of a moral nature were perceived to have been broken. Individuals caught stealing, telling lies or even found to be not doing their best will suffer a loss of 'lien'.

The Malay respondents did not express a similar degree of anxiety about success and its association with 'mianzi' as in the concept of 'face'. Social behaviour was associated with the training and development of character and not purely for economic gain. Hence, the greater concern for the loss of 'face' in terms of 'lien' (prestige as a result of moral integrity) rather than 'mianzi' (prestige as a result of economic achievement) found among the Malay respondents.

In contrast to the Chinese and the Malays, there appeared to be some qualitative difference in the Indian respondents' perception of the concept of 'face'. Social behaviour among the Indian respondents was measured both in terms of the amount of 'lien' or 'mianzi' which the fulfilment of culturally assigned duties would bring to the family.

For both the Chinese and the Malay clients the impact of losing 'face' was focused primarily on the individual who enacted the undesirable behaviour, and only secondarily on the family. However, among the Indian clients the impact of individual behaviour was first focused on the implications for the 'face' of the family, especially the parents, before the consequences for the individual concerned. This family-centredness in the perception of the consequences of individual behaviour had also been noted in literature on the Indian population in Singapore and abroad (Mehta, 1989; Narayanan, 1985; Mani, 1979).

b) The caseworkers

Compared with their clients, the caseworkers placed less emphasis on social impact as a major motivation for individual behaviour. The concept of 'face' was largely ignored in their perception of success or in the enactment of behavioural rules associated with family and social rôles. Success was viewed not in terms of its implication for the social status of the group but for the personal satisfaction and welfare of the persons directly associated with it. This kind of self-oriented achievement motivation said to be typical of American society has been described as "a kind of functionally autonomized desire, in which the course of achievement-oriented behaviour, the standards of excellence, and the evaluation of the performance or outcome are defined or determined by the actor himself or herself". (Yang, 1988: 113-114). The caseworkers' measurement of a behaviour was thus focused primarily on whether it would produce a socially, emotionally and intellectually integrated individual rather than the enhancement of 'face' for the family.

However, the caseworkers' apparent lack of concern for 'mianzi' as related to material success did not mean that they had a similar disregard for the concept of 'face' as in 'lien'. This was reflected in their concern for 'lien' as associated with the respect for hierarchy in the concept of 'place'.

The concept of 'lien' had implications for the help-seeking behaviour of some Asian clients. First, 'lien' was one of the reasons for the presence of a high degree of internal locus of control in problem-solving. The reluctance to seek external help was explained by a client as the "fear of losing 'face'". Seeking help from others, even those in the client's natural network, was affected by fear of gossip and inconvenience to others.

Secondly, 'lien' also had implications for the clients' willingness to work with an outsider on issues that demanded self-disclosure associated with moral behaviour. Resistance in marital counselling, especially on sexual relationships, was noted among work with Chinese families as described by the response of a male client reported below:

> Case 2 (Chinese), Husband: "...and you (wife) go out and tell everyone that I have a woman outside; do I really have one?"
> (After this outburst the husband walked out of the interview.)

The man described the reason for his reluctance to talk about his marital relationship as "of course we don't tell everyone outside the family .... we need our 'lien'. If you go and tell people this one is bad, that one is bad, then people will wonder why is your family like that .... so what's the point of telling ...?"

Thirdly, an Indian social worker remarked that "dealing with Indian ladies is different from Indian men. Indian ladies never reveal anything until the day they cannot keep it in anymore .... then they pour out everything. An Indian lady is not supposed to tell anything .... brings gossip ....". The differences in behavioural rules for males and females because of the concept of 'lien' in the Indian culture was found to be one of the major determinants of stress tolerance among young Indian females in Singapore (Mehta, 1989).

Fourthly, attributing blame to the parents is observed to be a common phenomena among professionals. The working assumption is that the child's difficulties are "reflections of disturbances in the adults around him. He is, therefore, not the culprit but the victim of unhealthy forces in the environment, particularly in the family ..." (Ho, 1981: 139). This would result in a loss of 'face' for the parents. A more useful approach may be to encourage new positive parental behaviours incrementally. Telling clients to immediately give up existing problem-management strategies that are more socially congruent in favour of the helper's more alien approaches may be threatening and not always effective. New behaviours, if found effective, will slowly lead to the displacement of old ones.

3. The concept of social influence

Human nature is conceptualized in many different ways in the social sciences in various psycho-social personality theories. In the Asian context, the development of human nature is viewed mainly from a sociological rather than a psychological perspective (Ho, 1981). Firstly, man is conceived of as being born without knowledge but has the potential for good or bad. Secondly, man is thought to be a product of the environmental forces acting upon him. Lastly, change in human behaviour is usually the consequence of the influence of positive environmental forces acting upon him. Therefore, in order to produce the kind of adult of whom society will approve, environmental forces external to the developing individual must be manipulated. The respondents' concept of social influence and the behavioural rules associated with it are closely reflective of their perception about the nature of man and the impact of environmental forces on human development.

The dichotomy between the two poles of any object or ideas and their co-existence has always been clearly defined in the Asian worldview. They are epitomized in such beliefs as the existence of 'yin' and 'yang' among the Chinese, or the male and female forces of 'prakrti' and 'purusa' in the Indian culture (Mehta, 1989: 53). Good and evil, black and white are believed to be always in juxtaposition with each other.

a) The clients

Among the clients, perceptions of social influences were divided into two major types: those influences which had good effects and those perceived to have bad effects.
i) Bad influences:
Unacceptable social behaviour was perceived to be the result of bad influences brought about by contact with non-familial forces in the social environment. However, this myth was consciously moderated with a degree of personal culpability by the Chinese respondents as reflected in the oft-quoted saying that "if a cow does not want to drink, you can't push its head down".
ii) Good influences:
The clients also believed that negative social influences could be counteracted by the action of more positive social forces. The change process was therefore perceived as the struggle between good and evil.

The Asian concept of persons as being born without knowledge and being dependent on the parents naturally leads to the belief that the best healing source for their problem is within the family and not outside. Therefore, those social forces which can effectively counteract negative influences from outside will be those within the familial network or approved by the family. These people were always described as 'others' even though they were seen as representatives of the clients themselves in the problem-solving process. A general belief among the clients across cultural and religious affiliations is that the individual presenting the problem will pay more attention to 'others' than they would to their own parents. Obtaining the help of 'others' was one of the major reasons for seeking help from social service agencies.

These 'others' acting as a 'middle-man' in the problem-solving process must, however, possess the following qualities in order to be acceptable as sources of good influence:

> i) to ensure that they have the appropriate motivation for helping, they must belong to the family network or be approved representatives of the family such as older relatives or friends of the parents;

ii) if possible they must also have official authority such as the police, medical personnel or social workers. Official authority was correlated with superior knowledge and resources as well as power. This fact is particularly significant in societies where relationships are strongly hierarchical.

iii) those who provide help must also have similar or more experience with the problem than the client. The helper must be perceived as being credible in knowlege.

b) The caseworkers

The caseworkers' perception of social influence was different from that of their clients in many ways. Formal education, especially social work training, was said to be one of the influential factors in the development of the caseworkers' worldview. It was therefore inevitable that their perception of human nature would be different from that of their clients. Non-Asian theories of personality (e.g. Freudian, Rogerian and others) have produced some common themes in social work literature on human nature which may be briefly summarized as:

i) all human beings are born with an innate drive to seek what is most comfortable for themselves and will strive to fulfil this goal;

ii) every human being has the potential for the fulfilment of life goals and this potential must be discovered, nutured and utilized; and

iii) the development of potential should lead to the achievement of long-term rather than short-term goals for the individual. Change must therefore be of a permanent and not transitory nature.

Caseworkers in the research sample generally favoured a 'deficit in the family environment' concept in labelling the causes of problems rather than the concept of negative social influence. Negative influences by factors external to the family were usually perceived as precipitating factors rather than causes of the problems.

One important implication of this discrepancy in worldview was the corresponding difference in expectations about the degree of directiveness in the problem-solving process as illustrated by the diagram below:

Degree of directiveness in the process of influence

Social worker Client

Minimal Maximal

<-->

Smile/ Frown	Nod/ Shake Head	Verbally Agree/ Disagree	Suggest	Advice	Physical Control

Ho (1989) noted that the Asian client expects the helper to be more directive than passive with the necessary air of confidence in their own competence to help. Pedersen (1983) also believed that Asian clients expect the exercise of a certain amount of power in the counselling process.

While the clients perceived the caseworkers as active 'rescuers' in a problematic situation, the caseworkers saw themselves as detached 'facilitators'. In seeking a long-term solution to the clients' interpersonal problems, the caseworkers preferred an interactional rather than a linear approach. Instead of focusing change on specific situations or individual behaviours, the caseworkers worked on changes in the behaviour of people as part of a dynamic system. The major assumption was that when the needs of all the parties involved were being addressed, people would interact in a more functional manner. This reflected their attempt to exercise influence over more areas of the client's situation than the client would normally desire.

4. The principle of self-control

In the Asian context, excesses in any form are considered to be inappropriate. The first behavioural rule arising from such a philosophy is the need for man to exercise emotional control. The Chinese clients adhered strictly to the concept that there is a season for everything under the sun. Impulsive behaviour such as the inhibited expression of feelings was often viewed as a form of 'excess'.

The data showed that the principle of self-control was a crucial aspect of the clients' worldview of social behaviour. Controlled or regulated behaviour was highly appreciated and considered the norm. Such behaviours were viewed as products of direct teaching and the inculcation of prevailing values in society.

This worldview has some implications for practice as follows:

First, the clients tend to express problems or stress in concrete and external forms since expressing feelings or emotions is not a usual way of communication. These external forms are often described as behaviours or events in the environment impinging on them rather than internal reactions. Catharsis is therefore difficult to initiate.

Secondly, the clients preferred to discuss matters which are less likely to provoke the expression of emotions and the precipitation of uninhibited behaviour such as crying or extreme anger. Self-disclosure, especially of inter-personal issues, is often avoided.

Thirdly, a strong rapport and a high degree of trust between the clients and the social worker are important factors facilitating the discussion of emotive topics such as family relationships, the family budget, the care of an ill family member, the rôles and responsibilities of different family members, and anything related to grief, pain and anger. The worker's rôle becomes a 'friend with power' to help.

Conclusion and implications for practice

The data provided evidence of many differences in the clients' and caseworkers sources of worldviews. The 'stock of knowledge' which contributed to the clients' worldviews was derived mainly from family socialization and informal, experiential knowledge. The worldviews of the caseworkers, on the other hand, were based mainly on social science knowledge developed primarily from non-Asian population groups. The holistic picture which emerged was that individual behaviour was not interpreted separately from social behaviour by the clients. All behaviour was viewed in the light of its impact on the individual's social environment, especially the family.

Since the counselling process consists of the interfacing of these two 'stocks of knowledge', a discrepancy between them will lead to a further discrepancy in perceptions in the process of helping. Such discrepancies in expectations put the onus on the helper to examine the clients' perceptions of help as valid approaches in the counselling process.

REFERENCES

Bond, M.H. and Hwang, K.K. (1988) 'The social psychology of the Chinese people'. In Bond, M.H. (ed) *The Psychology of the Chinese People*. Hong Kong: Oxford University Press.

Germain, C.B. and Gitterman, A. (1980) *The Life Model of Social Work Practice*. Columbia: Columbia University Press.

Goffman, E. (1955) 'On face-work: an analysis of ritual elements in social interaction'. *Psychiatry*, Vol. 18, 213-231.

Hammudah Abd al Ati (1977) *The Family Structure in Islam*. American Trust Publication.

Henderson, G.E. and Cohen, M.S. (1984) *The Chinese Hospital: A Socialist Work Unit*. New Haven: Yale University Press.

Ho, D.Y.F. (1981) 'Childhood psychopathology: a dialogue with special reference to Chinese and American cultures'. In Kleinman, A. and Lin, T.Y. (eds) *Normal and Abnormal Behaviour in Chinese Culture*. Boston: D. Reidel Co.

Ho, M.K. (1989) *Family Therapy with Ethnic Minorities*. Beverly Hills, CA.: Sage Publications.

Hu, H.C. (1944) 'The Chinese concepts of 'face''. *American Anthropology,* Vol. 46, 45-64.

Li, T. (1989) 'Malays in Singapore: culture, economy, and ideology'. *East Asian Social Science Monographs*. New York: Oxford University Press.

Mani, A. (1979) 'Caste and marriage amongst the Singapore Indians'. In Kuo, E. and Wong, A. (eds) *The Contemporary Family in Singapore*. Singapore: Singapore University Press.

Mehta, K. (1989) *Giving Up Hope: A study of attempted suicide amongst Indian women*. Singapore: Times Books Inter-national.

Michael, A. (1979) *Radhakrishnan on Hindu Moral Life and Action*. New Delhi: Concept Publication Co.

Narayanan, V. (1985) 'A Hindu woman rebels'. *Asia Magazine*, March 10, p.28.

Ow, R. (1991) 'Implications of Worldviews for Social Work Education' *Asia-Pacific Journal of Social Work*, 1(1), 48-58

Pedersen, P.B. (1983) 'The cultural complexity of counselling'. *International Journal for the Advancement of Counselling*, Vol. 6, 177-192.

Sue, S. and Moreshima, J.K. (1982) *The Mental Health of Asian Americans*. San Francisco: Jossey Bass Publications.

Tham, S.C. (1979) 'Social change and the Malay family'. In Kuo, E. and Wong, A. (eds) *The Contemporary Family in Singapore*. Singapore: Singapore University Press.

Yang, K.S. (1988) 'Chinese personality and its change'. In Bond, M.H. (ed) *The Psychology of the Chinese People*. Hong Kong: Oxford University Press.

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