Social Work INTERVENTION IN Health Care

The Hong Kong Scene

Edited by
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In the first chapter of the first section, Cecilia Lai-wan Chan introduces the reader to some of the characteristics of the Hong Kong health care system, and the dominant attitudes and beliefs of Hong Kong people regarding health issues. The scene is set with the introduction of intrinsic concerns such as the meaning of health and illness to people, their responses to illness and their help-seeking patterns within a given health care system, described at a practical, behavioural level. The social workers' contribution to overall health care is sketched. This general outline is fleshed out with more details about social work practice in the health field in later chapters.

In Chapter 2, Joyce Lai-chong Ma theorizes about what goes on behind people's observable behaviour when facing ill health. She presents a conceptual framework which provides the health workers with a structured perspective from which to operate systematically, favouring a biopsychosocial approach, and drawing in particular on theories of crisis, stress and coping. This broad framework allows a worker to appreciate individual differences in reactions to the crisis of illness and can also be useful at a macro level. The biopsychosocial implications of a particular condition like, for instance, pneumoconiosis and the concept of coping can be relevant in planning support schemes or preventive action.

The knowledge foundation for health workers presented here constantly underpins the social work practice modes presented in subsequent chapters.

Chapter 1

Introduction

Cecilia Lai-wan Chan

There is an old Chinese saying that 'birth, old age, sickness and death' are natural phenomena in life that every individual has to experience. We are excited by a birth in the family, but frustrated by chronic illness or disability, and saddened by loss and death. We are not adequately prepared to cope with a life in pain and are not equipped for poor health, illness, disability, and death in old age.

Small ailments such as a 'runny nose' or headache can affect one's mood and subsequently, interaction with other people. Major illnesses can be depressing and disabling (Miller, 1983; Holosko and Taylor, 1989; Germain, 1984). Physical well-being is very closely linked to emotional and spiritual stability, and vice-versa (Siegel, 1986). A diagnosis of cancer is a great source of stress and anxiety to patients and their family members (Tang, 1994; Kwong, 1994; Ngan et al., 1994). A depressed widower may develop cancer soon after the death of his wife. Lack of financial means and poor access to medical and health services can be major barriers to recovery for some people (Miller, 1983; Oen, 1991). Financial hardship and work pressures may lead to stomach ulcers (Travis, 1966). Health issues are concerned with the psychological and behavioural well-being of individuals on a micro level as well as health policy and welfare systems on a macro level. Social work in health care requires multilateral intervention at different focuses of change (Miller and Rehr, 1983; Carlton, 1984).

THE CHINESE CONCEPTION OF HEALTH AND ILLNESS

Traditional Beliefs and Eastern Philosophy

There are mixed and actually conflicting traditional conceptions of illness, disability and health among the Chinese population (Ho, 1991). The Confucian philosophy promotes perseverance and tolerance: wise and virtuous persons can tolerate pain, hardships and difficulties. The Buddhist believes in cause-and-consequences: hardships and mishaps may be caused by misdeeds in a person's previous lives. People should try to participate in philanthropy so as to wipe out previous sins. In the Buddhist philosophy, pain and suffering are explained by 'desires' (慾). If one can dissociate from desires for food, comfort, goods, relationships, lust and power, there will no longer be any suffering. The Taoist philosophy emphasizes the integration of individuals with nature, finding meaning in and appreciating the paths of life, learning about suffering through retreat into existential philosophies of the here-and-now. These philosophies encourage submissiveness, acceptance, tolerance, meditation and almsgiving (Chan, 1995).

In the folk religions, ghost spirits are associated with sickness, misfortunes, natural disasters and death. People think that ghost spirits can usually be calmed by prayers, offerings and gifts. The fortune-teller asks the client to organize religious rites and make offerings. By spending money, the misfortune may be allayed. Such a belief system may foster acceptance of the 'unpredictability' and 'inevitability of misfortunes' in life. Unfortunately, folk religion can promote fear and revenge instead of love and forgiveness. There can be undesirable consequences in seeking refuge from a ghostly answer.

> Mrs. Ho was married with three children. Her husband, Mr. Ho, had cancer of the colon. Mrs. Ho could not accept the fact that her husband, at the age of 45, could be dying. She went to a fortune-teller who told her that her husband's illness was due to her youngest son, whose astrological arrangement was in conflict with Mr. Ho's. With this explanation, Mrs. Ho transferred her anger to her son.

The Balance

The traditional Chinese conception of health is based on the ideas of homeostasis, balance, inter-generational cause-and-effect, the internal homeostasis of the five elements (metal, wood, water, fire, earth), yin-yang balance, the flow of *qi* (氣) in *jingluo* (經絡) (meridian system), the balance of hot/cold, wet/dry, wind/fire (Pachuta, 1989; Koo, 1989). The dynamic balancing or harmony is guided by the Taoist naturalist ideas of harmony between man and the environment. The trust in *feng shui* (風水) (wind-and-water) as a main fortune telling approach signifies entrusting man's life to be in balance with the environment under the assumption of the sky-earth-man continuum (Topley, 1978). With fatalistic environmental-determinism, the Chinese readily turn to supernatural interpretation of the environment, such as fortune-telling, astrology, physiognomy and geomancy. This is a form of externalizing the health locus of control.

The Body-Mind Integration

There is no dichotomy of the body and the psyche in the traditional Chinese concept of health. The mind and the body are integrated as one, for example, Chinese people equate 'open-heart' to happiness, 'small gall-bladder' to timidity, 'liver fire' to anger, 'red eye' to jealousy. The internal systems are linked to physical functioning and emotional well-being (Koo, 1987). Discomfort is often named as imbalance between the systems or the five elements. Doctors trained in Western medicine often scold patients, especially elderly ones, for giving non-specific complaints of 'hot-*qi*', 'wet-hot' or 'cold-heat' symptoms, which do not correspond to the Western physiological and anatomical classifications. Chinese people also tend to somatize emotional tension by using physical descriptions, because there are no commonly used non-somatic mental health terms in their language (Cheung et al., 1984).

Traditional Practices

Some traditional Chinese health practices are widely adopted even today, for instance, girls do not wash their hair or women should try to stay indoors during menstrual periods; women eat vinegar and eggs after giving birth to a baby; new-born babies are not taken out of the house for the first twelve days of their lives; small children have to wear many clothes or be covered with a blanket to protect their stomach from getting chilled; people eat meat (cat, dog, mice, owl and rare animals' meat besides pork and beef) to keep warm. The strong emphasis on a nutritious diet involves expensive herbs and tonics (補品) (*bupin*). Tonics are believed to stimulate body energies of *jing* (精) (sexual energy), *qi* (氣) (physical energy) and *shen* (神) (spiritual energy), to maintain good health and achieve longevity. Tonics, high protein food, wine, meat extracts and offal are believed to 'recharge' energy, especially sexual energy. These cultural practices were appropriate in a poor agricultural society because of the cold weather as well as scarcity of protein and oil in the normal diet. However, continuity of traditional heavy consumption of meat and oil in this age of affluence has led to increased heart diseases and strokes among the population.

Morning walks, *taiji* (太極) and *qigong* (氣功) are popular forms of health activities for the Chinese, especially among the elderly population. *Taiji* and *qigong* promote the philosophy of 'letting go' of struggles and interpersonal conflicts, maintaining peace of mind and a sense of harmony, which are congruent with the traditional aspiration of life fulfilment.

The Chinese Response to Symptoms

The characteristic of coping with symptoms among the Hong Kong Chinese people may be identified as passive-fatalistic on the one hand and action-oriented on the other. Emotional discharge did not seem to be the dominant mode of coping; self-directed coping strategies of psychological endurance and active coping were most common (Cheung and Lau, 1982; Lau et al., 1981).

When a person has a symptom, the first usual response is to ignore it. Sometimes, individuals may relate the symptoms to past experiences or to other people's experiences, which may be positive or negative. For example, if another family member has naso-pharyngeal carcinoma, symptoms of ringing in the ears may be recognized right away as something that deserves attention. If that other family member has suffered greatly in the treatment process, the individual may try to ignore the ringing in his or her ears with the hope that it is something else, and delay seeking medical attention.

The illness-related decision-making and action process of the Chinese in Hong Kong can be summarized as follows:

1. incubation: ignore the symptom, wait and do nothing;
2. self-medication or self-care: drink herbal tea, take a tonic or drugs from common knowledge;

3. popular care: seek information and care from family and friends, receive tonic soup and specially prepared foods, go to bed early;
4. folk medicine: go to the herbalist, acupuncturist or faith healer, seek advice from temples, fortune-tellers or *qigong* masters;
5. Western medicine: go to a general practitioner before referral to specialist care;
6. pragmatic mix: combine use of folk healing and Western medicine in case of severe illness.

Although most of the Hong Kong population believe that Western medicine is more fast-acting than traditional methods, a significant portion of the population has strong faith in traditional Chinese medical practitioners, such as herbalists, acupuncturists, and especially bone-setters (Lee, 1978; Koo, 1989). The Hong Kong population consumes many tons of birds' nest, sharks' fin, ginzhen, and expensive herbs a year. Self-medication and taking tonics are common practices for almost everyone in all age groups. Active marketing of such tonics further reinforces the cultural belief system and dependency. In case of severe, chronic or life-threatening illnesses, most families will consult a shaman or fortune-teller for spiritual instructions on what to do, in order to get out of the 'misfortune'. Although Western doctors often advise against mixing Chinese and Western treatments, the population does it as a regular practice (Lee, 1984).

PLURALISTIC AND ENTREPRENEURIAL HEALTH CARE SYSTEM IN HONG KONG

Chinese people are pragmatic. The nurturing component of health maintenance is regarded as more important than the curing component. Even young professionals trust the very bitter herbal tea if they have symptoms of 'hotness'. Therefore, the medical system in Hong Kong is a pluralistic and entrepreneurial one (Lee, 1978, 1984). There are large numbers of private clinics run by Western doctors, Chinese herbalists and bone-setters. There are also restaurants which offer medical consultation to customers before they order their food. The private market is very active. The government provides comprehensive out-patient service, specialist clinics and hospitals at very affordable costs (Working Group on Primary Health Care, 1991). The Department of Health runs a wide network of out-patients clinics as well as maternity and child health centres. The Hospital Authority runs the hospitals and specialist out-patients services. Since the establishment of the Hospital Authority, there have been marked improvements in service standards such as in waiting time, medical records, drug labelling, health indicators, access to information on illness, and public consultation.

Power Gap Between Doctors and Patients

Owing to the strong cultural respect for authority and the learned man, Chinese people in Hong Kong are conditioned to surrendering health responsibility to doctors. Cheung (1986) suggested that Chinese people's tendency to employ self-directed coping strategies might be related to the Confucian tradition of self-discipline. The Chinese aspire to the rule of the golden mean (中庸) (*zhongyong*), controlling emotions and maintaining an even temperament instead of being upset by unpleasant feelings. Together with respect for authority figures such as doctors, patients are expected to comply. Most patients dare not even ask the doctor about their diagnosis, treatment plan and prognosis (Lee, J.C.K., 1995). Nor are patients expected to make demands on the doctors or show their dissatisfaction with the treatment. There is an enormous power difference between the doctor and the patient. Patients have few rights. Not until 1994 was a very modest set of patients' rights and responsibilities promoted officially, but the emphasis was on responsibilities rather than rights.

As medical doctors dominate the health policy decision-making, other professionals and patients have very little or no influence on public resource allocation. Most of the medical and health resources are assigned to acute hospital care and relatively few resources to health promotion and public education.

SOCIAL WORKERS IN HEALTH CARE

The Neglect of Psychosocial Intervention in Health Care

As the medical model of treatment for physical illness has been taken as the main mode of intervention, the psychosocial needs of patients have been neglected.

> Betty was an eight year old girl with osteosarcoma. The doctors amputated her left leg as the operation seemed to be the most

> feasible treatment to contain her cancer. She was depressed and seldom spoke. After the operation, the orthopaedic surgeons, the oncologists and the nurses all congratulated each another on the 'successful' operation. Betty remained silent. She participated in the physiotherapy sessions and adjusted well to her prosthetic leg. The day she left hospital, she walked to the top floor of her building and jumped.

This is a typical, tragic case of superb medical intervention without psychosocial care. All health professionals should take 'total patient care' as their goal and 'improving the overall quality of life' as the ultimate measure of success. Betty could not accept her cancer right from the start. Doctors discussed her treatment with her parents but she herself was left in the dark. The medical social worker helped the family to apply for funding for her prosthesis but was too busy to talk to the child. The physiotherapists were excited by the quick rehabilitation process but they were not trained in psychosocial intervention. Nurses provided Betty with an excellent environment for recovery but did not regard counselling as their job. Without high quality psychosocial care, our medical system will only be treating diseases, not treating the patient as a person.

Health Issues in Social Work

Many social workers feel helpless about illness. Lacking knowledge of specific illnesses and their prognoses, the implications of treatment, side-effects, precautions in diet or life pattern, skills in home care, social workers find themselves poorly equipped to work with health issues. Too frequently, social workers do not have basic knowledge of such matters as how to control diabetes and arthritis, pain, heart health, how to manage dementia symptoms, although they may frequently come across these syndromes amongst their clientele. According to Travis (1966):

> Probably one explanation is that it is difficult to secure information from doctors or hospitals. Perhaps the most important reason for this is lack of sufficient knowledge to know what to ask, or to understand such technical information as is obtained. Medical terminology is complex and seems shrouded in mystery; even a doctor's

> handwriting may be difficult to read, let alone the substance of what he has written down (Travis, 1966:viii–ix).

Inside the hospital, without proper orientation to the hospital culture, it is sometimes impossible to understand the medical jargon. A medical social worker found this instruction in a patient's file: 'Discharge, MSW ppp'. The social worker did not have any idea what 'ppp' meant and only later found out that the doctor was asking the medical social worker to 'please prepare patient' for discharge.

Outside the hospital, health is an integral component of the situations social workers have to handle. Besides being familiar with the theories and concepts emphasized in the following chapter on the knowledge foundation for social work in health care, the practitioner needs a general understanding of Hong Kong people's conceptualization of health, the health care system and available resources (Wong and Chan, 1994).

Mr. Ding was a 68 year old man with dementia. His wife escorted him to a social centre for the elderly every day. One day, her youngest daughter was about to deliver her baby, so Mrs. Ding went to the hospital while Mr. Ding went to the social centre as usual. Mr. Ding and other elderly members were taken to a park that day. When the time came to go home, the welfare worker in charge could not find Mr. Ding and assumed he had gone home by himself. Mr. Ding was never seen again. When the welfare worker was interviewed, he said he had found Mr. Ding 'very healthy' as he played ping-pong everyday. The welfare worker did not understand that loss of orientation, one of the first symptoms of dementia, had nothing to do with the psycho-motor skills of Mr. Ding.

Social workers serving elderly persons are not trained in health care knowledge. They rely heavily on doctors and nurses for support and when medical support is not available, they are helpless. The general public is also very behind in health knowledge and information. If social workers and health professionals could be better trained in the physical and psychosocial needs of patients, a number of tragedies would be avoided.

Social workers are constantly being confronted with health issues in all practice settings. Community workers working in deprived neighbourhoods encounter problems of infection, environmental pollution and respiratory difficulties. Family service social workers are working with families suffering from chronic stress from caring for family members with physical or mental disabilities. Hospital medical social workers are bombarded by social problems of child abuse, battered wives, substance abuse and suicide (Lui and Adamowski, 1995). Social workers in industrial settings may have to deal with the trauma of industrial injury and death. Examples of health issues confronting social workers in different types of settings and their possible modes of intervention can be found in Table 1.1.

Table 1.1 shows that health is an integral part of social work practice in all settings. Social workers have to be equipped and confident in health-related interventions. Social workers encounter health issues and problems at an individual level, group and family levels, as well as policy and societal levels, therefore, it is essential for us to train our social workers at all levels of intervention.

Medical social workers are the ones who are working with illness-related issues all the time in their work (Tibbitt and Connor, 1989). I will now provide a brief account of the development of the medical social service in Hong Kong.

Medical Social Service in Hong Kong

Medical social service was first introduced in Hong Kong in 1939 in the form of financial relief. Miss Margaret Watson was the first appointed 'almoner' in the Medical and Health Department. Four Chinese assistants joined her later in the year. They were responsible for giving advice to patients in the utilization of welfare and health care centres, assessing the financial condition of patients who could not afford medical expenses, and forming a link between patients and voluntary welfare associations (Wong, 1990).

Medical social service was administered by the Medical and Health Department until October 1982 when the Social Welfare Department took over. Since then, there has been consistent emphasis on financial assessment. Doctors and planners in particular regarded medical social workers as 'fee-waivers'. This is despite the fact that the stated general objectives of medical social service in the Manual of Procedures for Medical Social Service of the Social Welfare Department (SWD, 1987) are much more comprehensively directed to the social and emotional needs of patients and their families. These objectives are:

1. to assist patients and their families with the social and emotional problems involved in illness situations;

Table 1.1 Health Issues and Areas of Intervention for Different Types of Social Workers

Social Workers	*Health Issues*	*Modes of Intervention*
Community Workers	poverty, unemployment, malnutrition, environmental deprivation and hazards, pollution	advocacy, volunteer mobilization, self-help, empowerment, networking
Industrial Social Workers	industrial health and safety, occupational hazards	adjustment to industrial injury and death, advocacy, legislative reform
Family Service Workers	family breakdown due to health crisis, illness and disability, domestic violence	counselling, bereavement, care-giver support, community care
Medical Social Workers	psychosocial issues arising in acute hospitals, specialist clinics, methadone clinics, homes and institutions	counselling, case management, financial and material assistance, fee waiving, discharge planning, patients' advocacy
Mental Health Workers, Psychiatric Social Workers and Rehabilitation Workers	stress, mental retardation, psychiatric crisis, suicide	mental health promotion, rehabilitation, social skills and life skills training, community rehabilitation
Youth Workers and School Social Workers	physical and sexual abuse, high risk behaviour, substance abuse, attempted suicide	rebuilding of self, adjustment to crisis, sex education and family planning, behaviour modification
Health Promoters especially Workers in the Field of Services for the Elderly	chronic illness, pain, mental health and self-care issues	prevention and early identification of health issues in elderly social service centres and community centres
Social Planners	social apathy, lack of health knowledge and awareness, gaps in service delivery, low consumer participation	research, problem identification, continuity of care, effective resource allocation, management and organizational reform, policy change, patients' rights

2. to enable them to make the best use of medical/rehabilitative services in the community;
3. to contribute to the total rehabilitation (physical, mental and social) of individuals and their re-integration into society; and
4. to strive for the promotion of health of patients, their families and the community.

The planning standard of one medical social worker to 90 hospital beds was established in 1975 and has not been revised since. Medical social workers are handling more than 100 beds each, besides having chronic patients to follow-up in the specialist out-patients' clinics. In a hospital of 1000 beds, there may only be 11 social workers who are responsible for serving all in-patients and out-patients (Wong, 1990). Owing to the manpower constraints, the psychosocial care of hospital patients is not provided satisfactorily.

> Mr. Lee was a computer technician. He broke his neck when he was 25 years old in a diving accident. He stayed in an acute hospital for six years, then in a convalescent hospital for three years. The medical social worker saw him five times during this period of nine years in relation to acquiring an electric wheelchair as Mr. Lee was totally paralysed. The electric wheelchair, which would have cost $50 000 was regarded as too expensive and the application was turned down. Mr. Lee was angry at not being offered support by the hospital when he needed it. He appealed to the public in a newspaper and received donations which enabled him finally to ride an electric wheelchair. Mr. Lee felt that he had not been given proper information about rehabilitation, had received no counselling after the traumatic injury, and no help with discharge planning or psychological support.

In a study of referrals to medical social workers in a hospital in 1993, only two out of 1000 admissions were referred to the medical social service and most of the referrals were because of financial difficulties. It seems that social workers based in hospitals need to do a lot more advertising of their proper role amongst other health professionals and need to be more assertive in seeking a wider range of referrals. Along with this, they will need to insist on a better staff-patient ratio.

The Psychosocial Needs of Persons with Severe or Chronic Illness

As mentioned above, the psychosocial needs of patients, especially those of people suffering from severe and chronic illness, are much neglected in the present health care system. And yet, serious illness can have deep and long-lasting impacts on people's mental health and social functioning. Psychosocial aspects need to be addressed from the very beginning of the illness (Dillon, 1985).

Upon diagnosis, patients and their families are desperate for information and support. The lack of adequate knowledge about the disease, about the diagnosis, the treatment, the prognosis, and about home care are the main stressors. The hospital Patients' Resource Centres can provide patients and family members with more information. A psycho-educational approach is found to be most helpful to patients upon new diagnosis.

Patients are often physically and emotionally vulnerable. Ill health has been found to have an effect on people's self-concept, sense of confidence and dignity (Charmaz, 1990; Chan et al., 1992). From local studies of patients with strokes and cancer, their major areas of disability and handicap include: household management, ambulation, sleep and rest, recreation and pastimes, and work. Financial problems and difficulties, housing problems, and problems of social isolation are also frequently reported (Chow, 1995; Chan et al., 1995). Most persons with chronic illness face financial problems and many are discriminated against and stigmatized in the labour market (Alliance of Patients' Mutual Help Organizations, 1994).

The disabling effects of illness on patients take different forms. For example, laryngectomees lose their speech, children with Cooley's Anaemia do not have the capacity to produce blood, locomotor functioning of elderly persons with Parkinson's disease deteriorates, the lung capacity of a person suffering from pneumoconiosis is limited, patients with chronic renal failure have to rely on dialysis. Moreover, the side effects of treatment can be disabling (Kwong, 1994). The side effects of steroids for patients with Systemic Lupus Erythematosus and rheumatoid arthritis for instance, can be life-threatening, significant numbers of these patients having frequent infections or chronic renal failure (Lee, P.S.H., 1995).

The mood and temper of persons with chronic illness are affected by the stress of prolonged suffering, which can, in turn, create further burdens for carers (Caroff and Mailick, 1985; Tang, 1994; Yiu, 1995).

> Elizabeth is 43; she is living with her mother who has had Alzheimer's disease for the past ten years. Her mother's mood changed suddenly and she started to scold her daughter all the time. Elizabeth could not understand this as her mother was always gentle and considerate in the past. Elizabeth worked full time and took care of her mother in the evenings. The emotional stress of the last ten years led to sleep problems for Elizabeth, who had to seek psychiatric help. There seemed to her to be no end to her problems.

Family members of chronically ill persons are frequently exhausted physically and emotionally, and are at a loss what to do. Yet there are no community support services for them or any information and advice available. If more resources were invested in health promotion and health awareness, family members could be more confident in dealing with their ill relatives (Tong, 1995).

Feeman and Hagen (1990) found that children with a health problem and their non-afflicted siblings are at risk of developmental lag and related problems. In addition, families of children with chronic illness will function less effectively than families without such a child. Adolescents' reactions to illness can include: anxiety, mourning, resentment, increased hypochondriacal symptoms, and flight. Tong (1995) organized a group of adolescents suffering from diabetes to help elderly people and children with diabetes (see Chapter 15). These teenagers were previously quite rebellious, often denying their health status by non-compliance with their regimen. After they joined the group and were given the responsibility of helping others, they began to change. They converted the dietary food into calories and participated actively in helping others. They found some meaning from their illness, becoming more caring and sensitive to the suffering of others (Chan et al., 1993).

Psychosocial Intervention Can Help

A few illustrations of successful intervention in psychosocial aspects of illness will suffice here. The Community Rehabilitation Network of the Hong Kong Society for Rehabilitation organized 367 programmes for chronic patients over a period of 14 months (April 1994 – June 1995). The programmes served 58 410 participants. More than 2000 patients participated in support groups and self-help groups. Findings from a quality of life study of patients before and after receiving psychosocial intervention from the Community Rehabilitation Network, support the view that appropriate psychosocial intervention can ameliorate feelings of helplessness, depression, dependency, and isolation (Hong Kong Society for Rehabilitation, 1995; Lee, J.C.K. 1995; Chow, 1995).

Mr. Choy was 58 when he was diagnosed as having cancer of the larynx which had spread to his oesophagus. He underwent surgery and lost his speech. He wound up his business and retired. For ten years, he stayed home. He stopped going to church as he was angry with God. Life was miserable for him and his wife. Then he met other long-term laryngectomy survivors in the Hong Kong New Voice Club, and realized that he was not the only person who suffered from loss of speech, and that it can be compensated for with many devices for regaining verbal communication. He realized that he could find meaning in his life by acting as a volunteer in the self-help group. At the age of 68, he devoted all his time to organizing activities in the Hong Kong New Voice Club. Partly thanks to his participation, the Club obtained donations from the Hong Kong Cancer Fund and the Community Chest to hire its own full time social workers. Mr. Choy also helped in setting up the Alliance of Patients' Mutual Help Organization in 1992. He was at peace when he passed away in 1993.

Impact of Psychosocial Support on Cancer Patients

Mr. Choy can be said to have adopted constructive coping strategies and through helping others, helped himself. The Community Rehabilitation Network for chronic patients adopted other coping strategies when it organized a 'cancer fighters' training course for cancer patients. From June 1994 to June 1995, the Network organized five training courses in which more than 60 patients participated. Members then organized themselves into self-help groups and provided support to one another. They also acted as volunteers and peer counsellors to newly-diagnosed cancer patients. The members were asked to fill in a questionnaire on their mental health, social support, life satisfaction, communication with health professionals and quality of life over a period of six months. All members reported significant improvements in their quality of life and life satisfaction at the end of the six month period (after their training course) (Chan, 1996a, 1996b).

Pain Control

Pain is a constant source of torture for patients (Baszanger, 1989). Patients living with perpetual pain may be irritable and depressed. Diseases such as ankylosing spondylitis and rheumatoid arthritis cause great pain. Counselling programmes, therapeutic groups, meditation and self-help are found to be useful in supporting patients in the tolerance of pain and its control (Favier, 1990; Williams, 1989; Lee, P.S.H. 1995).

> Ling, a woman of 38 years, had been diagnosed as having rheumatoid arthritis when she was 18. Her knees and fingers had started to bend. She had tried Chinese medicine but it had not helped and her condition had deteriorated rapidly. Over the last 20 years, she had both knees, shoulder and elbow joints replaced by artificial joints. She lost her job in a public utility company and became welfare dependent. However, she learned to type in Chinese in a rehabilitation centre and could type 40 Chinese words per minute with her remaining one usable finger. So she took on a job as a part-time typist. Through her support group, Ling also learned to live with her pain and became more independent. Later, not only did she tolerate her own pain, she visited other patients and provided them with peer counselling.

Support for Family Members

Family support to patients is of paramount importance and social workers are usually the people who get family members involved (Oen, 1991). Wallander and Varni (1989) found that positive affect, affirmation, and reciprocity from both partners and family were associated with less depression, higher marital quality, and better family functioning. Sick children with high familial and peer social support were found to be significantly better adjusted than those with only one or neither of these sources of support.

It has been found that psychosocial intervention can increase parental coping skills in handling children with chronic illness (Lewis, et al., 1989; Tong, 1995). The Community Rehabilitation Network organized support groups for mothers of children with diabetes, epilepsy, Cooley's Anaemia, and cleft palate.

Social and Community Mobilization

Having friends and social support are vital to the quality of patients' lives (Ma et al., 1993). Satisfaction with one's health and lower levels of worry and stress are associated with higher levels of satisfaction with friends and outside activities (Wilson et al., 1990). Social centres and activities for patients and their care-givers could be crucial in keeping them connected to society. Programmes such as family counselling, social skills training for patients and family members, self-help and support groups can increase support for persons with chronic illness or disability (Wallander and Varni, 1989; Wong and Chan, 1994; Chang and Chan, 1994). An educational approach to health promotion and self-care education means a great deal to patients. Health professionals need to be active in the education and training of patients (Black, Doran and Allegrante, 1986). Up to the time of writing, the Community Rehabilitation Network of Hong Kong has mobilized more than 100 volunteer health professionals to help in patients' groups and in illness-related education.

The examples quoted throughout this chapter give some idea of how vital and how effective psychosocial intervention can be in matters of health. Later chapters will go into further detail to show more precisely how different modes of social work intervention can be effective with different client target groups.

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The underlying concepts of crisis and coping expressed in Chapter 2 underscore each chapter in this section, but each chapter proposes a different intervention mode in response to the different crises and target population.

In Chapter 3, Lianne Yau-yee Tai uses the concepts of crisis and coping that were introduced in the previous chapter. Taking Roberts' (1991) definition of a crisis as 'a period of disequilibrium experienced as a result of a hazardous event . . . that cannot be remedied by using familiar coping strategies', she holds that a person's functioning following such a crisis can not only be restored by crisis intervention, but that such a crisis can be a learning opportunity leading to better coping in the future. She demonstrates this when working with unwed teenage mothers, as she applies the steps of 'classical' crisis intervention systematically at the different stages of the girls' experience before and after the birth of their babies, activating coping responses at each stage.

Shing-fu Li, highlighting the critical nature of suicidal situations in Chapter 4, describes handling suicidal cases and crisis intervention. To enlighten the reader about the specific crisis of suicide, he first of all presents some explanatory theories. There can be common conceptualizations of crisis with variations on intervention. After stressing the importance of the therapeutic relationship in work with suicidal clients, the writer proposes logotherapy — enabling clients to find meaning in life — as an appropriate intervention method.

In Chapter 5, working with the crisis of cancer, Pamela Pui-yu Leung emphasizes the stress component of the crisis theory expounded in Chapter 2. She gives an account of a Psycho-educational Support Group for Cancer Patients. Her choice of a psycho-educational approach derives from Lazarus' argument that stress begins with one's appraisal of a situation (Davis, Eshelman and McKay, 1988). Her stress management model thus embraces cognitive restructuring and positive thinking and includes a behavioural dimension in the shape of behavioural exercises. She also includes emotional, physical and spiritual dimensions to complete a holistic framework.

The concept of coping continues to run through this section, though in chronic rather than crisis situations. Stress and coping are themes in Chapter 6, this time in the context of bringing up handicapped children. Here the authors, Leung, Tsang and Wong draw on ideas from the developmental perspective to enhance coping, in particular the assumption that people have within themselves the capacity for self-help. The parents of handicapped children are seen as the experts, or potential experts, in helping a handicapped child. This chapter shows how these parents' potential for self-help, mutual help and for assuming advocacy roles in the community can be actualized.

In Chapter 7, Ho-yee Ng gives an exposition of coping enhancement with chronically ill children. She takes Johnson's (1985) three goals for parents of chronically ill children: to help the child manage the illness, to help the child cope with the realities of the illness while developing as normally as possible, and to maintain the normal functioning of the family. She illustrates how a selection of intervention modes can be adopted to help parents and children achieve these goals, emphasizing a psychosocial approach.

The stress factors involved in childhood epilepsy are examined specifically in Chapter 8 by Debbie Oi-bing Lam who proposes a concentric systemic model, intervening with this target group at multiple levels. She suggests ways of enhancing coping by working with individuals and with groups, and drawing on a developmental perspective, advocates self-help groups and the participation of those who have epilepsy themselves in community education, at the environment level.

Ivy Kin-yi Chan discusses the biopsychosocial approach in assessing drug addictive behaviour in Chapter 9, taking the reader through the treatment stages of assessment, detoxification and relapse prevention. Goals are to consolidate adaptive coping and problem-solving skills, and perspective building, where clients are helped to make physical, emotional and social changes in their lives. The writer concedes that the biopsychosocial approach, though useful in assessment, fails to provide explicit treatment guidelines and incorporates other models to concretize intervention in helping clients cope with the physical, emotional and social stresses confronting them.

Engaging people's cognitive abilities (perhaps residual ones following some trauma) in coping with stress and learning new adaptive skills are the common threads throughout this section. The social worker frequently assumes a teaching role. In Chapter 10, Sandra Kit-man Tsang shows how systematic training based on learning theory can help sufferers of schizophrenia remedy cognitive deficits (such as poor memory, short attention span and low motivation), and acquire new or improved social skills. She suggests that family members can also be trainers and help clients maintain these skills.

In Chapter 11, Alice Ming-lin Chong and So-fong Wong present in detail a reminiscent group model with institutionalized elderly persons, based on the assumption that the process of reminiscence can boost the self-concept in times of stress (Lewis, 1971). Exercising their cognitive powers to recall and reassess the past and relate it to the future, has been found to strengthen the personal adjustment of elderly people and can help them adapt positively to institutional living (Havighurst and Glasser, 1972).

In Chapter 12, Rosanna Kam-hing Soo describes a structured and controlled concept-based therapeutic community for women drug abusers, where intervention is based on a programme of social learning, emphasizing the importance of the women's active participation in the therapeutic community. The women learn to take responsibility for themselves and for others in the community, as all members are expected to be role models. Peers and staff are regarded as therapists and the residential staff are ex-addicts. Soo comments on her own experience as a social worker in such a controlled setting.

In the last chapter of this section, David Wai-kwong Man discusses the rehabilitation of cognitive functioning of those who have suffered from brain injuries. In this new field, cognitive rehabilitation and skills training aim to maximize the remaining capacities of these brain-damaged patients, the patients and their families or other support systems all being involved in the teaching and learning of compensatory or alternative strategies, to cope with everyday living.

The many definitions of empowerment have been broadly summed up by Simmerman and Rappaport (1988) as a process whereby individuals gain mastery and control over their own lives and democratic participation in the life of the community. The three chapters in this section each focus on a particular chronic condition that brings enormous stress and anxiety and often a sense of powerlessness to the individuals themselves and to their families. Empowerment procedures are yet another approach to coping with stress.

In Chapter 14, Donna Kam-bun Wong explains the social oppression of the government's earlier rationing policy regarding dialysis treatment for renal patients. She describes how renal patients were organized and trained to form an advocacy group to change the rationing policy. Social work students and patients participated in gathering information, in lobbying and negotiating with Legislative Council members, government and other organizations, with the gratifying result of the rationing policy being changed. She concludes that participants gained an awareness of their power to contribute to change in the environment, and a sense of control over their own lives.

In Chapter 15, Choi-ying Tong uses the concept of empowerment to describe her work with three target groups of diabetics: elderly diabetics, diabetic youth and mothers of diabetic children. She portrays some of the many psychosocial implications of diabetes and finds that different psychosocial issues have prominence in the different groups. She describes empowerment programmes that were run, acknowledging the variation of psychosocial needs in the different groups. She made use of Miller's (1983) empowerment model of increasing knowledge of the illness, raising the self-concept and the physical reserves, improving the social network, strengthening the belief system, motivation and energy.

In Chapter 16, Eva Yee-wah Liu gives an account of a self-help group for parents of children with Cooley's anaemia, which was inaugurated in 1981. In those days, 'empowerment' was not heard of in Hong Kong, but the principles underlying self-help and empowerment have much in common, and empowerment concepts are implicit throughout the development of this group. Intervention aimed at increasing knowledge of the condition, improving self-management, providing opportunities for mutual support, and also opportunities for decision-making and action. Liu describes the development of the group which graduated from a pilot social work group to a self-help group with the social worker acting as consultant, to becoming a registered association.

'Resources' are widely interpreted in this final section, referring to resources within the family, within an institution or in the hands of the government. Interventions at individual, group and community levels are suggested.

In Chapter 17, Veronica Pearson and Sin-ping Ning recognize the family as a valuable resource in caring for family members with schizophrenia. They also recognize how exploited families can be when the community gives them little or no help in their demanding task. The authors plead strongly for more professional input to teach family members about schizophrenia, to make services more user-friendly, with respite care to reduce the stress on carers, and to regard families as partners in the care team.

In a hospital institution, as Zarina Chu-lee Lam points out in Chapter 18, the social worker has to be resourceful in mobilizing and coordinating services. Lam presents here a systematic discharge planning process, depicting the social worker's role at each step. She argues that discharge planning should be an inter-organizational effort, and that community resources management and resource development are neglected areas that need more attention.

On a wider canvas, Siu-hong Kong presents in Chapter 19 an action plan for mobilizing resources through policy change at a government-provision level. His plan includes analysis and evaluation of existing and proposed policies, illustrated with a proposal for supported employment for disabled people. He gives guidelines for gaining the support of policy makers, involving the disabled themselves as advocates.

In Chapter 20, Kan-kam Chan and Ernest Wing-tak Chui also deal with social work intervention at a macro level, showing how community workers, acting as change-agents, achieved legislative changes to improve the financial position of previously neglected silicosis victims. They describe the case of the Hong Kong Worker's Health Centre which, following rigorous policy analysis, trained and organized silicosis victims to participate in comprehensive strategies for influencing government decisions, thus gaining their goals.

The final chapter shows how social workers actively intervene in primary health care, and how the people in a community can be mobilized to achieve improved dental health services. Edward Chin-man Lo and Cheong-hay Chu report on a multi-disciplinary community organization approach to promote oral health in a rural district. Community participation was the key; community leaders, school teachers and dentists took part in the planning, promotion and implementation of programmes which were mainly targeted on the elders and the children. Clinical evaluation showed improved dental health, especially among the children, of the district.

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