Family-Based Mental Health Care in Rural China

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— Britta Erickson, *The Art of Xu Bing*

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CHINESE FAMILIES AND MENTAL HEALTH

In Chinese society, people with mental health problems, such as schizophrenia, are recognized by the rapid mood changes or very obvious behavior problems. Traditionally, mental disorders are differentiated by seven kinds of emotions. Emotional disorders may be described in somatic terms of having a physical discomfort. In Western society, a mental illness, such as schizophrenia, is termed a primary thought disorder. However, a thought disorder is difficult for people to accept in Chinese society (Xiang, Ran, & Li, 1994; Chiu, 1987). Even health care professionals refer to the Chinese medical classic Huang-Ti-Nei-Ching Su-Wen (皇帝內經素問), where functional psychoses (Tien-Kuang, 癲狂) are described as disturbances of mood or behavior, rather than of thought.

There are also many Chinese traditional beliefs or prejudices about mental illness and people with symptoms of mental illness. These beliefs, which are prevalent in the rural areas, include sorcery. Spirits and ghosts are thought to be responsible for illness. People with mental illness are believed to be possessed by a ghost (Gui Shen Fu Ti, 鬼神附體). Psychotic patients are believed to be cruel and prone to violent acts (Jing Shen Bing Ren Jun Can Bao, 精神病人均殘暴). Mentally ill people are believed to be lunatics (Feng Zi, 瘋子). These beliefs result in severe stigmatization of people with psychotic symptoms (Zhang, Yan, & Phillips, 1994; Xiang, Ran, & Li, 1994).

Mental illness may also be considered as punishment for an ancestor's misbehavior or for the family's current misconduct. This comes from an old proverb, "The ancestor's misconduct will result in punishment of children and grandchildren" (Qian Bei Zuo Lie Hou Bei Shou, 前辈做劣后辈受). Such Chinese proverbs as "Like father like son" (You Qi Fu Bi You Qi Zi, 有其父必有其子) reflect the belief that mental illness is hereditary. Other beliefs include

traditional views held by community members that mental illness is related to family problems, such as "geomantic omen" (Feng Shui, 風水) or "ancestor's tomb" (Zu Fen, 祖坟). These beliefs imply pathology in the family karma. This, in turn, may lead to discrimination of those suffering from mental illness and their family. Unfounded fears and misunderstandings about people with mental illness and their families are prevalent in all sectors of Chinese society and, even more so, in the undeveloped rural and ethnic minority areas.

It will take concerted effort over a prolonged period to bring about a change in public awareness and attitude toward people with mental illness (Wang, S. C, 1994). In these situations, family members of people with mental disorders, such as schizophrenia, often have strong feelings of shame and guilt about the illness and the ill family member. Many of these families blame themselves for causing the illness. As a result of these feelings, many family members believe in witchcraft and fate. Consequently, they seek spiritual treatment for the ill member, especially in rural areas. It is not surprising, then, that a high proportion of rural residents with mental illnesses are treated in the community by alternative healers, such as shamans (Li & Phillips, 1990) or "witch doctors" (Xiang, Ran, & Li, 1994). Over half of the interviewed persons with schizophrenia in rural China had accepted spiritual treatment (Xiang, Ran, & Li, 1994; Ran et al., 2003c). More women (58.6%) accepted spiritual treatment than men (41.4%) ($p < 0.05$). In another study of 145,201 mental disorder cases from 28 counties of Sichuan Province from 1987 to 1988, 42.7% of people had sought witchcraft treatment (Xiang et al., 1990).

The myths and beliefs surrounding mental illness constrain those with the symptoms, their family, and the community (Wright, Watson, & Bell, 1996). These constraining beliefs prevent recognition of the illness and, in turn, prevent the family from seeking other mental health care options. In this way, many people who experience mental illness go unrecognized, while at the same time, continue to suffer with severe symptoms. Families usually accept the notion that mental illness cannot be cured and that medication has no effect on the illness, but only wastes the family's money (Ran et al., 2003a). Thus, patients usually only receive treatment when they show severely destructive behavior. In one of our studies (Ran et al., 2003c), results indicated that, among 354 patients with schizophrenia who accepted treatment, initial symptoms causing their relatives to take them to seek help included: bizarre speech and other bizarre behaviors (268 cases, 75.7%); violent, aggressive, or suicidal behavior (40 cases, 11.3%); change in life routine, including personal hygiene, sleep, and diet (24 cases, 6.8%); disabilities of social function at school, work, and home (14 cases, 3.9%); and complaints of physical discomfort or pain (8 cases, 2.3%). The results indicated that most families would not take patients to the doctors unless the patients had severe behavioral symptoms.

Moreover, for these 354 treated patients, their relatives' recognition of the above abnormal symptoms was as follows: 169 relatives (47.7%) did not know what problem the patients had, 105 (29.7%) thought that something was wrong with the patient's brain, 45 (12.7%) believed that the patients thought too much, 28 (7.9%) insisted that the abnormal behavior was caused by ghosts or gods, and 7 (2.0%) believed that the patients suffered from physical illness (Ran et al., 2003c). The results indicated that most relatives in the rural community had no knowledge of mental illness.

Beliefs also influence how family members deal with the psychotic symptoms (Wright, Watson, & Bell, 1996). It is commonly thought that people with mental illness cause social disruption, destruction of property, or personal injury (Zhang et al., 1994). When these events occurred, they had been expected. If there were no serious disruptions, family members would let people suffering from mental illness live as normal a life as possible. Maintaining harmony in the family is highly valued in Chinese society, however, if behavior becomes unmanageable, family members often lock up ill persons or restrain them at home (Xiang, Ran, & Li, 1994; Ng, 1990).

A Chinese proverb, "Not spreading shameful news out of the family" (Jia Chou Bu Wai Yang, 家丑不外扬), reflects a strong belief that family matters should be kept within the family and should not be discussed with outsiders (Xiong et al., 1994; Ran et al., 2003d). This is another constraining belief that often prevents the family from seeking help from outsiders or government agencies. Unfortunately, until these attitudes change, families and people with mental illness will not benefit from available mental health care.

FAMILY ROLE IN MENTAL HEALTH

The Chinese proverb, "Family is a cell of society" (Jia Ting Shi She Hui De Xi Bao, 家庭是社会的细胞), is reflective of the importance of family as the functional unit of society, as well as the central role families have in caring for members with mental health problems. Families are expected to exert "control" over and "direct" the lives of their mentally ill members. This originates in the traditional Confucian values of family self-reliance and lifelong interdependence, "faithfulness" (*Zhong*, 忠) and "filial piety" (*Xiao*, 孝). The Chinese government reinforces these values to ensure families continue to provide service for their ill members. For example, "filial piety" has been used as the basis for a welfare network to support the elderly in the rural areas (Chow, 1991). By reinforcing these values, the government diminishes the role of the state in service provision.

The 1980 Marriage Law formalized a long-standing tenet of Chinese culture by stating that the family "takes care of its own needs." This law was put in place primarily because the government could not provide sufficient resources to care for the large numbers of disabled citizens. The law emphasized the obligation of spouses, parents, and children to offer each other support and assistance during times of incapacity, including mental illness. Although this was appropriate for most families, it seemed to be the only option with no other alternatives (Pearson & Phillips, 1994).

With the traditional values and sociopolitical environment in China, it is not surprising that over 90% of persons with chronic schizophrenia live with family members. This is much higher than in Britain and America, where 60% and 40%, respectively, of persons with schizophrenia live with their family (Torrey, 1988). With the lack of community mental health services and the ill member having to live at home, family members have no choice but to become primary caregivers for the chronic mentally ill. . Family members are involved in providing food and housing. Families also often organize employment and arrange marriage for the person with mental illness.

Unmarried people in China usually live with their parents. Finding a spouse and maintaining a marriage is important in Chinese society. Marriage is so central to the concept of adulthood that unmarried persons over the age of 25 may be considered social misfits (Pearson & Phillips, 1994) or even troublemakers. Unfortunately, the social stigma or discrimination associated with mental illness is so great that it makes finding a marriage partner very difficult for the person with mental illness. In rural China, the problem of marriage may be more severe for men than women. It is also very difficult for people suffering from mental illness to maintain the marriage after the initial episode and, even more so, if there are relapses. This is exemplified by the fact that the divorce rate of married schizophrenic patients is almost 10 times higher than that of the general population (Phillips, 1993).

The family acts as the intermediary between the person with mental illness and the larger system of community services. Family members often make all health care decisions for their ill family member, including seeking out specific health care practitioners. These might be a Western doctor, a Chinese traditional doctor, or a folk healer (Phillips, 1993). Family members always accompany the ill member to clinic visits and play an important role if hospitalization occurs (Fan et al., 1994). The family is instrumental in the success of any mental health service intervention. It is important, then, that all mental health service networks include the family and collaborate with them in implementing interventions.

According to cultural values and Chinese law, unemployed and unmarried people suffering from mental illness remain the lifelong responsibility of their

natal families. The Western practice of preparing people with a long-term psychiatric illness to live independently, therefore, is unrealistic in China, unless there are sufficient alternative community facilities.

Currently, traditional Confucian values of family self-reliance and lifelong interdependence (e.g. "Raise a son for security when getting old" [Yang Er Fang Lao, 养儿防老], "Serving the elderly" [Shan Yang Lao Ren, 赡养老人]) are threatened by various factors. These include the one-child-per-family policy, higher rates of divorce, greater mobility, low-level specialist medical care and other welfare services, individualism, and consumerism. Although families remain the most important social unit in China, urbanization and Westernization may lead to changes in traditional values. Traditionally, families have accepted unlimited responsibility of supporting other family members. This is being eroded, however, and is most evident in families trying to cope with the increasing burden of caring for chronically disabled family members (Phillips & Pearson, 1994b; Ran, 2002).

Social changes are affecting both the capacity and willingness of the family to provide care for the ill relatives. With the one-child–policy, family size is decreasing, and there are fewer family members to share the responsibility of caring for ill members, therefore, home care is becoming more difficult. The need for social care or welfare will increase because family members will not be available to provide the necessary care at home. At the same time, hospital costs of care to the family are increasing. Families are less willing to bear the long-term financial and social burden of caring for mentally ill family members. Currently, the Chinese government cannot supply sufficient mental health care for most people who suffer from mental disorders. Thus, there is a dilemma looming on the horizon. When family size is substantially reduced as parents die and siblings leave home to get married, who will provide care for the people with mental illness? How can provision for mental health services be made available for homeless people who suffer from mental disorders? How does the Chinese government and society face these challenges?

FAMILY BURDEN

The burden of mental illness is a staggering worldwide problem. There are many socio-cultural changes in contemporary China that will increase the family's care- giving role. The government focus is on the development of community care, implying care by the community. This has meant the burden of care "by the community" has shifted from the state to the family, however, there has been no corresponding shift in social support resources for the caregiving families

(Zhang et al., 1988; Ran & Zhang, 1999). In addition, people with mental illness and their families have difficulty accessing the appropriate and limited mental health service resources that are available (Johnstone, Owens, & Gold, 1984; Meltzer, 1991; Hunt & Hemmings, 1991).

In both Eastern and Western society, family members of those suffering from schizophrenia share similar concerns and complaints. They have indicated a need for guidance and advice in handling the ill member's disturbed behavior at home, gossip of neighbors, and fear of another relapse (Pearson & Phillips, 1994). They struggle to assist their ill family member to live a normal life. The situation is often hindered because families in many Eastern cultures, including China, can be primarily passive in their relationship to the mental health care system. The hierarchical power structure between physician and patient has prevented families from expressing their needs that could justify more professional interventions. At the same time, officials who are required to develop services obtain small amounts of financial support from the government, but they often have little training, interest, or experience to guide the families.

It seems unreasonable to expect families to deal with their care-giving problems without help and knowledge of the situation. Ethically, people with a mental health problem and their family members have a right to understand the illness and related problems. This means that every person has the right to receive counseling or education on how to manage his/her illness. The rise of consumerism has also highlighted the rights and responsibilities of individuals with schizophrenia and their families for mental health services (Lehman, 1996). A crucial issue in mental health services, therefore, is how to protect the rights and reduce the burdens of caregivers for persons with schizophrenia.

Although families have to bear the long-term financial and social burden of caring for mentally ill family members, they are noticeably absent in any initial discussion of policy development. Traditionally, the role of people suffering from mental illness and their families has been neglected in the development of mental health policy. Because of the lack of consumer input in the development of policy, the rights and needs of patients and their families may continue to be neglected. In addition, the families' therapeutic potential and capacity to affect the illness are largely ignored (Pearson, 1993; Ran et al, 2003a).

SCHIZOPHRENIA

Mental illness is a major health problem in China and was the ninth cause of death in 2000 (China Health Year Book Editorial Committee, 2001). Severe mental illness, such as schizophrenia, is of major significance for China's health

resources. Schizophrenia is the most frequently diagnosed severe mental illness.

There is evidence indicating that one in every 100 people worldwide may develop schizophrenia (Ascher-Svanum & Krause, 1991; Mueser & McGurk, 2004). The prevalence of schizophrenia was 6.55 per 1,000 persons in China in 1997, which is a significant increase over that reported in 1982 (4.26 per 1,000 persons) (Chen et al., 1998; Cooper & Sartorius, 1996). In 1996, the total number of persons with schizophrenia (age from 15 to 65 years) in China was estimated to be approximately 5.3 million, of whom 4.3 million live in rural areas (Ran et al., 2003a).

Schizophrenia, a term given to a complex group of mental disorders, exacts a heavy toll on the lives of both those who develop this disorder and their families, and which constitutes a major health care cost (Ran & Zhang, 1999; Lehman, 1999). The nature of schizophrenia is found in the interface of environmental, behavioral, and biological factors. It is a heterogeneous disorder that is characterized by extreme disruptions of thought, perception, behavior, and emotion. The causes and symptoms may differ but all persons with schizophrenia have one thing in common: at some point, they are seriously out of touch with reality. Approximately 30% of people with schizophrenia have a number of exacerbations that lead to a chronic residual state and is characterized by pervasive impairment in social, cognitive, affective, and daily functioning. This is due to the illness itself or to psychosocial environmental factors, or to the interaction of both. For this reason, schizophrenia is the most disabling of the major mental illnesses (Birchwood & Smith, 1987; Ran, Xiang, & Jiang, 1992; Xiang, Ran, & Li, 1994). In the 1987 Chinese national investigation of disabilities, 90.6% of persons with schizophrenia were assessed as disabled (Ran, Xiang, & Jiang, 1992). Mental disability refers to the individual with mental illness whose current sustained illness duration is more than one year, and the illness has affected the patient's family and/or social functioning (Editor Committee of Epidemiological Survey Handbook of Mental Disability, 1987). The prevalence of mental disability was significantly higher in rural areas (0. 43%) than in urban areas (0.38%). Schizophrenia was one of the major mental disorders with the highest rate of disabilities.

Studies over the past three decades indicate that over 90% of suicide victims have a psychiatric disorder at the time of death (Cheng, 1995; Conwell et al., 1996; Beautrais et al., 1996; Henriksson et al., 1993; Vijayakumar & Rajkumar, 1999). Schizophrenia is one of the most common psychiatric disorders with the highest suicide rate (from 147 to 750 per 100,000 person-year, with 9% to 15% of patients completing suicide, 18% to 55% attempting suicide) (Westermeyer, Harrow, Marengo, 1991; Harkavy-Friedman & Nelson, 1997; Schwartz &

Cohen, 2001; Schwartz & Petersen, 1999). Suicide is also the most frequent cause of premature death in patients with schizophrenia (Allebeck, 1989; Caldwell & Gottesman, 1990). In one study in Xinjin County, the first author's team found that the rate of suicide attempts was 7.45% in patients with schizophrenia (Ran et al., 2003b). Suicide attempts were significantly associated with depression and hopelessness in these patients. Patients with suicide attempts were younger and had an earlier age of onset than those without suicide attempts. The rate of suicide attempts in these patients may be largely influenced by the illness itself. Community-based services may contribute to the prevention of suicide among these high-risk patients.

For various reasons, many of these patients (43.7%) do not receive drug treatment or may experience repeated relapse even when on medication (Ran, Xiang, & Jiang, 1992). Only 15.9% of patients with mental disabilities were hospitalized once, and 15.4% of these patients were taking medication. These people, for whom medication is not effective, will experience a poor quality of life (Li et al., 1998a; Tang, Xiang, Ran, 1998; Wang et al., 1996).

Individuals with schizophrenia constitute a major psychological, economic, and welfare burden for the state, the community, and the family (Hou, Xiang, Ran, 1997; Li et al., 1998). Schizophrenia typically develops in late adolescence or early adulthood. Because of the early age of illness onset, many people with schizophrenia remain jobless because companies do not want to take responsibility for the lifelong commitment to health costs that this will entail. Some families can bear the financial burden themselves, but most will not. In our studies, 57.8% of families did not wish to take active care of the ill family member (Hou, Xiang, Ran, 1997). Moreover, people with schizophrenia caused severe disturbance to their communities, including murder or arson (0.7%), damaged property, violence- causing injury or disturbance to social order (37. 5%) (Xiang et al, 1990). In the West, the cost of health care for persons with schizophrenia comprises 22% of the total mental illness cost (Rice & Miller, 1996). Given the enormous personal hardship for individuals with schizophrenia and their families, as well as the staggering costs of the illness for societies, research in schizophrenia has become one of the top priorities in many countries.

The etiology of schizophrenia is multifactorial, which means that a combination of biological predisposition and environmental circumstances is necessary for the manifestation of the illness. This shift in orientation, in the past few decades, away from an either/or (biological or environmental, e.g. family interaction) point of view, has instigated a great deal of research. Substantial evidence indicates that, in almost all course and outcome measures, patients from developing countries fared better than those in the industrialized world (WHO, 1973; Lin & Kleinmann, 1988; Jablensky et al., 1992). What is the reason for

this outcome? One crucial issue in contemporary society is determining ways to improve the prognosis of schizophrenia in different societies.

Patients with schizophrenia and their families are one of the major consumers of mental health services in China. What can be done to provide mental health services for these people and improve their illness prognosis? One solution is described in the following chapters. A description is given of a psychoeducational family intervention and a research project that demonstrates the intervention, using a randomized controlled trial in Xinjin County, Chengdu.

3

OVERVIEW OF PSYCHOEDUCATION FAMILY INTERVENTION

INTRODUCTION

Psychoeducational family intervention is one of the major psychosocial family intervention approaches to schizophrenia. Other major psychosocial family interventions include behavioral family therapy, social skills training, support in coping with residual psychotic symptoms, and cognitive rehabilitation (Penn & Mueser, 1996). Psychoeducation refers to "the use of educational techniques, methods and approaches to aid in the recovery from the disabling effects of mental illness. It is frequently used as an adjunct treatment for mental illness, usually within the framework of another ongoing treatment approach or as part of a research programme" (Barter, 1984). This definition is broadly applied to the family education studies.

Psychosocial family interventions were developed to provide information and skills training directed at improving patient and family functioning, as well as support to prevent relapse (secondary prevention). Family interventions vary both in content and delivery. The intervention can be in the form of a short course, community education campaign, small ongoing training, or intensive family intervention. Education is easy to understand, can avoid confusion, and can be available to a greater number of families than any other intervention. Education can be provided at relatively low cost (Hatfield, 1994). Educating family members is also an ethical and moral issue. Consumers have the right to be informed and their need for information is often great (MacCarthy, 1988). This means that patients and family members should be provided with support, information, and management strategies. Goldstein and his team (1978) first reported positive results from a crisis-oriented family therapy intervention. Prior

to designing a psychosocial family intervention for schizophrenia in the Chinese population, it was important to evaluate the characteristics and effects of previous family interventions, particularly from a cultural perspective.

There are several major aims of psychosocial family interventions. These include: 1) transmitting information with the goal of explaining treatment and increasing knowledge; 2) reducing family members' guilt, blame, and shame, particularly about etiology; 3) encouraging realistic expectations regarding the prognosis and rehabilitation process; 4) giving practical advice about management, including ways of reducing negative expressed emotion (EE) (Atkinson & Coia, 1995) and coping with the illness; and 5) changing illness-related behavior or increasing the use or contact with the mental health care system.

International studies related to family education suggest changes in four particular areas.

1. Knowledge Gain

Family members have responded positively to the educational approach. Education can provide considerable knowledge gain for both family members and the individual suffering from mental illness. The length of the educational sessions can vary, and research reports indicate that three education sessions may lead to a more significant knowledge gain than just one session. Brief education sessions, however, cannot increase the knowledge level in all aspects of the illness, and, although the education effect is positive, it may not be sustained for a longer period of time (Lam, 1991). Sometimes the knowledge gain can be maintained, but other cognitive, emotional, and behavioral changes cannot. For example, Smith & Birchwood (1987) found that knowledge gains were maintained after the educational sessions, but all nonspecific effects disappeared at the six months' follow-up. Research studies have also failed to show a relationship between the amount of knowledge acquired and other outcomes, such as stress reduction and attitude change (Lam, 1991).

2. Belief Systems Change

The beliefs of people with mental illness and their families have a major impact on how they view the illness and how it is managed long term. Education on its own has been found to have a limited effect, or no effect at all, on family belief systems. Belief systems about mental illness and its management vary and may include family's beliefs and expectations about their role in treatment, the effectiveness of medical treatment, the patient's control over symptoms, and family fears about the individuals and their behavior. Beliefs largely determine the interactional patterns and relationships in families (Wright, Watson, & Bell, 1996).

Families did report positive changes as a result of psychoeducational programs. Families were satisfied with their knowledge of schizophrenia, and there was a trend for family members to be more optimistic concerning their role in treatment. Families also indicated a new belief that individuals with mental illness had a role in improving their own mental health status (Leff & Berkowitz, 1996). Psychoeducational programs that consisted primarily of an educational component, however, were found to have little effect on the negative, hostile, and critical thoughts and behavior of family members toward the mentally ill (Cozolino et al.1988; Abramowitz & Coursey, 1989) (Table 3.1).

Table 3.1 Factors affected and not affected by a brief family education program

Factors may be affected	*Factors may not be affected*
Support from treatment team	Information retention
Family's sense of responsibility for the illness	Perception of symptoms
Understanding of illness	Interactions with patient
Patient behavior not intentional	Burden from illness
Less rejection of patient	Hope for future

3. *Effect on Relatives' Distress and Burden*

Families in China are expected, both culturally and politically, to provide care for their ill family members. The unpredictable nature of schizophrenia and the chronic nature of the mental illness can place great burden on family members. There have been questions raised about the impact of psychoeducational programs on family members' fears, worries, anxieties, distresses and burdens, and their subjective feelings of support. There is some evidence indicating that education has decreased family reports of stress symptoms and fear of the patient. In turn, this reduction in stress may enable relatives to become more tolerant and accepting, especially in low-risk family environments (Greenley, 1979; Kuipers, 1979; Leff et al., 1985). There is also some evidence indicating that education can reduce anxiety, personal distress, and family disruption, resulting in a significant perceived reduction in family burden during the six-month follow-up (Abramowitz & Coursey, 1989; Smith & Birchwood, 1987).

The concept of EE has served as a main theoretical paradigm for family psychosocial interventions (Brown, Birley, & Wing, 1972; Leff & Vaughn, 1985; Brown, 1985; Kuipers, 1987; Jenkins, 1991). EE refers to a global index of particular emotions, attitudes, and behaviors expressed by relatives about a family member diagnosed with schizophrenia. Families living with patients experience a significant level of stress and express their emotion in various ways: critical comments (CCs), emotional over involvement (EOI), hostility , warmth , and positive remarks (PRs). According to this theory, families with high levels of

EE may be predictive of patient relapse (Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976; Karno et al., 1987; Kavanagh, 1992; Bebbington & Kuipers, 1994). Studies focusing on family EE indicate that relatives are capable of influencing the course of schizophrenia in a positive as well as a negative direction (Leff & Berkowitz, 1996).

Based on the EE model, certain environmental stressors, such as an intolerant family climate, may precipitate psychotic relapse, and, by inference, may hinder recovery. Certain factors have been associated with stressful environments. These include misunderstandings about the illness, resulting in conflict or unrealistic expectations of the ill person, difficulties with problem solving, and poor communication or coping skills. It would appear that by reducing stressful interactions and providing purposeful activity involving reciprocal relationships, the recovery process might be enhanced. This suggests the need to provide a milieu with optimal stimulation and minimal stressful interaction. Related psychosocial family interventions, therefore, have focused on reducing the families' EE and improving communication.

The EE model can be combined with the vulnerability-stress model to explain the course of the illness (Kavanagh, 1992; Lalonde, 1995). The ill person's vulnerability may be exacerbated by the family's range of behaviors and emotions (Anderson, 1986). The ill person's vulnerability and family conflict probably interact in a spiraling manner, to the ill person's disadvantage. The ill person's vulnerability to stimuli causes symptoms that upset family members, who, in turn, express high EE and upset the ill person, and so on. Moreover, high-EE relatives in the education group felt more supported than the high-EE relatives in the control group (Cozolino et al., 1988). Education may also have an important role in reducing the stigma of mental illness in that it demystifies mental illness (MacPherson, Jerrom, & Hughes, 1996). The outcomes associated with psychoeducation for mental illness have all been reported from research in Western societies and within the context of Western mental health care models.

In China, no such research has been conducted, and there has been no development of an indigenous mental health care model. The Chinese specific cultural and ethnic differences should have special impact on EE. In our previous study of EE in Xinjin County, we found that the proportion of relatives of people with schizophrenia rated as high EE was 28.2%. Chengdu relatives expressed significantly fewer CCs (mean number: 3.93) and less EOI (8.5%) than respondents in other similar studies in London (mean number: 8.4; 36%) (Ran et al., 2003d). Moreover, city dwellers were significantly more expressive than villagers showing warmth, PRs, and EOI. How can a model of family intervention in the West be adapted to Chinese culture? What are the implications of reducing EE for Chinese people in which EE is not high compared to populations for

which the interventions were originally developed (Ran, Hou, & Xiang, 1998; Ran et al., 2003d)?

4. Change in Behavior and Relapse Rate

Family education may increase the family members' contacts with community mental health care resources. Some reports indicate that increased contact with community resources may benefit not only the ill member but also the family members as well (Abramowitz & Coursey, 1989), thereby potentially reducing the rate of relapse.

Relapse rate is a common outcome indicator used to measure the effectiveness of mental health interventions for people suffering from schizophrenia. Findings from several studies that used a short education-only intervention had mixed results. In Japan, Shimodera and colleagues (2000) found that short educational sessions were an adequate psychoeducational intervention that reduced relapse rates in families who had a high incidence of critical comments. Another educational study (Tarrier et al., 1988) showed that the high-EE education-only group had a relapse rate of 43% compared to 53% of the high-EE control group at nine months, and 53% and 60%, respectively, at two years. Similarly, the low-EE education-only group had a relapse rate of 22% compared to 20% in the routine management low-EE group at nine months. It seems that education alone was not effective in preventing relapse in this population. For other families of people with mental illness, brief educational programs had no effect on the frequency of arguments (Cozolino et al., 1988) and rehospitalizations (Posner et al., 1992).

PRINCIPLES OF A FAMILY PSYCHOEDUCATIONAL MODEL

The six principles listed below are usually included in a model of family psychoeducation for schizophrenia (Lam, 1991; Glynn, 1993).

1. Psychogenic theories of the origin of mental illness are discounted.
2. A primary objective is to reduce biological vulnerability and environmental stress.
3. Family members are given basic information on the psychiatric disorder.
4. The focus of family sessions is on the "here and now."
5. The goal is to improve the well-being and growth of all family members, not only the individual with mental illness.
6. Emphasis is placed on improvements over the course of the illness and increasing the functional capacities of the patient and family through behavioral change (e.g. the ability to problem solve).

INTERVENTION COMPONENTS

Specific intervention strategies have been developed in line with the principles and goals of creating a psychoeducational model for people with schizophrenia and their families. These are discussed in several different themes or components below.

1. To maintain a positive therapeutic approach

Care must be given to maintain a positive therapeutic approach and generate a genuine working relationship between family and therapist. The strengths of the family and the family's ability to negotiate change are emphasized, rather than blaming the family. The therapist's goal is to understand every family member's perspective, emphasize the positive intentions of the family, and promote healthy interactional patterns among the family members. Relatives are respected as individuals with their own needs, and the challenges of caring for a family member suffering from schizophrenia are explored and acknowledged. Families are offered options on how to deal with problems, which, in turn, may reduce the guilt and sense of helplessness.

2. To strengthen the family structure and functioning

Interventions are also designed to strengthen the family structure and functioning. The family is the unit of care, and each member has an influence on the thoughts, emotions, and behavior of the others. Lam (1991) describes a structural therapy approach whereby the therapist attempts to eliminate diffuse generational and interpersonal boundaries by supporting a marital coalition and encouraging respect for interpersonal boundaries. In this way, families might be enhanced by strengthening parental boundaries or a marital alliance and promoting independence and separation if appropriate.

3. To provide education and cognitive restructuring

All educational programs present facts about schizophrenia, although the means of presenting the information varies from group to group. Teaching the families problem-solving techniques is central to family interventions. The educational component provides a model for relatives to make sense of both the patient's and their own behavior and feelings. The patient is no longer viewed as malicious, irresponsible, and deliberately failing to control the disturbing behavior. Relatives need to understand that delusional accusation is real to the patient, and they need to develop better ways of handling situations, rather than heated arguments or counter-accusations.

4. To improve communication

It is important to assess how the family interacts, how each family member perceives the problem, and how they cope. The therapist then facilitates a more positive problem-solving family environment by discouraging criticism, over-involvement, and permissiveness, and by encouraging better coping strategies (Lam, 1991; Kuipers, 1992). Communication patterns are strengthened because the family members were trained to speak for each other and to express clear supportive or reinforcing statements to each other whenever appropriate.

5. To provide structure and stability

Another goal is to encourage family members to re-engage with or extend their social networks. Relatives are told that patients are more likely to respond to appropriate limit setting while maintaining a moderate interpersonal distance. Contracts of regular contacts are clearly spelled out for families who might be experiencing a strong sense of uncertainty and loss of control resulting from the schizophrenic behavior (Lam, 1991).

6. To encourage realistic expectations

Most family members hold unrealistic expectations, hoping that the ill person will rapidly return to the previous level of functioning after an episode of illness. Interventions emphasize the importance of adjusting expectations to a level that the ill person is capable of attaining. At the same time, it is also important to sustain the family's hope over long periods of time.

7. To be ombudsman

People suffering from schizophrenia and their caregivers often require a wide variety of services provided by a number of different agencies. Therapists should advocate on the family's behalf and take them on as care managers. This is a radical departure from traditional Chinese views on the role of the therapist.

In addition, characteristics of a successful family intervention program, as defined by Dixon and colleagues (2000) include: 1) schizophrenia is presented as an illness; 2) programs are created and led professionally; 3) programs are offered as part of an overall treatment package that includes medication; 4) programs enlist family members as therapeutic agents, not "patients"; 5) the focus is on patient outcomes, although family outcomes are also important; and 6) traditional family therapies, which presume that behavior and communication within the family play a key etiological role in the development of schizophrenia, are not included.

EFFECTIVENESS OF THE PSYCHOEDUCATIONAL INTERVENTIONS

The findings of many controlled studies suggest that a substantial reduction in major exacerbations of schizophrenia can be achieved when interventions are provided in association with optimal neuroleptic drug therapy. Furthermore, it seems that sustained reduction in the clinical, social, and family morbidity associated with schizophrenia can be achieved when a behavioral or psychoeducational approach is used. Long-lasting improvements in family communication have also been demonstrated. Overall, these family approaches provide a significant (and cost-effective) advance in the community management of schizophrenia.

Although the combined treatment of family therapy and social skills training provides an additional and important prophylactic advantage (Anderson, 1986), this approach seems to be unable to engage or maintain people who are actively psychotic at the time of discharge. Coping strategies may not improve mood, negative symptoms, or social functioning. Behavioral intervention does not appear to produce greater changes in communication or problem solving than less intensive intervention (Bellack et al., 2000).

PSYCHOSOCIAL FAMILY INTERVENTION IN CHINA

A review of psychoeducational family interventions related to work in China was carried out. The interventions were analyzed and are presented in Appendix 1. From the analysis, the interventions were found to have the following specific characteristics.

There is a difference in the way family members perceive a counseling intervention in China compared to the West. In the West, patients and family members are more inclined to accept counseling or "talking therapy" as a legitimate method of treating mental disorders. The primary social goal of the family is to change the dependent individual with a mental illness into an independently functioning member of society (Grinspoon, 1989). In addition, there is an overall mental health care system that will provide ongoing services to patients and families during and after the intervention (Xiong et al., 1994).

In China, the family role is different. The family relationships are knit closely together by a strong sense of loyalty, obligation, and mental dependency on each other. Collectivism has been emphasized in all aspects of social activities. Individualism and independence are not valued in the same way, so having a

goal to train an individual to be completely independent is not always appropriate or feasible in China. This needs to be balanced with the individual's role as a contributing member of the family and society. The health care system in China is such that many gaps exist in the system, particularly the kind of discharge follow-up services that are required for people with mental illness, such as schizophrenia. It is important that family-based intervention strategies be modified to fit the context of Chinese culture and not be entirely based on a Western model of care.

The idea of conducting research related to psychosocial family interventions for the severely mentally ill has been prevalent in the West since the early 1970s (Lam, 1991). In China, however, it has only been a commonly accepted treatment modality and the impact of the intervention researched since 1990. There are several factors that may have influenced the development and acceptance of a psychosocial family intervention in China at this time. The development and success of the intervention in the West is one factor. Another factor is the increase in mental health professionals. This has resulted in an increase in the recognition of mental illness, such as schizophrenia, and the importance of family members to recognize symptoms and assist the ill family member to manage the illness (Xiang, Ran, & Li, 1994; Ran et al., 2003b). Families want to know more about the illness and how to handle the ill member's symptoms at home. Many of them acquire information from other families, outpatient waiting rooms, hospital wards, and other resources to try to make sense of their own family member's condition. From a larger perspective, the open-door policy and reform has facilitated the recognition of mental illness and acknowledged the important role family members have in managing the illness. This, in turn, has also encouraged the development of psychosocial family intervention in China.

Although there are several models of psychosocial family interventions in the West, the intervention in China focuses on brief family education (Zhang et al., 1993, 1998; Weng et al., 1994; Chen et al., 2000; Liu & Xu, 2000). Family education is important because many Chinese families believe the family may, in some way, be blamed for the illness. The illness also causes a great burden on the family. Information about the progression of illness and how to manage the symptoms may help to reduce the burden of care. Knowledge of symptom recognition may also assist families to identify early signs of illness and relapse. Without this information, there is often poor treatment compliance or excessive somatization of emotional stress. Education, when compared to other interventions, is an easy format to understand and to deliver widely. In addition, it is of relatively low cost and more affordable in contemporary China.

As in the West, patients are usually recruited on admission to a mental hospital (Xiong et al., 1994; Zhang et al., 1994). In the West, interventions are

often conducted in a clinic or at home (Schooler et al., 1997; De Giacomo et al., 1997; Barrowclough et al., 1999), but in China the intervention is conducted more frequently in communities, especially urban communities (Zhang et al., 1993, 1998; Weng et al., 1994; Ling et al., 1999; Zhao et al., 2000). A few of our previous studies focused on the intervention in rural communities (Xiang, Ran, & Li, 1994; Ran & Xiang, 1995). This may reflect partly the development of family intervention in community mental health services in China.

Many studies showed that the combined family education and intervention was effective in improving the outcome of illness with respect to the relapse rate, social functioning, and family burden (Xiong et al., 1994; Xiang, Ran, & Li, 1994; Zhang et al., 1993, 1998; Liu & Xu, 2000; Chen et al., 2000). Xiong and colleagues (1994) also found that family-based intervention for schizophrenic patients might be less costly than standard treatment. Given the constraints of the Chinese mental health system, this model of intervention was suitable for families of people suffering with schizophrenia in urban China. It also seemed that family education intervention in China reported greater success than the West. The reasons for such difference will need to be studied further.

In general, the sample sizes were large for the majority of community mental health service studies carried out in Chinese urban or rural communities. This may be related to the high rate of compliance of subject participants in China. The studies also indicate that it is appropriate to train physicians, nurses, or primary health workers (e.g. village doctors) to provide family education or counseling in urban and rural communities to compensate for the severe shortage of mental health professionals in China (Zhang et al., 1994; Xiang, Ran, & Li, 1994; Ran & Zhang, 1999).

CHARACTERISTICS OF CHINESE PRACTICES

Compared with research reported in the West, psychosocial family interventions in China has had the following limitations:

The concept of family education was not clear in some studies. There is a lack of culturally specific theoretical background for such interventions in China. In addition, psychiatrists have limited knowledge on how to develop intervention strategies or research protocols. This would account for the strong evidence of a family educational component, but lack of the fundamental application of other approaches, such as behavioral family therapy (Falloon et al., 1985) or social skills training (Hogarty et al., 1991). At the same time, a lack of knowledge about EE also hampered the development of relevant interventions to reduce the high EE of family members. It was critical at this time to increase the

knowledge and skill level so that individually tailored interventions could be developed.

From the review of research studies, there is a need to identify a balance of gender and to get more samples from the rural areas. It is crucial to develop family interventions in rural China because that is where most of the population lives. The review described earlier in the chapter, however, indicated that no psychoeducational family intervention studies had been conducted in rural China.

Most studies also lacked a randomized design and thus limited the credibility of the conclusions. Some studies had no control group (e.g. Ran & Xiang, 1995). This limited the implications and the ability to generalize from the findings. Without a vigorous design, it was difficult to determine with confidence the efficacy of drug treatment and family intervention (Ling et al., 1999).

The duration of the educational programs were usually short (Xiang, Ran, & Li, 1994; Weng et al., 1994). In some studies, the dropout or refusal rate was high (15%, Ling et al., 1999; 18%, Chen et al., 2000), which limited the generalizability of the findings. Measurements usually did not focus on individuals' strengths (e.g. social functioning). Some studies lacked blind assessment (Zhang et al., 1993). Undoubtedly, it is extremely difficult to maintain blind assessments in a long-term, follow-up study of family intervention because families and patients often tell the evaluator, during the evaluation interviews, that they receive family intervention.

Measuring clinical outcomes can be complex. It is not really appropriate to use the hospital readmission as a measure index of clinical outcome (e.g. Xiong et al., 1994). Hospital readmission may be affected by many factors other than the severity of patients' symptoms, so it might have been better to use relapse as the index of outcome. There have been no reported studies on the effect of family intervention for nonschizophrenic patients in China, even though the interventions (e.g. skill-building exercises) (Falloon, Boyd, & McGill, 1984) have been implemented to treat other diseases (e.g. bipolar disorder or anorexia nervosa) in the West (Eisler et al., 2000).

How to provide culturally appropriate community mental health care is a crucial question facing mental health professionals in China. The Chengdu Study, a research demonstration project, was designed to take into consideration the strengths and weaknesses of both international studies and previous studies conducted in China. The Chengdu Study requires understanding and respect for traditional values, beliefs, and practices that may differ significantly from those typical of Western societies. The research team tried to place the research in this larger historical and cultural context of rural China.

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