

Cultural influence on psychoeducation in Hong Kong

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In Hong Kong, it is estimated that there are 1.2 million people with different types of mental illness, comprising one-sixth of the total population (Rehabilitation Division, Health and Welfare Bureau, 1999). Hong Kong has a well established mental health service and community support, yet many people still hold a biased view of psychiatry.

Mental illness is especially stigmatising in Asian cultures (Hong Kong Council of Social Services & Mental Health Association of Hong Kong, 1996; Kramer *et al*, 2002). Many of these notions about psychiatry have a strong Chinese cultural influence. Chinese explanations for mental health problems differ from, and indeed often conflict with, the Western concept of psychiatry. This can lead to distress for individuals affected by mental health problems. Bartlett (1928) suggested that the ideas and values of a new culture are more likely to be accepted if they can be accommodated within an existing belief continuum ('preferred persistent tendency'), whereas those that conflict with tradition are more likely to be ignored. Therefore it is important to understand why effective communication between healthcare providers and the general public concerning mental health issues may be hindered.

Culture and psychoeducation

Culture provides the context in which an illness is experienced, and shapes an individual's illness explanatory model that affects his or her interpretation of symptoms (Kleinman, 1980). 'Mental health' is a Western expression with no exact equivalent in traditional Chinese (Yip, 2004) and only in recent years has the idea of a bio-psychosocial model for mental illness been introduced. To give an illustration, there was a middle-aged woman who suffered from generalised anxiety disorder. She refused to take any tablets prescribed by psychiatrists because she did not think she was 'crazy'. Despite repeated explanations, she would not be convinced otherwise. She eventually went to a Taoist temple to ask the gods for advice by means of a ritual called *Qiu Qian*, which involves shaking a cylindrical case of sticks with special codes written on them until one falls out; it is believed that an answer from the gods is thereby delivered to the person seeking guidance. Through the interpreter at the temple, the message from the special code was related to her. She was told that the deity instructed her to 'follow her doctor's advice' and she diligently took her medications from then on. The use of concepts and languages that are in line with people's personal and cultural beliefs may be more effective in achieving a desired outcome.

Confucianism, Buddhism and Taoism are the three pillars of Chinese philosophy. These systems constitute six

perspectives on mental illness: moral, religious, cosmological, traditional Chinese medical, psychosocial and personality perspectives (Pearson, 1993). Some differences in the cultural conceptualisation of mental illness arising from each of these perspectives are outlined below (Wong *et al*, 2004).

- Traditional moral beliefs of Chinese people suggest mental illness is a punishment for the misconduct of their ancestors or family members. Common beliefs about the hereditary nature of mental illness also implicate the family as pathogenic or having a moral defect.
- From a religious perspective, traditional Chinese thinking suggests that mental illness is a fate inflicted by supreme beings, and that one should accept it as inevitable.
- A cosmological concept is that supernatural forces are at work, and that inauspicious people or evil spirits have a bad influence on one's karma, or fortunes.
- The traditional Chinese medical view of illness emphasises the proper balance of yin and yang forces and the correct proportion of the five elements: metal, wood, water, fire, earth. Although the Western and Chinese concepts of psychosis are quite similar, when it comes to non-psychotic illnesses Chinese patients and carers often do not accept the validity of Western psychiatric diagnoses (Hsiao *et al*, 2006a). These illnesses are conceptualised as psychological problems that arise when one is faced with hardship but has a weak character, an imbalance of yin and yang, bad luck brought on by inauspicious people around, or even punishment for one's ancestors' mistakes. As a result, Western dualism, which separates the body and the mind, is unlikely to convince people of the concept of a psychological illness.
- The psychosocial perspective maintains that excessive life stresses borne by an individual, which surpass that person's stress tolerance threshold, will exert negative effects on his or her mental health. Thus one accepts fate as it is, and simply endures hard times, in a manner akin to learned helplessness.
- Lastly, the Chinese also consider personality characteristics to be a cause of mental illness. A flawed personality and a weak character lead people to develop such illnesses, whereas if they were robust and willing to suffer in silence, they would again simply endure the hard times and come out a better person. The tendency to shift the blame to the patient, for being weak or inadequate, will lead to more conflicts and greater burden on patients and their carers.

For comparison, in the Indian cultural context, maturation of the person is attained through coming into harmony within social relationships. Self-identity is extended into a familial self by fulfilling a complex system of obligations and responsibilities towards others throughout one's life. Beliefs

concerning the nature of health and illness stem from this extended sense of self. Disease is not just localised in the individual. Well-being is viewed as a balance or harmony of forces maintained by the proper observance of social obligations and other interpersonal behaviours.

Help-seeking behaviour

An unwillingness to approach others for help may be due to a strong belief in self-reliance and stigmatisation of mental illness in Chinese communities. Carers and patients often do not conceptualise the problems as mental illness, and consequently neither are inclined to access Western mental health services (Hsiao *et al*, 2006b). Also, the 'loss of face' and high level of shame felt by the whole family contribute to treatment being sought late (Hsiao *et al*, 2006b).

Traditional coping mechanisms, such as *Feng Shui* (to utilise the laws of both heaven and earth to help one improve life by receiving positive *Qi*), *Yuan* (that events happen as deigned by the laws of nature) and endurance are used in facing stress (Yip, 2004). In Confucian ideals, interpersonal harmony is the key element in maintaining a healthy state of mind. Those who fail to fulfil culturally expected roles, such as that of a parent, offspring, partner or even friend, contribute to disturbance in interpersonal relationships, diminished self-worth and increased sense of guilt and shame (Hsiao *et al*, 2006b). For example, a man would be expected to be good to his parents and take care of them in their later years, be caring towards his wife and children, be the breadwinner and decision-maker in the family, and be cordial towards colleagues and respectful towards seniors. Any role reversal or out-of-tune behaviour would be seen as the man being inadequate and failing to perform his duties.

In Chinese culture, the family is the 'great self' and an individual is embedded in the family. This contrasts with the Western idea of self, which emphasises an individual's autonomy. Instead of self-actualisation and self-development, Chinese people will be more inclined towards being harmonious with the laws of nature; thus inaction, self-endurance and tolerance with respect to hardship and suffering are preferred (Yip, 2004). Treatment, such as psychotherapy, which emphasises an individual's growth and autonomy may conflict with the importance of maintaining interpersonal harmony in Chinese culture.

The lay system exerts a great influence on the help-seeking pathway of Chinese people (Pearson, 1993; Kramer *et al*, 2002). In a society with a collectivist and familial orientation, elders in the family still strongly believe that they are responsible for taking care of their offspring (Young, 1996). Chinese family collectivism leads people to sacrifice their own goals to provide care for an ill relative and to maintain harmony in the family; occasionally, some of them even become victims of the violence of members with mental illness (Yau, 2003). Moreover, the decision to seek help does not rest with the individual (Wong *et al*, 2004) but incorporates the views of different members of a family or friends. It is often difficult to adhere strictly to patient confidentiality when relatives request details of the illness, sometimes going as far as to ask the doctor not to divulge the information to the patient. Many management decisions need to be endorsed by the family before the doctor can proceed, so as to minimise

antagonistic relationships with the patient and family. This in turn hampers education on the nature of the illness, drug adherence and precautionary measures to be taken by the patient and relatives. With this in mind, psychoeducation should be focused not only on the patients but also on family members and carers, who greatly influence both drug adherence and recovery.

Often the attitude towards coping with a family member with a mental health problem is to ignore it, to cope within the family for as long as possible or even overtly to deny its presence. People are reluctant to see a psychiatrist as it suggests that they are *Feng* (crazy) or *Dian* (psychotic) (Hsiao *et al*, 2006a), while those who have long-standing psychotic illnesses would insist they are seeking treatment only for 'milder' complaints such as insomnia or anxiety. Internalisation of these negative conceptions of mental illness in Chinese societies leads to anticipation of social rejection and discrimination towards those who are mentally ill.

Conclusion

The government and local community in Hong Kong have put great effort into mental health awareness programmes in recent years, but healthcare providers still struggle to help patients understand what psychiatry is all about. Perhaps Chinese healthcare professionals who are familiar with Western medicine are not aware of how difficult it may be for others to accept a different model of mental illness. It would be more effective to introduce Western concepts of psychiatry in a way that is initially more palatable to the lay person, and to build on those foundations to modernise the way psychoeducation is provided in primary care. A simple example would be to use the term *Tiao Li* (the restoration of the yin and yang balance by medicinal means) when explaining how antidepressant or antipsychotic drugs work, rather than saying they alter the neurotransmitters in the brain, as *Tiao Li* is generally felt to be more harmonious with nature and therefore less damaging to the body. By drawing parallels to similar beliefs, hopefully the gap between Western and local concepts of mental health can be bridged.

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NEWS AND NOTES

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President's international activities 2009

2009 was a busy year for the President, Professor Dinesh Bhugra, not least because of the many international visits he made in order to support and promote psychiatry and mental healthcare around the world and to meet a few of the 2684 members of the Royal College of Psychiatrists who reside outside the UK. The President attended and spoke at a variety of conferences, including the World Health Organization's Mental Health Gap Action Programme Forum in Geneva, and conferences in India, Singapore, the USA and Hong Kong. Professor Bhugra was also honoured with an International Fellowship by the American Psychiatric Association at its annual meeting in San Francisco and was conferred as a Fellow of the Academy of Medicine of Singapore at the 43rd Singapore–Malaysia Congress of Medicine. Professor Bhugra said 'the Royal College of Psychiatrists is committed to supporting its members in the UK and around the world and it is our goal to be at the forefront in setting and achieving the highest standards through education, training and research. We lead the way in developing excellence and promoting best practice in mental health services.'

As part of realising that goal, the President and the Registrar, Professor Sue Bailey, took a study tour, run by the Health Foundation, to Boston, Massachusetts, in October 2009. Many senior figures from other medical Royal Colleges and the UK National Health Service attended the tour. Its purpose was to explore the potential held by the Royal Colleges to improve quality across the National Health Service, both for clinicians' working lives and for patient outcomes. The trip included visits to a youth development organisation, a cancer institute and a media lab to see what could be learned from different systems. The President said: 'This was a unique opportunity to learn from organisations that you would not normally expect to learn from and to gain greater insight into our role as a medical Royal College in improving the health system for our members and our patients'.

International activities of the Faculty of Psychiatry of Old Age

The Faculty of Psychiatry of Old Age, since its inception as a Section in 1978 and Faculty in 1988, has been a forerunner in maintaining standards for mental health services for older people and improving education and training. The Faculty

has been eager to use this expertise for the benefit of people outside the UK and become a true player in globalisation, pursuing the recent change in College policy. In 2007/8, the Faculty established links with the Geriatric Section of the Indian Psychiatric Society and offered help with the curricula and training in old age psychiatry in India. Some final details are still being sorted out.

In 2009, the Faculty's annual residential conference was held in Barcelona and there were two pan-European symposia, with speakers from different parts of Europe. This was a good opportunity to come to an agreement with the Sociedad Española de Psicogeriatría (SEPG) (Spanish Old Age Psychiatry Association) about improving the interaction between the two organisations in exchanging speakers, training postgraduate students in old age psychiatry and utilising research opportunities.

The Faculty has recently established a bursary (£1500) open to old age psychiatrists in low- and middle-income countries for attending and presenting research at the Faculty's residential conference. The first recipient of the bursary was Dr Xia Li from China, who presented her work on suicide in older people in China.

Also in 2009, the Faculty signed an agreement on education and training with the Old Age Psychiatry Faculty of the Royal Australian and New Zealand College of Psychiatry.

Legislative innovation in Northern Ireland

Northern Ireland is set to become the first jurisdiction in the world to introduce a single piece of legislation for mental health and mental incapacity, so that people who are unable to make decisions for themselves, whether this is for physical reasons or because of mental health conditions, will come under the same legislation. The law will be based on the assumption of capacity, and will have four core principles, of autonomy, justice, benefit and least harm. The Royal College of Psychiatrists' Northern Ireland Division had lobbied hard for this, arguing that it is necessary not only because there is such a strong interface between the two pieces of legislation, but also because it is important to tackle the stigma for a person who is detained under mental health legislation.

Dr Philip McGarry, Chair of the Northern Ireland Division, said a single piece of capacity-based legislation is a step towards equality for people with mental health problems. 'The modernised legislation promises to be better for people