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**Mental Illness And Families  
In  
Contemporary Hong Kong**

*An Ethnography Of Mental Illness And Chinese  
Families In Hong Kong At The Time Of Transition  
Of Sovereignty*

A thesis submitted in fulfilment of the requirements for the degree of

**DOCTOR OF PHILOSOPHY**

by

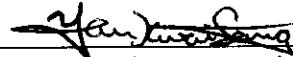
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**FACULTY OF HEALTH SCIENCES  
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2001**



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Matthew Kwai-sang Yau

**Dated: 20 March 2001**



**To**

*The families with mental illness*

*Their dedication, courage, and sacrifices to care for their sick family members have helped me understand the true meaning of love*

## ABSTRACT

Hong Kong, being at the crossroad of East (*yin*) and West (*yang*), has developed its own unique culture under 150 years of British colonial rule. The political transition has merely accelerated the pace of searching for a new cultural identity. It also has created the momentum for the revision, and in some cases the resurgence, of traditional concepts and interpretations of life among Hong Kong Chinese. These events have affected both the concept of mental illness and the experiences of families with mental illness.

This study explores, describes and documents the concept of mental illness, the meanings ascribed to the concept, and the impact of mental illness on the coping and experience of families with mental illness in Hong Kong during the period of transition of sovereignty from March 1996 to early 2000. An ethnographic approach with multiple data sources was adopted. Besides formal and informal interviews of family members and experts in the field, other data sources include the English- and Chinese-language literature on related topics, field observations, a questionnaire survey on public attitudes towards mental illness, newspaper clippings on issues related to mental illness, and self-reflection. The *yin* and *yang* analogy, a uniquely Chinese philosophical framework, is employed as a lens to describe the social reality where the concepts of mental illness and experiences of families with members with mental illness intersected during this transitional period.

The converging findings indicate that several inter-related factors influence the impact of mental illness on families. They include the historical and political transition; the socio-cultural transition in searching for a cultural identity; transitions in the health care system, the existing explanatory models of illness and healing, mass media, public attitudes towards mental illness; and transitions in family structure and care giving.

It also is demonstrated that although there is an increase in the public's awareness of

its own mental health and understanding of mental disorders, the negative attitude toward people with mental illness perpetuated by the mass media still prevails. People with mental illness are often projected as unpredictable, violent and dangerous, and this affects the responses of the community towards them and their families. “But-not-in-my-backyard” appears to be the most common public attitude toward the re-integration of persons with mental illness into the community.

Mental illness is not an individual’s matter but a family affair. Family members often have to cope with the illness as a family entity, as everyone is affected by social stigma and the restricted repertoire of explanatory models caused by the dominancy of Western medicine and modern science. Keeping the “family secret” of the disorder is not uncommon. Chinese family collectivism has led family members to sacrifice their own goals to provide care for the ill member and to maintain harmony in the family; occasionally some of them even become victims of the violence of members with mental illness. Families are confronted with the day-to-day caring and managing of the mentally ill member at home. Their experience may include the discovery of the illness, explanations to others, disruptions of daily life, family role re-examination, grieving of loss to the family, and possible adjustment to the illness. However, the family coping process does not necessarily follow a developmental sequence as described in some literature.

It is postulated that respecting families’ explanatory models and allowing the practice of the alternative healing methods seen fit by the families, in conjunction with or parallel to Western psychiatry, may help Chinese families with mental illness not only live with the disorder but also have a better experience. Finally, constructive dialogue between Chinese and Western medicine and the adoption of the *yin* and *yang* analogical approach to health and life are believed to be complementary perspectives to mental illness and may help people maintain mental health in this transitional metropolis.



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**“What does man gain from all his labour at which he toils under the sun? Generations come and generations go, but the earth remains forever.... What has been will be again, what has been done will be done again; there is nothing new under the sun.”**

**(Ecclesiastes, 1:3-4 & 9, The Bible – The New International Version)**

**“In ancient times those people who understood Tao [the way of self cultivation] patterned themselves upon the Yin and the Yang and they lived in harmony with the arts of divination.... They were tranquilly content in nothingness and the true vital force accompanied them always; the vital spirit was preserved within; thus, how could illness come to them? They exercised restraint of their wills and reduced their desires; their hearts were at peace and without any fear; their bodies toiled and yet did not become weary. Their spirit followed in harmony and obedience; everything was satisfactory to their wishes.”**

***Huang Ti Nei Ching Su Wen* (the Yellow Emperor’s Classic of Internal Medicine), translated by Ilza Veith (1992, p. 97-98)**

**“The recognition of mental illness is not a simple process but one that only becomes crystallized after a complex series of interpretations.”**

**(A. Horwitz, 1982, p.31)**

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**Unit One**

**Background**

**And**

**The Scope Of The Study**



# CHAPTER ONE

## Introduction

### Background

Sociologists and anthropologists perceive family as the basic social unit of a society and the frontline social institution for the socialization process. In a Chinese society like Hong Kong, it is the family, rather than the individual, that is the basic structural and functional unit. Family is so important to the Chinese that a special kind of strong familialism has been formed, stressing the undeniable predominance of the family over its members in almost all domains of life (Cheng, 1944; Hsieh, 1982; Lee, 1982; Lei, 1984; Li, 1985; Yang, 1988; MC Yang, 1972). The Chinese individual has a strong relational orientation. Family is where this relational orientation is established and strengthened (King & Bond, 1985). Most scholars also agree that the Chinese place great emphasis on the family, not only as the basic unit of social organisation, socialisation or familialisation, but also as a basic source of support for problem solving. Familialism is also one of the common features or threads of Chinese culture that impacts mental health (Tseng, Lin & Yeh, 1995a). This chapter aims to outline the background and rationale for the study on the concepts of mental illness and its implications for families with mentally ill relatives in contemporary Hong Kong.

Mental illness is not only a biopsychological phenomenon. It also is about education, economics, social structure, religion, and politics. Marsella and Yamada (2000) describe the post-modernist views, which currently characterise and inform the study of relationships between culture and mental health. They suggest that these views

emphasise the importance of the social context of psychological problems (i.e., powerlessness, poverty, marginalisation, inequality) in understanding the aetiology and expression of psychopathology. These views also point out that the individual psyche comes to represent and reflect the struggles and conflicts in our cultural environment and the subjective nature of our knowledge about the world in which we live.

In Hong Kong people often use the term "*chìsin*" (Py *chìxià*) (癡線), literally, short-circuited (hey-wire) — "*a blown fuse in the brain*," to describe someone behaving oddly or expressing bizarre ideas. Besides this term, people with mental illness also are described as a person having "*sàhngìbihng*" (Py *shénjīngbìng*) (神經病), a neurological defect or disease; or being "*fūngkòhng*" (Py *fēngkuáng*) (瘋狂), crazy/lunacy or "*sòh*," (Py *shǎ*) madness (傻). To the family, having a mentally ill relative often is described as "*shame to the family name*," "*retribution for wrong-doings of previous ancestors*," "*bad fēngshui*, bad geomancy or astrology" and "*never-ending troubles*."

This study on mental illness and families with mentally ill relatives took place in the fast growing metropolitan city of Hong Kong, which is currently going through rapid transitions economically, politically and socio-culturally. These transitions are not merely the responses to the trend of globalisation in this post-modern age, but are, most important of all, responses to the departure of the colonial government and the reunification with Mainland China. During this volatile transition period, I reflected on myself and re-examined my belief system. I started to question my previous concepts of mental illness, as well as to search for my identity as a Hong Kong Chinese. I have had the opportunities to be exposed to both Western and Hong Kong Chinese cultures and education systems. This thesis begins with my reflection as an active participant in the Hong Kong scene who has negotiated between two sets of cultural values and belief systems to interpret the observed phenomena. It was part of my attempt to understand

and describe the concepts and meanings of mental illness in Hong Kong, as well as their relationship to the experiences among families with mentally ill relatives during the period of transition of sovereignty. The specification of a particular time period serves as a device to circumscribe the scope of the study. The goal is not to focus on what happened in the past or to predict what will be developed in the future. However, it is clear that the current concepts or phenomena originated in the past and certainly will contribute to future developments. The analysis and results represent what was going on during the time of data collection through the eyes of a “banana man,”<sup>1</sup> having yellow skin but a white heart — a person who has been exposed to two different cultures and is the balancing of two polarised perspectives within (see further elaboration of the use of the term “banana man” in Chapter 4). The analogy adopted and the subsequent interpretations represent the understanding of some people in a situation similar to mine.

Hong Kong, despite its small size, plays an important role on the world stage. It is not only known for tourism, financial and commercial activities, but also for its position as the crossroads for Mainland China and the rest of the world. It not only acts as a “window” on Chinese culture through which others can take a glimpse, but one also can trace the process of the transformation of Western ideology and culture into a unique style of living in Hong Kong. Within such context, mental illness is likely to take on different meanings that are neither the same as in Western Countries nor the same as in Mainland China. Mental illness in Hong Kong is not an individual matter, despite a family member carrying a Western psychiatric diagnostic label and perceiving mental illness according to the Western medical paradigm. It is a family affair. Because everyone is affected in terms of daily routine, social role, care giving, discrimination in career choice, marriage and social network, family members have to cope with the illness as a collective entity as everyone is affected in terms of daily routine, social role, care giving, discrimination in

career choice, marriage and social network. Thus, to describe the experience of mental illness within the Hong Kong context, one does not focus on the individual with mental illness, but on his/her family as a whole.

### **The Transition Of Sovereignty And The Search For Identity**

I began working on this thesis on the eve of the transition of the sovereignty of Hong Kong to China, i.e., 30 June 1997. The downpour of rain that continued for the week had not elevated the mood of people in Hong Kong for this “once in a lifetime” event. Actually, this event brought about mixed feelings in me as well as most of the people in Hong Kong (Lǚ, 1997; Wáng, 1997).<sup>ii</sup> In terms of patriotism and nationalistic identity, it was a glorious moment that Hong Kong, which was ceded to Great Britain in 1842 after the Opium War, was finally “returned” to or “re-unified” with, in local terminology, the motherland, China. The people of Hong Kong might now confirm their identity and nationality as Chinese, instead of as stateless citizens or “second class British” as in the past.

However, this feeling was also mixed with apprehension as there were many uncertainties ahead. For example, would the Chinese Government honour the Sino-British Joint-Declaration of 1984 to let Hong Kong have “full autonomy” under the scheme of “*One-Country-Two-Systems?*” Would she allow Hong Kong to be governed under the Basic Law, the constitution of Hong Kong Special Administrative Region of the People’s Republic of China (HKSAR), which is supposed to guarantee the preservation of existing freedom of speech and to keep the economic and social systems and life style unchanged for 50 years?

As Hong Kong is so close to the mainland of China, Westerners, and even some Chinese, may have a misconception that all Chinese share the same cultural beliefs and

customs. People on the two sides are supposed to share the same value and belief systems. This is only true to a certain degree. The Hong Kong Chinese do maintain many of the old, traditional customs and beliefs that seemingly have disappeared in Mainland China since the communist rule in 1949. However, Hong Kong is different from the mainland in many aspects, as it has evolved from a barren rocky island and rural fishing village to a world-class financial centre less than 155 years of British rule (Lau & Kuan, 1991; *Lù*, 1995). Western values and beliefs, first from the British and later from the Japanese and Americans, have been picked up by the Hong Kong Chinese through the education system and mass media. The culture of Hong Kong is a mix or interbreeding of East and West, with the British or Western values having penetrated into every aspect of life of the local Hong Kong Chinese. Therefore, Hong Kong has its unique cultural character and value system. This situation caused me to wonder how such factors influenced and shaped the current perception and concept of mental illness; to what extent the traditional folk and medical views on mental illness are still adopted by Hong Kong people to explain the illness phenomenon; and, more specifically, how families with mentally ill relatives cope with and explain their experiences within the Hong Kong context?

Nevertheless, the data reflects more than I originally anticipated. It sheds some light on the analogy of transition in a larger context. The detailed discussion will come in the later chapters. In the meantime, before going into an in-depth exploration of the mental health and illness concepts, and the experience of families with mental illness in this unique and vibrant city, I need to define a few operational terms that often are misinterpreted and, thus, in this way set the background for the study.

## Definitions Of Terms

There are a few terms require further elaboration in the context of this study. They include “culture,” “healing,” “disease,” and “illness.” In particular, the term “culture” is an ambiguous word. It can be defined in various ways, even to the extent that it becomes an abused term in modern discourse (Fitzgerald & Mullavey-O'Byrne, 1996a; Fitzgerald, Mullavey-O'Byrne, Clemson & Williamson, 1996b). In the literature, there are various definitions which range from a simple and general one, such as “a set of learned values, beliefs and customs, and behaviour that is shared by a group of interacting individuals” (Mosby’s Dictionary for Medical, Nursing, & Allied Health, 1990, p. 326) to a relatively complex one, such as the one given by Kroeber and Kluckhohn (1952):

Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other as conditioning elements of further action (p.181).

As the definitions of culture number in the hundreds (Triandis & Brislin, 1984), there is a need to select a “consensus” one to form the conceptual background for this study. I find that the definitions given by Lewis-Fernandez and Kleinman (1995) and Evans and Tam (1997) are appropriate for such a purpose. Lewis-Fernandez and Kleinman (1995) perceive culture in the following way:

Culture is not a top-down covering that fits over the real; rather, culture is a bottom-up process that makes up the local world and is made up by it. Whereas material reality and professional ways of knowing that reality are affirmed, they are not regarded as falling

## Chapter One

outside of culture, but rather as constantly made over by interaction within culture. From this perspective, culture is also fundamentally moral, in that the ongoing negotiations and contestations among individuals and groups that make up daily living are directed at understanding what is most at stake and how that which matters is to be sought and gained.... The upshot is culture as a moral process of interpretation and collective experience, composed of many voices, created by and, in turn, creator of social action, and located not in the minds of individuals, but between people, in the medium of intersubjective engagements that spread through the social world of families, work settings, networks, and whole communities (p. 434).

When Evan and Tam (1997) discussed the cultural identity of Hong Kong Chinese after the transition of sovereignty of Hong Kong from the British to Mainland China in 1997, they defined culture, not as an identifiable “thing”, but rather,

[I]t is an ongoing social process of debate, dialogue and negotiation, primarily conducted among people who place themselves within the broad parameters of that culture, recognise its symbols, and use its language. But it can also include outsiders who choose to participate in that ‘internal’ cultural debate.... Culture is the ongoing, never-ending process of construction of human meanings; it is the ongoing process of trying to say who we are and what our lives mean – which includes the many rituals and symbols within a culture. It includes trying to decide what it means to be ‘Chinese’, ‘Japanese’, ‘Thai’ or ‘Australian’, ‘man’ or ‘woman’, etc. These meanings are always changing - sometimes slowly, sometimes fast. (p. 12)

Culture, therefore, is a complex concept. It is not the kind of superficial, prescriptive, rule-ordered system of etiquette that some people tend to think of (Avruch & Black, 1991). Culture is not a “thing” but a process that people adapt to over time and in which

they interpret and make meanings of their daily experiences and structure their internal and external environments. Kleinman (1980) conceptualises this process as people creating their own “social reality”. He explains that:

Social reality signifies the world of human interactions existing outside the individual and between individuals. It is the transactional world in which everyday life is enacted, in which social roles are defined and performed, and in which people negotiate with each other in established status relationships under a system of cultural rules. Social reality is constituted from and in turn constitutes meanings, institutions, and relationships sanctioned by society. Social reality is constructed or created in the sense that certain meanings, social structural configurations, and behaviours are sanctioned (or legitimated) while others are not. The individual absorbs (internalises) social reality — as a system of symbolic meanings and norms governing his behavior, his perception of the world, his communication with others, and his understanding of both the external, interpersonal environment he is situated in and his own internal, intrapsychic space — during the process of socialisation (or enculturation). (Kleinman, 1980, p. 36)

In addition, culture is not a static concept, despite the fact that people often refer to it as “tradition”. Culture is dynamic and changes with time. It also is interesting to note that when the native culture is in contact with a foreign culture, a hybrid culture is formed which is neither native nor foreign (Groce, 1999). For example, many traditions, such as those associated with health and illness, are exceptionally long-standing, and are intricately interwoven into many aspects of the local cultural belief system. However, such belief systems change over time, and often change rapidly when traditional systems intersect with Western ideas and rapidly modernising national and regional trends (Groce, 1999). The culture of Hong Kong is a good example of a hybrid of Chinese and Western



(British and American) cultural interchange (*Bái-shí*<sup>m</sup> (白石), Ming Pao Monthly, January, 1997).

Furthermore, Fitzgerald and colleagues (Fitzgerald, Mullavey-O'Byrne, Twible, & Kinebanian, 1995; Fitzgerald et al., 1996a; Fitzgerald et al., 1996b) emphasise that while culture is learned and shared, cultural knowledge, beliefs, values, attitudes, and behaviours are not equally shared by all people in any society. For example, the concepts of health, illness and healing are not the same among everyone within the society. Every individual tends to have a different interpretation of his/her health, illness and healing experiences based on his/her own learning process.

“Disease,” as defined in the modern medical texts, is “an objectively verified disorder of bodily functions or systems, characterized by a recognizable cause and by an identifiable group of signs and symptoms” (Morris, 1998, p.37). Illness can be seen as an indication of a person’s subjective experience of discomfort, which may or may not be caused by the presence of disease. Therefore, disease is a pathological condition in the human body, which is objectively identifiable. Illness is the subjective experience of the believed pathological condition, and the person and/or caregiver’s belief system (explanatory model) shapes such experience.

There are often discrepancies between the health professionals and the clients/patients in their understanding of the illness/disability experience and interpretation of the healing/rehabilitation process (Kleinman, 1980; Yau, 1996). Scholars like Fabrega (1970, 1977), Kleinman (1980), Young (1982) and Tseng (1997) attempt to explain such phenomenon by drawing an artificial distinction between the concepts of “disease” and “illness” in order to illustrate that there exists a potential gap between the healer (or doctor) and the help-seeker (or patient) in viewing the health problems. According to their definitions, as adopted in this study, “disease” is the

pathological or malfunctioning condition that is diagnosed by the doctor or folk healer. The clinician's conceptualisation of the patient's problem derives from the paradigm of disease in which the clinician was trained. For example, the conceptualisation of a biomedically-oriented psychiatrist will differ from that of a psychoanalytic trained psychiatrist. On the other hand, "illness" is defined as the experience of being ill and the meaning of being ill as interpreted by the patient. It is the patient's subjective perception, experience, and interpretation of his/her suffering. Therefore, two persons from different cultural backgrounds (in fact, even from the same culture) can be diagnosed with the same disease or disorder by the same healer; yet their illness experiences are likely to be different. The following extract from Kleinman, Eisenberg and Good (1978) can well sum up the distinction between the concepts of "disease" and "illness".

That distinction holds that disease in the Western medical paradigm is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Illness is shaped by cultural factors governing perception, labelling, explanation, and valuation of the discomforting experience, process embedded in a complex family, social, and cultural nexus. Because illness experience is an intimate part of social systems of meaning and rules for behaviour, it is strongly influenced by culture; it is, as we shall see, culturally constructed....

Neither disease nor illness should be regarded as entities. Both concepts are explanatory models mirroring multilevel relations between separate aspects of a complex, fluid, total phenomenon: sickness. They derive from and help construct the special forms of clinical reality.... For patients, illness problems – the difficulties in living resulting from sickness - are usually viewed as constituting the entire disorder. Conversely, doctors often disregard illness problems because they look upon the disease as the disorder. Both views are insufficient (p. 252).

To avoid confusion and to standardise the use of these terms, unless being specified, I use the term “mental illness” throughout the thesis to signify my focus on the illness experience of having mental disorder rather than the disorder itself. The term “mental disorder” is only used when I discuss pathological condition. The term “mental health” is meant as the health condition of absence of mental disorder.

There are two other terms, “explanatory model” and “healing,” that need to be operationalised for the study. Explanatory model, which will be discussed in detail in later chapters, is defined as a conceptual framework to explain the illness and disability by health care practitioners and their clients/patients (Kleinman, 1980). “Healing” does not merely mean treatment or cure. It is an art, and renders patients at ease as whole persons within the structure of their spiritual world-view, their families, and their culture (Nuland, 1997). The philosophies of healing often are woven through individuals’ personal belief systems, which are predicated on their heritage (Spector, 1996).

Lastly, although the term “Western” is used in this thesis, it is used in a loose and generalised sense for comparison with Chinese culture. To the Hong Kong Chinese, Western countries generally include the European countries, countries in North American and Australia. There is no intention to ignore the cultural differences among those countries.

### **Cultural Studies In Hong Kong**

To set the background to understand the need to conduct cultural studies in Hong Kong and the research topic area, I examine how cultural studies are being perceived and developed in Hong Kong. Journalist Richard Hughes once commented that Hong Kong is “a borrowed place, living on borrowed time,” which aptly depicts the historical

predicament of colonial Hong Kong (Chan, 1997). Hong Kong was also described as a “cultural desert” — a land with no culture. How true are these two statements reflecting the culture of Hong Kong? Before going on to discuss the existence of Hong Kong culture, I first want to highlight the debate in the local arena about the substance and directions of cultural research on Hong Kong and what should be the areas of focus.

Before I began to have an interest in cultural issues, my impression of cultural studies was, as most of the general public in Hong Kong believe, that it meant the study of performing arts, music, painting, drama and literature writing, and so on. This impression can somehow be understood through the expression of Chan Hoi-man (1995).

In Hong Kong, therefore, there is no unified, coherent cultural foundation to speak of, whether in the sense of a high culture, a national cultural or a traditional culture. One ventures to observe, the only socio-cultural arena that comes closest to providing an overarching cultural framework of some form is the arena of popular culture. And even in so far as popular culture does perform this function to various degrees of success; it still remains a cultural framework erected upon a fragmentary ground. (p. 23)

Social life in Hong Kong is dominated by financial and commercial activities in which there is a high emotional intensity of daily consumption. The so called “cultural activities” that receive official endorsement are mainly those represented by the elitist and middle-class options of performing arts, exhibition artworks and classical music that parallel places like London and Paris (Lù, 1995). These activities mostly receive sponsorship from the government, political groups or non-profit organisations. In order to survive in this free market-driven environment, publications, performance arts, and mass media that are on the margin, without official sponsorship, must either dictate or cater to the consumer’s taste. Therefore, one may wonder about the role of “mass media

culture” and ask questions about the social identity generated from popular cultural practices (Ng, 1995; *Zhōu*, 1996). In this regard, there was a series of studies by social commentators and practitioners in the field of popular culture, which has been collected in *Shī* and *Wú*'s edited book of studies of popular culture in Hong Kong (1997). The topics that have been explored include: “consumerism and living”; “popular culture and ideal home”, and “mass media and culture.” Nevertheless, over the years there have been other studies that variously touched on issues of the “Hong Kong ways of living” and there is no question that they yielded invaluable findings on specific facets of life of the colonial territory in the post war decades (Ng, 1995). Unfortunately, only recently has cultural study been recognised as a legitimate academic focus in Hong Kong.

Being the “window” of Mainland China, Hong Kong has been an important place for local and overseas scholars to take a glimpse at Chinese culture; in other words, Hong Kong culture was considered a “proxy” for Chinese culture (Ng, 1995). For example, there have been many cultural studies, largely anthropological, of cultural practices, including traditional Chinese kinship and familial practices (e.g. Baker, 1979), the rites and rituals of Chinese religion (e.g. Wong, 1974), and the effects of social changes in rural Hong Kong (e.g. Anderson, 1967; Blake, 1981). Freedman (1979, p. 212) concluded that the aim of these early studies was more “to study traditional Chinese social organization on its homeground” than to see Hong Kong as a developing entity in its own right. There is little research that examines how traditional Chinese cultural practices have been preserved, elaborated, and transformed for the last 150 years when Hong Kong was being changed from a rural fishing village into a world-class financial and commercial metropolis. It appears that cultural studies on the territory's own developmental dynamics, attendant problems and possibilities are largely absent (Ng, 1995).

Beginning in the 1970s, a few studies started to look at the cultural life of Hong Kong as it was affected by rapid industrialisation and urbanization, particularly in areas like family life, industrial behaviour and political outlook. Some were collected in King and Lee's (1981) edited volume entitled *Social Life and Development in Hong Kong*. As they were conducted mainly by sociologists with an emphasis on empirical social science methodologies, in general quantitative studies, in particular survey methods, dominated over qualitative studies. Thus, in-depth ethnographic description and exploration of the different facets of cultural life became a marginal enterprise in the social scientific circle in Hong Kong (Ng, 1995). Ng (1995) advocates a new direction in the cultural studies in Hong Kong: "Cultural studies does not have to be marginal, soft, esoteric or flimsy. Cultural studies should not exclusively, or even primarily be concerned with artistic standards and moral benchmarks" (p. 18). Evans and Tam (1997) echo that idea and further suggest:

If Hong Kong culture is in fact constructed through a process of social argument, a discussion about what is relevant from the Chinese past for the present, about what is relevant from the rest of the world for the constitution of meaningful lives within Hong Kong, then analysis should try to trace the participants in these cultural arguments, to try to understand their reasons for selecting one aspect of culture and discarding another, and for choosing one set of symbols while disregarding others. So the question would become not how an inert tradition continues to affect the present but how people in the present 'choose' or do not 'choose', to keep alive certain cultural beliefs and practices from the past. Or even why they may revive them after having discarded them for some years or decades.... The social and cultural logics which inform this process of selection and rejection is what defines Hong Kong culture and its uniqueness. (p. 13)

## Culture And Mental Illness

Why is there a need to study mental illness from a cultural perspective? It has been well documented in the literature that culture influences one's concept and interpretation of health, illness and healing experiences (e.g., Kleinman, 1980; Castillo, 1997; Marsella, 1993; Tseng, 1997). Kleinman (1977) emphasises that culture can influence mental illness in terms of the conception, perception, experience of symptoms, recognition and labelling, classification, treatment, and course of mental illness. Kleinman and Lin (1981) summarised the cultural influences on people's health, illness and healing experiences in seven aspects which include: 1) cognitive, affective and communicative processes; 2) the management of interpersonal transactions; 3) perception of and reaction to common stressors; 4) creation of and coping with culture-specific stressors; 5) susceptibility, epidemiological rates, symptomatology, illness behaviour, help seeking, and treatment response associated with particular psychiatric disorders; 6) labelling of and societal reaction to social deviance; and, 7) indigenous and professional systems for treating mental illness and the psychosocial concomitants of physical illness.

Tseng (1997) also draws our attention to the different levels of cultural impact on psychopathology which form a base for clinical assessment:

1. Phenomenology of psychopathology (as a symptom). Culture shapes the presentation of symptoms. For example, the content of delusions or auditory hallucinations is subject to the environmental context in which the pathology is manifested.
2. Variations of psychopathology (as a syndrome). The effect of cultural factors on pathology may be so prominent that it affects not only the level of symptom content, but also the syndrome as a whole.
3. Unique psychopathology (as a specific psychiatric condition). Culture may contribute to the development of a unique psychopathology that is observed only in a

certain cultural environment. For example, *Koro* (impotence panic), which is the occurrence of intense anxiety associated with the fear that the penis will shrink into the abdomen, resulting in death, is a unique psychopathology observed mainly in the South Asia region.

4. Frequency of psychopathology (as a surveyed psychiatric condition). If the variable of the socio-cultural environment favours the development of a certain psychopathology, that pathology will be more prevalent; if not, it will be less prevalent.

The Western concepts and classification of mental disorders are based on the biomedical model and a reductionistic orientation that assumes the presence of identifiable maladaptive bodily function or pathogen in any kind of disease. Those in positions of power and influence often assumed this view so that mental disorders were considered universal in their onset, expression, course, and outcome, and any variations (e.g., culture-specific disorders such as *Koro*, *Latah*, *susto*) were simply minor deviations within a prototypic universal disorder (Marsella, 2000). There was a tendency to ignore the cultural factors that influence people's perceptions of mental disorders (Castillo, 1997; Kleinman, 1987; Marsella, 1993; Tseng, 1997). Lin (1982) pointed out that clinical universalism originates in the belief that all human beings basically live, feel, think and behave alike, so that the symptomatology, course, and outcome of a disease, as well as the treatment or theories of causation should apply in all cases in spite of any individual, racial, ethnic or cultural differences. Kleinman (1987) calls this the "category fallacy", where a label that is developed for a particular cultural group and its behaviour is being imposed and interpreted by another person of a different cultural group without careful consideration of the meaning of that behaviour within that person's cultural context. In spite of this, the view of the universality of mental disorders still prevails today among



those Western psychiatric trained professionals whose professional and scientific worldview is based on assumptions of universals rather than cultural differences in mental disorders (e.g. Chiu & Rimon, 1987; Murphy, 1976; Singer, 1976a, 1976b; Yap, 1951). A concluding remark on the influences of socio-cultural factors on mental health from Singer, a pioneer psychiatrist who worked in Hong Kong, may be a good example to illustrate such a view:

Notwithstanding the foregoing observations so far as variations in psychodynamics from the western pattern are concerned, an appraisal of the literature and our own experience suggest that similarities far outweigh differences (as comparing the Western and Chinese concepts of mental illness), a point that seems obvious to many but needs emphasis. Cultural factors provide but a superficial colouration to a primary core of personality functioning common to all cultures. This applies even to the so-called culture-bound syndromes which are usually invoked to bolster the argument for significant differences. Such syndromes are in the first place rare. Secondly they are not as phenomenologically distinctive as is commonly made out. Their apparent distinctiveness is an artefact of linguistic problems and the pitfalls of interpreting alien symbols of behaviour: psychiatrists familiar with the culture face little difficulty in finding a place for such conditions in western nosology. Thus *koro* is usually obvious as an anxiety state whilst possession and *latah* can be relegated to the hysterical and other neurotic reactions. Culture-bound syndromes have never been shown by clinical studies to be distinctive in form, symptomatology and course let alone aetiology. In psychodynamics and in phenomenology the main themes run clearly through all cultures; variations are in the orchestration. (Singer, 1976b, p. 54)

However, Woo (1991), among others, argues against the notion of “universality.” Even though there may be universal processes underlying mental health problems, they are mediated by cultural theories, values, and conceptions, which are fundamentally different.

In addition, Patel (1995) sees that cross-cultural research in psychiatry has been polarised into two schools of thought: the etic approach advocates the universality of mental disorder while the emic approach argues that mental disorder categories need to be generated from within cultures. The former approach assumes that mental disorder is similar throughout the world and that psychiatric taxonomies, their measuring instruments and models of health care designed in the West are globally applicable (Patel, 1995). Conversely, the emic approach has been criticised for its ethnocentricity in viewing mental disorders and its failure to recognise that its assumptions and methods are deeply rooted within Western cultural traditions. Ethnocentrism typifies the subjectivity (often unconscious) of a mental health professional who tends to judge clients, or human beings in general, as normal, abnormal, or even pathological, based on the criteria of his/her own culture (Lin, 1982). Thus, at best, the etic approach provides only a limited and restricted perspective on the nature of psychopathology beyond Western cultural borders (Kirmayer, 1998; Lin, 1982; Marsella & Yamada, 2000; Mezzich, Kleinman, Fabrega & Parrone, 1996; Tseng, Lin & Yeh, 1995b).

Marsella and Yamada (2000) criticise the tendency to minimise the importance of cultural differences in psychopathology in Western psychiatry, suggesting it is a perfect example of the unintentional abuses of power that can occur even among persons of good will. A quote from Chakraborty (1991, in Marsella & Yamada, 2000), an Asian Indian psychiatrist, can well represent such a critique.

Even where studies were sensitive, and the aim was to show relative differences caused by culture, the ideas and tools were still derived from a circumscribed area of European thought. This difficulty still continues, and despite modifications, mainstream psychiatry remains rooted in Kraepelin's classic 19<sup>th</sup> century classification, the essence of which is the description of the two major "mental diseases" seen in mental hospitals in his time –

Schizophrenia and manic depression. Research is constrained by this view of psychiatry. A central pattern of [Western] disorders is identified and taken as the standard by which other [native] patterns are seen as minor variations. Such a construct implies some inadequacy on the part of those patients who fail to reach “standard”. Though few people would agree with such statements, there is evidence of biased, value-based, and often racist undercurrents in psychiatry.... Psychiatrists in the developing world, who are far away from any contact with research centres, have accepted a diagnostic framework developed by Western medicine, but which does not seem to take into account the diversity of behavioural patterns they encounter. (p. 1204)

Similarly, Misra (1996, in Marsella & Yamada, 2000), an Asian Indian psychologist, also comments:

The current Western thinking of the science of psychology in its prototypical form, despite being local and indigenous, assumes a global relevance and is treated as a universal mode of generating knowledge. Its dominant voice subscribes to a decontextualised vision with an extraordinary emphasis on individualism, mechanism, and objectivity... This peculiarly Western mode of thinking is fabricated, projected, and institutionalized through representation technologies and scientific rituals and transported on a large scale to the non-Western societies under political-economic domination. As a result, Western psychology tends to maintain an independent stance at the cost of ignoring other substantive possibilities from disparate cultural traditions. Mapping reality through Western constructs has offered a pseudo-understanding of the people of alien cultures and has had debilitating effects in terms of misconstruing the special realities of other people and exoticizing or disregarding psychologies that are non-Western. Consequently, when people from other cultures are exposed to Western psychology, they find their identities placed in question and their conceptual repertoires rendered obsolete. (p. 497-498)

Woo (1991) further comments that mental illnesses in the West were historically differentiated from physical illnesses by the fact that they were “functional” disorders for which no organic or physiological cause could be found. The Chinese approach, though with less differentiation between physical body and mind, has been more biologically oriented from the start and continues to be so. Even so, Chinese psychiatric practice contains apparent contradictions, which suggest that theoretical coherence is not an overriding issue in defining mental illness within the Chinese context.

### **The Need To Go Beyond A Superficial View**

The concept of mental illness and the meaning ascribed to the concept is highly contextualised, i.e. depending on the situation in which the illness label is applied. In Hong Kong, the label of “being mentally ill”, “*chisin*” or “*sàhngìbihng*” exudes a negative connotation and a strong social stigma. People may create prejudices from the labels, which can have a great impact on the person with mental illness and his/her family. The following is my childhood experience growing up in Hong Kong and learning about mental illness for the first time.

As I recollect, my first encounter with a person with mental illness was not a pleasant experience. The incidence occurred when I was about 10 years old and living in a 9-floor public housing estate for the working class. The residents were mainly people resettled from wooden squatter huts. There were 30 units on each floor, and the unit that my family of seven lived in was only about 400 square feet. The story begins in a neighbouring unit in which there lived the parents, maternal grandmother and three sons. The parents and grandmother were acquainted with my parents as they spoke the same dialect, *Hakka*. The youngest son was believed to be mentally handicapped, and was always teased by other kids, including myself, as “*sòhjí*,” (*Py shǎzǎi*) (mad boy) (傻仔)<sup>iv</sup>.

The family explained the cause a delay in treatment for a high fever when he was young, as the family was poor. He often was treated quite badly by other kids in the neighbourhood, particularly when he behaved “oddly”, such as chasing younger kids around (perhaps just an attempt to play), taking off his clothes, and muttering and laughing to himself.

Actually my story does not end there. One of the elder sons of this neighbour was also unemployed and had been idle at home for some time. There was often the sound of quarrels coming from their unit, sometimes between parents and sons, other times between parents. It was well known in the neighbourhood that they were a troublesome family and people tended to avoid them as much as possible. The unemployed son started behaving unusually: sleeplessness and pacing in the unit and along the corridor where the doors and kitchens of all the units were facing. After destroying a portrait of the Virgin Mary in his home (both the maternal grandmother and mother were converted Catholics), he was preoccupied with his painting of the Chinese god, *Guāngōng* (關公),<sup>v</sup> who, he claimed, was able to protect him. This apparently caused more conflicts between the mother, grandmother and him.

One day, as I was playing with my younger sister and other neighbourhood children, I heard a scream for help coming from their unit. Later, I saw the grandmother run out of the unit and cover her bleeding forehead with her hands. It was a frightening scene. My reaction was to lock the security-gate and close the wooden door of my unit immediately. The grandmother was able to rush into my next-door neighbour's unit for refuge as her grandson was still chasing after her holding a chopper. At that moment, as I peeped through my kitchen window, I saw the grandson return to his unit. The grandmother was partly pushed out and asked to leave my neighbour's unit for fear that her grandson might return, try to force his way in and cause harm to others in the unit. The grandmother was

given a stool to sit on outside and a towel to stop the bleeding. The grandson came out again, this time holding a mop, and kept threatening to kill his grandmother. Luckily, the grandmother was able to keep a distance from him and he did not take further action.

Apparently, someone had called the police and they came in full riot gear — riot-control shields and battens — to confront him. While he was distracted, a couple of the policemen dashed forward and apprehended him. The grandmother was taken to hospital by the ambulance with a wound on the forehead, but survived. The grandson was subsequently committed for treatment in a psychiatric hospital.

The grandson was discharged from the hospital after about half a year. A few months later, he was able to find a job in the local council and I did not hear of any further incidences of relapse before I left Hong Kong to study in Australia.

The whole neighbourhood adopted two different attitudes toward that family after the incidence. On the one hand, sympathy was expressed towards the family, especially the grandmother and mother, who were seen as the victims in this family; a curse might have been put onto the family as they had two sons with mental problems. Neighbours tended to comment behind their backs that this was retribution for some bad things the family members had done in the past. On the other hand, fear developed towards the family and people tended to avoid them by keeping a distance from the two sons as if they were unpredictable and dangerous. A cold attitude was often expressed towards the “ex-mentally ill” son, and the other son with a mental handicap was still treated harshly by the neighbours. This reflection illustrates my early concept of mental illness and the “social reality” that was created by myself and among the neighbours through the application of our own explanatory models.

In addition, socio-cultural factors seem to influence one’s perception of mental illness, and the meaning of mental illness to him/her is depended on the context. The

following example from my field notes illustrates that the perceived fear toward a person with mental illness is also contextual.

I frequently come across a man on a busy footbridge on the way I walk to work. Every time I see him, he is busily, but quietly, going through the few rubbish bins on the footbridge to sort out cans and papers. Perhaps he just wants to make some money by selling them to the recycle shop. Occasionally, he will eat whatever leftover food he can find in the bins. Another strange behaviour is that he will ritually use whatever liquid he can find, including leftover soft drink, to clean the bins with a newspaper. There are a lot of people using the footbridge, particularly during the peak hours, as it connects the train terminal and a business district. Some people may give this man a stare and then just walk by. Others just continue with their journey without taking any notice of him. I once asked my students, who use the footbridge very often, what they think of this man and what he is doing. The answers were “he is a loony”, “he is an ‘abnormal’ man who just cleans the bins with soft drink”, “he is an ‘odd’ man, but he is alright. He does not disturb others if they don’t bother him.”

People passing by do label this man as “abnormal”, “weird” or “loony”, but they do not feel he is a threat, as he has not shown any sign of aggressive behaviour, which is often perceived by the public about a person with mental illness (see Chapter 7).

One more interesting example is a well-known mentally ill person who is known to paint graffiti on walls all over Hong Kong and proclaims himself as the emperor of Hong Kong. The media has interviewed him, and his graffiti has even been used in a designer’s fashion. Pictures of his graffiti appear in some tourist magazines. Actually, his graffiti of Chinese characters even once stirred up a debate among the local Chinese calligraphers on whether they can be classified as art. He has never been portrayed as a violent or dangerous person by the mass media, and people seem to readily accept him

and his graffiti as icons of Hong Kong, despite his mental disorder (*Apple Daily*, 24 April, 1997; *Ming Pao Daily News*, 8 June, 1997; *Sing Tao Daily News*, 27 April, 1997; *The Next Magazine*, 7 March, 1997).

These stories raise questions about how the meanings and concepts of mental illness are interpreted under different situations. What are the implications of those interpretations for the families with mentally ill relatives, in terms of coping, provision of care and adaptation?

### **Objectives Of The Study**

Besides the questions raised above, there is very little writing on how the Chinese and Western medical paradigms interface in Hong Kong. One may question the cross-cultural applicability of psychiatric theories (Woo, 1991). A qualitative research method that can help to uncover locally based understandings can, thereby, create the basis for a more sophisticated epidemiological comparison than the traditional research which is positivistic-oriented and outcome-focused, and based on quantitative methods. In addition, there are also other questions that still need to be answered: what are the concepts and meanings of mental illness among people in Hong Kong? Do they differ from people of other places, particularly Chinese elsewhere? How do the Hong Kong people acquire such concepts? In what ways has the process of transition of sovereignty influenced the care and service for people with mental illness in Hong Kong?

Before we can be more proactive for change and improvement in service planning and development, we first need to understand the families' and clients' explanatory models of mental illness, as well as their needs and expectations. This led me to carry out a study in this area.



The present research was first designed to gain a better understanding of Chinese families and mental illness during the period of transition of sovereignty. The aim of the study was to explore, describe and document the meaning of mental illness among the Hong Kong Chinese and how families with a mentally ill relative cope and adapt. The areas to be explored included the “integration” of the East’s and West’s concepts and meanings of mental illness among the people of Hong Kong, the coping process and the strategies employed, and the help-seeking behaviours by the families with mentally ill members. I adopted an ethnographic approach for data collection and analysis. Besides one-to-one individual interviews, other data sources include field observations, informal interviews, a questionnaire survey, analysis of secondary data, such as newspaper articles and cultural artefacts, and self-reflection that drew on my own clinical experience as a mental health care professional.

Based on the questions generated, I anticipated the objectives of the study would include the following:

1. To describe the contextual background of Hong Kong during the period of the transition of sovereignty and its relation in shaping the concept and meaning of mental illness in this transitional metropolis;
2. To explore and apply a relevant framework to perceive and interpret the emerging phenomena, as well as the meaning of, and coping with, mental illness among the Hong Kong Chinese;
3. To examine the influence of mass media on the acquisition of public attitudes towards people with mental illness;
4. To investigate the extent of the identified influences or factors that have impacted the coping and experience of family with mental illness; and,

5. To explore possible implications of the findings for mental health practice and service provision.

### **Significance Of The Study**

I anticipate that the findings will contribute to our understanding of 1) concepts of mental illness and their meanings among the Hong Kong Chinese, and 2) the coping process of families with a mentally ill relative and how the general meanings influence the coping process. These may help to clarify some of the myths and misunderstandings about mental illness among Chinese, particularly the Hong Kong Chinese. As a result of these findings, the impact of the social stigma of mental illness on clients' and their families' lives may be minimized.

The understanding of clients' and families' perspectives of mental illness and coping processes, and identification of their service needs, acquired through this study may provide valuable information for service providers in developing services. In addition, as the public begins to be aware of mental health issues and problems associated with mental illness, the research interest and funding in these areas may gradually increase. Last, but not least, I hope this study will increase the knowledge base for occupational therapists and other health care professionals who practice in the area of mental health, particularly those servicing the Hong Kong Chinese.

### **Outline Of The Thesis**

To see how the study objectives are achieved, this thesis records my research methodology and its rationale, as well as a summary and analysis of data that I collected from multiple data sources. For clarity, this thesis is divided into four units and each unit represents a different but related theme. Unit One introduces the background and the

scope of the study, and includes this chapter and Chapters 2 and 3. Chapter 2 outlines the design of the study and rationale for adopting such an approach to address the questions raised above. Chapter 3 describes the yin and yang analogy, a uniquely Chinese philosophical framework, which I have adopted to understand and interpret the themes and phenomena that have emerged from the data analysis. The concepts of mental illness in traditional Chinese medicine are also detailed in the chapter.

Unit Two concentrates on the description of the contextual background, and its role in shaping the concepts and meanings of mental illness in Hong Kong. In Chapter 4, I attempt to describe the social reality by exploring how Chinese (*yin*) and the Western (*yang*) cultures interact to create the unique culture of Hong Kong and the identity of Hong Kong Chinese. This social reality has influenced, and will continue to influence, the nature of the transition in other spheres, i.e., political, press media and public opinion, health care, the family, and the individual. In Chapter 5, I describe how the Chinese and Western medical paradigms interact and evolve to create the clinical reality in Hong Kong.

The theme in Unit Three is the concept of mental illness as projected by mass media and perceived by the public. As mass media play an important role in shaping people's concept of mental illness, Chapter 6 examines how the press media portray mental illness. Chapter 7 displays the general public views on mental illness and the social stigma attached to it. The contents of these two chapters reflect the influences of culturally defined personhood, the dominancy of the Western medical paradigm, and the mass media's dramatisation of news reporting in constructing the public concepts of mental illness. These concepts, in turns, have affected both the coping and the experiences of families with mental illness.

The last unit focuses on families with mental illness and the implications of the findings. Chapter 8 examines the changes that have occurred in family structure and

function and the impacts this has on the caring for persons with mental illness. Both Chapter 9 and 10 describe how the families experience, cope, experience and adjust to mental illness, which is not an individual problem but an entire family affair within the Chinese familial collectivistic context. In the final chapter, I summarise and reflect upon the research methodology, the findings, and the arguments according to the objectives of the study. Then, I draw on the findings and self-reflection to suggest the implications of the findings and the ways forward in maintaining mental health and encountering mental illness in a transitional metropolis.

## Notes

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<sup>i</sup> The term “banana man”, (the local Cantonese term is *wòhongpèihjiu* – yellow banana), is a commonly used colloquial name-calling term for a local Chinese who are Westernised or acculturated to Western civilisation and ideologies. Though it is slightly demeaning in a local sense, it is quite often used in humour and casual speech with good friends.

<sup>ii</sup> Names of Chinese authors of Chinese literature are written in English using romanisation in *Pinyin*. They are italicised to differentiate them from the authors of English literature. A reference list of Chinese literature is included for those articles that do not have an English version.

<sup>iii</sup> Mainland China and Taiwan name Chinese language differently, *Putonghua* and *Kouyü* (or *Zhongwen/Mandarin*) respectively, but both are more or less the same language. There are two romanisation systems for Chinese characters, *Pinyin*, by Mainland China, and the Wade-Giles system is used in Taiwan’s literature. Adding to the complexity, the Wade-Giles system was often used for romanising Cantonese, which is the most common dialect in Hong Kong.

To minimise confusion, I adopt the *Pinyin* system for romanisation of the Chinese characters and are italicised throughout this thesis. Cantonese romanisations are italicised and underlined for differentiation, but the *Pinyin* romanisations are also provided in brackets. The following two publications are the references for romanisation in this thesis.

Chik, H.M., & Ng, S.Y. (2000). *Chinese-English dictionary*. Hong Kong: The Chinese University Press.

Chung, L.K. (Ed.) (1998). *Pû tōng huà dú yìn cí huì*. Hong Kong: Hong Kong Educational Publishing Co..

<sup>iv</sup> Actually he became one of my patients 14 years later when I worked in a psychiatric hospital in Hong Kong after I graduated as an occupational therapist. I was told that his mother was not able to contain his behaviours at home, and he created a nuisance in the neighbourhood. Thus, the family decided to keep him in the hospital until a permanent placement was found for him. Recently, I was told he died of cancer about 10 years ago.

<sup>v</sup> *Guāngōng* was a historical figure in the early 3rd century AD. He formed a brotherhood with another two historical figures, *Liú Beǐ* and *Zhāng Feí*, to try to restore the East Han Dynasty (25 AD – 220AD). In the legend, he was a person with a strong sense of fidelity towards friends and others. Later, and into the present day, he was worshipped as the God of Fidelity.

## CHAPTER TWO

### Methodology

*“Gong yù shàn qí shì, bì shàn lì qí xì”*

“工欲善其事、必先利其器”

An old Chinese saying

*(This phrase is a verse from the Chinese classics. It means if one wants to do a good job, one has to sharpen the tools first.)*

#### **My Cultural Orientation: A “Westernised Man’s” View**

This chapter describes the rationale for the research design and the data collection methods adopted for the study. I was born in Hong Kong and received my primary and secondary school education in the public schools system. The public school system was (and still is) modelled on the British system in terms of general structure, operation and curriculum, and English being the major medium of instruction (Hu, 1998). In addition to my family, many of my basic values and concepts came from the HongKong education system and the Australian tertiary education system, where I was further exposed to Western ideas. As a result of this experience I re-evaluated and reconstructed some of my original values and concepts so that I call myself a “*banana man*” — “*yellow skin but with a white heart,*” — a “Westernised man.” This term is frequently used by the local people to describe those who are influenced or “indoctrinated” by Western values and thoughts.

With this background, I have advantages as well as problems in viewing the cultural issues of Hong Kong. I am able to provide an insider’s view of culture and the lives of Hong Kong *ren* (people). At the same time, because I am bilingual, I am privileged to read

and understand literature written in Chinese with an insider's view of relevant concepts or issues that may be distorted or misinterpreted when translated into English. In spite of this, I may easily lose my ability to identify issues or phenomena because I take many daily experiences for granted. My education, mainly based on Western values, also have shaped my views and values in interpreting the local meanings. Furthermore, a "Westernised man's" perspective is also a unique way of perceiving local matters and the world.

There is also another inevitable fact: bias always exists in the process of interpretation. Postmodernists often use this bias to criticise the validity and generalisability of findings from ethnographies or anthropological methods (Anderson, 1996). Thus, I may have bias in perception and interpretation of the "social reality" of the local situation, as well as the "clinical reality" of mental illness in Hong Kong. This problem is also shared by both Donald Campbell (1979) and the medical anthropologist, Nancy Scheper-Hughes (1992), respectively.

That is not to say that common-sense naturalistic observation is objective, dependable, or unbiased. But it is all that we have. It is the only route to knowledge - noisy, fallible, and biased though it may be. We should be aware of its weakness, but must still be willing to trust it if we are to go about the process of comparative (or mono-cultural) social science at all (Campbell, 1979, p. 54).

I grow weary of these postmodernist critiques, and given the perilous times in which we and our subjects live, I am inclined towards a compromise that calls for the practice of a good enough ethnography. The anthropologist is an instrument of cultural translation that is necessarily flawed and biased. We cannot rid ourselves of the cultural self we bring with us into the field.... Nonetheless, we struggle to do the best we can with the limited resources we have at hand – our ability to listen and observe carefully, empathically, and compassionately (Scheper-Hughes, 1992, p.28).

Spiro (1992) further argues that it will never be possible to characterise a whole society with absolute precision. It is not even possible to define the personality of a single individual with precision. The purpose is too vague and societies and individuals are too complex, riddled with inconsistencies and repeated changes. Despite these realities, much about cultures often can be described with confidence. Based on this notions, Anderson (1996), like Schepher-Hughes, proposes that we need to do what he calls “good enough” ethnography. He believes that all methods have biases and that only by using multiple techniques can the researcher triangulate the underlying truth. Thus, he suggests that the repertoire of the ethnographer should include many techniques for acquiring information about various aspects of a culture. Each is useful in some ways, if not in others. Such a process of triangulation can reliably and validly obtain informants’ responses and develop data sources relating to a particular cultural domain. The research methodology I designed for this study has its origin in such beliefs.

### **Overview of Research Design**

An ethnographic approach was adopted in order to gain a better understanding of the Chinese culture in Hong Kong from a local perspective; the ways in which this culture has shaped the concepts and meanings of mental health and mental illness; and, the impact of these concepts and meanings on the families in coping with mentally ill relatives.

Wolcott (1990, p. 48) suggests:

Ethnography traditionally has meant to commit to looking at, and attempting to make sense of, human social behaviour in terms of cultural patterning. To pursue ethnography in one’s thinking, doing, and reporting is to engage simultaneously in an ongoing intellectual dialogue



about what culture is in general — and how culture influences without controlling — while attempting to portray specific aspects of the culture of some human groups in particular.

In the broadest and simplest sense, ethnography can be defined as the systematic process of observing, describing, documenting, and analysing the particular patterns of a culture (or subculture) in order to grasp the life-ways or patterns of the people in their familiar environment (Leininger, 1984, p.35). In practical terms, ethnography is social research that has a substantial number of the following features (Atkinson & Hammersley, 1994, p.248):

1. a strong emphasis on exploring the nature of particular social phenomena, rather than testing hypotheses about them;
2. a tendency to work primarily with “unstructured” data, that is, data that have not been coded at the point of data collection in terms of a closed set of analytic categories;
3. investigation of a small number of cases, perhaps just one case, in detail;
4. data analysis that involves the explicit interpretation of the meanings and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations with quantification and statistical analysis playing a subordinate role at most.

I was not able to conduct a large number of ethnographic interviews, as described by Spradley (1979), with families due to the difficulty in recruiting informants, which I will explain further in Chapter 10. I adopted Frake’s view (1964, p. 111) that “a description of a culture, an ethnography, is produced from an ethnographic record of the events of a society within a given period of time, including, of course, informants’ responses to the ethnographer and his queries, tests, and apparatus.” Thus, an ethnographic study should

not be solely dependent on interview data. In Spradley's (1979) description of making an ethnographic record, he suggested that it should consist of field notes, tape recordings, pictures, artefacts, and anything else that documents the cultural scene under study. Emerson (1988, p.39) further maintains that undertaking ethnography is not a matter of methods as described in a textbook, i.e. establishing rapport, selecting informants, transcribing texts, taking genealogies, mapping fields, keeping a diary, and so on. It is an interpretive analysis, called a "thick description" (Geertz, 1983), of meanings people attribute to their daily living experience.

Fitzgerald (1997) further suggests that ethnography is neither a research technique nor a method, but more a frame of mind.

Ethnography involves the use of any technique or method which will allow the researcher to address the issue at hand, and rarely involves the use of any one technique or method. Ethnography is multi-methodology research par excellence. (Fitzgerald, 1997, p. 52)

Furthermore, making an ethnographic record acts as a bridge between discovery and description, linking them into a single, complex process (Spradley, 1979). Therefore, in order to make such a record, to provide a comprehensive description and understanding of the issue from various perspectives, I decided to include many data sources instead of in-depth interviews alone. They include field observations, informal interviews, a questionnaire survey, analysis of secondary data such as newspaper articles and cultural artefacts, and critical self-reflection on my more than six years of clinical experience as an occupational therapy practitioner in mental health.

### **Data Collection: Informants/Sources Of Information**

The aim of the study was to explore, describe and document the meanings of mental illness among the Hong Kong Chinese, and how do these concepts impact on the experience of families with a mentally ill relative during the period of transition of sovereignty. Several objectives were set to achieve such aim and they are outlined in Chapter 1. There is no single set of data can address each objective adequately. Thus, multiple methods of data collection from different sources were incorporated in the study. They were then merged and integrated for analysis and interpretation. An overview of the process of data collection and analysis is given in Figure 1. Through triangulation of data from different sources, a better understanding of phenomena can be achieved.

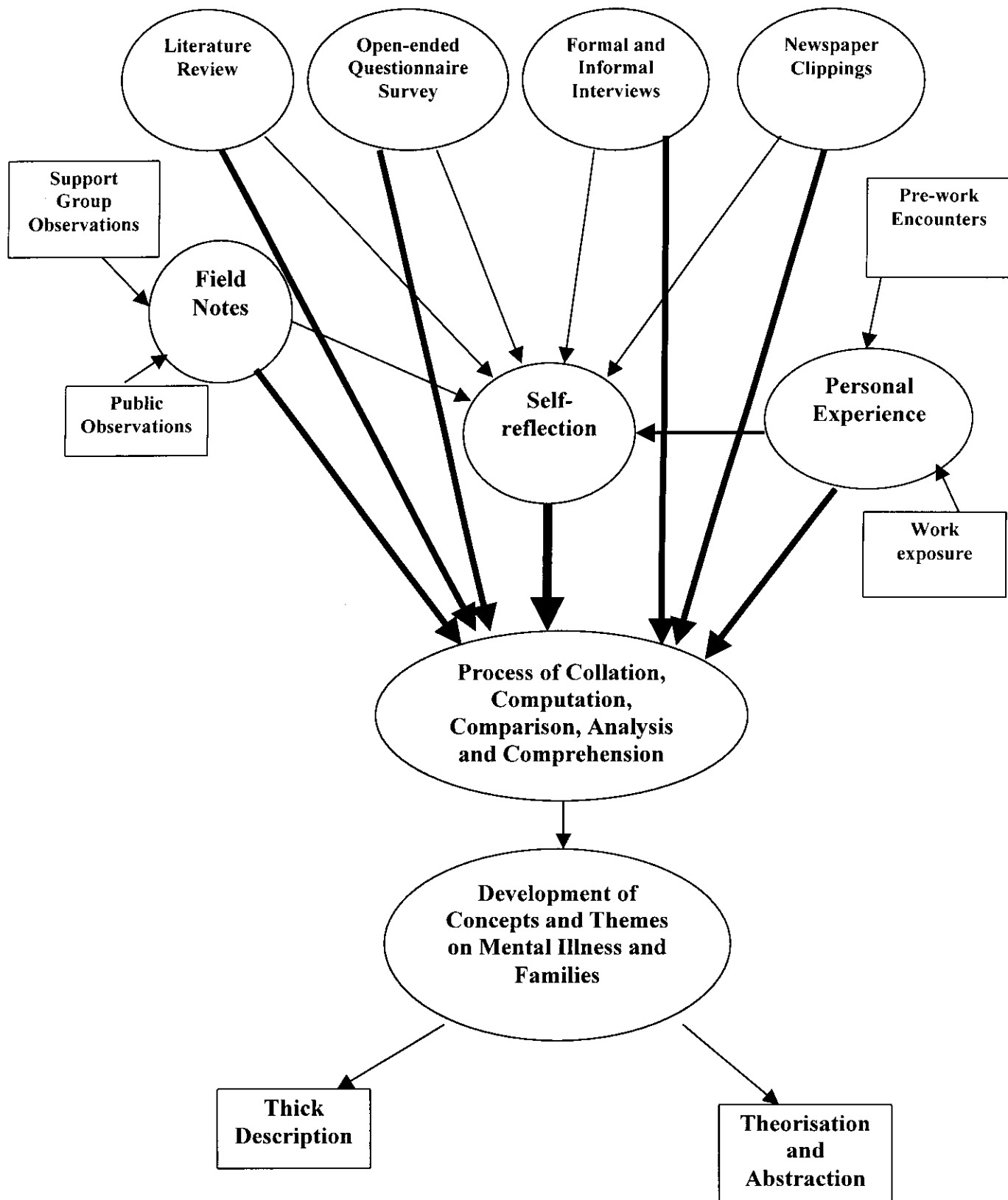
The people (family informants, questionnaire respondents, colleagues, journalists, and the others) who informed my study were everyday Hong Kong Chinese, some of whom had a family member or friend with a mental illness. Some contributed in personal interviews, others in support groups discussions, some responded to the questionnaires, and others provided information during day-to-day conversations or newspapers. Specifically, data for the study came from the following sources:

1. A review of both Chinese and English literature on Hong Kong cultural identity and family, Chinese and Western medical perspectives of mental health and mental illness, and coping and adjustment of families with a mentally ill relative (see Chapter 3, 4, 5 and 9);
2. Local newspaper clippings on issues relating to culture, mental health and mental illness (see especially Chapter 6);
3. A questionnaire survey on concepts of mental health and mental illness and attitudes toward people with mental illness, collected among local informants recruited by a convenient sampling method (see especially Chapter 7);

## Chapter Two

4. In-depth interviews with families with mentally ill relatives (see especially Chapters 8 and 9);
5. Field notes of participant observations was collected to enrich all other data and triangulate interpretations arised from them. It came from two situations:
  - a) while I was giving talks or conducting seminars for the public on the care of people with mental illness; and,
  - b) observing people's reactions to people with mental illness on the street and in out-patient clinics; and,
6. Critical reflection that drew on my previous experience as a participant observer, as well as a mental health care professional practicing within the Hong Kong context.

**Figure 1: Methods of Data Collection and Data Analysis**



The rationale for selection of the above mentioned sources of information are briefly elaborated as follows; however, the detailed process of data collection from each information source is described in the relevant chapter.

1. *A review of the literature, both written in Chinese and English, on Chinese culture and mental illness*

Being a bilingual person, I am able to read both the Chinese and English literature. This not only allowed me access to the Western view of mental health, particularly its perspective on Chinese culture, family and mental illness, but also allowed me to compare such views with those of the Chinese scholars who published their works only in Chinese. By comparing and contrasting, I present two perspectives on the family and mental illness issues, as well as demystify or clarify previous misunderstandings held by Western scholars.

2. *Local newspaper clippings on issues/events related to mental illness*

There are more than a dozen daily newspapers circulating in Hong Kong. Besides the television and radio, they provide a major source of information/knowledge for the locals and a means of socialising the local public to new values and beliefs. Articles written by the reporters and local writers in some ways reflect the value and belief systems of the Hong Kong society. Analysing this “second-hand” literature provides a glimpse into what the locals know about and/or believe.

3. *A questionnaire survey of concepts and attitudes toward mental illness*

A semi-structured open-ended questionnaire was designed to collect Hong Kong Chinese concepts of mental illness and attitudes towards people with mental illness (Appendix I).

The questionnaire was administered using a convenience sampling method. The seventy-two informants either wrote down their responses or recorded them on a cassette-tape, which was later transcribed.

#### 4. *Interviews with families with mentally ill relatives*

Unstructured interviews were conducted with volunteer members of families with mentally ill relative. They were recruited through personal networks and referrals. Besides giving their basic demographic data, they were encouraged to describe their experiences of living with a mentally ill relative, their ways of coping, and the management strategies they employed. I had great difficulty recruiting family members as informants for formal interviews. They were hesitant to talk on the topic or comment on their mentally ill family members. Some were even afraid that others might learn their identity (or that of the mentally ill relatives), despite my repeated assurances of confidentiality. Thus, informal methods also were used. The interview data include:

- 1) Interviews that were carried out by myself with 10 informants recruited through personal contacts and indirect channels. In addition, informal discussions with 4 relatives were conducted by a trained research assistant who was acquainted with them. She was briefed by me regarding the structure and process of the interview prior to those interviews each time. Interviews ranged from one hour to two and a half hours at the informant's choice of venue. (See Appendix II for their profiles)
- 2) Casual conversations with more than 10 relatives that I came into contact with through my advisory role with a relative support group and in seminars where I had been invited as guest speaker to talk on topics related to living with a relative with mental illness. (See Appendix III for the nature of those seminars).

- 3) An audiotape of a discussion carried out in one of the relative support group meetings, when I was not physically present.

Although most of interviews were carried out in an informal manner, they were conducted with the knowledge and consent of the participants (Appendix IV Consent Statement/Form). The point is that people did not mind talking on the topic, but only within certain contexts and in an informal way. Therefore, it seemed more appropriate, and ethical, to conduct the interviews in that way. I was able to audio-record the majority of the family interviews and later they were transcribed for analysis. Generally no notes were taken during the informal interviews or events. Nonetheless, notes were recorded as soon as possible after the event as field notes. Finally, the data from the family interviews includes 14 long interviews, a number of informal conversations and a recording of a relatives' support group meeting.

5. *Interviews with relevant scholars, health care professionals, and the general public*

Not only did I receive comments from colleagues through my presentations in research seminars both in The University of Sydney and The Hong Kong Polytechnic University, I was able to gain valuable feedbacks on my study from staff and visiting scholars at The Transcultural Mental Health Centre, Sydney, Australia. I was also honoured to have opportunities to hold informal interviews or conversations with other scholars who are regarded as experts in the field in The Chinese University of Hong Kong, The University of Hawaii and the Ghongzhou Civil Affairs Psychiatric Hospital. All these encounters, conversations, and comments inspired my subsequent series of reflections, which were incorporated into my analysis. In addition, selected health care professionals, my relatives, and members of the general public also were interviewed informally to explore their views



on phenomena generated from the data and to identify any discrepancies for further exploration. Their responses were mostly recorded as field notes for further analysis.

*6. Field notes from participant observations*

Field notes were written and compiled as facts or reflections which arose during my day-to-day observations of daily life in Hong Kong, as well as informal interactions and observations in my own daily events. Furthermore, I made notes on my reflections when I was invited by voluntary groups or parent groups to give talks or conduct seminars for the public on mental health topics. The field notes were collected from 1996 to 2000, and include descriptions of public reactions to people with mental illness as observed by myself during the data collection period.

*7. Working experience and personal reflections on issues related to mental health and mental illness*

I had worked as an occupational therapist in mental health practice for more than 6 years, both in Hong Kong and in Australia. To provide an insider view on the topic area, I drew on those pre- and post-clinical experiences, as well as personal reflections on the collected data and phenomena generated, and incorporated them into the final data analysis and discussion. Although the self-reflection is not a data set by itself, it contributes to the interpretation of the results that arise from the data analysis. Such a method is supported by Ermarth (1978) who maintains that “Lived experience is the ‘originary’ way in which we perceive reality. As living persons we have an awareness of things and ourselves which is immediate, direct, and nonabstractive. We ‘live through’ life with an intimate sense of its concrete, qualitative features and myriad patterns, meanings, values, and relations” (p.97). Therefore, in that sense it is important to “uncover meanings in everyday practice in such a

way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalised” (Benner, 1985, p.6).

### **Data Analysis**

Data analysis was an on-going process in which several methods were involved which, at times, overlapped with each other. First, as data came from various sources, an analytic inductive approach of content analysis (Berg, 1995) was adopted where existing dimensions or word units, emerging themes, and categories were identified through repeatedly reading the transcripts and notes. Concepts or categories were generated by reviewing each individual source of data and by comparing sub-categories within one data source with other data sources. All the categories were then refined and abstracted to form a few broader themes. This process was continued until either my research questions were answered or new insights were gained in understanding the topic area or phenomena which emerged.

In addition, the approach of content analysis, as suggested by Patton (1990) and Bernard (1994), also was employed to make interpretations of themes and categories emerging from all the data sources. Incoming data were constantly compared to previous data for repeating features, similarities, and differences (patterned regularities). In this way, a constant comparative method was adopted for the study (Glaser & Strauss, 1967; Corbin & Strauss, 1991).

Immersion, incubation, and interpretation are important phases of constructing meaning and insight in data analysis (Rossman & Rallis, 1998). As indicated in Figure 1, self-reflection, comparison, theorisation, and abstraction were used to make sense of what was happening in the daily life of Hong Kong and to understand the meaning of the themes identified from the data. In the process, I drew on my knowledge and experience, and

allowed statements, behaviours and observations of the informants to “reverberate” in my mind against extant knowledge and information in order to come to some interpretation or conclusion; then I went back to the data to check if it was really there (Devereux, 1967; Fitzgerald, Paterson & Azzopardi, 1997). In this sense, I made myself an integral part of the analytical process and there was no need to pretend about being objective, nor any need to rigidly control or deny the subjective part of the process. After all, the descriptions aim to “accurately” reflect a “banana man’s” view of the social reality. I was inclined to adopt Emerson’s view (1988), as well as others (e.g. Geertz, 1983), that there is no such thing as “simple description” but that all such work is inherently interpretive. Geertz (1983) called this “thick description” of humans’ “thinking” of meanings of daily living experience that constitutes culture. Descriptions of this kind are all filtered through the mind and experience of the one doing the describing or interpreting (Fitzgerald et al., 1997).

As briefly mentioned earlier, ethnography is not merely a research technique or a method, but more a frame of mind. It involves the use of any technique or method that will allow the researcher to address the issue at hand (Fitzgerald, 1997). For “good enough” ethnography, it also should involve multiple techniques that the researcher can triangulate on the underlying truth (Anderson, 1996). Each technique or method of data collection requires its own “standard” way of analysis. Thus, descriptive statistics of quantitative approach also were used to summarise data, particularly for information generated from the questionnaire survey and newspaper clippings, and to assist in the explanation and presentation of the findings so as to enhance better understanding. It should be noted here that further information on the analysis is embedded throughout the thesis in order to better place it in context.

In the following chapter, I describe the philosophical framework of yin and yang and the rationale for adopting it to interpret the data. In the subsequent chapters, I shall

## Chapter Two

demonstrate its relevance for understanding the cultural context of Hong Kong and the meanings of mental illness to an individual, his/her family, and the general public at large.

## CHAPTER THREE

### **The *Yin And Yang* Analogy: A Chinese Perspective Of Understanding Life Issues**

#### **Introduction**

The replacing of the Union-jack flag of the United Kingdom with the flag of the People's Republic of China on all the government buildings of Hong Kong took place on 1<sup>st</sup> July, 1997. It not only symbolised the transition of sovereignty that had already taken place, but also officially signified the transitions in cultural, social and economic systems to come. Actually, the transitions in political, socio-cultural and economic systems had already started 10 years before the final countdown.

Although I started off with aims to explore the issues concerning the concept of mental illness and coping in the families with relatives with mental illness, the data that I collected told me more than I had anticipated. The information seems to reflect events in transition. In another words, it seems to be a kind of pendulum swing in which Hong Kong has swung to one end in the past and now begins to swing back. In spite of this, the data reflect more than a linear motion back and forth; instead it seems to be a non-linear motion, or even a 3-dimensional motion, as new elements emerge and old elements are transformed.

This thesis is about the concept of mental illness in Hong Kong during the period of transition of sovereignty, not what had happened before or what can be predicted in the future. However, it must, of necessity, draw upon the past and should provide a foundation for thinking about the future. The present is embedded in a context that is a product of both the past and the present. In addition, as a participant observer in the study, I make sense out

of the data based on my personal experience and understanding of the Hong Kong culture as a “Westernised man.” The data analysis, though interpretive in nature, represents what was taking place during the time of data collection. A unique Chinese conceptual framework was deemed to be necessary to interpret and to make sense of the social reality, as well as to understand the meanings and experiences of mental illness where they are being constructed. This chapter intends to: 1) describe the “*Yin and Yang*” analogy and the rationale for adopting such an analogy as a framework for analysis and interpretation of data; and, 2) examine the concepts of mental health and illness in traditional Chinese medicine.

### **The Selection Of A Framework For Better Understanding**

I originally intended to present results from the data sets to provide a glimpse, though a possibly disjointed perspective, of the concepts in Hong Kong of mental illness and how the families cope with mental illness. Ethnography is about interpretation (Geertz, 1983). In order to understand the bigger picture, or see the phenomena in a more coherent way that creates meanings, I decided to take a macroscopic, interpretative view of all the data through the application of a specific conceptual framework. As I was investigating the concepts of mental illness and family in Hong Kong, where the East is interacting with the West, it seemed appropriate to adopt a Chinese analogy, the *yin* and *yang*, to understand the results generated from the different sets of data.

The underlying reason for adopting the *yin* and *yang* analogy is its uniqueness in symbolising Chinese culture. It represents a particular culture that greatly contrasts with Western culture, which can also be symbolised by the Cross. The following quote from Zhù's (祝業平, 1995) writing on Taoist culture and science best summarizes the differences in the two cultures, represented by these two unique symbols.

東西方文化幾乎同時孕育於地球的兩端，但其文化上的差異又是如此分明。如果找到兩者之間的最能表示其特點的象徵符號，恐怕沒有甚麼符號象 ☯ 與 ✝ 這樣更能表達兩種文化的特徵了。中國文化與科學的象徵符號是 ☯ -- 太極圖，它精煉地表達了中國科學的基本思想。而產生於基督文化背景中的西方科學，也可以用 ✝ -- 十字架來表示。這象是一個性標，可以沿縱橫方向無限延伸，代表了西方文化爲了征服自然而進行的無窮探索。東西方文明的這兩個符號既是兩種不同宗教的符號，又表達了超出宗教之外的文化含意。兩者比較，我們可以看出他們各有優劣。東方文化重平衡、思維傾向封閉性較強，但有着有機的辨證特點，善於對事物進行整體把握。西方文化重對稱，思維傾向是外向性佔優勢，在分析問題上是由小處着手，注重邏輯推理。這些思維方式的特點導致兩種文化有其不同特點，也造就了以有機論爲指導的中國古代科學和以機械論爲主導的西方近代科學。

祝業平 《道家文化與科學》1995. 合肥: 中國科學技術大學出版社。(p. 472)

#### Translation<sup>i</sup>

The Oriental and Western cultures were born and nurtured at the two ends of the world almost at the same time, but the differences between them are quite significant. If one wants to find the symbols that are the best representatives of the uniqueness in the two cultures, there will not be anything better than to use the symbols of ☯ and ✝. They can best represent the unique characteristics of these two cultures. The symbol that represents Chinese culture and science is ☯ -- the Tai Chi icon. It diligently symbolises the fundamental theories of Chinese science. Western science that was originated from the Christian culture can be symbolised by ✝ -- the Cross. This is like a direction post that can unlimitedly extend horizontally and vertically. It represents the Western culture that is ever searching for ways to conquer nature. The symbols that represent the Oriental and Western civilisation do not only signify two different religions, but also contain cultural meanings that are beyond religion. Comparing the two cultures, we can see they both have strengths and weaknesses. The Oriental culture's emphasis is on equilibrium. The thinking process inclines toward enclosure, but consists of an organismic analytic character and is able to view things from a holistic perspective. However, the Western culture's emphasis is on contrasting. The thinking process leans toward external conquering. When coming to analysis, it prefers to start with small parts and emphasises logical induction. These two unique but different thinking processes lead to the differences in

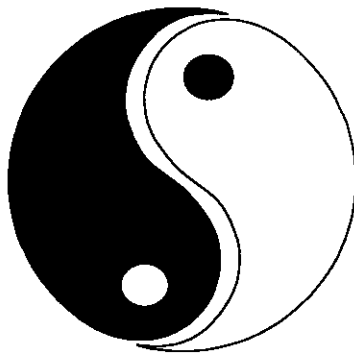
the unique characteristics of the two cultures. Thus, these have created the organismic-oriented Chinese classic science, and the mechanistic-oriented Western science.

*Zhù Yè-píng* (1995). Taoist culture and science. Hefei, (p. 472)

Furthermore, the culture of a small group in a society is often a microscopic reflection of the culture of the larger society. By the same token, the mega-culture of a particular ethnic group is actually the amalgamation of all the mini-cultures of the sub-sectors. With this assumption, we can understand a broader cultural context via studying a sub-cultural group or culture of a sub-sector, and vice versa. Taking Hong Kong during the transition period as an example, understanding the context in which the meanings of being mentally ill are ascribed and in which the experiences of families with mentally ill members occur, will, I suggest, shed light on understanding the experiences of Chinese in transition in other parts of the world. By using the *yin* and *yang* analogy, I intend to see things and interpret phenomena from a unique perspective that is uniquely part of the Chinese belief system.

### **The *Yin* and *Yang* Analogy**

The words *yin* and *yang* were first recorded in one of the oldest classic books, *I-Ching* (*The*



*Book of Change*), believed to be written by the first legendary emperor *Fùxī* (2852 BC). The actual author or authors and the time it was written still remain a mystery. This classic text not only laid down the theoretical framework and principles for traditional Chinese



medicine, but also for architectural design, social relationships and political structure. The theoretical concept of yin and yang also formed the foundation of Taoism. The symbol of Tai Chi (*Tàiji*) represents the dynamic interplay of the two forces, *yin* and *yang*. Each force is represented by a swirl wind with head and tail after each other within a cycle. The outer cycle represents *Qi* (air), of which the universe is made and from which the yin and yang originate; other elements come out from these two forces (Yang, 1998). The reason that yin and yang were symbolised in a curve shape, instead of an absolute linear division in the middle of the circle, is because they are inter-related and inter-restrained. Each consists of each other's extreme form, which is represented by the small dot in the other's head. This means that they originate in each other, and they depend on each other as they evolve. Extreme yang will create yin and extreme yin will give birth to yang (Yang, 1998). The two forces are not static, but are constantly interactive, developing and moving as the whole system is exposed to the external world.

The yin and yang concept is different from the Western dichotomy of good and evil, where good virtue is declared, labelled, and promoted whilst evil is stigmatised, suppressed, ignored, and disposed of. Yin and yang are believed by Chinese to be the primogenital elements from which the universe has evolved; they are endowed with innumerable qualities (Veith, 1992). The yin force represents the moon, cold, water, earth, standstill, care, nurture, inward and downward. The yang force means the sun, hot, metal, fire, motion, conquest and destruction, outward and upward.

In order to understand mental illness in Hong Kong at this point in time, we need first to understand the Hong Kong context. Although this model is not perfect and is unable to explain all phenomena derived from the data, it provides a unique Chinese perspective. Because the *yin* and *yang* nosology has been incorporated into traditional Chinese medicine, I shall begin by describing how the concept of yin and yang forms the theoretical

framework for traditional Chinese medicine through a review of literature. In turn, we also shall look at how the Chinese medical system explains the concept of mental illness. The following two sections are drawn from a number of English and Chinese publications on the topic (Achtenberg, 1983; Collins, 1982; *Y.Y. Li* (李亦園), 1996; Liu, 1981; Nathan, 1974; Tseng, 1973; Veith, 1992; Walls, Walls, & Langsley, 1975).

### **Concept Of *Tao*: An Alternate View On Adaptation To Transition**

Besides the cultural factor, modernisation and industrialisation also provide fuel for change in contemporary society. The teaching of *I-Ching* emphasises that change is an inevitable part of life. Paradoxically, the only thing that does not change is “change.” Since change is always there, there is nothing we can do to stop it, nor can we hide ourselves away from it. Very often, humans attempt to deal with change head-on, or to remove it, but the result is uselessness. When one change has been dealt with, another change created by the “successful” dealing of the previous change will follow. It is like throwing punches in the air, we gain nothing except our own exhaustion. It may sound pessimistic. From the view point of Taoism, with the yin and yang concept as its foundation, being active and confrontational will get one nowhere, except for more disputes, disharmonies and even wars. Everyone has a role to play in the society. As in the yin and yang analogy, each role is interdependent and complementary with the other. Without thefts and criminals, we do not need a law enforcer. Without greed, there is no need to accumulate worldly fortune. Without something being labelled as bad, how can we define the good and its value? One needs the other to make a complete whole. But that does not mean one can take over the other. The yin and yang concept tells us that as one side swings to the extreme, it will lead to the creation of the antagonist component that will trigger the balance mechanism, and the new emerging component may start off the next evolving and balancing process, and so on.

Does that mean we just sit there and do nothing? Not necessarily. We need to practise *Tao* (Dào 道) — self-cultivation — accept change as an inevitable fact of life, and observe the patterns of change. *Tao* originally meant “the way and the beyond, that is, by shaping earthly conduct to correspond completely with the demands of the other world” (Hackmann, date unknown, cited in Veith, 1992, p.11). Veith (1992, p.11) further elaborates that Chinese believed that the entire universe followed one immutable course which became manifest through the change of day to night, through the recurrence of the seasons, through growth and decay. Therefore, humans in their utter dependence upon the universe could not do better than follow a way that was conceived after that of nature. The only manner in which a person could attain the right Way, the *Tao*, was by emulating the course of the universe and complete adjustment to it. Thus, a person saw the universe endowed with a spirit that was indomitable in its strength and unforgiving towards disobedience. In other words, we need to recognise those patterns in the course of the universe from which we can generate principles, and then, from those principles, develop a philosophy of life, i.e., follow the “float” of life. There are frequent but patterned changes in nature and human life. For examples, the sun rises and sun sets; seasons change that are associated with patterned changes of climate; changes in life cycle — babies are born, they grow and die; and further still, changes in life forms: the continuity of life through reincarnation. In Western philosophy, it is believed that people can overcome nature and manipulate it to generate benefits. In contrast, the classic Chinese intellectuals believed that one needs to live with nature, i.e. to live in peace with heaven and earth, so that the triad bonding of heaven, earth and people can be harmonised to bring about health and prosperity (Yang, 1988). Therefore, the *Tao* that we need to practise is what *Lǎozǐ* called “recovering the pure and innocent nature of the ancients”, and “cherish no worries and keep away from fame and gain” (<<返璞歸真>>, <<清靜無爲>> cited in Zhang Enqin, 1994, p.5).

According to the Taoists, excess in mental, emotive and cognitive activities will lead to illness, and is the source of all illnesses. Thus, containing desire and mediating excess are the foundation for preserving and refining life. *Lǎozǐ* said, “Look for blankness and embrace simplicity; lessen selfishness and reduce desire” (見素抱樸、少私寡欲) (cited in *Zhù* 祝業平, 1995). Excess of internal desires is the root of an unsettled heart (or the cause of worry). When there is desire, one’s mind will be directed to the outside world. That means he/she will be continuously exposed to external stimulants and thus the innate desire for simplicity will be disrupted and illness will arise in the body. According to the Taoist’s beliefs, emotion and desire are the internal factors for illness. Therefore, Taoists propose emptying thoughts, dispelling worry, and living simply with no desire so as to preserve *Qi* – life (*Zhù*, 1995, p.415). That seems to be a passive life philosophy, but it is a proactive method for maintaining health. Instead of focusing on healing acute disease or providing emergency care, we need to see that health starts with prevention and is maintained through the continuing practice of *Tao*. For example, instead of developing new antibiotics to eradicate germs, which is certain to fail, we should learn to maintain our health and prevent getting sick. This can be accomplished by living modestly so that we live harmoniously with the microbiological environment.

Furthermore, the characteristics of the Chinese commonly described in the literature, patience, pragmatism, avoidance of open confrontation and strong preference for harmony, can be understood through Taoism in that there is no urgency for change, as change will eventually come when things become extreme. Therefore, it is important to prepare the self and cultivate our minds to pass through time and preserve health to the fullest extent.

## **Beliefs About Health And Mental Illness In Chinese Culture**

Under the influence of Taoism, and later Buddhism, the Chinese concepts of mental health and mental illness have unique characteristics that are reflected in the practice of traditional Chinese medicine. The beliefs about health and mental illness in Chinese culture are elaborated and discussed under the following subheadings: 1) the concept of health in traditional Chinese medicine,<sup>ii</sup> 2) the theoretical foundation of traditional Chinese medicine, 3) the traditional Chinese medical perspective of mental illness, 4) the classification and treatment of mental illness in traditional Chinese Medicine, and 5) the dominance of traditional Chinese medicine among Chinese: A myth or a fact?

### **1. The Concept of Health in Traditional Chinese Medicine**

The Chinese, like other cultural groups, have their own unique set of well-developed concepts of health that systematically have evolved been organised through history. In Polgar's view (1962, 1968), many cultural or ethnic groups see health as a near perfect or "asymptote" state. It is also an ideal condition that humans seek but are never able to achieve. For a long time, Chinese have seen health as a multifaceted or multi-dimensional concept. The traditional Chinese concept of health is integrated as a part of the foundation of a human's value system. This value system is not only applicable to daily living, but also represents a cosmic view of the interplay between heaven (nature), earth (self) and humans (others). It emphasises the importance of maintaining harmonies across the three systems and within the subsystems that contribute to the development of personhood: 1) harmony with nature, including time and space; 2) harmony with self, internally and externally; 3) harmony in social relationships, including people on earth and the supernatural world. In another words, illness will occur when there is imbalance or disharmony within and across these systems. The development of one's personality or character will also be affected.

Therefore, striving for harmony with nature and humans means not only that one should try to achieve an ideal health state, but also that one should adopt this as the ultimate goal of one's personal development. Based this belief, three common characteristics can be found among Chinese all over the world: 1) a unique food customs or eating habits; 2) a peculiar family system and its extension to social relationships (however, see Chapter 8 and 9); and, 3) a belief in fortune-telling and *fēngshui* and their application in daily living.

## **2. The theoretical foundation of traditional Chinese medicine**

According to the earliest Chinese records, i.e., oracle bone inscriptions (c150 - 1030 BC), the archetypal word for medicine was etymologically composed of two parts: "cure" and "divination." Later, in the Zhou Dynasty (1030 - 722 BC), the word was transformed into the contemporary form, made up of "cure" and "bottle", thus indicating that medicine had been separated from sorcery, which was commonly practised in the preceding Shang Dynasty. The first medical books, *Nèijīng* (The Canon of Internal Medicine), compiled between 300 BC and 100 BC, *Nánjīng* (The Book of Inquiring), *Shānghánlùn* (On Suffering From Cold), and *Jīnkùyāolüè* (A Sketchbook in a Golden Box), have been the outstanding medical classics ever since they were written. The first two books were compiled by a number of unknown authors, but the last two books were written by a famous doctor, *Zhāng Zhòngjīng* — the Hippocrates of China in the third century. The theoretical foundation of Chinese medicine is reflected in these texts. That is, they are based primarily on the concept of "Yin and Yang," the theory of Five Elements, and the idea of correspondence between microcosm and macrocosm — depending on natural rather than supernatural philosophy.

The concept of yin and yang stipulates that the human body, like the cosmos, can be divided into a positive force and a negative force, which both confront each other and

complementary to each other. This concept of positive and negative forces applies not only to anatomy and physiology, but also to symptom and treatment. If the two forces are balanced and in harmony, health is maintained; if not, illness will result. For example, excited insanity is the result of excessive positive force, while falling sickness (epilepsy) is caused by excessive negative force (refer to Table 1).

**Table 1 Examples of matters classified according to *Yin* and *Yang***

<i>YIN</i>	<i>YANG</i>
Earth	Sky
Night	Day
Autumn and Winter	Spring & Summer
Cold	Hot
Dark	Light
Rest	Active
Descending	Ascending
Internal	External
Suppressed	Excited
Deterioration	Growth
Retreat	Advance

The theory of Five Elements explains that everything in the human body and in nature belongs to one of five categories represented by the five elements: wood, fire, soil, metal and water. The five viscera (liver, heart, spleen, lungs and kidneys), five emotions (anger, joy, worry, sorrow and fear), and five climatic factors (wind, heat, humidity, dryness, and cold) all correspond respectively to the five elements. In addition, there is a certain sequential order (*yin*), as well as antagonistic relationships (*yang*) existing between these five elements. Since each element, as a concept, represents many aspects of things in the area of body structure and bodily functions, the relationships among these aspects are revealed by the relationships among the five elements (refer to Table 2).

**Table 2 The Medicine of Systematic Correspondence of the Five Elements**

Five Elements		Wood	Fire	Soil	Metal	Water
Five Organs		Liver	Heart	Spleen	Lung	Kidneys
Correspondence Between	Colour	Virid	Red	Yellow	White	Black
	Vessel Movement	In the depth  Tense Stringy	At the surface  Strong Dispersed Vast	In the centre  Relaxed Intermittent	At the surface  Rough Hairy Short	In the depth  Soft Stony Smooth
Correspondence Between	Vessel Movement	Tense	Frequent	Relaxed	Rough	Smooth
	Skin	Tense	Frequent	Relaxed	Rough	Smooth
Five Seasons		Spring	Summer	Prolonged Summer	Autumn	Winter
Five Climatic Factors		Wind	Heat	Humidity	Dryness	Cold
Five Pitches		Shouting	Laughing	Singing	Wailing	Groaning
Five Odors		Rank	Burnt	Aromatic	Frowzy	Foul
Five Tastes		Sour	Bitter	Sweet	Acrid	Salty
Five Emotions		Anger	Joy	Sorrow	Worry	Fear

(Source: adapted from Unschuld, 1985, p.95)

Furthermore, the idea of correspondence between microcosm and macrocosm indicates that human beings are governed by the principles that rule nature. Therefore, the phenomena occurring inside a person can be understood in terms of the phenomena occurring in nature. As the four seasons and five elements (manifested as cold, heat, dryness, humidity, and wind) change in nature, there will be a parallel change in the five viscera and the five spirits (expressed in the emotion as joy, anger, worry, sorrow, and fear) within the body. A person's emotions are viewed as equivalent to the weather of nature.

The order and relations between the visceral organs also are described in terms of individuals in a political structure: the heart is considered as the sovereign of the soul; the lung is likened to the prime minister who rules the country; the liver, as a general, makes plans; and the gallbladder, as a judge, make decisions. There is communication between the body and nature. Thus, the spirit of the sky communicates with the lung, the spirit of earth with the larynx, the spirit of wind with the liver, the spirit of thunder with the heart, the



spirit of rain with the kidney. The condition of nature will have a corresponding effect upon the condition of the body. Extraordinary conditions of wind, cold, heat, humidity, and dryness as external causes, as well as extraordinary conditions of joy, anger, worry, sorrow, and fear as internal causes, are seen as contributing to the cause of illness.

In traditional Chinese medicine, it is believed that emotions are raised through the various visceral organs. The heart is to house the mind, while the liver is to control the spiritual soul, the lung the animal soul, the spleen ideas and intelligence, and the kidney vitality and will. When the “vital air” is concentrated on the heart, joy is created; on the lung, sorrow; on the liver, anger; on the spleen, worry; and on the kidney, fear. Emotion is related to the circulation of vital air in the body. The sequential order is: anger creates an adverse current of circulation elevating the level of the vital air; joy improves circulation so that the movement of vital air becomes mild and relaxed; sorrow disturbs circulation and diminishes the amount of vital air; fear obstructs circulation lowering the level of vital air; finally, contemplation stabilises the circulation condensing the vital air. However, it must be mentioned that although the visceral organs are named in traditional Chinese medicine, they are still an abstract concept rather than discrete organs as seen in Western medicine.

### **3. The Traditional Chinese Medicine Perspective Of Mental Illness**

In general, an excessive explosion of emotion is considered in traditional Chinese medicine as harmful to health. Excessive worry and apprehension will injure the heart, which in turn will make the mind weak. Therefore, people are advised to live according to the principle of *yin* and *yang*, i.e., to be orderly and harmonious in the areas of eating, living, and sex so as to maintain proper vitality and assure a long life. It is believed that to achieve such a state is to follow *Tao*, the way and the method of maintaining the harmony between this world and

the beyond by shaping earthly conduct to correspond completely with the demands of the other world.

During the early period (before 300 AD), knowledge of medicine, including psychiatry, was not yet systematised and psychiatry was not a distinct specialty. Nevertheless, for over 2000 years traditional Chinese medicine has diagnosed and treated mental illness, beginning with *Nèijīng*, written in the format of a dialogue with questions and answers. It has a chapter describing the feverish diseases due to problems with the Pulse of “Sunlight” (*Yang Ming*) that sometimes is also regarded as the chapter on “insanity and maniacs.” In this chapter, it was noted that when the liver gets hot, i.e., inflammation of the liver (urine turns yellow in colour, abdominal pain occurs, and fever develops), an evil agent is fighting with the spirit of the liver resulting in “crazy talking,” fear, irritability, and similar symptoms. The following extract from the chapter indicates the diagnosis of a state of delirium.

The Emperor said, “Excellent! When the illness is grave, should then the clothes be cast aside and should one ascend the heights chanting songs or is it best to fast for one day? And all those who transgress a wall or who dwell upon height, are they not able to maintain their original constitution, and can the disease come back to them?”

Ch’i Po answered, “The four limbs all originate from the element of Yang. When Yang is flourishing then the four limbs are in a state of sufficiency, and when there exists this state of sufficiency one can ascend the height.”

The Emperor asked, “Should the clothes be cast aside?”

Ch’i Po answered, “When the heat is sufficient for the body, the clothes can be cast aside if one intends to walk.”

The Emperor asked, “Those (people) who tell lies, and scold and curse and do not shirk treating their relatives distantly, and yet chant songs – what [can you tell] about them?”

Ch’i Po answered, “When the element of Yang is plentiful, it causes man to tell lies, he does not shirk treating his relatives distantly, and he does not have a desire for food. Since he does not have a desire for food, his actions become reckless and disorderly (Veith, 1992, p. 237).

In the above dialogue it was stated that when a person caught a fever, the abdomen would get distended, his/her appetite would be poor, and he/she would become overly talkative and incoherent. This last result was attributed to the fact that the lung and heart, which have charge over the voice and mind respectively, were affected by the invasion of an evil agent after fever. From the contemporary medical view, what were described are the organic mental symptoms of delirium usually associated with high fever.

In addition to the four classics mentioned above, there were a number of ancient books written between 1100 BC and 300 BC that recorded psychiatric symptoms. For example, Xùnǐ (313 - 238 BC) recognized that people with a mental handicap of limited intelligence

would, under psychological stress, develop psychotic symptoms. Ancient books, such as *Lǎozǐ* (in the sixth century BC) and *Zhùangzǐ* (in the third century BC), put great emphasis on ways (*Tao*) to maintain mental health and preserve life. People in those days recognised that the elimination of psychological factors facilitated the remission of psychogenic illness.

#### 4. The Classification and Treatment of Mental Illness in Traditional Chinese Medicine

Mental diseases, or more specifically in modern terms psychoses, were divided into two groups according to the mental syndromes of patients in terms of traditional Chinese medicine, i.e., *Kuáng* 狂 (mania, psychosis with excitation), and *Dīn* 癲 (psychosis without excitation or epilepsy). The basic mechanism of psychosis was considered to be an imbalance of functions in human body. *Kuáng* was considered to be due to hyper-functioning, plentiful yang, and *Dīn* was the opposite, excessive yin. The primary causes of psychiatric illness were suggested to be vicious air, abnormal weather, and emotional stress. Some symptoms, such as sleeplessness and emotional fluctuation, were attributed to somatic disorders.

Furthermore, epilepsy was identified as “falling sickness.” It was described as a person who would fall to the ground suddenly with eyes closed, seemingly asleep, as if all positive vital forces were gone; this as a the result of excessive negative force. This disease, afflicting one from birth, was attributed to the fact that the patient’s mother received a bad scare while pregnant, causing the obstruction of vital air which in turn affected the foetus in such a way as to cause the illness.<sup>iii</sup>

The treatments of mental illness such as psychosis, as prescribed in *Nèijīng* and *Nánjīng* (the Canon of Internal Medicine and The Book of Inquiring), were rather simple.

Fasting and acupuncture were recommended. The only drug used for mania was a drink of water with fresh iron flakes. But in *Zhāng Zhòngjīng*'s two classic books, a number of prescriptions of Chinese herbal drugs were introduced for various psychiatric illnesses. There was an interesting case described in a history book, *Lǚ's Chūnqiū*. A king of *Qi* in the third century BC fell ill and could not be cured by drugs. A famous doctor, *Wēnzǐ*, visited him and made him angry deliberately. To everyone's surprise the king promptly recovered from his illness. This may be the earliest case in history treated with special psychotherapy.

In the third century, a form of “guidance therapy” was used, which included physical training to strengthen the physique and to eliminate the undesirable mental condition. This is something like modern exercise therapy nowadays. Around the tenth century, people began to adopt the “*Qìgong*” (breathing therapy) as a way to regulate one's psychological and physiological activities. In the 15th century, the “*hutao*” (substitution therapy) was put to use, which confirmed the old saying “to treat mental illness with mental drugs” that is, to substitute a healthy emotional state, e.g., “*shishenyu*” (to overcome sorrow with happiness). In addition, acupuncture was used to treat psychotic symptoms, such as depression, catatonic stupor, and excitement.

Although the predominant mode of treatment for mental illness (madness), as described in classical texts, was the use of herbal medicines or acupuncture or both, records also show that a number of influential physicians also practised “psychology” to treat their patients. The following example from the classical texts written in the seventeenth century is cited by Vivian Ng (1990); I use it to illustrate my point. There are a few more examples in her text.

Zhang Congzhen (1156-1228), for example, who was famous for his unorthodox methods, was once called upon to treat a woman who had suddenly lost all her appetite for food. Moreover, she had frequent screaming fits and was dangerously violent. She was given different medicines but none seemed to work. Feeling desperate, her family overcame their initial reservations about Zhang's methods and turned to him for help.

On the first day of treatment, Zhang ordered two female assistants to dress up in an outlandish fashion and sent them to his patient. When the sick woman saw the weirdly garbed assistants, she burst into laughter for the first time in many months. The next day, Zhang again sent his two assistants to see this patient, this time disguised as animals. Once again, the sick woman laughed heartily. On the third day, he arranged for the patient to witness his two collaborators wolf down an exquisitely prepared meal. With her senses titillated by the sight and smell of the feast, the sick woman recovered her long-lost appetite for food. After several days of similar treatment, she recovered from her long illness

(*Qinding gujin tushu jichen yibu chuanlu*, [欽定古圖書集成醫部全錄], 1962; cited in Ng, 1990, p.39)

In contemporary China, traditional Chinese medicines, including herbs, roots, leaves, acupuncture, exercises of various kinds, and other traditional methods, are still being used in the treatment of mental illness, but mostly as complementary to Western psychiatric interventions, i.e. drugs treatment (Zāng, 1996).

Chinese physicians shared a common language in explaining diseases in terms of disharmony and imbalance; the goal of medicine was to restore and maintain harmony and balance. Regardless of the orientation in the various schools of thought, Chinese physicians universally understood the many forms of madness to be organic disorders. The language used to explain the pathology of *dīn* and *kuàng* was not at all different from that used to explain other illnesses (Ng, 1990). The notion that madness could be a mental illness was never advanced, not even by those who saw a distinct relationship between

emotions and madness. The holistic approach of classical Chinese medicine has made the distinction between “physical” and “mental” alien to the Chinese experience.

There seems to be little change in classification or treatment developed in China after the seventeenth century. Veith (1955) suggested some reasons for this slow development of mental health sciences. These hypotheses include that the Chinese were traditionally less concerned about mental illness than the Europeans (despite mental illness being as common in China as in other countries) and that the traditional respect for elders (filial piety) and the practice of using go-betweens in potentially embarrassing situations (part of the tradition of saving face) may have done much to lessen the impact and importance of mental illness in individual cases. However, *Chén Shèngkūn* (陳勝崑) (1979), a Chinese practitioner of traditional Chinese medicine, believed that the reasons for the slow development were due to the delay in establishing systematic training in Chinese medicine, a lack of sufficient case studies because of the shame of disclosing by the families, and the fact that the human rights movement did not take place in China.

Veith (1955), as well as Liu (1981), pointed out that in China mental illness was never associated with any religious stigma, such as that which stimulated much controversy and theoretical discussion in the west. Precisely because mental disorder was often regarded as an organic disorder, it carried no stigma as far as the medical community was concerned. In the classical medical texts, there is no reference to moral turpitude as a cause of madness. This is in marked contrast to late eighteenth- and early nineteenth-century England, where a connection between madness and morality was made. With such a connection, a specialised approach towards the mentally ill was developed, in which mental illness occupied the middle ground between medicine and religious notions such as possession by the devil. In the late nineteenth century it evolved into moral management of people with mental illness. With the growth in the professionalisation of medicine, physicians moved

to appropriate moral management for themselves, and eventually succeeded in monopolizing the treatment of madness (Ng, 1990). Even so, in China, such social and professional dynamics did not come into the play.

### **5. The Dominance of Traditional Chinese Medicine among Chinese: A Myth or a Fact?**

Physicians who practise traditional Chinese medicine have never been able to monopolize the management of illness in China, even before the introduction of Western medicine. According to Ng (1990), there were two levels of traditional explanations and cures for madness in Chinese history. One level consisted of explanations expressed in “natural” terms such as *yin* and *yang*, five evolution phases, and the emotions as I have described in the above section. Such explanations, found primarily in classical medical texts, reflected the view of the elite. The other level consisted of explanations expressed in “supernatural” terms such as spirit-possession, loss of the soul, and divine retribution. Such explanations, found primarily in stories, folk wisdom, and folklore, typically reflected the views of the common people. However, these two levels of explanation were not mutually exclusive (Ng, 1990, p.28).

Sick people also used home remedies, prayers, sacrifices, restitution, and even rites of exorcism, as well as other folk healing methods that had been used for many generations. The recourse chosen at a particular time depended on the explanation adopted by the patients and/or their families. Veith (1963) observes that there are three commonly accepted phenomena as causes of madness among the Chinese: retribution for sinful deeds, possession by malevolent spirits, and separation of the soul from the body. The way a mad person was received in the community depended to a large extent on the attributed cause of the illness. Madness resulting from sin or from spirit possession did not invite feelings of



magnanimity from others. Thus, unlike the traditional medical texts, madness in the popular perception carried with it a certain stigma.

The health care system changed forever when the first Western-style medical school was established before the turn of the twentieth century by Li Hung-chang (*Lǐ Hóngzhāng*), a reformist official in the late Imperial *Qīng*. Its purpose was to train doctors for his army and navy. It was later revamped by Yuan Shih-K'ai, the Grand Warlord, and became the Tientsin (*Tiānjīng*) Army Medical College. An academy that taught some Western medicine was established at the Imperial University in Peking in 1903.

The acceptance of Western medicine was further enhanced when a plague broke out in Manchuria in 1910. Traditional Chinese medicine soon proved powerless against the plague, so authorities from the Emperor down resorted to modern preventive measures, despite their strangeness and unpopularity. In doing so they appeared to be acknowledging the superiority of modern Western medicine. This was perhaps the most dramatic and significant official support of Western medicine up to that time (Nathan, 1974).

Western psychiatric ideas were introduced to China when the first Western-style mental hospital to receive patients was established in 1897 in *Guǎngzhōu* (Canton). A course in psychiatry was taught at the Peking (Beijing) Union Medical College for the first time in 1922.

The situation and the attitudes among Chinese when Western medicine was introduced were best summed up by Nathan (1974).

Western medicine was both embraced by and forced upon the Chinese in the early twentieth century due to a combination of medical and political emergencies (counteracting the extension of influences from Russians and Japanese in Manchuria); and that the acceptance of Western medicine by certain leaders was greeted with a very mixed response on the part of the

Chinese people and their doctors [traditional Chinese Medicine practitioners], a response reflecting pragmatism rather than superstition or backwardness (p. 73).

How Western psychiatry developed in China has been described in detail in the literature (e.g. Achtenberg, 1983; Bloomingdale, 1980; Brown, 1980; Collins, 1982; Liu, 1981; Saku, 1991; Tseng, 1973; Veith, 1992; Visher & Visher, 1979; Walls, Walls, & Langsley, 1975). I do not intend to elaborate on this history in the thesis; however, its impact on the concepts of mental health and illness in Hong Kong will be discussed in Chapter 5. Lamson (1935) summarised a number of popular Chinese beliefs about mental illness that reflect the pluralistic popular medical culture, which was an odd assortment of religious, traditional/classical, folk and Western medical views on mental illness at that time. Actually most of the beliefs still prevail in many Chinese societies to date. He found that insanity was thought to be the result of:

- 1) some misdeed of the sick person in this or a previous life;
- 2) punishment by offended ancestors;
- 3) possession or soul loss to evil spirits or ghosts;
- 4) impersonal fate;
- 5) natural or supernatural forces intending it as an omen signalling disaster to a family;
- 6) a “god of wind” occupying a man’s body;
- 7) displeased ancestors or gods striking the victim on the head with a magical rod;
- 8) deformity or loss of function of a particular internal organ;
- 9) reversed circulation of blood with loss of mental control by the heart and associated loss of direction of the body;
- 10) sudden mental shock such as loss of a lover, family member, job, home; and,
- 11) an assortment of other problems, including excessive worry, over-work, fear, and heredity (Lamson, 1935, p.415-416).

Matched with these results is Lamson's list of popular treatments for mental illness in the China of his day: exorcism by priests and sorcerers; prayer at temples; putting the patient into a cage and/or beating him to drive out a demon; use of beautiful natural surroundings to restore the "lost" mind; good deeds and charity to appease the gods; various herbal remedies; touching temple idols or sleeping before them in order to induce a healing dream; incantations and magical works; ceremonies to restore the lost soul; acupuncture; burning or defiling patients to frighten or disgust them back to sanity; diet; treatment of physical bodily problems in order to stem their effects upon the mind, and so on. However, Lamson did not explore how these ideas and treatments were functionally linked and actually operated in the local Chinese social systems.

From the literature review, we certainly can see that Chinese medicine is based on a different paradigm than Western medicine and that the Chinese concept of mental illness and its healings is multi-faceted. Traditional Chinese medicine in China throughout history has never dominated the health care system (Ng, 1990; Veith, 1963) and it even faced a greater challenge when contemporary Western medicine was introduced. The interplay of Chinese and Western medicine in Hong Kong reflects the dynamic motion of equilibrium between yin and yang, in which neither end is able to maintain dominance forever as people are adopting a pluralistic approach to managing diseases, maintaining health, and most of all preserving life. In Chapter 5, I will describe how the two medical paradigms interacted and evolved within the health care systems of Hong Kong, and thereby created the unique clinical reality of the local scene. To understand the island in transition, we first need to understand know about the historical and cultural context of Hong Kong. To accomplish this we need to understand how the transitions in the concepts of mental illness and family are precipitated, as well as the social reality that is being created.

## Note

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<sup>i</sup> Unless specified, the translations in the thesis are my own.

<sup>ii</sup> The terms “traditional Chinese medicine” and “classic Chinese medicine” are used interchangeably throughout the thesis.

<sup>iii</sup> A detailed description of Western psychopathology according to traditional Chinese medical concepts is given in the book: 何裕民 (*Hé*) (1995). 《中國傳統精神病理學》 (*Chinese traditional psychopathology*). 中國上海：上海科學普及出版社。

**Hong Kong**

**OF**

**The Social And Clinical Realities**

**Unit Two**

## CHAPTER FOUR

### The Context And Cultural Identity Of Hong Kong Chinese

#### *“Hong Kong people rule Hong Kong”<sup>4</sup>*

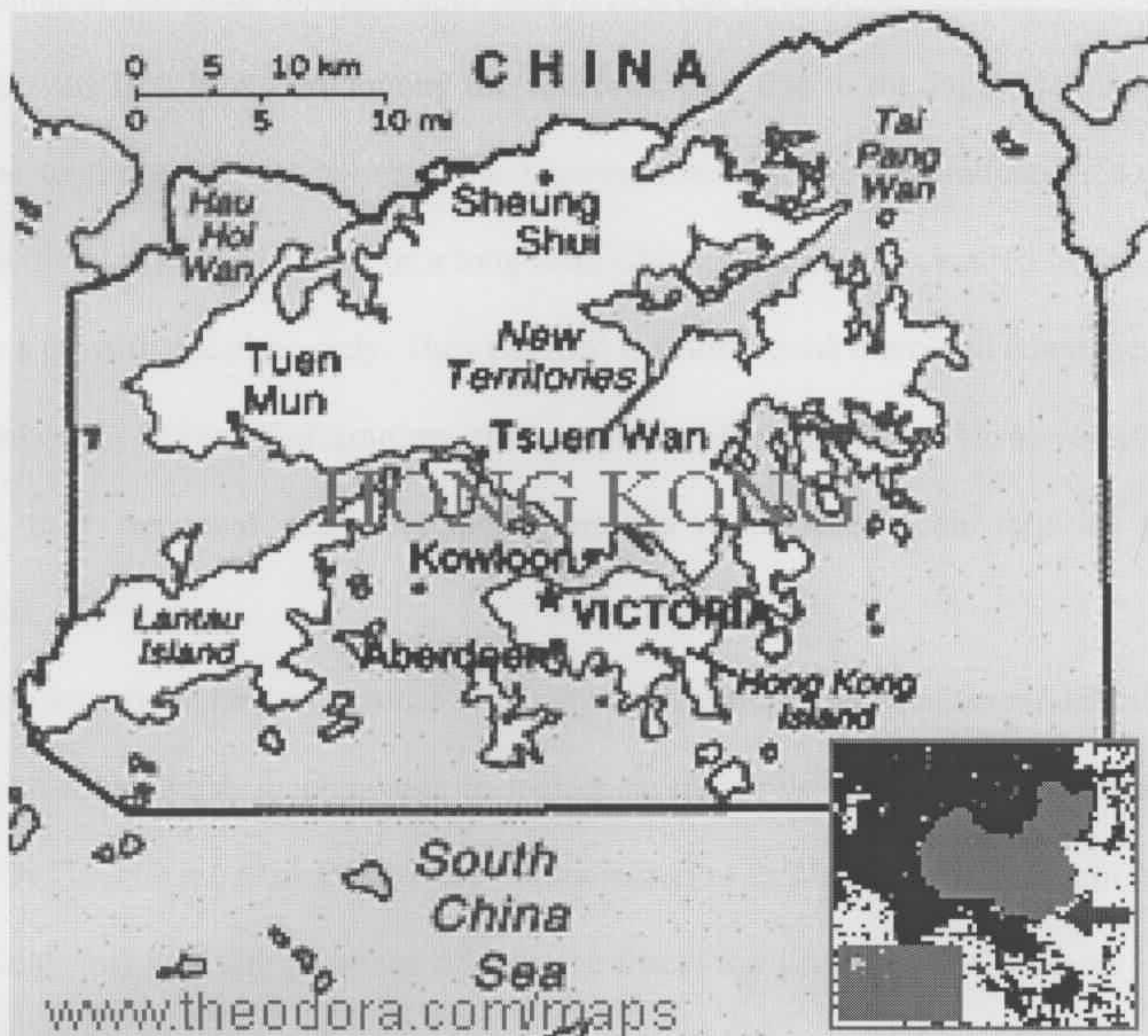
A promise made by Deng Xiaoping, the late paramount leader of China that Hong Kong can have its autonomy after the transition of sovereignty

#### **Hong Kong: The Geographic And Historical Context**

This chapter relates the historical development and cultural background of Hong Kong to the search for cultural identity among the people of Hong Kong. The Chinese (*yin*) and Western (*yang*) cultures interact to create the unique culture of Hong Kong and the identity of Hong Kong Chinese. This social reality has influenced, and will continue to influence, the nature of transitions in other spheres, i.e., political, press media and public opinion, health care, the family, and the individual. The evolvement of cultural identity of Hong Kong Chinese can also be seen in the changing concepts of mental health and illness, and the healing methods. This will be discussed further in subsequent chapters.

Hong Kong is a metropolitan city and one of the world's economic and financial centres. It is situated at the south-eastern tip of the mainland of China and at the entry of the Pearl River, which flows from the northern highland of Guǎngdōng Province and passes through Guǎngzhōu city. From 1841 to July 1997 Hong Kong was a British colony. Its total area is about 1100 square kilometres and includes Hong Kong Island, Kowloon, the New Territories and Islands (as shown on the map below). In mid 1999, the population stood at 6.72 million and migration, mainly from the mainland, is the major source of population growth (Census & Statistics Department, 2000). Hong Kong's population is

over 95% Chinese, with the rest being ethnic Indians and Pakistanis, and people of European descent.



Hong Kong was originally a fishing village. Its cultural, social and political developments were linked with the mainland of China until the first British fleet landed in 1840. At that time there were only a few thousand people scattered around Hong Kong Island and Kowloon Peninsula (Lù, 1995). The demand for more open trading and the sale of opium by the British brought the Sino-British existing conflicts into the open. The First Opium War broke out in 1841 and Imperial China (*Qīng* Empire) was defeated. In the peace treaty signed in 1842, China had to cede Hong Kong Island and the Kowloon peninsula to the British as one of the settlement terms. Further conflicts and wars broke out because the *Qīng* Court was too weak to defend itself. In the subsequent “peace treaties” the rest of Hong Kong, including the outer islands and the New Territories, was leased to

the British government for 99 years commencing in 1898. British governing administrative structures, judiciary, and education systems were gradually put in place to secure control. The population had gone through rapid growth first due to refugees arriving from Mainland China as wars first broke out among the warlords, then due to the Japanese invasion, and later due to the civil war between the Communists and the Republican (*Kuomintang*) armies which lasted till 1949. For a long time Chinese immigrants tended to regard Hong Kong as a transitional place only. They planned to return to the mainland when the situation improved or to continue their journey of migration to other countries. However, for various reasons, they remained and established families or resettled their families from the Mainland.

For a long time, the transitional mentality of the Hong Kong Chinese indirectly helped the British to establish mechanisms to legitimise their rule with little resistance (Lau & Kuan, 1991). The measures that were implemented to establish colonial dominance over Hong Kong included the presence of military force, the adoption of Common Laws and elements of independence in the judiciary system, the creation of subtle versions of the doctrine of the economic prowess and cultural superiority of white people, and establishing an elitist educational system that favoured the use of English language in schools and work places (Hu, 1998; Lau & Kuan, 1991). In the health care arena, only the practice of Western medicine was given official recognition, while the practice of traditional Chinese medicine was neither officially recognised and regulated, nor suppressed. These measures prevailed until 1984 and the signing of the Sino-British Joint-Declaration for transferring (“*húigūi*” – re-unifying, in China’s word) the sovereignty of Hong Kong to China on the first of July, 1997.



### **The Political Transition In Hong Kong: “One-Country-Two-Systems”**

Prior to the transition of sovereignty, the British colonial system, which can be represented by the yang force, was dominant in Hong Kong. Despite the upheaval that occurred in Mainland China after 1949, the Chinese political system, the yin force, had little influence on local politics until a decade prior to the change over. The Chinese political influence found a way to infiltrate into the local scene through the pro-China intellectuals and unionists. However, it had never been able to establish a strong power base under the strict colonial policy of a passive process of the de-Chinese-isation of the Hong Kong people. Nevertheless, this Western dominance was destined to change after 1997 when the pro-China groups gradually regained their influence and political power. Actually, the Westerners, who were sceptical of the transition and China’s intentions, were the first group to perceive that things were changing in this direction. Hong Kong journalist, Chris Young cried out his concern under the news headline, “In Danger Of Losing Our Own Identity” (*South China Morning Post*, 3 July, 1999). He concluded that, after reviewing a series of public opinion polls, there were significant changes occurring, that confidence in Hong Kong’s future and in the policy of “one-country- two-systems” had fallen across the board, and that Hong Kong was becoming more like one of the cities in Mainland China. In another example, *The New York Times* on 1 January 1999 stated: “After two years, Hong Kong looks more like China.” On the same day, the *Los Angeles Times* also concluded: “Overall, Hong Kong seems to be losing some of its vibrancy, not just in politics but in the economic realm.... For years, Hong Kong was the most dynamic city in Asia. Now, it seems to be slowly drifting into more modes, a subdued future in which it will become merely the most dynamic city in the Cantonese-speaking part of China.”

Although not all the local Hong Kong Chinese share these alarming claims, changes are inevitable as the new and the old political structures interact and negotiate a new

balance point. One obvious and amusing change in the local political scene is the position of those people and political groups that had influential power during the colonial time. They often backed the government's policies on the pace of the development of democracy, particularly in the last decade before the change over. They have now become abandoned children who no longer hold a significant power base in the new administrative structure. On the opposite side, the pro-China group, which includes a few prominent left-wing unionists and business people and which had been suppressed or ignored by the colonial government, is now an influential group. The new administration depends on this group for support and for balancing the pressure from the democrats.

On one hand, China needs to preserve the economic status and financial structure of Hong Kong to help it to enter the world market. This is one of the reasons it agreed to guarantee in the Sino-British Joint Declaration that the existing economic, judicial, and political systems remain unchanged for 50 years, which was supposed to ensure a smooth transition of sovereignty. On the other hand, the ideology and life style differences between the two places do create tensions at times. In particular, the Chinese government guards against the democratic system and ideology infiltrating into the Mainland. It keeps a close check on the development of democracy through the new administration in Hong Kong, as well as deferring the development of a general-elected Legislative Council and restricting its power.

A new political system is gradually emerging as the two systems are evolving and interacting to find an equilibrium point. Certainly the new political system in Hong Kong will not be either the China's system or the previous colonial system, but will be a system with a unique character of its own. This political interplay of two major political forces can be represented well by the yin and yang analogy. This is also well demonstrated through the searching for identity among the Hong Kong Chinese. Before we can identify the Hong

Kong Chinese, we may question what we mean by the word “Chinese”? Does it mean the specific race, culture or just the people in China? Are there unique characteristics that tie all Chinese together?

### **Chinese People And Chinese Culture: Which Chinese Are We Talking About?**

Not only among Westerners but also among Chinese, there is often a take-it-for-granted view on the uniqueness of Chinese culture. Both groups tend not to differentiate the cultural differences among Chinese people. Culture is dynamic and ever changing. It is also shaped by political, social and economic changes. It is difficult to define exactly what Chinese culture is without oversimplifying and falling in narrow-minded and stereotyped definition of Chinese characteristics. Despite this statement, I have to accept that there is a thread, which is made up of cultural abstracts, that link all the Chinese, and gives them a general identity no matter where they live (Tseng, Lin & Yeh, 1995a; Yang, 1988). Tajfel, an English social psychologist, suggests that the reason why a person chooses to remain in, or identify with, a social group is because the group can offer him/her pride and substance to improve his/her own self-image (Tajfel, 1974).

Nevertheless, what is Chinese, we need to define who the Chinese are that we are talking about. Are we referring to ethnicity, or people who live within a certain geographic boundary, or just a group of people who share a few common cultural values and customary practices? *Helen Siu* (蕭鳳霞), professor of anthropology at Yale University, states that the identity of Chinese people consists of cultural, geographical, political, historical, and national facets (*Siu*, 1996). She maintains that “Chinese” does not form from a set of innate and fixed factors or elements, and the social and political meanings of being a Chinese are developed through continuing negotiations and compromises in different times and contexts (*Siu*, 1996, p.18).

Owen (1997) criticises the illusions of unity of the past in Chinese history. He argues that we need to dispel the myth or stereotyping of “Chinese culture” as a unique thing that exists.

There never was a single thing called “Chinese culture” in the way we often use the term. There never was a single body of values, beliefs, and practices to be characterised, as internally coherent and consistent through time, essentially native, and impervious to outside influence. (p.10).

He believes that the idea of “traditional” Chinese culture was a modern necessity, either to serve as an adversary to be rejected in modernization or as a nostalgic utopia forever lost. People believe in its existence as a way of thinking about themselves in comparing current modernity to the past – the “pre-modern” world with some imagined unity of the past, a past which is now over for good (Owen, 1997, p.11). Nevertheless, despite variations in specific content, a belief in the existence of a unique “traditional” culture is one of the threads that tie all the Chinese together.

Barbara Ward (1985) was one of the earliest anthropologists to make a systematic study of modern Hong Kong. She explained the phenomenon of why Chinese tend to perceive a unity in Chineseness by referring to the conscious model of the social system. The Chinese carry this model in their minds in order to explain, predict, or justify their behaviours as “Chinese”. However, people in different locations of China have different ideas about what it means to be “Chinese”. There are, therefore, a variety of conscious models, “a number of different Chinese ideal patterns varying in time and space with varying historical development and the demands of particular occupations and environments” (Ward, 1985, p. 42).

Chinese construct a model of other groups as distinct from the model of their own way of doing things. Ward (1985) calls this their “immediate model.” Thus, they carry in their minds an ideal or ideological model of Chineseness, their observer models of other Chinese groups, and their immediate model of themselves, which may vary considerably from other groups and from the ideal model. Only outsiders can observe the differences between immediate models; what a Chinese layperson compares is one’s own immediate model of his/her own social arrangements with one’s own “observer’s” model of the other person’s (1985, p.51). This may explain why Chinese, despite being aware of variations among themselves, still see themselves as a homogenous group sharing unique culture when compared to those non-Chinese groups, no matter whether they are in Mainland China, Hong Kong, Taiwan or overseas.

### **The Search For Cultural Identity Among Hong Kong Chinese**

To a great extent Hong Kong is still predominantly a Chinese society, despite it being under British rule for nearly 150 years. Despite the subtle changes that have taken place in the political and social systems during the colonial period, culturally, many traditional values and customs are still preserved. Nevertheless, these traditional values have been “modernised” and transformed through the interchange of East and West in this city (*Jin Yàoji* (金耀基), 1997). Therefore, some of the current values and beliefs held by the Hong Kong Chinese are different from the “traditional” ones. Conversely, in some instances one can say the Hong Kong Chinese are more *Chinese* than the Chinese in Mainland China. This is because over time the communist system and various political and social movements in Mainland China have changed many traditional values, as well as social structure and customary practices (Siu, 1996).

As noted in the introductory chapter, there are opponents to the notion of a Hong Kong culture. *Wú* (*Wú Hànwén*, 1996), a local popular pro-China commentator, denied the existence of Hong Kong culture and claimed that the uniqueness in Hong Kong is only in terms of a life-style which is created by the economic success. Others also argue that there is a lack of a “unified, coherent cultural foundation” that allows for the development of a cultural identity of Hong Kong (Chan, 1994, p. 447; 1995; *Lǚ*, 1997).

On the contrary, given the earlier discussion on the concept of culture, one cannot deny that Hong Kong has developed a certain cultural uniqueness through the East encountering the West. Over the years, many cultural conflicts have been resolved by compromise, adaptation and integration to yield a unique culture under the colonial administration. On one hand, the values of familialism, hard work and a high sense of achievement that have been part of the Chinese culture still prevail in Hong Kong. On the other hand, Western concepts of individual rights, social justice, law and citizen’s duties, well-being are highly respected and valued by *Xiānggǎng réns* (people of Hong Kong). Words that are often used to describe the uniqueness of Hong Kong people include: opportunistic, easily adaptable, hardworking, entrepreneurial and achievement-oriented. Lau and Kuan (1991) point out that the Chinese society of Hong Kong possesses characteristics that are unique and different from traditional and modern Chinese society. They summarise those unique characters as follows (Lau & Kuan, 1991, p. 40):

On the whole, the Chinese society of Hong Kong differs from traditional and modern Chinese society in many essential ways: its high degree of modernisation, industrialisation and urbanisation; its dominance by market forces; the erosion of tradition; the adapted changes in the family and other primary and quasi-primary structures; the lack of a moralising elite and the dominance of an economic elite; the fluidity of society and the extent of social mobility; the self-select character of the immigrant-settlers; the high standard of living; the exposure to

foreign influence; the rapidity of social change and its political and economic dependence. Its “borrowed time, borrowed place” (Hughes, 1976) character, grossly magnified by the 1997 malaise, can in fact stand alone to differentiate Hong Kong sharply from (Mainland) China. The high degree of societal autonomy from the state and the more or less spontaneous development of society are also an experience which modern China has yet to undergo.

However, not until the recent decade has the search for cultural identity been a prominent matter among the Hong Kong people (*Xiānggǎng réns*). Many came as refugees to escape from wars or famine on the mainland and thought that Hong Kong was only a transitional place. They were waiting for the opportunity to move overseas or assumed they would move back when the conditions on the mainland, more specifically their *hèunghái* (Py *Xiāngxia*) (native/ancestral home), had improved. This belief was quite commonly held among those Chinese immigrants who came after 1949 (Siu, 1996). Nonetheless, the identity as Hong Kong people (*Xiānggǎng réns*) emerged slowly due to political conditions and campaigns launched by the colonial government to counteract the rising identification with mainland Chinese. This identification was particularly strong among the low-paid factory workers during the period of the Cultural Revolution (1966-1976) and among the intellectuals since the early 1970s. A few cultural campaigns were launched after the riots of 1967 to reinstate the uniqueness of being *Xiānggǎng réns*; these included the Hong Kong Festivals, the Clean Hong Kong Campaigns, and the “Hong Kong is my home” Campaigns. Despite, these luke-warm attempts by the colonial government to have people develop a sense of belonging to Hong Kong, both the British and Chinese governments were apprehensive about acknowledging a distinctive Hong Kong culture. A good example is in the Sino-British Joint Declaration of 1984. In this there is no such word as “people” of Hong Kong. Indeed, the population is described in neutral term as “inhabitants” or “residents,” while local culture is rendered merely as a “lifestyle”

which was guaranteed to be unchanged for 50 years. Nevertheless, the identity of *Xiānggǎng rén* developed vaguely among the local-born Chinese, who tend to see themselves as owning unique characteristics that can not be found in Chinese elsewhere (Evans & Tam, 1997; Lù, 1995; Lǚ, 1997; Siu, 1996).

The transition of sovereignty could be accomplished overnight, but the search for identity may be a long road with many uncertainties for the people in Hong Kong. The signing of the Sino-British Joint Declaration in 1984 in preparation for the transition signified a turning point where Hong Kong people started to ask who they are. To face the changes brought by the transition of sovereignty, Hong Kong Chinese have had to adjust their identity accordingly.

However, this adjustment has proven to be an ambivalent process, a schizophrenic one, if we use the literal translation of the term — “*jīngshénfēnlèi*” (精神分裂) “split personality.” Sceptical about the Mainland’s political stability and the continuity of the current open economy, many Hong Kong people lost faith that the Chinese government would uphold the agreement to keep Hong Kong the same for 50 years after the transition. They started to migrate to other countries. The huge exodus was especially pronounced after the crackdown on the student movement in the “June 4 Massacre or Incident” in *Tiananmen* Square in Beijing in 1989.

For those who remain, there is a choice to be made in searching for and re-establishing their own identity, i.e., to identify with Mainland Chinese or to recognise the uniqueness of Hong Kong people. This dilemma remains unresolved to date. Recent incidents that highlight this struggle have divided local public opinion (Seymour, 1998).<sup>ii</sup> The search for *Xiānggǎng rén*’s identity is criticised particularly by pro-China scholars (e.g. *Wú Hànwén*, 1996) who see this as an anti-unification and unpatriotic act which should be condemned. They believe that the differences and conflicts between Hong Kong and Mainland China



are mainly due to the long separation of Hong Kong from the motherland and that the uniqueness of Hong Kong is only in terms of lifestyle. The proponents of this argument are more optimistic that, because both places share the same cultural origin, the conflict and cultural mismatch will soon be smoothed out after there are more exchanges and dialogue (Wú Hànwén, 1996; Zhōu, 1996).

What does the younger generation think regarding the *Xianggǎng ren*'s identity? A social survey was carried out by the Hong Kong Transitional Studies Group, (faculties from the Hong Kong University and the Hong Kong University of Science and Technology), to compare the national identity among the youths in Hong Kong and Guangzhou (N = 9226 and 899, respectively) (reported in *Ming Pao Daily News*, 16 November, 1998). It was found that youths in Guangzhou had a stronger sense of Chinese identity than those young people in Hong Kong. Hong Kong youths (33.9%) had a stronger sense of being Hong Kong *ren*: 39.9% identified themselves as *Xianggǎng ren* first, and second as Chinese. Only 15.8% felt they were Chinese first then *Xianggǎng ren*. Another survey was conducted by the Hong Kong Young Women's Christian Association (YWCA) on the knowledge of Mainland China and national identity among children and adolescents in Hong Kong (N = 630) (reported in *Apple Daily*, 1 July, 1999). The results indicated that only 30% of children, and less than 20% of adolescents, identified themselves as Chinese. The rest identified themselves as *Xianggǎng ren*, Chinese *Xianggǎng ren*, or Hong Kong Chinese.

#### **My Interpretation: A "Westernised Man's" View**

As mentioned in Chapter One, I have adopted Evans and Tam's (1997) definition of culture to explore the cultural context of Hong Kong. Based on this definition and my personal reflection I can certainly identify the uniqueness of Hong Kong culture that has been

constructed through social argument, dialogue, and negotiation among the different social groups in Hong Kong (Evans and Tam, 1997, p.13). As I have mentioned earlier, in the Sino-British Joint Declaration of 1984 the local culture is rendered merely as a “lifestyle” which is guaranteed to be unchanged for 50 years. However, culture is a dynamic abstraction that is constantly evolving, and no society can remain unchanged for 50 years! Thus, Mathew Turner criticises in his essay “60’s/90’s — *Dissolving the people*,” such an agreement between the United Kingdom and China on Hong Kong’s future lays a slippery neologism, which may be interpreted to mean almost anything (cited in Evans and Tam, 1997, p.14).

Evans and Tam (1997) also state that Hong Kong’s unique place within a wider Chinese cultural universe further complicates the “cultural/political” manoeuvres swirling around it. Through films, magazines and Cantonese pop songs, Hong Kong reaches out to the large overseas Chinese population. This is evident in the kinds of media that are printed in Hong Kong and produced by Hong Kong’s artists and that can be found abundantly in the grocery stores, newsagents or record stores in every Chinatown around the world. Lynn Pan (1991) agrees that Hong Kong is the world capital of overseas Chinese popular culture, the heart of a whole climate and ambience of thinking.

Chinese historians and scholars appear to have a similar view of the uniqueness of Hong Kong culture, but with a different orientation. They see the uniqueness of Hong Kong culture as an inevitable fact of imperialism. Professor *Jin Yaoji* (金耀基), a well respected social scientist summarised such a view in an interview with a reporter, saying that the development of Hong Kong culture is a rare one and only one special case within China’s five thousand years of history (*Hou Jun* (侯軍), 1997). He saw that for centuries Chinese had never prepared to face the “invasion” of Western culture through gun and power. Without any choice, Chinese and Western cultures met in Hong Kong after the

opium wars. Throughout the 150 years of colonial rule, there were conflicts, ambiguities, and resistance, and, at times, there was mutual compromise between the two cultures (*Hou Jun*, 1997, p.29). Thus, at last, both cultures reached, to a certain extent, a balance point of mutual adjustment and integration. It is one example of a successful dialogue between Chinese culture (*yin*) and foreign culture (*yang*).

Hong Kong's culture and social system evolved through navigating among conflicts and ambivalent ideas of social demands as in the analogy of *Tao*, which is being re-found and followed. Things or behaviours which are acceptable or tolerated in one context, may be rejected or labelled as deviant in another context. *Shae Wan-chaw* (佘雱楚) (1997, p. 6) applies a critical hermeneutic method to understand the local pop-culture. His comment represents one of the underlying thoughts of this thesis.

我們到底生活在一個充滿矛盾的國度裡！不單我們的社會內充滿著各種各樣的利益衝突及結構矛盾，就連我們賴以描述社會生活的一些字句或詞，也離不開不盡相同時有衝突的詮釋。

Basically, we are living in a world filled with ambiguities and contradictions! Not only are these filled with different conflicts of interest and structural contradictions in our society, even the words or phrases that we depend on to describe our social lives are not all the same, at times, they conflict in interpretation (*own translation*).

Navigating among all these ambiguous and conflicting ideas and belief systems, I am going to further illustrate the yin and yang analogy by reflecting on the struggle and discovery of my own cultural identity.

### **Self Struggle And Discovery**

As described in the early chapter, I grew up in two different cultural environments. On one hand, the Chinese value system has been operating in me through learning from my parents

and my early education in Hong Kong. Western values, as well as the Western medical concepts, were introduced when I studied and worked in Australia. The two value systems somehow contradict each other, like the interaction between yin and yang forces, and produce anxiety in me at times. Depending on the situation, I might lean on one system more than the other to justify my decisions or behaviours. I prefer to operate on the system that will help me to deal with a particular situation and help me solve the problems at hand. On one hand, working in mental health in Hong Kong and in Australia, I need to depend on the Western medical concepts that dominate there to orient and make sense of the clients' problems, communicate with my colleagues, and plan interventions. On the other hand, when I am in the companionship of my ethnic group, or to indicate my identity as a Chinese among my Western colleagues and friends, I am inclined to adopt the Chinese value system to communicate and to present and assure my identity. Juggling between the two systems, just like the yin and yang analogy, means that there is an interplay and interaction until a comfortable belief system has emerged and where equilibrium is maintained or nearly maintained. The new belief system is challenged and modified again when a new event occurs or when a previous situation, in which the belief system operated comfortably, no longer exists. A new situation demands a different interpretation. Thus, the juggling cycle resumes until a newer belief system again emerges — a banana-man with a new view. With this thought in mind, we shall see how the two medical paradigms, Western medicine and traditional Chinese medicine, through the lens of the yin and yang concept, have shaped concepts of mental illness, and how they are competing and evolving to find a new equilibrium during transition.

## Notes

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<sup>i</sup> This is the slogan that has often been used, prior to and after the transition of sovereignty, to signify the Mainland China government's assurance to the Hong Kong people that they will not interfere with local affairs.

<sup>ii</sup> Examples include the re-interpretation of the Basic Law by the Politburo of the People's Congress of Mainland China to overrule the decision of the Hong Kong's Court of Final Appeal on granting the right of abode to children born in Mainland by Hong Kong residents. The public was divided in supporting such an action. The supporters saw it was a necessary step to protect the locals from an uncontrollable influx of immigrants from the Mainland that may worsen the livelihood and employment situation in Hong Kong. However, the opponents viewed this as a precedent for China's interference in local affairs. They believed it was part of the basic human right of family reunion. A second example is the pace of development of democracy in Hong Kong, i.e., the undecided date for the full, generally elected Legislative Council. The democrats and their supporters want this to take place sooner, while the Pro-China groups want to delay the final date to minimise a possible backlash on the new government and open conflicts with China's government.

## CHAPTER FIVE

### The Interplay Of Western Medicine And Traditional Chinese Medicine In Mental Health Care: A Matter Of Power Play

#### *“One-Country-Two-Systems”*

Deng Xiaoping, The late paramount leader of China

#### Introduction

Hong Kong’s health care system is pluralistic in nature, with Western medicine, folk medicine and classical (traditional) Chinese medicine existing alongside each other (Lee, 1975, 1980; Cheung, 1987). It provides a rich example of the diversity in perception of health and illness that was discussed in Chapter 3. The eclectic approach of health care consumption will be discussed further in Chapter 10 when I examine help seeking behaviours among the Hong Kong Chinese, particularly with reference to mental illness. In this chapter, I describe the power play between the Western and traditional Chinese health care and healing paradigms, over the last 150 years in Hong Kong and how they have created a clinical reality for mental health and mental illness in the local arena.

#### Health Care Systems As Social And Cultural Constructs

In addition to the cultural and individual identity issues that have emerged during the transition of sovereignty period, the position of traditional Chinese medicine in Hong Kong, in terms of power and popularity, has also changed. Traditional Chinese medicine had been accorded second-class status over the 150 years of colonial rule, and often was labelled “unscientific” and “pre-modernised” health practice (Wu, 1998). Only now is it receiving

official recognition. Its acceptance as a prominent and a parallel alternative to Western medicine is also gathering momentum among the local people (Health & Welfare Bureau, 2000). Folk medicine historically has played a significant but subtle role in the local health scene, despite the struggle for power and influence that has existed between Western and Chinese rival health care systems.

Kleinman's (1980) view of social and cultural constructs provides a framework for examining the existing health care systems in Hong Kong. Kleinman sees the health care system, like other cultural systems, as a system that integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; and socially legitimated status, roles, power relationships, interaction settings, and institutions (Kleinman, 1980, p.24). Thus, they are forms of social reality. Beliefs about sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways in which family and practitioners respond to sick persons are all aspects of this social reality.

According to Kleinman's (1980) view, a health care system is constructed of three overlapping subsections: the professional sector, the folk sector, and the popular sector. Each sector creates its own clinical reality. In the case of Hong Kong, the professional sector consists of the predominant Western modern medicine, which has legitimate status. It is comprised of professionals such as physicians, nurses, and other Western trained health professionals. It also is heavily institutional and associated with strong political power. The folk sector, besides traditional Chinese medicine, includes a mixture of many different components, e.g., diet therapy, shamanism, massage, marital arts, and so on. Some are closely associated with the professional sector, but most are more closely related to the popular sector. With official recognition and increased popularity among the public, the previously suppressed and marginalized classic Chinese medicine practitioners are

gradually shifting from the folk sector to the professional sector. This includes herbalists, acupuncturists and the bonesetters. The popular sector is the largest and most diverse part of any health care system. It contains a matrix of several levels: individual, family, social network, and community beliefs and activities. It is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated (Kleinman, 1980, p.50).

Developments since Kleinman's initial presentation of this framework suggest a fourth, alternative medicine sector, between the folk and professional sectors (Helman, 1994). Labelled the complementary medicine sector, it includes alternative health care practitioners — such as chiropractors, homeopaths, and osteopaths — who also provide alternate health care in Hong Kong. In any given system, each sector exhibits cultural diversity; in some it is rich and complex (Armstrong & Fitzgerald, 1996). It is also obvious to say that social realities differ between different societies, different social groups, different professions, and, even at times, different families and individuals (Kleinman, 1980).

In the following section, I only focus on the power play between Western and classic Chinese medicine, as they are the two dominant groups in the health care arena. The interplay between the two may reflect a unique characteristic that is emerging during the transition period — the subtle drive for equilibrium between two rival but complementary forces.

### **A Brief History Of the Mental Health Service In Hong Kong**

In an earlier chapter I briefly explained the history of Chinese medicine and its perspective of mental illness. In this section I look at the contemporary mental health system in Hong Kong. Little is known about how the mentally ill were dealt with in Hong Kong before



1895 as there is a lack of documentation in the official literature (Lo, 1981). However, it is known that in 1873 Chinese “lunatics” in the colony were sent to the Tung Wah Chinese Hospital, the first general hospital for Chinese residents of Hong Kong, set up through donations from local merchants (Fan, 1994). Surprisingly, it also is known that traditional Chinese medicine was predominantly practised in this hospital until the end of the Second World War (Editorial, *Ming Pao Daily News*, 22 January, 1999). European “lunatics” were confined in the Goal until they could be sent back to their native home (1883 Annual Report of Colonial Surgeons). In 1895 a small wing of the public hospital on Hong Kong Island was designated as a “lunatic asylum” for the management of people with mental illness (Lo, 1981). The first few patients admitted to this unit were non-Chinese. The first Chinese patient was not admitted until 1912. But from then onward the number of admissions rose; in 1913 there were 242 admissions (Lo, 1981). Many Chinese families would tolerate the burden of caring for a mentally ill member in the family for fear of disgracing the family by revealing its “poor heredity” (Lo, 1981). Further, there was no clear distinction between mental illness and mental retardation in those days. Children who displayed abnormal behaviours would be classified as “*sòhjáí*” (mad boys) or “crazy boys,” and people tended to relate this to bad genes in the family. To a certain degree, this belief was revealed in my story in Chapter One about my first encounter with mental illness.

Wealthy Chinese families built extensions in their gardens to house their mentally ill relatives. Some even sent their ill relatives to Guangzhou to seek treatment from the few European doctors who were practising psychiatry there. Over 75 per cent of patients in Hong Kong were eventually “disposed” back to Mainland China and 13 per cent died in the asylum, while only 10 per cent were returned to their families (Lo, 1981).

The first mental hospital in Hong Kong was built in 1925, with a capacity of 130 beds (Foo, 1981). This hospital was mainly used as a custodial and transitional place before

patients were sent back to China. Treatment received in this hospital was limited to physical restraint and temporary custodial care for disturbed patients. Lo (1981, p. 48-49), one of the earliest Western trained psychiatrists, provides a good description of the scene at that time.

Disturbed patients had to be restrained with the help of straight jackets and placed in padded rooms. "Hydrotherapy" which consisted of immersing a patient alternately in hot and cold water was thought to "shock" him back to his senses. It appeared then that the main function of the mental hospital was to provide custodial care for disturbed patients before their transfers to Fong Chuen Hospital in Canton (it was the first Western psychiatric hospital in Guangzhou). Once a month 10 to 20 patients would be escorted there by 1 or 2 male nurses. Probably in this mental hospital in Canton the management of mental patients was even more unsatisfactory because from time to time a few patients would escape, stole a ride on a train to Hong Kong and would seek admissions to the mental hospital in High Street (where the hospital was situated).

The Mental Health Association of Hong Kong, the first non-governmental association for promoting mental health education and mental health care for the mentally ill, was formed by a group of concerned health professionals in 1954 (Foo, 1981). Those who joined the association were mainly Western trained medical and health care professionals.

The Western perspective of mental health and mental illness gradually gained credibility and status while other, alternate healing methods were discouraged or not legally recognised. Subsequently the Western perspective was passed on to the general public through the education system and the mass media.

Until the first Mental Health Ordinance was enacted in 1960, the Hong Kong Government had not taken any major initiative to develop the mental health service.<sup>ii</sup> The

Mental Health Ordinance was the first ordinance for the certification, detention, and treatment of the “unsound minds” in Hong Kong (Hong Kong Government, 1972). Since the opening of the Castle Peak Hospital in 1961, systematic expansion of the mental health service has taken place (Lo, 1981). Another 1,000-bed psychiatric hospital opened in the early 1980s. Currently, besides these two large psychiatric hospitals, services provided by the government and the charitable organisations include smaller psychiatric units in the major general and/or teaching hospitals, outpatient clinics, day activity centres, sheltered workshops, supported employment, half-way houses and aged and care homes. The formal service provision for people with mental illness in Hong Kong is largely based on the Western psychiatric model.

#### **The Interplay of Western and Traditional Chinese Medicine at the Power Level**

Despite the fact that the majority of people in Hong Kong are Chinese and that there is a long history of using traditional Chinese medicine in treating mental illness in China (Hé, 1995; Zāng, 1996), traditional Chinese medicine has never played an important role in the Hong Kong mental health care system. Neither has it been recognised as a valuable treatment alternative for mental illness in Hong Kong. This situation is reflected in the findings of the general questionnaire survey on perceived effectiveness of traditional Chinese medicine for treating mental illness. The majority of respondents saw Chinese medicine as having little or no effect in the treatment of mental illness (see Chapter 6). Among the explanations for this perception, is that previous policy was rather more politically motivated than concerned about treatment effectiveness. Its purpose was to preserve the dominance of Western medicine and minimise the possible competition from traditional Chinese medicine (Lee, 1975). In addition, undermining traditional practice and artefacts that might arouse a Chinese identity among the Hong Kong people also was an

unwritten policy to secure the colonial government's control (Kào, 1997; Lau & Kuan, 1991). The history of mental health service development in Hong Kong described above reflects such a process. The description by Rance Lee, though in 1975, can still give a glimpse of a situation that has not changed until recently.

In the pluralistic health context of Hongkong [sic], there co-exist two major systems of professional services with different technical orientations and social-organizational patterns; they are the classical Chinese and the modern Western medicine. Instead of coexisting in a coordinated fashion, the two systems are competitive on an unequal basis. Western-scientific doctors constitute the dominant profession of medicine in Hongkong, while Chinese medical practitioners work in a subordinate and disadvantaged manner (p.222).

With expert authority granted by the government in the realm of health, the profession of Western medicine has the greatest influence on the social organization of medical care in the colony (as in 1975) as a whole. In the formulation of major policies dealing with health, the government normally consults with representatives from two major medical professional associations: The Hongkong[sic] Medical Association and the Hongkong Branch of the British Medical Association; both associations are oriented towards Western medicine. The government rarely seeks advice from Chinese [medicine] practitioners; and, furthermore, there is no Chinese [medicine] practitioner working in the government's Department of Medical and Health Services. All doctors in public service are trained in Western medicine. It is, thus, not surprising to see that though the government has provided and sub-vented (subsidised) an increasing volume of different kinds of medical and health programs, none of them is involved with [sic] (involves) Chinese medicine. With regard to the future development of health care services, the Governor, in early 1973, appointed a Medical Development Advisory Committee to make recommendations appropriate for the next 10 years. Some of the Committee members are Western-trained doctors, but none is a Chinese

medicine practitioner. The plans recommended by the Committee are primarily concerned with the provision of hospital beds and increasing the number of doctors and nurses in Western medicine (Report of Medical Development, Hong Kong Government, 1973). There is no discussion about the development of Chinese medicine. Apparently the social organization of medical care in Hongkong [sic] has been under the influence of the Western medical profession, rather than the Chinese medical [sic] (medicine) practitioners. (p. 222-3)

There are currently two heavily government subsidised Western medical schools in Hong Kong. The first one was set up in the early 20<sup>th</sup> Century in The University of Hong Kong. The second one, in The Chinese University of Hong Kong, admitted its first students in 1981. Both are equipped with comprehensive laboratories and associated teaching hospitals and train more than 200 graduates each year. To practise as a specialist in psychiatry, medical practitioners have to pass the fellowship examination of the College of Psychiatry in the United Kingdom (before the transition) or the College of Psychiatry in Hong Kong (set up a few years before the transition date). Other mental health care professionals are trained in various hospital-based nursing schools or universities that are based on the Western medical paradigm. Examples are the psychiatric nursing school at Kwai Chung Hospital, The Hong Kong Polytechnic University, and The Baptist University.

The first formal programme for traditional Chinese medicine only began in 1998, after some 150 years of colonial rule! Formal professional registration requirement to practise Chinese medicine were only introduced recently when an ordinance was enacted to set up the Chinese Medicine Council to regulate and oversee the practice of Chinese Medicine in Hong Kong. Prior to that, the colonial government enticed people away from traditional Chinese medicine through education and practices mainly based on Western health concepts, such as infant vaccinations and eradication of diseases. Quality assurance of service provision and professional codes of practice for traditional Chinese medicine

appear to have never been established. News of malpractice and overcharging for consultation and prescribed medicine were not uncommon among traditional Chinese medical practitioners and were often highly publicized by the media. Coupled with these factors, there had been a reluctance of the colonial government to publicise Chinese medicine (Topley, 1975). All in all, this cumulatively created an image that Chinese traditional medicine was “unscientific” and that the practitioners were unprofessional. Despite there having long been formal programmes on the Mainland to train classic Chinese medical practitioners, traditional practitioners often were projected as unethical in practice, as having no formal training or recognisable qualifications, and as less capable of dealing with modern diseases (Bloomingdale, 1980; Lee, 1975; Saku, 1991).

Another example of the official recognition and endorsement of Western medicine is that when an epidemic breaks out in the community, the Western medical concepts of classification, aetiology and intervention become the only official explanation and prescription in Hong Kong. People are led to accept these as the only acceptable explanations for health and illness. The situation is the same for mental illness. The following table (Table 3) provides examples of how mental health and mental illness are interpreted to the public by the media.

**Table 3 Examples of news headlines/headers on mental health and illness issues**

Newspaper	Date	News Headlines/Headers	Invited Comment/Abstract of the news
Apple Daily	15.10.1996	港人百中有一，病發情緒激動：躁狂症宜及早就醫 (Translation) One out of one hundred Hong Kong people with elated mood onset: Manic illness needs to be treated earlier	An interview with a psychiatrist who explained bipolar disorder and manic depression.
Apple Daily	22.7.1996	精神分裂症患者活在自己想像的世界中 (Translation) Schizophrenics live in their own imagined worlds	A column based on information supplied by the Hospital Authority and Castle Peak (psychiatric) Hospital to educate families on how to cope with mentally ill relative.
Ming Pao Daily News	27.9.1999	怪異行爲應尋求治療 (Translation) People with strange behaviours should seek therapy	Western trained psychiatrist: [其實精神病跟糖尿病及高血壓一樣，都是疾病，是病人腦部分泌不平衡引致，藥物治療就是改變這個不平衡。如果你患了這些病，不會埋怨家宅風水不好，精神病也是一樣。] (Translation) Actually, mental illness is just like diabetes and high blood pressure, they are all illnesses (diseases). As there is an imbalance in the patient's brain's secretions, medication can correct such an imbalance. Therefore, if you have those illnesses (diabetes and high blood pressure), you won't blame it on bad <i>feng shui</i> , and the same applies to mental illness.
Apple Daily	10.3.2000	股市大起大落、影響精神生活 金融風暴後自殺多近三成 (Translation) Big ups and downs in the share market affects mental life 30% increase in suicide after financial crisis	Comment by a psychiatrist that there is an increase in suicide/self destructive behaviours, and psychiatric incidents after the Asian economic crisis.
Apple Daily	29.3.2000	不能預知未來平添緊張 西醫：遇事占卜實為減壓 (Translation) Not knowing about the future creates anxiety. Western trained doctor: Using fortune-telling to confront problem – a way to reduce stress	Comment by one psychiatrist. [他並指出，人對不可預知的後果，會特別感到有壓力，以往中國人遇到問題時，喜以術數，如占卜等法去探知未來，其實這是中國人的減壓方法。] (Translation) The psychiatrist points out that when one is faced with unknown consequences, he/she will feel pressured. In the past when Chinese came across problems, they liked to use geomancism, such as fortune-telling, to predict the future. Actually, this is one method that Chinese can use to reduce stress.

The superior status of Western medicine is not without criticism. With the rise of the consumer movement, Western-trained physicians are now expected to be more accountable. Their past position of infallibility as the sole experts in healing illness and sufferings is now

being questioned. Complaints of malpractice, negligence, and misconduct are becoming regular news items in the mass media. There is continuous pressure for restructuring or reform of the Medical Council, which oversees the practice of Western medical practitioners, as it is perceived as protecting the practitioners' interests. The Council is being asked to be more transparent in its disciplinary decisions regarding complaints of medical misconduct or malpractice (*South China Morning Post*, 14 October 2000).

Because the Hong Kong Special Administration Region (SAR) Government is committed to promote professionalism and modernisation of its practice (*PC Leung*, 1998; *Ming Pao Daily News*, 7 June, 1999), some positive changes in the use of traditional Chinese medicine also have taken place since the 1997 transition. These include: 1) the burgeoning development of formal training programmes in traditional Chinese medicine in local universities; 2) an increase in systematic, "western scientific" research on the efficacy of Chinese medicine; 3) the inventive pharmaceutical production of herbal medicine in easily consumable forms, e.g. pills; 4) the introduction of legislation and the establishment of the Regulatory Board for Chinese Medicine to oversee the training, licensing and practice of traditional Chinese medicine; and, 5) the opening of outpatient clinics for traditional Chinese medical practice in general hospitals.

There are several explanations for such a rapid swing in the development of Chinese medical practice in Hong Kong. First, revival of traditional Chinese medicine and support for the complementary practice of both Western and traditional Chinese medicine have taken place on the Mainland since the communists' takeover of the government in 1949 (*Zang*, 1996). In response to Mao's call for "maintaining on our own efforts" and his assertion "Chinese medicine, explore it and raise it to a higher level," has meant that medical and health workers in China have been struggling hard to restore and revive their own medical tradition (*Hou*, 1970). In Hong Kong, promoting traditional Chinese



medicine not only provides a connection with the mainland, but also an identity symbol of being Chinese. Such a symbol is urgently needed by the Hong Kong SAR Government to signify the difference in national identity from the past.

The second reason for the increased attention to traditional Chinese medicine is that most of the traditional Chinese medical practitioners were educated and trained on the mainland. Despite the fact that many of them came to Hong Kong as refugees or migrants prior to 1997, the nation-state concept and a patriotic feeling towards China are still with them. They have been among the supporters of re-unification of Hong Kong with the mainland, in contrast to those Western trained medical professionals who seem to have little nationalist and patriotic spirit among them. In returning the favour, the SAR government has been trying to do its part to raise their professional and social status in Hong Kong.

Last but not least, achievements and advancement in the practice of Chinese medicine, particularly on the mainland, have often been reported in the news. For example, recently there was news about the invention and successful trial of anti-manic drugs that are produced purely from herbs in Mainland China (*Seng Pao*, 31<sup>st</sup> December, 1998).

Together with the emerging consumer movement, people are demanding more options in health care and healing services, the Hong Kong SAR government is also under pressure to provide more resources to assist the further development in traditional Chinese medicine.

Despite all these positive developments for traditional Chinese medicine, the date for gaining wide acceptance and equal status with Western medicine is still remote. This may be reflected in a few recent events as reported in the news:

- 1) The restricted practice of medicine by traditional Chinese practitioners includes prohibition of performing any surgical interventions; prescribing western

pharmaceutical drugs, such as psychotropic drugs and antibiotics; and using any medical equipment, except the stethoscope and the blood pressure sphygmomanometer. However, Western medical practitioners can include acupuncture in their practice after attending officially recognised courses (*Apple Daily*, 19 November, 1999; 5 January, 2000).

- 2) Western trained doctors object to the sharing of power by excluding traditional Chinese medical practitioners from the voters list for the Medical Constituent seat in the Legislative Council, despite dentists having been included earlier (*Ming Pao Daily News*, 9 June, 1999; *South China Morning Post*, 30 October, 1999).
- 3) The registration fee for traditional Chinese medical practitioners is proposed to be double (nearly) that of Western medical practitioners. The excuse government gives is to cover the administrative costs and yet this does not apply to western medical practitioners' registration (*Ming Pao Daily News*, 13 April, 2000).

Negotiations and compromises are still continuing between the two health care and healing systems to come to an agreeable balance of power and to provide equal and informed access to the public. It is against this complex background, where Eastern and Western conceptualisations of mental illness meet, that Hong Kong society confronts its problem of mental illness (Tsoi & Tam, 1990).

### **The Explanatory Models**

Despite the dominant role played by Western medicine in defining health, illness, and the healing process, Western medicine has never been able to totally replace traditional healing methods. There are many people in Hong Kong who still use traditional Chinese medicine to deal with their health and illness issues (*PC Leung*, *Ming Pao Monthly*, December Issue, 1998; *Ming Pao Daily News*, 30 October, 1998). Leung, a prominent local Western trained

medical practitioner, researcher, and academic, who promotes combining both medicines in clinical practice, believes there are two reasons for this. First is the peculiar help seeking behaviour among the Hong Kong Chinese, which is quite patterned. They tend to seek Western medical help first when they are having minor health problems or common colds. That is because it is relatively more convenient to take the ready-made drugs/pills than undertaking the time-consuming process of cooking herbal tea or dieting. Hong Kong people like to feel trendy and believe Western medicine is more “scientific” and modern. However, if their health condition does not improve after taking the medication, then they are inclined to consult traditional Chinese medical practitioners. In addition, for those diseases that cannot be cured by Western medicine, such as chronic illness and cancer, people will also turn to traditional Chinese medicine for a cure.

Second, Hong Kong people prefer to use traditional Chinese medicine when they are dissatisfied with the specialisation- and reduction-oriented Western medicine, from which the idea of holistic care seems to have disappeared. Furthermore, there is a distancing relationship between the practitioners and the clients. This phenomenon is particularly obvious with chronic illness, such as mental illness. Chesla (1989, 1991) studied 14 families and found that families often had an understanding of, or a way of explaining the mental illness of their relative that differed from that of professionals. As Kleinman and others note, this difference in explanatory models is common, and the understanding of illness influences what family members believe to be the appropriate treatment for, and response to, the ill relative.

Obviously, a cognitive framework is operating among the patients and/or their families to understand what has happened to them and how to decide what needs to be done to restore normality again. Kleinman, Eisenberg and Good (1978) attempted to explain this cognitive framework by introducing the concept of “explanatory models.” Kleinman

defines an explanatory model as “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (1980, p.105). Explanatory models reveal sickness labelling and cultural idioms for expressing the experiences of illness and have been shown to influence health seeking behaviour and health service utilization (Patel, 1995). An explanatory model is partly conscious and partly outside one’s awareness. It is based on a cognitive system that directs reasoning along certain lines. In clinical practice, clients either do not volunteer their explanatory models to health professionals or, when they do, report them as short, single-phrase explanations because they may be concerned about the embarrassment of revealing their beliefs while in formal health care settings. They may fear being ridiculed, criticized, or intimidated because their beliefs appear mistaken or nonsensical from the professional medical viewpoint.

Explanatory models are also characterized by tacit knowledge, so that they are often incoherent and ambiguous. In responding to an illness episode, individuals strain to integrate views in part idiosyncratic and in part acquired from the health ideology of the popular culture (Kleinman, 1980). Furthermore, patient’s and family’s explanatory models often do not possess single referents but represent semantic networks that loosely link a variety of concepts and experiences. To sum up, the explanatory model describes the dynamics of cognitive and communicative transactions in health care. Also, it provides a means of comparing the transactions in traditional and modern health care systems, and of evaluating process.

In work based on Kleinman’s interviews with Taiwan Chinese about interventions for mental illness he quoted the following informant’s response to illustrate how explanatory models can be used to shine light on the pattern of help seeking:

Chinese medicines have fewer side effects than Western medicines. Western medicine works much quicker, but it only removes symptoms. It does not, like Chinese medicine, remove the

underlying cause of the illness. Chinese medicine may not help you sometimes, but it won't hurt you. Western medicine may remove your symptoms or illness, but sometimes the treatment is worse than the illness. There are many ways of treating an illness, not just one. Different ways must be used depending on the specific illness and the person. But as for your talking therapy (said with a laugh), I don't think it is of any use at all. You can't treat anyone with that alone (Kleinman, 1980, p.87).

Despite its usefulness as a concept, the explanatory model is not without its critics. Young (1980, 1982) criticised the explanatory model proponents for trying to explain the surface meaning of informants' statements in terms of a single set of underlying cognitive structures, i.e. explanatory models of illness. He pointed out that there are two problems with the explanatory model view (Young, 1982). First, it overlooks the fact that power originates and resides in arrangements between social groups and between classes. Second, the path followed by explanatory model writers seems reasonable only because there is a term missing from the disease-illness scheme upon which their work is based, i.e. "sickness," which he defines as a process for socializing disease and illness transactions (Young, 1982). He suggests that the disease-illness view is taken from the point of view of the sufferer, and thus neglects the fact that many medical practices develop and persist because they are useful for other people and for reasons unconnected with curing and healing. Thus, sickness rather than illness determines the choice and form of many clinical interventions. He further explains that sickness is the process through which worrisome behavioural and biological signs, particularly ones originating in disease, are given socially recognizable meanings, i.e., they are made into symptoms and socially significant outcomes. I have incorporated Young's argument while reviewing the data, but I am inclined to adopt Kleinman's view of explanatory model in analysing and interpreting the data.

### Pluralistic Health Care System

The existence of various explanatory models in the community for health, illness and healing has led to the formation of a pluralistic health care system. Lee (1980) described how the pluralistic health care system in Hong Kong operates: in the public sector, only Western health services are provided as the government recognizes only the Western medical tradition. In the private sector, both Western-style and traditional Chinese health services co-exist. In particular, previous government control over Chinese medical practice in terms of qualifications of practitioners and use of Chinese medicine was minimal. Hong Kong Chinese tend to integrate Western-style and traditional medicine in their own ways, shifting between the two types of practitioners while continuing to depend on some forms of self-medication in addition to their medical consultations. This pragmatic approach among the lay people may be well reflected in this statement by a group of hospital directors:

Chinese and European (Western) medicines each have their own use, and we should not have different views of ...[them] ... if a cure can be effected all the same.

(Board of Director's Tung Wah Group of Hospitals, 1970; cf Topley, 1975, p. 260)

In recent years there has been a significant increase in the understanding and acceptance of the alternate explanation and healing of physical disease from the traditional Chinese medical perspective among the general public. In the mental health arena, the dominance of Western psychiatry will still prevail and take up the major role in the defining and prescribing interventions for mental illness in Hong Kong for sometime to come. A very good example, as illustrated in Table 3, is that Western trained psychiatrists are often invited by the media to comment on any recent incidents that concern people with mental

illness, and/or to provide advice to improve mental health or to care for the relatives with mental illness.

As a pluralistic health care system operates in Hong Kong, the way the family and/or the person with mental illness interpret the mental illness experience will determine how they select treatments and care. To sum up, the impact of social relationships and power distributions between different healers, and between the healers and the patients; the interplay of modern Western medicine, traditional Chinese medicine, and folk healing methods; and the influence of mass media, all contribute to shaping an individual's explanatory models for mental illness, and thus to one's help seeking behaviour and coping. In the next chapter, I shall examine how the media, in particular the press media, perceive and describe mental illness. I suggest that this may influence public opinion toward mental health and people with mental illness.

## Notes

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<sup>i</sup> This is one of the slogans often used by the Chinese government to assure the Hong Kong people that they will not interfere with Hong Kong's existing capitalist, free market system after the transition. I use it to indicate the pluralistic nature of the health care system in Hong Kong.

<sup>ii</sup> All pieces of legislation passed in the Legislative Council are called "ordinances" instead of "acts" as the Council is only a quasi-parliament. The tradition has not changed since the transition of sovereignty, because the Council is also perceived as a local council equivalent of the Special Administrative Region under the Politburo of Mainland China.



# **The Concept Of Mental Illness**

## **Unit Three**

## CHAPTER SIX

### The Media Game: Balancing Freedom Of Speech And Censorship In Reporting Mental Health Issues

#### Introduction

Although there are still contradictory findings regarding the mechanism and the extent of the mass media's influence on people's belief systems and behaviours (e.g. YW Cheung, 1997, Coleman, 1993; Harrison, 1997), there is no doubt that the mass media does exert influence on society. Examples include perception of body image (Champion & Furnham, 1999); shaping public opinion (Anastasio, Rose, & Chapman, 1999); desensitising people's sympathetic attitudes toward victims of crime (Dexter, Penrol, Linz, & Saunders, 1997; Krafka, Linz, Donnerstein, & Penrol, 1997), voting behaviour (Schmitt-Beck, 1996), identification of violent acts (Cantor & Sheehan, 1996). The following story provides an example of the impact of television on people's behaviour in Hong Kong. In a locally produced television comic series the main male character keeps a cockroach as a pet. A few months after the series was on the air, it was reported that people developed a more positive attitude toward this pest and some people even started to look for different species of cockroach to keep as a pet (*Hong Kong Economic News*, 5 June 2000). This led to a warning from the Government that it is illegal to sell or keep pests like cockroaches in Hong Kong. The aim of this chapter is to describe the impact of press reports on public opinions on mental illness and people with mental illness.

### The Selected Press Media For The Study

Literature on the potential impact of the press suggests that the dominance of the Western medical interpretation of mental illness, as well as the perpetuation of myths, fears, stigma and stereotypes surrounding mental illness, is perpetrated by the mass media in Hong Kong. Content analysis was conducted to investigate: 1) how the press has projected mental health/illness and the image of the person with mental illness; 2) the influence of those reports on the public's concepts of mental illness; and, 3) the impact of press reports on families with mental illness. Because of the cost and difficulty in collecting such data, I limited myself to primarily collecting newspaper clippings from two major local newspapers. In addition, relevant articles that I came across in other newspapers, local magazines and periodicals during my leisure reading were also included in the database.

The newspapers from which I systematically collected the articles relating to mental health and illness were: a) the *Ming Pao Daily News*, locally regarded as a newspaper for intellectuals because of its high "academic" orientation and credibility in news reporting; and, b) the *Apple Daily*, one of the two most popular and best selling local daily newspapers at the time of data collection. The latter is well known for its tabloid style and dramatised news reporting and the use of alarming or shocking tactics in presentation. In a recent survey on the credibility rating (trustworthiness) of newspapers conducted by the Department of Journalism and Media at The Chinese University of Hong Kong, the *Ming Pao Daily News* came second in the trustworthy/credibility rating and the *Apple Daily* was in the ninth position among the 14 daily newspapers in the study (*Ming Pao Daily News*, 20 May, 1998).<sup>i</sup> Another survey, conducted in April 1998 by the ad hoc group the Society for Truth and Light,<sup>ii</sup> assessed the presence of pornographic and tabloid contents in 13 local daily newspapers. The *Apple Daily* was rated as the most "polluted" newspaper with significant amounts of pornographic content and exaggerated reports, while *Ming Pao*

*Daily News* came at the eleventh position (*Ming Pao Daily News*, 20 May, 1998). The rationale for examining these two newspapers with divergent creditability and readership was to include different reporting styles and content that appeals to the general public. Data from over 150 news clippings were collected daily over the period of March 1996 to March 2000.

In addition, a computer search was conducted on all the catalogues of newspaper clippings in The Hong Kong Polytechnic University's library collections over the same period of time by using keywords, such as mental health, mental illness, psychiatry and education. A hard copy of each relevant newspaper clipping was retrieved and compiled to form an additional database. Thus, one set of data is derived from my own content analysis of two popular papers, while the second includes articles classified by others as related to mental health or illness. The end result is that the nearly 250 articles represent a significant sample of the articles on these topics over a 4-year period.

The results of the analysis of the news articles, together with a literature review, will be discussed under the following headings: 1) the Hong Kong press media: when business means business; 2) mental illness as projected in the press; and 3) the impact of press media on families with mental illness.

### **The Hong Kong Press Media: When Business Means Business**

As one of the financial powerhouses and business centres in the region, Hong Kong needs to have free access to global information to maintain its prominence and vibrancy as an international metropolitan city. Both before and after the transition, the people of Hong Kong have had free access to all kinds of media, such as local television shows, cable television programmes, the Internet and the press. They can subscribe or collect information from anywhere around the world. The extent of non-interference with the

mass media is often used by the West to measure the degree of freedom that the Mainland China government is willing to tolerate and permit in Hong Kong.

Despite the fact that television appears to be the most effective method to have an impact on people, radio and newspapers still remain as important and common ways that people receive news and information (Austin & Husted, 1998). With a population of nearly seven million in Hong Kong, there are more than a dozen major local daily newspapers and dozens or more locally produced weekly and monthly magazines. In addition, hundreds of newspapers and magazines are shipped on a regular basis from all over the world. Thus, the press is a very competitive business where the companies use whatever marketing tactics they can to increase their market share of the readership. Nearly all the major local newspapers are colour printed with many pictures and graphics. Shocking or stirring news headlines/headers, particularly on the front page, together with “on the spot”, “live” pictures and graphic descriptions of human tragedies or accidents are often used to attract readership. The following example illustrates this point well. It is extracted and translated from a newspaper report on violence associated with people with mental illness.

一名曾患精神病須定時覆診服藥的男子，聲稱懷疑妻子紅杏出牆，凌晨以鐵枝擊斃熟睡的妻子，然後致電報警自首。

A mentally ill man, who required regular [psychiatric] follow-up and medication, claimed that he suspected his wife of having an affair. He beat to death his deeply sleeping wife with an iron bar at mid-night and then he reported himself to the police by phone.

*(There was a graphic description of the dead victim in the news report.)*

『右面、右額及後腦出現明顯骨裂，部分腦漿溢出，據悉她的左眼曾被人以鐵枝直刺，因而出現一個血洞，死狀非常恐怖。』

There are obvious marks of a broken skull on the right face, forehead, and the back of the skull. Some brain tissues had filtered out. It was said that her left eye was pierced straight through

with an iron bar, and thus it became a bloody hollow. The appearance of the dead woman was horrific (*Apple Daily*, 24 June 1997).

In addition to the daily news, each paper also features a variety of other types of articles, which can only be found in the magazine supplement section of the newspaper. They range from news commentaries, consumer guides, travel information, and health issues to serialised fiction stories. Because sexual images and content create sales, pornographic content, such as erotic stories with explicit sexual themes and detailed descriptions of services in various brothels and massage parlours, commonly are found in a few of the most popular newspapers, such as the *Oriental Express*, *Apple Daily* and *The Sun*.

What else makes as much news as human tragedies and natural disasters? They tend to touch the vulnerable human's mind: reinforcing their existing fears, reassuring them of their own fortunes, and providing a means by which to channel their unlimited sympathy. Nowadays, victimhood has become a commodity for sale, and victims' stories in the print media increase their circulation. Altheide and Michalowski (1999) suggest that the use of fear in the news media is consistent with a popular culture oriented to pursuing a "problem frame" and entertainment formats. This has social implications for social policy and reliance on formal agents of social control.

There have been discussions of increasing censorship of the press by the government and in the community to tame press activities that are apparently out of control. However, such initiatives are often interpreted as a sign of Mainland China tightening control of the press through the SAR government or as an indication of government interference with the free market system that is perceived to be the major reason for Hong Kong's economic success. Debates and discussions still continue at the time of writing. An equilibrium

between censorship and freedom of speech, and between social conscience and market driven consumerism, will not be reached for sometime to come.

### **Mental Illness As Projected In The Press**

The mass media in Hong Kong demonstrates conflicting attitudes towards people with mental illness. On one hand, they try to increase their sales or number of readers by dramatising and sensationalising any incidents associated with violence by people with mental illness. On the other hand, they act as a social conscience to remind people of the prejudices and injustices that are experienced by people with mental illness. Because any incident of social disturbance caused by people with mental illness is quickly publicised through the mass media, myths about mental illness continue to be generated and negative feelings against mentally ill persons are maintained. The Yuen Chou Estate incident in 1982 was the first widely reported incident in which violence was associated with people with mental illness. In that incident, a mentally ill person went into a kindergarten with a chopping knife (a meat cleaver), killed six people, and injured a number of others, including teachers and children.

Table 4 provides examples of the news headlines or headers of incidents that occurred during the period of the study. These illustrations indicate how those incidents were reported or, perhaps, even sensationalised.

**Table 4 Examples of news headlines/headers describing incidents associated with persons with mental illness**

Newspaper	Date	News Headlines/Headers	Quote from Report
Apple Daily	12-2-2000	(Front page) 慈母身擋九刀救兩子女 父狂刀斬死 13 歲親兒 (Translation) Kind mother received 9 slashes to save her two children. Maniac father chopped 13 year-old son to death	一名仍在接受精神病治療的失業漢，爲了兩包朱古力與十三歲長子爭執，疑病發竟涉嫌操刀將長子斬斃，並追斬兩名企圖逃走子女，其妻救子情切，不惜兩度以血肉之軀擋下兇徒至少九刀，救回兩子女，但自己亦受重傷及受受刺激。 An unemployed father, who was currently receiving psychiatric treatment, quarrelled with his 13 year-old son over two packs of chocolate. He took out a chopper and killed his son, and then chased after two other children. His wife came to save them, but was slashed by her husband 9 times, and suffered serious cut wounds.
Apple Daily	25-2-2000	斧頭行兇、利刀自盡 病漢弑母燒屍自刺亡 (Translation) Axe for murder, sharp knife for suicide: Chronically ill man murdered and burnt mother's corpse then stabbed himself to death	牛頭角下邨昨發生的火警揭露一宗倫常慘劇，一名體弱多病兒子，疑病發失常，用斧頭劈死七十六歲母親，再放收燒屍，他弑社後躲在衣櫃內用刀刺胸自殺 A family tragedy was uncovered in a fire. A chronically ill son, suspected to have lost control, murdered his 76 year-old mother with an axe then set the flat on fire. He stabbed himself to death with a knife behind a wardrobe.
Ming Pao Daily News	25-2-2000	中年漢失業近患精神病 癡兒殺母燒屋復自刺亡 (Translation) Middle aged man, unemployed and recently suffering mental illness: madly attacked and murdered mother, burnt down flat and stabbed self to death	Same story as the above but the header is not congruent.
Ming Pao Daily News	20-7-1999	精神病漢街市斬母自吻死 (Translation) Mentally ill man chopped mother and stabbed self to death in market	一名十多年前因抵受不了感情折磨而患上精神病的中年男子，昨晨陪同母親前往黃大仙大成街市買菜時，突然狂性大發，[從某海鮮檔搶來一把十吋長、四吋闊的利刀，從後襲擊] 亂刀斬傷母親，再揮刀自刎而死。 A middle aged man who could not cope with a broken romance over 10 years ago became mentally ill. While accompanying his mother to market yesterday morning, he suddenly went manic and berserk. He took a 10-inch long and 4-inch wide sharp knife from a seafood stall nearby and injured his mother and then slashed his neck and died.
Apple Daily	5-10-1998	借完又借遭拒疑精神病發作 男子爲 20 元斬友跳樓亡 (Translation) A mentally ill man relapsed when he was declined for borrowing money again. For just \$20 he knifed his friend and jumped to his death.	headers: 愛睇鹹帶常自言自語 從高處墮下當場斃命 (Translation) Liked to watching porno videos and was often found self-muttering. Jumped to his death from a height



**Table 4 Examples of news headlines/headers describing incidents associated with persons with mental illness (cont')**

Newspaper	Date	News Headlines/Headers	Quote from Report
Apple Daily	27-12-1998	指司機是雨夜屠夫林過雲 的士怪女客跳車 (Translation) Thinking taxi-driver was a psychopath, weird female passenger jumped out from the taxi	The woman had a history of mental illness and started to receive treatment 3 years ago. Her boy friend stated that she was often suspicious about strange male persons.
Apple Daily	18-2-1997	立法局前“請願” (Translation) “Protest” in front of Legislative Council Building	懷疑精神病女子請願, 手持標語投訴, 令人啼笑皆非, 用莫名其妙字句和高聲叫囂, 驚動警員到場 (Translation) A lady suspected to be mentally ill held a protesting banner with weird words that might be laughable. Her shouting led to the attention of the police and she was escorted away.

From these examples of how the mentally ill are described in the press, we can understand why a person with mental illness in Hong Kong is often associated with being a murderer or psychopath and running amok or acting strangely. With the negative images of people with mental illness in their minds, vocal community groups often show their rejection of the mentally ill persons, by, for example, protesting against the setting up of half-way houses in their housing estates. They feel uncertain about how these residents will behave (Tsoi & Tam, 1990). Thus, the mentally ill population is often isolated by society. Prevailing strong social stigma either has forced them to be hidden away by their families and/or to comply with the prescribed medical and social treatments. They are one of the minority groups being discriminated against and their needs are likely to receive less attention from the government and the public. In addition, perceived threats and unpredictable outbursts of violence seem to be the main factors accounting for the public's fear and rejection of people with mental illness. Bord (1971) argued that these factors were often derived from extraneous characteristics of the mental patients, such as social class and occupation, and were not necessarily related to the nature of the illness itself. In my questionnaire (see

Chapter 7), nearly 30% of the respondents (N = 72) believed that people with mental illness have a tendency to be violent, attack others, and are dangerous to self and others.

Although it is still not clear whether the mass media can actually change people's perceptions, as opposed to merely strengthening their existing beliefs, there is little doubt that they do influence people's perceptions (Anastasio et al., 1999; Champion & Furnham, 1999; Coleman, 1993; Corrigan, 1998). Corrigan (1998) suggests that the mass media have been a vehicle for communicating the societal experience of severe mental illness and in doing so tend to misrepresent reality. Persons with psychiatric disability suffer societal scorn and discrimination because of the stigma that evolves from these misrepresentations. This kind of rebuff frequently leads to diminished self-esteem, fear of pursuing one's goals, and loss of social opportunities for people with mental illness.

As I went through the newspaper clippings, I found that they are not one-sided. They do not report only the horror and tragic stories of the mentally ill. They do occasionally present success stories of persons with mental illness who became productive members of the community and educate the public about mental illness and how to maintain mental health. In Table 5, I include a few examples to illustrate this point. Sadly, this positive reporting is rare and is found mainly in the supplement section.. Among the newspaper clippings that I collected, the ratio of negative to positive articles was approximately 20:1. Negative reporting is often presented as the main news and often is on the front page.

**Table 5 Examples of news headlines/headers projecting positive aspect of mental illness**

Newspaper	Date	News Headlines/Headers	Quote / Remark
Ming Pao Daily News	9.9.1996	產後抑鬱分三級·攜子自殺悲劇怎預防? (Translation) Postpartum depression classified into 3 levels How to prevent murder-suicide of mother and child?	Description of postpartum depression with case studies, and the management methods.
Apple Daily	20.11.1996	健康專題之精神分裂症:精神分裂者徘徊幻覺與現實世界 (Translation) Special health report on Schizophrenia: Schizophrenics wandering between hallucination and the real world	A special report on schizophrenia. Information supplied by the Faculty of Medicine, The Hong Kong University and Queen Mary Hospital.
Ming Pao Daily News	8.10.1997	神經衰弱切勿灰心 (Translation) Don't give up on neurasthenia	An educational column written by a psychiatrist on neurasthenia and its treatment
Apple Daily	25.8.1997	性格異常,成績好到加零一 誰是天才,誰是瘋子 (Translation) Abnormal personality, but excellent in academic results Who is the genius and who is the loony?	A special report: a poor widower who brought up two daughters on his own till they both graduated from university. It was discovered both were mentally ill.
Ming Pao Daily News	27.2.1998	怪癖就是輕微精神病?基因組合觸發精神病 (Translation) Is weird obsessive behaviour a minor mental illness? Genetic combination triggers mental illness	Translated from Newsweek re genetic link to mental illness - "Shadow Syndrome." Debating whether deviant behaviour is a kind of minor mental illness.
Apple Daily	3.1.1999	精神病康復者售貨送溫情 新生會輔助就業令市民感覺一新 (Translation) Ex-mentally ill person selling goods with a warm heart. Supported employment of New Life Association brings fresh feeling to the public	A description of a supported employment programme run by a non-government agency for people with mental illness.
Apple Daily	10.6.1999	暖流:服務弱社群寫作撰心路 楊淑彝精神康復活得精彩 (Translating meaning only) A report on an ex-mentally ill woman who wrote about her experience	When asked whether she worried about other's prejudice as she stood out and declared that she was an ex-mentally ill patient, she gently but firmly said: "if I had not come out, there would never be any chance to make changes."

In addition to the above examples, the newspapers, on rare occasion, also publish information on alternative treatments for mental illness or methods for maintaining mental

health outside the Western psychiatric approach. Table 6 displays some examples among my collection.

**Table 6 Examples of alternate treatment for mental illness and alternate methods for maintaining mental health as reported in newspapers**

Newspaper	Date	News Headlines/headers	Quote / Remark
Ming Pao Daily News	19.8.97	精神病康復者自助六大門法 (author: 喬安妮) (Translation) 6 major self-help principles for ex-mentally ill persons	Using a case study to discuss the 6 ways of recovery from mental illness: 1. Divert your thoughts 2. Read different kinds of books 3. Have more contact with nature 4. Obtain more strength through prayer 5. Be aware of diet and rest 6. Listen to the advice of family and friends
Ming Pao	October 1999	中醫EQ：七情影響健康 (Translation) Emotional Quotient (EQ) in traditional Chinese medicine: 7 emotions that affect health	我們總以為EQ是西方人的產物，其實，這個有關情緒的 concept，在中醫學上有著較西方更長遠的歷史。美國科斯特蘭大學中醫學博士陳秀雯醫師把它歸納起來，以中醫角度分析EQ，不但有理論，還有治療情緒問題的食療及穴位按摩介紹。 (Translating meaning only) To view EQ from a traditional Chinese medical perspective. Content also covers introduction to diet therapy for emotional problems and acupressure point massage.
Seng Pao	31.12.1998	中藥抗狂劑 精神病者得安康 (Translation) Chinese medical anti-manic drug makes mentally ill persons settled and healthy	精神病在當今醫學界仍屬疑難之症。香港國際傳統醫學研究會高級會員、山西運城市醫藥科學研究所專科醫院副院長裴鴻醫師，在臨床三十多年中傾心研究探索各類精神病的發病機理及治療途徑，用該所研製出的純中藥製劑——抗狂劑，先後為海內外六萬多位患者解除沉痾之苦。 (Translating meaning only) Report of invention and successful clinical trial of anti-manic drug that is made of pure Chinese medical herbs in Mainland China.

There is a dilemma for both the press and the general public. The dramatised news headlines/headers and reports attracts readership so as to keep business viable and profitable. They feed the public with what they want — the news of human tragedies. Nonetheless, the media also feel their responsibility to be the voice of the people and the guardians of social justice. The general public, on one hand, is crying out for some kind of censorship on the newspapers. On the other hand, they chase after the news stories and prefer not to miss any so that they can become “knowledgeable” when they communicate with others. Applying the yin and yang analogy on the dilemma, the two counteracting

forces exist interdependently and interact. However, once one force becomes extremely dominant, it will give birth to the other force. At the moment, there seems to be an imbalance. The press are enjoying their “full” freedom of speech and exploiting opportunities to make profits, and yet ethical considerations and the social conscience of the journalists raise their concerns about social responsibility. The Hong Kong people are enjoying many media options and have inexpensive access to all information. This has led to an imbalance, and if such a desire is without limit, people will be given information that they may not need, or information that may have repercussions on theirs and the next generation’s mental well-being. Currently the pressure for bringing in media censorship seems to be gaining momentum in the community as observed in the mass media in Hong Kong (e.g. *Apple Daily*, 2 March 2000; *Ming Pao News Daily*, 8 November, 1999; *South China Morning Post*, 27 November, 1999).

### **Families With Mental Illness Projected In The Press Media**

Up to this point I have discussed the kinds of stories found in the local press and their potential impact on the general public. There is yet another aspect of the press that needs to be addressed: the impact on people with mental illness and their families. As we take a closer look at the newspaper stories of persons with mental illness and their families, we can easily identify a series of repeated stories of human tragedies and misfortunes. They also reveal repeated assaults on the families and the persons with mental illness, particularly those with severe mental illness. I discuss the analysis of the contents under the following headings: 1) counting the casualties; 2) suicide is a part of everyday life; 3) name calling; and, 4) the forgotten mental illness.

**1) Counting the casualties**

The following table (Table 7) displays brief statistics on the selected newspaper clippings collected over the last four years (March, 1996 to March, 2000). The criteria for inclusion for this analysis were: 1) the article was about people with mental illness or events (homicide, suicide, violence, and disturbance in public) caused by persons suspected of having mental illness; 2) the article appeared on the main pages of the newspaper; and, 3) the reported incidents happened in Hong Kong. If the incident appeared in more than one newspaper it was only counted once. Eighty-three articles were included for the statistics. These articles are only a sample and do not represent the exact number of incidents that occurred during the time of the study, which is likely to be greater.

**Table 7 Contents of news reports on incidents associated with people with mental illness (N = 83)**

<b>Classification</b>	<b>Frequency</b>	<b>Number of incidents where family member(s) were involved</b>	<b>Notes</b>
Fatal suicide	19 (23%)	1 (5%) (Injured by gas explosion)	
Suicidal attempt	7 (9%)	1 (5%) (Struggling to save the mentally ill relative)	
Violent threats (e.g. holding hostages, pointing a knife at others, setting flat on fire)	6 (7%)	5 (83%)	
Violence with bodily harm to other(s)	18 (22%)	13 (72%)	
Violence with bodily harm to self	1 (1%)	100%	
Homicide	15 (18%)	12 (80%)	(Including 4 incidents when the suspected mentally ill persons committed suicide after the homicide acts)
Public Disturbance (e.g. directing traffic, running naked in public)	17 (20%)		
<b>Total</b>	<b>83 (100%)</b>		

The most common incidents reported in the news headlines/headers were violent acts carried out by the mentally ill persons or persons suspected to be mentally ill. These acts included homicide, violence with bodily harm towards others, suicide, and public disturbance. On average, this kind of news appeared in the press at least once a month during the period of collection. Reports of homicide and severe bodily harm often appeared on the front page of the newspaper with colour photos of the scene. On a few occasions, the photographs were so horrific that they resulted in public complaints. Such presentations certainly present a vivid image of mental illness. If such images dominate the news, then they most likely influence public perceptions of people with mental illness.

One additional point suggested by the statistics in Table 7 is that family members are common targets and victims of the violent acts committed by people with mental illness; 83% of violent threats and 73% of violent acts reported in these articles were against family members. In the homicide articles, eighty percent of the victims were family members. The statistical results contrast sharply with the general public's fear for their own safety. The public generally presumed that they are the likely victims of violence from persons with mental illness and do not realise that the families of the mentally ill are almost always the victims and bear the brunt of this problem.

## **2) Suicide is a part of everyday life**

It may be cynical to say, "Suicide is a part of everyday life." In reality, I am just reflecting the situation, as suicide is common among people with mental illness, particularly those with depression, alcoholism, or a previous history of suicide attempts (Goldney, 1991; World Health Organisation, 1996). Out of the 83 articles I collected, nearly one-third of them were about mentally ill persons attempting suicide; completed suicides were the

majority. Among those suicidal reports (N = 26), 46% were by jumping from tall buildings and 19% had self-inflicted wounds, mostly by knife.

These suicides must be considered in the larger context of Hong Kong during this period. There were also many incidents of suicide among the general public at this time, particularly due to the Asian economic crisis when many people became unemployed or had gone bankrupt. In the Coroner's Report of 1997, as disclosed by the Hospital Authority and reported in the news (*Ming Pao Daily News*, 3 December, 1998, verified in the Coroner Report, 1997), there were nearly 600 cases of suicide, of which 48% were by unemployed individuals. The second largest group was housewives (13%). More than 200 persons died as results of falling from a height; most of these were identified as suicides. The figures became even more alarming in 1998. There were 868 persons committed suicide (Coroners Report, 1998). Among them, 444 were without occupation (including unemployed) and suicide among the aged, over 60 years old, was the largest group (285 persons, 33% of the total). If all incidents are examined closely, 468 persons jumped from a height and 283 chose hanging. In the 1996 Education Department's record 14 students committed suicide and 43 attempted suicide, with the age as low as 6 years (*Apple Daily*, 30 June, 1996). I do not imply that the political transition has caused more suicides. However, if we assume that suicide indicates an unresolved psychological or mental health problem, the statistics show that mental health is a broad community issue rather than one associated primarily with persons already diagnosed with a mental disorder and an issue that needs to be addressed urgently.

### **3) Name calling**

Despite the fact that mental illness includes a large spectrum of diagnostic categories and symptoms, among laypersons it is often associated with severe disturbances such as



schizophrenia and bipolar disorder. The presentation by the press has no doubt perpetuated this association. Reviewing all the newspaper clippings that I have collected, persons with mental illness or their acts are commonly described in the words or phrases listed in Table 8.

**Table 8 Common words and phrases used in news headlines/headers to describe people with mental illness and their acts**

精神病青年屋中縱火 (Mentally ill youth set house on fire)	精神崩潰自殺 (Mental collapse and suicide)
精神分裂青年墮樓 (Schizophrenic youth jumped to his death)	
精神病患者斬傷鄰人 (Mentally ill patient chopped and injured neighbour)	
失常老婦圖跳樓 (Old woman lost her mind and jumped from height)	精神有異常 (abnormality in emotion/mood)
神經漢扮交警 (Loony man dressed as traffic policeman)	裸婦狂奔 (naked woman ran wild)
父親家中發狂持刀見人亂劈 (Father suddenly went berserk at home and chopped others with knife)	情緒長期抑鬱釀悲劇 (chronic depression led to tragedy)
瘋保姆殺三婆孫復自吻 (Crazy nanny murdered grandmother and 2 grandchildren, then slashed her own neck)	精神病康復者 (Recovered/ex-mentally ill person)
狂漢推老翁出馬路輾斃 (Maniac man pushed old man into oncoming traffic)	精神分裂 (Schizophrenia)
產後抑鬱婦涉擲斃親女 (Postpartum depressed woman suspected of throwing her baby daughter to her death)	優異女生變狂躁 (Intelligent girl suddenly went manic) 躁狂症女生 (Manic Girl)
‘妄想症’女工索償 260 萬 (female worker with “delusion illness” asking for 2.6 million in compensation)	與母同患精神病有暴力傾向 (Suffering mental illness like his mother and having tendency for violence)

Words, such as loony, mad, berserk, crazy, and mentally ill are commonly used in the news headlines/headers and in news reporting in the mass media. With the increase of knowledge about mental illness, based on the dominant Western psychiatry, newspapers tend to use more general terms as adopted by the medical community. Perhaps we may say they have started to become more sensible than the general public at large when describing people with mental illness and their behaviour (see Chapter 7). However, when those words go together with the graphic details of an incident, plus “live” colour photos,

certainly the impact will be greater than words alone. The headlines/headers and phrases such as these (displayed in Table 8) certainly can make an impact on the public:

Mentally ill youth sets house on fire;

Father suddenly went berserk at home and chopped others with knife;

Old woman lost her mind and jumped from height;

Mentally ill patient chopped and injured neighbour.

A live horrific image is likely created in the reader's mind. The following is another translated extract from a news clipping to further illustrate my point.

駭人聽聞的倫常愕劇中，懷疑因精神病發在寓所中揮刀砍下母親頭顱，並將之拋出街外

In an ever-shocking family tragedy, a son, who is thought to have a relapse of mental illness, took a chopping knife and chopped his mother's head off at home, and he threw her head out of the window onto the street. (*Ming Pao Daily News*, 13 February 1997)

*(This was accompanied by two colour pictures showing blood and a head that was already covered by the police)*

### **5) *The forgotten mental illness***

Although the public tends to associate mental illness with severe psychiatric disorders, such as schizophrenia, bipolar disorders and major depression, the number of incidents of minor mental illness is on the rise, particularly among the unemployed and students. In the 3<sup>rd</sup> quarter of 1998, according to the Hospital Authority's record, the number of new referrals per month on the waiting list for psychiatry consultation was 60% higher than the same time the previous year (*Ming Pao Daily News*, 3 December, 1998). The following are summaries of the studies that were reported in the newspapers.

- 1) The Society of Samaritans, a charitable organisation that provides counselling services, reported that there were 3080 people asking for help from the Society between January to September, 1996, a 15% increase over the same period the previous year (*Apple Daily*, 3 November 1996).
- 2) A study on mental health among people aged over 70 by the Department of Psychiatry of the Chinese University of Hong Kong found that 7% had depression. This was particularly common among females and people in institutions. With 1034 persons interviewed in the study, only 5% of them recognized the symptoms. The causes of depression among the aged population were hypothesized to include: changes in family values and the elderly person's role; a trend towards nuclear family structure (and away from multi-generation household), unavailability of a well organized pension/provident fund system, and insufficient community support for aged persons living alone (*Apple Daily*, 21 May 1998)
- 3) A study of insomnia by the same department interviewed 9000 persons. It found that 6% of respondents reported frequent insomnia, while 15% reported having it sometimes. There were more female subjects suffering insomnia than male (*Apple Daily*, 25 April 1999)
- 4) A study of unemployed persons by the Christian Family Services Centre interviewed 221 unemployed persons over 18 using the Beck Depression Inventory between the end of 1998 and April 1999. It found that 44 % of the interviewees were within the normal range; 22% were emotionally disturbed; 34% suffered depression; and about 25% had thoughts of suicide. Among 123 married interviewees, 16% were having serious marital adjustment problems and 15 respondents were separated or divorced (*Ming Pao Daily News*, 13 December 1999).

People realise that they may be vulnerable to mental illness, but they may not realise the seriousness and impact until they become mentally ill. An old saying in Cantonese slang well represents such an attitude: “You never know how fire can hurt until you have been burnt.” The newspaper clippings are just like the tip of the iceberg in depicting the experience of mentally ill persons and their families; the problem is clearly larger and more insidious than the newspaper accounts might suggest.

### Summary

There is obviously a dilemma facing the press industry in Hong Kong. It can be perceived as the yin and yang forces at interplay in an attempt to reach a compromise or balance point. First, the press industry is a competitive business in Hong Kong where freedom of speech and access to information is the icon that signify the freedom that the Hong Kong people still enjoy after the transition. These freedoms are also the signals the Mainland Chinese government uses to convince the world that it is keeping its promise of non-interference in local affairs. In order to expand its market share and readership, each newspaper uses various methods. Besides the presence of a variety of articles or features and colour print, the press is inclined to use exaggerated news headlines/headers and graphic details to increase readership. The incidents associated with people with mental illness, particularly when violence is involved, are always good news stories that often provide great headline materials, as victimhood is a commodity for sales. Thus, persons with mental illness are often projected by the media as unpredictable, aggressive, violent and dangerous. This further perpetuates the public’s fears of mentally ill persons and makes the social stigma on mental illness inevitable.

The newspaper articles on persons with mental illness and their families reveal a series of repeated human tragedies, misfortunes, and assaults on the families and the mentally ill.

It would appear that families could easily become the victims of violence of the members with mental illness. The persons with mental illness also have high risk of committing suicide, as well as suffer from prejudice and derogatory name calling from the public. The articles also indicate that people with less severe mental illness often are unnoticed. This may be due to denial or ignorance in both individuals and the society at large.

In addition, some of the common explanations for the etiology of psychiatric disorders reported in the news are related to the family, such as heredity, retribution of ancestor's wrongdoings, and a reflection of poor guidance and discipline in the family. The family is not only subject to social rejection and isolation, but also is shamed by the identification of a mentally ill member (Kuo & Kavanagh, 1994). Thus, the sick individuals are not the only ones affected by the social stigma. Stigma also affects family members in terms of their marriage, work, and social network (see Chapter 9). All and all these situations do not help the families with mental illness to cope and adjust in order to preserve the valued family structure and function. In the next chapter, I will explore the concepts of mental illness among the general public and to what extent the press media has influenced their attitudes toward people with mental illness.

## Notes

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<sup>i</sup> The reasons for not choosing the newspaper most highly rated in terms of its trustworthiness were its higher cost, English language content and relatively smaller circulation. However, I did subscribe to the Saturday edition from which I collected a few articles for the analysis.

<sup>ii</sup> The Society for Truth and Light is a non-government watch-dog, pressure group set up in May, 1995. It aims to “police” mass media and promote public “policing” of the media; to lobby for legislation to impose censorship on the mass media with pornographic materials; to raise public attention to the accuracy of information on sex for adolescents. The organization often conducts public opinion polls on the conduct of the mass media, and holds street demonstrations against sex and violence in the media. (Source: *Ming Pao Daily News*, 8 November, 1999)

## CHAPTER SEVEN

### ***“But Not In My Backyard”: Concepts Of Mental Illness In Hong Kong — The View Of The General Public***

*“Haywire, loony, madness, crazy, psychopath”*

A respondent in the questionnaire survey describing persons with mental illness

#### **Introduction**

Although the introduction of the Western psychiatric classification system may have provided a means of systematic diagnosis and management of mental illness, it also has introduced undesirable social stigma towards people with mental illness in Hong Kong. It is even taboo to talk about mental illness in certain contexts, such as during celebration or festival times. The potential for prejudice and rejection is there, but action related to mental illness largely lies dormant unless stimulated by external events, such as political candidates using mental illness issues to gain public support or a major tragedy instigated by a mentally ill person (Pearson & Yiu, 1993).

The Yuen Chou Estate incident in 1982 is a good example of an event that shocked the colony. Before this incident people had never felt any immediate threat from persons with mental illness, particularly persons who were severely mentally ill. As noted earlier, in the incident an apparently relapsed mentally ill man went into a kindergarten of a public housing estate carrying a chopping knife. He killed several persons and injured a number of others, all of whom were teachers and children. He later was charged with 6 counts of murder and 19 counts of wounding with serious bodily harm and was committed to life imprisonment in a prison for forensic psychiatric patients. Following

that incident, which was publicised extensively by the mass media, the prejudice and rejection towards mentally ill persons among the public that had largely lain dormant emerged. As noted in Chapter 6, these negative attitudes have been maintained and occasionally are reinforced by subsequent the reporting of similar incidents. This chapter recaptures the discussion on social labelling and mental illness, and how has the Chinese concept of personhood strengthened the social stigma on persons with mental illness. Report of a survey of public attitudes towards people with mental illness is used to indicate the current situation.

### **The Social Labelling Of Mental Illness**

Lemert (1967) first proposed the “social response” or “labelling” theory. This theory is concerned with the effects of social experiences on a sick person (or any other deviant persons), and most particularly, with the processes through which society labels a person as “sick.” The theory draws our attention to what happens to a person after symptoms appear. This view is quite different from social psychiatry theory in which the concern is with social factors that contribute to the aetiology of mental illness. Labelling theory is not interested in explaining the primary cause of the initial psychiatric disorder, or “primary deviation.” Whether psychiatric disorder results from genetic factors, biochemical defects, certain family dynamics, or anomie is not important. Instead, what is important is how society responds to and processes the sick person once the symptoms have occurred. In fact, it is assumed that many such symptoms appear in many people at one time or another; yet relatively few people find their way into formal treatment systems and into the sick role. The theory predicts that it is the societal response to the person with psychiatric symptoms that is the prime determinant of whether he/she will remain sick and will receive treatment. It is the societal response to him/her that will



further determine whether s/he becomes a “secondary deviant,” that is, a person whose major role identification is that of a sick person (Lemert, 1967). Thus the career of the sick person is influenced, not by biological or social factors that have caused the severe or mild symptoms, curable or incurable illnesses, but by the ways his/her family, his/her neighbours, and, most significantly, his/her doctors respond to him/her once symptom occurs (Waxler, 1974, p.383). Waxler (1974) further argues that societies neither cause different rates of mental disorder nor tolerate different degrees of deviance; instead, depending on the contexts, they respond differently to psychiatric disorder as it occurs. Differences in societal response, in turn, account for differences in rates and outcome.

The social labelling theory of deviance provides concepts and hypotheses that help to explain how different societies may succeed in moulding the mentally ill person to match societal expectations. Of greatest importance in this process are the belief systems of the society and the extent to which the patient has power over his own role as a sick person. Waxler uses the example of the study by Murphy and Raman (Murphy & Raman, 1971; Raman & Murphy, 1972) to illustrate her point. In that study, people who received treatment for schizophrenia in the peasant villages of Mauritius were systematically followed-up. They showed that clinical symptoms and social performance after 12 years were significantly better than a comparable group of patients in Britain even though the Mauritian treatment was considerably more limited. Waxler explained that in societies such as Ceylon (Sri Lanka) and Mauritius, where beliefs about mental illness centre on supernatural causation and the person is not held responsible for his/her illness, where his/her “self” remains unchanged, he/she could shed the sick role quickly and easily. In contrast, where psychiatric illnesses are believed to involve personality change and personal responsibility, the sick person receives many messages that something is seriously wrong with his/her self. Consequently, his/her self-perception and behaviour

may conform to these messages and his/her illness may have a long duration (Waxler, 1974, p.379).

Later we will see that whether a person sees him/herself as sick, and the remedy or help he/she seeks is a more complex phenomenon. Such a perception is related to one's adopted explanatory model, i.e., the cognitive framework a person uses to make sense of the illness that he/she is experiencing and explain it to the others.

### **Mental Illness And Social Stigma**

The Chinese view of the cause of mental illness is multi-faceted (Lin & Lin, 1981; see also Chapters 3 and 9). It may be regarded as moral transgressions towards ancestors or social norms whereby the family is also held responsible. It also can be attributed to hereditary or even ancestral inheritance of misconduct, so that traditionally the sufferer, and sometimes even siblings, are excluded from marriage. Common beliefs also include cosmological forces, the wrath of the gods and ancestors, possession by spirits, demons and foxes, hormones, diet, brain dysfunction, and even political ideology (Lamson, 1935; Ng, 1997).

Traditional Chinese medicine has been largely "non-psychological" in orientation (Woo, 1989). It has generally been distinguished from Western medicine in terms of its "holistic" orientation, its concern with delineating larger patterns or configurations around illness rather than with isolating specific disease entities. While mental illnesses were historically classified into types in traditional Chinese medicine, as I have discussed in Chapter 3 the scheme was neither highly elaborated nor something that was continually refined (Liu, 1981), as in the case of Western psychiatry. Quite often, the illness is labelled as malfunctions of the organs or imbalance of *Qi*, and rarely is it diagnosed as specific as "mental disorder" in Western psychiatry. Woo (1991) also argued that while

mental illnesses in the West were historically differentiated from physical illnesses by the fact that they were “functional” disorders for which no organic or physiological cause could be found, the Chinese approach has been more biologically oriented from the start and continues to be so. Therefore, deviance among the Chinese that comes under the label of mental illness invites medical attention, instead of other forms of control, such as imprisonment or social sanction. Furthermore, the vague definition of mental illness in traditional Chinese and other folk medicines had contributed to the labelling process being awkward. Therefore, one could avoid the mentally ill label by using other explanatory models. In contrast, the requirement of precise diagnosis in Western psychiatry makes the assignment of the deviant label easier and, thus facilitates social stigma.

Throughout Chinese history, even in Mao’s period of the Cultural Revolution, there is a willingness on the part of the Chinese to separate the political from the medical issues and, at the same time, to explicitly acknowledge that political or social factors may be related to mental illness (Woo, 1991). Unlike the mentally ill, political deviants are deemed responsible for their actions and therefore sent to prisons or labour camps. Deviance is managed directly and forthrightly for what it is (Woo, 1991). Therefore, if a person is labelled as mentally ill, regardless of whether its cause is perceived as politically related, the sufferer will receive leniency and is expected to be cared for in a psychiatric hospital or at home.

The problems encountered in eliciting meaningful discussions about mental illness have to do not only with the culture-bound nature of the concept but with the fact that behavioural referents cannot be separated from the “context” in which they are viewed as deviant. That is, the labelling of mental illness depends as much on the labeller’s ability or inability to impute meaning, as it does on the presumably objective elements of the

phenomenon itself (Woo, 1991). (See also the section on “Culture and mental illness” in Chapter 1).

The introduction of Western Psychiatry into the Hong Kong health scene has changed the local concepts of mental illness or the definition of insanity. Whereas in the past insanity was a vague but multi-faceted concept now under Western psychiatry, the definition of insanity is more refined and systematic. Comprehensive diagnostic classifications have provided a repertoire of social labels, which are reductionistic and concrete compared with the diagnostic labels in traditional Chinese medicine and other folk medicines. Every diagnostic category not only has a specific name it also comes with an explicit description of aetiology, symptoms, signs, diagnostic procedures, and predictive prognosis. These provide a different vocabulary for people, particularly the professionals, with which to communicate. But this does not necessarily imply that laypersons are able to comprehend it. The preferential treatment given to Western medicine by the colonial government has helped spread such a system of definition and categorisation in Hong Kong. Woo (1991) criticises the fact that professionals working in the field of mental health often operate within recognisable diagnostic contexts, remediation and prognosis. In addition, their job descriptions are readily recognised and accepted. Nevertheless, it is a fact that categorisations of mental illness are artefacts of the need for researchers and funding agencies for precision (Castillo, 1997). They appear to elude many who teach and work within the health professions (Houston, 1986). Nevertheless, even today there is unquestioning acceptance of the validity and certainty of labelling and categorising those with dispositions to mental illness.

The specific bizarre behaviours (the pathological symptoms in Western psychiatry) that are described under each diagnostic label may help professional communication, but they increase stereotyping among the general population, especially when those labels are

associated with serious psychiatric problems, such as schizophrenia, bipolar disorders and major depression. Such stereotypes often are identified in the increasing number of empirical studies on the public's attitudes towards people with mental illness that have been conducted in Hong Kong over the last decade (e.g. Chou, Mak, Chung, & Ho, 1996; Hong Kong Council of Social Services & Mental Health Association of Hong Kong, 1997; Pearson & Yiu, 1993). Despite the public education programs on mental health and mental illness that have been implemented, negative attitudes toward mental illness appear unchanged since the introduction of Western nosological categories.

As is discussed in Chapter 4, the dominance of Western medicine in Hong Kong for 150 years has made it the "only" authentic explanation for disease occurrence and illness experience. The previous explanatory models and healing strategies for insanity that evolved over thousands of years are seen as unscientific, superstitious and "inhuman", and eventually they have disappeared or moved into the background. In their place a new system has been adopted which is alien, mechanistic and focuses mainly on curing, instead of balancing between prevention and caring. The impact of such a change on the families with mentally ill relatives will be discussed further in Chapter 9.

### **Concept Of Personhood And Social Stigma**

The formation and maintenance of the negative attitudes are not only the result of the mass media, but also are related to the social labelling generated from the Chinese concept of personhood. The Chinese concept of personhood, which defines a valuable and socially acceptable person, also defines normality and deviance in Chinese culture. The concept of personhood answers the questions: What is needed to be a full "capable" person, especially in adulthood and how important are individual ability and achievement as a source of social identity? Nevertheless, there is no universal set of qualities or

qualifications; nor is there any single answer for any specific culture. Further, assessments of individual's ability and achievement are ongoing across the life course and across situations and are, to some extent, negotiable (Armstrong & Fitzgerald, 1996). The Chinese have a unique concept of personhood — how to be a “full person” — which lays down the moral standard and social norms for labelling. Social labelling acts as a mechanism to create and develop social stigmas and prejudices towards mental illness and people with mental illness. The mass media, to a certain extent, simply assists in nurturing and maintaining those stereotypes, social stigmas and prejudices.

The characteristics that define of personhood show considerable variation across cultures in accordance with variations in core values, worldviews and environment of daily living. Armstrong and Fitzgerald (1996) propose two general types characteristics: attributes and achievements. Attributes refer to the physical and mental abilities that a person needs to carry out daily functions and socially expected roles. The ability to fulfil one's role as son/daughter, husband/wife, or worker/student is especially important in the Chinese context where it affects one's identity and value as a social person. Achievement characteristics are based on the person's productivity and sociability. That the person is able to earn an income and to connect with and be interdependent on others are important aspects of being a culturally and socially competent adult. The typical Chinese definition of a fully “capable” person is the ability to complete the life tasks as mentioned in Confucian classic literature, i.e., “*xiūshēn*、*qíjiā*、*zhìquó*、*píngtiānxià*,” (修身、齊家、治國、平天下), “cultivate yourself, have a family with children, govern the nation, and rule the world”. In a modern interpretation: be educated, marry and establish a family, develop a career, and excel in one's work. This is the ideal personhood that the ancient scholars believed one should seek. Perhaps in a patriarchal society like that in Mainland China and Hong Kong, the expectation is greater on a man than a woman.

Tang (1992, p.376) sums up the ideal person as the one who shows self-restraint, is in control of his emotions, places his family's needs above his own, recognizes and fulfils the duties of his role within the family, and pursues knowledge to the best of his ability with the goal of developing his character.

Furthermore, sociability is even more emphasised in Chinese culture. The ability to communicate with and relate to others in the society will determine one's personhood and social identity. One must integrate into society before he/she can be regarded as a person (Chu, 1972). If a person's behaviour deters him/her from establishing contact with others, or he/she does not have the ability to connect and interact with others in socially appropriate ways, his/her personhood and social identity will be diminished. As a result, he/she is seen as detached from the society. Therefore, the existence of a strong stigma towards people with mental illness among the Chinese is understandable. This is particularly the case for those who have difficulties in fulfilling the socially expected roles are lacking achievements, and are unable to establish social connections with others.

### **Studies On Attitudes In Hong Kong Towards People With Mental Illness**

Social stigma and prejudice towards people with mental illness are common in many societies, including Hong Kong. One consequence of this is that I had great difficulty in recruiting family members as informants for my study. They did not want others to know about their mentally ill members because of the fear of isolation and prejudice if friends or relatives found out. For example, one parent insisted that I could only interview her by telephone at a certain time when other family members were not at home. She explained that the family did not want her to talk to anyone about her son's mental illness. Another parent declined my interview for fear that the neighbours might find out about her mentally ill son, even though I assured her I would be happy to disguise myself

and come at the most appropriate time.

There are limited empirical studies that assess the public's attitudes towards mental illness in the context of Hong Kong. Studies of public knowledge about mental illness and how it compares to public knowledge in the West were rare until recent years. In 1986, the local council (or District Board as it is known in Hong Kong) conducted a survey in a satellite town in the New Territories. In this survey (N = 1500), three quarters respondents recognised different degrees of severity in mental illness and understood the importance of support from family, friends and the community. In spite of this, the same proportion of people admitted that their understanding and knowledge of mental health problems were insufficient and that they did not know where to seek psychiatric help. Their source of knowledge about mental illness was mainly from the mass media, whose information they acknowledged was either biased or incomplete in most cases (Sha Tin District Board, 1986).

In an analysis of textbooks and curricula in Hong Kong schools, Shek and his associates (Shek & Lam, 1985; Shek, Lam, & Lee, 1986) point out that information about mental health and illness presented to children is both inadequate and inaccurate. The researchers felt that children lack a sound foundation of mental health knowledge and this offers them little protection against a hardening of attitudes in later life.

A small-scale study by the Baptist Oi Kwan Social Service on the public's knowledge of mental illness was published in their newsletter around 1992 (*exact date unknown*).<sup>i</sup> It involved telephone interviews of 135 people in two selected districts in Hong Kong. According to their findings, twenty-seven percent of the respondents believed mental illness is caused by stress; twenty-five percent thought it is caused by erratic events. The other attributions include inheritance 13%, brain damage 12.5%, social environment 11%, family education 7%, and divine retribution 3%.



A telephone survey was conducted by the social service agency, Breakthrough (Yu, 1996).<sup>ii</sup> Nearly 1000 persons (N = 973), ranging in age from 11 to 59, were interviewed. They found that the general public had restricted or distorted views of mental illness. According to this study, mental illness is often perceived as a disease to be avoided and feared. People with such disease are viewed as dangerous and unpredictable.

Nevertheless, an earlier study showed some positive, though ambivalent, public attitudes towards people with mental illness. Pearson and Yiu (1993) interviewed 245 people who lived near the site of a planned halfway house for formerly mentally ill persons. In the study, pedestrians were interviewed on a main street next to where the halfway house was to be located. Every fifth person was stopped and asked if they would be willing to participate in a short interview; only 30 refused. The results indicate that on a whole the respondents did not express overwhelmingly negative beliefs about the mentally ill, or the imagined facility's impact. The researchers suggest that two factors might account for such a phenomenon. First, public education may have had some success in enhancing acceptance of the mentally ill. Second, respondents may be giving what they perceive to be the "correct" response to the interviewer, masking less sympathetic attitudes. Furthermore, people may have fewer difficulties in accepting the mentally ill in theory, but are more reluctant to bear the perceived cost or responsibility of a halfway house to be built nearby (Pearson & Yiu, 1993).

In a recent study, Chou and his associates (Chou et al., 1996) found that negative attitudes towards people with mental illness and the associated community facilities have not changed much despite the quite intensive public campaigns and education since the late 1980s. They conducted total of 1,043 successful telephone interviews in March 1994, based on a list of 2,202 valid telephone numbers. Although the response rate was about 60%, the authors claimed that the sample was representative of the Hong Kong adult

population in terms of sex ratio, age, educational achievement, and economic status. The purpose of the survey was to understand how the people of Hong Kong perceive mental health, mental illness, mental patients and mental health facilities. Results indicated that the majority of people in Hong Kong were very concerned about their mental health. Their knowledge of mental health was fairly good, using Western mental health concepts. Their attitudes towards mental patients and mental health facilities were, however, quite negative and similar to Pearson and Yiu's (1993) findings. This indicated the existence of a "but not in my backyard" phenomenon in Hong Kong, as nearly 40% of people were not willing to live near people with mental illness and preferred that rehabilitation facilities for the mentally ill be far away from the community. In addition, these views towards mental patients and their rehabilitation facilities, unlike previous Western findings, were weakly associated with socio-economic factors such as age, educational level, and household income (Chou et al., 1996).

Although the sampling methods of these studies may lead us to question the generalisability of their findings, they have consistently indicated the prevalence of negative attitudes toward mental illness and prejudice and rejection towards persons with mental illness. The study of Chou et al. (1996) shows that knowledge of mental illness is not a major determinant of the public's attitude towards people with mental illness. Knowledge of mental illness alone does not guarantee the acceptance of the mental patients as neighbours. The researchers hypothesise that either knowledge of mental illness that was not captured in the study is more related to attitude or there is really a gap between the knowledge and acceptance of the mentally ill (Chou et al., 1996). Ng (1997) supports the second hypothesis and explains that people are currently better informed about mental illness and seem to accept it like any other illnesses. Nevertheless, their feelings about persons with mental illnesses are not consistently shaped by this cognitive

awareness. “But not in my backyard” seems to be the common attitude toward reintegration of people with mental illness into the community. Imposing laws to change such an attitude does not necessarily solve the problem, as persons with mental illness will be put under the spotlight for public scrutiny. Even some persons with mental illness do not like the idea, as they fear that they may become easy targets as scapegoats. For example, I held a focus discussion group on equal opportunity in the workplace with five mentally ill persons who were living in a group home and were working or looking for open employment. When I raised the question whether there should be legislation to enforce equal opportunity, they responded that they did not believe that would happen in a business- and profit-driven place like Hong Kong. Most of them expressed their desire to find a job, but not by legislation that forces employers to employ people with a disability; instead, they wanted to get the job through their own effort and ability alone. Otherwise, they worried, they would be a likely target for mocking and prejudice by their colleagues.

### **The Questionnaire Survey**

As I am interested in the descriptive concepts of mental illness, as well as the nature and content of public attitudes toward persons with mental illness, an open-ended questionnaire survey was conducted to address these questions. The questionnaire survey is described here under the headings: a) background; b) the results of the questionnaire survey; c) summaries of responses; and, 4) discussion.

#### **A. Background**

In order to gain a more descriptive view of the concepts of mental illness and the attitudes toward people with mental illness among the general public, I conducted an open-ended

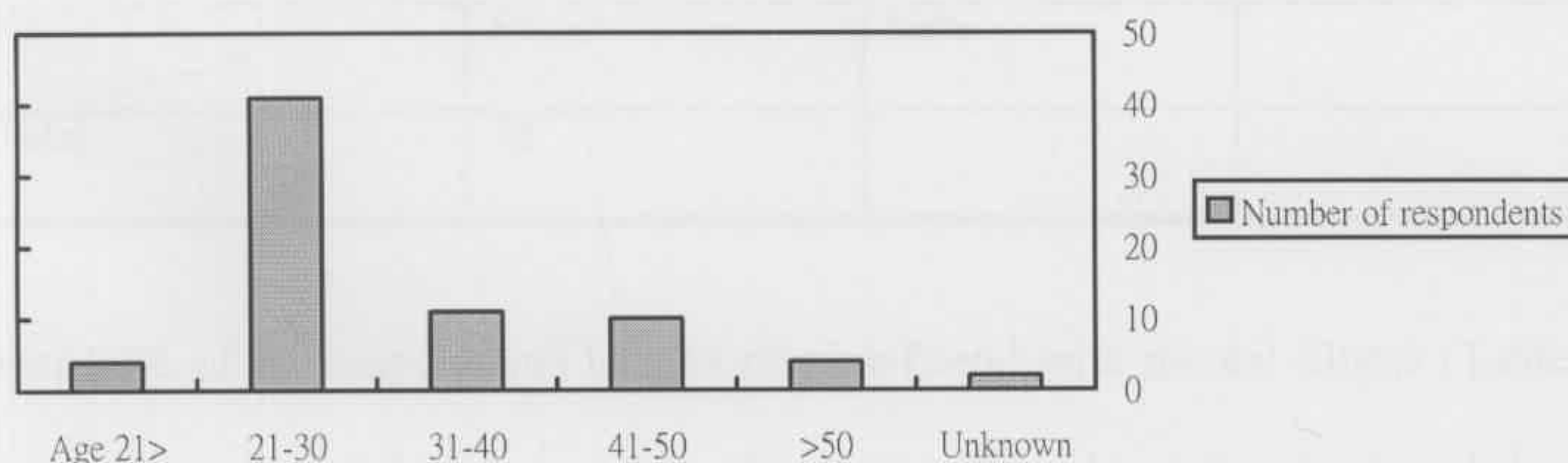
questionnaire survey (see Appendix I) between 1996 and 1997. The secondary aim was to examine to what extent the current public view matches the results of the previous attitude studies, thus indirectly measuring the influence of press media. The questionnaire items were constructed based on a review of the literature and the objectives of the study. As the methodology of the survey has been mentioned in detail in Chapter 2, I just want to highlight here that a convenience sampling method was used to recruit respondents by giving out an open invitation to my students and their relatives, neighbours and friends. Student helpers were recruited to distribute the questionnaires and to collect them later. Respondents were encouraged to answer the questions by either writing on the questionnaire or recording their answers on an audiotape, which was later transcribed.

At the end of the study, a total of 72 people had agreed to participate and responded. (See also Appendix V — the Summary of demographic data of the respondents). The following figures and tables summarise the results of the demographic and questionnaire data.

**B. The results of the questionnaire survey**

**1. The demographic distribution of respondents**

**Figure 2 Age Distribution of Respondents**



Over 50% of the respondents were in the age range of 21 to 30 (Figure 2), a larger percentage than in the general population. Two-thirds of the respondents were female (N = 53) (Figure 3). More than 80% of the respondents had secondary to university level of education (Table 9).

**Table 9 Level of Education**

EDUCATION	NUMBER OF RESPONDENTS	PERCENTAGE
Primary	5	6%
Secondary	15	20%
Post-Secondary	5	6%
University	47	65%
Total	72	

**Table 10 Relative with mental illness**

RELATIVE/FRIEND HAVING MENTAL ILLNESS	NUMBER OF RESPONDENTS	PERCENTAGE (N =72)	RELATIONSHIP	
Yes	13	18%	Friend	2
			Relative	2
			Colleague	1
			Not mentioned	8
No	59	82%		
Total	72			

Over 80% of the respondents had no relative/friend with mental illness (Table 10). For those who reported having mentally ill relatives/friends, sixty percent of them did not state the relationship. There was a wide range of occupations among the respondents,

with nearly 40% being university students (Table 11). Thus, a significant amount of the information collected represents views of young intellectuals. (Refer to Appendix V for the demographic data of the respondents).

**Table 11 Current Occupation of Respondents**

CURRENT OCCUPATION	NUMBER OF RESPONDENTS	CURRENT OCCUPATION	NUMBER OF RESPONDENTS
Student	28	Programme Officer	1
Housewife	9	Security Guard	1
Clerical worker	5	Retiree	1
Marketing (including director) employee	3	Social Worker	1
Administrative (including Assistant) officer/employee	2	Accountant	1
Supervisor (including sales)	2	Self-employed person	1
Teacher	2	Insurance Broker/Salesman	1
Manager	1	Nurse	1
Chinese Language Officer	1	Consultant	1
Civil Servant	1	Driver	1
Physiotherapist	1	Research Assistant	1
Church Minister	1	Caterer/Waiter	1
Quantity Surveyor	1	Bank employee	1
		Did Not State	2
		Total	72

**C. Summary of responses**

Responses for the major questions are summarised and discussed below:

**1. Description of mental illness**

Respondents were asked, “In your own understanding, what is mental illness?” Their answers were grouped into two categories: abstract philosophical responses and concrete behavioural observations. The majority of responses fell into the latter category. The abstract responses often were vague, generalised statements such as “mental imbalance,”

“psychological or emotional abnormality,” and “loss of control over (either self or own thought).” The concrete responses described mental illness according to either observed behaviour or the assumed aetiology.

The concrete behavioural observations can be categorised into the following themes and sub-themes: (A) internal factors (organic/genetic factors and physical illness, emotional or psychological problems, and thought disorders); and (B) external factors (observable behavioural deviations and functional deficits). It is interesting to note that the responses were similar to those for the next question: “What do you think are the possible causes of mental illness?” Thus, the cause of the mental disorder seems to define the meaning of mental illness.

An interesting observation from the responses is that the use of popular local terms for mental illness, such as “haywire (short circuited)” and “loony (*sh'en jing*),” were not common in this survey. In fact, a significant number of responses were similar to academic or textbook descriptions. This, perhaps, might be due to the fact that about 80% of the respondents had education at the secondary school level or above.

## **2. The causes of mental illness**

The respondents were asked, “What do you think are the possible causes of mental illness?” The perceived causes of mental illness could be categorised under four major aetiologies: organic and genetic, thought disturbance or inappropriate life philosophy, psychological or emotional, and environmental. Most of the respondents believed that mental illness is caused by a combination of these four.

### **a) Organic and inherent factors**

The examples that the respondents listed include brain damage or brain injury due to external source (e.g., a blow to the head), hormonal imbalance, congenital deficits, birth

trauma, biochemical imbalance in brain's neurotransmitters, and inheritance.

b) Inappropriate thinking

The examples include: immature thinking (思想不成熟), "wrong" values, excessive or low self confidence, unrealistic plans or goals, inability to face reality (不能面對現實), distance between own thoughts and reality, lack of guidance resulting in thoughts becoming extreme (自己的思想離開現實太遠，越想越極端，沒有正確引導), inability to resolve problems, and inability to detach self (自己不能解決問題，不能解脫自我).

c) Psychological or emotional factors

The psychological or emotional factors that were thought to cause mental illness include emotional disturbance or emotional trauma due to loss or grief, excessive anxiety, emotional over-stimulation, depressive personality, preoccupation with an unsuccessful experience or unachievable desire, and childhood tragedy, and so on.

d) Environmental factors

The major environmental factor that was indicated by the respondents to cause mental illness was not bad *fēngshui* or Karma, but the inability to cope with or release stress. The identified sources of stress included relationship or family problems, financial worries, work, study (school), over-crowded living environment, prolonged loneliness, failure, death of close relative, abuse, and a fast-paced life. Difficulties in relationships were repeatedly highlighted and included not being able to communicate properly or effectively and being misunderstood by others.

It is interesting to note that, in contrast to frequently reported causes of heredity, hormones, and brain dysfunction, no respondent related the cause to traditional beliefs such as cosmological forces, the wrath of gods and ancestors, possession by spirits, and



demons and diet (Lamson, 1935). It appears that the Western psychiatric concepts have dominated the explanatory models of mental illness among this sample.

### 3. The perceived characteristics and behaviours of a person with mental illness

“What are the typical characteristics and/or behaviours of a person described as ‘mentally ill’?” Most of the responses described a generalised impression of people with mental illness. The commonly used phrases or words can be categorised under the following headings: describing emotional presentation, personality, behaviours, appearance, and social interaction. The following are just a few examples:

- a) Describing emotional presentation: frequently laugh madly, crying loudly, temperamental (經常傻笑，大哭，大吵大鬧), emotionally labile (情緒大起大落), depressed (憂鬱), and anxious (緊張);
- b) Personality: hot temper (暴躁), suspicious (多疑), having suicidal tendency (有自殺傾向), asocial (自閉), self-indulging (內向), not being brave enough or cowardly (膽小), egocentric (自我), loner (孤僻), and lacking a sense of security and fearful in facing reality (怕面對現實);
- c) Behaviours: tendency to be violent (有暴力傾向), always talking and self-muttering (時常說話 自言自語), uncontrollable hands and leg movements (不能控制手足活動), losing control if stimulated or provoked, up to the stage of harming others (受刺激，會行爲失常，甚至有危害他人的行), fear of strange persons and environment (害怕陌生人和環境), behaving strangely (行爲怪異), harming others and chopping people (亂打人，斬人), appearance of strange and abnormal behaviours (行爲古怪，失常), hyperactivity or passivity (過份

活躍或被動), having visual and auditory hallucinations and self-muttering (有幻覺, 幻聽, 胡亂說話, 自己對自己說話);

- d) Appearance: untidy appearance (儀容不整), looking dull (神情呆滯), depressed (憂鬱), do not know what oneself is doing (自己不知道在做甚麼); and,
- e) Social interaction: tendency to be self-indulging and have less communication (偏向內向/寡言), difficult to talk to others or do not like to work (不善與人溝通 / 不願工作), and lack of social interaction skills (缺乏社交技巧及能).

Only three respondents described that there are different types of mental illness and, thus, each person would present with different symptoms/behaviours. Nearly 30% of respondents believed that people with mental illness have a tendency to be violent, attacking others, and are dangerous to self and others.

#### **4. How others described mental illness and people with mental illness**

To check whether what respondents reported is the same as what they have heard, I asked them: “In your experience, how do other people describe mental illness and persons with mental illness?” The two types of responses show some similarities. The most commonly used terms to describe people with mental illness by others, as perceived by the respondents, were “haywire (short-circuited),” “crazy,” “lunatic/loony.” People with mental illness were described to be “violent, dangerous and harmful.” They are to be avoided or separated from “normal” people due to their “strange or abnormal behaviours” (see Table 12). A good example to define the term “haywire (short-circuited)” was given by one of the respondents.

What is “haywire?” It is when they [people with mental illness] are scolding others everywhere, chopping up others, etcetera and etcetera ... abnormal behaviours. Abnormal

behaviour is, as I have said, when what they do or produce has deviated from their usual practice or habit. It can possibly be the sign of mental illness.

### **5. How people with mental illness are treated**

The respondents were asked: “In your experience how are people with mental illness treated?” A few people claimed they had no experience with people with mental illness so they could not answer the question. The responses of the rest could be divided into two groups: positive and negative. Within each of these two groups, the responses could be further categorised into passive and active, where active means that the action is obvious and is initiated by the person towards people with mental illness, while passive action is the opposite (see Table 13).

**Table 12 Words or terms used by others to describe mental illness and people with mental illness**

WORDS/TERMS USED NUMBER OF RESPONDENTS = 72	NUMBER OF OCCURRENCE IN THE RESPONSES
Haywire (Short-circuited) (竊線)	28 (39%)
Dangerous/violent/harmful (有暴力傾向/有攻擊性/危險)	15 (21%)
Crazy (顛) 、(佢會發神經架) 、(瘋)	14 (19%)
“Loony, lunatic” (神經、發神經)	12 (17%)
Mad (傻傻地、傻的、傻佬)	11 (15%)
Strange/abnormal behaviours (行爲異於常人、行爲失常)	10 (14%)
To be avoided or separated (不要走近他們，不要刺激他們) 、(需要隔離)	10 (14%)
To be feared or horrible (生人勿近) 、(無端端鬧人，打人，情緒不受控制) 、(恐怖)	8 (11%)
Stupid/low intelligence/ mentally handicapped (弱智人士、白痴、白痴仔)	7 (10%)
Uncontrollable 失控	5 (7%)
Murderer/psychopath (殺人狂、心理變態)	5 (7%)
“Incurable” disease (無得醫) *	5 (7%)
Superstitious/possessed by evil/retribution for previous wrong doing (被“鬼上身”) *	4 (6%)
Dirty/poor appearance(儀容不整), Dress abnormally (衣不稱身、不修邊幅)	4 (6%)
Impulsive/annoying/manic (不受控制、乞人憎、瘋子)	4 (6%)
Emotionally Disturbed (情緒混亂、時常情緒不定)	4 (6%)
Self muttering/laughing (自言自語，問非所答、喃喃自語、語無倫次)	3 (4%)

*\*Terms used to describe mental illness. The rest of the terms/words were used to describe persons with mental illness.*

*Respondents might give more than one term/description. Percentage represents the frequency of the description being given by the respondents.*

**Table 13 How people with mental illness are perceived to be treated**

POSITIVE		NEGATIVE	
Passive	Active	Passive	Active
<ul style="list-style-type: none"> <li>Show sympathy &amp; pity</li> </ul>	<ul style="list-style-type: none"> <li>Show compassion/support</li> </ul>	<ul style="list-style-type: none"> <li>Cold or unfriendly attitude</li> </ul>	<ul style="list-style-type: none"> <li>Scold (including health care professionals)</li> </ul>
	<ul style="list-style-type: none"> <li>Respond similarly to them</li> </ul>	<ul style="list-style-type: none"> <li>Distancing, avoidance or ignoring</li> </ul>	<ul style="list-style-type: none"> <li>Discriminate</li> </ul>
	<ul style="list-style-type: none"> <li>Show care &amp; concern</li> </ul>	<ul style="list-style-type: none"> <li>See them as non-human</li> </ul>	<ul style="list-style-type: none"> <li>Walk away if see them coming</li> </ul>
	<ul style="list-style-type: none"> <li>Talk to them</li> </ul>	<ul style="list-style-type: none"> <li>Afraid of them</li> </ul>	<ul style="list-style-type: none"> <li>Criticise, tease</li> </ul>
	<ul style="list-style-type: none"> <li>Supportive staff or therapists in action</li> </ul>	<ul style="list-style-type: none"> <li>Have no trust in them</li> </ul>	<ul style="list-style-type: none"> <li>Hostile or ordering the mentally ill person around</li> </ul>
	<ul style="list-style-type: none"> <li>Assist in activities of daily living</li> </ul>	<ul style="list-style-type: none"> <li>Less sympathetic toward them than other disabled persons</li> </ul>	<ul style="list-style-type: none"> <li>Take their photo without consent</li> </ul>
		<ul style="list-style-type: none"> <li>Pretend not to see when they display odd behaviours on the street</li> </ul>	<ul style="list-style-type: none"> <li>Throw stones at them</li> </ul>
			<ul style="list-style-type: none"> <li>Irritate them</li> </ul>
			<ul style="list-style-type: none"> <li>Give them a staring look</li> </ul>
			<ul style="list-style-type: none"> <li>Send them to psychiatric hospital, psychiatrist</li> </ul>
			<ul style="list-style-type: none"> <li>Keep them at home or send them to wander on the street</li> </ul>
			<ul style="list-style-type: none"> <li>Too scared to walk with them or share a table</li> </ul>

A few respondents also expressed ambivalence towards people with mental illness.

Have to pay attention to their reactions and do not try to run away to embarrass them. Nevertheless, we have to keep a distance, otherwise, they will only create more trouble for us.

Ignore them and afraid of them. Care about them, but that may break your heart.

Talk to them as you talk to normal people, but only limit to greeting.

**6. Can mental illness be cured?**

**Table 14 Attitudes toward the curability of mental illness**

	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Absolutely Yes	4	6%
Yes, but depends	35	49%
No	29	40%
Don't know or not sure	3	4%
Did not respond	1	1%
Total	72	100%

When respondents were asked whether they believed that mental illness could be cured and why, few (6%) believed that mental illness could be cured. They believed that either the illness is curable due to advances in medical science, or it is only a psychological defect and not a terminal disease. Nearly 50% of respondents indicated that they believed mental illness could be cured, but that recovery depends on the presence of the following factors: 1) severity of the illness — the less severe the higher likelihood of a cure; 2) compliance to medical treatment and therapy; 3) family support; 4) social acceptance; 5)

ability to cope or absence of stress; 6) caring doctors and health care professionals; and, 7) religious belief. According to the respondents, these factors would help the mentally ill person to recover and maintain a normal life.

In contrast, 40% of the respondents believed that mental illness could not be cured. Their reasons or explanations included: 1) it is a kind of irreversible brain damage; 2) there is a great chance of relapse; 3) medication can only control the symptoms but can not take away the illness; 4) there are insufficient resources for rehabilitation; 5) the perseverance of social stigma; 5) it is a congenital or genetic problem which is irreversible; 6) bad experience has been “implanted or crafted” in the patient’s life; 7) the persistence of life stress; and, 8) “not knowing the cause of mental illness, how can one be treated!”

#### **7. How mental illness should be treated**

A follow-up question was asked: In your opinion, how should mental illness be treated? Forty-two respondents (58%) answered the question. They suggested that mental illness could be cured with various combinations of medications, counselling, learning new attitudes or skills, support from family and friends, social acceptance and living in an appropriate environment with minimal stress. Four respondents emphasised the importance of identifying the cause first and then the treatment accordingly. Over half of the forty-two respondents believed that medications could cure the disease or at least help the mentally ill person to control their own emotion. It is interesting to note that a small number (N = 8) felt that persons with mental illness needed to see a doctor (general practitioner) or psychiatrist or to be hospitalised until they become well enough to live in the community. Besides medication and counselling, many respondents also thought that

the family's and friend's support (N = 11) or social acceptance (N = 9), are also two of the determining factors for whether the mental illness can be cured or not.

### **8. How persons with mental illness should be related to**

This question, together with the previous one, was intended to see whether the respondents make a distinction between the illness itself and the individual who has the illness. There were 22 respondents (30%) who either gave no answer or claimed to have no opinion. Two of the respondents' answers were similar to those in the previous question. Thus, 66% of the respondents who answered this question did make this distinction. They also tended to indicate more positive attitudes towards people with mental illness. The attitudes mentioned include: acceptance, treating them equally or like "normal" people, "love and patience," being helpful, and caring. Some felt that we needed to treat them as "normal" people, but should not add stress to their lives or, literally, "not over-stimulate or pressurise" them.

### **9. Persons with mental illness experience more discrimination**

The respondents were asked whether they thought people with mental illness experienced more discrimination than those who had other types of disability or illness. Eighty-two percent thought this to be the case. Here are some of their explanations.

I believe the mentally ill people face more social prejudice. It is because, under normal and non-dangerous (harmful) circumstances, people tend to show more caring and loving attitudes toward people with disability or illness because of their compassion and sympathetic hearts. However, when they are face-to-face with the mentally ill persons, they often assume that they are dangerous and violent. Even when they appear to be calm and stable, people still tend to assume them to be potentially emotional. Therefore, people often



take a separatist attitude toward them and show more social prejudice toward them (people with mental illness).

Mentally ill people are not always alert. Thus, they do not know how to protest or be assertive even when they are being discriminated against. Thus, people will more permissively and severely criticise or attack them.

Yes, certainly! Because people with other disabilities or illnesses have self-control and are able to know right or wrong, what is permitted action or not. For those with other disabilities, they tend to be accepted and helped by compassionate and kind people as they are pitied and not dangerous to others. For the mentally ill, their illnesses are caused by psychological reasons. Once they cannot control themselves, they may harm others. Therefore, even those compassionate people are driven away. But when you think harder, they [people with mental illness] are very sad and pitiful. They do not receive help or sympathy from others.... but what can you do! Everyone needs to protect her/himself.

A few respondents (N = 10) thought that people with mental illness do not experience more discrimination than people with other disabilities.

Their appearance (the mentally ill person's) is not much different from the general public and is difficult to notice.

[It is] because others will find it difficult to notice whether a person is mentally ill or not. Therefore, discrimination will not happen immediately.

If they do not relapse, they will look like "normal" people, thus, they will not experience more discrimination.

## 10. Mental illness is not a modern illness

There were 69 respondents (96%) who responded to this question: “Do you think mental illness is only an illness in the modern world?” Among them, 84% stated that mental illness is not only a contemporary illness. The explanations that they gave included: 1) stress and emotional disturbance in people have occurred throughout history, although the contents of stress may be different; 2) “crazy people” are documented in Eastern and Western literature throughout history; 3) it is an hereditary disease, but more stress in the modern world leads to an increase in the number of patients; 4) the causes of mental illness are varied, including physical injury, abnormal thoughts and other external pressure or factors; and 5) it was not noticed in the past due to limited knowledge about the disease and it was usually explained by what we consider superstitions reasons. The most common example they gave to indicate that “crazy” people existed in history is Emperor *Qin Shǐhuáng*, the first emperor of united China, who brutally wiped out his enemies by burying them alive!

On the other hand, there were a few who believed that mental illness is only a modern disease. The explanations they gave can be summarized into three factors: 1) the modern world is filled with stress; there is more competition and a greater the desire for a better materialistic life; 2) lack of a clean environment and of personal space for relaxation; and, 3) human relationships have become more complicated.

It is because in this current competitive society, those who are psychologically weak will experience failures or relationship (courtship) failures. They may not be able to cope immediately. If we return to the more primitive society, where there was no material temptation and no competition among humans to compete with each other or to seek a higher quality of life, or more money or achievement, then mental disturbance would be less likely to occur.

In today's society, there is too much stress in our life: work, pressure from family, and human relationships are becoming less close. These will lead to an increase in the number of mentally ill patients.

### **11. The incidence of mental illness is perceived to be increasing**

For the question: "Do you think the incidence of mental illness is increasing? Why?", ninety percent of the respondents answered "yes" and 8% answered either "don't know" or "not sure". Only two respondents said no; one explained:

It is because we can start solving the problem through education. It will be better for the next generation in terms of education, quality of life and environment.

### **12. Traditional Chinese medicine in treating mental illness**

When the respondents were asked whether they believed that traditional Chinese medicine is effective in treating mental illness, the answers were quite divided. Thirty-three percent of respondents' answers were positive, twenty-eight percent negative and thirty-three percent said they did not know or did not have sufficient knowledge to comment.

Those who thought traditional Chinese medicine is effective in treating mental illness cited the following reasons: 1) it must have value to have existed for so long a time; 2) some traditional Chinese medical interventions, such as acupuncture, herbal medicine, acupressure, massage and *Qigong*, are effective in treating some illnesses or diseases.

Traditional Chinese medicine has been passed down in history for a long time and it must have its values.... It is only that there is inadequacy in the theoretical and scientific bases of Chinese medicine. Therefore, it has not been systematically developed and passed down in history.

Like the Western medicine, traditional Chinese medicine, to a certain extent, can be helpful in treating mental illness and should not be ignored. This is what we call “take the best to compensate for the inadequacies; complimenting each other and developing each other’s strength.”

It is because Chinese medicine is wide and deep. Until now, there have been continuous developments and expansions in the application of Chinese medicine. A lot of its treatments have greater influence than the Western medicine, such as *Qigong* therapy, massage, and Chinese herbs. Therefore, there might have already been effective treatments a few hundred years ago [for mental illness]. Unfortunately, they were gradually lost in the last few hundred years.

I think Chinese medicine must also have its effect in treating mental illness. For example, Chinese acupuncture has been used to treat neurological problems. Nevertheless, I have not heard how effective Chinese medicine is in treating mental illness, but I do hear the extent of Western medicine in controlling the exacerbation of illness.

In addition, some responses were categorised as philosophical because the respondents perceived the mental health/illness phenomenon in a more idealistic, intellectualising manner. Here are some examples:

In every era of history, there were different methods of treatment used. Some people in the past also wanted to have long life! I think they used herbal medicine for treatment. On the other hand, modern people tend to prefer Western medicine for treatment.

Without doubt *Qigong* can give people an opportunity to release depression and doubt that have been kept in the heart; and to provide opportunities for people to rest and to reduce the burden of thought. It can be counted as a treatment for the mentally ill.

[It is] because there is a possibility that mental illness and the neurological system are related, and acupuncture can trigger reactions among neurological transmitters and stimulate the brain. It belongs to non-drug oriented natural therapy, but herbs will not have such an effect.

As Chinese acupuncture can help to relax the patient's nerves which leads to a relaxation effect, thus it resolves the insomnia problem. And I believe it is useful.

I do not believe there is any kind of medicine that can cure mental illness. But I believe Chinese medicine is more helpful because it has fewer side effects.

Doctors always treat people. It does not matter whether it is Chinese medicine or Western, there must be a way to treat any illness or disease. I absolutely believe that Chinese medicine is effective for mental illness.

### **13. Experience with relatives or friends with mental illness**

There were only 23 (32%) respondents who answered this question: if you have a relative or friend who has or had a mental illness, describe your thoughts and experience with him/her. Their experiences and thoughts of associating with a friend or relative with

mental illness included acceptance, concern, care, sympathy, avoidance, annoyance, fear, and horror. The following are a few examples:

I have attempted to understand their feelings and then encouraged them to try again....

Gave them care and concern.

Basically, they are no different from the “normal” people unless they are stimulated by something that makes them angry or excited. Actually, they are very nice.

At the beginning, I felt it was very sudden and I did not know what to do.

When I was about two or three years old, my auntie suffered from schizophrenia. She was hospitalised in CPH. But now she seems to have recovered and her behaviour seems to be normal. Under normal circumstances (until now), she behaves as “normal” as us. But if she has some problems that she can’t solve by herself, e.g., when she is concerned about her grown but unmarried sons and daughter, she will have some “abnormal” behaviours, e.g., crying loudly, blaming herself, and so on.

She also often thinks that things at home are obstructing her and that she needs to throw them away. She will throw them out through the window or take them to the rubbish depot.... When I visit her at times, she mostly goes to sleep or paces around the flat and self-mutters. I dare not to look at her because I am afraid that she may be angry. I take no notice of her because I want to avoid her.

When I first found out that she had mental illness, I felt helplessness. I did not know what to do to help her. Later, I used a lot of time to pray for her. There was a very kind-hearted

doctor helping her, plus her circumstances were relatively good, and she found out that people with mental illness could recover.

Unpredictable, no [common] sense, troublesome, frightening.... Suddenly moves in front of you and holds your forearm, and asks you to [go out] for dinner together. Making herself look cute despite the fact that she is close to 40 years old.

Try to avoid him, but sympathise with him.

Even though he is my relative or friend, I still do not feel natural [comfortable]. I won't discriminate against him. I won't let him know that I have such a feeling. I will try my best to see him as a "normal" person.

#### **D. Discussion**

As I took a closer look at the results of the questionnaire survey, I found that they revealed more in-depth information that would require further interpretation. It is discussed under the following sub-headings: 1) dimensions of attitudes toward people with mental illness; 2) perceptions and Attitudes toward people with mental illness: A closer look; 3) personal reflection on my own attitudes towards people with mental illness; and, 4) context, concept of personhood and the implications.

##### **1. Dimensions of attitudes toward people with mental illness**

Attitudes towards people with mental illness can be classified on four different dimensions (Taylor, Dear & Hall, 1979), i.e., authoritarianism, benevolence, social restrictiveness, and community mental health ideology. Authoritarianism refers to a view of the mentally ill person as someone inferior who requires coercive handling.

Benevolence corresponds to a paternalistic and sympathetic view of the mentally ill person that he/she needs to be taken care of. Social restrictiveness refers to the belief that the mentally ill persons are a threat to the society and should be avoided. Community health ideology concerns the acceptance of mental health services and persons with mental illness in the community. A review of the responses on the questionnaire survey, as well as findings in other studies, it is not too difficult to identify examples for these four dimensions. In the frequency count on the responses to the questionnaire shown in Table 12 and 14, it appears the responses reflect mostly the authoritarianism and social restrictiveness dimensions. Even those with sympathetic attitudes towards people with mental illness are still ambivalent about where to place the mentally ill person in the society. People feel that they need to be protected from the mentally ill persons in case they lose their minds, i.e., relapse again, while they also deserve to be treated decently.

## **2. Perceptions and Attitudes toward people with mental illness: A closer look**

The findings from my open-ended questionnaire survey were similar to those of previous studies in Hong Kong. Respondents were able to describe some of the symptoms and signs, as well as aetiologies, of mental illness as described in the Western texts. It is likely that they obtained the information from textbooks and the mass media, including newspapers and television programs produced by public and private television stations. Despite this knowledge, their attitudes towards the mentally ill are still quite negative and they focus on themes of fear of violence and unpredictable outbursts of aggression among people with mental illness. They even felt vulnerable, helplessness, and hopelessness in avoiding or changing the situation. For example, some respondents said people with mental illness are very sad and pitiful, yet they do know what they can do except to protect themselves from the mentally ill persons.



In addition, economic factors may have also contributed to the ambivalent attitude toward the mentally ill persons in Hong Kong. The middle class and professional groups are those most likely to be living in private housing in Hong Kong. Due to the scarcity of land and high speculation on the property market, the value of private properties is high and often means a significant investment. An institution or community centre for mentally ill persons within or near the compound will adversely affect the property value. Thus, the investment return will likely be reduced. The findings of the study on public attitudes towards mental illness by the Hong Kong Council of Social Services and the Mental Health Association of Hong Kong (1997) actually indicate such a factor. The study concluded that personal interest and the perception of people with mental illness as a threat are the two major factors that affect public attitudes — sense of insecurity, fear of unpredictable violent behaviour, devaluation of property prices.

After reviewing the literature on public attitudes toward mental illness, Rabkin (1974) commented that medical researchers more frequently produced studies indicating positive attitudes while social scientists obtained more negative attitudes. It also has been noted that methodological techniques are important determinants of the outcomes of attitude surveys. Closed-ended interviews had more positive results and open-ended interviews or self-response questionnaires had more negative results (Brockman, D'Arcy, & Edmonds, 1979). This may explain the negative findings of the open-ended questionnaire survey.

Furthermore, despite the fact that mental illness includes a wide spectrum of diagnostic categories and symptoms, respondents may consider severe mental illness, i.e., schizophrenia and bipolar disorder. As I have discussed in the previous chapter, the dramatised and sensationalised projection by the press media on the violent acts of the persons with mental illness has no doubt perpetuated this association.

However, people seem to ignore the fact that newspapers frequently publish articles on other psychological problems or mental illnesses, e.g., youth's mental health (*Ming Pao Daily News*, 24 April, 1999), insomnia due to stress (*Ming Pao Daily News*, 25 April, 1999), and anorexia among teenagers (*Ming Pao Daily News*, 5 October 1999), etc.

### **3. Personal reflection on my own attitudes towards people with mental illness**

When I reflect on the survey findings and relate them to my personal experience, I immediately identify with the feelings of vulnerability and fear, and I share the attitude of “but not in my backyard”. An actual incident happened to my close relative who worked as a mental health care worker in a day-activity centre for former patients of mental illness. It happened one day when one of the clients apparently relapsed and developed a persecutory delusion that staff, including my relative, were threatening him. He threw temper tantrum and went home. Two hours later he came back with a chopping knife and threatened to kill everyone that he thought was persecuting him. Though later he was calmed down and his father was called to take him home and a follow-up appointment with his psychiatrist was booked, my relative still felt very vulnerable and worried, as she did not know whether he would come back. When I was informed about this incident, I shared this feeling of vulnerability and was concerned about her safety. On one hand I comforted her that he should be quite “well looked after” now by his father and the doctor treating him. On the other hand, I advised her to take the safety precaution of a few days leave to wait for the situation to “cool down,” as there was still a chance that he might get “out of control” again. Despite the fact that I work, study, and advocate for people with mental illness, I just could not help developing the feeling — “not in my backyard” for that moment.

The cognitive understanding and emotional response to an incident do not always

match. This may be one of the reasons why the defensive or negative attitude towards mentally ill persons is difficult to change despite good public education on the matter. However, we can also see the phenomenon from a different perspective. It is the behaviours which are behind the issue — the socially unacceptable behaviours — that cause the fear, anxiety and other reactions. With a lack of understanding of mental illness people, we do not know who is likely to present a danger. In fact, the media coverage encourages people to think that all people with mental illness are potentially dangerous.

The fear of persons with mental illness is contextualised, i.e., depending on the context in which mental illness is being interpreted. As I deconstruct my understanding further, the fear towards persons with mental illness is no different than the fear toward triad members or any people with a violent intent. In spite of this, society has a stereotyped view that all violent acts are associated with someone that is not “normal”, as “normal” people will not take such actions. Even when the newspapers report violent acts, they often include a comment that the suspects may be mentally insane, (whether or not there is any evidence for the statement).

We are living in a modern city where violence seems to be an inevitable thing and we live everyday among people with different kinds of mental illness. The ambivalent attitude may also be a product of the fact that mental illness has a broad spectrum. As illustrated in the findings of the questionnaire survey, when we talk about mental illness issues, we often only focus on a small group of violent persons who happen to have severe mental illness, which represents only a small proportion of the people with mental illness. The number, I should think, must be far less than the number of triad members and people with aggressive tendencies who have not been known to have a history of mental illness. Some people with mental illness are scary and unpredictable. Some types of mental illness are more likely to be associated with socially unacceptable and

frightening behaviours than others. On the other hand, we feel comfortable with those who present no threats – or even go unnoticed. It is easy to tolerate or even care for them, as they pose little or no threat. Referring back to the examples I gave in Chapter 1 regarding the person cleaning rubbish bins on the footbridge and the man who paints graffiti everywhere in public, people passing by may label them as “abnormal,” “weird” or “loony.” However, they do not feel they are a threat, as they do not show any sign of aggression or socially unacceptable behaviours.

#### **4. Context, concept of personhood and the implications**

In an economically prosperous and productivity-driven metropolis like Hong Kong, the stigma will not be easily removed from people with mental illness. To reiterate the Chinese concept of personhood that I have mentioned in Chapter 3, once the illness has affected individual's productivity or the mentally ill label is known to others, the development to be a full “capable” person will be perceived as coming to a halt or regress. The path to achieve such “fullness” for persons with mental illness is difficult, not only because of limited opportunities due to prejudices, but also because of reduced abilities and aspirations. As they fail to be fully “capable” persons due to a lack of ability or opportunity, their social identity will be as a deviant and outcast, and thus starts the vicious cycle of discrimination. Persons with mental illness can quite readily develop hopelessness and helplessness. The highly valued concept of personhood has created the expectation of people to be productive, high achieving, and excellent in their jobs. This may become an unbearable pressure to some who are unemployed or who have not excelled in their jobs or studies. The previous, traditional explanations for bizarre behaviours, related to external forces such as possession of an evil agent, an act of god, or retribution of ancestral wrongdoings, helped patients and their families explain their

problems and seek relevant help with living in the community. Now it seems that these have been discarded as “unscientific,” “primitive” and “superstitious.” In their place, “scientific” explanations of aetiology and healing strategies based on Western medicine have taken over. The explanations include genetic defects, personality deficits, psychosocial dysfunction, inability to cope, and hormonal imbalance. All of these point to a dysfunctional human body for which an individual is partly or wholly responsible. If the dysfunctional body is perceived as unable to make a soon-enough recovery, or is beyond repair to achieve full personhood, dependency on other’s care or finishing one’s last breath on earth seem to be the only two alternatives. This is reflected in the increasing number of fatal suicides and suicidal attempts among the aged, unemployed and students as reported in surveys and the press media.

The fact that physical ability is highly valued and more obviously noticed may explain why a few respondents in the survey thought people with mental illness would experience less discrimination than those with physical disability. Even for those who think the person with mental illness will experience more discrimination, they believe it only happens if others know them.

I believe the mentally ill people face more social prejudice. It is because, under normal and non-dangerous (harmful) circumstances, people tend to show more caring and loving attitudes towards people with disability because of their compassion and sympathetic attitudes. However, when they are face-to-face with mentally ill persons, (if they are known to be mentally ill), people often assume that they are dangerous and violent. Even if they appear to be calm and stable, people still tend to assume them to be potentially emotional. Therefore, people often take an apathetic attitude toward them and impose more social prejudice on them [people with mental illness].

What this means is that if one's mentally ill identity is kept a secret and the affected person does not show any obvious symptoms, he/she will be treated as a "normal" person. Preventing the official label of "mentally ill." is the reason why families try so hard to delay Western psychiatric treatment. Alternatively, they try to explain the odd behaviours of their relatives in ways other than identifying them as mentally ill (see Chapter 10). In order to try to be perceived as achieving a full "capable" personhood, some families with mentally ill children arrange a marriage with a person from a lower socio-economic background, in this instance peasant girls from mainland China or older men. This can be seen as a symbolic attempt to achieve the person's personhood, in addition to having someone to take up the caring task.

### **Summary And Discussion**

The mentally ill person is often burdened with the social stigma of deviance. That is not a modern phenomenon and it occurred in the past in Chinese History. The introduction of Western Psychiatry into the Hong Kong health scene has changed the local concepts of mental illness. Whereas in the past, mental illness was a vague but multi-faceted concept now under Western psychiatry, the definition of mental illness is more refined and systematic. Thus, the primary deviance of mental illness is relatively easier recognised in the community. The prevailing of negative attitudes towards persons with mental illness perpetuated by mass media, the discrimination in many aspects of daily living, and the failure of achieving the socially expected personhood status have further confirmed the secondary deviance among people with mental illness. This stigma creates shame and stress not only to the individual with mental illness, but also to the family as a collective entity.

The findings of the questionnaire survey of 72 respondents, despite its small sample size, are similar to those in previous studies in that stereotypes and prejudices are still largely present. Nevertheless, through public education and new information being introduced, the people in Hong Kong appear to show more positive and caring attitudes toward people with mental illness and their families. This caring and understanding attitude appeared in the open-end questionnaire survey and a few recent studies (e.g. Pearson and Yiu, 1993). Participants indicated their sympathy as well as their understanding of the suffering of people with mental illness. On the other hand, they are afraid of persons who are mentally ill, whom they describe as dangerous and unpredictable, with possible outbursts of violence. They worry that one day they will be one of the victims. The “but-not-in-my-backyard” mentality among the public well represents such a dilemma. These two different attitudes do not seem contradictory or to create anxiety in the public, as long as each attitude operates alone in situations where the other attitude is not evoked. That is, when people face a person with mental illness, they are likely to express a sympathetic attitude. However, when they are at a distance and overhear tragic or horrific news about people with mental illness, the emotive reaction will overpower their cognitive understanding and their attitudes become more defensive or negative. They will then feel that mentally ill persons are a threat and the horrific news reporting reinforces such beliefs. Using the yin and yang analogy, there seems to be no new system emerging in this scenario, but equilibrium is maintained after a period of alarm and unsettlement, and they resume their previous strategy and apply the more benevolent belief system situationally. The equilibrium will be tilted again when people come into contact with another mentally ill person or another graphic report of violence carried out by people with mental illness, then, the balancing process will re-commence.

Nevertheless, this is not the nature of life as suggested in the yin and yang concept. Resuming the origin equilibrium is not necessary the ultimate state for matters in nature where new elements enter, or emerge from the system, from time to time. The system is dynamic and ever evolving, and new equilibriums often occur. Thus, when understanding mental illness and the pain and stress that the families experience, is achieved, people are likely to develop more sympathetic attitudes towards persons with mental illness. This will trigger the new equilibrium process. Hopefully, this can be accomplished through sound public education and accurate and non-sensationalised mass media reports. At least that is evident in some of the respondents in the survey who indicated more positive attitudes toward people with mental illness.



## Notes

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<sup>i</sup> Baptist Oi Kwan Social Service is a local charitable organisation that provides various kinds of welfare services, including rehabilitative and support services for people with mental illness.

<sup>ii</sup> Breakthrough is a Christian charity organisation which is known to provide counselling services to the general public.

**Unit Four**

**Families With Mental Illness**

**And**

**Conclusion**

## CHAPTER EIGHT

### Families In Transition: The Changing Concepts Of Family And Familial Support In Hong Kong

*“Family is just a herd of pigs living under the same roof!”*

A movie script based on *Bā Jīn*'s novel, “*Jiā*”

#### Introduction

The family, rather than the individual, is the basic structural and functional unit in Chinese societies. A special kind of strong familialism exists that emphasises the undeniable predominance of the family over its members in almost all domains of life (Cheng, 1944; Hsieh, 1982; Lee, 1982; Lei, 1984; Li, 1985; CF Yang, 1988; MC Yang, 1972). Family is also where the individual establishes and strengthens the relational orientation that is valued by Chinese (King & Bond, 1985). However, because the family is so highly valued, it is also a potential source of stress and problems. Familialism is one of the common features of Chinese culture that impacts on mental health (Tseng, Lin & Yeh, 1995a). The quotation at the beginning of the chapter came from an old Cantonese movie script which was based on the novel “*Jiā*”, (which literally means *family*), written by *Bā Jīn*, a well-known Chinese writer in the 1930s. The novel describes the changes in a traditional Chinese family – the power plays, problems, pains and sorrows — that occurred during the political transition from Imperial China to the Republic. The conflicts between traditional values of family collectivism and modern (Western) ideology of individual choice were well displayed in this novel. As Hong Kong is going through a socio-political transition, one wonders how much

this has affected the Chinese family's structure and care giving functions. This chapter, using the findings from literature review and the in-depth interviews of members of families with mentally ill relatives, aims to explore and describe the changing concepts of family and familial support system.

### Familial Collectivism

The Chinese family has gone through further changes since *Bā Jīn* wrote the novel. Superficially, nuclear families have more or less replaced the extended three to four-generation households. The traditionally valued virtue of filial piety is also slowly eroding (Tsui, Ho & Wong, 1994). One example of this is the apparent preference of help-seeking from the health and social welfare systems rather than from extended family members (see Chapter 10). Nevertheless, the fundamental beliefs and functions of the family still largely remain intact (Tseng, Lin & Yeh, 1995a). Chinese individuals are still locked into a hierarchical and cohesive family structure (King & Bond, 1985). Despite living apart, parents still exercise a great deal of influence on the daily affairs of their children, both before and after they are married. On the reverse side, children have a strong sense of reciprocal responsibility toward their parents till death. There is also a strong bonding among the siblings. A good example can be found in an interview with one of my informants, the ex-girl friend of a man with depression. The following is an extract from my note after the interview: (Unless specified, all family members and close friends who were involved in the in-depth interviews are addressed with fictitious names. See Appendix II for the characteristics of each interviewed informants.)

Xie-yin<sup>i</sup>, aged 27, had been dating this man in his early 30s for one and a half years. He worked as an insurance salesperson when they first met. For reasons that had not been disclosed by Xie-yin, he was fired from his work and subsequently developed a major

depression. He refused to answer any calls, even from her, and to meet other people. He was currently doing some kind of part-time work at night, but had not been actively looking for regular work since the dismissal more than one year ago. Xie-yin's parents never approved of this man even when they first started dating. They thought this man was not suitable for her because he worked as a salesman, with no steady income. Her parents worried that he would not be able to provide a sufficient "safety net", i.e. financial viability, for the future if they married one day. So even when she broke up with him, she did not tell her family for fear of criticism from her parents and the proof that she was wrong and they were right about this man.

From this story, we can see that parents tend to give strong "advice" about their daughter's friends and social network. If one goes against his/her parents' choice, or does not receive their approval, he/she will face strong criticism, particularly when the romance or friendship fails. The underlying fact is associated with "losing face" and the guilt arisen from disobeying parental advice.

One of the greatest concerns of the families was that persons with mental illness might increase the burden of their parents or family, because their inability to look after themselves and their living on the limited amount of disability allowance would make them financially dependent. There also was a particular concern expressed to me by parents in the relative's support group seminars where I presented on topics related to living with a relative with mental illness. Besides the struggle with medication compliance, parents were concerned about their mentally ill sons or daughters dating another person with mental illness. They asked me to give advice on whether to stop them dating each other or not, and how.

Socialisation among the Chinese has centred on learning the expected roles of children, siblings, or parents. "Proper" social interactions are one illustration of these roles. In addition to filial obligations, the child should strive to achieve and honour parents' expectations (Kuo & Kavanagh, 1994). Traditionally being a patriarchal society (Ho, 1987),

Chinese idealise the father-son alliance, which provides the basic model for many relationships, e.g., that between employers and employees (Kuo & Kavanagh, 1994). The ideal person fulfils societal obligations with grace and dignity. Self-esteem involves a psychosocial homeostasis focused on meeting the expectations associated with culturally defined roles (Kuo & Kavanagh, 1994). Due to the emphasis on family, personal actions reflect not only the individual but also the entire family, including past, present and future generations. Thus, familial socialization practices emphasise the cultivation of collective consciousness and responsibilities of the members (Ho, 1979). As obligations to the family transcend personal concerns (Kingston, 1977, 1980), the behaviour of individual family members is viewed as shared by the entire family. Thus, the individual's sense of responsibility towards other members of the family is sharpened. A strong sense of obligation and responsibility to one's family is still cherished as a Chinese virtue, not only in Mainland China and Hong Kong, but also among overseas Chinese, despite other values may have given way to Western influence (Lum & Char, 1985).

A good description of this virtue is in the autobiography, *Joy Luck Club*, by Amy Tan (1989). The book describes the tensions and dynamics in four Chinese women's lives and families before and after they migrated to the United States. Even though the daughters' conflicts between caring for aging mothers and their desire for independence were significant, the virtue of unquestionable responsibility toward the family, particularly the parents, still prevailed in the end. Other examples from my data are:

- 1) Mr. Mak, the father informant of a son with mental illness, took early retirement so that he could take care of his son.
- 2) Miss Wan, who has a younger brother with mental illness, spends most of her time, other than working, with her brother. She claimed that other than work and church activities, she spends most of the evening chatting to her brother and wants to know

what has happened to him during the day. When I asked her what motivated her to do that. She just answered plainly that, “I am his sister. The other siblings have lives and families of their own.”

- 3) Mr and Mrs Yin are parents with a teenage daughter who was just diagnosed with schizophrenia. Because of financial reasons, both of them have to work to support the family. Mrs. Yin has to take night shift work so that both parents can take turns looking after the daughter 24 hours a day.
- 4) A mother, whom I met in one of the relatives support group seminars, said she gave up her “rewarding” teaching job and has stayed home to look after her son for six years since he was diagnosed as having schizophrenia.

Familial collectivism causes the Chinese to subordinate their personal goals, interests, and welfare for the sake of their families. The existence, solidarity, glory, and future of the family are much more important than those of individual members because the family is judged by society in terms of a collective presentation of “face.” Under these conditions, an individual cannot but surrender himself/herself to the family. As a result, the family member seems to lose his or her individuality and idiosyncrasies (KS Yang, 1995).

From the Western psychiatric viewpoint, the “over-protective” parent-child and sister-brother relationships mentioned above might be labelled as co-dependency, a pathological condition that needs to be remedied. In contrast, the Chinese cultural values and the social expectations of family members influence, and even dictate, their response in these situations. Among Chinese, there is an alternate set of meanings and explanations for these devoted and caring responses from the family towards the sick members. In some instances, the non-performance of those caring roles may be seen by the Chinese community as uncaring, cold-blooded, and indicating an absence of *rén* (sense of Benevolence). Thus, an analysis of family care giving strategies must simultaneously consider at least four

dimensions: (1) the range of paradigms of family behaviour available in the culture; (2) the modal paradigms of family behaviour in the community; (3) the internalised ideal paradigms of family behaviour held by the social actors involved; and (4) the status of particularistic factors that are known to affect the family behaviour under consideration (Philips, 1993, p. 305).

### **The Hong Kong Families In Transition**

The family system has gone through further evolution over the years in Hong Kong with influence from Western culture. In this highly commercialised and urbanised metropolis, one may wonder how much the traditional familial values have been preserved, given that the family plays a diminishing role in taking care of the sick (Lee, 1985). Surprisingly, the collectivism concept of the Chinese family still remains intact (Tseng, Lin & Yeh, 1995b), though the form may have changed. For example, instead of making the personal sacrifice to physically look after the sick, it is perfectly acceptable to provide financial support for employing a caregiver to perform the caring tasks. The traditional Chinese extended family network consists of several generations, and, though rarely seen in the physical form of living under the same roof as such, it still is the predominant structure. The interdependence among relatives in the extended family can still be seen in most of the families in Hong Kong. This becomes even more obvious during the festival dates and times of hardship. At such times, all family members tend to congregate together. Nevertheless, families in Hong Kong are facing challenges similar to those in most of the developed countries in the world: the widening of the generation gap, the increased alienation of urban living, and the increase in divorce rates. According to the official statistics reported in the news (*Ming Pao Daily News*, 30 November, 1999), over the last few years Hong Kong has the third highest divorce rate in Asia. The number of first marriages in 1998 dropped more than 20 % compared to the



previous two years. At the same time, the number of re-marriages has increased by nearly 28%. Although these figures tend to fluctuate with time, they indicate that families in Hong Kong are inevitably going through changes at the beginning of the new millennium. Furthermore, political change has brought about new social issues that may rock the foundations of the traditional family structure and its values. Two new structures of family are emerging and new family values appear to have arisen. They are the “single parent family by-default” and the “astronaut family,” plus a possible hybrid one — the re-emerging of the “concubine family.”

The first is a family that exists on paper but the two parents with children are living separately in Mainland China and Hong Kong due to immigration policy and/or economic reasons; such a family is called locally “single parent family by-default.” The “astronaut family” is the family with one partner left behind in Hong Kong for work and/or financial reasons, and the rest of the family has already migrated to another Western country to escape from the uncertainties after 1997. The “concubine family” is an additional family established, usually by men, apart from their legally recognised family. If the new family structures do not take over the traditional ones, they will at least co-exist with each other.

As I mentioned earlier, the growth of the Hong Kong Chinese population began with the movement of refugees or immigrants from the mainland. In the beginning, most of the immigrants only had plans to stay in Hong Kong for a short period of time. Once the situation had improved on the mainland they would return, otherwise they would leave to join their relatives overseas. It was not uncommon to find that many of them came to Hong Kong by themselves and left families behind on the mainland. As time went by, the political situation became unfavourable for a return. In addition, the “white man” policy was prevailing in many Western countries and, thus, had deterred many from leaving Hong Kong. Once the head of the family, usually the patriarch, decided to set up home in Hong Kong, a

family reunion commenced and the rest of the family on the mainland also moved to Hong Kong. A new generation of locally born Chinese also was formed. This pattern of family transition also continues today, as people have never stopped emigrating from the mainland, either legally or illegally. They are simply repeating the same pattern of transition. Madam Chan, one of my interviewees, told me her experience, which may accurately reflect this pattern of transition. The following is a note that I made from the interview with her.

Madam Chan, in her early seventies, is articulate and looks physically well for her age. The reason for interviewing her was that she has a son with mental illness. Once we got acquainted, she talked openly about her own life experience, which is filled with hardship, sacrifice, courage, and determination.

She left her husband one son and three daughters in Guǎngzhōu for Hong Kong in 1960, looking for a better future. She worked in a clothing factory and became the main source of financial support for the family in China. Her son came to join her in 1962 when there was a severe famine in China. Madam Chan was only able to afford to rent a “one-bed accommodation”, where all their living space is just one level of a bunk bed in a crowded apartment with a few dozen other people. She, like many parents, worked very hard and saved up enough money to send her son to the US for education. Her son was later diagnosed with schizophrenia while studying there. After a few incidents, her son finally graduated in the US. However, instead of returning to work in Hong Kong, like many overseas graduates in those days, driven by a sense of patriotism he chose to work in Mainland China in 1983. He had his ups and downs with his mental illness while he was in China. Finally, after two broken marriages he returned to Hong Kong alone and has lived here ever since.

Madam Chan’s two daughters came to join her in 1970. Through some kinds of “introduction” by relatives in the US, they both married Chinese-Americans and have lived in the U.S. ever

since. Madam Chan's husband died in 1976 in China and had never joined her in Hong Kong. Her youngest daughter later also followed the same path as her sisters, marrying and settling in the U.S. from the mainland.

Madam Chan, not knowing a word of English, also lived in the US for 12 years. She first worked as an illegal migrant for 5 to 6 years. She took up various jobs, such as an assistant in Chinese grocery stores and a kitchen hand in Chinese restaurants. Other than working, she lived between her two daughters in California and looked after their children. Later she was granted permanent residency status, and became an American citizen in 1993. A quote from Madam Chan reflects her life: "Life fills with lots of *wúnài* (uncontrollable and unavoidable tragedies/events or simply no alternative). My life was not good.... Just came to this world at the wrong time!" It appeared to me that her conversation was filled with a great deal of bitterness and regrets.

The transition of sovereignty in Hong Kong has indirectly hastened changes in the family that affect the family's care giving. On one hand, the process of family reunion with relatives on the mainland has become easier and more frequent. On the other hand, the suspicious and pessimistic middle class and intellectual groups who were already settled in Hong Kong are uncertain about Hong Kong's future and beginning another period of family transition. This time they are considering moving overseas. The largest exodus of Hong Kong people was from the late 1980's to the early 1990's. The coming of new immigrants and the leaving of the established population only reinforced the existing image of Hong Kong — a place in perpetual transition. In parallel with the family transitions, cultural and social issues and the political agenda are becoming more dynamic and are constantly evolving in response to the ever-changing population mix.

A border is still maintained between Hong Kong and the mainland since the transition

of sovereignty in 1997. A special entry document is required for Hong Kong Chinese entering the mainland, although it is relatively easy to obtain. Hong Kong Chinese are mostly free to travel, work, and live in any part of the mainland. The mainland's Chinese, however, do not receive the same treatment from Hong Kong. For fear of a sudden influx of immigrants or travellers from the mainland, it was agreed prior to the transition date that a quota system would be set up to restrict the entries. It is also a rather complicated process for a mainlander to apply for an entry permit to Hong Kong. There are two separate quotas for family reunions and tourists, and the entry permit for the latter is relatively easier to obtain. During the application process, bribing the mainland officials seems to be an inevitable action to hasten the process.

The "single parent family by-default" and the "astronaut family" are newly found structures of family in Hong Kong. Not only the extended family, but also the nuclear family, the predominant structure of family in this highly urbanised and commercialised city, is also under threat. Inter-marriages between people of two places have been becoming common for decades. However, the mainland spouse does not have the immediate right of abode in Hong Kong. He/she has to wait for his/her turn on the entry quota list. If the children were born in Hong Kong or with a parent who is a Hong Kong permanent resident, they will be guaranteed the right of abode in Hong Kong. This policy, of course, is the main source of producing "single-parent family by-default" in Hong Kong.

On the other hand, in the "astronaut family" the partner who stays behind in Hong Kong for work and/or financial reasons is like an astronaut travelling between the earth and another planet in a space shuttle travelling between Hong Kong and his overseas home, such as Canada or Australia.

There is also a re-emerging marginal family structure that is a hybrid from the mainstream family. This is what I call the "concubine family" or "mistress family".

Although it is illegal within the law of monogamy, it has become a popular social phenomenon. Polygamy was commonly practised in Imperial China for thousands of year, particularly among reasonably well off men. However, it became illegal in Mainland China after 1949, and a bit later in Hong Kong in 1971, with the enactment of the monogamous marriage law. Recently there has been a significant differential, in terms of economic power and wealth, between Hong Kong and Mainland China, particularly in rural China. As China opens up its ports to trade with the world, it cannot avoid the same social problems experienced by all developing countries in that a large number of rural people move to the cities for work or a better future. There is also a shift in manufacturing industries from Hong Kong to the mainland due to cheaper labour and land costs and improved transportation between the two places. Many Hong Kong people, mostly men, are now working in China or are frequently travelling between two places. Because of the distance from their families or partners in Hong Kong and the booming sex industry in every major city on the mainland, it is not uncommon for men to have an affair or become a regular customer of the sex industry. Some even go so far as to set up another “family”, the “concubine family,” on the mainland. The “concubine family” also may co-exist with the “the single parent family by-default” and “astronaut family” so that the partner left behind is also involved in an intimate relationship with another person in Hong Kong or on the mainland. The extra-martial affair, or extra-intimate relationship, phenomenon has become so alarming that the China government has made prostitution and sex outside the marital relationship a criminal offence that incurs a monetary penalty, imprisonment, or confinement in a re-education camp. Hong Kong, which has its own generally independent judiciary system, does not impose similar measures. Instead, counselling services are being established to deal with these marital and family problems.

For the Chinese, worshipping ancestors, showing filial piety to parents, and having a united family are the basic conditions that are stressed for maintaining the family system. Failing to fulfil these culturally expected obligations can become a source of emotional pain (Tseng, Lin, & Yeh, 1995a). No doubt these three new family structures have an impact on the existing family. However, it may be too early to judge their effects on family harmony and familial collectivism in Hong Kong. Empirical studies need to be conducted. Nevertheless, reports about problems in these three structures of families are now often found in newspapers. It appears that the mental health of members of these families has taken its toll. The incidence of mental illness in these families seems to be high enough to draw our immediate concern. The extracts from the news articles in Table 15 illustrate this point.

**Table 15 Samples of news headlines/headers associated with issues in the new family structures**

NEWSPAPER	DATE	NEWS HEADLINES /HEADERS	REMARK/EXTRACT
Apple Daily	22.6.1997	福利政策不足生活易陷困境 (Translation) Inadequate welfare policies, Living will easily deteriorate	1996 Statistics from the Society of Samaritans: <ul style="list-style-type: none"> <li>● 4187 help seeking cases, 15% increase from last year.</li> <li>● Nearly 60% are female, main problems with marriage and family, in particular husband's extra-marital affair.</li> <li>● Broken romance is the major type, followed by family, work, and marriage.</li> <li>● An increased number of help seekers with unemployment and financial difficulties</li> </ul>

**Table 15 Samples of news headlines/headers associated with issues in the new family structures (cont')**

NEWSPAPER	DATE	NEWS HEADLINES /HEADERS	REMARK/EXTRACT
Ming Pao Daily News	30.6.1997	<p>移民滿懷壯志 病倒始知不易                      97精神科併發症實錄                      (Translation)                      Ambitious migrants found migration too difficult when become sick                      A record of 1997 psychiatric syndromes.</p>	<p>A special report on 4 persons, who became mentally ill after migrating overseas:</p> <ol style="list-style-type: none"> <li>1. A 21 year old man studying overseas</li> <li>2. A female university teacher, age 31</li> <li>3. A chef who migrated to Japan</li> <li>4. A clerical officer</li> </ol> <p>Comment features drawn by the reporter:</p> <ul style="list-style-type: none"> <li>● Age between 20 and 35</li> <li>● Their lives seemed to be all right prior to migration/moving overseas</li> <li>● They gave up their study or work in Hong Kong, but seemed to be ill prepared for the change. Their claimed motive for migration is "worry about 1997"</li> <li>● Their mental health symptoms emerged shortly after migration</li> <li>● They appeared to have the same ending: decided to stay in Hong Kong after treatment and their mental illness symptoms did not appear anymore.</li> </ul>
Apple Daily	7.8.1999	<p>狂漢認推人落路軌侯判                      姨丈: 新移民悲劇錯在黎香港                      (Translation)                      Crazy man pushed man on to MRT track pending judgement                      Uncle: new migrant's tragedy – it's wrong to come to Hong Kong</p>	<p>A court report: A new immigrant, who had difficulty adjusting to living in Hong Kong, suffered schizophrenia. Possibly due to delay in receiving treatment from the public psychiatrist, his condition deteriorated. He pushed an innocent man onto the MRT track in front of the coming train. He was charged and pleaded guilty.</p>

**Table 15 Samples of news headlines/headers associated with issues in the new family structures (cont')**

NEWSPAPER	DATE	NEWS HEADLINES /HEADERS	REMARK/EXTRACT
Apple Daily	19.10.1997	小移民患精神病驟增 新環境及讀書壓力病者年紀最少歲半 (Translation) Increase in psychiatric incidence among young immigrants due to new environment and pressure of study, the youngest patient is one and a half years old.	Report of a survey by the Child Psychiatry Department of Kwai Chung Hospital ● Reported an increase in the new migrant children being admitted to their child & adolescent wards in recent years. ● One of the causes: single parent by-default – Children experienced adjustment problem as mother in China and father working full-time in Hong Kong.
Seng Pao	18. 6.1999	五成新移民乏可援助親朋 20%不適應 新環境 導致失眠頭痛情緒低落 (Translation) 50% new immigrants lack dependable support from friends and relatives 20% experienced adjustment difficulties that lead to insomnia, headaches and low mood.	Report of a study by a child welfare organisation (小童群益會) in October, 1998 on new immigrant's family and work. 102 families were interviewed

### Family Care Giving In Hong Kong: A Transition In Form

The concept of care giving appears in much recent literature and appears to be a relatively modern concept. However, the concept of care has been a part of Chinese culture over thousands of years. Reciprocal care was emphasised in the teachings of Confucius on filial piety, i.e., parents should care for their children in return for their care when they get old. There is a Chinese belief that the quality of care the aged parents receive is a reflection of how much care they invested in their children in the past. Nevertheless, the care giving that I am discussing here takes a narrower meaning. It describes the relationships that exist among adult individuals who are related through kinship. A caregiver is the person who assumes an unpaid and unanticipated responsibility for another (Guarnaccia & Para, 1996). The care recipient is typically disabled and unable to fulfil the reciprocal obligations



associated with normative adult relationships. Care becomes care giving when it is out of synchrony with the appropriate stage in the life cycle. Caregivers are bound by kinship obligations that go beyond those normally associated with a family role at a particular stage. It is the addition of the care giving role to existing family roles that makes it burdensome, despite the fact that care giving may also be a source of satisfaction (Fisher, Benson, & Tessler, 1990; Bulger, Wanderman, & Goldman, 1993). In virtually all societies caregivers are disproportionately female (Ascher-Svanum & Sobel, 1989).

Guarnaccia and Para (1996) have pointed out that there are cultural differences in the perception of burden and that the more family members see care giving as part of what one ordinarily does for an ill family member, the less likely they are to provide accurate information on care giving tasks that others have defined as burdens. In the past when life was relatively simple and there was less division of work tasks, virtues such as family harmony and unity, filial piety, respect for the senior family members, and interdependence within the extended family living close proximity, were socially praised and valued. This was especially the case in rural China. In this situation the tasks of caring for the sick member were easily distributed and there was a strong social sanction for those who did not comply.

Given these values families first try to resolve the problem of a disabled family member by accessing a care-delivery network that includes extended family: friends, folk healers, and professional health-care providers (Philips, 1993). If the care-delivery system is unable to “cure” the disability and the individual is permanently unable to perform expected social roles, the family must then develop strategies that provide for the long-term security of its ill family member while protecting the interests of the family as a whole. The strategies developed to achieve these goals are the product of a dynamic interaction of patient, family, and social factors (Philips, 1993).

In these days, before we can say whether or not the solidarity and devoted caring within the Chinese family has diminished, we need to understand what care giving is and what the appropriate caring behaviours are. These need to be defined within a social and cultural context and are judged in that context.

Lefley (1996) stated that care giving is more than a matter of concern for the well being of a loved one. It also is linked to societal concepts of personal and collective responsibility and particularly to notions of what is right and appropriate with respect to obligations to kin. The major premises underlying care giving are related to (a) cultural conceptions of personhood, of the self in relation to others, and (b) cultural notions of interpersonal morality.

Miller (1994) conducted a cross-cultural study to compare Western (white American) and non-Western (Hindu Indian) self-concepts and morality of caring. He noted that Americans have an individually oriented interpersonal moral code that stresses personal freedom of choice and individual responsibility, whereas Indians have a duty-based interpersonal moral code which emphasises mandatory responsibilities based on one's position vis-à-vis another in the social matrix.

Miller's study (1994) enriches the body of anthropological research that distinguishes individualistic cultures (typically designated as Western or modern) from socio-centric or group-oriented cultures (typically designated as non-Western or traditional). Traditional cultures usually have an interpersonal moral code that stresses responsibilities towards kin and clear gender distinctions that impose a non career-oriented, homemaking, care-giving role on women. Hence, care-giving tasks are likely to be perceived as less burdensome in cultures that view this as a natural role commitment. As the vast majority of caregivers throughout the world are female, care giving has become a feminist issue in Western cultures (e.g., Ascher-Svanum & Sobel, 1989; Cook, 1988). In modern societies, women are no

longer culturally valued for sacrificing their own needs to serve others. As a result, there are clear frustrations and fewer secondary gains when mothers, daughters, or wives have to abandon other interests or even competitive career choices to fulfil a care-giving role.

In Hong Kong, women are still expected to carry a major nurturing and caring role in the family. Nevertheless, with abundant opportunities for women to pursue their careers, many women will continue to work, or give priority to their work, after they have married and have children. Double income families are a common phenomenon in Hong Kong. For some people this is needed to improve their standard of living; for others it could mean the only way to meet the basic daily necessities. In these families, to physically look after the sick member at home is not a viable option. However, familial collectivism has not disappeared. It has just changed to another form or is accomplished through other means. For example, it is a quite common practice for people to employ a housemaid to take over the caring tasks at home. When it becomes quite impossible to look after a fragile aged parent or a member with chronic illness at home, particularly if he/she requires nursing care or close attention, finding a good private nursing home, with financial support from the children or other family members, is also seen as a proper care giving duty. This ensures that the sick relative is “well” looked after, even when the family is physically no longer able to do so. It is a socially acceptable way to fulfil the filial piety duty to a fragile, aged parent in Hong Kong. Similarly, it is also acceptable to keep the mentally ill relative in institution, if immediate care or close attention is impossible, provided regular visits and concern are expressed. This is one reason why private nursing homes have been a booming business in recent years and that this practice correlates with the growing economy and increasing aging population. A good example of this issue is the story told by Mr. Pang. The interview took place when Mr. Pang was making one of his visits to his mother. She had been transferred

from a nursing home to the psychogeriatric unit of a psychiatric hospital for the second time for depression and disturbed behaviours.

Mr. Pang's mother, aged 64, apparently suffered from a depression after a stroke. Prior to the stroke, she had been complaining for sometime of "being chased after by someone with a chopper wanting to harm her. Someone in the neighbourhood wanted to kill her too." She did not "recover" from the stroke, [she still has significant residual disability] and the doctor advised the family to put her into a nursing home. Mr. Pang and his siblings all contribute to the nursing home costs and have been taking turns to make regular visits to her in the nursing home. His younger sister, in particular, spends time visiting her mother and caring for her after work.

Caring within the family also means having sufficient financial resources to purchase necessary services, or make appropriate arrangements for the member in need. The findings from Michael Philips' study on Mainland China on familial coping with a member with schizophrenia can be used as a comparable example to illustrate the responses similar to those by the families in Hong Kong (Philip, 1993). The findings are from a multi-centre, cross-sectional study (N = 299) and two longitudinal studies (N = 129). Philips found that family members play the major roles in assessment and management of the problems that may be encountered by ill relatives. Family members co-ordinate contact with care providers, negotiate with employers on the patient's behalf, negotiate with schools, and use their social contacts and financial assets to arrange marriages (Philips, 1993). Furthermore, the familial collectivism that emphasises familial obligations makes parents feel obliged to use all the family resources for the benefit of the sick family member.

Examples of this sense of family obligation are evident in the data I collected. A mother with a mentally ill adult son who works in a sheltered workshop approached the workshop staff for assistance to set up a "business" for her son so that he could pursue a

“proper” career. She was willing to pay the initial costs for setting up the business. In a second example, Madam Chan, had been visiting different departments and agencies for assistance to have her ex-daughter-in-law’s right of abode’s application processed sooner. Her ex-daughter in-law had just broken up another relationship after divorcing her son on the mainland. She came to Hong Kong with her daughter (Madam Chan’s granddaughter) on a tourist permit, but wanted to settle in Hong Kong. Madam Chan hoped that her ex-daughter-in-law could join and care for her son in Hong Kong, so she could be relieved and return to the United States.

Family performs its function to provide care and shelter for its members. This provision is not unconditional, in an absolute sense. Each member needs to perform his/her social or familial assigned tasks. Non-compliance with those tasks may lead to exclusion from family affairs or even being cut off from the family. This is particularly the case when the sick member has created a disturbance for the family that damaged the family name. The interaction and evolution of coping and caring in the family, together with families’ experiences of living with relatives with mental illness, will be explored in more detail in the next chapter.

### Summary

Modernisation or “Westernisation” has fostered the rise of individualism in Hong Kong. Nevertheless, the family is still regarded as the primary mediator and decision-maker for many life transitions and stressful life events. In addition, although living space is generally limited for a family and the nuclear family has become the dominant family structure in Hong Kong, the Chinese family virtues have disappeared. There is still a strong collective feature that runs through most Chinese families, particularly when families are faced with tragedies, care for the sick, or have to deal with other major daily problems.

Using the *yin* and *yang* analogy, the ultimate strategy for family existence is to maintain the balance between the two forces. When the family's condition has gone to the extreme and the harmony is disturbed, an equilibrium mechanism will be triggered in which family collectivism will emerge to re-establish the balance and, thus, harmony, prosperity and preservation of life can be achieved. Families will make every effort to maintain a kind of balance and harmony despite the ever-changing external environment. Therefore, instead of totally taking on the Western concepts of family and structure, Hong Kong families integrate both Oriental and Western cultures to form their own unique family structure. Through carefully negotiating along the middle ground, harmony is maintained and stability can be established so that the family can face the challenges brought by adverse life events. This approach may explain why the Chinese family, in terms of its values and functions, has not changed much over thousands of years of upheavals. Thus, caring behaviours must be defined and be judged as appropriate or not within a particular socio-cultural context. Otherwise, we may fall into the trap of what Kleinman (1977, 1987) called "category fallacy," and in so doing fail to accurately reflect the social reality in the particular cultural context.

## Notes

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<sup>i</sup> All the names of the interviewed informants are fictitious to protect their identities (see Appendix II for their profiles). I have also adopted the Chinese way of courtesy in addressing a person, i.e. I address those informants with formal names to indicate the special respect given to them either due their senior in age or life experience. I address those informants who are younger than me using their given names or first names.

## CHAPTER NINE

### Families With Mental Illness: Coping And The Context

*“Shame, pain, troublesome, everlasting war”*

A parent with a son with mental illness

#### Introduction

Although the manifestations may be different, Hong Kong, like any part of the developed world, experiences mental health problems arising from rapid development. Nevertheless, Hong Kong is still vibrant and maintains its role as one of the major commercial and financial centres of the world. In general, Hong Kong people have developed their own mechanisms to cope with, and adjust to, various historical changes, including changes in the concepts of mental health and mental illness. Confucianism and Taoism, which are embedded in Chinese culture, have to an extent helped this population to survive and adapt in the past. However, with the introduction of Western culture to China, conflicts between the two cultures are inevitable. The integration of Western values and ideologies into local culture generates confusion, ambiguity, and hostility in daily life. This situation will evolve until a new equilibrium point is reached, in which people will be comfortable with the new set of cultural values. How does the Chinese family system weather the storm of change and evolve? How do families with mentally ill relatives cope and adapt during the transition?



As discussed in previous chapters, understanding and accepting people with mental illness is difficult for the general public. Without any doubt it also is difficult for the mentally ill persons themselves and their families. The phenomenon of mental illness is not an individualistic concept as described in Western psychiatric literature. Under Western psychiatry, mental disorder is diagnosed when the person is exhibiting the prescribed onset, symptoms and prognosis under the DSM-IV or ICD-10 classification. The family may be seen as one of the causes of mental disorder or as a source of support to prevent mental disorder or relapse. The diagnosis and the stigma, to a great extent, seem to be an individual's business. However, as I have discussed in the last chapter, the familial collectivism of Chinese culture has not changed significantly over time, except in the forms of presentation. Disease affects individuals, even when it becomes an epidemic, as only the individual receives the diagnosis. But illness most often affects others as well, family, social network, and, at times, an entire community (Kleinman, 1980). In another words, mental illness is not an individual matter, but a matter for the whole family, thus one has grounds to talk about the family with mental illness. This chapter and the next focus on exploring the issues for families with mental illness. In this chapter, a review of the literature, which is supplemented by the collected data, is used to examine coping and adjustment in families with mental illness in the West and among the Chinese in general.

### **Families With Mental Illness**

Extracts from group discussions with parents who described their experiences in caring for their mentally ill children provide good examples to illustrate that mental illness is not an individual phenomenon, but a collective family affair.

A while ago, Mrs. Kan and Mrs. Shih asked me whether I am bored with accompanying my son for follow-up consultations. It has been 10 years now. I can remember only once that I did not accompany him to see the doctor. So up to now, I still accompany him to see the doctor. This burden is quite heavy.

*(One of the parents commented about those “recovered persons” [“kāngfùjiě” 康復者, a term locally used for a person with mental illness.] who want to find a high paying job)*

Well, including you and me, everyone wants to find a job with higher pay than others. Everyone is the same. If an individual does not have this high achievement intention, he is not aiming for progress.... However, relatives should see this differently. Business is not good, many people are returning from overseas, and many people are looking for work, such as graduates, university students, secondary school students.... We have to tell them (the recovered persons) what the reality is. We should tell them that when comparing with others, they are already lucky to find a job. You can see there are so many people unemployed. Thus, they should feel, psychologically, that they are doing quite well.

My recovered person is seeing a private psychiatrist. I accompany him every time. After a few years, he has trust in the doctor and will turn up for his appointment every time. The doctor and myself will also listen and wait until he has finished. The doctor will ask me about his condition. For example, I will praise him in front of the doctor if he has been good. If he has done something not so good, I will also bring it up with the doctor. The doctor will then give him advice.

Sometimes, I will be doing the same thing as mentioned by Mr. Wong. I record down his fits. There is an advantage. The recovered person will feel that the family is concerned about him. Accompanying him to see the doctor, you can see how the doctor communicates with him.

At the same time, he can really feel the family cares about him. The relationship between the doctor and family will be improved and mutual trust can be gained. Well that happens when seeing a private psychiatrist.

*(The following parent complained about the dosage the doctor prescribed for his son)*

So, I believe that the family needs to accompany the recovered person to see the doctor. We need to tell the doctor about his condition so that the doctor can adjust the dosage or change to another drug.

As the recovered person is still a patient, he does not know how to present himself at times. Sometimes, what he thinks is right may not be the same as we see. I know the doctors are busy; they tend not to take much notice of you. Sometimes you just don't want to talk to the doctor in front of the patient. Therefore, I wrote down his condition and faxed it to him before the appointment date, and, thus, he had a rough idea about the patient's condition. If you don't have a fax machine, you can send him a letter. As the patient only sees the doctor once a month, he can only care about the patient's physical condition. The doctor does not have knowledge of what has happened to him and whether he has relapsed again or not. Therefore, it all depends on us, the families, to inform the doctor, and I think it is also very important.

Miss Wan, the sister that devoted all her time and attention in caring for her mentally ill brother, talked about the family's response to her brother's psychiatric disorder.

My mother started not to give in just because he threw a temper tantrum because she worried that he would demand more next time. I felt, at times, that it was not his mental problem, but that he just liked bullying us. So we [the family] learned to work cooperatively to deal with

his temper/emotional outburst. We started to reason with him and corrected his problems, and we found that worked well.

*(When I asked whether she is the only one actively taking care of her brother)*

Only my mother and me take an active role. Perhaps my other sisters are just busy with their own families. Secondly, I may be more devoted in looking after him. You know I am involved in the families support group. Perhaps, just having more experience will make me understand the families more. Thirdly, although they have also attended those educational seminars and counselling, they may not be touched as much as I am, with the exception of my mother as he is her son.

My father is relatively less involved and a bit cold towards my brother. He used to be hostile or impatient towards my brother, but he has changed and now he is able to show that he cares and know how to help him, or to avoid quarrelling with him. Nevertheless, father is still a bit disappointed with my brother as he has not turned out the way he expected.

Yes, I do sacrifice something. As I am spending time with him and talk to him, my social circle has become smaller. I talk with him nearly every night, as I want to know what has happened to him during the day so that I know how to comfort or encourage him. So my life circle is quite narrow.

The above examples indicate that when we look at mental illness in Hong Kong, we have to take the family, including the mentally ill member, as a whole entity. With this point of view, I do not mean we should interpret the family as a pathological entity, that causes the psychopathological symptoms in the member, as mentioned in Western psychiatric texts,. Nor do I totally adopt the family therapy perspective that the whole

family needs therapy. What I intend to explore is the meaning of mental illness, the ways of coping with mental illness, and adjustment to mental illness, of the family unit. This leads to the questions: How do families with mental illness actually cope and adjust in Hong Kong? Does the current literature reflect their actual experience? As most studies have been carried out with non-Chinese populations overseas, can their findings be compared with the local experience? A literature review on culture, coping and adjustment, and the results from my study are presented and discussed in the chapter to bring a better understanding of the experiences of the families with mental illness in Hong Kong during this period of transition.

### **Stress, Coping And Culture**

Dealing with the crisis at the onset or relapse of the disorder is often difficult for the families. Families living with relatives with severe schizophrenia face numerous additional difficulties, such as the economic burden of supporting the relative, the stress of coping with the relative's disturbed behaviours, persistent disruption of household routines by the relative, and problems of coping with the social withdrawal and awkward interpersonal behaviour of the relative (see also Falloon, Boyd, McGill et al., 1985; Hatfield, 1987). It is not surprising that many families report considerable stress and dissatisfaction in the relationship with their relatives with schizophrenia (see also Hatfield, 1987; McElroy, 1987; Bernheim, 1989). The lack of attention to the relatives' needs among the health care professionals and researchers is also reflected in the reliance on relapse as the primary index of outcome in most family intervention studies.

In Western countries such as the United States and United Kingdom, the stress related to care giving has been extensively documented in both the professional literature and in

first hand accounts by family members (e.g., Bulger, Wanderman, & Goldman, 1993; Leventhal, Leventhal, & Nguyen, 1985; Pai & Kaipur, 1982; Potasznik & Nelson, 1984; Thompson & Doll, 1982; Vine, 1982). The chronic nature of much mental illness and the tendency for relapse and hospitalisation create a situation of chronic stress for family members. Relatively little research has been done in Mainland China and Hong Kong (e.g., Pearson & Chan, 1993; Philips, 1993) about the ways in which the stress is managed by Chinese family members or the ways in which families deal with their own reaction. Therefore, I begin by exploring the coping phenomenon with a review of the Western literature. Coping and adjustment to mental illness in the family in the West, and among Chinese, are explored under the following headings: culture and coping; coping in the family; perceived burden of care giving; coping with mental illness in the Chinese context; and coping and adaptation to mental illness in the Hong Kong Chinese families.

#### **A. Culture and Coping**

Lazarus and Folkman (1984) defined coping as cognitive and behavioural efforts that are directed toward the management of external or internal demands that are appraised as taxing or exceeding the resources of the individual. There are two functions of coping: managing or altering the problem (problem-focused coping) and regulating the emotional response to the problem (emotion-focused coping). Lazarus and Folkman believe that coping is determined by resources and by constraints that may mitigate the use of resources. Resources include health and energy; existential beliefs; general beliefs about control; commitments; problem solving skills; social skills; social support; and material resources. They classify the constraints into two groups: personal, including internalised cultural values and beliefs, and environmental, including competing demands. In addition, Philips

and Pearson (1996) maintained that the culture and socio-economic environment of a community affects the types of stressors that are expected or experienced in that community, the availability of resources, the perception of the severity of the stressor, the importance of different stressors, coping strategies, and adaptive outcomes.

Numerous studies have indicated that culture can influence the stress and coping process (e.g. Jachke & Doi, 1989; Lin, 1982; Phillips, 1993; Phillips & Pearson, 1996; Shek & Cheung, 1990). Its effects can be influential in four ways: 1) the cultural context shapes the types of stressors that an individual is likely to experience; 2) culture affects the appraisal of the stressfulness of a given event; 3) culture affects the choice of coping strategies that an individual adopts in any given situation; and, 4) culture provides different institutional mechanisms by which an individual can cope with stress.

In studies of coping effectiveness, contemporary psychological work operationalises “successful coping” as that which is associated with the fewest psychological symptoms under stress (Folkman & Lazarus, 1980). Cultures clearly vary in the type of emotion-focused coping sanctioned in different situations. Some cultures focus on the suppression of emotions while others demand the display of emotions in a culturally appropriate manner.

Problem-focused coping is defined as an attempt to control or manage a stressful situation. Western conceptions of control generally dichotomise this into active versus passive; internal versus external, and so on. Reynolds (1976) argued that the active versus passive dichotomy might be too simplistic. He emphasised that the contrast between Oriental and Western approaches to problem solving lies in the locus of preferred activity. The West is more accepting of activity directed toward changing objective reality while the East seems more readily to tolerate or accept the situation as fate or karma.

Lazarus' model of coping (Lazarus & Folkman, 1984) postulates an ongoing feedback loop of thinking and behaviour. Primary appraisal occurs when an individual appraises the potential threat of a situation. Secondary appraisal follows when the individual assesses the available resources for dealing with the threat. This is followed by the initiation of coping intervention, and, subsequently, by ongoing reassessments until the perceived threat is removed or minimised. However, Philips and Pearson (1996) comment that a major limitation of this theory is its dependence on research using urban samples from Western countries. This approach for coping may only apply to relatively affluent communities that value individualism and pragmatic positivism. Western theorists assign a dominant role to the individual as the primary social unit that engages in coping transactions. This may not be appropriate in a more collectively-oriented culture such as in Hong Kong, Taiwan and Mainland China.

Coping in a non-culturally prescribed manner may result in greater stress. Hwang (1979) examined how people cope with residential crowding in Taiwan. Lower socio-economic groups cope in ways characterised by lower self-confidence and fatalism. Regardless of social class, persons who used coping styles that emphasised traditional cultural values and interpersonal co-operation experienced less interpersonal stress and lower symptom levels. Shek and Cheung (1990) argued that cultures might be divided into those that place greater reliance on the self (internal locus of coping) and those that place reliance more on others (external locus of coping). Coping styles that emphasised self-assertion and achievement enhancement were associated with more interpersonal stress, psychosomatic disorders, and depression (Philips and Pearson, 1996).



## **B. Coping in the family**

Figley (1983) has enumerated eleven characteristics that differentiate between functional and dysfunctional family coping. He sees functional family coping as consisting of the following characteristics:

1. an ability to identify the stressor;
2. a family centred approach;
3. a solution-oriented approach;
4. high tolerance of other family members;
5. a commitment to and affection for family members;
6. open and clear communication;
7. high family cohesion;
8. effective resource utilisation;
9. an absence of physical violence; and,
10. a lack of substance abuse.

According to Lazarus (1977), cognitive appraisal mediates the relationship between the individual and the environment and determines the extent to which a particular event is experienced as threatening and the nature of the response to that event. The commitments and beliefs of family members also influence the adaptation process. Beliefs are essential components of the family experience since the personal meaning of mental illness for family members is likely to define the nature of their experiences and to determine their responses. Terkelsen (1987b) identifies five variables that influence the personal meaning of mental illness in family members:

1. the extent of family members involvement in the daily life of the client;

2. models of causation, symptoms, and outcomes assumed by family members. For example, family members who adhere to biological models of causation may experience helplessness and despair in the face of an unalterable illness and may ignore areas of preserved functioning. They also may experience less guilt. Models of prognosis also influence the meaning of mental illness, e.g., simplistic views of complete cure or of inevitable deterioration are likely to have different consequences for the family;
3. the phenomenology and natural history of the illness;
4. personality and life history, life cycle issues, generic responses to hardship and prior experience with mental illness; and,
5. the social support network.

Adopting the coping and adaptation framework for conceptualising the family experience, professionals have examined the role of coping strategies in order to better understanding and assisting families (Hatfield, 1987; Kanter, 1984). Spanoil and Jung (1987) and Zipple and Spanoil (1987) described four categories of family coping responses: problem oriented, emotional, cognitive, and physical. The following are a few examples of each category.

1. Problem oriented strategies include getting and using practical advice, developing tangible supports and resources, learning coping skills, and becoming involved in advocacy.
2. Emotional oriented strategies include sharing problems and feelings with others, joining a support group, making time for oneself, and enhancing spirituality.

3. Cognitive strategies include recognising the long-term and serious nature of the illness, recognising the limits of mental health interventions, recognising the possibility of a personal life under these circumstances, and gathering information.
4. Physical strategies include exercising; maintaining proper diet and nutrition, getting sufficient sleep and relaxation, and meditating.

Researchers also have tried to identify potential mediators of the stress experienced by family members. Mastery (sense of personal control) was of considerable importance in enabling individuals to cope with mental illness in a family member (Noh & Turner, 1987). Relatively low levels of family burden were also found to be associated with small dense social networks, satisfaction with support received, satisfaction with support from their self-help group, and spouse involvement (Crotty & Kulys, 1986; Potasznik & Nelson, 1984). Hatfield (1981) assessed three dimensions of coping effectiveness: emotional mastery, cognitive skill, and need fulfilment. In her view, if families are optimistic in outlook, realistic about the family member's condition, and maintain an adequate livelihood, they are coping effectively. However, what is not clearly understood is the extent to which family members' appraisal of situations of mental illness, and their use of specific coping strategies, influence these outcomes.

There are other empirical data about coping strategies among families' members in Western societies. Hatfield (1979) investigated coping strategies among families who were members of the Schizophrenic Association of Greater Washington (SAGW) in the U.S. Over two-thirds of respondents indicated that the following were of some or great value (listed in order of importance): 1) parents of other people with schizophrenia, 2) lectures and books, 3) SAGW staff, friends and relatives. It is noteworthy that various forms of

therapy were ranked below most other resources and that approximately half of respondents receiving individual or family therapy reported that it was of no value for them.

Hatfield (1981) went further and conducted an exploratory study of family caregivers of relatives with mental illness over a period of thirty months to identify factors related to effective coping. She reported that effective “copers” tended to be older and somewhat better educated and that their relatives tended to be older, been ill longer, and less functional. Greater difficulty in coping was reported when the relative was functioning at a higher level and was living at home or under family supervision in the community. When family caregivers were asked to rate the effectiveness of their own resources, they rated the natural network of family, friends and other parents as most valuable.

### **C. Perceived Burden Of Care Giving**

Perception of the burden of care giving is one of the important factors that influences family's coping with mental illness. Very often family life is disrupted and reallocation of tasks and/or reassignment of roles assumed by a particular family member occur. Studies in Western countries (e.g., the United States, United Kingdom, Canada and Australia) indicate that living with mentally ill relatives imposes burdens on other family members (e.g. Hoening & Hamilton, 1966; Lefley, 1985; 1987a; 1987b; Lewis & Zeihner, 1960). They may experience objective burdens, such as financial hardship, role strains, disruption of family and social routines, as well as strain related to the need for increased supervision of the ill relatives (Thompson & Doll, 1982). In addition, family members may experience subjective burdens, attributable to the ongoing emotional strain of having the ill relative at home. These burdens are characterised by embarrassment, emotional overload, and conflict with the ill relative over disruptive behaviour and the need to take medication

(Lefley, 1987b). Poor prognosis for future improvement further inflicts family members with a sense of loss and a feeling of helplessness (Lefley, 1987b). Guilt regarding their roles in putting the ill relative into hospital against the patient's wishes and fear of an ill relative's violent behaviours have also been described by some families (Rose, 1983).

Studies of the problems and needs of family caregivers of persons with chronic mental illness indicate that the burdens are long-standing and pervasive and that families often experience feelings of worry, guilt, resentment and grief. The major problems and needs of these families (Biegel & Yamatani, 1986; Grad & Sainsbury, 1963; Lamb, 1982; Leff, 1983; Spaniol & Jung, 1987; Thompson & Doll, 1982), are summarised as follows:

1. coping with behavioural problems of their ill relative;
2. feeling isolated with no one to talk to;
3. insufficient help in providing care, even for those caregivers having a strong overall social network;
4. interference with household routines and with the personal needs of family members;
5. inadequate information about the family member's illness;
6. needing assistance when the family member refuses to take medication regularly or is unable to regulate medication use;
7. inability of the ill relative to carry out daily living tasks and to participate in family life;
8. lack of a respite from care giving responsibilities; and,
9. insufficient help from mental health professionals.

In addition, the perceived burden of care giving is one of the determining factors that affects the extent of care a family will provide to the member with mental illness. The few

early studies focusing on perceived burden among family caregivers of persons with mental illness were conducted in England (e.g., Brown, Bone, Dalison, & Wing, 1966; Grad & Sainsbury, 1963; Hoeing & Hamilton, 1966). They indicated that families experience considerable strain. Grad and Sainsbury (1963) conceptualised and measured “burdens” in caregivers or persons with mental illness. They reported that over half of all families in their studies had suffered some difficulties because of the patient’s illness and one fifth of the families reported severe hardship. More than half of the respondents reported excessive anxiety about the patient and one-third reported restrictions of social and leisure activities and upset in domestic routine.

On the other hand, instead of perceiving the mentally ill relatives as a burden, Francell, Conn and Gray (1988) discovered in small group interviews of eighty-six family caregivers that families experienced profound burdens as a result of their interactions with the mental health care system. Particularly difficult were negotiating crisis situations; acting as patient advocates and case managers; obtaining adequate community resources, continuity of care, and information; dealing with legal barriers; and communicating with mental health professionals.

#### **D. Coping With Mental Illness In the Chinese Context**

despite the influence of Western psychiatry ,Chinese have been generally reluctant to define mental health problems in highly individualised psychiatric terms. The literature has identified a few unique patterns of coping and adaptation to mental illness in the Chinese context. These are discussed further under the subheadings of: 1) the “stage models” of coping; 2) challenges to the “stage models;” 3) notions of somatisation of psychological distress; and, 4) coping and adaptation to mental illness in Chinese families.

1. *The "stage models" of coping*

Cheung (1987) investigated how Chinese psychiatric clients conceptualise psychiatric problems in relation to the patterns of help seeking and ways of coping. She found that clients who conceptualised their initial problems in purely psychological terms were more likely to use self-directed psychological coping methods and to delay initial professional consultation. Clients who used only somatic concepts were least likely to approach mental health professionals initially or at any time during their previous consultation history, and tended to seek medical resources to cope with their problems. Clients who conceptualised their problems in mixed terms approached professional help early on and reached psychiatric resources soonest.

Lin (1982) observed that in most cases of Chinese mental disturbance, sufferers were isolated within their home and family. When the family could no longer cope, a physician was summoned for treatment of a "physiological" ailment. If the client was sent to a mental hospital, he/she was rejected by the family because of the stigma attached to mental illness. Lin postulates that the process of coping with mental illness among Chinese families involves five phases (Lin & Lin, 1981; Lin, 1985). The first phase is intra-familial coping where the family tries to contain or influence the abnormal behaviour using every possible means and resource within the family. In the second phase, the family will seek help from its own social network, e.g., close relatives and friends, to cope with the problems associated with the mentally ill relative. This is followed by the third phase where the family will invite outside helping agencies, e.g., Chinese medical practitioners, physicians, or religious healers, in an attempt to treat the mentally ill relative while he/she is still kept inside the family. The fourth phase begins when the family member is labelled as a mentally ill person by a physician or trusted outside agency. The labelling also signifies

that the family is at its limit in dealing with the mentally ill relative, and a specialist's help is required, first in the outpatient clinic and finally by admission to a mental institution if the situation has not improved. The final and fifth phase starts when scapegoating and rejection set in. This is the time when families come to grips with, and attempt to reconcile themselves to, the "fate" of having mentally ill relatives. The family members give up hope for the mentally ill person to ever recover again and permanent placement planning is initiated, very often without the involvement of the sick relative.

## 2. *Challenges to the "stage models" of coping*

Although these stage models offer a reasonable way of conceptualising some of the changes that families undergo, they are only theoretical reference points when considering particular families (Marsh, 1992). Different stages of the coping process and different coping strategies may occur concurrently and recurrently as families integrate the powerful and unresolved feelings that accompany the experience of mental illness. In addition, some recent literature challenges the "stage models" of coping, arguing that families of mentally ill persons are not a homogeneous group and that the coping process does not necessarily follow a developmental sequence (Guarnaccia & Parra, 1996; Marsh, 1992; Wong, 2000). Romanucci-Ross (1969) in her earlier work on "the hierarchy of resort in curative practices" suggested that there is rarely a clear pattern of help-seeking behaviours (see Chapter 11). There are a number of factors, individually and in combination, that can affect the coping strategies, level of adjustment, and adaptation of families with members with disability (e.g. Yau & Li, 1999). Those factors include characteristics of the mentally ill family member, diagnosis, onset and duration of illness, progress, socio-economic status, marital relationship, personal resources possessed by family members, and so on (Lefley,



1990). Culture not only plays a very important role in shaping the interpretation of stressors, but also influences the choice of coping strategies and the process of adjustment. Terkelsen (1987a) emphasises that there are several aspects involved: the complexities and prolonged nature of the process of family adaptation, the diversity and fluidity of attitudes within and among family members, and the dramatic forward strides and reversals. The “stage models” emphasise the importance of achieving a balance that meets the needs of all family members. However, Terkelsen criticises that this “sought-after balance is hard to discover and [even] harder to maintain” (1987a, p.116).

Further, Featherstone (1980) comments that the straight-line progress of the stage theories is too limiting, and that the final harmony is implausible. She offers an alternative view and suggests that few parents reach an emotional “Promised Land;” most have good days and bad days. Parents solve one set of problems only to uncover another, and very often insight comes without blotting out confusion and regret.

### 3. *The notion of somatisation of psychological distress*

Lin (1982) concluded from a review of the literature the phenomenology of Chinese depression differs greatly from that in the West and is characterised by somatisation. Some of the early literature explained the tendency toward somatisation among Chinese (Cheung, 1982; Cheung & Lau, 1982), with ideas such as 1) denial, suppression, or repression of emotions; 2) lack of a vocabulary or semantic network to express affective states; and, 3) lack of differentiation between mind and body. On the contrary, the latest literature disputes the belief that somatisation of psychological or emotional problems is exclusive to Chinese (Cheung, 1985; Kleinman, 1986). One of the earliest challenges came from Singer (1975), who pointed out that the phenomenon of somatization is not exclusive to Chinese

patients, but is also commonly found in other non-Western cultures and among lower social classes and less well-educated patients in Western countries. Kleinman (1986) supports the view that somatisation is also very common in the West and is not limited to depression or psychiatric disorders. The cultural attributions were criticised by Cheung (1982, 1985) as post hoc explanations using cultural generalisations. Kleinman (1986) broadened the concept of somatisation among the Chinese beyond that of the manifestation of depression in bodily complaints and a pathway of medical help seeking. He summarizes four cognitive hypotheses to explain somatisation: 1) suppression of the affective component of psychophysiological arousal; 2) amplification of normal sensations; 3) misattribution and labelling of somatic symptoms of affective arousal as illness; and, 4) use of introspective, cognitive coping processes centred on the body to handle stress, resulting in common pathways of coping for dysphoria and disease.

Furthermore, in his revised socio-cultural analysis of somatisation, Kleinman (1986) suggests that the concept of somatisation should include an interpretive schema for making sense of life problems, rhetorical means for controlling local relationships by persuading others to provide greater access to scarce resources and empower the somatiser, and symbolic forms that constitute and express salient models of life in particular cultures. Kleinman and Kleinman (1991) criticise the simplistic, dichotomous interpretations of the psychosocial dynamics of Chinese society in Western anthropology, which reduce the analysis of Oriental and Western societies to a “sociocentric-egocentric” dichotomy. Instead of interpreting emotions as “irrelevant idiosyncrasies lacking in serious implication for social relationships,” emotion means a “contextualised response” which is “simultaneously sociocentric and individualistic in the unity of experience” (Kleinman & Kleinman, 1991, p. 281). Kleinman concludes that biomedicine has “entified” the suffering

in somatisation as disease, while medical social science has invalidly professionalised somatisation into undeciphered anthropological codes apart from the human experience (Kleinman & Kleinman, 1991).

#### 4. *Coping in Chinese families*

Philips and Pearson (1996) summarise and discuss the current research on coping in Chinese communities. They maintain that traditional philosophies in China, like Confucianism, Buddhism and Taoism, share an approach to the understanding and management of life stress that is different from that adopted by Western philosophies. In Eastern philosophies, life stresses, which are often subsumed under the rubric “suffering,” are determined by fate. For Chinese, the patient forbearance, or “*rěn*,” of such suffering is highly valued as it repays the debts of previous lives and cultivates the character. It also is believed that forbearance may prevent future mishaps. Philips and Pearson (1996) further state that Confucian values also emphasise the centrality of the family in the management of life problems and the importance of maintaining harmonious social relationships, even at the cost of increased person stress. Under the influence of the collectivist culture, Chinese often consider the reaction of others in dealing with life stressors.

The influence of traditional views on Chinese families depends on the extent to which the community has been “modernised” by urbanisation, nuclearisation of the family, and the level of contact with and assimilation of Western values. Nevertheless, the traditional views, though diminishing in influence, still prevail among the Chinese: the continued belief in an external locus of control (Hosftede, 1980), the frequent use of fatalism as a coping strategy (Hwang, 1977; RPL Lee, 1985 and 1995), and concern with the proper

conduct demanded by a situation rather than with the direct expression of opinions or emotions (Chen, 1988; Hsu, 1953).

Hwang (1977, 1978) conducted unstructured interviews with 180 married males from Taipei between the ages of 30 and 60 years discussing “the belief or method” that helped them the most to deal with troubles in their life. The content analysis of those interviews identified 5 coping strategies: 1) mobilising personal resources; 2) help-seeking from social resources; 3) appealing to the supernatural; 4) adopting a philosophy of doing nothing; and, 5) avoidance. Mobilising personal resources was the most commonly adopted strategy among the Taiwan Chinese, particularly for the younger respondents. For those who sought help from social networks, the order of importance of sources of help was friends, kin, officials and spouse. It is interesting to note that this is the reverse of the order specified by 85 married males in Shanghai (Chen, 1988). They identified their spouse as the most important social support and work leaders as the second most important social support. However, Hwang used a highly selective sample and his results may not be applicable to females, those under 30, or those from rural settings.

#### **E. Coping and adaptation to Mental Illness in Hong Kong Chinese Families**

Shek and Mak (1987) developed the Chinese Coping Scale based on a dichotomization of Hwang’s five types of coping (1977). These two types are internal strategies (using personal resources, doing nothing, or avoidance) and external strategies (using social resources or appealing to the supernatural). The authors administered the scale to 1000 working adults in Hong Kong. The participants were asked to report the extent to which they use 16 different methods of coping in four common life problems (marital stress, family-related stress, interpersonal stress, and work-related stress). The results

demonstrated the scale's empirical validity. The authors argue that to classify coping strategies as internal or external is more stable, global, and parsimonious than Lazarus's classification of problem-focused and emotion-focused coping strategies. Lam and Hong (1992) also questioned the validity of Lazarus's dichotomous classification of coping strategies for Chinese subjects. Based on their work on examination stress among Hong Kong students, they suggested, "Problem and emotion-focused coping should be viewed not as two discrete categories but as independent dimensions which can both be applied to the description of any coping strategy" (p. 304).

Based on the literature and his own clinical experience, Lee (1995) described the coping strategies commonly adopted by people in Hong Kong "fatalistic voluntarism," a combination of self-directed approaches to altering conditions and fatalistic acceptances of the situations. The self-directed and the fatalistic are perceived in the West as mutually exclusive, but Chinese often simultaneously adopt the "Confucian strategy of self-cultivation" (an active striving to achieve moderation in life) and the "Taoist strategy" of self-transcendence (detachment from worldly affairs).

In a large scale study in Hong Kong, more than half the families of over 600 mentally ill patients diagnosed as having schizophrenia for at least two years reported that the emotional well-being of the family members, the family financial situation, the household routine, and families' sleep had been impaired by the patient's illness (Pan & Lieh-Mak, 1987). Over 80 percent of the family informants expressed sympathy and concern towards the patients and admitted that they had to tolerate the symptomatic behaviour of the patients, particularly their incongruous and blunted affect, incoherent speech, and social withdrawal. Yet nearly 90% of the families preferred not to have the patients hospitalised. Apparently the immediate families were struggling on their own, as 60% of them were not receiving

any help from other relatives. This finding is similar to what I found in my interview and field notes data. Hospitalisation and seeing a public psychiatrist are the last resorts for help and families will defer or avoid these as much as possible. The meaning and rationale behind this response will be discussed later in the chapter.

In my study, families appeared to go through the classical stages of acceptance of mental illness: denial, anger, depression, and acceptance. In spite of this, acceptance of mental illness is not where the family stops. They are confronted with the day-to-day caring and managing of the mentally ill member at home (see Chapter 10). Families do not “adjust” or “come to terms” with the mental illness as health care professionals may imagine. Rather, they constantly try to devise a viable strategy for getting through each day, continually varying their self-definitions to cope with the immediate problems of daily living (Armstrong, 1994).

Wong (2000) examined the difficulties and stresses experienced by the local (Hong Kong) caregivers of relatives suffering from schizophrenia. He found that the caregivers experienced the most difficulty and stresses related to the management of negative symptoms such as refusal to perform household duties and neglect of personal hygiene; handling positive symptoms such as bizarre behaviours and thoughts was less problematic. He also indicated that stress associated with the care of relatives with schizophrenia accounted for poorer mental health among the caregivers (Wong, 2000).

The definition of mental illness in traditional Chinese medicine and other folk medicines is less precise than in Western medicine. This has caused the labelling process to be less clear. Therefore, one can avoid the social stigma associated with mental illness through the use of more traditional explanatory models. However, the traditional repertoire of explanatory models of mental illness (Lamson, 1935; also see Chapter 3) that

help families with mentally ill relatives weather out the storm of prejudice and cope with the caring demands now are being discouraged and often are labelled as unscientific or superstitious. Families are now faced with stronger social stigma associated with secondary labelling of mental illness and this limits the choice of healing methods. As well, they have to deal with the bureaucratic “modern” health care system that is established in the name of professionalisation (Guarnaccia & Parra, 1996).

Thus, with strong social stigma, the bureaucratic and hierarchical system of modern health care services delivery, and the lack of other community support to replace the eroding collective familial care, it is not surprising to see that families feel hopelessness and helplessness and are physically and mentally exhausted. Mr. Pang’s interview may provide an insight into this. Mr. Pang’s mother was admitted to the psychogeriatric unit of a psychiatric hospital; he talked about the burden he perceived the family was experiencing.

It is especially difficult for my younger sister (she has been playing the major caregiver role since mother has been put into the nursing home). She comes very often and just after work. We do not come that often and also we can “think it through” (meaning: we have accepted mother’s poor progress). Therefore, she has more chance to be depressed. She will be upset, particularly when my mother throws a temper.

It would be good to have a structure or procedures to follow. For example, with my mother who is chronically ill, you don’t know how long her condition will last. It is a burden both to the patient and her family, financially and emotionally.

They [medical professionals] need to know what to communicate to us. They need to explain to us my mother's condition and what we, the children, need to do. Tell us what to prepare and so on.

An eldest sister among three children in the family talked about her doubt about her younger brother's progress with his mental illness in a focus discussion group.

It is not useful to send him to hospital. For example, if his condition is really bad and extremely emotional, it is all right to send him to hospital. However, it is a long-term illness. How many times can you send him to hospital? Even admitting him to hospital, it is just to ensure his compliance with the medication. A few weeks later he will be discharged and becomes better for a while. Later the cycle repeats again. Hospitalisation is not helping at all, as they won't keep him in there all the time.... He is also quite smart. He does not like to stay in the hospital, therefore, he will behave well while he is there. He will hide his symptoms so that he appears to be normal and will soon be discharged again.

A mother in a relatives' support group meeting expressed her difficulty in making her son take medication and attend follow-up appointments with the psychiatrist.

In this year, we have had to grind the drug (pills) and mix it with his food. Now the only trouble is getting him to see the doctor. You can only lie once or twice that he is busy working and cannot come. When it comes to the third or fourth time, the doctor will refuse to prescribe medication until he can actually see him in person, and that gives me a headache. No matter whether it is a private or a public doctor, he refuses to go. If he does not see the doctor, he will run out of medication soon.



Xie-yin, one of my informants went against her parents' wishes to date a man who appeared to have a major depression for more than half a year and was unemployed for a considerable length of time. She talked about her broken relationship with him.

We have separated. I know I cannot accept this kind of life. What I mean is this kind of life is not suitable for me as, to a certain extent, I know his condition will not change within a short time. I know myself.... That is I just cannot accept his kind of life.

*[What kind of life are you talking about? I asked]*

It is extremely fluctuating – that is, his emotion. It has been fluctuating a lot for a long time. Very often I was just being affected by it. Before I decided to terminate the relationship, I was depressed over a period of time. So finally, I just could not bear it any longer.

### Summary

The Hong Kong Chinese families in this study exhibit characteristics of coping and adjustment similar to those in the West and among the Chinese. The findings indicate that families with mental illness are inclined to adopt the Western psychiatric frame of mind in explaining the illness experience as well as in seeking help. However, some still employ a fatalistic view in “rationalising” the adverse experience. This may lead to criticism from modern health care professionals for being passive and unsupportive to the person with mental illness. There is no obvious dichotomisation of coping and adjustment strategies into fatalism and external locus of control versus eradication the disease and internal locus of control. Very often families place themselves in different positions on these continua in response to different situational demands. Thus, the coping process among the families with mental illness does not necessarily progress in a developmental or stage sequence. Few families will reach the emotional “Promised Land;” most will swing between the good

and bad days. Families solve one set of problems and this may lead to uncovering another. They are confronted with the day-to-day caring and managing of the mentally ill member at home, and very often insight comes without blotting out confusion and regret.

Strong social stigma, the bureaucratic modern health care system, and the lack of other social support to replace the eroding familial collectivism, all contribute to the families' feelings of hopelessness, helplessness, and physical and mental exhaustion. In the following chapter, I take a closer look at the experiences of families with mental illness through my interview data and examine how they make sense of, and cope with, such an extraordinary life event.

## CHAPTER TEN

### Families With Mental Illness: The Experience Of “Having No Alternative” (*Wúnài* – 無奈)

*When I found out he had this kind of illness, I was in shock. It came so suddenly that I felt completely lost.*

A father shared his pain when he discovered his son's mental illness.

*I am just “wúnài” (無奈) (inevitably without alternative), but you also need to comfort yourself. You need to take it easy, otherwise, what would happen if you collapse. My responsibility has not been finished yet. I still need to help them [her mentally ill son and family] in many ways.*

An aged mother expressed her feelings toward the continued care for her mentally ill son.

#### Introduction

As discussed in the previous chapter, coping and adjustment to mental illness in a family is a continuous process, instead of a set of discrete developmental stages. Mental illness, particularly severe mental illness, can make repeated attacks to the integrity of the family system. Every relapse is a new assault to the family's cohesion and structure. Family members go through this roller-coaster experience, preparing for the worst at all times. Therefore, coping and adjustment are not necessarily part of a progressive process. Families are likely to shift back and forth in response to internal situations, including the progress of the member with mental illness, familial changes, and external situations, including inventions of new treatments, availability of services, and changes in societal attitudes towards mental illness. In this chapter, I take a closer look at the experience of families with mental illness in Hong Kong using my data and findings in the literature.

Finally, I explore medication compliance and help-seeking, as they are two of the most mentioned issues concerning families with mental illness.

### **The Experience Of Families With Mental Illness**

The experience of families with mental illness will be revealed through a content analysis of the interview data and relevant field notes. (See Chapter 2 for the methods of conducting interviews and recording field notes). The family experience is discussed under the following themes as they emerged from the data: 1) the discovery, 2) the explanation, 3) disruptions, 4) role re-examination, 5) grief, and 6) family secrecy. However, in real life these themes do not necessarily occur in this sequence, or in any sequence at all.

#### **1. The Discovery**

The experience of finding out that a member of the family is mental ill is a journey full of surprises, chaos, pain, grief, and uncertainty. Mental disorder and psychological problems strike not at birth, but later in life when the family has accumulated many expectations about the member's future. This situation is different from that of people who are born with congenital problems, or people with physical disability. In these cases one may have more time to prepare for acceptance. The onset of mental illness is varied and even when the person is in remission, the family does not know whether or when relapse will occur. Mr. Mak, one of my interviewees, recollected how he felt when he found that his son had a mental illness. His son had sat for the university entrance examination in 1975 but failed. He then studied engineering at the one of the technical institutes. It was an advanced institute, which mainly offered certificate and diploma programmes, and was perceived as less prestigious than a university. Mr. Mak said, out of a sense of guilt, that he had had high expectations for his son to succeed and that this might have created pressure for him. His

son exhibited psychiatric symptoms in 1976, at the age of 20. Later he was diagnosed with manic depression.

When I found out he had this kind of illness, I was in shock. It came so suddenly that I felt completely lost (*lùshēnwúzhǔ* 六神無主). At that time, mental illness was not that commonly known. We had a very difficult time.

Although I knew my son was sick, and I didn't mind if other people knew, my wife had a different view (not accepting). Therefore, we had two different points of view. I could not control my emotions and often cried in front of others. My wife appeared to be settled and pretended nothing had happened. She could put up with the situation, but not me.

Agnes, 25 years old and the eldest of three children living with her widowed mother and a brother with mental illness, also shared how she found out about her brother's mental illness and how she tried to convince the family that he needed help.

I remembered that he started to behave differently in 1993. In the past, he went to work everyday and came home straight after work. Occasionally, he would watch TV or go out to the movies. In 1993, he became reluctant to go to work. He kept complaining there was something wrong with his work and that his colleagues had been treating him badly. Later, he even refused to go onto the street. He was preoccupied with talking to the voices. When we tried to talk to him, he seemed to be deaf. Since 1993, he had been changing jobs. The first one lasted for half a month. The next one only lasted for one week and the latest ones lasted for only one day! He claimed someone was bullying him; he heard the voices that harassed him. He became more irritable and hot-tempered. I insisted that he had psychological problems and needed to be sent to see a doctor.

Although both my mother and brother disagreed about him seeing the psychiatrist, I kept bringing the topic up from time to time. At that time, I was studying at the university, and I had some free time. I actually took him to see the doctor while my mother was at work. His illness had become worse. Gradually, they accepted, not the mental illness, but at least that he had problems.

Mr. And Mrs. Lam talked about their realisation of their teenage daughter's mental illness with sadness.

She started refusing to go to school. She complained of a poor relationship with classmates, and thought that they played tricks on her.... She had slashed her wrists a few times; one ending up having stitches from a family doctor. We just did not recognise that she was mentally ill.

One evening she behaved strangely and we called the school social worker, who felt her speech was abnormal. So we sent her to casualty (emergency department), but she was discharged with medication only. Her condition deteriorated and later she was sent to the psychiatric hospital — all within 10 days of the first appearance of symptoms!

Coming to terms with mental illness is not easy for the family, particularly when there is a strong social stigma attached to it. Reaching a consensus explanatory model for the illness in the family is also difficult as the issue may lead to confrontations among the family members. Agnes, the eldest sister of a brother with mental illness, told me about how they struggled with understanding and accepting mental illness in the family.

My mother and other elderly relatives could not accept this. They thought he had no problem and said he was just dissatisfied with his job, or he was timid and could not put up with stress,

and that he was lazy and pretentious. So, they did not agree to let me take him to see a psychiatrist. They are still not very supportive today.

I think my mother and the relatives could not accept the fact that my brother was mentally ill. They do not want other people to know. Although they know that there was something wrong with him, they think he still has a good chance to recover. They have taken him to a Chinese herbalist at times and thought he might have insufficient blood or *Qi*. They still hope he has nothing wrong, but is just being lazy and cheeky. So all along they have not wanted him to see a psychiatrist and have negative attitude toward the medication.

## 2. The Explanation

Explanatory models of mental illness differ among all stakeholders within a social reality, i.e. individuals, families, health professionals and the general public (see Chapter 5). As familial collectivism is strongly established among Chinese, the family's explanatory model usually overshadows an individual's model. Despite the fact that a family consists of different individual members, there is a consensus model that develops under the leadership of the most knowledgeable or powerful member in the family; very often the patriarch (Phillips, 1993).

The interplay of Western psychiatry and traditional Chinese medicine also manifests itself in the family "boardroom" when two members have a different perspective in explaining a member's illness. A good example can be seen in the account of Miss Jiang, one of my interviewees. She talked about how her parents had a different interpretation of her young sister's mental illness. The sister was apparently experiencing delusions and anxiety. Her father believed that her vomiting, headache, diarrhoea, fainting, and stomach ache were signs of weakness in the body and that they should consult the Chinese herbalist from whom he had previously received good treatment. Nevertheless, both the mother,

who worked as a health care assistant in a hostel for the blind, and Miss Jiang, who was studying a professional health care course at the time of interview, believed that their family member was experiencing a mental illness. They insisted that she should see a private psychiatrist and be put on medication. Miss Jiang stated that the somatic symptoms of headache, vomiting, and so on were “cured” after several servings of herbal tea. But her psychiatric condition deteriorated as she did not comply with the medication regime.

The dominance of Western psychiatry and the power of the associated health care practitioners in defining mental illness and prescribing remedies have moulded Hong Kong people’s concept of mental illness. The results of the questionnaire survey indicated that such a preferred concept is commonly adopted by lay people when talking about mental illness. Thus, diagnostic categories under Western psychiatry were commonly quoted and elaborated upon, although they were used for severe psychiatric disorders (see Chapter 7). Most of the respondents gave less respect to traditional Chinese medicine and other folk healings; either they totally denied its efficacy, saw it as a complementary remedy to Western psychiatric intervention, or they described it as serving a tonic purpose. Therefore, relatively speaking, the families readily defined help needs and interpreted the illness experience from a Western psychiatric paradigm. For example, Mrs. Yin has an 18-year-old daughter who was diagnosed with schizophrenia at 16. She described how her husband had been coping with the situation. He was not able to accept things as well as she did and was still searching for other remedies, including Chinese medicine. The following extracts are from my notes written after the interview, since Mrs. Yin declined to have the interview taped.

Her husband is said to continue getting some herbal medicine for the daughter but Mrs. Yin stated that it is mainly for tonic purposes, maintaining and keeping the body healthy because



mother considers her daughter too thin. Otherwise she hasn't had any other serious illness except occasional sinus problems.

At one stage, Mr. Yin suggested sending the daughter back to China for treatment and also sending her to stay with relatives, where she could lead more of a "country life", with fewer people to encounter. The environment would be quiet, and thus might be good for her health. However Mrs Yin disagreed because the daughter would be far away from home, she would not have many relatives and friends around, and she might miss what young people enjoy in Hong Kong. So the plan was not implemented.

This extract reveals the belief, at least among some families, that a peaceful and sedative life style will enhance the recovery from psychological problems. Very often, the mainland is the family's choice of where to send the mentally ill relative for alternative treatment, care, and recovery.

To summarise, coming to acknowledge the presence of mental illness in the family is difficult, particularly when there is strong social stigma attached. Health care professionals may think that the family is denying the illness. However, they may fail to realise that the explanatory model has affected the perception and interpretation of the illness experience, and thus affects the decision about when and how to seek help. From the Western perspective this erroneously looks like denial. Even with acceptance of mental illness, families may not follow the way of coping and adaptation prescribed in the literature. One reason is that the disruption to family life is seldom a "one-off affair"; families have to deal with the day-to-day caring of the sick members and maintaining the family harmony.

### 3. Disruptions

The interviews highlight various disruptions in family life that result from mental illness. They include disruptions to the family life cycle, to family member roles, and to caring responsibilities. Having a family member with mental illness, to a certain extent, disrupts the family life cycle by being “off time” (Bee, 1998). Traditionally, parents would be expected to do the best for and give the best to their children and, naturally, they could then expect their children to look after them when they become old. Children are all socialized to take filial piety seriously and as one of their major life tasks. Even though Hong Kong has evolved into a commercial and financial metropolis, these traditional values are largely intact.

Having a mentally ill family member means not only that the family has lost “face.” If he/she is also unemployed, which is highly likely, he/she will not be financially independent and will thus increase the burden on parents. Instead of expecting the “reciprocal care” and being looked after when they have completed their life duties, parents realise that their parenting tasks will not be finished until they die. Not only do they have to cope with the disappointment, but their choice of life roles has also been adversely affected. Madam Chan is a good example in that she is still busy with helping her mentally ill son by assisting him to obtain public housing and with attempting to have her ex-daughter-in-law immigrate from the mainland so that her caring duties can be passed on.

I am just *wúnài* (無奈) (inevitably without alternative), but you also need to comfort yourself. You need to take it easy, otherwise, what would happen if you collapse. My responsibility is not been finished yet. I still need to help them [her mentally ill son and family] in many ways.

Now, I have to look after myself. I have high blood pressure. If I don't look after myself, and I have a stroke, then I don't deserve it! No one will take care of me and I cannot help others too. So, I really have to take care of myself. I come here [the day activity centre] to teach cooking [to keep me occupied].

If parents are not able to carry on with the caring tasks, siblings will have to make the "sacrifice" and carry the torch. Miss Wan is good example in that she sacrifices her private time, and even her other friendships, to spend time with her mentally ill brother.

In addition, family members' daily routines are easily upset, particularly when the mentally ill relative is having a relapse. The disruptions include taking time off work to accompany the sick relative for consultation, visiting him/her in the hospital, stopping everything else to control or contain the aggression and emotional outbursts.

Besides those disruptions, Western literature (e.g. Bulger, Wandersman & Goldman, 1993; Greenberg, Greenley & Bedit, 1994; Lefley, 1987) has identified the positive and contributing roles that the member with mental illness can play in the family. When care giving is perceived as a natural function and there is no perception of inordinate stress, mastery may be an implicit component of the caregiver task. In fact, family care giving is not necessarily burdensome and there are certain gratifications and rewards in care giving, both in the practical and psychological sense. Elderly adults may suffer from the burdens of taking care of dependent adult children (Lefley, 1987a), but these adult children may become supports to older parents who benefit from their companionship and physical help in running the household (Bulger, Wandersman & Goldman, 1993). In a study of 725 clients with serious mental illness in rural Wisconsin, Greenberg, Greenley and Bedit (1994) found that 24% of the subjects lived with families and that these clients tended to provide substantial help at home. Within this group, between 50 and 80% helped in the family by doing household chores, shopping, listening to problems, providing

companionship, and sharing news about family and friends. The researchers pointed out that recognition of the client's contribution could help reduce stigma and expand community opportunities for persons with serious mental illness.

This positive regard for the contribution of the mentally ill persons is missing from my Chinese data. Besides the fact that the informants were not a representative sample, either the family members were too humble (a Chinese virtue) to explicitly mention this or it is an irrelevant issue for them. Thus, families only speak about the pains and burdens when caring for their mentally ill relatives. The traditional Chinese virtue of forbearance (*rěn*) seemed to have provided the basic energy for them to put up with the adverse situation. The sense of familial collectivism may have strengthened the adjustment and adaptation process or at least has helped to minimise the aversive impact on the mentally ill person and/or the family. The strategies may include: making financial contribution for the future care and placement of the sick relative and arrangement of job and/or marriage for the fulfilment of personhood as expected by the society.

#### **4. Role re-examination**

Role changes among family members are obvious in my data: spouses become the breadwinner for the family, parents take up the other parent's role, older siblings take up the major caring role even when they are supposed to looking after their own families, and so on. Nevertheless, such role changes are not necessarily without protest from other family members. Sarah, in her mid-20s, showed a fair amount of hostility and passive aggression towards her elder brother, who was described as having behavioural problems with frequent aggressive emotional outbursts. She talked about some open conflicts with him.

We always fought for toys when we were young. I did not like him already. Although we made up afterward, there was always a sting in my heart. He did not give way and care about me. So I already disliked him, and I don't have a bit of feeling toward him.

So what are brother and sister? They are just blood-related and come from the same parents... The rest means nothing to me.

*[Have you ever thought of having an elder brother like other people have? I asked.]*

No, I absolutely never thought of that. There are more problems with brothers and sisters. I would rather just have me only. Now I already have a boyfriend. I need love: I have God, I have a boyfriend, and I don't need this (brotherly-love) anymore.

*[How will the family react/respond when he displays his temper? I questioned.]*

Just talking about my approach: if he steps on my toes, in the beginning I would try to tolerate it. Just like what the Christians say, to mellow him with love and pray for him. That is just bullshit! It never works. Later I found a method that is very useful. Because he is not sensible, (if you are a sensible person, you will deal with him sensibly), I have found a solution – to argue back with him.... 'Yes, I am an alien and now come to tame you.' This sounds like a joke, doesn't it? Well, at least he can't win. So I grumble and talk nonsensically, and he does not know what I am doing. Once he screamed at me at a very close distance. I just screamed at him in return. He just did not know how to respond and I don't know why. I just behave as mad as him. In that way, I think I have tamed him. This is a new discovery and very effective method!

My mother's method is even more effective. She just uses a "classic woman's response." It is because my brother will swear at my mum at times. Then you know she is our mother! "How dare you swear at me like this!" So she will be very angry. She will scold him repeatedly. So

now if my brother swears at her one sentence, she will scold back repeatedly for hours. My brother is afraid of this.

Perhaps, superficially we may conclude that this is typical of a high “expressed emotion” family and is also pathological. Nevertheless, there is a need to understand the frustration, the pain and trauma from the family’s perspective and may just regard this as a way to cope. Often there are no other alternatives for the families due to the perceived and socially expected obligation of care for the family members in need, as well as there are insufficient support services available in the community. Normal family social life also seems to be affected by the unpredictable behaviours of the mentally ill relative. Mr. Fung, father of a 24 year old daughter with mental illness, talked about the disruption to the family social life caused by his daughter. The following is an extract from my notes made after the interview.

The family is reluctant to invite friends to come for fear that her [the mentally ill daughter’s] temper tantrum may occur. The father expressed experiencing a lot of stress, because they don’t know when her temper will flare up. She may just wear a bra and underpants and walk around the flat!

One of the family members may have to take her out before friends can come to visit so that embarrassment can be avoided.... Father is said to prefer concentrating on work once he is in the office so that he does not have to think about his daughter.

Miss Jiang, who has a mentally ill sister, also expressed her grievance about living with her sister. She complained of being neglected by her mother, as her mother spent a lot of time caring for the mentally ill daughter.

At the beginning I did accept the situation, i.e., my mother gave all the attention to my sister. I didn't mind that much as I knew she really had problems and needed someone's care. But one year like this, then another year, and the same in the third year. Well, I thought there was no problem, but... I am a human and I do need someone's care, too. When I am having a headache or not happy with things outside, no one in the family asks how I feel. They may even think I can fix things myself. You guess what I hear every time when I come home? Everything is about my sister: what she has done. Then mum will tell me about what my sister has done wrong or why she was unhappy today. So, I am just a listener, but no one wants to be my listener.

It is not hard to imagine that the sick sibling may become one's natural enemy, carving out their individual niche and jockeying for parental favouritism, or just parental attention. Very often one also has to bear with the disturbance and embarrassment created by the sick sibling. Despite this, siblings are also natural allies joined by blood, shared history, and common environmental ground. No matter how bitterly they may quarrel, or how rough their justice, when confronted by a common enemy, i.e. the family's mental illness, they will often be loyal (Secunda, 1997). This is well reflected in Miss Wan's experience in living and caring for her brother with mental illness. For example, Miss Wan was pleased with how the family (including her parents and other siblings) worked cooperatively to tame her mentally ill brother's temperament. She further commented that:

My parents' relationship was improved through family counselling, as the family sought help from outside. It was the first time I felt love in the family. When we faced any problems, we would pray together. We just did things together, to cheat my brother if we needed to. My brother started to feel loved by the family too.

In addition, the experience of mental illness in the family has helped members to re-examine their roles or relationships. Miss Wan, who spends most of the time with her mentally ill brother, re-asserts her role as the “big sister” in the family, where there has to be one person to take charge of family affairs in order to maintain the collectiveness and integrity of the family. She explained in the interview, “As a daughter myself, on one side I had to face my mad brother; on the other side, I had to face my parents’ deteriorating relationship and try to help them towards harmony. At the beginning, my mother was very reluctant to see the counsellor. So we tried to talk to her and motivated her to try. It was hard.” It appears that the Christian faith, instead of traditional Confucianism, has defined her “mission” in the family.

Besides going to [Protestant Christian] church, I spend time on the operational matters of the relatives’ association. Someone did ask me whether what I am doing is worthy or not. All I think is that what I have done can help others. I really value the opportunity to help others, and perhaps because of my religious belief, I am quite satisfied. Compared to others, not to say people with mental illness, I am really fortunate.

Agnes, another eldest sister, also shared an experience similar to that of Miss Wan in struggling with the “big sister” role.

I don’t particularly feel lonely or helpless. Although my youngest sister does not live at home (as she was living in the university student quarter), we are very close. Actually it is even better if she is not living at home. There are fewer conflicts. She comes home occasionally and calls regularly. I also have my own friends. They always know my family problems. Perhaps, I just get used to it; so I don’t feel any particular difficulties with my family.



In a quick flash of thought, I do hate my brother and the family situation. For example, he smashes up too many things at home. At that particular moment, yes, this thought of hate crosses my mind. However, when I settle down, I realize there is nothing you can do. Perhaps, I would also think that no one wants this thing to happen. To keep carrying this kind of hate feeling is not necessary. This will only make me unable to let go.

*[“Why did you not move out from the family as you are troubled so much by your brother on top of other stress?” I asked.]*

The biggest problem is I am the eldest. My mother depends on me a lot. From the very beginning, I have had to bring my brother to see the doctor or to admit him to hospital. Someone suggested that I move out, but this is a big decision to make, and would take a lot of determination. At the moment, only my mother and myself work to support the family. So financially, it would be difficult to move out alone to another place, as it would become my extra burden.... I really don't think the problems will be solved if everyone moves away from home. My brother is bored at times and he needs someone to talk to. Therefore, he needs his family and friends. Even though I am living with him now, I don't have much time together with him, or talk to him patiently for a whole afternoon. But still at least there is some contact. I am still concerned about him and answer his questions. Since my younger sister is already not living here, if I move out too, then he will be the only one living with my mother. That means his contacts with others will become less. I have thought whether it would be good for him or not.

In addition, regarding moving out of the family unit, my mother loves my brother very much, even more than me. So if I want to move, I shall be the only one moving. She will never move. I work during the day and have other things to do at night. My time in the family is already short. If I even do not use this limited time to stay at home, I will not know what is going on at home. It is difficult! I just want to make myself feel good by moving out, but that does not help the situation, and my mother will be the one who suffers most.

Elaine, in her late 20s, is a social worker and has an elder sister with mental illness. In a health care professionals seminar, she talked about gradually learning how to appreciate the sacrifice and strength that her mother has given to hold the family together while coping with her sister's mental illness. Her mother is a primary school teacher and seemed to be the major breadwinner in the family of nine. Elaine has 6 siblings. Her father was running a small business but appeared to take up a major domestic role in the family. The condition of the sister with mental illness has been fluctuating and she has not been able to hold a steady job since onset, after finishing secondary school. Applying her knowledge from social work, Elaine began with complaints about her parents, especially her mother, as the major cause of the mental breakdown in her sister. She first related the cause to the "second-child syndromes", i.e. this sister was missing parental attention, as she is the second child in a family where parents tended to give more attention to the eldest and the younger siblings. She described her mother as a harsh and demanding person. On another occasion, as she was sharing with others her experience of living with a mentally ill relative, she began to reflect on what had been said by another parent about her relationship with her mother. She expressed, "I am now able to understand my mother better: her difficulty coping and her disappointment over my sister."

## 5. Grief

The grief and the concern seem to be even stronger among parents whose mentally ill children are still young. Mrs. Yin expressed her great concern about her teenage daughter's future. The following is an extract from the notes I wrote after the interview as she declined to have the interview taped.

Mrs. Yin said the mental history of her daughter could be traced back to when she was in Form 3 of secondary school. That was the first time she showed signs of mental illness. Mrs. Yin described that at that time her daughter was experiencing sleeplessness and couldn't go to sleep or woke up during the middle of night. She often cried and argued with her brother. At that time, she didn't realize that her daughter had a mental illness, so she tended to blame her for her laziness and criticised her for some odd behaviours. Later, she was able to get help through contacting the social worker in the community centre.

Through the social worker and the community centre's assistance, she was able to see a counsellor. But the counsellor mainly concentrated on her, instead of her daughter, as she thought the mother was the one who had problems in coping with a teenage daughter. Later, she discussed this with the social worker and the social worker asked her to describe her daughter's symptoms. She suspected that the daughter had a mental illness and recommended her to see a private psychiatrist. Nearly a year passed from the first awareness of the symptoms to the day of getting help from the psychiatrist.

Since then, the daughter has kept seeing that psychiatrist. According to Mrs Yin, the treatment is quite expensive, \$900 for each monthly consultation. Although they are not well off financially, it appears that mother is quite keen to keep her daughter in the private system; she has never been admitted to hospital.

She was put on medication, and went back to school. She failed in the Form 3 examination, but still went on to Form 4. Unfortunately, she failed the Form 4 examination and needed to repeat. On the night before she went back to school, she couldn't sleep, paced up and down, and cried. From then on, I think, her mother decided to withdraw her from study — that was last year. Subsequently, through the help of a social worker, her daughter was referred to attend a day centre for formerly mentally ill persons at Kwun Tong, which was about half an hour away from home by public transport. In the daily centre, there are activities similar to the

living skills centres in New South Wales, including vocational training and interpersonal skill training. Mother seems quite happy with her progress there. She is still on a steady course of medication and appears to be doing quite well.

At one stage, Mrs. Yin started to cry. She tried to stop herself from crying and got me talking to her daughter so that she could walk away for a while to pull back herself. It seemed that she didn't want to show her emotions too much, since she said that whenever she talked about her daughter she just could not control herself. She felt very anxious about her daughter's future.

Another example comes from Mr. and Mrs. Lam, who showed great concern for their 15-year-old daughter who was suspected to have schizophrenia.

Mrs. Lam: What I am worrying about is her future. Whenever I think of her future, it is grey and I am not sure what to do.... Her personality is playful. At the moment she is acquainted with other day patients. I don't know if it is good or not... She gives up too easily in trials and does not make effort. If she continues like this, how can she look after herself in the future?

Mr. Lam: She is just immature and does not listen to anybody. We have done all we can.... She is all right, same as her mental state. She just cannot let go (looks beyond the horizon). Otherwise, there is nothing wrong with her. She is just playful and not interested in study.... She likes to go out with her hospital friends (co-patients). Perhaps she won't feel inferior when she is going out with them, as they are the same.

My notes also include:

Mr. Lam mentioned his dislike of his daughter going out with an older man, more than 30 years old, who is also attending the day hospital. Once he saw that they went out together, he took the "boy" aside and "talked" to him. On another occasion, both Mr. & Mrs. Lam took a

day off work and went to check on their daughter at the day hospital. They found that both their daughter and the man did not attend the morning session, so Mr. Lam gave his daughter a “lecture” afterwards. They now impose restrictions on her. They were particularly worried when they heard that this man is not of “good character” — drinking and unemployed, whereas many people who had attended the day hospital had already found jobs.

They also mentioned difficulty communicating with her. They now pick her up at the end of the day hospital session, but worry that she will soon protest against such an arrangement. Actually she is growing older. “As parents we do really want to help her, but she rejects or avoids us. I really don’t know what to do!” said Mrs Lam.

Atkinson (1994) compared the grief of parents who had an adult child with schizophrenia to that of parents who had “lost” an adult child through death or a head injury that resulted in an organic personality disorder. The results suggested significant differences in grief reactions and the content. The parents of children with schizophrenia had more ongoing grief; in contrast, the parents of children with head injuries were more likely to abuse substances or drugs. Atkinson found an inverse grieving pattern for parents of a schizophrenic child when compared to the other parents. Parents whose child had died or who suffered from head injury had a greater initial grief reaction than the parents of children with schizophrenia. However, grief diminished over time for those parents whose child was still expected to die from head injury or was not expected to recover fully. In contrast, the lower level of grief in parents of children with schizophrenia tended to have low initial levels of grieving which increase over time. The research found that most of these parents were not told the diagnosis and prognosis but learned it piecemeal over a period of years. Atkinson (1994) also suggested that the characteristic pattern of exacerbations and remissions in the course of schizophrenia might play a unique role in

shaping the parent's reaction. This is well illustrated in Mr. Mak's story, told earlier, about his shock when he discovered his son's mental illness and the pains and struggles he suffered until recently when his son has been relatively settled at work and at home. Actually, Mr. Mak has become an active member of a relatives support group that meets regularly for mutual support and political lobbying. On the other hand, Madam Chan, who expressed her grief over her mentally ill son and her harsh life, attempted to moderate her previous perception by becoming philosophical.

My life was not good, I just came to this world at the wrong time.

I am just *wúnài* (無奈) (inevitably hopeless) and you also need to comfort yourself. You need to take it easy, otherwise, what would happen if you collapse.

I think that in this world there are not too many people like me: life is tough and hard work....

Ai! Just too much for me!

## 6. Family Secrecy

Having the diagnostic label of psychiatric disorder is detrimental to the individual as well as to the family. It is not only the social stigma attached to mental illness that affects the individual's fulfilment of personhood in the society. It is also the meaning and the implication for the family that it is no longer an individual member's matter, but a family affair. Having a mentally ill member in the family who is not able to fulfil the expected social roles will lead the family to lose "face" or have a sense of incompleteness. Parents experience a great deal of guilt that they may have done something wrong in the past, or even in previous lives, to deserve such punishment. They also may feel that because of poor

parenting skills their children have become deviant. Parents feel they cannot “lift up their heads in front of their relatives.”

The social stigma of mental illness not only applies to the sick member, but also to other members of the family. Having a parent with mental illness may affect the children's chance of employment or job promotion. It also may jeopardise siblings' marriage prospects (Phillips, 1993). A recent court report on job discrimination is a good example. A man appealed to the court against the dismissal decision of the Customs and Excise Department. He was discharged from his job for having a history of mental illness in the family, coming from his mother (*Apple Daily*, 17 August, 1999; *Ming Pao Daily News*, 17 August, 1999; *Hong Kong Standard*, 17 August, 1999). The reason given by the Department for terminating the employment was that the person did not fulfil the medical requirement that a candidate must be free from a family history of mental illness of a hereditary nature. The rationale behind this was claimed to be that an officer would be required to carry firearms while on duty and it would be dangerous to the public and himself if he was mentally disturbed. It is obvious that the Department has adopted an explanatory model that mental illness is hereditary. Thus, they have assumed that the person carried a “pathological” gene that may manifest itself at any time. A great deal of blame must be assigned to the employer. On the other hand, there is another way to interpret this incident in that new discoveries in medical science do not necessary lead to improvement of the human life situation. A new stereotype or new element for stigma may arise that may cause more pain to the person involved and his/her family.

The family has to decide if the potential benefits of enlisting aid from the health-care delivery system and negotiating with the official representatives of social institutions are worth more than the loss of family status that occurs when they admit to having a disabled family member (Phillip, 1993). If the cost of disclosing is too great, it will become a secret

that family members keep to themselves. Delaying the visit to the psychiatric specialist is one way to defer or avoid the confirmation of the diagnostic label of psychiatric disorder. Even when they need to seek treatment, they will try to see a private psychiatrist if affordable, as they are perceived to be able to shield the sick member's label from the outside. The other alternative is to disguise the fact by explaining the situation in other terms, such as a physical disease or a personality problem.

Miss Jiang, one of my interviewees with a younger sister diagnosed with schizophrenia, talked about the family's struggle between seeking psychiatric help and the avoidance of social stigma.

She [the younger sister with mental illness] was always unhappy. We felt there was something wrong with her. So we took her to see the school social worker. The social worker suggested she should see a psychiatrist and she referred us to one. My mother then took her to see this private psychiatrist.... My mother told me that the psychiatrist told her, when my sister was not around, that my sister had paranoid schizophrenia as she always thought someone was boycotting or persecuting her. Therefore she had to keep her on medication.

It cost us one thousand dollars [approx. US\$150, one-sixth of an average worker's monthly wage] for one consultation! Consultations began once every fortnight, then later were once every 3 weeks, and later, once a month. Her condition did not improve, and she was still crying and laughing all day. My Mum got worried that she needed to see the psychiatrist for a longer time. At that time, she still wanted to continue, though struggling with the limited family income. The reason why? It was because both of my parents believed that if we once sent her to see the public psychiatrist [the consultation fee is less than 10% charged by the private psychiatrist], she would have a "record", and consequently stigmatisation would then follow. How could she find a job in the future? There were also people saying that even if the person did not mind, how could his/her sister or brother look for job? Once someone finds out



there is a mentally ill relative at home, the family member's future will be doomed. We actually came across such an incidence happening to one of our neighbours.

Eventually, because of financial reasons, the family decided to send her to see psychiatrists in the public system. Mrs. Yin also reported a similar experience with her daughter's mental illness.

When I asked whether Mrs. Yin had told any relatives, or whether the relatives knew about the situation, she replied that all the close relatives knew about daughter's condition and they seem to be very supportive. However, she didn't disclose to other people, including neighbours or friends, about her daughter's mental illness. Occasionally her mother would take her to a restaurant to meet with friends. Some friends commented that she was very quiet with her head down and not saying a word, and so they might question about it. However, Mrs. Yin claimed that they never enquire about her daughter's mental illness. Mother also did not try to explain or even mention that she has mental illness as she was worried about the possible stereotypes or the stigma that might be applied to her daughter.

Other evidence to indicate this phenomenon of family secrecy is that I had great difficulties in recruiting family members as informants for my study, as they did not want others to know about their mentally ill members, for fear of isolation and prejudice if friends or relatives found out. For example, one parent insisted that I could only interview her by telephone at a certain time when other family members were not at home. She explained that they did not want her to talk to anyone about her son's mental illness. Another parent declined my interview for fear that the neighbour might find out about her mentally ill son, even though I assured her I would be happy to disguise myself and come at the most appropriate time.

Avoiding being known as mentally ill and the diagnostic label seems to be a major affair for a family with a mentally ill relative. As long as the relative with mental illness does not exhibit a lot of bizarre behaviour, mental illness can still be seen as a “hidden disability” (Fitzgerald et al., 1997). If no one knows s/he is mentally ill, s/he will not have to put up with the social prejudice, hostility, and discrimination that other persons with physical disability do. Being hospitalised is seen as the formal confirmation of the mental illness label. Therefore, families tend to protect the mentally ill member either by not exposing him/her too often in public, i.e., remaining home bound, or visiting a private medical doctor or psychiatrist for treatment secretly. Many of my family informants expressed worries about having neighbours or relatives aware of the mentally ill member for the fear of more isolation and discrimination. Miss Jiang and Mrs Yin’s interviews, quoted earlier, are two good examples.

It may seem strange that people want to avoid the mental illness label. However, it reflects the family’s pain and desperation, not only in protecting the member with mental illness, but others in the family and the family’s integrity. Thus, protecting the family is not just for “saving face”, but also to protect the mentally ill individual and the other family members from experiencing discrimination in employment. Unfortunately, health care professionals often interpret this as a sign of over-protection of the member with mental illness, or denial of the problem among family members. The following is an extract from a special feature of a newspaper that reported an interview with a psychiatrist who talked about his clinical observations of 20 years. It may provide a reflection of such a dilemma.

Source: Ming Pao Daily News (12-4-1999)

News header: 治療精神病廿載 葉恩明看盡狂人

**(Treating psychiatric illness for 20 years, Dr. Yip Yan Ming has seen all the crazy persons)**

Extract:

香港人對精神科病症認識膚淺，葉醫生入行二十一年，見盡不少啼笑皆非的人生百態，他認為，香港人在這方面的認識，是民智未開。

以前的人有精神病，誘因多數是與家人不和，家庭環境擠迫等等切身問題，但今日，港人的精神病誘因則多是擔心自己在他人眼中的形象、名、利和物質的得失。

「為人父母者有時會扮兒女的精神病症狀，來到診室，要求我為他們診斷，我當然知道他們根本無病，只是擔心兒子一旦看過精神科醫生，會影響前途。父母親寧願拿藥後，再轉給兒女吃，而不想兒女曝光，原因是怕『有底』，真是非常可笑」。

「病人有時又會用假名登記看病，在外邊出事後，醫院致電診所了解病歷，我們找尋大半天，都找不到，始發現有人用了假名。」

**(Translation)**

The knowledge of psychiatric illness is quite shallow among the Hong Kong people. Dr. Yip has been in this field for 21 years, and he has seen many wonders of human experience. He thinks the knowledge of this area [psychiatry] among the Hong Kong people is yet to be cultivated.

Some of the parents came to the clinic and acted out the symptoms of their children's psychiatric illnesses as if they were their own. They asked me for the clinical assessment or diagnosis. Of course, I knew they were not sick. They were just worried that their children's future will be affected once their children have seen a psychiatrist. So, once they got the medications, they would take them to their children. They did not want their children to be exposed, as they were afraid that a "record" would be kept for them. This is really just laughable.

Sometimes patients would register under a false name. If anything happens to them outside, and when the hospital calls us for their records, we would spend half a day looking for them, then we found out that they had used a false name.

### The Balance And Adaptation

Coping with mental illness in the family is not an intermittent problem like a cold or flu. It stays, drags on, and eventually consumes everybody in the family. Mr. Mak eagerly talked about the relapse of his son's mental illness in 1987, as if it seemed to be happening now. In his words, "It strikes with almighty suddenness and sucks you into a black hole."

Everybody in the family was affected. He just tricked us and fooled around with us, not taking his medication and demanding this and that. We were just running out of counter-tricks to deal with his. We were so helpless and hopeless at that time. I got these tremors in my hands. I did not realize until the doctor told me that I also had anxiety disorder, and I have been taking medication ever since.

It is unclear what coping processes serve to moderate the sense of burden. Grad and Sainsbury (1968) and Robins, Copas and Freeman-Browne (1979) suggested that time may be a moderate factor — perhaps families learn to cope through experience. Noh and Turner (1987) found that families that have adequate social support and feel in control of their life circumstances experience less psychological distress related to the relative's illness than do families that do not have many resources. Does this mean that Chinese with a strong sense of familial collectivism will cope better with mental illness? That does not seem to be necessarily the case.

The generalisation of familial collectivism to all Chinese groups and the interpretation that individualism rarely occurs among Chinese may be an over-statement. This is particularly true when Chinese society is transforming from an agricultural society to industrial and commercial society (Yang, 1993; KS Yang, 1995). Reflecting on my knowledge and experience, individualistic elements seem to exist within Chinese familial collectivism; that is, the yin and yang also co-exist in the family. Perhaps, individualism

can only exist if it does not upset the function and operation of familial collectivism (*Yang*, 1993). A member can choose his particular career path or even marry someone that may not have the endorsement from the elders. As long as he or she is performing certain expected or consensus social roles, the detailed content of those roles will become a minor issue. However, if a person chooses a career or adopts a role that may disgrace the family, such as professional theft, prostitution, or being unemployed, staying single without a particular reason except indulging in one's own pleasure, or engaging in homosexuality, and so on, these roles will be seen as challenging the integrity of the family structure and function. Social sanctions will then be applied as attempts to restore the equilibrium. This is just like the small dot at each end of the two swirl winds on the *Tai Chi* symbol. The two dots are represented by two different colours that are opposite to the background. This means that individuality is permitted but should be minimised and contained by the surrounding collectivism, otherwise chaos and disharmony may result.

A mentally ill family member receives “unconditional” love and care from parents and/or siblings. In exchange he/she needs to follow their plan to achieve the personhood status mentioned earlier, or, reciprocally, to perform the assigned tasks that bring praise to the family or parents: companionship for aging parents, carrying out domestic duties, maintaining good self control, and maintaining the social network. The *yin* force of caring and the *yang* force of coping and controlling disruption interplay and, depending on the situation, one force may dominate over the other. However, somehow equilibrium will be maintained in the end through familial adjustments, so that harmony in the family, as the ultimate goal, can be achieved, at times irrespective the costs. Medication compliance is one example of this.

### Medication Compliance: A Struggle For Control Among Individual, Family And The Western Medical Practitioner

The data, including field notes, the questionnaire survey, and interviews, have consistently revealed a major theme: the concern with medication compliance. Non-compliance with medication is the major complaint or source of stress mentioned by family members. It is also a major factor for disharmony in the family. Non-compliance often is used by medical professionals and the mass media as the major explanation for violent behaviours among mentally ill persons. The following newspaper clippings are good illustrations of this point (Table 16).

**Table 16** Samples of news headlines/headers associated with non-compliance with medication among persons with mental illness

Newspaper	Date	News Headlines/Headers	Abstract/Remarks
Apple Daily	20.11.96	抗拒服藥不依期覆診：精神病者不聽話危險 (Translation) Refusing to take medication and defaulting follow-up: The danger of non-compliance in mentally ill patients.	(Abstract) Non-compliance with medication is reported to be related as the cause of relapses – Drawing conclusions from a few violent acts by mentally ill persons recently as reported in the media. (Extracts) 本港近兩個月來，先後發生多宗精神病患者嚴重傷人的血案。精神科醫生指出，不少行兇者音襲擊家人，甚至傷及無辜的途人的原因，是本身沒有依期到醫院覆診，以及停止服藥引致舊病復發。醫管局最近的調查發現，了港有一成精神分裂者正是這類不聽話的病人。雖然本港現時有四間醫院成立了外展社區治療組，親自找上門，惟苦於人手有限，醫生呼籲病人家屬，若發現康復者有任何病發徵兆，應立即求診或致電志願團體的熱線，避免慘劇發生。
Apple Daily	13.2.97	弑母漢疑停葯精神病發 死者三刀斷頭折十肋骨 (Translation) Mum's murderer suspected of stopping taking medication. The victim received 3 chop wounds to the head and 10 fractured ribs.	(Abstract) Aged mother was in hospital for fractures caused by a previous quarrel between her and the mentally ill son. No one had supervised him on his medication for some time. Non-compliance with medication was named as the cause of relapse and the subsequent murder. (Remark) There is also an extract of an invited comment from a psychiatrist: Defaulting medication for 6 months, 60% of patients would relapse.

**Table 16** Samples of news headlines/headers associated with non-compliance with medication among persons with mental illness (Continue)

Apple Daily	20.7.97	精神有異無服藥 多次圖撞途經車 狂漢蓄意衝出馬路撞車死 (Translation) Mental abnormality with no medication. Repeatedly throwing self into coming traffic. Crazy man premeditated to dash out on road killed by on coming traffic.	Man suspected to have mental illness or had lost his mind, threw himself out into the coming traffic and got killed.
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The general community appears to believe in the potency of psychiatric medication in controlling violent or deviant behaviours. However, the side effects of those psychiatric drugs (something not mentioned in the newspapers) discourage the compliance of mentally ill persons. Due to budget constraints and the drug monopolies (most of the drugs are supplied by a few big pharmaceutical companies), first generation psychotropic drugs are still widely prescribed by the psychiatrists in Hong Kong. Due to cost, second generation drugs, such as Clozapine and Risperidone, which are said to have fewer side effects, have not been widely adopted.

Mental illness can present repeated attacks to the integrity of the family system, particularly with severe mental illness like schizophrenia. Every relapse can be seen as an assault to the family. Family members will go through a roller-coaster experience where they need to be vigilant all the time. We have also seen the disruptions to the family life as mentioned above. We can imagine the tension and exhaustion experienced by the family. Noh and Turner (1987) points out that the perception of mastery and control of the situation by family members seems to result in minimal subjective burden. When care giving is perceived as a natural function and there is no perception of inordinate stress, mastery may be an implicit component of the caregiver task. This may explain why families are quite preoccupied with the medication compliance of their mentally ill relatives. At least from

their experience, medication is the most effective way to control the sick family member's madness. Medication compliance can likely ensure that harmony can be restored to the battle-torn family by containing the sick member's disruptive behaviour. The families in my interviews tend to relate medication non-compliance to the mentally ill member's lack of insight or denial of his/her illness. That means they will need to continue with the battle to convince the mentally ill relative that he/she is sick, using every possible means. A few family members shared their experience of enforcing drug compliance on their mentally ill relatives. The following is Mr. Mak's experience.

I was a bit annoyed about the 1989 admission. He was attending a day activity centre, and they were supposed to have someone providing training and keeping an eye on him. That means he was cared for by professionals. But still he relapsed. Anyhow, I knew him. If he does not take the medication, even God cannot help. His biggest problem is refusing to take medication. He would do everything to avoid taking the medication, for example, put the pills behind his teeth and spit them out when no one is watching.

Madam Chan remembered her son's situation when he was in the U.S. and her recent experience.

After he met a girl, who was an illegal Chinese immigrant in the US, he wrote to me and asked me not to mention about him taking medication. He said he was old enough and also he did not want his girlfriend to know he was on medication. When I phoned to remind him, he dared not to speak louder. When he did not take his medication, he became more stubborn and refused to take any advice at all, even from his girlfriend.

If you do not accompany him for injections (psychiatric medication by injection), and it happened twice, he would not take it. Subsequently he relapsed.



Miss Wan also shared her family's struggle to keep her brother on medication.

He refused to take medication, so we used all kinds of excuses and mixed them [the psychiatric drugs] with his flu tablets. We just used whatever means we could to seduce him to have psychiatric follow up. We gave in to him at the beginning. We did not know what other methods we could use. We were afraid of his temper tantrums. When he was in a bad mood, he might hit out at the others. Actually he did this at times. We also worried that when he was in a bad mood, he might attempt suicide again.

To manage medication compliance is another example of coping. Preoccupation with medication compliance is an indication of the presence of stress. If the sick relative refuses to take the medication, and will most likely relapse (particularly people with severe mental illness), this will shake the existing "harmony." Subsequently, the family will have problems in coping. When the mentally ill relative consistently takes medication, this stress to the family is eliminated and balance returns. In the extreme case that the member is too sick, outside help will be sought, including hospitalisation, to put him/her back on a course of medication so that s/he is under control again.

On a related issue, most studies of families with a relative with schizophrenia have concentrated on the impact of family interactions on the mentally ill relative. Many researchers and mental health professionals fail to recognise the burden that living with a person with schizophrenia places on family and the impact of distressed family interaction on the non-schizophrenic members (Hatfield, 1987; Bernheim and Switaliski, 1988). The newspaper article on Dr. Yap's interview shown above is an example illustrating such an attitude by a health care professional. When relatives look to health care professionals for assistance, they do not necessarily receive the help that they want and express considerable frustration and dissatisfaction with the service (Holden & Levine, 1982). There are a few

incidences in my data that reveal such situations and there is one related to prescription of medication. In a focus group discussion, one of the parents expressed the professional bigotry that she experienced.

As I have said earlier, every time the doctor sees the patient, he enters and asks, “Mr. so and so, how are you? Working now? Are you happy?” Just these few sentences only. That is the reason why I said that if the family could record those minor details and tell the doctor, that they will adjust the dosage. I remember years back when my son was taking mental [anti-psychotic] medication, three times a day and 1mg each. The social worker had mentioned to him that my son’s delusions and hallucinations were getting more serious. So, he changed his dosage to 15mg [each time and 3 times a day]. Then I asked the doctor whether there would be any problems if it was changed to such a heavy dose. He replied, “Are you the doctor, or am I!” He tried to shut me up. But I did not back down, and I said, “Doc, if I do not believe that you are a 100% qualified psychiatrist, I won’t bring my son to see you. When you prescribe the dosage, you examine the illness condition. Of course, you can use your professional knowledge. But would you listen to one word I say? You know the recovered person’s [the patient’s] condition well, but I know him even more. So you tell me!” Immediately, he had nothing to say. Still, he was the specialist; he won and prescribed my son with 15mg. However, I knew nothing about medication at that time. I took my son to see an eye-specialist as he complained about dizziness, but without realizing it was the side effect of the medication. Then I talked to that doctor again. Eventually, he agreed to reduce the dosage to 10mg and 2 times a day.

Not only the administration of medication, but also the prescription of it is a power issue. The Western trained medical practitioners have the monopoly over the prescription of this potent “magical cure” for mental illness. They often play a role similar to a high priest in a traditional or ancient culture. They hold a role that is to be feared, respected, and

worshipped by the lay people, as they have created for themselves an image of possessing an unchallenged divine power — the power of healing. Any challenge to their knowledge or use of potent drugs will likely result in retaliation, in terms of scolding words or threats or removal of benefits. Therefore, the public rarely checks the abusive use of power among the psychiatrists. This does seem to be changing slowly as the Medical Council responds to increased public pressure for accountability. Despite the rising status and recognition of Chinese traditional medical practitioners in Hong Kong, they cannot pose any significant threat to the psychiatrists or mental health professionals as long as mental illness is only defined and treated according to the Western medical paradigm. Furthermore, quick-fix medicine derived from traditional Chinese herbal medicine is still not available to provide immediate relief of symptoms in this fast-paced, “time-is-money” commercialised metropolis. Thus, in the near future, healing for mental illness will still be dominated by the Western approach, which predominantly uses synthetic chemical substances.

### **The Help-Seeking Process**

The help-seeking behaviours are often found to be situational rather than following a certain sequence. The current help-seeking pattern in Hong Kong is different from that of the past, as it has been heavily influenced by Western psychiatry for nearly 100 years. Over 150 years ago there was a swing in the preferred mode of healing for mental illness from one based on a traditional explanatory system to one based on modern science. Using the yin and yang analogy, the extreme yin will create yang or vice versa. Within the current Hong Kong context, the extreme yang (Western medical domination) seems to have reached a point where the swing back has begun with the revival of traditional and alternate healing methods, particularly the gradual increase of popularity in traditional Chinese medicine. There are already claims that traditional Chinese medical practitioners can play

a more prominent role in managing neurotic cases involving psychosomatic problems, sexual dysfunctions, and cases of culture-bound syndromes such as *shenk'uei*, and *koro'* (Lin, 1982; Zāng, 1996). Nevertheless, I need to emphasise that I am not advocating the replacement of Western medicine with traditional healings, as this is not what has been suggested in the yin and yang analogy. This point will be addressed further in the next chapter.

Despite the debate about the applicability of “stage models” in describing families’ coping and adaptation to mental illness, help-seeking is still the most important strategy in the coping process. Help-seeking here is defined as any communication about a problem or troublesome event that is directed toward obtaining support, advice, or assistance in times of distress. Help-seeking thus includes both general discussions about problems and specific appeals for aid. In addition, it encompasses requests for assistance from friends, relatives, and neighbours as well as professional helping agents (Gourash, 1978).

Tseng, Lin, and Yeh (1995a) summarise the following threads of Chinese culture that affect mental health and that influence the help-seeking behaviours of the persons with mental illness and their families:

1. harmonious attitude toward nature
2. balance and conservation for optimal health
3. family as the basic resource for support
4. humanistic and interpersonal orientation
5. practical and dynamic adjustment in life situations.

Cheung and Lau (1982) believe there are situational variations among the Chinese in help-seeking. Chinese culture has been described as “situation-centred” (Hsieh, Shybut, & Lotsof, 1969). Likewise, the help seeking behaviour of Chinese patients and their families in different clinical settings would be determined by the situational context of their

problems and their expectations of the help they could receive. Therefore, the eclectic, idiosyncratic, yet pragmatic response of the family to the patient's illness is also typically Chinese.

Based on his experience among Chinese communities in Taiwan and North America, Lin (1982) points out that patients with mental illness often sought help from traditional Chinese medical practitioners at an early stage and often maintain contacts with them throughout the course of treatment. He also highlighted the differences in help-seeking for minor mental health problems and major psychiatric illness. For minor mental health problems, the afflicted individual is first of all more self-directed and the family tends to play a reduced or secondary role in decision-making. Second, there exists a willingness to go beyond family boundaries in help-seeking with less intra-familial coping. Third, in the great majority of cases, the outside help sought by patients consists of Western-trained doctors, Chinese traditional practitioners or both (Lin, 1982). In a number of instances, they received treatment simultaneously from both Western-style doctors and Chinese-style practitioners, with the later mainly to seek remedies for tonic purpose. Tsoi and Tam (1990, p.211) cited the following case vignette to illustrate the dual approaches that are quite commonly adopted by the family.

[The] 20-year-old daughter of a fisherman appeared at the Emergency Department of the hospital with clouding of consciousness, repetitive and dramatic movements of her limbs, and incoherent speech. The history revealed that she had broken down shortly after her boyfriend deserted her. She was treated as a case of reactive psychosis [and treated] with supportive psychotherapy and medication. After she recovered from her condition and began to adjust to life and work on [the] land, her father revealed that they believed a spirit had bewitched her: that they had seen this before and that they had asked someone to carry out [an] exorcism for her. When asked why they brought her to see the doctor so regularly, the father said that it did

not matter who was right as long as the daughter got well. He remarked, 'You do your part, doc, and we do ours.'

Cheung, Lee and Chan (1983) asked 78 Hong Kong university students to list the likely causes and appropriate solutions for five types of health problems: weakness, anxiety, difficulty in sleeping, emptiness, and headache. They found that a wide variety of self-help methods were preferred if the problems were perceived as mild, but medical treatment from a general physician was preferred if the problems were perceived as severe. Psychiatrists and counsellors were not the preferred sources of help even if the perceived cause of the problem was psychological. This is because of the stigma related to having mental illness. Cheung (1985) further suggested that the emphasis on self-directed coping strategies is related to the Confucian tradition of self-discipline, an ideal expected of persons with high educational and social standing.

Studies in developing countries (e.g. Li & Philips, 1990) often find that non-Western health services are more heavily utilised by people from lower socio-economic groups. However, this is not the case in Hong Kong. The reason may be that non-Western health services, like herbalists, acupuncturists, folk healers and private professionals, are relatively expensive while the public health service, which is predominantly based on Western medical practice, is more readily accessible and relatively cheaper as it is heavily subsidised by the government (Hay, 1992; Yuen, 1992).

Cheung, Lau and Wong (1984) described a typical help-seeking process for dealing with mental illness among the Hong Kong Chinese. Clients preferred to consult family members and friends when they had a psychological problem. When the problem became so serious that it was unmanageable, then there was usually a contact with a medical doctor, from whom a referral would be made to seek psychiatric service. The local health delivery system allows multiple consultations at different places. These initial contacts can be a

medical doctor, practicing either Western or Chinese medicine, but can also be a legal or religious professional. By the time the patient sees a psychiatrist it is already the second or third contact. This phenomenon is certainly revealed in my data, such as in the stories of Miss Jiang's sister, Agnes's brother and Mr. and Mrs. Lam's daughter.

One may argue that other healing methods may have been attempted at the very beginning when the family seeks help from extended family members and friends, i.e. they may have tried out other folk and/or popular healing methods. However, in my data, apart from seeking help from the traditional Chinese medical practitioners, there appears to be no indication of help seeking from sources other than the Western medical practitioners, social workers and professional counsellors, such as temple worships, shamanism or fortune-telling. Nevertheless, information regarding seeking alternate healing methods might not have been revealed by the informants unprompted or without a trusting relationship with the interviewers as these methods are often criticised as "superstitious" and "unscientific." Disclosing the information may lead others to perceive informants as foolish or stupid and therefore may create a sense of shame or "losing face." A better strategy may need to be developed to solicit such information from the informants in future study on this topic.

Emily Ahern (1978) points out that the choice of healer depends largely on the patient's (or the family's) perception of the cause of an illness. The individual's and/or family's pattern of help-seeking also is shaped by the individual explanatory model and the context in which they live. Each explanatory model is formed by various combinations of knowledge from the three sectors in a particular society, namely professional, folk, and popular (Kleinman, 1980). It is difficult to conclude that help-seeking behaviours fall into specific patterns or stages such as those pointed out by Lin (1982). As revealed from my data, how families interpret their experiences will influence their help-seeking behaviours

during the coping process. Of course, social stigma and the family's explanation model will shape the interpretation. Some experienced a shock while others tried to keep the family secret, and a few sought help from relatives or medical practitioners. Furthermore, besides the process of acceptance of mental illness, families are confronted with the day-to-day caring and managing of the mentally ill member at home. They do not necessarily adjust to the mental illness in the ways that health care professionals may imagine. Rather, they try constantly to devise a viable strategy for getting through each day, continually varying their self-definitions or explanatory models according to the context in order to cope with the immediate problems of daily living.

Therefore, the help-seeking behaviours do not necessarily follow in a sequential manner, but often depending on the situation (Romanucci-Ross, 1969; Cheung & Lau, 1982). Families may also seek help from more than one source at the same time, such as the situation with Mr. and Mrs. Yin. While Mrs Yin sought help from a social worker, Mr Yin looked for a cure from traditional Chinese medicine. They also thought of sending her to their relatives in Mainland China for a more sedate life to enhance her recovery. Miss Wan is another example. While she was caring for her brother's mental illness, she also sought help to cope and hold her parents' marriage together from her Christian friends and from the social welfare system. Agnes failed to convince her mother that her brother needed psychiatric help and quietly took her brother to seek medical advice. Other parents tried to look for more permanent solutions, such as arranging a partner or spouse to take over the caring tasks, or using their own financial resources and seeking help to create employment for their children with mental illness.

Perhaps it is just a coincidence that a number of the family members I interviewed mentioned seeking help or comfort from Christianity, particularly in the earliest stage. This mainly took the form of prayer, counselling, and social support. That is because either they



have been converted to Christianity or they are influenced by other Christian family members, such as in the case of Miss Wan and Miss Jiang. Both are Christians and when they were aware of the problems with the mentally ill relative, they first sought help from the pastors and friends in their Churches. Others would first seek help from the social workers, such as Mrs. Yin who sought help from a social worker in a local community centre once she found her daughter showing signs of mental disturbance. Nevertheless, the data indicate that family, friends, and religious personnel are still the first groups of people involved in the help-seeking process. They are used primarily to help define the problem. The contemporary medical professional, particularly a psychiatrist, is often the second or third in line. The following extracts of conversations in a focus discussion group of relatives provide good illustrations of this point.

*[A parent talked about what has helped her to cope]*

Another thing is we need to go to church. I have been visiting various churches, why? First, people in the church do care about the recovered person and me. They are actively concerned for the recovered person. Every time I attend church, they shake my hand and thank me for coming. They even come to my home and talk to my recovered person.... It is important that the recovered person feels accepted.... I don't feel much stress. It is because I am a Christian and my faith is getting stronger so I don't have much stress.

*[Another parent commented that parents are too anxious about their mentally ill children]*

In my experience, I still have not fully learned that yet. But I hope my son will improve. So I would like to tell you that Chinese are overly concerned about their children and can't let go. After I became a Christian, I changed. To let go... normally, if you love and show you love him that is already sufficient.... It is heart breaking, I have been frightened, and have cried. Now we must learn to let go and not be too anxious. We have to learn more about the disease,

but not be too over concerned with the child. What I have learned now, at least one thing: that is not to be too anxious.

Although it is difficult to judge from the data how common these help-seeking behaviours are, they have certainly indicated some of the changes that are occurring and that deviate from what has been described in previous literature, such as Lamson (1935). With religious freedom and an improved social welfare system in Hong Kong, people have more exposure to religions other than Buddhism, Taoism, and popular folk beliefs. Furthermore, the relatively “hassles free” and effective social welfare system has gradually replaced some of the functions of the extended family and has filled up the gaps created by the diminishing familial collectivism in Hong Kong. To some people, Christian faith also has replaced the traditional Chinese religions in shaping their help seeking behaviours and coping mechanisms.

Symptoms and signs of mental illness have been widely published in books and the mass media. Increase in knowledge about mental disorders, which is based on the Western modern science paradigm, does not necessarily help with better coping in the families of the mentally ill. The findings of the questionnaire survey described in Chapter 5 indicate that the increase in knowledge only makes people more aware of their own mental health and of Western psychiatry’s diagnostic labels, aetiologies, and so on. In spite of this, their negative attitudes and prejudices have not been removed, and the “Not in my backyard” phenomenon continues to exist. Families with mental illness still appear to experience a great deal of stress and suffering induced by stigma and the burden of care, as well as a limited repertoire of coping strategies. The traditional or classic explanatory models of mental illness and healing methods cannot any longer be held, as they are being criticized as superstitious, unscientific, uncivilized, or just a psychological defence mechanism of denial. Unless new explanatory models are adopted or old models are revised, families can

only resume a passive role as their only option in coping and adjusting to the social stigmas and existing situation, and wait for things to happen or change.

### Summary

Acknowledging the presence of mental illness in the family is difficult, particularly when there is strong social stigma attached. In addition, mental illness can make repeated attacks to the family's cohesion and structure. Any new conflict among the family members or relapse of the sick member may shake the existing balance, although it also may lead to a new cycle establishing equilibrium in the family's coping and adjustment process. Family members often may go through this roller-coaster experience, preparing for the worst at all times. Thus coping and adjustment are not necessarily a progressive process. The family experience may not always be clearly marked by stages, as family copes with the day-to-day care of the member with mental illness, minimising the disruptions associated with the illness, and maintaining the family harmony. However, the data reveal certain patterns of experience, although they do not necessarily occur in a sequence. They may include the discovery and acceptance of mental illness, explaining the illness, disruptions of family life cycle and routine, re-examination of roles, grieving the loss, and keeping of the family secret.

Medication compliance is perceived as a means to resume normalcy in the family. Thus, the sick member is often coerced to comply with the medication regime so that symptoms are controlled and the disruptions are perceived to be minimised. It seems that medication compliance is not only a family's preoccupation, but also the medical practitioners' and the general public's belief of keeping people with mental illness under control and maintaining social harmony. There seems to be less attention to the side effects of those psychotropic drugs on the persons with mental illness. Furthermore, the

help-seeking behaviours of the individual and family are influenced by their interpretation of the illness experience, which is shaped by their adopted explanatory models. With the strong social stigma associated with mental illness and the predominance of Western psychiatry and modern science, there are limited explanatory models available for families to manoeuvre and select to understand and explain the illness experience, and thus the healing process appears to be adversely affected or delayed.

## Notes

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<sup>i</sup> *Shen-k'uei* is a diagnostic term in traditional Chinese medicine to describe weakness in the kidney that may lead to tiredness and impotence. *Koro* or *suoyang* is believed to be a culturally-bound syndrome common in Asia, particularly among Chinese, Malaysian and Indonesia. It is a syndrome of acute anxiety accompanied by a conviction that there is penile shrinkage and dissolution (Yap, 1965).

## CHAPTER ELEVEN

### The Yin and Yang Analogy:

#### An Alternate Way Of Understanding Families With Mental Illness, A Principle For Maintaining Mental Health, And Guidance For Health Preservation

*“It does not matter whether it is a black cat or white cat, as long as it catches mice it is a good cat”*

Dang Xiaoping

#### Introduction

This final chapter intends to recapture the findings from the various data sources. It is also my attempt to draw the different threads and findings together to highlight the implications for understanding mental illness and the provision of healings and services in contemporary Hong Kong.

The purpose of this study was twofold: (1) to explore, describe, and document the concepts and the meanings ascribed to mental illness among Hong Kong Chinese and (2) to examine how these concepts impact on the experience of families with mental illness in Hong Kong during the period of transition of sovereignty. In this chapter, I summarise and reflect upon the research methodology, the findings, and the arguments according to the objectives that I set for the study (see Chapter 1). As revealed in the data, Hong Kong continues its path of transition. The yin and yang analogy stipulates that as one force swings to an extreme, it will lead to the creation of an antagonist component and thus trigger the balance mechanism. Reflecting on my application of the yin and yang concept to understanding mental illness issues in Hong Kong, I suggest that it can be an alternative paradigm for understanding transitions in society, to interpret the experiences associated

with mental illness, and can be adopted as a principle for preserving mental health and guidance for maintaining longevity in this ever-changing world.

### **Methodology For Exploring The Contextualisation Of Meaning**

Throughout the thesis, I have explicitly, as well as implicitly, emphasised the necessity of understanding the concept and meaning of mental illness within its context, i.e., the transitional metropolis of Hong Kong. In the first few chapters I discussed in detail the important influence that the social reality, made up of historical, political and socio-cultural contexts, has on one's concepts and interpretations of health, illness, and healing experiences. Such a notion is consistent with those proposed by medical anthropologists and researchers in the field of cross-cultural psychiatry (e.g., Castillo, 1997; Fitzgerald et al., 1996b; Kleinman, 1980, 1987, 1988; Kleinman, Eisenberg, & Good, 1978; Marsella, 1993; Marsella & Yamada, 2000; Tseng, 1997; Tseng, Lin & Yeh, 1995a). In order to have an in-depth understanding, a single data source, for example interviews, would not have been sufficient to accurately reflect the full picture. Although my "Westernised man" views of mental illness issues in Hong Kong may be considered biased, they are a product of the sociocultural context and reflect one of the points I am trying to make. This interweaving of East and West occurs not only within a single individual, it can occur within an entire community. Thus, rather than being biased, my background provides a unique lens through which we can see what is happening in Hong Kong today in the area of mental health and illness. My "Westernised man" perspective reflects what I believe is happening in Hong Kong as a community and within many individuals, and certainly within me there is also this balancing of yin and yang.

The difficulty of recruiting informants for in-depth interviews at the time of my study further reflects many of the points I have tried to raise in this thesis. The reluctance to

engage in interviews due to the social stigma of mental illness not only provided insight into the issue of interest, it forced me to widen my data base. Had I not done so, I would not have been able to develop the understanding or the ideas about mental illness in contemporary Hong Kong where I live. I could easily have become locked into the same kinds of superficial understandings as others have who have used narrowly defined methodologies or databases. The multimethod approach I used in the end not only allowed me to compare data from different sources, it allowed me, perhaps even forced me, to reflect more deeply on the social reality of mental illness in families in Hong Kong. This was, however, a hard lesson for me to learn.

Like others, I had originally planned to base my entire exploration on interviews with family members. Despite pressure from my supervisor to open up my data collection activities and to use all my senses and opportunities, I was reluctant at first to do so. My early training in research and my lack of familiarity with the ethnographic process was, at least initially, a barrier to collecting the kind of information I needed to develop an in-depth understanding of the focal phenomenon. Thus, in the process, I not only learned about mental illness among families in Hong Kong, I also learned about other ways of knowing and other methods of research. Even in research, the yin and yang principle can be seen as providing a conceptual balance to the research process.

Furthermore, my ability to read both Chinese and English literature helped me to examine issues from different and wider perspectives. As suggested by Fitzgerald, Paterson, and Azzopardi (1997), by being a participant observer, not only could I perceive the issues as local, I could also draw on my knowledge and experience. As a result, I allowed the statements, behaviours and observations of the informants to “reverberate” in my mind against extant knowledge and information in order to triangulate and come to an interpretation or conclusion. In this sense, I made myself an integral part of the analytical



process. Thus, there was no need to falsely pretend objectivity, nor any need to rigidly control or deny the subjective part of the process. After all, the descriptions aim to reflect, as accurately as possible, a “Westernised man’s” view of the social reality where he lives and make sense out of his life experiences.

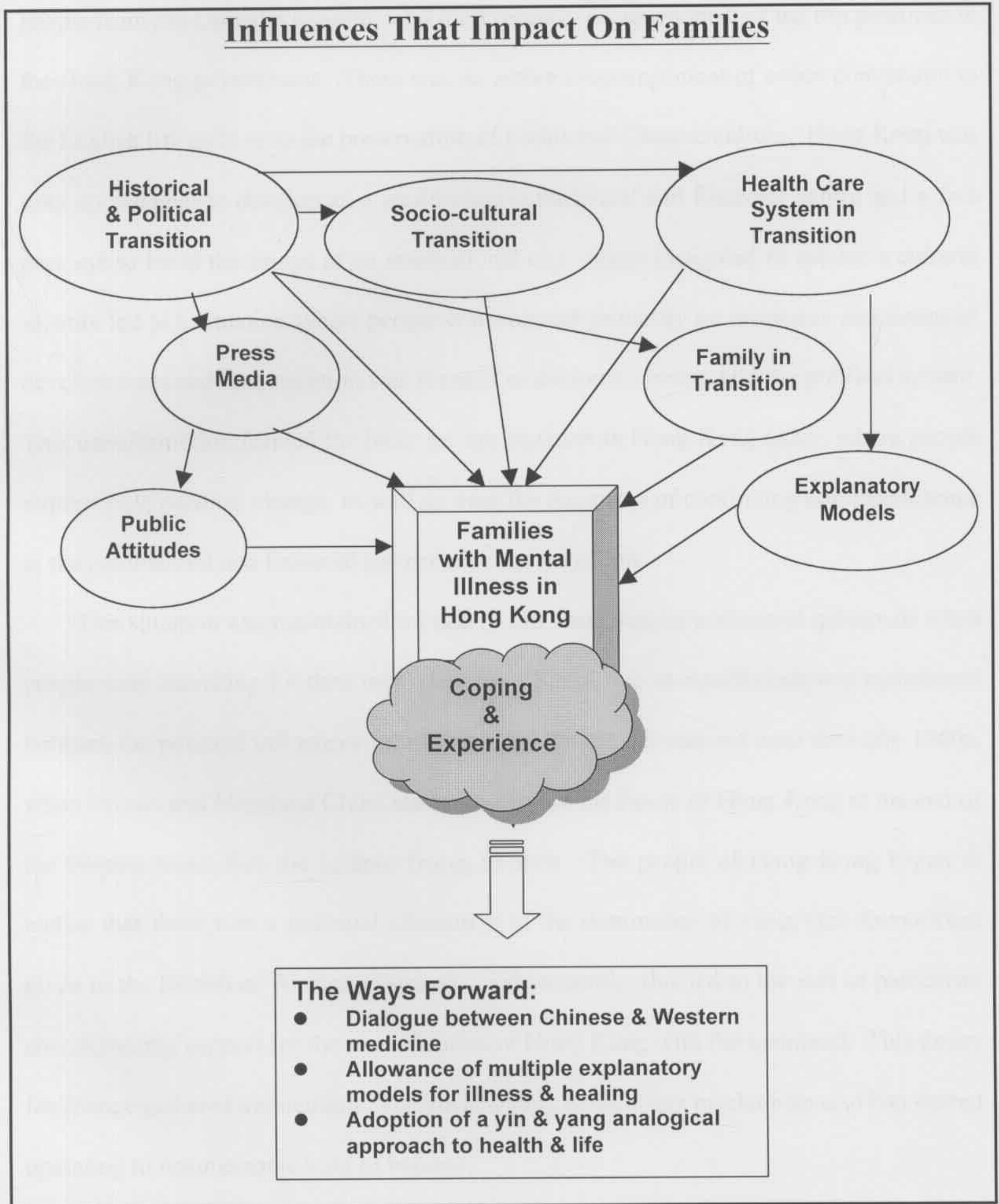
### **Summary Of Findings**

Figure 3 is a diagram of the factors (transitions) identified as having an impact on the concepts of mental illness and the experiences of families with mental illness. I will review and discuss the main findings of the study under the following headings (as illustrated in Figure 3): 1) the historical and political transition, 2) the socio-cultural transition, 3) the health care system in transition and explanatory models, 4) the press media dilemma, 5) public attitudes towards mental illness, 6) the family in transition, and 7) coping and striving for harmony in families with mental illness. The implications of the findings and the ways forward will be discussed under a separate heading.

#### **1) The historical and political transition**

This study took place when Hong Kong was going through a volatile and significant period in its history, the transition of sovereignty from the British government to the Communist Chinese Government. Prior to that, Hong Kong had enjoyed a *laissez faire* life style, with economic and financial prosperity under the British administrative and legal system; but it had no role in making political decisions. The transformations that occurred over the years changed Hong Kong from a fishing village to one of the commercial and financial centres of the world.

Figure 3 The inter-relationship of factors (transitions) impacting on families with mental illness



Signs of British rule were the adoption of the English language as the official language, the judicial system based on the Common Law, the official endorsement of a health care system based on a Western medical paradigm, and the privileges given to people from the United Kingdom, who until recently occupied most of the top positions in the Hong Kong government. There was no active encouragement of either conversion to the English life style or to the preservation of traditional Chinese culture. Hong Kong was only encouraged to develop as a world-class commercial and financial centre and a free port and to build the image of an international city. Steps instigated to subdue a cultural identity led to a situation where people concentrated primarily on economic and financial developments and less attention was focused on national identity and the political system. This transformation formed the basis for the situation in Hong Kong today, where people request little political change, as well as want the guarantee of continuing non-interference in the commercial and financial sectors after the transition.

This situation was maintained for nearly 150 years despite occasional upheavals when people were searching for their own identities. Status quo or equilibrium was maintained between the political influences from China and Britain. It was not until the early 1980s, when Britain and Mainland China started to discuss the future of Hong Kong at the end of the 99-year lease, that the balance began to shift. The people of Hong Kong began to realise that there was a potential alternative to the dominance of yang, (the favouritism given to the British or Western systems). Subsequently, this led to the rise of patriotism and increasing support for the re-unification of Hong Kong with the mainland. This desire for change gathered momentum. The yin and yang equilibrium mechanism also had started operating to resume some kind of balance.

Although the Mainland China government made a promise that everything would remain the same in Hong Kong under the spirit of “One-Country-Two-Systems,” the

political structure changed to ensure continuing manoeuvres of the Mainland government. Pro-China groups (including some Chinese medicine practitioners). These people who had been suppressed and isolated by the British colonial government are now enjoying their share of political power while the pro-British groups and the democrats have lost their favoured position. The changes in the political arena are continuing as both sides try to find a point of equilibrium. Some people, feeling uncomfortable with the new situation, have started to leave Hong Kong and migrate overseas. Others, from the mainland, have made use of the opportunity of re-unification to move to Hong Kong, like their forbearers did in the past, to search for a better quality of life. Therefore, Hong Kong will still remain a transitional place for people from the mainland for the foreseeable future. It was within such a context that I examined the concept of mental illness and the experience of family with a mentally ill relative.

## **2) The socio-cultural transition**

While the transition of sovereignty took place in the political arena, the people of Hong Kong started to search for their own cultural identity. Under colonial rule, the blurring of the issue of national identity was intended to minimise local resistance to the colonial administration. There was (and still is) no censorship on the importation of Western ideology, culture, religions, and life styles, while, at the same time, there was no active promotion of traditional Chinese cultural values and customs. Both cultural systems have been allowed to mix and integrate spontaneously. Thus, Hong Kong has developed a unique culture of its own despite the denial by some pro-China scholars that this was only a specific kind of “lifestyle.” The search for a cultural identity and the identification with the mainland culture can be represented by the interaction of the *yin* and *yang* forces. Hong Kong Chinese are themselves negotiating between the two forces and will decide a point at

which they will be comfortable when they are required to make a stance. This situation also applies in trying to understand illness and help-seeking: a multiple-belief system is operating in each individual — although the scope of the multiple-system can be influenced by, and restricted by, the predominant health beliefs. The underlying principle is that one needs to be pragmatic and flexible within a certain context.

The essence of the *yin* and *yang* analogy is also reflected in my search for my own cultural identity. In my case, as a “banana man,” I identify myself as Chinese when something requires calling up my cultural heritage, such as making reference in front of my overseas colleagues. When I need to take a stance on a local issue that is in opposition to Mainland China and the local government, I call myself a *Xianggǎng rén* with an overseas background to express my different view. There may be conflicts at times, but it provides a wider perspective that allows me to make sense of events taking place around me and respond to them in a flexible way.

### **3) The health care system in transition and explanatory models**

Initially, Western medicine and Chinese medicine existed in parallel in Hong Kong, but official recognition and power were only given to Western trained medical practitioners and health care professionals. Despite the fact that traditional Chinese medicine has been practised in China for thousands of years, its importance and potential efficacy has been overshadowed by Western medicine in Hong Kong during colonial times. Only in the last few decades has it undergone vigorous testing by modern scientific methods, the results of which could be used for marketing the potency of the treatments. The preferential treatment given to Western medicine in Hong Kong was not only a means for the colonial government to undermine the Chinese identity, it also helped create an elite class of Chinese socialised to Western values and to promote the acceptance of policies and

practices that guaranteed and facilitated assimilation and the removal of resistance. A non-regulatory policy was applied to traditional Chinese medical practice, which often led to instances of malpractice. In contrast, there are formal, systematic training programmes for Western medical practitioners in two of the local universities. Graduates are given the sole official and legal authority to define sickness and sick roles for the community. They appeared to be the only practitioners who can validly define diseases, explain illness, and perform healings. In such a context, the concepts of mental illness are largely defined according to Western psychiatry.

Nevertheless, analogy holds that the extreme dominance of yang would eventually lead to change. The transition of sovereignty appears to be the turning point in creating the swing towards equilibrium. Since the transition, formal training programmes of traditional Chinese medicine have been established and legislation has been enacted to regulate its practice. The traditional Chinese medical practitioners will soon be given similar legal status and privileges as the Western medical practitioners, such as allowing them to certify sick leave. And yet, the ultimate equilibrium is still to be reached. The two forces are still evolving, negotiating, and compromising for power and dominance. One piece of evidence that indicates the beginning of dialogue is the incorporation of traditional Chinese medical remedies into Western medicine, which has been carried out by a few Western medical practitioners who also have taken further training in traditional Chinese medicine (see Chapter 5). In contrast, at this stage there is no reciprocal arrangement for the traditional Chinese medical practitioners who were also trained in Western medicine on the mainland or in countries other than Hong Kong. They are still not allowed to incorporate any aspect of Western medicine into their practice. They are barred from incorporating such practices by protests from Western medical practitioners who still hold strong political power.

To date, with increased exposure people are beginning to accept the holistic Chinese medical view of disorder/disease. However, Chinese medicine still appears to have little influence on the interpretation of mental illness and the Western concept of dualism in physical and mental health still prevails, as reflected in the questionnaire survey and interviews. However, the interplay between the two health systems leading toward a constructive equilibrium seems to opening up alternative explanations for illness and widening the repertoire of healing methods. People in Hong Kong today seem just as ready to draw upon explanatory models from the Chinese tradition as they are from the Western.

#### **4) The press media dilemma**

The press media is a competitive business in Hong Kong where freedom of the press and access to information are two of the icons that signify the freedom that Hong Kong people still enjoy after the transition. They are also signals that the Mainland Chinese government uses to convince the world that it is keeping its promise of non-interference in local affairs. Each newspaper uses various methods to expand its market share and readership. In addition to a variety of topics or features and colour print, the media makes use of exaggerated news headlines/headers, graphic details of reporting, and pornographic content to increase the readership.

As the yin, the negative aspect of news reporting, accumulates excessively in the system, the yang, government control, which is partly under pressure from the public, is establishing measures to counter-balance the situation. To avoid high-handedness from the government, initiatives have been taken to draw up guidelines for self-regulation by the mass media industry. In spite of this, the responses within the industry are lukewarm, believing it may be the beginning of censorship and decreasing profit margins. It is also a dilemma for the public. On one hand they want freedom of press and freedom of speech.

On the other hand, some feel there should be some kind of censorship for the sake of social morality. The two forces (yin and yang, the press and the public) are currently negotiating and trying to find a compromise. This well reflects that the yin and yang forces are not static, but dynamic and constantly in motion. They are inter-related and jointly-restrained in reaching a dynamic equilibrium.

Within such a context, incidents associated with people with mental illness, particularly when violence is involved, are news stories that provide great news headline materials. Victimhood is a good commodity for sales. Thus, persons with mental illness are often projected by the media as unpredictable, aggressive, violent and dangerous. This further perpetuates the public's fear of people with mental illness and makes the social stigma associated with mental illness unshakable.

The newspaper articles on families and persons with mental illness also reveal a series of repeated human tragedies, misfortunes, and assaults on the families and the persons with mental illness. Family members are easy targets and victims of the sick members' violence. The persons with mental illness also have a high risk of committing suicide and are likely to experience prejudices and derogatory name calling from the public. The review of news articles also indicated that people with less severe mental illness are often unnoticed. This may be due to denial or ignorance of both the individual and the society. Nevertheless, there is a small balance of positive force in that some newspapers do try to present a more positive aspect of mental health and illness. For example, occasionally there are touching stories about the recovery process or the struggles of persons with mental illness, as well as education materials on mental health and illness, although mainly based on Western psychiatry.



### 5) The public's attitudes toward mental illness

The public's attitudes toward people with mental illness are shaped by the mass media and by the concepts of Western psychiatry. In general, public perception of people with mental illness reflects what has been projected in the media, mainly that people with mental illness are unpredictable, violent, and dangerous. Very often, people's attention to, and understanding of, mental illness is limited to severe disorders, neglecting other types of illness in the large spectrum of mental illness. People's knowledge of mental disorders has increased through public education. However, it is based mainly on Western psychiatry. Traditional explanatory models of mental illness are often criticised as being "unscientific," "superstitious" and "outdated."

In addition, the increase in knowledge of mental disorders and the rise in the consciousness concerning human rights do not necessarily lead to greater acceptance of people with mental illness. "But not-in-my-backyard" appears to be a common attitude held by the general public towards the re-integration of mentally ill persons into the community. This is not only because of the fear of mentally ill persons, but also due to the Chinese definition of personhood that defines socially acceptable behaviours and social roles and sets the rules for social control. Examples of socially acceptable behaviours include being polite and humble, practising self-control, working hard, and striving for material success. Examples of expected social roles are a hard working person who is able to excel in his/her job and a respectful person who is able to fulfil the duties of filial piety and uphold the values of family collectivism. Non-compliance with socially acceptable behaviours and/or the non-performance of socially expected roles lead to social sanctions. Persons with mental illness, particularly those with severe mental disorders, have difficulties in complying with those behaviours as well as performing the expected roles.

Consequently, they occupy a lower social status in the community and are often forgotten until they create a public nuisance.

It may seem somewhat cynical to think this way and, yet, a kind of balance is maintained. Yang, the dominant force of public attitude, is overriding yin, the passive response from the people and families with mental illness. Nevertheless, this “equilibrium” may not last very long, as new elements have entered the system. The advocacy and empowerment movement for minority groups has spread its seeds to this population and family and advocate groups have begun lobbying for their share of power.

#### **6) Family in transition**

Family is perceived among Chinese as the most important social institution for survival and for defining individual identity. Having a family is one of the essential components to signify one’s achievement of perfect personhood. As Chinese are relation-oriented, the family is where this relational orientation is established and strengthened. Due to over-industrialisation and commercialisation in contemporary society, changes in the family inevitably occur. Family structure has shifted from an extended family to a nuclear family. Other factors that are shaping the changes in familial structural include an increased cost of living, convenient travelling between Hong Kong and the mainland, a gradual deterioration of familial collectivism, and an increased incidence of stress induced diseases, including mental disorders.

Other “non-traditional” family structures besides nuclear family also have emerged or re-emerged, at least in public consciousness, during the period of transition: the “single parent family by-default,” the “astronaut family” and “the concubine family.” In addition, there has been an increase in the divorce rate in Hong Kong. The traditional family structure and values, the yang force, are unsettled as there is a surge of yin, the rise of

“non-traditional” families. The two forces are interacting as Hong Kong is entering the new millennium. When a balance is reached, a new definition of family structure will emerge which will be different from the original. It is still too early to predict the outcome of the interplay between the traditional and non-traditional family structure and values. Despite this, one thing is clear. The two systems can interact to create something new and, at the same time, counter-check the growth of the other system.

### **7) Coping and striving for harmony in families with mental illness**

The data, together with the literature, have revealed that the traditional functions and values of the family still largely remain among Hong Kong Chinese. Children are still obliged to honour their filial duties to their parents and siblings are bound together through strong bonding. We still trace the image of extended family during festival times as well as during times of hardship. Family collectivism is still the core value and caring for a sick member is not an option, but an obligation. The form of care may have changed so that services can be purchased and being physically present is not necessary. However, the intention and organisation of caring activities are the same. It is still the family's responsibility to be sure the person receives care regardless of who provides the service.

Furthermore, mental illness cannot be considered as an individual matter, but rather must be seen as a family affair in the Chinese context. Mental illness not only affects the individual member who has the illness, but also has an impact on the family as a whole. Findings in my study indicated that discrimination is not only experienced by the mentally ill member, but also by other family members in terms of career choice, social network development and marriage. Thus, they have to deal with the illness together as an entity.

The government and the community have not assisted sufficiently the family with mental illness. In contrast to the West, families largely are still a passive group for whom

shame and guilt overshadow the urge to fight for more services. Strong social stigma has often forced the families to keep the family secret from the outsiders. Families also closely supervise mentally ill relatives so that they will not create a public scene, which may disgrace the family and arouse the neighbours' and friends' prejudices. Family collectivism still prevails among the Hong Kong Chinese. However, a hybrid form seems to have emerged, one that has lessened the impact of mental illness. Family members are willing to sacrifice their own goals in order to provide care to the sick relative and to protect the integrity and harmony of the family. Unfortunately, sometimes they become victims of the mentally ill members' violence, although not to the extent suggested by articles in the newspapers.

Coping with, and adjustment to, mental illness in a family is a continuous process in which the family must face day-to-day events and crisis. It is not a set of discrete developmental stages as often thought by health care professionals. The experience of the family with mental illness may include the discovery of mental illness, the explanation to others, disruptions of daily life, grieving of loss in the family, and adjustment to the new situation. Every relapse in the mentally ill member can be a new assault on the family's cohesion and harmony. Thus, families are likely to adjust situationally in response to new challenges to the family's wholeness. To strive for harmony in the family, there is a need for a balance between the individual's desire and the family collectivism. A mentally ill member will receive "unconditional" love and care from the family provided that he/she complies with the family's plan to achieve personhood status, e.g., finding a job and agreement to an "arranged" marriage, and does not disrupt the harmony of the family. If the person cannot perform the expectations of full personhood, then he/she needs to perform other assigned tasks, such as accompanying the aging parents, being well-behaved,

and complying with a medication regime. In doing so, they move toward ideals of personhood (filial piety, service to the family, and so on), albeit in an alternative form.

There are often reports of families relinquishing the burden of care to institutions, especially if the mentally ill member is severely mentally ill and there have been repeated attacks on the family integrity. However, this was not an obvious phenomenon in my data. Families show their great concern and care toward their mentally ill relatives, although the caring may not have been in physical or personal forms.

Finally, the adoption of Western concepts of mental illness does not necessarily help the families to cope with mental illness. Increased public education on mental disorders seems only to lead people to become more aware of their own mental health. In the process they develop an understanding of the “new labels” or diagnostic categories, aetiologies, and so on. This does not help to remove negative attitudes and prejudices. Based on the data in hand, it may be difficult to conclude that the folk explanations for mental illness that were mentioned by Lamson (1935) are no longer adopted. However, evil possession, fate, karma, family retribution, and bad *fēngshui* were rarely mentioned as causes by my informants. Instead, the “scientific” and “modern psychiatric” concepts of causation were mentioned most often, e.g., stress, imbalanced life-style, physical injury, and so on. The repertoire of coping strategies also has been limited by the dominance of Western psychiatry. The previous explanatory models of mental illness and the healing methods in folk and popular sectors seem to have been largely discarded. The influence of modern science also has favourably oriented the public’s concept of mental illness and healing options toward Western medicine. The lack of alternate explanatory models for the illness, which can buffer the suffering and enhance family coping with this chronic disorder, has created an imbalance and, thus, may induce ambivalence and pain in the families. The

current trend towards looking for a new understanding of mental illness reflects, perhaps, the operation of the yin force to bring back the equilibrium.

In summary, the introduction of Western medicine to Hong Kong, a by-product of colonialism, had changed the concepts of health and healing among Hong Kong Chinese from a folk healing paradigm, including traditional Chinese medicine, to a modern biomedical paradigm. Western medicine once dominated the health care arena, but is gradually diminishing its influence, partly in response to the political transition and people's search for a cultural identity, and partly due to the re-emergence of traditional Chinese medical practice. Nevertheless, the transition in health paradigms is just in its infancy, the Western concept of mental illness is still dominating the public concept of mental illness. Furthermore, the dramatisation of news reports associated with persons with mental illness, to a great extent, has strengthened the negative attitudes of the public towards people with mental illness. Within the context of a limited scope for alternate explanatory models for the illness experience and hostility towards many people with mental illness, families with mentally ill relatives try to cope and adapt. The senses of hopelessness, guilt and pain often seem to be inevitably tied to these families. At times, family member also become the victims of relative's violence.

### **Towards A New Understanding Of Mental Illness**

The use of the yin and yang analogy as the framework for understanding the issues and events taking place in this metropolis was intended to enhance the exploration of the meanings of mental illness in the context of this Chinese community. Although I used yin and yang as an analogy to understand the data and the families, I have no intention of simplifying the richness and thickness of the philosophy embedded in the yin and yang

ideology. I have just used it as a way, an uniquely Chinese way, to understand the interplay of two forces that are driving the changes in Hong Kong and which shape the concepts of mental illness in this transitional metropolis.

I need to emphasise that it is not my purpose to discredit the contributions of Western modern biomedicine where it has had a record of brilliant success, from the eradication of smallpox to heart-lung transplants. It has brought many benefits to humankind and it will continue to do so, despite perhaps needing modification of its reductionistic approach and the mind-body dualism. Western psychiatric healing has shown its effectiveness in making the dysfunctional behaviors associated with mental disorders more manageable for both the individual and his/her family. Despite its inadequacy, the classification system of Western psychiatry provides a concrete and descriptive model to help lay persons understand mental disorders. Nevertheless, based on a review of the literature and my data, there seems to be a trend toward a new, but still unspecified, understanding of mental illness. This new understanding respects the wisdom and acknowledges the contributions of “non-scientific” traditional healings. It also recovers long lost knowledge about health (Morris, 1998). In addition, it advocates the necessity of contemporary medicine to incorporate the traditional methods, or at least to begin a dialogue with traditional concepts of health and illness and the healing methods.

I am not advocating ostracisation of Western psychiatry and making a full swing back to traditional explanatory models and healings. This would not be consistent with the yin and yang concept, in principle or as an analogy. I believe the revival of traditional explanatory models and healing methods, together with a dialogue with modern Western medicine, will lead to a new and better understanding of mental illness so that an equilibrium can be reached. This would not only widen the scope of explanatory models and provide alternate mechanisms for understanding the meanings of mental illness, but

would also provide alternate models to guide coping and adjustment in families with mental illness.

### **The Implications And The Ways Forward**

The application of the yin and yang analogy can provide further alternate guidance to assist professionals in understanding the coping process and the help seeking behaviours of families. From this understanding appropriate services and interventions can be planned within the unique cultural context of Hong Kong, and, with modification, other Chinese communities as well. Under the following headings I draw on my findings and self-reflections to discuss the study's implications and to suggest the ways forward: a) dialogue between Chinese and Western health care paradigms, b) multi-explanatory models for illness to enhance coping in families with mental illness, and c) the adoption of a yin and yang analogical approach to health and life.

#### **A. Dialogue between Chinese and Western health care paradigms**

I do not dispute the fact that there is a biogenetic link to mental disorders. Such ideas are present in both the Chinese and the Western perspective. However, I do claim that the manifestation of deficits is more related to the environment and habits of living. As I have discussed in Chapter 3, there are differences between Chinese and Western medicine in the conceptualisation of mental illness. In addition to folk beliefs about the causes of mental illness as described by Lamson (1935), traditional Chinese medicine believes that mental disturbance is caused by the imbalance of yin and yang forces and this is manifested in the malfunctions of internal organs that control people's thoughts and emotions. Therefore, from the viewpoint of the yin and yang analogy, to achieve a state of health there must be a balance between the two forces. However, this balance cannot be achieved through



external or artificial suppression, which deems to fail, but by respecting their unique characters of interdependence and inter-restrictiveness (*Mūn*, 1994). This approach depends on the individual's effort. However, many people do not realise that the support of the family is required to attain this attitude towards health — the harmony between individual and family is the foundation to achieve this ideal health state.

As discussed in the last chapter, the use of an external locus of control as a coping and adaptation mechanism is common among the Chinese. Western psychiatry focuses on treating the malfunction of the body with drugs or the malfunction of the mind with re-establishment of the internal locus of control system. This philosophy has replaced the previous Chinese mechanisms of coping and adaptation in families with mental illness. Health care professionals only focus on the body or the mind and the individual's belief system while the family's roles are put aside. This should not be the only "appropriate" and "scientific" approach within a Chinese context as such an approach may be confrontational.

Although it may be difficult to blend the traditional Chinese and Western health care systems as they are based on different paradigms, a dialogue between the two to increase understanding, and hopefully appreciation, of each other will certainly benefit service users in a pluralistic health care system. If such dialogue is commenced as *Tao* is being practised, there will be implications for the government, health care professionals, families with mental illness, and the general public. The government not only needs to provide funding for research and services under both health care systems, it should also equally promote both, or even other health care paradigms, so people can choose interventions. Health care professionals, particularly those trained under only one paradigm, need to practise with an open mind. They may need to re-examine their belief systems, and learn to appreciate the values of other health care systems. They should tolerate the existence of other healing

methods. These methods can even be incorporated into their daily practice to fit with clients' explanatory models. The families should be aware of their own explanatory models and educate themselves on other alternative healing methods so that informed choices can be made regarding coping and healing. Lay persons can be educated to understand interpretations of mental illness that are valid alternatives to the predominant Western concepts. Putting these into the framework of the yin and yang analogy, with such an understanding among all stakeholders, perhaps harmonies can be initiated and sustained in the society.

Therefore, depending on the meanings ascribed by the family with mental illness, a reconciling approach, which emphasises harmonising heaven (the supernatural), earth (the individual), and humans (the family) may need to be considered. The struggle over the control of medication may be seen as a reflection of such disharmony caused by the confrontational approach proposed by health care professionals within a Chinese context. Thus, restoring the lost knowledge of mental illness and its traditional healing methods, and showing respect for the practices of "non-scientific" alternative healings seen fit by the family could, in conjunction with Western psychiatric practice, help the Hong Kong Chinese family towards a more comfortable experience with the mental disorder. The balance of yin and yang is the best way of maintaining health and providing care and healing in the Chinese context. After all, it does not matter which system, or what combination, works better as long as the illness is healed — or at least controlled within bounds acceptable to the family.

## **B. Multi-explanatory models for illness to enhance coping in families with mental illness**

The help-seeking pattern of the individual and/or the family is shaped by one's explanatory model and the context where he/she or the family lives. Each explanatory model is formed from combinations of knowledge from three sectors in society: the professional, folk and popular (Kleinman, 1980). It is difficult to classify help-seeking behaviours into specific patterns or stages such as those identified by scholars such as Lin (1982). It is important to point out that the construction mechanism behind the explanatory model is the belief system that a person has adopted. This belief system, of course, is influenced by the socio-cultural context in which the person was brought up. Religious and cultural values influence the individual's way of adopting knowledge from the three sectors to form his/her own explanatory model, and, consequently, influence the interpretation of illness experience and choice of healing methods.

I am not advocating that traditional perspectives are better. But we need to allow alternate clinical realities to co-exist with the mainstream reality to achieve an equilibrium state. It is better being given a choice so that one can negotiate and navigate between the extremes to find a balance of the yin and yang. When one is given one choice as "correct" and other choices are criticized or condemned, it is difficult to negotiate to find satisfying solutions for individual situations. This principle is applicable to families with mental illness. When stigma is so strong and the task of caring is so demanding, families become trapped and stressed. They cannot use other healing methods — shamanism, prayer, or other explanatory models, e.g., fate, karma, past retribution, bad *fēngshui*, to resolve the grieving and pain. That, in turn, makes the family become the second victim with no alternative. By opening up an alternate view of the family with mental illness, contemporary mental health practitioners will also be able to reflect on their own daily

practices, so that appropriate care and services can be initiated to meet the client's needs. This is particularly relevant when they work with clients from Chinese backgrounds.

The pain and suffering of families that is brought on by mental illness is traumatic and, at times, frustrating, burdensome, and life threatening. The feelings of hopelessness and helplessness are particularly strong among families who have been struggling for a long time with the illness, stereotypes, explanatory models of limited scope, and inadequate social support networks and community resources. The consequences may well be reflected in the absence of appreciation for the potential contributions that can be made by persons with mental illness.

Despite the pain and suffering under the contemporary concept of mental illness, many families with mental illness continue with life as normally as possible. With the influence of Buddhism and the Taoist and pagan concept of *Bào* (retribution), suffering to many Chinese takes on a different meaning (*Zhāng & Lín, 1992*). Kleinman and Kleinman (1991) explain that Chinese have a different attitude towards suffering.

Suffering can be defined from the historical and cross-cultural record as a universal aspect of human experience in which individuals and groups have to undergo or bear certain forms of burdens, troubles and serious wounds to the body and the spirit that can be grouped into a variety of forms. There are *contingent misfortunes* such as serious acute illness. There are *routinized forms of suffering* that are either shared aspects of human conditions — chronic illness or death — or experiences of deprivation and exploitation and of degradation and oppression that certain categories of individuals (the poor, the vulnerable, the defeated) are specially exposed to and others relatively protected from. There also is suffering resulting from extreme conditions, such as survivorship of Holocaust or the Atom Bomb or the Cambodian genocide or China's Cultural Revolution. The cultural meanings of suffering (e.g. as punishment or salvation) may be elaborated in different ways for current day Sri Lankan

Buddhists or Medieval Christians, but the intersubjective experience of suffering, we contend, is itself a defining characteristic of human conditions in all societies (p.280).

According to Buddhism and Taoism, suffering is just a part of human life. It is the karma of the individual, or the retribution for what oneself or one's ancestors have done in the past. When life is seen as a continuity, instead of time-limited with death of the body and the soul waiting for the judgement day, it contains other meanings. The suffering that the person is currently bearing is perceived as the karma or retribution that cannot be removed by modern healing methods. A person may need to endure the suffering in order to make an easy passage to the next life or to accumulate more credits for entering heaven. Furthermore, healing, as I have defined it in Chapter 1, is not just a treatment or a cure, such as the administration of drugs, the application of high technology, or a surgical operation. Healing is an art that renders the sick persons at ease as whole persons within the structure of their mental and spiritual world-view, their families, and their culture (Benson, 1996; Nuland 1997).

Culture is a dynamic concept; it does not stop at any point of time, but evolves continuously. Therefore, when we talk about traditional values, we are talking about the values that have been passed down and transformed over time. The culture that we have now is just segments from the preceding period of time, and even those segments have been constantly evolving. Despite this, there are still core cultural values and customs that remain largely the same. In his article commenting on the rapid changes occurring in Hong Kong, Topley (1976) maintained that Hong Kong Chinese are still clinging on to centuries old customary practices to deal with urban living and intolerance of daily life stress:

Hong Kong is undergoing rapid change, and large numbers of young people have received a modern education and pay little attention to Chinese customs. A superficial glimpse may

incline the visitor to believe that Hong Kong is a thoroughly cosmopolitan city. But at festival times the entire pattern of life is rearranged to expose its Chinese nature. We have come a long way from the belief that science, rationalism, and empiricism would drive out “superstitions.” When the pressures of urban life and new ways place intolerable burdens on individuals, they seek comfort in practices and ideas that are centuries old (p. 264).

Therefore, at times of adversity, people tend to resort to traditional customary practices for comfort and problem solving. The practice of “non-scientific” traditional methods not only provides one with meanings and reconnections with his/her cultural roots, but may also help to reduce the pain, make an easier life passage, or even simply adjust one’s own perspective. Making a pilgrimage, offerings to the gods, seeking help from a shaman, getting advice from a fortune-teller, or simply blaming it all on past ancestors are examples of alternative healing methods. They can enlarge the repertoire of belief systems that allow the individual meanings to attach to their experience. They also can enrich the individual’s explanatory model, help-seeking behaviours, and methods of coping.

The statement made by Deng Xiao-ping quoted at the beginning of the chapter may well summarise the characteristics of Chinese: being pragmatic and flexible. The Hong Kong Chinese seem to be the faithful followers of this motto, perhaps in order to survive in this vibrant and transitional metropolis. We have seen the benefits of the labelling system of Western medicine, as well as the stereotypes and prejudices projected on the individuals and families with mental illness. I have also highlighted how the values of Taoism, one of the traditional belief systems, guide the practice of traditional Chinese medicine, which is concerned with preventing illness, preserving health and maintaining longevity. Instead of giving preference to either health paradigm, which may create more vulnerable conditions for health issues, a new balance point should be sought so that more options can be introduced to understand the illness experiences created by mental disorders.

To label the traditional explanatory models and healing methods as “unscientific” is not a “scientific” way to develop knowledge. The current situation may be the right opportunity to examine the functions, meanings, and effectiveness of those models and healing methods in helping the individuals and families to contain the pain and chaos created by the disorders.

### **C. Adoption of yin and yang analogical approach to health and life**

Through encountering the numerous disasters, hardships, and conflicts brought about by both natural and human factors throughout history, Chinese have learned that it is useful to be practical, flexible, and dynamic in adjusting to life’s events. Although their teachings seem to have been abandoned and replaced by contemporary materialistic and hedonistic beliefs, classical Chinese scholars taught us a long time ago that life swings between the extremes of prosperity and disaster, success and failure, and that it is wise to be prepared for all situations. An old Chinese saying reflects such a belief: “*jū ān sī wēi* 居安思危 (start to think of danger when you are feeling secure).” Clinging to this belief, the Chinese people have learned how to adapt flexibly, practically, and dynamically to both physical and mental life (Tseng, Lin, & Yeh, 1995b). Families and individuals should behave following the *Tao*, the invisible but already existing path that will ensure balance at the end; if done, a person (or family) will be able to weather the storm and resettle again.

Besides being a treatment for mental disorder, practising *Tao* is an alternative method to prevent mental illness and maintain mental health. The principles to achieve this include: respect the natural rules, harmonise with the social environment, live modestly and cultivate self to withstand the distractions that arise from the extremes, and seek health and cultivate life. Maintenance of longevity is an ancient notion, which originated in Confucianism and Taoism. It is based on achieving the goal of prolonging life through

cultivating life, building up health, and preventing disease. It was also known as “striving for health,” “conserving health,” and “cultivating temperament” (Zhang, 1994, p. 3). This notion and associated concepts and strategies are particularly unique to traditional Chinese medicine (Mün, 1994). The notion is embedded in the Chinese culture and forms one of the ideal characters of personhood. The following quote from the *Yellow Emperor’s Classic of Internal Medicine* may sum up the message for achieving mental health:

In ancient times those people who understood Tao [the way of self cultivation] patterned themselves upon the Yin and the Yang and they lived in harmony with the arts of divination.... They were tranquilly content in nothingness and the true vital force accompanied them always; the vital spirit was preserved within; thus, how could illness come to them? They exercised restraint of their wills and reduced their desires; their hearts were at peace and without any fear; their bodies toiled and yet did not become weary. Their spirit followed in harmony and obedience; everything was satisfactory to their wishes.

*Huang Ti Nei Ching Su Wen* (the Yellow Emperor’s Classic of Internal Medicine), translated by Ilza Veith (1992, p. 97-98)

Furthermore, *The Yellow Emperor’s Classic of Internal Medicine* first laid down the principles and methods for health preservation. They can be classified into four aspects (Zhang, 1994). First, cultivate one’s mind, which demands the individual to maintain peace, tranquility, optimism with own self, and to be happy spiritually. Second, prevent the invasion of exopathogens. One needs to adapt to the changes in the natural environment, i.e., to guard against the invasion of pathogenic factors at all times especially when the weather changes abruptly and unexpectedly (e.g., avoid excess heat or cold by wearing appropriate clothes). Third, attend to variations in diet and food and daily life, i.e., live modestly and have regular life patterns. Finally, attend to physical activities, i.e., get



regular exercise and balance between work and rest. Chinese medical philosophy emphasises the importance of prevention of disease and maintenance of health. With appropriate life attitudes, reducing desires, striving for a simple life, and observing the natural rules, i.e., practising Tao, one can anticipate attaining health and longevity. Thus, the effect of living life this way will be manifested in harmony with the natural and social environments, a sense of well being, and a longer lifespan.

### **Conclusion**

The aim of this study was to explore, describe, and document the concepts and meanings of mental illness and their impact on coping and adaptation in families with mental illness in Hong Kong during the period of transition of sovereignty. Meanings and concepts cannot be interpreted without an understanding of the context. In order to gain a better understanding of the social reality of mental illness in Hong Kong, an ethnographic approach with multiple data sources was adopted. Besides formal and informal interviews, other data sources including reviews of the relevant English and Chinese language literature, field observations, a questionnaire survey, an analysis of newspaper clippings and self-reflection on my own experiences, i.e., active participant observation, were used. In the process of data analysis, the yin and yang analogy was adopted as the conceptual framework for understanding transitions in the society and exploring mental illness issues in Hong Kong during transition.

The converging findings from all the data sources have revealed several inter-related factors that influence the impact of mental illness on families. They include historical and political transition, the socio-cultural transition in searching for a cultural identity, transition in the health care system, the existing explanatory models of illness and healing, mass media, public attitudes towards mental illness, and transition in family's structure and

care giving. The political transition has brought about the search for cultural identity among Hong Kong Chinese. Despite some disagreements, Hong Kong has developed its own unique culture under 150 years of British colonial rule. Through non-interference from the ruling administration, a subtle mix of Western and Chinese culture has emerged where people can preserve their traditional values and customary practices and, at the same time, open themselves to the influence of Western ideology, cultural values, and life styles. Although traditional Chinese medicine was allowed to co-exist with Western modern medicine, the privileges and legal recognition given to Western medicine, largely for political reasons, had changed the balance. Subsequently, Western medicine, including Western psychiatry, appeared to be the only valid and “scientific” explanatory model to define diseases, interpret illness, experience and guide healing methods. All other health concepts and healing, including traditional Chinese medicine, were often classified as “unscientific,” “superstitious” and “primitive”.

Sensationalising news reports and alarming news headlines, together with increasing varieties of features and porographic materials, are some of the common tactics to attract the readers in the competitive press media industry. The public has requested that censorship be imposed on the mass media for the sake of upholding social morality. News associated with people with mental illness is often reported in a dramatised way with graphic details. Persons with mental illness are often presented as unpredictable, violent and dangerous. This also has perpetuated the public’s fear. Thus, the social stigma on mental illness has become difficult to remove.

The findings also indicate that the increase in public education on mental illness, which is based primarily on Western psychiatric concepts, has increased the public’s awareness of their own mental health and their understanding of mental disorders. However, it does not seem to have reduced negative attitudes toward people with mental illness.

“But-not-in-my-backyard” appears to be a common public attitude toward the re-integration of people with mental illness into the community and discrimination and prejudice still prevail among the public. Within such a context, families with a member with mental illness have no other alternative but to cope with the illness as a whole entity since every member is adversely affected by discrimination in career choice, marriage, and social network.

The data suggest that, although the family coping process does not necessarily follow a developmental sequence or a stage process, the experience may include the discovery of mental illness, explaining the illness to others, disruptions of family life and routine, re-examination of roles within the family, grieving of losses in the family, and keeping the family secrecy of mental illness. Family collectivism still appears to be largely unshaken among Hong Kong Chinese, despite the upheavals created by the political, socio-cultural and economic changes before and during the transition. It has led family members to make self-sacrifices to care for the mentally ill member, as well as maintain a kind of harmony in the family, although they may feel “*wúnài*” (inevitably no alternative) at times. Thus, under the condition of limited alternate explanatory models for the illness experience and discriminatory and hostile attitudes of the public, families with mentally ill relatives try to cope and adapt. The senses of hopelessness, guilt and pain seem to be inevitably tied to the family. At times, family members also become the victims of a mentally ill relative’s violence.

Nevertheless, the yin and yang analogy emphasises that as conditions swing to one extreme, it will lead to the creation of the antagonist component that will trigger the balance mechanism. As it applies to health (both physical and mental), it is not advisable for a person to be on either extreme. One needs to strive for equilibrium or harmony with the supernatural, nature, and the social world in order to prevent illness, maintain health

and preserve life. The Hong Kong Chinese family could be helped to better live with mental disorder by restoring the long-forgotten traditional knowledge of mental illness and its healing methods and by respecting the practice of “non-scientific” alternative healings seen fit by the families, in conjunction with Western psychiatric practice. After all, it does not matter which system or method works better or in what combination as long as successful healing occurs for the family with mental illness. Thus, disequilibriums that were once brought by the disease or disorder to the relationships among heaven, nature and human have resumed their balances again.

**References**  
**And**  
**Appendices**

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**Appendix I      Open-Ended Questionnaire Survey**

**INFORMED CONSENT**

**同意通知書**

This survey is being conducted as part of a study, titled: An ethnography of Chinese families and mental illness in Hong Kong, which is supported by the Departmental Research Fund, The Department of Rehabilitation Science, The Hong Kong Polytechnic University.

The main aim of the research project is to understand and describe the meanings of mental illness to the Chinese in Hong Kong, and to describe how families cope with such illness in Hong Kong.

Your participation in this project is much appreciated. However, you are free to withdraw from the research at anytime as you desire.

Your consent to participate in this survey is indicated by answering the following questions, either in writing or recording on an audio-cassette tape, and returning to the researcher.

**Thank you very much for your cooperation.**

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這項問卷調查乃一項名為“香港華人家庭與精神病之人種誌”的研究計劃之其中一部份。這項研究並獲得香港理工大學復康治療學系部門研究基金的支持。

這項研究之主要目的是去瞭解和描述精神病對香港華人的意義，與及探討香港家庭如何面對患有精神病的家人。

您的參與對於是項研究非常重要。不過，您可依個人意願而隨時退出參與是項研究計劃。

如您同意參與是項研究，請以文字或錄音的形式，回答問卷內的問題，並交予研究者。

**多謝你的合作!**

**Matthew K. Yau (邱貴生)**

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Department of Rehabilitation Sciences

The Hong Kong Polytechnic University

Hung Hom, HONG KONG

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**You may answer the following questions in written English, or Chinese, or a combination of both, or by recording your answers on an audio-cassette tape. If you choose the last option, please ask the research for a blank audio-cassette tape.**

你可以用英文、中文或中英文並用，或用錄音的方法回答以下問題。假如是用後者的方法，請向研究者索取一盒空的錄音帶。

**Section A:**

**甲部**

Year that you were born: 19 \_\_\_\_\_

你出生的年份

Sex: Male/Female

性別:男/女

Education: Never attended school / Primary / Secondary / Post-Secondary / University

教育程度:從未入學 / 小學 / 中學 / 預科或工業學院 / 大學

Current Occupation: \_\_\_\_\_

現今職業:

Do you have a relative or friend who has or had a mental illness?: Yes / No

你有沒有親人或朋友現在或曾經患有精神病?

有 / 沒有

How is this person related to you? \_\_\_\_\_

(Please list all their relationship to you if you have more than one)

他(她)與你的關係: \_\_\_\_\_

(假如你有多過一位，請也全列出他們與你的關係)

**Section B:**

乙部

1. In your own understanding, what is mental illness?  
以你個人的認識，精神病是甚麼？
2. What do you think are the possible causes of mental illness?  
你認為甚麼原因或因素是最有可能引致精神病？
3. What are the typical characteristics and/or behaviors of a person described as “mentally ill”?  
請形容被稱為 <精神病> 患者的普遍性格和 (或) 行爲？
4. In your experience, how other people described mental illness and persons with mental illness? (Please give 2 or more examples)  
在你以往的經歷中，你聽過別人如何形容精神病和精神病患者？(請舉兩個或以上的例子)
5. In your experience, how are people with mental illness treated by others? (Please give 2 or more examples)  
在你以往的經歷中，你見過別人如何對待精神病患者？(請舉兩個或以上的例子)
6. Do you think mental illness can be cured? Why?  
你相信精神病可以被完全醫治嗎？原因何在？
7. In your opinion, how should mental illness be cured?  
以你個人的意見，精神病應如何被醫治？
8. Do you think there is a stronger discrimination against people with mental illness than people with other types of disability/illness? Why?  
比其他傷殘者或疾病患者，你相信精神病患者面對更多社會歧視嗎？原因何在？
9. In your opinion, how should persons with mental illness be treated by us?  
以你個人的意見，我們應如何對待精神病患者？

10. Do you think mental illness is only an illness in modern world?  
你是否認為精神病只是現代世界裡的一種疾病？

Yes / No  
是 / 否

Please explain  
請解釋

11. Do you think the incidence of mental illness is increasing? Why?  
你相信精神病的個案有增加的趨勢嗎？原因何在？

12. Do you believe traditional Chinese medicine is effective in treating mental illness?  
Why  
你相信傳統的中國醫術對精神病的治療有效嗎？原因何在？

13. If you have a relative or friend who has or had a mental illness, describe your thoughts and experience with him/her.  
如果你有親人或朋友現在或曾經患有精神病，試形容你對他(她)的印象和經歷。

14. Any other comment on the topic or issues relate to mental illness?  
關於精神病的題目或問題，你還有其他的評論或補充嗎？

\*\*\*\*\*

**If you know of any person who would like to participate in this survey or are willing to be interviewed, particular family members of person with mental illness, please kindly let the researcher know.**

假如你知道其他人有興趣參與這項問卷研究或願意接受訪問，特別是精神病患者的家人，請與研究者聯絡。

**Please kindly return the answered questionnaire or recorded tape to the researcher:**

請把填好的問卷或錄音帶交回與研究者：

*Matthew K. Yau (邱貴生)*  
*Department of Rehabilitation Sciences*  
*The Hong Kong Polytechnic University*  
*Hung Hom, HONG KONG*  
*Phone: 27666751 Fax: 23308656*

**Thank you once again for your cooperation and assistance!**

**再次多謝你的合作與幫忙！**

10. Do you think mental illness is only an illness in modern world?  
你是否認為精神病只是現代世界裡的一種疾病？

Yes / No  
是 / 否

Please explain  
請解釋

11. Do you think the incidence of mental illness is increasing? Why?  
你相信精神病的個案有增加的趨勢嗎？原因何在？

12. Do you believe traditional Chinese medicine is effective in treating mental illness?  
Why  
你相信傳統的中國醫術對精神病的治療有效嗎？原因何在？

13. If you have a relative or friend who has or had a mental illness, describe your thoughts and experience with him/her.  
如果你有親人或朋友現在或曾經患有精神病，試形容你對他(她)的印象和經歷。

14. Any other comment on the topic or issues relate to mental illness?  
關於精神病的題目或問題，你還有其他的評論或補充嗎？

\*\*\*\*\*

**If you know of any person who would like to participate in this survey or are willing to be interviewed, particular family members of person with mental illness, please kindly let the researcher know.**

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**Thank you once again for your cooperation and assistance!**

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**Appendix II Profile Of Family Member Informants**

Interviewee Name (fictitious)	Informants	Relative with mental illness
Elaine	Sister Age: Late 20s Occupation: Social worker in a resource centre for families with mentally ill relatives in a city in China	Relation: 2 <sup>nd</sup> Eldest sister Diagnosis: Claimed to be suffering Schizophrenia
Jody	Daughter Age: 18 Gender: F Education: Form 5 Occupation: accounting clerk	Relation: Father Age: 40-50 Education: Elementary Occupation: Renovation worker Diagnosis: unclear Onset: half a year after unemployed  Father was described to be withdrawn, bad temper, violence against wife, suicidal. He was hospitalised in a psychiatric hospital.
Mr. Wong	Father Age 57 Occupation: Retired	Relation: Daughter Age: 30
Mr. Fung	Father	Relation: Daughter Age: 24 Education: Form 3 Diagnosis: (Anxiety disorder), Schizophrenia, Borderline mental retardation Onset: 10 years ago Siblings: 1 brother and 1 sister Occupation: No working experience
Mr & Mrs Lam	Parents	Relation: Daughter Age: 15 Onset: end of 1995
Mr. Pang	Son	Relation: Mother Age: 63-65 Numerous hospitalisation since May 1995
Mr. Mak	Father Committee member of a relatives support group for mentally ill persons	Relation: Son Onset: January, 1976 at 20 Diagnosis: Manic depression
Agnes	Elder sister Age: 25 Played a "big" sister role	Relation: Younger brother



**Appendix II Profile Of Family Member Informants (continue)**

Interviewee Name (fictitious)	Informants	Relative with mental illness
Madam Chan	Mother Age: early 70s  Migrated to Hong Kong in the 1960s and later left for the US and worked there without much knowledge of English	Relation: Son  Studied in the U.S., and returned to work in Mainland China after graduation. Two broken marriages and currently worked as a clerk in a private company.
Miss Wan	Sister Religion: Protestant Christian Committee member of a relatives support group for mentally ill persons. Played a "big" sister role.	Relation: Younger Brother
Xie-yin	Ex-Girl friend Parents disapproved her dating with this boy friend who worked as a insurance salesman	Relation: Ex-Boy friend Occupation: insurance salesman Appeared to be suffering major depression
Sarah	Young sister Expressed her hostility and anger toward her brother in the interview	Relation: Elder brother
Miss Jiang	Elder Sister Occupation: health care professional	Relation: Young sister
Mrs. Yin	Mother Occupation: night shift worker to share the caring task with husband who worked as a tailor.	Relation: Young Daughter

**Appendix III Focus Group Recordings**

<b>Date</b>	<b>Occasion</b>	<b>Inviting Organisation</b>	<b>Data collected through</b>
26/1/1997	Seminar Talk "How to look after care givers' mental health"	Hong Kong Association of Relatives for Mental Health	Audiences' questions & answers
20/7/1997	Seminar Talk	Hong Kong Association of Relatives for Mental Health	Audiences' questions & answers
29/3/1998	Seminar Talk "Ex-mentally Ill persons and Marriage"	Hong Kong Association of Relatives for Mental Health	Audiences' questions & answers
19/4/1998	Focus Group Discussion	Hong Kong Association of Relatives for Mental Health	Audio- recording
August 1998	Workshop "How to communicate with people with mental illness"	Amity Club of Mental Health Association of Hong Kong	Informal dialogue and participants' questions & answers
17/5/2000	Focus discussion group on equal opportunity in employment	Residents of a hostel for ex-mentally ill clients	Part of another research project co-investigated by the author and other colleagues

**Appendix IV Participant Consent Form**

*[Translated into Chinese]*

**THE HONG KONG POLYTECHNIC UNIVERSITY  
Human research ethics committee**

**Participant Consent Form**

**Research Title: An Ethnography of Chinese families and mental illness**

**Researcher Name: Matthew K. Yau**

This research project is part of the researcher's doctoral study at the School of Occupation and Leisure Sciences, Faculty of Health Sciences, The University of Sydney, Australia. It is also supported by the Department of Rehabilitation Sciences, The Hong Kong Polytechnic where the researcher is currently employed as an Assistant Professor. The aim of this study is to find out how do the families with a member being mentally ill cope. The areas to be explored include the coping process and the strategies employed, as well as the help-seeking behaviours of the families.

You are invited to participate in this investigation that may involve several interviews (3 - 4 times) of family members in different occasions which will be at your convenience. Each interview will take one to two hours.

Your participation in this study is strictly voluntary. You are free to withdraw from the study at anytime without any disruption or jeopardy to the services that your family are receiving and/or will receive.

Should you have any queries regarding the study, please do not hesitate to ask the researcher (phone: 27666751). If you have any enquires regarding the conduct of the research please contact the Secretary of the Human Subjects Ethics Committee, Hong Kong Polytechnic University (phone: 27665134).

\* \* \* \* \*

**If you wish to take part in this research please read the Statement of Consent and sign below, then return this consent form to the researcher or mail to:**

**Matthew Yau,  
Assistant Professor,  
Department of Rehabilitation Sciences,  
Hong Kong Polytechnic University,  
Hung Hom, Hong Kong.**

**STATEMENT OF CONSENT**

I understand my (or my family's) participation in this study of families and mental illness is strictly voluntary, and that I (or my family) may withdraw at any time. I understand that though some personal data will be collected, my family and myself will not be identified in any report or publication. I also understand that the information generated from this study may help to expand knowledge of psychiatric rehabilitation and may benefit my family and/or my relative who has mental illness, and I consent for the data to be used in that manner.

I, \_\_\_\_\_ understand the explanation of this study and consent to participate in this study

**Signed:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

**Appendix V Summary Of Demographic Data Of The Respondents In The Questionnaire Survey**

	Year of birth	Age	Sex	Education	Current Occupation	Relative or friend having mental illness	Relationship with you
01	1974	23	F	University	Student	Yes	
02	1976	21	F	University	Student	No	
03	1976	21	M	University	Student	Yes	Friend
04	1974	23	F	University	Student	Yes	Relative
05	1976	21	F	University	Student	No	
06	1976	21	F	University	Student	Yes	Friend
07	1975	22	M	University	Student	No	
08	1966	31	F	University	Student	No	
09			F	Secondary		Yes	Colleague
10	1975	22	M	University	Student	No	
11	1974	23	F	University	Student	Yes	
12	1974	23	F	University	Student	No	
13	1976	21	F	University	Student	No	
14	1967	30	F	University	Student	No	
15	1976	21	F	University	Student	No	
16	1951	46	F	Secondary	Housewife	Yes	
17	1976	21	F	University	Student	No	
18	1975	22	F	University	Student	No	
19	1976	21	M	University	Student	No	
20	1947	50	F	Primary	Housewife	No	
21	1976	21	F	University	Student	Yes	
22	1975	22	F	University	Student	No	
23	1976	21	F	University	Student	No	
24	1962	35	F	Post-Secondary	Clerk	No	
25	1970	27	F	Post-Secondary	Clerk	No	
26	1962	35	F	Secondary	Typist	No	
27	1961	36	F	Post-Secondary	COII	No	
28			F	University		No	
29	1977	20	F	University	Student	Yes	Relative
30	1974	23	F	University	Chinese Language officer	No	
31	1952	45	F	Secondary	Housewife	No	
32	1975	22	F	University	Student	No	
33	1980	17	M	Secondary	Student	No	
34	1951	46	F	Secondary	Housewife	No	
35	1980	17	F	Secondary	student	No	
36	1965	32	M	University	Manager	No	
37	1967	20	F	Post-Secondary	Administrative Assistant	No	Relative
38	1967	20	M	University	Sales Supervisor	No	
39	1944	53	F	Primary	Housewife	No	

**Appendix V Summary Of Demographic Data Of The Respondents In The Questionnaire Survey (continue)**

	Year of birth	Age	Sex	Education	Current Occupation	Relative or friend having mental illness	Relationship with you
40	1964	33	M	University	Marketing Director	No	
41	1968	29	F	University	Civil Servant	No	
42	1975	22	F	University	Student	No	
43	1972	25	F	University	Physiotherapist	No	
44	1970	27	F	University	Teacher	No	
45	1974	23	F	University	Student	No	
46	1965	32	F	University	Minister	Yes	Sister
47	1972	25	M	University	Marketing	No	
48	?		F	University	Quantity Surveyor	No	
49	1971	26	F	University	Programme Officer	No	
50	1971	26	M	University	Marketing	No	
51	1932	65	M	Secondary	Watchman/Security	No	
52	1950	47	F	Secondary	Housewife	No	
53	1975	22	F	University	Student	No	
54	1947	50	F	Primary	Housewife	Yes	Sister-in-law
55	1939	58	M	Primary	Retiree	Yes	Elder sister
56	1971	26	M	University	Social Worker	No	
57	1973	24	F	University	Portfolio Accountant	No	
58	1973	24	M	Post-secondary	Businessman/self-employed	No	
59	1955	42	F	Secondary	Clerk (PT)	No	
60	1949	48	M	Secondary	Supervisor	No	
61	1957	40	F	Secondary	Housewife	No	
62	1964	33	F	University	Insurance Broker	No	
63	1964	33	F	University	Nurse	No	
64	1967	30	M	Secondary	Administrator	No	
65	1967	30	M	University	Teacher	No	
66	1966	31	M	University	Consultant	No	
67	1943	54	M	Secondary	Driver	No	
68	1974	23	F	University	Banking	No	
69	1950	47	F	Secondary	Housewife	Yes	Unknown
70	1948	49	M	Primary	Catering/Waitering	No	
71	1974	23	F	University	Research Assistant	No	
72	1977	20	F	University	Student	No	

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