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Editors' Introduction to Section II: Rehabilitation Interventions in In-Patient Settings

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Virtually all the professional mental health providers in China are hospital-based. Care for the mentally ill is also provided by family members, by folk healers in the community, and – in the large urban centres – by a small number of community-based mental health services, but for most Chinese people psychiatric care means hospital care. As discussed in our paper in section I of this supplement, the current changes in the financing of health care in China are likely to perpetuate this concentration of mental health resources and personnel in the hospital sector. This is, of course, a situation that is common in Asia and in most of the non-Western world. Nagaswami (1993) claims that much severe mental disorder in Asia (and this would also apply to China) goes untreated, and what treatment there is tends to take place in hospitals, for lack of any other facility. In a description of mental health services in Japan that is also relevant for China, Lin *et al* (1991) point out that in Japan mental hospitals were, and probably still are, the only mental health facilities where a concentration of trained mental health personnel are available.

This focus on hospital-based care has important implications for the evolution of psychiatric rehabilitation in non-Western countries. The cadre of professionally trained rehabilitation experts who provide services and train non-professional care-givers will, necessarily, come from psychiatric hospitals. The first steps in the development of rehabilitation services are, therefore, to convince these hospital-based biomedical practitioners of the importance of the psychosocial aspects of care, to expose them to the Western theory and practice of rehabilitation, and to encourage them to experiment with rehabilitative approaches that will, eventually, lead to culture-specific theories and methods for the provision of psychiatric rehabilitation in their own communities. Given the reluctance of professionals to leave the security of the hospital, most experiments in rehabilitative care will be based in hospitals, and community-based experiments will involve the training of non-professionals in the community by hospital-based professionals. For example, with the unique exception of the paper by X. Wang, all the Chinese-authored papers in this supplement are by hospital-based professionals.

To the Western reader, there may be a distinct sense of *déjà vu* in reading the five papers in this section on in-patient rehabilitation programmes. The issues that some Chinese psychiatrists and nurses are struggling with are ones that are all too familiar in the West, but from some time ago. There is, for example a long and respectable tradition in the West of studying the less than desirable effects of living in an institution on patients' symptomatology and behaviour (Stanton & Schwartz, 1954; Barton, 1959; Goffman, 1961; Wing & Brown, 1971). The conclusion reached by Wing & Brown (1971, p. 177) from their three-hospital study is nowadays accepted as commonplace by Western workers:

> "A substantial proportion, though by no means all, of the morbidity shown by long-stay schizophrenic patients in mental hospitals is a product of their environment."

Although most Chinese psychiatrists are aware of this Western concern about institutionalisation, they continue to view symptoms as the product of the illness, not as the outcome of an interactional process between individuals and their environments. They are either unaware or unconvinced of Wing & Brown's other finding (1971, p. 185):

> "the most important single factor associated with improvement of primary handicaps was a reduction in the amount of time doing nothing."

It is very evident to anyone visiting a Chinese psychiatric ward that the majority of patients spend most of their day doing nothing. Even acutely ill patients stay in hospital for around three months, which is quite long enough for institutionalisation to set in, given the right circumstances. Many hospitals organise special events for festival days or an annual sports day, but the difficulty lies in sustaining a programme of activities as a regular part of the hospital regime. Equally, some hospitals are able to show visitors a room devoted to practising calligraphy or a reading room, but few patients participate in these activities on a regular basis.

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The lack of appreciation of the psychosocial aspects of care is largely due to the absence of a tradition of social science training in medical and nursing schools, which exclusively focus on the biomedical model of care. If Chinese psychiatric staff were asked to define what 'caring' means, they would do it in terms of the physical well-being of the patient. To care for patients would entail making sure that they were sufficiently medicated, adequately fed, regularly washed, and appropriately dressed for the weather. The inability or unwillingness of mental health professionals to view patients as people with social and emotional needs – an interpersonal style that is usually limited to one's family members in Chinese culture – is sustained and magnified by the low morale of mental health professionals, most of whom are assigned to work in psychiatry against their wills.

Almost all Chinese mental health workers continue to see hospitals as the solution and not as part of the problem. The authors of the articles in this section are doing battle with this conventional wisdom. The first four papers use scientific methods to demonstrate that incorporating structured activities into hospital routines and providing a less-restrictive environment can improve the outcomes for both acute and chronic psychiatric in-patients. The fifth paper presents work on the development of a culture-specific instrument for the evaluation of in-patient psychiatric rehabilitation programmes. There are significant limitations in the work of these authors, notably the lack of post-intervention follow-up to determine the persistence of the improvements they report, and the failure to consider the problem of generalisation of the improvements to the non-hospital environment. But it is the results of their work and that of their colleagues – not the results of Western studies – that will convince Chinese practitioners to re-evaluate the role of the hospital and the role of the clinician in the provision of mental health care.

The first paper, by Li & Wang, directly confronts the issue of changing staff attitudes. Designed and conducted by a psychiatric nurse, the study concludes that psychiatric nurses in China – who are confined to the role of custodian and guard for in-patients (Bueber, 1993) – are a largely wasted resource. The authors show that patients will benefit if nurses become active participants in the provision of psychiatric rehabilitation, but this transformation of the role of nurses will require additional training for nurses and a fundamental change in the physician-dominated hierarchy of psychiatric care. In fact, all rehabilitation programmes in China will require significant changes in usual medical and nursing practices. It will, therefore, be necessary to change staff attitudes in order to change patients' behaviour. This problem is also central to the provision of psychiatric rehabilitation in the West (Barton, 1959; Wing & Brown, 1971; Watts & Bennett, 1991).

Li & Wang's paper also has the distinction of being one of very few studies in China that specifically tailors the reinforcement schedule to the individual characteristics of the patient. Almost all rehabilitation programmes in China are collectively provided to groups of patients; this is partly because of the limited numbers and limited training of staff and partly because of a political environment that praises collectivism and disparages individualism. Thus psychiatric rehabilitation in China lacks one of the fundamental characteristics of Western approaches: the detailed assessment of individuals' strengths and weaknesses and the development of individually tailored interventions (Bachrach, 1992). This paper reports on one of China's first tentative steps towards patient-specific interventions.

The second paper, by Tang *et al*, on music therapy for residual schizophrenic patients in an acute-care hospital, describes one of a group of recreational and artistic activities (including listening to audiotaped music, playing Western and Chinese musical instruments, dancing classes, calligraphy, and Chinese painting) provided to a small number of patients in both acute-care and chronic-care psychiatric hospitals. Communal singing, one component of music therapy, is a widely used recreational activity that most psychiatric in-patients find enjoyable because, in part, singing is an integral element of normal social life in China; in a culture that has only recently been introduced to the television, many social gatherings are still concluded by communal singing or by individual singing performances of each participant. Songs have played a part in psychiatric treatment regimes for decades (Livingstone & Lowinger, 1983) because they are an inexpensive and pleasant way of inculcating correct ideas in patients (many of whom are illiterate). It is not uncommon when visiting psychiatric wards in China to find that the song being sung to you has been jointly written by staff and patients (and to find, to your dismay, that you are expected to reciprocate by singing a song in your own language!).

Recreational and artistic activities in psychiatric hospitals have recently gained new stature because they have been redefined as types of 'rehabilitation'. Music therapy, in particular, has enjoyed a rapid increase in popularity because it has given hospitals

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a rationale for purchasing new technology (i.e. advanced multi-track audio systems) and for increasing patient charges. Music therapy, as it has evolved in China, is not an associational technique designed to release individual emotions and fantasies. Rather, it is assumed to affect basic physiological processes which in turn bring about psychological changes. The focus is not on introspection, an activity not valued in Chinese societies, but on relaxing patients and on increasing their opportunities for socialisation.

The programmes described in the papers by Fan *et al* and Jin are newer versions of the 'four-part integrated therapy' model that has been the official policy of the chronic-care psychiatric hospitals under the Ministry of Civil Affairs (the welfare ministry) for decades. In most locations the four-part integrated therapy programmes are watered-down versions of the in-patient industrial therapy programmes employed in the West (Morgan, 1991), but the more progressive hospitals have added organised recreational activities and collective forms of social skills training. The programmes described in these two papers are unique in that they also address two issues that are of central concern to Western practitioners: providing least-restrictive treatment and encouraging patients to participate in the design of rehabilitation programmes.

Open-door management of psychiatric hospitals has been strongly recommended by leading Chinese authorities at several points in the development of mental health services, including the ground-breaking Nanjing Conference in 1958. But clinicians have been reluctant to relinquish the control that locked wards provide over involuntarily admitted patients (which we estimate to be over 80% of all in-patients), so the vast majority of psychiatric wards in China remain locked. The open-door treatment advocated by Fan *et al* and Jin are responses to the increasing influence of the China Disabled Persons' Federation that advocates using the least restrictive method of treatment possible. Whether this new push for open-door treatment will be any more effective than previous attempts remains to be seen.

Consumer participation is not a concept that has taken root in the authoritarian-style medical care system prevalent in China. Most Chinese clinicians would dismiss as ludicrous the statement by Bachrach (1992, p. 1457) that 'psychosocial rehabilitation requires that patients be actively involved in their own care and, indeed, in the very design of their own rehabilitation protocols'. In the Chinese context, Fan *et al* and Jin are revolutionary in that they have involved patients in the design of their services. This is different from patient involvement in the West because in China the provided interventions are collective, not individualised, so patients are not involved in designing their personal protocols. It is, nonetheless, a significant departure from standard practice in China that may or may not survive the tests of time.

The paper by Fan *et al* also addresses another problem familiar to Westerners: where do we resettle rehabilitated in-patients? Some patients will still need to live in the protective environment of the hospital after successful rehabilitation, but many others could lead more independent lives. Given the virtual absence of intermediate care facilities, Chinese patients with adequate functioning who have no family members willing to take them back have little chance of being discharged. Fan *et al* estimate that there are 25 000 such patients in chronic-care psychiatric hospitals in China. Any solution to this problem is likely to lie with the hospitals and their willingness to extend their facilities to include some form of 'hospital hostel', as is being done for some of the long-stay patients in Britain who cannot be successfully deinstitutionalised (Bennett, 1980). But such a change requires a major transformation in the attitudes of hospital workers, in the physical plant of hospitals, and in financing arrangements; the model developed by Fan *et al* is one of very few such experiments in China.

The last paper in this section, by Li *et al*, about a scale to assess the outcome of in-patient rehabilitation programmes, is an example of the attempts by Chinese researchers to put the practice of psychiatric rehabilitation on a firmer scientific basis. The quality of much of the rehabilitation research currently being done in China is in doubt because outcomes are typically assessed in terms of changes in psychiatric symptoms, not in terms of changes in psychosocial functioning. Improvement in the replicability and comparability of rehabilitation studies depends on the development of culture-sensitive instruments that can reliably and validly measure the psychosocial outcome of rehabilitation programmes. Given the vast differences in the social worlds of psychiatric patients in China and the West, translated Western instruments about psychosocial competence do not comprehensively assess the functioning of patients in China. The development of indigenous scales, however, is particularly difficult in China because there are no sociologists who can aid in the conceptualisation of the basic constructs of social environment, social functioning, and social support, and there are few psychologists who can aid in the complex process of instrument development.

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Li *et al* have overcome this problem by canvassing input from a wide circle of psychiatric experts to generate items, by employing a multi-stage process to select final items, and by undertaking an extremely comprehensive assessment of the reliability and validity of the final scale. Similar efforts are needed to develop scales to assess the outcome of out-patient rehabilitation programmes.

Li *et al* also raise several issues that are relevant to rehabilitation research in the West. They contend that evaluation of patients' psychosocial functioning must be done over a period of at least one week to ensure that their competence in the different components of the rehabilitation programme (which usually include rotations of occupational, educational, social, and recreational activities on weekly schedules) can be considered in the final score. They develop a flexible scoring method that allows for the comparison of the psychosocial outcome of different rehabilitation programmes. And they have discussed in detail the problem of obtaining blind evaluations of patients' functioning when comparing the outcome of patients who do and do not participate in a particular programme. Their goal, as in the West, is to improve the scientific rigour of rehabilitation research without seriously compromising the qualitative richness of the social phenomena they are measuring.

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