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**Psychoeducational approach with chronically mentally ill
Chinese-Americans: A cultural framework**

Tom, Lily M., D.S.W.

City University of New York, 1989

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A

**PSYCHOEDUCATIONAL APPROACH WITH CHRONICALLY MENTALLY ILL
CHINESE-AMERICANS: A CULTURAL FRAMEWORK**

by

LILY M. TOM

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of Doctor of Social
Welfare, The City University of New York.

1989

1989

LILY M. TOM

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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abstract

**PSYCHOEDUCATIONAL APPROACH WITH CHRONICALLY MENTALLY ILL
CHINESE-AMERICANS: A CULTURAL FRAMEWORK**

BY

LILY M. TOM

Adviser: Professor Rebecca Donovan

A culturally relevant psychoeducational program was designed to help Chinese-American chronic mental patients increase their knowledge of Western concepts of mental illness and treatment. This program was conducted in a continuing treatment program staffed with Chinese bilingual, bicultural workers. The purpose of the present study was to examine the impact of the psychoeducational program on this particular population.

Patients in the continuing treatment program were randomly assigned to either the experimental or control group. The experimental group participated in the psychoeducational program in addition to standard treatment protocol; the control group only attended the regularly scheduled treatment activities. A set of questionnaires comprised of three instruments (Knowledge About Schizophrenia Questionnaire, Opinions About Mental Illness, and Client Satisfaction Questionnaire) were used to measure the patients' knowledge of mental illness and treatment, their opinions concerning mental illness, and their satisfaction with services. A week after the experimental group completed the psychoeducational

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program, both experimental and control groups answered this set of questionnaires, and the staff were instructed to rate both groups' level of participation in the continuing treatment program by using another instrument, the Task Check List.

One-tailed t tests were used to compare the difference between the mean scores of the two groups on the four instruments. Results showed that the experimental group was significantly more knowledgeable about Western concepts of mental illness and treatment than the control group. This finding was further substantiated by the qualitative data obtained. No significant differences were found between the two groups in their opinions regarding mental illness, satisfaction with program services, or their motivation for treatment. These findings suggest that psychoeducation is a useful treatment method for Chinese-American chronic patients in helping them to better understand their illness, to become more familiar with the mental health services available in the United States, and to make informed choices regarding their treatment. Utilization and treatment compliance may increase as a result of this knowledge. This investigation is exploratory in nature and future studies are needed to verify the effectiveness of this treatment approach with Chinese as well as other Asian Americans.

Acknowledgments

I like to thank Dr. Rebecca Donovan, the chairperson of my committee, who provided me with the motivation and support I needed to complete this study. In addition, I want to express my appreciation for the assistance of Drs. Mildred Mailick and Angela Shen Ryan, my committee members. They have made this dissertation an invaluable learning experience for me.

I especially like to thank Joana Chan, who had helped me with the translations, the slide presentations, and the many details during the implementation of the project. I am also grateful to Ann Hoang for her assistance with the translations and project implementation. Special thanks to the clients who participated in the study, and to Rix Chan for his help with typing.

Finally, I want to express my deepest gratitude to Stuart, who had been patient, caring, and understanding during my most difficult times. His continuous help and encouragement were crucial to the completion of this dissertation.

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INTRODUCTION

Within the past two decades, there has been increased interest in the mental health needs of Chinese-Americans. The overall issue of mental health has been under closer scrutiny as the general public's awareness of mental health problems became greater, and with the changes in national mental health policies. Additionally, the civil rights movement raised the level of ethnic consciousness in Chinese and other Asian Americans. Similar to other minority groups, Asians recognized the many social problems within their own community and voiced the need for governmental intervention (Kim, 1973). Concerned Asian American mental health professionals seriously questioned the myth that Chinese and other Asian Americans have few mental health problems (Berk and Hirata, 1973; Sue and McKinney, 1975; Yu, 1984).

The prevalence of mental illness among Chinese-Americans is unknown at this time due to the lack of adequate data. Available information, mainly derived from treatment sources, indicated that Chinese-Americans had lower admission and utilization rates to mental health facilities (Jew and Brody, 1967; Kitano, 1969; Berk and Hirata, 1973). Other investigations supported the finding that Chinese-Americans had lower utilization

rates, but exhibited more severe symptomatology among those who sought services (Brown, Stein, Huang and Harris, 1973; Sue and Mckinney, 1975). Moreover, those who were hospitalized were likely to have longer stays (Sue and Sue, 1974). The few population-based investigations, while inconclusive, indicated an underestimation of the incidence of mental illness among Chinese-Americans (Yamamoto, Cabezas and Loo as cited in Kuo, 1984). In his study, Kuo found that the prevalence of depression among Asian Americans (Chinese, Filipinos, Japanese and Koreans) was at least as prominent as that of the white population (Kuo, 1984). Lin, K. M. and his associates (1982) and Lin, T. Y. (1983) explained the low utilization phenomenon as the result of a different pattern of help-seeking behavior, rather than the lack of need for mental health services. They found that Chinese families tend to have a higher tolerance for symptoms, as well as a longer delay in seeking help because of social stigma, a different view of mental illness, and the reliance on traditional resources. The low utilization rate could be accounted for by the Chinese-Americans' lack of knowledge of existing resources, unfamiliarity with treatment methods, as well as the failure of existing mental health services to provide culturally relevant interventions (Chen, 1977; Chin, J. L., 1983; Chung, 1982; Lin and Lin, 1978; Uba, 1982).

Recent changes in immigration laws have resulted in the rapid growth of the Chinese-American population. According to the 1980 census, there are over 800,000 Chinese living in the United States. The characteristics of Chinese-Americans are not homogeneous. They vary depending on the individual's length of residence in the United States, country of origin (Taiwan, Hong Kong, China, Vietnam, etc.), socioeconomic status and educational level. The composition of this group is swiftly changing with the influx of immigrants in the past few years. Currently, sixty percent of Chinese-Americans are recent immigrants (Lorenzo and Adler, 1984). The experience of immigration is associated with a higher rate of mental illness due to the major changes in lifestyles and support systems (Rabkin and Struening, 1976). Language barrier, cultural conflicts, racism and poor socioeconomic status are common problems among recent immigrants (Kuo and Tsai, 1986; Sue and Morishima, 1982). The magnitude of mental health problems for Chinese-Americans most likely has amplified. It is imperative that appropriate treatment strategies and services be developed to meet the needs of this population.

The purpose of this project is to develop a psychoeducational program to improve mental health service delivery to Chinese-American chronic mental

patients. The program aims to enhance their understanding of the American culture's beliefs regarding the nature of mental illness, and to increase their familiarity with mental health treatment in the United States.

It is noted that the low utilization of mental health services and premature termination of treatment by Chinese-Americans are often the consequence of their differing views of mental illness and treatment (Chen, 1977; Flaskerud, 1986; Lin and Lin, 1978; Root, 1985; Sue and Mckinney, 1975; Uba, 1982). Chinese clients who are unfamiliar with the methods and goals of Western treatment, tend to fear and mistrust mental health professionals and service agencies. While mental health education is not novel to the mental health service delivery system, there has been no report of a formal, structured program to facilitate Chinese-American patients in utilizing mental health services in this country.

In recent years, the use of the psychoeducational approach has increased, especially in the treatment of the chronic mentally ill (Barter, 1984). The purpose of this study is to examine an application of this intervention on the Chinese-American chronically mentally ill population. The goals of this study are: 1) to facilitate the adaptation of Chinese-American clients to

the mental health services in the United States by utilizing a culturally sensitive intervention, and 2) to generate knowledge that could be linked to social work practice in the delivery of services to ethnic minority groups.

CHAPTER ONE: NATURE OF THE UNMET NEED**1. Historical Preface - Chinese in America**

Historically, social work practice has its emphasis placed on the need to understand individuals within the context of their significant environment (Turner, 1987). An overview of the Chinese experience in America is pertinent to this project as it highlights the adversities and struggles Chinese-Americans face, which are likely to have negative impact on their mental health. (Figure 1 illustrates the components pertaining to the Chinese-American experience.)

The Chinese were "imported" as a source of cheap labor in the second half of the 19th century during a period of industrialization and urbanization in the United States. Chinese laborers settled in the West and worked under "coolie contracts" which paid meager wages. Many became afflicted with physical or emotional illness because of poor working and living conditions. Suicide, and death resulting from physiological ailments were not unusual for this group (Chen, 1977).

The reception of Chinese in this country is at best described as ambivalent. They were accepted by the exploitative white entrepreneurs but were greatly resented by the white laborers, since the Chinese were

willing to work long hours for low wages. Furthermore, many Chinese were brought to the United States by business owners as strike breakers. During the depression of the 1870's, anti-Chinese sentiments were prominent as the Chinese were considered fierce competitors in the job market. Many Chinese were robbed, lynched, murdered, and their property damaged by mobs. They were driven from their jobs and their businesses were destroyed (Lyman, 1974).

The anti-Chinese movement became national policy with the passage of the Chinese Exclusion Act in 1882. This was the first of many anti-Chinese legislation on federal and state levels. Subsequent laws subjected the Chinese to immigration and occupational restrictions, as well as discrimination and harassment (Lyman, 1974). Many fled the country and returned to China, while others retreated to urban ghettos where there were large numbers of Chinese (Lyman, 1974).

The enactment of the National Origins Act in 1965 abolished the restrictive quota system and the Chinese were permitted to enter this country in larger numbers (Chen, 1977). The population of Chinese in the United States increased from 237,292 in 1960, to 431,583 in 1970 (Fessler, 1983). Today Chinese-Americans represent almost .4% of the national population. The 1980 census counted 812,178 Chinese-Americans and it is the largest

Asian group in the United States (1980 Census, U.S. Printing Office, Bureau of Census).

Chinese-Americans belong to one of the smaller minority groups in the United States despite its growth in population in recent years. They shared the disadvantages common among other racial minorities, from blatant discrimination to the more subtle forms of prejudice. Historically, they have been targets of racists attacks and practices by reason of their physically distinctive features and different cultural customs. More recently, Chinese-Americans are hailed as the "model minority", as a group that has become successful despite its minority status. The concept of "model minority" has a major drawback; it implies that minorities are capable of being successful if they work hard, and this view asserts that the difficulties minority groups face stem from individual shortcomings rather than the problems of society (Kitano and Sue, 1973). In actuality, Chinese-Americans are under represented in administrative and managerial positions, and are receiving lower incomes than their white American counterparts (U.S. Commission on Civil Rights, 1980, as cited by Yu, 1984). To accept the myth of the "model minority" would ignore the many problems this group encounters.

The Chinese community, traditionally, has been

isolated from mainstream society because of prejudice and discrimination, as well as its attempt to stay a close-knit group. Language barrier, and the Chinese's preference to resolve difficulties within their own community have kept social and health problems hidden from the larger society (Lorenzo and Adler, 1984). With the influx of new immigrants in the past two decades, the problems of the Chinese community intensified and the need for social services became more apparent (Yu, 1984). Unemployment, poor working and housing conditions, and adjustment difficulties to a strange environment, are factors that have impacted on the mental health status of Chinese-Americans.

2. Problems in Mental Health Service Delivery

Mental Health Status of Chinese-Americans

The incidence of mental illness among Chinese-Americans is unknown at this time due to the lack of epidemiological and other relevant investigations. Earlier statistical studies indicated the rate of hospitalization for Chinese-Americans in California state hospitals gradually increased from 1855 to 1955, to a comparable level with whites. The length of hospitalization was longer and the majority of Chinese patients were diagnosed as schizophrenics (Berk and

Hirata, 1973; Jew and Brody, 1976). In 1965, Kitano conducted an investigation of the rate of admission to California state hospitals by Chinese and Japanese-Americans. He found that per 100,000 patients, there were 90 Chinese patients to 180 white patients (as cited in Sue and Morishima, 1982). Sue and Sue (1974) studied a population of Chinese and other Asian college students in the student psychiatric clinic at the University of California at Los Angeles. They learned that Asian students were under represented in the utilization of clinic services. Furthermore, when compared with non-Asian Americans, Chinese male and female students had more psychotic profiles on the M.M.P.I. scales. Sue and Mckinney's study (1975) of seventeen community health centers in the Seattle area revealed that .1% of the clients were Chinese compared to the .6% Chinese population of the area served. Chinese and other Asians had a higher proportion of patients with a diagnosis of psychosis and the drop-out rate (52%) was extremely high for this group.

The use of treatment data alone has limitations in evaluating the prevalence of psychiatric disorders in any population; however, in this instance, population-based data are lacking and inadequate. The few studies completed showed that Asian Americans have poorer mental health compared to whites. Results of a study conducted

by Brown and his associates in 1973, demonstrated that Chinese-Americans in the downtown Los Angeles area underutilized mental health services, and they scored significantly higher on symptomatology than Caucasians in a matched sample. A 1982 survey conducted by Cabezas in California indicated Chinese and Filipino immigrants rated their mental health worse than the white sample (as cited in Kuo, 1984). Loo's 1981 report on the problems of San Francisco Chinatown showed that Chinese residents evidenced a higher incidence of mental health problems than the samples surveyed in midtown Manhattan and Hong Kong. Twenty-five percent were found to have serious psychopathology; however, only 5% of these individuals had utilized mental health services (as cited in Kuo, 1984). Kuo (1984) conducted an investigation of the prevalence of depression among Asian American residents in Seattle, Washington. A scale was administered to a sample drawn from the general population. Results concluded that Asian Americans (Chinese, Japanese, Koreans and Filipinos) scored higher on depressive symptoms than their white counterparts.

The findings of these studies suggest that the prevalence of mental disorders among Chinese-Americans has been underestimated because of low utilization rates. Chinese-Americans, as with other minority groups, are likely to experience greater stress as the consequence of

racism, as well as cultural and linguistic differences.

In the assessment of the mental health problems of Chinese-Americans, it is important to note that there is great within group differences. Native-borns, long-term residents and recent immigrants may suffer from different psychological stress because of dissimilar experiences. For example, it is likely that new immigrants from China would have greater adjustment difficulties as the result of their migration to a country that has vastly different political and social structures. These factors have important implications in the planning and delivery of mental health services for this population.

Factors Affecting Utilization

Kahn (1969) pointed out that some of the problems associated with service delivery are the unavailability and inaccessibility of services, lack of qualified personnel, and stigma for service recipients. Other factors such as racial and cultural biases, likewise discourage minority groups from using mental health services. Insensitivity of personnel and language barrier are also major hindrances to help seeking (Uba, 1984).

Existing studies showed that Chinese-Americans under utilize mental health services (Brown, et al, 1973; Chen, 1977; Kitano, 1969; Sue and McKinney, 1975), have long

delays in seeking help (Lin, K. M., Inui, Kleinman and Womack, 1982; Lin, T. Y. and Lin, M. C., 1978), and tend to terminate treatment prematurely (Sue, 1977; Sue and McKinney, 1975). These utilization patterns were explained as the consequence of unresponsive existing services. The major factors that negatively affected service delivery to Asian Americans included the shortage of bilingual and bicultural personnel, the lack of culturally relevant treatment modalities, insufficient publicity of the availability of services, and the incongruence between clients and providers' perceptions of mental illness and treatment (Chung, 1982; Kuo, 1984; Uba, 1982; Yamamoto, 1982).

The importance of the "match" or "fit" between client and service has been underscored in the literature on the treatment of minority clients (Devore, 1985; Ibrahim, 1985; Lum, 1982; Rogler, Malgady, Costantino and Blumenthal, 1987; Ziter, 1987). A number of studies had demonstrated that the use of bilingual, bicultural personnel was likely to increase the utilization of mental health services by minority members, when the worker's language and ethnicity matched those of the client (Flaskerud, 1986; Hatanaka, Watanabe and Shin, 1975 as cited in Chen, 1977; Wu and Windle, 1980). Flaskerud (1986) also observed that locating the service agency in the group's community tended to increase the

clients' continuance in treatment. This gain in knowledge has given impetus to the government, to attempt the rectification of the longstanding problem of inappropriate mental health care for minority groups. Currently, there are a few existing culturally sensitive programs for Chinese-Americans in the United States. They are located in the states where there are large numbers of Chinese residents (California, New York, Massachusetts). These programs are staffed with bilingual/bicultural mental health personnel and are situated in the Chinese communities. Such programs should only be viewed as a beginning effort to deal with the problems of delivering mental health services to Chinese-Americans. At this time, there is no comprehensive, up-to-date information that documents the current demand and utilization patterns of this group. Given the growing number of Chinese residents in this country, it is safe to speculate that there is a continuing need for the development of culturally relevant interventions and strategies. To further understand the difficulties of delivering mental health services to Chinese-Americans, it is essential to examine the role of culture in mental illness and treatment.

Cultural Issues

Health and illness are culturally defined and carry

social and personal significance. The expressions of symptoms and methods of treatment are based on cultural beliefs and values (Low, 1984; Marsella and White, 1984). Difficulties in mental health service delivery often engender from the disparaging systems of world view between the client and the service provider (Ibrahim, 1985; Kleinman, 1980; Schultz, 1982). The Chinese culture has a system of beliefs that differs from that of the Americans; therefore, each group has its own explanations of health and illness.

The Chinese, who view health and mental health as an interrelated phenomenon, consider the physiological and psychological systems as one. Mental health and health are achieved through harmony of bodily functions; hence, the imbalance of emotions would affect the organs and vice versa (Lin, 1983; Ryan, 1985). The treatment of mental and physical disorders follow the same guidelines of general Chinese medicine, in which herbs, diet and acupuncture may be used (Liu, 1981; Wu, 1984). The term mental illness is only used in the presence of extremely bizarre and inappropriate behavior (Lin, 1983). Depressive states of dysphoria and withdrawal are not recognized as mental problems because of the absence of blatantly deviant conduct (Lin, 1983). Suicide is often seen as a means of "saving face" when an individual is experiencing difficulties, rather than a manifestation of

mental disorder (Ryan, 1985). The reported causes of mental illness vary, depending on the particular local subgroup, and are commonly an amalgamation of indigenous and professional beliefs (Kleinman, 1980). Mental disorders are frequently attributed to factors such as vicious winds, excessive emotional stress, infections, nutritional deficiencies and bad weather, which can upset the body's balance (Liu, 1981).

Mental illness is strongly stigmatized in Chinese society. With the exception of overt psychosis, other mental health problems of a less severe nature are labeled as physical disorders (Kleinman, 1977). Kleinman had conducted extensive investigations on the relationship between culture and mental illness, especially with the Chinese population (Kleinman, 1977; Kleinman, 1980; Kleinman and Kleinman, 1985; Kleinman, 1986). His studies included Chinese from Taiwan, The Peoples' Republic of China, Hong Kong and the United States. He maintained that Chinese patients tend to present somatic complaints rather than psychological symptoms, as the label of medical illness is more socially acceptable. Kleinman explained that somatization often masks mental disorders such as depression because the Chinese discourage the direct expression of emotional stress. Likewise, cultural approval of physiological illness over psychological

problems accounts for the high prevalence of the diagnosis of neurasthenia in China (Kleinman, 1986). Neurasthenia is literally translated as "neurological weakness" in Chinese and is classified as a medical problem. This diagnosis originated from the United States but it is no longer in use by the mental health professionals in this country. The definition of neurasthenia is vague and could include disorders such as anxiety, hypochondria, hysteria and neurosis (Lin, 1983). This diagnostic label is culturally acceptable as it does not carry the negative connotations of mental illness. This dissimilar definitions of mental illness between the Chinese and the Americans represent one of the major problems in the delivery of mental health service to Chinese-Americans.

Another major factor that adversely affect mental health service delivery to Chinese-Americans is the service provider's lack of familiarity with the Chinese culture. Traditionally, the Chinese emphasize the importance of the family and the group to which the individual belongs (Ho, 1976, Tseng and Hsu, 1969). A person's behavior should conform to the expectations of his/her social circumstances. This differs from the American culture's emphasis on individuality (Saeki and Borow, 1985).

The Chinese tend to discourage verbal expression of

feelings. Verbalization of strong emotions is often considered socially inappropriate behavior, as well as harmful to health. Instead, the merit of being in harmony with oneself and the environment is stressed (Ryan, 1985). This is antithetical to the Western concept of psychotherapy, which underscores the curative effects of the disclosure of emotions.

For the Chinese, relationships and roles are clearly defined (Ryan, 1985, Tseng and Hsu, 1969). Respect and deference are given to authority. Service providers are seen as experts and are expected to actively intercede. Passivity and non-directive interventions on the helper's part may confuse the Chinese client who expect guidance and direction. The "mismatch" of cultural values and intervention techniques often resulted in the Chinese clients' premature termination of treatment. Chinese youngsters are taught at an early age that a person's wrongdoing would bring disgrace to the entire family. Shame is used as a means of social control. Problems are handled within the home to preserve family dignity (Toupin, 1980). The social sanction against sharing problems with strangers frequently deters the Chinese from seeking help in social agencies. Indeed, studies showed that Chinese-Americans rely heavily on intrafamilial resources and extended family involvement in coping with mentally ill family members, and have long

delays prior to seeking professional help (Lin, K. M., et al, 1982; Lin, T. Y. and Lin, M. C., 1978).

In summary, the service provider should be familiar with the Chinese culture, and search for a "match" or "fit" between the Chinese client and the treatment method. At the same time, the service provider should consider the unique characteristics of each subgroup of Chinese-Americans. These are the significant elements in a culturally sensitive mental health program, and their presence could enhance the service utilization of this population.

Since the project has its focus on improving mental health services to the chronically mentally ill Chinese-Americans in New York City, this particular group's needs and problems are examined below.

3. Chronically Mentally Ill Chinese-Americans in New York City

The President's Commission on Mental Health (1978) reported that the chronically mentally ill, and the minorities were two of the most underserved populations in the United States. Subsequently, the Mental Health Systems Act of 1980, in part based on the findings and recommendations of the Commission, required states to develop extensive mental health programs to meet the

needs of special priority groups, two of which were the chronically mentally ill and minority patients.

Deinstitutionalization brought attention to the chronic mental patients because of their visibility in the community. It is estimated that in this country, there are three million individuals suffering from severe mental illness, of which 2.4 million are chronic, and 1.7 million of the chronic patients are functionally disabled (Talbot, 1987). This is a population with special needs because of their diminished capacity to maintain themselves in the community independently. The paucity of community programs in housing, treatment and supportive services often leave these patients homeless. They are unable to function and are often seen as a menace to society (Pepper and Ryglewicz, 1982). Specialized and comprehensive services are required to assist them in improving their social and living skills, developing meaningful rehabilitative activities, and enhancing their quality of life.

In 1981, the New York State Office of Mental Health and its newly created Minority Advisory Committee developed a Minority Demonstration Project for three minority groups: Asians, Blacks, and Hispanics. An Asian American Mental Health Task Force was formed, and its proposal adopted for a demonstration project for this group. This demonstration project was contracted to a

social service agency in the Lower Eastside of Manhattan in 1982 and its goal was to improve mental health services for four Asian groups (Koreans, Chinese, Japanese and Filipinos). The Chinese component established a continuing treatment program to serve Chinese-speaking chronic mental patients (the other three components provided outpatient clinic services). The major objectives are to improve the clients' social and daily living skills, and to prevent re-hospitalization. This service is designed to be a culturally relevant program. It has bilingual, bicultural staff and is located in the Chinatown area. The demand for culturally sensitive mental health services for this population was proven by the program's service at capacity level. The project became a permanent program in 1985, with funding from the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. Since its inception, the continuing treatment program has received 156 formal referrals and served over 70 clients at the time of the study. Insufficient program space and limited resources have prevented this program from expanding to meet service demands. The program is expected to relocate to a larger site and will remain in the Chinatown area.

The great need for mental health services was documented by Weisman and Ryan's (1981) study of Asian

Americans in New York City. Key informants of the Chinese community reported "above-average" need for mental health, social services and health programs. The 1980 census counted 147,250 Chinese-Americans in New York State, which is nearly double that of 1970 (75,107), and is increased more than four times from 1960 (36,000). According to a recent demographic study of the Asian American community in the Tri-State area (New York, New Jersey, and Connecticut), there are 160,000 Chinese-Americans in this region and approximately 120,000 are residing in New York City. It is projected that the number of Chinese-Americans in the Tri-State area will increase to 450,000 by the year 2000 (United Way of Tri-State, Regional Plan Association, and Chinese-American Planning Council, 1989). The influx of immigrants is largely responsible for the rise in population. Approximately 74% of the Chinese population in New York are foreign-born (1980 census). The yearly Chinese immigration quota was changed in 1982 from 20,000 to 40,000 (to include the People's Republic of China). There are over 1,000 immigrants arriving into New York monthly, and is the largest immigrant group entering this country (Yu, 1984). With the drastic increase in the number of immigrants (a vulnerable population) in New York City, the demand for mental health services is rapidly growing as mental health problems of this group

are greater and more severe in nature (Weisman and Ryan, 1981).

4. Rationale for the Psychoeducation Program

As discussed earlier, differing conceptualization of mental illness and unfamiliarity with Western methods of treatment present major obstacles in the delivery of mental health services to Chinese-Americans. The most significant issues raised by the program evaluation team of the demonstration project at the end of the demonstration period, were the need to identify culturally relevant strategies to overcome clients' resistance to acknowledging mental health problems and to deal with their unfamiliarity with outpatient mental health services. Resistance is common phenomenon in the treatment process but for the Chinese-Americans, the problem is further complicated by cultural factors. The experience of the author and other program staff in working with this group, confirm the necessity to address these difficulties.

For the Chinese, one would go to a doctor or hospital when one is afflicted with illness. Many of the clients are often confused and perplexed by the services offered by the continuing treatment program. For example, they have difficulties comprehending the

significance of individual or group psychotherapy in relation to their care. They commonly do not know the roles and/or functions of the mental health professionals (e.g. social worker) other than those of the psychiatrists (as doctors who give medication). The strong inhibition of verbal expression of feelings and the shame associated with mental illness often prevented these clients from questioning the nature of their illness or treatment. Most adhere to the Chinese culture's perceptions of mental illness (i.e. imbalance of bodily energies) and are wary of Western medicine.

Many relatives reported that, initially, they did not know where to secure help for their family members with mental problems. Some families have brought the patients to a neurologist for treatment. This confusion occurs because neurological impairment and mental illness are often referred to by the same term in Chinese. Patients and families sometimes reject a diagnosis of mental disorder by the fact that the neurological evaluation revealed no abnormalities. Furthermore, there is a misconception that mentally ill people are totally deranged and incapacitated in all areas of their functioning.

For the Chinese chronic mental patients, especially those who are recent immigrants, their difficulties in adjusting to a new society are compounded by their

illness and problems in treatment. These clients do benefit from the services in the continuing treatment program, as the staff can speak their language, and program activities include cultural components (e.g. Chinese-style exercises). Nevertheless, many program clients cannot articulate their reasons for being in the program, and do not have a good understanding of the treatment modalities utilized in their care. Educational information is at times given during individual or group sessions but not in a systematic fashion. A more formal and structured program with a psychoeducational approach, may be an appropriate method to enhance this population's understanding of Western concepts of mental illness and treatment. It may help to maximize the clients' benefits from treatment, as well as to promote a more positive view of mental illness. Prior to a review of the use of psychoeducation as a viable tool to improve mental health services to the chronically mentally ill Chinese-Americans, the following justifications for an adaptational approach are presented.

Justification for Cultural Adaptation

As discussed earlier, the great disparity between the Chinese and Western culture's definitions of mental health and illness and methods of treatment, is one of the main factors that deters Chinese-Americans from

utilizing mental health services in the United States. The Chinese generally believe in the physiological and/or spiritual causes of mental illness, as opposed to the environmental and psychogenic perspectives of the Westerners. Today, modern psychiatry as practiced in the countries of China, Taiwan and Hong Kong employs some Western psychiatric theories and treatment methods. However, this is generally restricted to the use of psychopharmacology. Psychotherapy or "talk therapy" and other psychosocial approaches are not legitimized or practiced (Lin, T.Y., 1983). For the Chinese, effective treatment must involve concrete interventions such as medication, herbs, food or healing rituals (Kleinman, 1980). In the United States, Chinese-Americans only have access to Western psychiatric treatment methods, which are largely based on the values and social reality of white middle-class Americans. Consequently, Chinese immigrants who have had no previous introduction to Western psychiatry often are skeptical and rejecting of this new system of care.

There is an apparent need to help Chinese-American patients to better understand and accept the Western methods of mental health treatment, as well as to identify and develop effective interventions that could bridge the gap between the Chinese and Western methods of care. In this instance, an adaptation approach seems

necessary, but this should be accomplished without negating Chinese cultural values or the ethnic identity of the clients receiving services.

Dual Perspective

Cultural consideration is one of the main elements in a principled social work practice. The preservation and continuance of the minority group's values and customs are of paramount importance. Norton (1978) espouses a "dual perspective" in working with minority clients. She asserts that the helping professional should not demand the abandoning or changing of the minority individual's ethnic identity to conform to the standards of the majority group. Instead, the worker needs to recognize that an individual is part of two systems, the dominant society and his/her own immediate social environment (Norton, 1978). This concept is particularly appropriate for working with ethnic minorities. It permits the worker to identify the various areas of conflict the client experiences by examining the disparity between the two systems, and enables the worker to develop more effective interventions. (Figure 2 represents a model of practice utilizing the "dual perspective".)

In this scheme, the social worker acts in the role of a "cultural broker", providing linkage between the

ethnic groups and the services in mainstream society (Low, 1984). The minority client could be encouraged to draw on new experiences and knowledge to suit his/her own special circumstances, and adapting to the new culture in/her own unique fashion (Landes, 1965). The purpose of this project is only to enhance the Chinese-American clients' knowledge of mental illness and treatment, in order for this group to better utilize services. Cultural adaptation, in this instance, is necessary because staff may be bilingual and bicultural, are generally trained in this country. Treatment techniques, though modified, are derived from Western psychiatric and social work principles. At this point in time, it is inconceivable that the program (which is city-funded) would receive approval and resources to provide treatment in accordance with Chinese medicine tenets. The use and the legitimacy of Chinese medicine and practitioners pose questions that are beyond the scope of this project. Another possible benefit of the adaptational approach is that it may facilitate the adjustment process of the recent immigrants as they gain familiarity with the Western culture.

CHAPTER TWO: NEW APPLICATION OF KNOWLEDGE

1. Psychoeducational Approach

"The psychoeducational approach to psychiatric illness addresses the need for better information about mental illness and its treatment for the patient and the family" (Barter, Quierolo and Ekstrom, 1984, p.793). One basic tenet of this model is that illness can be identified and described, with the facts presented. The impartation of such knowledge is seen as helpful in securing the clients' acceptance of their treatment and in enhancing their ability to manage their illness (Heinrichs, 1984).

Traditionally, health professionals have shared and discussed with patients the nature of their illness and treatment; however, this is not a common practice among mental health professionals (Bernheim and Lehman, 1985; Gantt and Green, 1985; Heinrichs, 1984; Pilsecker, 1981). McGill and her associates (1983) explained that the reluctance on the part of mental health professionals to discuss information regarding illness with clients and their families is the result of: 1) concern with violation of client's confidentiality by disclosing information to families, 2) diagnostic uncertainty (difficulty in arriving at correct diagnosis), and 3)

fear of implicating family in the etiology of schizophrenia under certain theoretical frameworks. Gantt and Green's (1985) study demonstrated that in general, mental health professionals (psychiatrists, psychologists and social workers) were in agreement with the importance of providing patients and families with knowledge regarding mental illness, but most of them did not want to be the "bearers of bad news".

The impact of deinstitutionalization has led to the recognition of the need for more effective community management services and strategies (McGill, Falloon, Boyd and Wood-Siverio, 1983). The use of psychoeducational techniques in the treatment of mental illness has expanded in the past two decades, especially in the community care of chronic mental patients (Barter, 1984). The advocacy for patient's rights likewise increased the utilization of psychoeducation to provide patients with information regarding their illness and treatment (Jeffries, 1985).

The psychoeducational approach draws from the theoretical underpinnings of the social learning theory (Lillie and Armstrong, 1982). This approach to the treatment of mental illness emphasizes the learning of adaptive skills with increase in knowledge of illness. It accepts the probability of biological causes and the significance of the patient's environment, in determining

the course of illness (Bernheim and Lehman, 1985). Generally, the psychoeducational approach avails both didactic and experiential learning opportunities to clients, with relevant applications of pedagogical methods (Lillie and Armstrong, 1982).

Psychoeducation provides a cognitive framework for clients to understand their illness and rationale for treatment. This could assist them in accepting their illness and increase treatment compliance, as the result of enhanced awareness and familiarity with treatment techniques. Such an approach also helps to correct the myths and prejudices toward mental illness when information is given in a context of respect and hope (Heinrichs, 1984). The reduction in social stigma may help to alleviate the clients' guilt and shame.

2. Review of Literature

Psychoeducation and the Chronically Mentally Ill

The psychoeducational approach in the treatment of mental disorders is generally an adjunct to other therapeutic methods (Barter, 1984), and is considered an appropriate model in the treatment of chronic mental patients (Mechanic, 1980; Barter, 1984). Currently, most empirical studies on the psychoeducational approach with the chronically mentally ill focused on the treatment of

schizophrenics with the involvement of the families (Anderson, Hogarty and Reiss, 1981; Berkowitz, Kuipers, Eberlein-Fries and Leff, 1981; Falloon and others, 1985; Bernheim and Lehman, 1985; McGill, Falloon, Boyd and Wood-Siverio, 1983). This is partially due to the influence of a recent perspective, which states that families of schizophrenics who are either highly critical, or overly involved with the patient tend to have higher patient relapse rates (Anderson, et al, 1981; Berkowitz, et al, 1981). Studies suggested that educating families about the patient's illness and illness management could help to lower "expressed emotions" and thus decrease the likelihood of the patient's decompensation (Anderson, et al, 1981; Berkowitz, et al, 1981).

Anderson and her colleagues (1981) randomly assigned chronic psychiatric patients to the psychoeducational family treatment model. In comparison to the control group treated with drug and supportive individual therapy, the relapse rate of the experimental group was significantly lower (34%, 7%, respectively). A large portion of experimental patients (65%) were able to return to school, work or vocational training.

The use of the psychoeducational approach with families of schizophrenics was investigated by Berkowitz and her associates (1981). Results demonstrated that the

experimental relatives who received psychoeducation, showed a lowering of "expressed emotions" while the control relatives did not. Likewise, the patients of the experimental relatives had a lower relapse rate than the patients of the control group in which relatives received "routine clinical care".

Falloon and his group conducted extensive research in the family treatment of schizophrenia utilizing psychoeducational techniques (Falloon, Boyd, McGill, Strang and Moss, 1981; Falloon, Boyd, McGill, 1984; Falloon and Liberman, 1983; Falloon and others, 1985; McGill, Falloon, Boyd and Wood-Siverio, 1983). They found that, in comparison to individual supportive psychotherapy, "family education and behavioral family therapy had specifically enhanced family knowledge about schizophrenia, reduced functional communication deficits, and improve family problem solving" (Falloon and others, 1985, p.179). Furthermore, a reduction of the severity of symptoms and more complete remissions were observed, accompanied by a decrease in rehospitalizations and lower medication dosage.

Goldstein and Kopeikin (1981) evaluated a psychoeducational crisis-oriented family therapy program for acute schizophrenics and their families. In comparison to patients who received no psychoeducational family therapy and low dosage of medication, patients who

received psychoeducational family therapy and moderate doses of medication had improved outcome as measured by lower relapse rates.

There has been less attention paid to the direct effects of psychoeducation on the patients. For example, little is known about whether the gain in knowledge of illness can assist the patients in developing community living skills, or produce a change in their attitudes regarding their illness and treatment (Barter, et al, 1984). To date, there has only been a few systematic investigations in this area.

Barter and his associates (1984) described the use of the psychoeducational approach with chronic psychiatric patients in a community social rehabilitation program. They found that about 71% of their clients who received medical education showed an increased knowledge of antipsychotic medications. The significant role of the psychoeducational approach in improving chronic mental patients' community adjustment skills was emphasized.

Jeffries' (1985) day hospital program focused on intensive education about schizophrenia for patients in individual and group treatment. He asserted that providing patients with education about their illness tend to enhance their self-esteem and increase the likelihood of their treatment compliance.

Didactic presentations of the definition of schizophrenia, the positive and negative effects of medication, and the signs of relapse, were used by Fenn and Dinaburg (1981) in the group treatment of chronic schizophrenics. The authors suggested that formal educative techniques can help patients to regulate their own medication and facilitate the therapeutic process of group psychotherapy.

A majority (77%) of hospitalized psychiatric patients reported that Pilsecker's classes on schizophrenia were "helpful" and these patients were enthusiastic and attentive during the sessions (Pilsecker, 1981). The author suggested that in general, patients are appreciative of the information offered to them about their illness.

A controlled study was conducted by Goldman and Quinn (1988) in a state hospital, to determine the effects of an educational program about schizophrenia and its treatment on patients. In comparison to the control group, the experimental subjects, who received a three week educational program, showed a significant gain in the knowledge of mental illness and a significant decrease in negative symptoms. There was no significant difference found between the two groups in the level of positive symptoms. (In this study, negative symptoms were defined as the "deficits in functioning such as

asociality, avolition, apathy, affect blunting, attentional impairment, and anhedonia, while positive symptoms were "the overt, florid manifestations of disturbed mental functioning such as delusions, hallucinations, perceptual distortions, and bizarre behavior".) The investigators suggested that patients with chronic psychiatric disorders can benefit from information about their illness and this type of approach can help to improve their functioning.

The psychoeducational approach has been applied to various clinical settings (inpatient, outpatient, day treatment and rehabilitation programs). More empirical studies are needed to evaluate the effectiveness of this intervention, but seemingly this approach is gaining recognition in the treatment of chronic mental illness.

Compatibility of Psychoeducational Approach With Chinese Culture

No published literature has dealt with the specific use of the psychoeducation with the Chinese patient population. Earlier discussions of Chinese culture and behavior suggest that this approach may be compatible with this group. To begin with, the discrepancy between the Chinese and Western views of mental illness and treatment arise from the differences in cognitive orientations (Kleinman, 1980). The use of

psychoeducation, a cognitive approach, to address this issue appears suitable. Clients will be oriented to the Western conceptualizations of mental illness and treatment methods.

The psychoeducational approach, which stresses the probable biological and environmental causes of mental illness, is more likely to be accepted by the Chinese, who generally place less focus on the affective realm. Furthermore, the impartation of information regarding mental illness by staff clearly delineates an expert/client relationship, with which the Chinese are familiar. The Chinese's respect for experts and authority may help to facilitate the therapeutic alliance as well.

Because of the Chinese's reverence for teaching and learning, the use of educative methods can underscore the importance of the psychoeducational program to the clients. Moreover, the Chinese clients are likely to feel more comfortable with a didactic format rather than an interactive situation, as the former is less conducive to the experiential types of sharing which requires self-disclosure.

Seemingly, the psychoeducational approach is appropriate for the Chinese patient population because this intervention is more compatible with Chinese cultural values and beliefs, and it utilizes the

strengths of this group. Nevertheless, the effectiveness of psychoeducation with this particular population requires empirical support. This project marks an exploratory effort to determine the impact of the psychoeducational approach on the treatment of Chinese-American chronic mental patients.

CHAPTER THREE: PROGRAM DESCRIPTION

1. Program Design Issues

The design of this program is based on existing knowledge of mental illness and treatment in the current literature, and incorporates relevant cultural issues. A didactic format is used to enhance the receptiveness of the Chinese clients to the program.

The content of the program is a compilation of material drawn from the psychoeducational programs designed by Falloon and his associates (1984), and Bernheim and Lehman (1985). These programs address the biological etiology and environmental determinants of mental illness, and this view of mental illness is more likely to be accepted by the Chinese patients than a psychodynamic perspective.

Chinese concepts and terms of health and illness are essential components of this program. They are used to highlight the disparity between the Eastern and Western views of mental disorders. The Chinese perspective, combined with the biological/environmental view, are utilized to allay misconception concerning mental illness, and to clarify the confusion between neurological problems and mental illness. Another important feature of this psychoeducational program is

the use of Chinese in the sessions. Clients are likely to feel more comfortable with staff who speak their language and show understanding of their culture. The handouts and the illustrated slide presentations are in Chinese and English.

The content of the sessions do not hail Western ideas of mental illness and treatment as superior or as the appropriate methods. Rather, this information is presented to enhance the clients' understanding of the treatment available, thus enabling them to make informed choices of the types of treatment services they want or need.

One of the objectives of the program is to decrease the social stigma associated with mental disorders. It is emphasized that mental illness is an illness like any other, and that there is effective treatment available. Open communication about mental illness and treatment can help to dispel myths, lessen fear and guilt, as well as to instill a sense of hope (Heinrichs, 1984).

Measures are taken to alleviate the clients' anxiety and resistance, as speaking about mental illness candidly can be very threatening. Clients are not addressed directly in the group sessions, and the material is presented as general information for any audience. The issue of diagnosis is not discussed because these clients had not asked about their diagnoses previously,

indicating that this is an area they do not wish to handle. They can obtain this information should they inquire. A supportive and caring atmosphere is an essential component of these sessions, in which any sharing of personal experiences and feelings, or interactions with others are encouraged.

The duration of the psychoeducational program is five weeks; two group sessions are held each week during the first four weeks, and an individual session is conducted for each client in the fifth week. The length of each group session is approximately one hour long, as some of the clients would not be able to concentrate and be attentive for extended periods of time. Many of the clients' diminished cognitive skills necessitate a slower pace and the repetition of the material presented. Therefore, each of the four topics is covered in two sessions (one week) to enhance their retention. The illustrated slides and the handouts for the group sessions are designed to maintain the clients' attention and interest. From the experience of the program staff, the clients can learn and retain information better with concrete, visual cues.

The individual session is used to answer any client questions which he/she may not feel comfortable in asking in a group situation. The client is helped to identify his/her signs of relapse which could help to prevent the

gross deterioration of his/her psychiatric condition.

2. Organizational and Implementation Issues

Since this is a very small program in a relatively simple organization, there were few constraints in the implementation of the project. Permission was received from the director and written informed consent was obtained from the clients participating in the study (see Appendix A for copy of consent form).

The psychoeducational program was incorporated into the normal schedule of the continuing treatment program by conducting the sessions during one of the time slots for an activities of daily living (ADL) group. Clients in the experimental group attended the sessions first, while the control group participated in the regularly scheduled ADL group. Upon the completion of the study, the clients in the control group were then given the chance to be involved with the psychoeducational program as well. This method afforded all clients the opportunity to participate in the psychoeducational sessions. The explanation given to clients for this procedure was that the psychoeducational program is more effective when administered in smaller groups, as it provides clients with more time to participate in discussions or to ask questions. Plans for the

psychoeducational program were announced and discussed with the clients in a weekly community meeting.

The continuing treatment program operated in a home-like atmosphere because of its small size. With support from the director and supervisor, the staff morale was generally good. Due to the close relationship among staff, the need to elicit cooperation was not a major issue. The staff was genuinely interested in the program and the clients' welfare, therefore little resistance was encountered. Effort was made to minimize added work for the staff because of the study. Staff input was also encouraged in the design and content of the program (e.g. length and format of the sessions, relevant cultural issues in their practice). These factors contributed to an essentially smooth implementation process of the project.

3. Content of the Psychoeducational Program

Formats:

- Group presentation (lecture with a slide show and handouts, followed by a question and answer period and refreshments)
- Individual session

SESSION ONE (group presentation)**Objectives:**

1. orient clients to the program and study.
2. highlight the disparity between the Chinese and American views of mental disorders.
3. enhance clients' understanding between neurological problems and mental illness.
4. promote a more positive perspective of mental illness.

Brief Introduction

This is a study to find out how we can improve services in the program. We would like to know how we can better serve you and facilitate your treatment. You will participate in a series of group presentations and one individual session, over a period of five weeks. For the first four weeks, each week we will meet twice for one hour each time, covering one general topic. During the fifth week, you will be seen by a staff for an individual session. Please feel free to ask any questions during the group and individual sessions. A week after the completion of all the sessions, you will be asked to answer a set of questionnaires. This will not be a test. We will only be interested in your opinions and what you remember. Your attendance to these sessions are very important. We urge you to make every

effort to attend all of them without fail.

Topic: What is Mental Illness?

The nature of mental illness is often misunderstood by people. Today we hope to clarify some misconceptions about mental disorders. Let us now talk about what mental illness is and what it is not. First of all, people from different backgrounds sometimes do not look at health and illness in the same way. For example, Chinese and Westerners have dissimilar views on the nature and treatment of mental illness. The Chinese have a holistic view of health, and do not differentiate between psychological and physical well-being. Illness is seen as the imbalance of internal energies (Yin and Yan) and the malfunctioning of bodily organs. It is believed that external factors such as "bad winds", abnormal weather and nutritional deficiencies could damage bodily organs and upset the equilibrium of energies. Excessive emotions and stress are also considered harmful to health. Treatment of physical and mental disorders are based on the same medical principles and the focus is on physiological symptoms. Food and medicine are used to "repair" the damages done to the body in order to regain internal balance. Modulation of emotions is encouraged, but the examination of the cause of feelings and the resolution of conflicts by talking

are not practiced. Currently, a combination of Chinese (herbs and acupuncture) and Western (drugs) medicine are generally used in the treatment of mental illness in China and other countries in the East. In addition, folk and popular methods of healing are used in local areas.

On the other hand, there is separation between physical and mental health in Western medical practices. Mental and emotional disorders are classified as mental health problems and their treatment methods are different from those of physiological ailments. There are many theories to mental illness, but the exact cause is still not yet known. Recent research produced evidence that a combination of biological and environmental factors may be the cause of mental disorders. Treatment include medication, social and vocational rehabilitation, as well as psychotherapy, in which psychological issues such as feelings and emotional conflicts are addressed.

Chinese immigrants, especially those who recently arrived, usually are not familiar with the American mental health system. Often proper treatment cannot be obtained because they do not know where treatment facilities are located or how treatment is rendered. From our experiences, we learned that people are frequently confused between neurological diseases and mental illness (in Chinese, the two are sometimes referred to by the same term). In the United States, the

branch of medicine referred to as neurology deals with organic problems relating to the brain and the nervous system (e.g. brain injury). The medical specialty that treats emotional and mental disorders is known as psychiatry. For instance, someone with chronic headaches consults a neurologist and finds no physiological basis to his condition, may need to see a mental health professional because the headaches may be a symptom of stress or depression. Therefore, emotional and mental disorders refer to disturbances that are generally not of physical origin. The proper doctor to see for mental illness is a psychiatrist and not a neurologist. In later sessions, we will provide more detailed information regarding mental illness and mental health services in the United States. Hopefully, this will enable people to get the right type of help and to know what their treatment is about. This information is important because Western mental health treatment methods are mainly the services available in this country and we should be informed about them. We are not advocating that Western medical practices are superior to Chinese medicine or vice versa.

Lastly, we would like to emphasize that mental illness is an illness like any other. Many people are afraid to talk about mental illness or to seek treatment because of social stigma. This fear is often the result

of the lack of information or misinformation. The fact is, a large number (15-20%) of Americans are affected by mental disorders every year. Mentally ill people are not totally debilitated and insane. At times, they may behave in an unusual manner, but most of the time, they act appropriately. Many are able to function well in various areas of their daily lives. Very few people who are mentally ill are dangerous. People in poor mental health are very much in need of help and understanding from their families and the community. With proper support from society and families, they can lead productive and satisfying lives.

SESSION TWO (group presentation)

Objectives:

1. familiarize clients to the major categories of mental disorders as conceptualized in Western psychiatry.
 2. help clients recognize the symptoms of schizophrenia and psychosis.
 3. help clients understand the impact of mental illness on an individual's psychological well-being and social functioning.
 4. emphasize the importance of obtaining appropriate treatment.
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Topic: Types of Mental Illness

In the next few sessions we will speak about mental illness as defined by Western psychiatry, and the kinds of treatment available in the United States. We hope this will further clarify the function of the continuing treatment program and the rationale for our services.

The nature of mental illness is very complex and cannot be fully explained within the time limits of our program. For our purposes, we will simply divide mental disorders into two general groups: 1) the less serious mental problems in which patients are in touch with reality, and 2) major mental illness in which patients are often out of contact with what actually goes on around them. There are many types of disorders under each category but time will not allow us to cover all of them. We will provide some examples from each group.

Anxiety disorders and personality disorders are examples of the less serious type of mental disorders. People who suffer from anxiety disorders may have excessive worries about their jobs, families or money without apparent reasons. They may be afraid of being with people, being in high places or in crowded places. Some may have to do things in a certain way all the time. People with personality disorders may be dependent, choose the wrong friends or mates, or engage in antisocial acts without guilt or remorse. These

individuals are usually functional in other areas of their lives. In these cases, often psychotherapy and sometimes medication can help to break the maladaptive pattern of behavior.

Two examples of major mental disorders are manic-depressive illness and schizophrenia. People in the acute phase of these illnesses are psychotic, which means that, at times they cannot tell what is real from what is not real. Individuals with psychosis usually have difficulties handling many aspects of their lives. For instance, they often cannot hold their jobs or carry out family responsibilities. On the other hand, some may function quite well in the community once their symptoms are stabilized.

People who are afflicted with manic-depressive illness have severe bouts of feeling extremely depressed that may last for weeks, then may swing to extreme happiness and excitement for a period of time. Little is known about this illness but it may disappear and return. Medication is used to control the symptoms in conjunction with psychosocial treatment (e.g. psychotherapy).

Another common type of major mental illness is schizophrenia. We will talk more about schizophrenia because there has been more research and recent information available regarding this illness. In the United States alone, it is estimated about two million

people suffer from schizophrenia. We do not know how someone gets the illness. Some studies indicated the possibility of this illness being genetically inherited. The exact cause of schizophrenia is not clear either. Recent research produced evidence that suggest the illness is brought on by chemical imbalance in the brain and triggered by environmental stress. Environmental stress could be the "normal" stress of growing up and becoming independent, or other significant stress such as immigration, loss of a loved one, and educational or vocational pressure.

Schizophrenia affects a person's thinking, feeling, ability to work, to care for oneself, and to develop relationships. Symptoms of this illness include: 1) false perceptions such as hearing voices or seeing someone when there is no one around, 2) false beliefs (e.g. that he is God), 3) thoughts are being controlled by other people, 4) feelings of being persecuted unjustly, 5) people are talking about him/her on radio or television, 6) thoughts are being put into or taken out of his/her mind, 7) laughing or crying for no apparent reason. These symptoms make it very difficult for the patient to cope with daily living because of disorganized thinking and poor concentration. Relationships with people are often hindered by difficulties with conversation and/or suspiciousness of others. Some are

too preoccupied with their inner thoughts and failed to take care of their basic needs.

Schizophrenia is often a recurring illness. Some people have one episode and will never have another. However, up to 75% of the patients may have symptoms continuously or the relapse of symptoms periodically. Symptoms can often be controlled by medication and psychosocial treatment such as family counseling, individual psychotherapy and socialization groups. The best family environment for the patient is one in which he/she is encouraged to gradually do all the things he/she was able to do. Having nothing to do all day tend to make the illness worse. Other conditions that could make schizophrenic patients deteriorate are stressful life problems, poor family relationships, drinking alcohol, and stopping medication. In our following sessions, we will speak about the purpose of medication in the treatment of mental illness.

SESSION THREE (group presentation)

Objectives:

1. enhance clients' knowledge of the purpose of medication in the treatment of mental illness to increase medication compliance.
2. help clients identify their "warning signals" to

minimize the likelihood of future relapse.

3. help clients learn the names and dosage of their medications.

Topic: Management of Mental Illness and Medication

Psychiatric medications have been in use in the treatment of major mental illness for over thirty years. There are many different drugs and these drugs have varying strengths. Some medications frequently prescribed by psychiatrists for alleviating psychotic symptoms are Thorazine, Mellaril, Stelazine, Loxitane, Haldol and Prolixin. A medication called Lithium is sometimes prescribed to modulate mood swings. When taking this medication, blood tests must be taken regularly to ensure that the proper amount of drug is in the body.

Medication works in two ways. It helps to reduce symptoms and to prevent future relapse. Medication decreases symptoms in most patients (about 75%). This means that some people would continue to have some symptoms even when they are on medication. The best dosage is determined by the amount of symptoms the patient is experiencing. It is very important for the patient and psychiatrist to meet regularly to discuss the patient's condition and to adjust the dosage when necessary. Sometimes a medication may have to be changed

if there is no positive response. Patients should know the names and the dosage of the medications they are taking. They should also remember which medications were helpful and the names of those they did not respond favorably to.

Since taking medication regularly as prescribed can help to prevent relapse, medication should be continued at low doses even when symptoms are absent. Medication should not be stopped unless it has been advised by the treating psychiatrist. Studies have shown that within one year of an acute episode, fewer people (30%) had relapse among those who continued their medication. Within the same period of time, most patients (70%) who stopped taking their medication had relapses.

The management of chronic mental illness is similar to the treatment of chronic physical problems such as diabetes, in which insulin (a medication) is used to control and prevent the recurrence of symptoms. When medication is taken regularly, symptoms also tend to be less severe when relapse does occur. Hospitalization can often be avoided.

Each patient has his/her own "warning signals" which signifies a worsening of his/her condition. For some people it could be sleep difficulties and for others it could be irritability or suspiciousness. Patients should know their own "warning signals" or changes, and should

seek help immediately from their psychiatrists and social workers when these "signals" appear. They should try their best to cope with the stress, and to continue their daily activities with the assistance of their families and the mental health professionals.

These medications are not addictive but they have side effects. Some of the common side effects are drowsiness, sensitivity to the sun, shakiness, muscle stiffness, increased appetite and dizziness. Most side effects can be reduced or eliminated. Patients should inform their psychiatrist if they experience any side effects. Sometimes these side effects will go away after a few weeks or months. If they persist, the medication may be reduced or changed. Other medications such as Artane, Cogentin, and Benadryl are frequently prescribed to control these side effects.

It appears that taking medication regularly can greatly reduce the chance of relapse. Patients should not stop taking their medication, or change the type or dosage of medication without consulting their psychiatrist. They should also consult with their psychiatrist on taking other medications (e.g. Chinese herbal medicine) when they are on these drugs.

SESSION FOUR (group presentation)**Objectives:**

1. educate clients about the various modalities and settings for the treatment of mental disorders.
2. enhance clients' understanding of the roles of different mental health professionals.
3. increase clients' knowledge of community resources.

Topics: Other Treatment Modalities**Mental Health Personnel and Community Resources**

Medication is important for reducing symptoms, but other forms of treatment and rehabilitation are also necessary for improving other areas of the patient's functioning. Psychotherapy is a treatment method in which people try to work their problems out by talking to trained mental health professionals. Psychotherapy can be provided individually, in a group setting, or for a family unit. This type of treatment can help to improve interpersonal and family relationships, problem-solving skills and other difficulties individuals may encounter. It is also useful in giving continuous support and advice to those who seek help. Treatment with drug therapy and/or psychotherapy can be found in hospitals and outpatient facilities in the community.

The condition of the patient determines where

treatment should be rendered. Those with severe or acute symptoms may require a period of hospitalization in order to stabilize. Once symptoms are stabilized, the patient can continue treatment in community mental health programs. Social workers in the hospital assist in making such arrangements prior to the patient's discharge.

There are community residences with either 24-hour supervision or regular staff visits, to help patients who are not ready to live on their own and cannot live with their families. Upon return to the community, the patient should be encouraged to gradually regain former skills. Having nothing to do would only make the condition worse.

Day treatment programs are beneficial to people who are not yet prepared to resume their previous activities (i.e. school or work). The purpose of these programs are to help patients improve or restore their daily living skills, social skills, and eventually to lead more productive lives. Patients attend day treatment programs on a daily basis and participate in a schedule of therapeutic activities until they are ready to move on to vocational or educational pursuits. This treatment model is the basis of our program.

There are also vocational rehabilitation programs with job training and sheltered workshops, designed

specifically for individuals with a history of psychiatric problems. The emphasis is on restoring previous work skills or developing new ones under a supportive environment.

Lastly, there are outpatient clinics in hospitals or local communities where patients can obtain drug therapy, psychotherapy or counseling. Families are also important resources in providing ongoing support and care. It is essential that there is collaboration among patient, family and treatment personnel.

It is important that patients go to the appropriate professionals and the right places for the treatment of mental health problems. In the United States, there are a variety of mental health professionals who are trained to help people to deal with mental health problems through diagnosis, treatment and prevention. The following are some typical mental health professionals that people should be familiar with:

- 1) Psychiatrists- medical doctors who are experts in dealing with mental and emotional disorders. They diagnose mental illness, prescribe and direct treatment (psychotherapy, drug therapy, etc.).
- 2) Psychologist- experts in human behavior. They diagnose through psychological tests and observations, and provide psychotherapy.
- 3) Clinical Social Workers- help people deal with a wide

range of economic, social and personal problems. They provide psychosocial treatment to individuals and families through psychotherapy, advocacy, as well as referrals to needed services.

Other mental health professional include psychiatric nurses, rehabilitation counselors, occupational and recreational therapists. Each group has it own expertise in the field of mental health services. These professionals work in a variety of settings. They may work in mental health clinics in hospitals, in general hospitals with psychiatric units, in state psychiatric hospitals, in community mental health centers, community treatment programs, private psychiatric hospitals, Veterans Administration hospitals, or in private practice.

Finally, this is a list of facilities where mental health services or other related social services are available, and staffed with Chinese-speaking personnel.

State-licensed mental health facilities in the New York City community with Chinese bilingual, bicultural mental health professionals.

Gouverneur Hospital

The Asian Bicultural Clinic

227 Madison Street New York, New York 10002

(212)238-7332

Hamilton-Madison House

Asian American Mental Health Services

50 Madison Street New York, New York 10038

(212)349-3724

Chinatown Alcoholism Project

46 Henry Street New York, New York 10002

(212)964-9240

Chinatown Family Consultation Center

46 Henry Street New York, New York 10002

(212)964-9240

Lower East Side Service Center

46 East Broadway New York, New York 10002

(212)431-4610

New York State Office of Mental Health

Manhattan Psychiatric Center-Dunlap Outpatient Services

39 East 17th Street New York, New York 10003

(212)473-0500

Other types of assistance with bilingual staff available
on the premises

New York City Police Department

Fifth Precinct

19 Elizabeth Street New York, New York 10013

Chinese speaking service: (212) 334-0725

Medicaid Out-station at Chinatown Planning Council**359 Broadway New York, New York 10013****(212) 431-7800****(by appointment only, also other social services)****Medicaid Out-station at Gouverneur Hospital****227 Madison Street 1st Floor****New York, New York 10002****(212) 238-7153****(by appointment only)****Public Assistance(for Lower Manhattan residents only)****12 West 14th Street 2nd Floor****New York, New York 10011****(212)620-9267****Social Security Office****Grand Street Office****231 Grand Street 3rd Floor****New York, New York 10013****(212)226-4111****SESSION FIVE (individual session)****Objectives:**

- 1. further clarify material in psychoeducational sessions**

if necessary.

2. afford clients the opportunity to ask any personal questions regarding their illness and treatment.
3. help clients identify their "warning signals" and develop coping strategies.

Interview Schedule

1. Do you have any questions regarding the material presented in the group sessions? I will be glad to clarify anything you do not understand.
2. What medication(s) are you taking now?
(If client does not know this, correct information is given at this time.)
3. Are you able to recognize the changes in yourself when your condition begins to deteriorate? In other words, what are your "warning signals"?
(Help client identify "warning signals" and strategies on how to seek immediate help.)
4. Do you have any general questions regarding yourself and/or your treatment at the continuing treatment program?

CHAPTER FOUR: METHODOLOGY

1. Purpose and Objectives

Recently, the use of different psychotherapeutic treatment modalities (e.g. strategic-structural family therapy, group therapy) with Asian Americans have been explored, in attempt to identify culturally relevant treatment methods (Kim, S.C., 1985; Lee, Juan, and Hom, 1984). However, there have been few experimental studies to evaluate the effectiveness of the various treatment approaches on this population. The purpose of this study is to examine the impact of psychoeducation on a group of Chinese-American chronic mental patients. The purpose of this project was to develop a culturally compatible treatment intervention that could expedite the clients' adaptation to the treatment services in the United States, as well as to facilitate their treatment progress. The psychoeducational program is designed to "fit" this particular group's unique needs, and it is implemented in a treatment setting in the Chinese community staffed with bilingual, bicultural workers.

As mentioned previously, dissimilar views of mental illness, unfamiliarity with treatment methods, as well as the strong social stigma attached to mental problems frequently discouraged Chinese-Americans from seeking or

remaining in mental health treatment. This psychoeducational program aims to improve treatment services for the chronic mentally ill Chinese-Americans. One of the major objectives of this project is to increase Chinese-American chronic mental patients' knowledge of mental illness and treatment methods as defined by the American culture. Clients who have a better understanding of the nature of their illness may become more compliant to treatment. Another objective of the program is to promote a more positive view of mental illness by correcting the myths and misconceptions regarding the psychiatric conditions. A more benign view of mental disorders may help the clients to accept their illness, and to alleviate their feelings of guilt and shame. The third objective is to ascertain the clients' general satisfaction with services in the continuing treatment program, as well as to examine the impact psychoeducation has on their level of satisfaction. This information will be useful for the purpose of program planning. The final objective is to improve clients' motivation for treatment, as defined by their level of involvement in the continuing treatment program. The clients may function better in the continuing treatment program with an improved understanding of the treatment services provided.

2. Definition of Major Terms

Chinese-Americans- For the purpose of this study, persons of Chinese ancestry who were born and raised in the United States, as well as Chinese immigrants are referred to as Chinese-Americans.

Mental Illness- Diagnosed mental problems and disorders as categorized and defined in the Diagnostic Statistical Manual III-Revised.

Western concepts of mental illness and treatment- The term "Western" is used to differentiate from Eastern or Chinese and pertains to concepts and definitions of mental illness and treatment generally accepted by American trained mental health professionals.

Chronically mentally ill- This term refers to individuals who have psychiatric problems for one year or more in duration, usually characterized by repeated hospitalizations and impaired functional skills.

Continuing treatment- As defined by the New York State Office of Mental Health, this type of program is "A planned combination of diagnostic, treatment, rehabilitation and other remedial activities for mentally

ill individuals and collaterals for the purpose of maintaining or restoring the skills necessary to allow life in the community and to prevent deterioration of those skills. The usual length of treatment exceeds six months".

Client/patient- In this study, these terms are used interchangeably and apply to the recipients of mental health services.

3. Methods

Setting

The continuing treatment program is a component of an outpatient mental health service, and is located in New York City's Chinatown. Program hours are from 10:00 A.M. to 3:00 P.M., Monday through Friday. (For a description of the standard treatment protocol at the continuing treatment program, see Appendix B.) The program is staffed with two social workers with Master's degrees, two paraprofessionals, a kitchen service worker and a part-time consulting psychiatrist. All the staff are Chinese-speaking, including several dialects. Referrals are largely received from hospitals, outpatient clinics, social service agencies, and the outpatient clinics within the agency. The continuing treatment

program does not have a designated catchment area and can serve residents from all five boroughs in New York City.

Subjects

All the clients who were in the continuing treatment program at the beginning of the study were included (N=30). The name of each client was written on a piece of paper and the folded pieces of paper were placed in a container. Names were then randomly drawn and assigned to one of two conditions: continuing treatment accompanied by the psychoeducational program, or continuing treatment only (i.e. the first name drawn was assigned to the experimental group, the second one to the control group and this procedure was repeated until all subjects were assigned). There were fifteen clients in the experimental group and the same number of clients in the control group.

As per the admission criteria of the continuing treatment program, all clients have a history of chronic mental illness, some may have functional deficits but are ambulatory and able to travel to and from the program independently, and are "stabilized" as per psychiatrist's admission evaluation. These clients are male and female adults. The majority are diagnosed as schizophrenics and are on neuroleptic medication. All the clients are Chinese-speaking.

Procedures

The post-test only control group design is used in this study. This design is appropriate as it eliminates the practice effect of the pretest, and prevents the possibility of the subjects being sensitized to the experimental variables during the pretest (Campbell and Stanley, 1963).

The experimental subjects participated in a psychoeducational program (as described in Chapter Three) consisting of a series of eight group sessions and one individual session, conducted over five weeks. A week following the completion of the program, the experimental subjects were instructed to answer a set of questionnaires. The control subjects were only asked to complete the questionnaires at that time, without participating in the program. After the study, the clients in the control group were also provided with the opportunity to attend the psychoeducational program.

The psychoeducation sessions were conducted by two Chinese speaking psychiatric social workers (one was the author) with Master's degrees. Each session lasted approximately one hour and a variety of educational techniques were employed to enhance the clients' learning and to maintain their attention. The sessions were in lecture form, and were followed by a question and answer

and discussion period. Visual aides such as slide presentations with illustrations and charts, as well as printed material for distribution were used. All written materials were in Chinese and English, and the oral presentations were in Chinese. Refreshments were served at the end of every session to positively reinforce attendance.

Three training sessions were given to the staff involved in the project. The initial two pertained to the delivery of the program content, and the third focused on the administration of the evaluation questionnaires.

The questionnaires were administered in a group setting. Oral administration was used because it was shown that this form of data collection minimized the number of unanswered items (LeVois, Nguyen and Attkisson, 1981). Brief instructions were read to the clients. Each question was verbally articulated as written and then time was allowed for written response (one minute was given for multiple-choice and Likert-type items, and two minutes for open-ended questions). The administration of the questionnaires was carried out by a M.S.W. worker and one paraprofessional staff member.

Outcome Measures

This study assessed the effects of the

psychoeducational program on the sample population of Chinese-American chronic mental patients by four outcome measures:

- 1) knowledge of mental illness and treatment
- 2) attitude toward mental illness
- 3) satisfaction with services
- 4) motivation for treatment

The impact of the program on these variables was determined by comparing the mean scores obtained by the experimental and the control groups on the four instruments used to measure the above outcomes. Three of these instruments (Knowledge About Schizophrenia Questionnaire, Opinions About Mental Illness, and Client Satisfaction Questionnaire) comprised the set of questionnaires answered by the clients. The fourth instrument (Task Check List) was a rating scale completed by the program staff.

4. Instruments

I. Knowledge About Schizophrenia Questionnaire (see Appendix C)

This instrument is a two-part questionnaire developed and used by Falloon and his colleagues in their studies of psychoeducational intervention with schizophrenics and their families (1981, 1983, 1984, and

1985). The Knowledge About Schizophrenia Questionnaire (KSQ) was used to measure knowledge of mental illness and treatment. The first part consisted of six open-ended questions on diagnosis, causes of mental illness, medication and therapeutic services that clients considered most helpful. The second part of the questionnaire contained fourteen multiple-choice questions directed to evaluate clients' knowledge of schizophrenia, and this included symptoms, medications and side effects, other types of treatment, as well as factors that affect relapse. This instrument was pretested in a community mental health setting (McGill, Falloon, Boyd and Wood-Siverio, 1983) and was judged to have face and content validity. It was used with schizophrenic patients, their family members and mental health professionals.

A few modifications were made in the instrument to better suit the sample population of Chinese clients. One of the changes was in the open-ended questions... A number of questions were rephrased to address the patients only instead of patients and relatives. Additionally, the question which asked clients for the name (diagnosis) of the illness they were suffering from was eliminated as it was deemed too threatening to this group. Some terms on the questionnaire which were unfamiliar to these clients were replaced as well (i.e.

LSD, primal screaming). Lastly, two of the multiple-choice answers that dealt with percentages (10%, 30%, 50%, 70%, 100%) were changed to descriptive terms (very few, half, most), because it would probably be more difficult for chronic mental patients to recall the exact numbers.

The revised instrument contained six open-ended and fourteen multiple-choice questions. In the multiple-choice section, one point was given for each correct answer and one point was subtracted for each incorrect response. Some questions had more than one correct answer, and therefore the clients could obtain more than one point for each question. (This was the scoring system devised by the original authors.) It was feasible to obtain a minimum score of zero to a maximum score of forty-four points. Open-ended answers were not scored but the data were reviewed for content analysis, and comparisons were made between the experimental and the control groups' responses for qualitative differences.

II. Opinions About Mental Illness (see Appendix D)

To determine whether clients hold a more positive attitude about mental illness as the result of participation in the psychoeducational program, the Mental Hygiene Ideology Scale of the Opinions About Mental Health (OMI) questionnaire was utilized. The five

dimensions of attitude toward mental illness described in the OMI are: 1) Authoritarianism, 2) Benevolence, 3) Mental Hygiene Ideology, 4) Social Restrictiveness, and 5) Interpersonal Etiology. The Mental Hygiene Ideology Scale appeared to be most suitable to measure the level of favorable attitude, as it embodies a positive approach to mental illness, emphasizes the mental patient's similarity to normal people as well as his capacity to respond to treatment (Bentinck, 1967).

The OMI scales were developed by Cohen and Struening (1962) in their studies of the attitude of hospital personnel toward mental illness. This set of scales contained fifty-one likert-type items which were derived from factor analysis of the original seventy items. Both reliability and validity coefficients obtained were deemed satisfactory by the authors of the OMI. The OMI was used by Bentinck (1967) in her study of the attitudes of schizophrenics and their families toward mental illness.

The Mental Hygiene Ideology Scale consisted of nine items interspersed in the original OMI questionnaire. These items were extracted and grouped for the purpose of this study. In addition, the response categories were collapsed from six (strongly agree, agree, not sure but probably agree, not sure but probably disagree, disagree, strongly disagree) to three (agree, not sure, disagree)

to minimize the Chinese's tendency to refrain from extreme opinions. The simplified responses also seemed to be more appropriate for chronic mental patients because they may be confused with the extensive number of choices. The revised questionnaire contained nine Likert-type items. Subjects could achieve a minimum score of six to a maximum of thirty-four points. A higher score would indicate a more positive attitude toward mental illness.

III. Client Satisfaction Questionnaire (see Appendix E)

This instrument was used to find out whether clients who participated in the psychoeducational program were more satisfied with services than those who did not partake in the program. It was also used to evaluate the clients' general satisfaction with services and to identify aspects of the continuing treatment program clients find most helpful.

The Client Satisfaction Questionnaire (CSQ) was developed by Larsen, Attkisson, Hargreaves and Nguyen (1979) to assess client satisfaction with services in mental health facilities. The CSQ-8 consisted of eight items selected from the preliminary CSQ scale of thirty-one items. The CSQ-8 was administered to a large number of clients in a variety of health and mental health settings (including day treatment), and to diverse ethnic

groups (including Chinese clients). It was shown to be an instrument with good internal consistency (coefficient of .871 among non-whites and .877 among white clients), as well as construct validity (Nguyen, Attkisson and Stegner, 1983).

The CSQ-8 contained eight Likert-type questions and subjects could obtain a minimum score of eight to a maximum score of thirty-two. A higher score would indicate a higher level of satisfaction with services. The CSQ-8 also had two open-ended questions which requested comments from the respondents regarding program services. It was not necessary to make any revisions on this instrument.

IV. Task Check List (see Appendix F)

A modified version of the Task Check List (TCL) was used to evaluate clients' motivation for treatment, which was defined as the degree of participation in the continuing treatment program. The TCL was developed for the purpose of identifying functional levels of day treatment patients in a program that employed the psychoeducational approach (Lillie and Armstrong, 1982). Preliminary research by the authors showed that the TLC has satisfactory inter-rater reliability (.74, $p < .01$), when familiarity with the client is not considered.

The original instrument has a total of seventy

items, divided equally into seven categories. Twenty items were selected by the program staff for the revised version used in this project. It was the consensus of the staff that these items described positive behaviors that are easily observable, relatively objective, and showed the client's level of involvement in the treatment program. A higher level of participation in the program would signify a higher level of motivation for treatment. Because the scale required the rating of clients by the staff, this abbreviated version was also less burdensome for the already overworked program personnel. Staff were asked to rate the clients' level of participation in the continuing treatment program (rarely, sometimes, or often) by using the revised twenty item TCL. The possible minimum score is zero and the maximum score is forty. A higher score would indicate a higher level of involvement in the continuing treatment program and greater motivation for treatment.

The first three instruments (Knowledge About Schizophrenia Questionnaire , Opinions About Mental Illness, and Client Satisfaction Questionnaire) comprised the set of questionnaires answered by the subjects in the study. The instruments were translated into Chinese and then re-translated into English by different personnel to determine the accuracy of the translation. Discrepancies were corrected through discussions by the translators and

this author until agreements were reached. It was suggested that this method of "back-translation" is one of the most effective means of obtaining accuracy in the translation of questionnaires for cross-cultural research (Brislin, Lonner and Thorndike, 1973).

The rating of the Task Check List was completed by two program staff who had the most direct contact with the clients. To test inter-rater reliability, four of the clients were randomly selected and rated by both staff. One client obtained identical scores from both raters. Another client's scores had a five point difference. The remaining two clients had differences of one and two points in their scores. The ratings of the client with a five-point discrepancy were discussed until both raters achieved consensus on the scores. All the items were examine again by the raters and the author of this study to achieve further agreement on the scoring criteria.

5. Hypotheses

The following were the four hypotheses of this study:

- I. Clients who participated in psychoeducation would have greater knowledge of Western concepts of mental illness and treatment than the non-

participants.

II. Clients who were involved in psychoeducation would have a more positive attitude toward mental illness than the clients who did not participate in the program.

III. The participants of psychoeducation would expressed a higher level of satisfaction with services than the non-participants.

IV. The participants of psychoeducation would show greater motivation for treatment than the clients who did not participate in the program.

CHAPTER FIVE: FINDINGS

1. Overview of the Study

The purpose of this study was to examine the impact of a culturally relevant psychoeducational program on a group of Chinese-American chronic mental patients. Current mental health literature noted the need to address cultural issues, and to develop culturally relevant treatment strategies in treating minority clients. Individuals who are unaccustomed to the concepts and treatment methods of the new culture often have difficulties in accepting its mental health services. Minority clients who become more familiar with the dominant culture's treatment practices may increase their utilization and acceptance of services.

The psychoeducational approach has been widely used in recent years in the treatment of the chronically mentally ill. Studies have shown that this approach helps patients and their families deal with chronic mental illness through education and management strategies. A culturally relevant psychoeducational program designed to help Chinese-American chronic mental patients increase their knowledge of mental illness and familiarity with treatment services in the United States was conducted in a continuing treatment program staffed

with Chinese bilingual, bicultural workers. The cognitive approach was deemed more compatible with the Chinese population, as well as with the chronically mentally ill.

The present evaluation employed a post-test only control group design. A set of questionnaires comprised of three instruments (Knowledge About Schizophrenia Questionnaire, Opinions About Mental Illness, and Client Satisfaction Questionnaire) were used to measure the clients' knowledge of mental illness and treatment, their opinions of mental illness, and their satisfaction with services. Both experimental and control groups answered this set of questionnaires a week after the experimental clients completed the psychoeducational program. (The control clients participated only in the regularly scheduled treatment activities of the continuing treatment program.) In addition, a week following the conclusion of the psychoeducational sessions, staff were instructed to rate the level of participation of the experimental and control clients in the continuing treatment program by using the Task Check List.

The first hypothesis was that clients who attended the psychoeducational sessions would be more knowledgeable about Western concepts of mental illness and treatment, as evidenced by their higher scores on the Knowledge About Schizophrenia Questionnaire, than the

control subjects who did not partake in psychoeducation. The qualitative data obtained from the experimental clients would reflect a better understanding of their illness and treatment than those obtained from the control clients.

Hypothesis two stated that clients who received psychoeducation would have a more positive view of mental illness as the program was designed to dispel myths concerning psychiatric conditions. It was hypothesized that the experimental clients would score higher on the Opinions About Mental Illness than the control group.

The third hypothesis predicted that the experimental clients would score higher on the Client Satisfaction Questionnaire than the control clients. The experimental clients would be more likely to express greater satisfaction with overall program services as they gain better understanding of the services they receive.

The last hypothesis stated that the experimental group would show increased motivation for treatment, as manifested by the higher ratings they receive on the Task Check List than the control group. This hypothesis asserts that the clients who received psychoeducation would participate more actively in the treatment program with improved comprehension of the nature of their illness and treatment.

One-tailed t tests were used to compare the

difference between the mean scores of the two groups on the four outcome measures. It has been noted that the t test could be used if each of the two sampled populations is normally distributed and they have the same standard deviation, even in small samples (Kachigan, 1986). However, the variances of the samples need not be identical for reasonably correct results when the two samples are the same size (Twaite and Monroe, 1979). Due to the small size of the sample, other data were limited only to descriptive analyses.

2. Demographics

Of the thirty subjects, only twenty-four (80%) successfully participated in the study. In the experimental group, two of the clients were excluded because they did not attend a sufficient number of the psychoeducational sessions (only those clients who attended at least seven of the nine sessions remained part of the study). Another client, who had not been attending the continuing treatment program regularly (prior to the announcement of the study), did not attend any sessions at all. There was no discernible difference between the characteristics and diagnostic profiles of these clients and those who completed the psychoeducational program. The instability of the

chronic mental patients' functioning, was probably responsible for their failure to attend or complete the program.

In the control group, one of the clients did not attend the continuing treatment program during the week the questionnaires were administered because of deterioration in his psychiatric condition, and therefore did not participate in the study. Two other clients, who had been attending the continuing treatment program irregularly, agreed to take part in the study but did not show up for the administration of the questionnaires. The characteristics and diagnostic profiles of these clients were likewise similar to those of the other clients in the continuing treatment program.

As a result, there were twelve subjects each in the experimental and control groups. Table I describes the characteristics of the experimental and control subjects. The mean age of the experimental group was somewhat younger than that of the control group. The mean age of the experimental subjects was 34.08 and their ages ranged from 18 to 56 years. Half of the experimental clients were below age 35. The control group's mean age was 36.67 and their age range was 26 to 60 years. Likewise, half of the subjects in this group were younger than 35 years of age. The gender distribution of both groups was similar, and the great majority of the subjects were

males. The experimental group consisted of ten (84%) males and two (16%) females, while the control group had nine (75%) males and three (25%) females. Nine (75%) of the experimental clients were single and three (25%) were married. Of the control group subjects, ten (84%) were single, one (8%) was married, and one (8%) was divorced. The majority (84%) of the experimental clients lived with their families. Only one client (8%) lived in a community residence and one (8%) lived alone in his own apartment. Similarly, ten (84%) of the control group clients lived with family members and the remaining two (16%) lived alone. All clients resided in the boroughs of Manhattan, Brooklyn and Queens. Overall, the number of clients from each borough was approximately equal.

Eight (67%) of the experimental subjects had some high school (tenth grade and above) or college education and one was a college graduate. The remaining four (33%) did not have any secondary education. The years of education received by the experimental clients ranged from 6 to 16, and the mean was 11 years. In the control group, seven (58%) of the clients did not receive any education beyond the ninth grade. Only five (42%) of these clients attended high school or college. The range of their years of education was 6 to 14 and the mean was 9.33 years.

Half of the experimental clients had lived in the

United States for less than ten years; the remaining half had a longer length of residence. The range was 3 to 25 years and the mean was 11.08 years. In the control group, three (25%) of the clients had a length of residence in the United States for less than ten years, seven (58%) had lived in this country for more than ten years, and two (17%) were native born. (Of the two clients that were born in the United States, one was raised and educated in China and returned to this country about 20 years ago.) The range of the length of residence for the control clients was 2 to 24 years, and the mean was 14.3 years (excluding the native-borns). The majority of the clients in both experimental and control groups (seven or 58% in each group) were born in China; however, most resided in Hong Kong for a number of years prior to migrating to the United States. Smaller numbers of clients were born in Hong Kong, Taiwan, and Southeast Asia (Vietnam, Burma and Malaysia). All clients were of Chinese decent and Chinese-speaking. Approximately one-third of the clients in both groups had the ability to speak fair to good English. The remaining clients could speak little to no English at all.

None of the clients in either group were employed. For approximately eighty percent of the clients in both groups, Supplementary Security Income (SSI) was the major source of income, and the remaining were supported by

their families.

Schizophrenia was the most common diagnosis for both groups. Ten (84%) of the experimental clients and nine (75%) of the control clients were diagnosed with some type of schizophrenia. Other diagnoses included schizoaffective disorder, and bipolar disorder.

The length of illness (defined by the onset of symptoms) for the experimental group ranged from 1 to 29 years and the mean was 11.25 years. Nine (75%) of these clients had been ill for more than five years. Of the twelve experimental clients, seven became mentally ill from one and a half to thirteen years after their arrival in the United States. For the control group, length of illness ranged from 1 to 35 years and the mean was 16 years. Ten (83%) of the control clients had a duration of illness of more than five years. Similarly, seven of the clients in this group became mentally ill after immigrating to this country, and their psychiatric problems began anywhere from two to fourteen years subsequent to their arrival to this country. Eight (67%) of the experimental clients had been in the continuing treatment program for over one year. Length of stay ranged from two months to 4.5 years and the mean was 2.25 years. In the control group, nine (75%) of the clients were in the program for more than one year. Their length of stay ranged from two months to 4.58 years with the

mean being 2.51 years.

Clients from both groups had previous mental health treatment, and the majority received inpatient as well as outpatient care. Three (25%) of the experimental clients and two (17%) of the clients in the control group had outpatient treatment only and were never hospitalized. All clients in the experimental group and the great majority (92%) of the control group clients were on psychotropic medication. Two-thirds of the clients in both groups were referred by outpatient clinics. Other sources of referral included inpatient units, day hospital, and community residence.

3. RESULTS

Raw scores were obtained from the questionnaires answered by the clients and the rating scale completed by the staff. The mean scores of the experimental and control groups on the four instruments (Knowledge of Schizophrenia Questionnaire [KSQ], Opinions About Mental Illness [OMI], Client Satisfaction Questionnaire [CSQ-8], and Task Checklist [TCL]) were computed, and one-tailed t tests were performed to determine the impact of participation in the psychoeducational program on the clients' knowledge of mental illness and treatment, attitude and opinions about mental illness, satisfaction

with program services, and motivation for treatment. Table II summarizes the post test results on the KSQ, OMI, CSQ-8, and the TCL for both groups. The results of each outcome measure are described below.

Knowledge of Mental Illness and Treatment

Clients who participated in the psychoeducational program demonstrated substantial greater knowledge of mental illness than the control subjects. The mean score of the experimental group on the multiple-choice section of the Knowledge of Schizophrenia Questionnaire (KSQ) was 23.58 and the range was 7 to 33. In comparison, the control group obtained the mean score of 16.83, and the scores ranged from 2 to 27. The difference in the mean scores of the two groups was found to be significant ($t=2.03$, $df=22$, $p<.05$).

Examination of items on the multiple-choice section of the KSQ revealed that the experimental group generally obtained higher item mean scores than the control group except for items 1 and 2. Item 1 required the subjects to identify the symptoms of schizophrenia, and in item 11, they were asked to choose the elements that would constitute the most favorable family environment for a schizophrenic patient. For these items, the control group acquired higher mean scores than the experimental group but the differences were small. The control

group's mean score on item 1 was 1.75, and the mean score obtained by the experimental group was 1.17. On item 11, the mean scores of the control group and the experimental group were .33 and -.17, respectively.

The experimental group had registered the most gains over the control group on four particular items (2, 3, 5, and 9). On item 2, the experimental subjects demonstrated that they were more capable of recognizing the factors associated with schizophrenia than the control subjects. The mean score of the experimental group was .50, in comparison to the mean score of -.50 obtained by the control group. Similarly, the experimental group's mean score on item 3 was greater than that of the control subjects (4.08 and 3.08, respectively). The results of this item showed that the experimental group was generally more aware of the impact of schizophrenia on the patient's life than the control group. Item 5, which concerned the medications used in the treatment of schizophrenia, registered the largest difference in mean scores. The mean scores of the experimental and the control groups on this item were 1.92 and .50, respectively, indicating the greater ability of the experimental subjects to identify the standard drugs used for the treatment of schizophrenia. Likewise, there was a substantial difference between the mean scores of the experimental and control groups in

item 9. For the experimental group, the mean score was 1.42, while the control group had a mean score of .25. The higher mean score of the experimental group in item 9 demonstrated that the subjects who participated in psychoeducation were more able to recognize the importance of medication in preventing the relapse of symptoms.

Items 10, 13, and 14 showed the least differences between the mean scores of the experimental and control groups. On item 10, the mean scores of the experimental and control groups were .50 and .25, respectively, indicating no major difference between the experimental and control groups' ability to identify other types of treatment for schizophrenia other than medication. The mean scores of the experimental and control groups were similar on item 13 (3.42 and 3.17, respectively), suggesting that both groups were equally able to discern thought and perceptual disorders. On item 14, the mean score of the experimental group was 1.50, while the control group obtained a mean score of 1.17. These results showed that the experimental and control subjects' abilities to distinguish the appropriate ways patients should handle pressure and stress were comparable.

Results of the above analysis suggest that the patients who participated in psychoeducation had greater

knowledge in the following areas: 1) the possible causes of schizophrenia, 2) the impact of the illness on the individual's functioning, 3) the names of the typical drugs for the treatment of schizophrenia, and 4) the relationship between medication and relapse of symptoms. These items, 2, 3, 5 and 9, may largely account for the higher overall mean score of the experimental group on the KSQ. Psychoeducation seemed to have the least effect on the experimental subjects' ability to identify: 1) other standard treatments for schizophrenia besides medication, 2) thought and perceptual disorders, or 3) the best methods for patients to handle pressure and stress.

The experimental subjects' superior knowledge of mental illness and treatment was further substantiated by the qualitative data obtained from the open-ended questions on the KSQ. Content analysis showed that eight (67%) of the clients in the experimental group felt that mental illness is caused by environmental stress. The following are examples of their responses to the question of "What do you think causes mental illness?" : "family environment, problems in living, death and losses, sickness"; "thinking too much"; "competition on the job"; "stress, depression, and environmental changes". The remaining four experimental clients (33%) believed that mental illness is of biological origin, or caused by a

combination of biological and environmental factors. Their responses were as follows: "(mental illness is) naturally occurring"; "imbalance of brain chemistry"; "mental illness is inherited, depression and stress in living (also cause mental illness)"; and "excessive internal or external stimulation which harms normal body regulation". The last response was actually more concordant with the Eastern view of illness.

Three (25%) of the control clients indicated they did not know what causes mental illness. Four (33%) cited physiological factors as the cause of mental problems, with responses such as "multiple illness will cause mental illness"; "poor health"; "not enough sleep, not taking care of oneself, getting older, lack of activities, not enough exercise, and poor eyesight"; and "working too hard without rest". Others (33%) believed that mental illness is caused by "personal problems and stress"; "nervousness"; "too much stressful stimulations"; and "bad people and things, and job". One control client's answer was "all of us do not have mental illness".

Seemingly, clients from both groups mainly attributed to external factors as the cause of mental illness, with little or no reference to intra-psychic conflicts. However, none of the clients in the experimental group reported health problems as the cause

of mental disorders, and almost all of the clients in this group were able to name one or more factors associated with mental illness. In general, the responses of the experimental group were reflective of the material presented in the sessions, which demonstrated the influence of the psychoeducational program.

Half of the experimental clients reported more psychologically-oriented problems as the cause of their illness. Examples of their responses to the question of "What do you think causes your illness?" included: "psychological factors, withdrawal and isolation, overwhelmed by disorganized thoughts, and sleep difficulties"; "could not make things clear"; "too much stress, not listening to God"; and "depression, hearing voices". In contrast, half of the control subjects indicated that their illness was caused by physical problems. The following are examples of such responses: "high fever, seizures"; "I did not feel well frequently"; "weak body"; and "got sick naturally and did not see a doctor until much later". Three (25%) of the clients from the experimental and two (17%) of the clients from the control group described their symptoms only (i.e. hearing voices, sleep disturbance) rather than indicating the cause of illness. One control subject believed that his illness was related to "environmental causes", while

another client from the control group felt that his illness was caused by "drinking and too much stressful stimulation". There were some idiosyncratic responses from both groups. For example, in the experimental group, one client reported his illness was caused by "talking too much"; another client felt that she became ill because she was "rushed to learn English". A client from the control group remarked that "all of us do not have illness". Only two clients were able to provide more specific information regarding the cause of their illness. One experimental client indicated, "I worried when I was in my job. This caused anxiety and my illness". In the control group, a client reported, "My illness was caused by the separation from my husband".

Apparently, the majority of the clients from both groups were not able to describe the specific problems or circumstances that led to their illness. Noteworthy was the control subjects' higher tendency to attribute to physiological factors as the cause of illness, whereas the experimental group appeared to be slightly more psychologically oriented.

The majority (ten or 84%) of the experimental clients showed some familiarity with the typical medications used in the treatment of mental illness, and were able to name one or more psychotropic medications. On the other hand, only one client in the control group

could name a single psychotropic medication. Furthermore, all the clients in the experimental group knew the names of the medications they were taking. Eight (67%) of them reported correctly the exact dosage and frequency, in addition to the names of the medications they were prescribed. In comparison, half of the control clients had no knowledge of the medications they were taking and only three (25%) could correctly report the name, dosage, and frequency of their medications.

Eight (67%) of the clients in the experimental group were aware that they were in a day treatment program. Most (nine or 75%) of the experimental clients indicated that they received psychotherapy (group, individual and/or family therapy), in addition to pharmacotherapy. In the control group, none of the clients reported that they were in a day treatment program, and only two (17%) indicated that besides medication, they received psychotherapy. Some of the control subjects reported that they received "exercise" therapy (Chinese-style exercises), recreation therapy and help from workers, in addition to pharmacotherapy. In actuality, all clients were in group therapy and the majority of the clients from both groups were receiving individual therapy and family counseling.

Almost half (five or 42%) of the experimental

clients felt that a combination of medication, psychotherapy and social contacts was most helpful to their illness, and three (25%) believed that medication alone was most beneficial. Two (17%) experimental subjects reported that relaxation and sleep were most important in the treatment of their illness. One client from the experimental group stated that "concentrate my mental effort to get in touch with reality (was most helpful to my illness)", and another felt that "understanding that there are joy and bitterness in the world and the feelings of loneliness with prolonged illness, having a million dollars, and working together with family, social worker and doctor" were most useful.

In the control group, four (33%) of the clients reported that medication in combination with social support, or attendance to the continuing treatment program were most helpful to their illness. One control client thought that medication alone was the most beneficial component in his treatment, and another indicated that psychotherapy in conjunction with activities were most helpful. In addition, one control subject reported the activities of "arts and crafts and helping out with lunch" as being most beneficial to his mental illness, while another cited "proper diet". The remaining four responses (33%) varied from "girlfriend", "time to solve problems", "do not know" to "mental

comfort and support".

In general, the qualitative data seemed to indicate that clients who attended the psychoeducational sessions had a better understanding of mental illness, a better conceptualization of their illness and treatment, and were more likely to be able to identify the types of treatment they were receiving, when compared to the clients who did not participate in the psychoeducational program.

Attitudes About Mental Illness

The mean scores of the experimental and control groups on the Opinions About Mental Illness (OMI) questionnaire were practically identical and therefore showed no significant difference statistically. The mean score of the experimental group was 25.67, with a range of 12 to 34. The clients in the control group obtained a mean score of 25.83, and the range of 18 to 34. Participation in the psychoeducational program did not have any apparent impact on the clients' attitudes and opinions toward mental illness.

Satisfaction with Services

The mean score obtained by the experimental group on the Client Satisfaction Questionnaire (CSQ-8) was 24.58, and the range was 21 to 27. The control group's mean

score was 23.42, with a range of 14 to 29. The difference between the mean scores of the two groups was not statistically significant. Clients from both groups reported a similar level of satisfaction with services in the continuing treatment program, regardless of their participation status in the psychoeducation program.

Clients were also asked to indicate what they liked best about the continuing treatment program, and content analysis was performed on the qualitative data obtained. In the experimental group, three (25%) of the clients cited socialization, three (25%) reported therapy (group therapy or talking to therapist) and activities (arts and crafts, recreation), and two (17%) mentioned English class and socialization or meals. Additionally, one client liked the activities in the program, another reported help from the staff, one mentioned the psychoeducational program, and one enjoyed the "relaxing atmosphere" of the program. For the control subjects, five (42%) indicated their preference for socialization and activities, and two (17%) reported that they liked the assistance that staff provides with concrete services. One client stated help with concrete services and activities were the best things about the program, and two (17%) reported learning English and activities. In addition, one client mentioned meals and another liked the fact that "(one) can learn something everyday".

In response to the request to name one thing about the continuing treatment program that should be changed if possible, almost half (five or 42%) of the experimental clients stated no changes were necessary in the program. Two (17%) suggested more outings. Other responses (four or 33%) included "more free time", "fewer physical exercise/movement classes and more math classes", "less arts and crafts classes", and "a change in kitchen staff". One client indicated that he did not know if anything should be changed, because almost every part of the program was helpful. In the control group, four (33%) of the clients felt that the program was fine the way it was and should not be changed in any way. Two (17%) mentioned more physical exercise/movement classes and two (17%) made suggestions about meals. One client asked for shorter program hours while another suggested more participation from staff and clients. In addition, one client felt the need to establish a work program, and another remarked "I don't know". Seemingly, a significant number of clients from both groups saw no need for specific changes in the continuing treatment program.

Motivation for Treatment

There was no significant difference statistically

between the mean scores of the experimental and control group subjects on the Task Check List (TCL). The mean score of the experimental clients was 25, and the range was 15 to 34. The control group achieved a mean score of 23.5, and the range was 14 to 33. It appeared that clients who participated in psychoeducation did not show a significantly higher level of involvement or participation in the continuing treatment program.

Educational Level and Psychoeducation

Table III displays the KSQ, OMI, CSQ-8, and TCL group mean scores obtained by experimental clients and control clients when they were grouped by educational level (less than high school-up to the ninth grade, and high school and above-tenth grade and beyond). In both experimental and control groups, clients who had a higher level of education achieved a higher mean score on the KSQ than those who were less educated. Experimental clients who had an educational level of high school and above obtained the highest mean score on the KSQ ($M=25.25$), indicating that this group knew more about mental illness and treatment than the others. However, control clients who attended high school and beyond did slightly better than experimental clients who had a less than high school level of education ($M=21.60$ and 20.25 , respectively). The mean score of the control subjects

with a less than high school level of education was 13.43.

On the OMI, experimental clients with a higher level of education obtained a higher mean score than those experimental clients who did not attend high school (M=26.75 and 23.50, respectively). In contrast, the mean score of the control clients who had a less than high school level of education was higher than the mean score of those in the same group who were better educated (M=28.29 and 22.40, respectively). Apparently, the control clients in the less educated group had the highest mean score on the OMI which signified that they held a more positive view of mental illness than the clients in the other categories.

There was only a small difference between the mean scores of the experimental subjects in the higher and lower educational groups (M=24.38 and 25, respectively) on the CSQ-8. Likewise, the mean scores of the control clients in both educational levels were highly similar. The control clients with a level of education of high school and above had a mean score of 23.80 and those with a less than high school level of education obtained a mean score of 23.14. The mean scores of the experimental clients on the CSQ-8 were only slightly higher than those of the control subjects in both educational groups, indicating that there was little difference in

satisfaction with services regardless of educational level or participation in psychoeducation.

On the TCL, the experimental subjects with a higher level of education did slightly better than the experimental subjects who were less educated. The former had a mean score of 25.38 and the latter obtained a mean score of 24.25. In the control group, clients with a high school or above level of education likewise obtained a higher mean score than those with a less than high school level of education (M=25.20 and 22.29, respectively). Notably, experimental subjects whose educational level was high school or above obtained a similar mean score as the control clients from the same educational group, indicating that there was no difference in the level of involvement in the continuing treatment program between the participants and the non-participants of psychoeducation.

Length of Illness and Psychoeducation

Table IV compares the group mean scores obtained by the experimental and control clients on the KSQ, OMI, CSQ-8, and TCL when categorized by length of illness (five years or less, and more than five years).

Experimental clients who were mentally ill for more than five years achieved a mean score of 24.22 on the KSQ, while those who had a duration of illness of five

years or less obtained a mean score of 21.67. In the control group, clients who were ill for five years or less had a higher mean score than the clients with a longer length of illness (18.50 and 16.50, respectively). Overall, clients who participated in psychoeducation received higher mean scores on the KSQ than the client who did not, regardless of length of illness.

On the OMI, the experimental subjects who had a length of illness of five years or less obtained the highest mean score (M=28). The experimental clients with a longer duration of illness had a mean score of 24.89, similar to the mean score obtained by the control clients who had been ill for five years or less, which was 25. Control clients who were ill for longer than five years had a mean score of 26.

Experimental clients with a longer length of illness obtained a slightly higher mean score on the CSQ-8 than the experimental clients with a shorter duration of illness (24.89 and 23.67, respectively). On the other hand, in the control group, clients with a psychiatric history of five years or less had a higher mean score on the CSQ-8 than those who were ill for more than five years (26.50 and 22.80, respectively).

The mean score of the experimental clients with a longer psychiatric history on the TCL was 26.89, which was higher than the mean score of 19.33, obtained by the

experimental clients with a length of illness of five years or less. In contrast, control clients with a history of illness of five years or less received a higher mean score than the control subjects who had been ill for more than five years (32.50 and 21.70, respectively).

Length of Residence in the U.S. and Psychoeducation

The KSQ, OMI, CSQ-8, and TCL group mean scores of the experimental and control clients are compared by length of residence (less than ten years, or ten years and more) in the United States in Table V.

Experimental clients who had lived in the United States for less than ten years achieved a similar mean score on the KSQ as those experimental clients with a lengthier residential tenure (23.83 and 23.33, respectively). In the control group, clients with a length of residence in the United States for less than ten years obtained a mean score of 19 and those who had lived in this country for ten years or more had a mean score of 16.11. Apparently, clients who received psychoeducation obtained higher mean scores on the KSQ than the clients who were without psychoeducation, in both length of residence groups.

On the OMI, the experimental clients with a shorter residential tenure had a mean score of 27.33, which was

somewhat higher than the mean score of 24, obtained by the experimental clients who had a length of residence of ten years or more. However, the control clients with a longer length of residence had a higher mean score on the OMI than the control subjects who had lived in the United States for less than ten years (26.22 and 24.67, respectively). Seemingly, experimental clients with a length of residence of ten years or more expressed similar opinions about mental illness as the control clients with a shorter length of residence.

In the experimental group, there was little difference between the mean scores on the CSQ-8 of the clients with a shorter length of residence and the clients with a length of residence of ten years or more (24.33 and 24.83, respectively). The control clients with a length of residence of less than ten years obtained a higher mean score on the CSQ-8 than the control clients who had resided in the United States for ten years or more (25.67 and 22.67, respectively).

On the TCL, the experimental clients with a longer length of residence had a higher mean score than the experimental clients with a shorter residential tenure (26.17 and 23.83, respectively). In contrast, the control clients with a length of residence of less than ten years received a mean score of 30 on the TCL, which was higher than the mean score of 21.33, obtained by the

control subjects who had lived in the United States for ten years or more. Interestingly, the control clients who had a length of residence of less than ten years had the highest mean score on the TCL, indicating that this group was most involved in the treatment activities at the continuing treatment program.

Age and Psychoeducation

Table VI summarizes the group mean scores obtained by the experimental and control subjects on the KSQ, OMI, CSQ-8, and the TCL when compared by age groups. Clients were assigned to one of two age categories (below age 35, and age 35 and above).

On the KSQ, experimental clients who were below age 35 obtained a mean score of 25.50, while the older group of experimental clients achieved a mean score of 21.67. In general, control clients from both younger and older age groups had lower mean scores (15.83 and 17.83, respectively) than the experimental clients. It appears that the younger clients who participated in psychoeducation had the highest mean score in regards to knowledge of mental illness.

The experimental clients who were below age 35 had a mean score of 26.67 on the OMI while the experimental clients in the older age group received a mean score of 24.67. In the control group, the younger subjects

obtained a higher mean score on the OMI than the older clients as well (27.67 and 24, respectively).

The mean score of the experimental clients from the younger age group on the CSQ-8 was 24.50, similar to the mean score of 24.67, obtained by the experimental subjects who were age 35 and older. The control clients who were younger than age 35 received an identical mean score as the older experimental subjects on the CSQ-8, which was 24.67. The control clients from the older age group had a mean score of 22.17.

On the TCL, the younger experimental clients obtained a slightly lower mean score than the experimental clients from the older age group (24.50 and 25.50, respectively). On the other hand, the younger control subjects had a mean score of 24.33, higher than the mean score of 22.67 received by the control subjects who were age 35 and older.

4. Impact of the Implementation Process on Clients, Staff, and the Overall Program

The psychoeducational program was designed to be minimally disruptive to the overall operations of the continuing treatment program. As mentioned earlier, the psychoeducational sessions were integrated into the daily schedule of program activities. Due to the

cooperativeness of the administrator, staff and clients, the impact of the psychoeducational program was generally positive.

At the time of implementation, the continuing treatment program was a stable entity with the same staff working in the program for almost three years. Because of the small size of the program and low client turnover, the clients and staff developed a close working relationship. Essentially, the continuing treatment program was the clients' "home away from home," because the majority of them attended the program on a daily basis.

There was no visible enthusiasm from the clients when the psychoeducational program was announced. This changed somewhat after the program began. The majority of the clients in the experimental group attended regularly without prompting. Many of the clients liked the slide presentations and showed interest in the content of the sessions as evidenced by their attentiveness and attendance. In general, there was not much interaction among the clients during the sessions. However, there were a few clients who were able to speak about their experiences and shared some of their feelings regarding their illness. For example, during the session on types of mental illness, one of the clients was able to talk about his symptoms and behavior during some of

his psychotic episodes with vivid details. He lamented that his lengthy illness had negatively affected his family relationships, as well as his vocational functioning. His openness led to the self disclosure of two other clients about their own problems. They were able to provide each other with support and the staff positively reinforced these interactions. Clients were also encouraged to further discuss these issues during group therapy sessions. In retrospect, the sessions in which types of mental illness were presented were probably most anxiety provoking for the clients as the symptoms they generally experienced were described. However, these sessions also aroused more reactions from the group than the others.

Some of the concerns raised in the sessions were related to theory of genetic inheritance, long-term effects of medication, the combined use of Chinese and Western medicines, the need for appropriate residential facilities for the mentally ill in the Chinese community, and their entitlements.

A few of the clients' attendance to the continuing treatment program increased during this period because they wanted to attend the psychoeducation sessions. Some clients felt that they "learned a lot" and others stated that the sessions were "helpful" but were unable to specify how they helped. For a small number of clients,

there seemed to be no apparent impact as they did not verbalize any particular feelings or thoughts.

None of the clients asked about their diagnosis during the group presentations, nor in the individual sessions. For the most part, the individual sessions were used to help clients identify their "warning signals" and how to get help, and to review the names and dosages of their medications. A couple of clients expressed some degree of acceptance of their need for long-term treatment, although they were apparently distressed (and appropriately so). They were provided with support and were encouraged to further discuss their feelings with their primary therapist in individual sessions and/or in group therapy sessions.

Some of the clients from the control group were quite curious as they awaited their turn and were anxious to attend the sessions. They frequently asked when they could begin to participate. The majority of the control clients also attended the psychoeducational sessions on a regular basis. Similar issues and concerns were raised and discussed during the sessions. Likewise, none of the clients in the control group asked about their diagnosis. Like the experimental group, some of the control clients also felt they had learned a great deal about their illness and treatment.

A very positive outcome had been observed by staff

after the implementation of the psychoeducational program. Clients appeared to be more aware of each other's psychiatric condition. For example, a client who was showing signs of deterioration was confronted by others in group therapy on whether he was taking his medication. He was encouraged to speak about his problems in the group session, and to talk to his worker in an individual session.

The staff were quite interested in the psychoeducational program for a variety of reasons and therefore cooperative with its implementation. They perceived it as a learning experience for themselves, and a break from the routinized schedule. Furthermore, the staff had frequently expressed the need to educate the clients on treatment issues. They were hopeful that psychoeducation would help to enhance the clients' understanding of the purpose of the continuing treatment program and consequently facilitate their treatment process.

Seemingly, the psychoeducational program was generally a positive experience for the staff and clients involved. For the continuing treatment program, it had helped to substantiate its significance as a place of helping and "healing", and not just a "school" for "learning" and "playing".

Case Vignettes

Case A

Client A usually coped with stress (whether it was real or imaginary) by staying home in a state of withdrawal. He somaticized a great deal during these periods and presented physical complaints such as headaches and stomach problems. His social worker had been working with him to verbalize his difficulties and to find coping strategies. His participation in the psychoeducational program appeared to have made some positive impact on his treatment. Shortly after the conclusion of the program, client A was somewhat more willing to talk to his worker about the problems that were troubling him. He stated that "talking it out" made him feel a little better. He learned from the psychoeducational program that his "warning signals" were headaches or an upset stomach, with an increase in auditory hallucinations. He agreed to seek the help of his worker and/or psychiatrist immediately at the onset of these symptoms. Client A tried to attend the continuing treatment program on the days in which he "did not feel well". He would stay for two or three hours instead of the full day (an agreement he made with his worker). He gradually realized that isolating himself at home did not always help him to feel better. Client A

attributed his changes to the psychoeducational program, as well as the help and support from his worker. Although he was not yet able to make the connection between his somatic symptoms and his psychological stress, his general functioning had shown some improvement.

Case B

Client B was extremely wary of Western medication, especially after a terrible experience of severe side effects. This negative experience also fed into her paranoia, and made her very suspicious of psychiatrists and social workers. This lack of trust had resulted in her frequent non-compliance with medication. Her fear of authority figures had deterred her from talking to her worker or psychiatrist about her feelings toward medication. She liked to practice Chinese-style exercises to moderate and balance her bodily energies and this was encouraged by the staff. However, without medication, she would become disorganized and increasingly paranoid. After the psychoeducation program, client B stated that the information in the sessions had helped her to better understand how medication worked. She became less reluctant to talk about her fears regarding medication and more willing to cooperate with the psychiatrist, as she saw her

medication reduced with the improvement of her condition. She also learned to recognize her "warning signals" and requested prompt assistance.

Client B continued to require a great deal of structure and support in order to comply with treatment and to function in the community. However, she became more accepting of Western methods of treatment and she attended the continuing treatment program regularly, where she could also practice Chinese-style exercises and meditation.

CHAPTER SIX: DISCUSSION

1. Summary

Past studies have shown that Chinese-Americans under utilize mental health services because of cultural factors and the failure of existing services to meet their needs. One of the major issues identified was that dissimilar views of mental health and illness frequently created a gap between the Chinese client and the American mental health service provider. Consequently, Chinese-Americans showed a lower rate in the utilization of mental health services. In recent years, the steady growth of the Chinese population in the United States increased the demand for the development of more culturally relevant mental health treatment methods. A psychoeducational approach was used to enhance the treatment of a group of Chinese-Americans with chronic mental illness. This psychoeducational program was designed to increase the clients' knowledge of Western concepts of mental illness and treatment methods. Additionally, the program intended to facilitate the clients' involvement in treatment services, as well as to promote a more positive view of mental illness. This psychoeducational program included in its content,

specific issues that are pertinent to the treatment of Chinese-American chronic mental patients, and it was conducted in a bilingual, bicultural treatment setting.

Thirty Chinese clients from a continuing treatment program were randomly assigned to either the experimental or control group. Due to attrition, only twelve clients from each group completed the study. The experimental subjects (N=12) participated in a psychoeducational program consisting of a series of eight group sessions and one individual session, in addition to receiving the treatment protocol of the continuing treatment program. The control subjects (N=12) only received the standard treatment services at the continuing treatment program. One week after the conclusion of the psychoeducational sessions, clients from both groups were asked to answer a set of questionnaires. These instruments measured their knowledge of mental illness and treatment, opinions about mental illness, and satisfaction with overall program services. During the same time period, staff also rated the participation and level of functioning of the clients from both groups in the continuing treatment program. The mean scores of the experimental and control groups obtained on the questionnaires and the rating scale were compared by using one-tailed t tests. Because of the small number of cases involved, it was difficult to perform other statistical tests of significance. Hence,

this study should be regarded as exploratory in nature and its findings viewed as preliminary.

The results supported only one of the four cited hypotheses. Hypothesis one was supported since the clients who participated in psychoeducation achieved a mean score on the Knowledge of Schizophrenia Questionnaire (KSQ) that was significantly higher than the mean score of the control clients. These findings substantiated the use of the psychoeducational approach in enhancing the Chinese-American chronic patients' knowledge of Western concepts of mental illness and treatment methods.

No significant difference was found between the mean scores of the experimental and control groups on the Opinions About Mental Illness (OMI) questionnaire, the Client Satisfaction Questionnaire (CSQ-8) and the Task Check List (TCL), indicating that psychoeducation had no prominent impact on the experimental clients' attitude toward mental illness, satisfaction with program services, or motivation for treatment (Hypothesis two, three and four were not supported). These findings suggest that psychoeducation may only be effective to the extent that it augments the clients' knowledge of mental illness; however, life long beliefs and behaviors cannot be easily altered. Nevertheless, psychoeducation may be valuable as one of the components in the treatment of

Chinese-American chronic mental patients.

Demographic characteristics of the clients (i.e. educational level, length of illness, length of residence in the United States, and age) were examined in relation to the results obtained.

2. Discussion

The results of this study indicate that Chinese-American chronic mental patients who participated in a psychoeducational program were more knowledgeable about mental illness and treatment methods than the non-participants. This finding is similar to the results obtained in the studies of McGill, Falloon and their associates (1983), and Goldman and Quinn (1988), in demonstrating that psychiatric patients are capable of learning about mental illness and treatment with a cognitive approach. This outcome also suggests that Chinese chronic mental patients respond better to formal educative methods in learning about their illness than in individual, group or family therapy setting.

The long term effects of the psychoeducational program is unknown at this time. Although the experimental clients seemed to have gained more knowledge in certain areas than others (i.e. cause of mental illness, the types of treatment they were receiving, the

medications they were taking, and the impact of schizophrenia on the patient's daily functioning), it is possible that they may further integrate what they learned over a longer period of time, especially if psychoeducation becomes an integral component of the treatment program. Over time, it is likely that medication compliance would increase, as well as the clients' ability to recognize and cope with stressful situations. The clients may also become more accepting of Western treatment methods and more frequently utilize the resources available to them.

In comparison to the control group, the experimental group had a greater mean in years of education. This could have been a contributing factor to the higher mean score obtained by the experimental clients on the KSQ. Individuals who are better educated may be more capable of comprehending the complex nature of mental illness and treatment. Overall, the participants of psychoeducation who were younger in age, better educated, or had a longer duration of illness, were most knowledgeable about concepts of mental illness and treatment; however, other clients who were involved with the psychoeducational program demonstrated a greater knowledge of mental illness than the clients who did not participate in psychoeducation. These findings suggest that the younger, more chronic patients with at least a high

school level of education would benefit the most from the psychoeducational program in learning about their illness and treatment. In general, psychoeducation is likely to enhance the knowledge of mental illness in all those who participate.

Length of residence in the United States was not a significant factor in influencing knowledge of mental illness, as was participation status. Participants of psychoeducation who lived in this country for a shorter period of time were as knowledgeable about Western concepts of mental illness and treatment as the participants with a longer length of residence; however, they were more knowledgeable than those clients who were not involved in psychoeducation.

Seemingly, psychoeducation can be useful in enhancing the knowledge of Chinese American clients in Western concepts of mental illness and methods of treatment, and can be an important component in the overall scheme of treatment services for the chronically mentally ill.

The study's results showed that participation in the psychoeducational program had little impact on the clients' attitude toward mental illness. It was hypothesized that individuals who were involved with psychoeducation would develop a more positive view of mental illness because the program intended to reduce the

social stigma attached to mental illness. The difference between the mean scores of the experimental and control subjects on the OMI was not statistically significant despite the experimental clients' demonstration of greater knowledge of mental illness and treatment. This finding implies that a greater understanding and knowledge of mental illness in itself is not sufficient to alter the clients' attitude toward psychiatric disorders, and that attitudes and beliefs are derived from a system of values that cannot be easily modified. It appears that in order to change one's attitude, it would be important for the individual to be consistently exposed to the new information and to integrate this knowledge. Furthermore, it is noted that an individual's capacity for attitude change is affected by the degree of similarity between his/her initial attitude and new message communicated, and that the individual will only incorporate communication that is within his/her "latitude of acceptance" (Fisher, 1982, p. 460). Apparently, the bridging of the gap between the Chinese and Western perceptions of mental illness cannot be accomplished easily. Moreover, attitude is a complex concept and the phenomenon of attitude change is probably influenced by the interaction of a number of variables. The results of this study did not indicate a clear relationship between psychoeducation and attitude toward

mental illness when educational level, duration of illness, length of residence, and age were considered. It appeared that the less educated non-participants and the participants with a shorter duration of illness expressed the most positive opinions regarding mental illness.

The findings of the study likewise did not support the hypothesis that clients who participated in the psychoeducational program would show a higher level of satisfaction with overall program services. Seemingly, the experimental clients' greater knowledge of mental illness and treatment did not significantly influence their satisfaction with program services. This implies that even though they were more informed, they may still prefer the more traditional, or culturally acceptable forms of treatment. Furthermore, the mean scores of both experimental and control clients on the CSQ-8 were lower than the mean score obtained by a national sample of 3,120 mental health service recipients (24.58, 23.42, and 27.09, respectively) in a study conducted by Nguyen, Attkisson and Stegner (1983). This finding indicates that Chinese-American clients were less satisfied with the services they received than the national sample, and generally reported only a medium level of satisfaction. In an earlier study on client satisfaction, Larsen and his associates (1979) did find that non-white clients

were less satisfied with mental health services than white clients. Chinese-American clients may be more satisfied with treatment services if Chinese healing methods such as acupuncture, Eastern meditation and relaxation exercises, are used in conjunction with Western psychiatry. Moreover, psychiatric symptoms were found to be negatively correlated to satisfaction of services (Levois, Nguyen, and Attkisson, 1981). Clients who reported a higher number and more severe psychiatric symptoms gave lower ratings in satisfaction with services. These findings suggest that Chinese-American chronic mental patients may have felt that existing services were not meeting all their needs; however, the severity of their illness may also be responsible for the reported lower level of satisfaction with services. It should be noted that there is a trend that favors the direction of the hypothesis. It appears that non-participants of psychoeducation who were older, had a longer psychiatric history or lengthier residential tenure in the United States, were the least satisfied with services. It is conceivable that this group may become more satisfied with services if they become involved in the psychoeducation program.

The effort to obtain the clients' opinions for the purpose of enhancing program services, nonetheless, remains significant. It was noted that client

satisfaction influences the utilization of treatment services and treatment compliance (Kalman, 1983; Slater, Linn, and Harris, 1982). Satisfaction may increase if clients feel that staff are concerned and their suggestions and opinions are of value to the operation of the program.

Involvement in the psychoeducational program did not substantially influenced clients' motivation for treatment as evidenced by the lack of statistical difference between the mean scores of the experimental and control groups. It was hypothesized that clients who participated in psychoeducation would become more actively involved in the overall treatment program, as the result of the enhanced understanding of their illness and treatment. The short-term application of this program may be responsible for the absence of significant change in the experimental subjects. As with other psychosocial treatment methods for the chronically mentally ill, psychoeducation may need to be employed for a consistent period of time to be efficacious. Ongoing psychoeducation in conjunction with other treatment methods (e.g. behavioral contingencies) conducted over a longer period of time may prove to be more helpful in improving the chronic mental patients' level of functioning. Results showed that psychoeducation participants who were older, more chronic, or with a

longer length residence in the United States, were more involved in treatment activities than their counterparts who were not involved with psychoeducation. This trend indicates that psychoeducation has some beneficial effects on motivating the chronic mentally ill. The study conducted by Goldman and Quinn (1988) demonstrated that educating schizophrenic patients in a state hospital about their illness resulted in a decrease in negative symptoms as well as gain in knowledge of mental illness and resources, in comparison to the control group (negative symptoms were described as functional deficits such as "asociality, avolition, apathy, affect blunting, attentional impairment, and anhedonia"). However, the means by which psychoeducation and increased knowledge influenced negative symptoms were not identified.

Lastly, satisfaction with services and motivation for treatment are not independent factors. Hence, the clients' motivation for treatment is likely to be affected by their level of satisfaction with program services and vice versa. Since clients from both experimental and control groups expressed a similar degree of satisfaction with services, they likewise displayed a comparable level of motivation for treatment. Ostensibly, the impact of psychoeducation on the treatment of individuals with mental disorders, and specifically on Chinese-American chronic mental patients,

requires further exploration and investigation.

3. Limitations of the Study

There are a number of limitations to the study that should be considered in the interpretation of the results. This study was conducted with a small group of Chinese-American chronic mental patients living in New York City. These results cannot be generalized to other populations. The small size of the sample posed limitations on the types of data analyses that could be performed. As a result, causal relationships among the various variables could not be examined.

The instruments used in the study were largely designed for the average White American. With the exception of the Client Satisfaction Questionnaire, other questionnaire and scales did not include Chinese subjects in the standardization of these instruments. The modification of some of the instruments likewise may compromise the dependability of the results (i.e. the contraction of the response categories).

This study only examined the short-term effects of the psychoeducational program. The long-term impact of the program, and the amount of knowledge of mental illness and treatment retained by the clients in the future remains unknown. Future studies should consider

the inclusion of several post test periods to determine the long-range effects.

4. Conclusions and Recommendations

A culturally relevant psychoeducational program was conducted by bilingual, bicultural staff in an outpatient mental health facility located in the Chinese community. Surprisingly, the majority of the clients showed interest and participated in the program. The clients were able to accept the psychoeducational program largely because of the ongoing relationship they had with the continuing treatment program, as well as the trust they had in the staff. The results of this study indicate that Chinese-American chronic mental patients who participated in the psychoeducational program were significantly more knowledgeable in Western concepts of mental illness and treatment methods than those who were not involved in the program. In addition, there were no undesirable consequences observed as the result of the psychoeducational program on treatment activities or the clients' daily functioning.

Despite the earlier cited limitations of this study, the findings indicate that psychoeducation is a useful treatment method for Chinese-American chronic mental patients. It helps these clients to better understand

their illness and to become more familiar with the treatment services available in the United States. Chinese-American clients will be more able to make informed choices regarding their treatment. As a result, utilization and treatment compliance may increase. More studies should be conducted to verify the effectiveness of this treatment approach with Chinese and other Asian Americans. Empirical data are also needed to ascertain the effectiveness of other treatment methods (e.g. individual, group, and family therapy, behavior modification) on Asian Americans. Such information will help to identify the modalities/approaches that are more compatible with this group, as well as provide valuable insight into how these methods can be modified to best meet the needs of Asian Americans.

Results of the present study showed that the participants of psychoeducation did not differ significantly from the non-participants in their opinions regarding mental illness, satisfaction with services, or motivation for treatment. Little is known about the relationship between psychoeducation and each of these factors, or the interaction among these variables. If the psychoeducational program is conducted over a longer period of time, or serves as an ongoing component in the treatment program, greater changes may be found. Future studies with larger samples, and designed to measure the

long-range as well as the short-term effects, could generate more valuable information to determine the effectiveness of this treatment intervention.

It is of interest that clients from both experimental and control groups expressed similar attitudes and opinions regarding mental illness, despite the significant difference in their knowledge of mental illness and treatment. This suggests a possible relationship between ethnicity and attitude toward mental illness. The Chinese may have different opinions about mental illness from other groups. Studies involving various race/ethnicity groups in this country could help to shed light on this issue. Comparisons could also be made between Chinese-American patients and non-patients. It is conceivable that the Chinese American chronic mental patients' experience with illness had affected their attitude toward mental disorders. Ongoing education in the community is needed to lessen the stigma associated with mental illness, and to create a more accepting social environment for the Chinese patients. It is probably difficult for the Chinese clients to have a more positive view of psychiatric disorders if they feel highly stigmatized by those in their own ethnic group. Attempts should be made to mobilize the Chinese community, especially the families of the clients, to advocate for the mentally ill.

The level of satisfaction with program services expressed was not significantly different between the experimental and control groups. Furthermore, the results were not consistent with the high levels of reported satisfaction commonly found in studies on client satisfaction (Larsen, et al 1979). Future investigations should include the examination of clients' expectations of treatment outcome, and satisfaction with life in general. Such data could help to identify the factors associated with satisfaction as well as dissatisfaction with services, which are significant information for program planning.

As discussed previously, to increase the clients' motivation for treatment would require a multifaceted approach, in which psychoeducation could be one of the components. Because the majority of the clients in this study lived with their families, family involvement would be another essential element in the treatment of this population. Recent studies on the effectiveness of the psychoeducational approach in the treatment of chronic mental patients demonstrated the importance of involving family members. In the Chinese community, the strong stigma associated with mental illness makes it difficult to engage families of the mentally ill in a group setting. Community education could be the initial step in enhancing the community residents' understanding of

mental health problems, as well as the benefits of early treatment and mutual support.

In summary, results of the present study showed that Chinese-American chronic mental patients can benefit from a culturally relevant psychoeducational program. It was demonstrated that psychoeducation enhanced the clients' knowledge of Western concepts of mental illness and treatment. This increase in knowledge is significant as it could bridge the gap between the Eastern and Western views of mental illness and treatment, thus increasing the likelihood of the Chinese clients' utilization and acceptance of mental health services in the United States. This treatment method has the potential to develop into a meaningful, culturally sensitive intervention, and should receive further attention and investigation.

Table I. Characteristics of Experimental and Control Subjects Presented in Numbers and Percentages.

<u>Characteristics</u>	<u>Subjects</u>			
	<u>Experimental</u>		<u>Control</u>	
	<u>(no.)</u>	<u>%</u>	<u>(no.)</u>	<u>%</u>
Age				
Below 35	(6)	50	(6)	50
35 and above	(6)	50	(6)	50
Sex				
Male	(10)	84	(9)	75
Female	(2)	16	(3)	25
Marital Status				
Single	(9)	75	(10)	84
Married	(3)	25	(1)	8
Divorced	(0)	0	(1)	8
Educational Level				
< High School	(4)	34	(7)	59
High School & >	(8)	66	(5)	41
Length of Illness				
5 Years or <	(3)	25	(2)	16
> 5 Years	(9)	75	(10)	84
Length of Residence in US.				
< 10 Years	(6)	50	(3)	25
10 Years or >	(6)	50	(7)	59
Native Born	(0)	0	(2)	16
Diagnosis				
Schizophrenia	(10)	84	(9)	75
Schizo - affective	(1)	8	(3)	25
Bi-polar	(1)	8	(0)	0
Length in Program				
< 1 Year	(4)	34	(2)	16
1-2 Years	(2)	16	(3)	25
> 2 Years	(6)	50	(7)	59

Table II. Comparison of Experimental and Control Group Scores On The KSQ, OMI, CSQ-8, and TCL.

<u>Questionnaire</u>	<u>SD</u>	<u>Mean</u>	<u>df</u>	<u>t-value</u>
KSQ			22	2.03*
Experimental	8.19	23.58		
Control	8.12	16.83		
OMI			22	-.075
Experimental	5.41	25.67		
Control	5.06	25.83		
CSQ-8			22	.96
Experimental	1.85	24.58		
Control	3.75	23.42		
TCL			22	.58
Experimental	6.14	25.00		
Control	6.63	23.50		

* One-tailed t-test significant at .05 level

Table III. Comparison of Mean Scores of the Experimental and Control Subjects on The KSQ, OMI, CSQ-8, and TCL When Grouped by Educational Level.

<u>Questionnaire</u>	<u>Educational Level</u>	
	<u>< High School*</u>	<u>> High School**</u>
KSQ		
Experimental	20.25	25.25
Control	13.43	21.60
OMI		
Experimental	23.50	26.75
Control	28.29	22.40
CSQ-8		
Experimental	25.00	24.38
Control	23.14	23.80
TCL		
Experimental	24.25	25.38
Control	22.29	25.20

* < High School = 9th grade and below

** > High School = 10th grade and above.

Table IV. Comparison of Mean Scores of the Experimental and Control Subjects on The KSQ, OMI, CSQ-8, and TCL When Grouped by Length of Illness.

<u>Questionnaire</u>	<u>Length of Illness*</u>	
	<u>5 Years or Less</u>	<u>More Than 5 Years</u>
KSQ		
Experimental	21.67	24.22
Control	18.50	16.50
OMI		
Experimental	28.00	24.89
Control	25.00	26.00
CSQ-8		
Experimental	23.67	24.89
Control	26.50	22.80
TCL		
Experimental	19.33	26.89
Control	32.50	21.70

* Length of Illness begins at the point of onset of symptoms.

Table V. Comparison of Mean Scores of the Experimental and Control Subjects on The KSQ, OMI, CSQ-8, and TCL When Grouped by Length of Residence in The United States.

<u>Questionnaire</u>	<u>Length of Residence</u>	
	<u>Less Than 10 Years</u>	<u>10 Years or More*</u>
KSQ		
Experimental	23.83	23.33
Control	19.00	16.11
OMI		
Experimental	27.33	24.00
Control	24.67	26.22
CSQ-8		
Experimental	24.33	24.83
Control	25.67	22.67
TCL		
Experimental	23.83	26.17
Control	30.00	21.33

* The Control Group included two subjects who were born in the United States

Table VI. Comparison of Mean Scores of the Experimental and Control Subjects on The KSQ, OMI, CSQ-8, and TCL When Grouped by Age.

<u>Questionnaire</u>	<u>Age</u>	
	<u>Less Than 35 Years</u>	<u>35 Years and Above</u>
KSQ		
Experimental	25.50	21.67
Control	15.83	17.83
OMI		
Experimental	26.67	24.67
Control	27.67	24.00
CSQ-8		
Experimental	24.50	24.67
Control	24.67	22.17
TCL		
Experimental	24.50	25.50
Control	24.33	22.67

Figure 1. The Person-in-Environment model as applied to the Chinese-American.

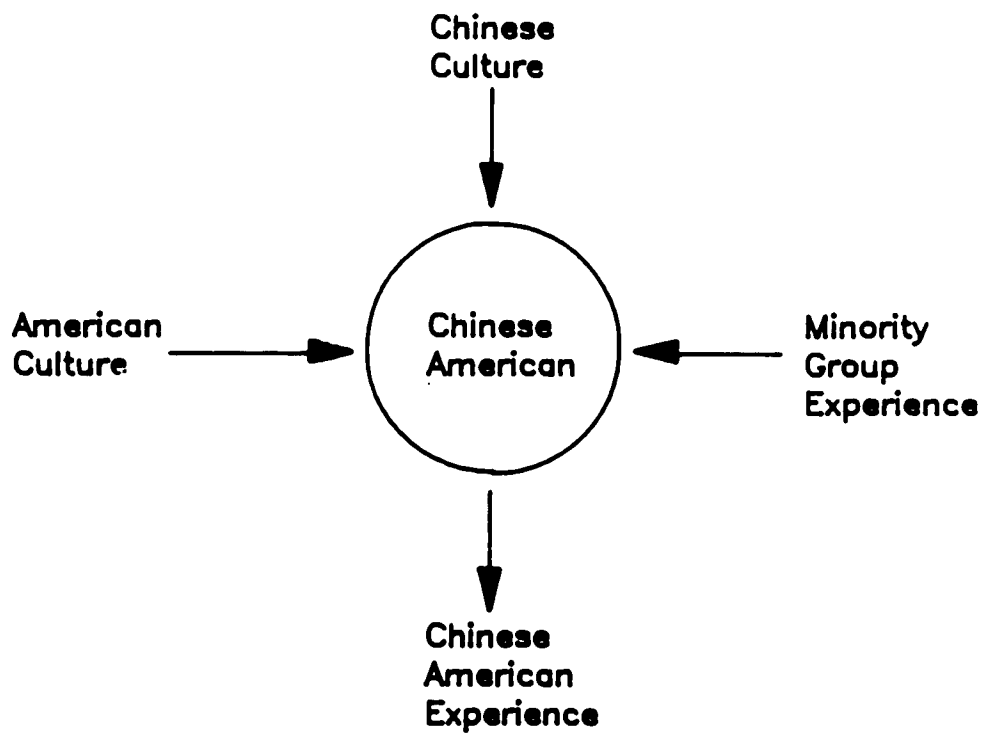
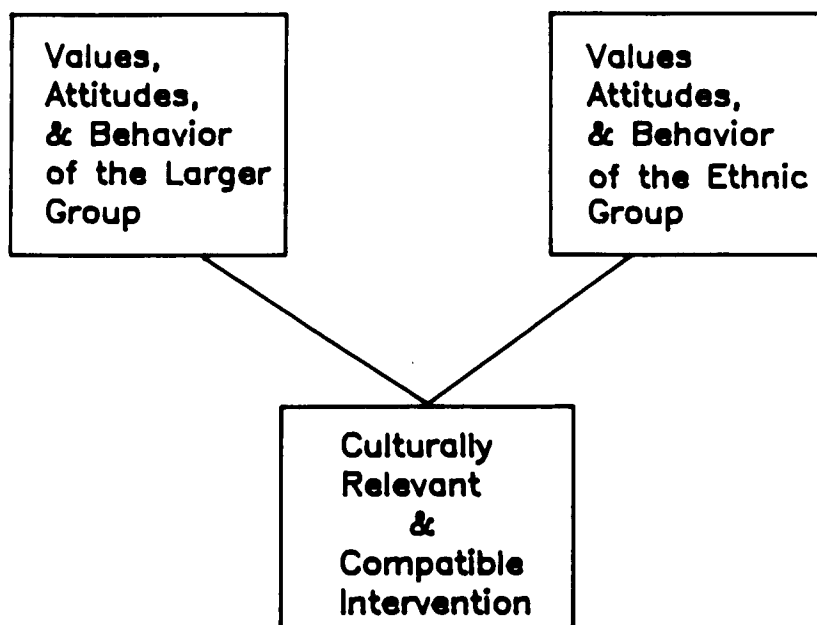


Figure 2. The Dual Perspective conceptual framework.



APPENDIX AConsent Form

Project Title: Psychoeducation Program
 Purpose of Research: To improve treatment services
 Procedures: 8 group sessions(2 times weekly for 1-hour sessions)plus 1 individual session; completing a questionnaire.
 Possible Risks or Discomfort Expected: None

I, _____, agree to participate in the study described above. The procedures have been explained to me as described above.

I understand that all data collected as a result of my participation in this project will be made available only to the investigators directly associated with the project. I also understand that all effort will be made to preserve my anonymity in the use of this material, and to maintain confidentiality concerning my project participation.

I have received assurance that participation is voluntary and that I may withdraw from participation at any time. I understand that this will not affect my benefits or treatment in the treatment program.

同意書

計劃名稱：心理教育活動
 研究目的：改善治療服務
 程序：八次小組講座(每星期兩次·每次一小時);另加一次個別研習;及填妥問卷。
 預計之冒險及不適感：沒有

本人, _____ 同意參加以上之研究。程序是如上方解釋。本人明白在參加這活動而收集的資料只提供給直接有關之研究人員。本人也明白這資料將作不署名用途, 參與這活動也是絕對保密。本人確實知道這次參與是自願的而可以在任何時間退出。本人知道這樣也不會影響我接受本會之得益或治療。

簽署:

日期:

Signature _____

Date _____

Daily Activity ScheduleAPPENDIX B

	Monday	Tuesday	Wednesday	Thursday	Friday
10:00-11:00	Daily English	Daily English	Recreation	Daily English	Recreation
11:00-12:00	ADL Training	Social Skills Training	Group Socialization	Group Therapy	Group Socialization
12:00-12:30	Movement Therapy	Movement Therapy	↓	Movement Therapy	↓
12:30-1:00	Lunch	Lunch	Lunch	Lunch	Lunch
1:00-1:30	Free time	Free time	Free time	Free time	Free time
1:30-3:00	Cultural Video Program	Group Therapy	Cultural Video Program	Arts & Crafts	(Announced Weekly)

Office hours: Monday - Friday
9:00 a.m. - 5:00 p.m.

Program hours: Monday - Friday
10:00 a.m. - 3:00 p.m.

Trip or outing: Once a month

Birthday Party: Once a month

Lunch: Free

The Chinese Unit of the Asian American Mental Health Services is a continuing treatment program for Chinese-speaking psychiatric patients. It implements a culturally sensitive day treatment model with Chinese bi-lingual staff.

This program provides psychotherapy, occupational and recreational therapy with a specialized cultural orientation. The treatment program includes:

- a) psychotherapy(individual, family, group)
- b) skills of daily living, e.g. shopping, cooking, budgeting, grooming, etc.
- c) English language class
- d) arts and crafts
- e) physical activities(movement therapy and exercise)
- f) cultural activities
- g) field trips and outings

Each client is assigned a caseworker who will coordinate the client's treatment, with input from client on his/her treatment plan.

PLEASE NOTE:

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These consist of pages:

142-145, Appendix C

U·M·I

OPINIONS ABOUT MENTAL ILLNESS

Please check (/) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item.

* * * * *

1. Most patients in mental hospitals are not dangerous.
 Agree _____ Not sure _____ Disagree _____
2. Most mental patients are willing to work.
 Agree _____ Not sure _____ Disagree _____
3. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.
 Agree _____ Not sure _____ Disagree _____
4. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.
 Agree _____ Not sure _____ Disagree _____
5. The best way to handle patients in mental hospitals is to keep them behind locked doors.
 Agree _____ Not sure _____ Disagree _____
6. The patients of mental hospitals should be allowed more privacy.
 Agree _____ Not sure _____ Disagree _____
7. People who are unable to work because of mental illness should receive money for living expenses.
 Agree _____ Not sure _____ Disagree _____
8. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.
 Agree _____ Not sure _____ Disagree _____
9. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.
 Agree _____ Not sure _____ Disagree _____

CLIENT EVALUATION OF SERVICES ¹

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you have received?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>

2. Did you get the kind of service you wanted?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<i>No, definitely not</i>	<i>No, not really</i>	<i>Yes, generally</i>	<i>Yes, definitely</i>

3. To what extent has our program met your needs?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
<i>Almost all of my needs have been met</i>	<i>Most of my needs have been met</i>	<i>Only a few of my needs have been met</i>	<i>None of my needs have been met</i>

4. If a friend were in need of similar help, would you recommend our program to him or her?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>

5. How satisfied are you with the amount of help you have received?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<i>Quite dissatisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Mostly satisfied</i>	<i>Very satisfied</i>

6. Have the services you received helped you to deal more effectively with your problems?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
<i>Yes, they helped a great deal</i>	<i>Yes, they helped somewhat</i>	<i>No, they really didn't help</i>	<i>No, they seemed to make things worse</i>

7. In an overall, general sense, how satisfied are you with the service you have received?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
<i>Very satisfied</i>	<i>Mostly satisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Quite dissatisfied</i>

8. If you were to seek help again, would you come back to our program?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>

PLEASE WRITE YOUR COMMENTS

The thing I like best about the center is: _____

If I would change one thing about the center, it would be: _____

TASK CHECKLIST

Directions: Circle number in appropriate column and add for total.

	<u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>
1. States desire to attend	0	1	2
2. Stays through classes	0	1	2
3. Attentive	0	1	2
4. Answers Questions	0	1	2
5. Keeps Appointments	0	1	2
6. Accepts contacts with staff	0	1	2
7. Adheres to schedule	0	1	2
8. Complies with treatment	0	1	2
9. Is punctual	0	1	2
10. Attends regularly	0	1	2
11. Accepts feedback	0	1	2
12. Works productively	0	1	2
13. Asks questions	0	1	2
14. Makes suggestions	0	1	2
15. Tries new behavior	0	1	2
16. Requests feedback	0	1	2
17. Initiates activities	0	1	2
18. Sets treatment goals	0	1	2
19. Completes tasks	0	1	2
20. Is self-motivated	0	1	2

TOTAL

Name _____

Rater _____

Date _____

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