

FAMILY MANAGEMENT OF SCHIZOPHRENIA IN CHINA

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SUMMARY

The development of family management programs of schizophrenia in China is summarized in this brief review. With regard to future directions, it is proposed that an integrative program of family management should be adopted, in which outreach home-care and family psychoeducation approaches are combined having the flexibility to engage individual families as well as groups of families in the community.

Key words: family management, family intervention, family psychoeducation, home-care program, CCMD-II, Chinese

INTRODUCTION

In recent years, research on family management of schizophrenia has flourished in China. Articles on family management can be divided into three categories: family intervention, family psychoeducation, and home-care program. However, the essence of these programs is quite similar to each other and their operations are also partially overlapping. In a broad sense, all these programs can be named "Family intervention", and belong to the scope of psychosocial interventions. In this brief review, the development of these programs in China will be summarized.

FAMILY INTERVENTION

There are different schools and models of family intervention in western countries. (Lieberman et al, 1984; Falloon, 1985; Goldstein & Strachan, 1986; Hogarty, 1986; Leff, 1990). Most of the programs carried out in China are adopted from the psychoeducational and behavioral schools. The major studies of family intervention for schizophrenia in China are listed in Table 1.

Although there were methodological differences among the above-mentioned studies, all of them were designed with control subjects and used standard diagnostic criteria such as DSM-III-R or CCMD-II. These studies included either individual or group psychoeducation, and were often combined with antipsychotic drug treatment. Furthermore, almost all studies applied the basic concepts of family intervention developed in western countries, though changes were made to address Chinese cultural characteristics. The content of psychoeducation in these studies included general information on mental illness and medication, communication and problem-solving skills, coping strategies for maladaptive behaviours and other skills for coping with daily living. In implementing psychoeducation, researchers put much emphasis on the participation and cooperation of patients' family members. The aim of psychoeducation was to rebuild the confidence of patients and their relatives, and to help them support one another.

The advantages of family intervention programs were clearly demonstrated in these studies. There was marked reduction in relapse rates, an enhancement of patients' quality of life and social functioning, and an improvement in family relationship and social environment.

However, these positive results came from pilot studies with relatively small samples size ($n=20-60$) and thus might not be generalized to the large schizophrenic population of China. Besides, practical problems such as insufficient manpower and financial restraint, and the uncooperative attitude of some family members made it difficult to adopt family intervention programs. As a result, family intervention programs are still not widely used as an adjunctive treatment in community mental health services in China.

FAMILY PSYCHOEDUCATION

Supported by WHO, Zhang & Yang (1993) and his colleagues conducted a random sampling cohort study in five Chinese cities (Shanghai, Hangzhou, Jinan, Shengyang and Suzhou) to explore the feasibility and effectiveness of group psychoeducation for relatives of schizophrenic patients. The experimental group ($n=2076$) received psychoeducation as well as routine community mental health care, while the control group ($n=1016$) received routine services only. Psychoeducation was given by psychiatrists to groups of 20-40 relatives. The program consisted of 10 lectures and 3 sessions of group discussions. During the first five weeks, lectures and group discussions were held weekly. In subsequent months, such activities were held on a monthly basis. From the 7th to the 12th month, they were held once every two months. At the end of the study, researchers found that the annual relapse rate was 20.4% ($n=424$) in the experimental group, and 31.1% ($n=316$) in the control group, the difference being statistically highly significant ($P<0.001$). Total scores on the DAS (an instrument assessing disability and social functioning) were 16.7 ± 11.1 in the experimental group, and 20.6 ± 12.8 in the control ($p<0.001$). Mean total scores of the FIS (Family Burden Interview Schedule) were 11.5 ± 10.4 in the experimental group and 17.7 ± 14.0 in the control group ($p<0.001$). After one year,

Table 1. Family Intervention Studies Conducted in China

<i>Author</i>	<i>Comparison groups</i>	<i>Length of study (yrs)</i>	<i>Educational programs</i>	<i>Sample (N)</i>	<i>Mean age</i>	<i>Duration of illness (yrs)</i>	<i>Relapse rate (%)</i>
Kang M. (1992)	Home visit + medication vs. Medication	2	Treatment period: 2 home visits/ wk Maintenance period: 2 home visits/ mth	exp = 60 cntl = 60	34.6	8.2	exp 11.7 cntl 33.3 P<.01
Wang S. C. (1993)	*Home visit + family meeting + medication vs. Medication	1	Family meeting: 2/mth x 1 mth Home visit: 2/mth x 2 mths 1/mth x 3 mths 1/2 mths x 6 mths	exp = 60 cntl = 60	41.3	16.9	exp 20 cntl 65 P<.05
Xiong W. (1994)	Outpatient individual interview + family meeting + medication vs. outpatient follow-up	1.5	out-patient interview: 1/2wks x 2 mths outpatient interview + family meeting: 1/mth x 16 mths	exp = 34 cntl = 29	31	7.5	exp 43.8 cntl 64.3 P< .05
Zhang M.L. (1994)	Outpatient follow-up + family meeting vs. outpatient follow-up	1.5	Family meeting: 1/3mths x 18 mths	exp = 39 cntl = 39	23.5	2.9	exp 15.4 cntl 53.8 P< .01

* Home visit: home visit to each family, psychoeducation to patients and relatives

Family meeting: Each meeting had 15-20 families for group psychoeducation.

Outpatient individual interview: Individual psychoeducation.

Table 2. Home-care Research

<i>Author</i>	<i>Duration of follow-up</i>	<i>Location</i>	<i>Sample (N)</i>	<i>Stage of illness</i>	<i>Treatment</i>	<i>Effect</i>
Shen Y. C. (1990)	15 yrs	Haidian (rural Beijing)	387	Chronic	Antipsychot. p.o.	Marked improv.: 60% Social recov.: 36.4% Return to work: 69.7%
Yao J. Y. (1990)	12 yrs	Yantai (rural Shanghai)	3385	Chronic mean duration of illness 8 yrs	Antipsychot. p.o.	Marked improv.: 77.5% Ann relapse: 16.2%
Zhang W.H. (1994)	4.7 yrs	Teiling (rural area of Liaoning)	6000	-	Depot. antipsychot.	Recov.: 20-27% Return to work: 75-80%
Chen K (1994)	3 yrs	Jinan (urban area of Shandong)	101	Remitted discharged, chronic; Mean duration of illness: 10.4 yrs	Antipsychot. p.o.	Relapse in 3 yrs: 24% Return to work: 75.2%

more experimental than control subjects showed good compliance to treatment [1692 (81.5%) vs 581 (57.2%) $p < 0.001$]. Relatives in the experimental group had more knowledge about schizophrenia and better coping strategies in dealing with abnormal behavior (Zhang et al, 1994).

In sum, the results of this study suggested that family psychoeducation program could benefit both the mentally ill patients and their caregivers. The effectiveness of psychoeducation for relatives in acquiring a basic understanding of schizophrenia was also confirmed.

HOME-CARE PROGRAM

Over the past three decades, the home-care program has been developed as a major community health care service in China. Because of its outreaching effects, home care program was also introduced in the management of mentally ill patients in many provinces, particularly in some rural areas. However, as this type of service has been mostly conducted at primary care level, there has been little scientific research conducted and insufficient data collected to evaluate its effectiveness, especially in relapse prevention of schizophrenia. Nevertheless, some of the recent studies are briefly summarized in Table 2.

Although the procedures and methods of home-care programs reported by these authors tended to be incomplete and oversimplified, their results did indicate some favorable effects. There was marked clinical improvement with diminished relapse rate. In addition, many patients managed to return to work. Because the home-care program was carried out on primary health care level, the most significant implication for clinical practice appears to be its applicability in community settings.

CONCLUSION

Family management is obviously an effective and promising treatment modality in rehabilitating chronic schizophrenic patients in the community. There are still some problems in developing a model of family management most suitable for the Chinese culture. Furthermore, the widespread application of such family intervention in areas with large patient population remains a major challenge. With regard to future directions, it is proposed that an integrative program of family management should be adopted, in which out-reach home-care and family psychoeducation approaches are combined having the flexibility to engage individual families as well as groups of families in the community. More research is needed in this area of psychosocial rehabilitation to develop the most cost-effective model of family management.

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