MENTAL ILLNESS IN THE PEOPLE'S REPUBLIC:

AN EXPLORATORY STUDY OF CHINESE EXPERIENCE

VERONICA PEARSON

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Department of Social Policy and Social Work
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<u>ABSTRACT</u>

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This thesis is based on the analysis of policy documents, and on extensive field research in China. The first four chapters introduce historical, policy, cultural and legal issues in the development of mental health services in China. Chapters five to nine are concerned with a study of a hospital in Guangzhou (Canton), with a large population of chronic psychiatric patients. A comparison between a sample of these patients with a diagnosis of schizophrenia and patients with a similar diagnosis in two London hospitals, Friern and Claybury, is presented. In chapters ten and eleven, wider questions of hospital and community care in China are discussed.

While the Chinese government's prevention-focussed health policies have been successful in combating endemic and epidemic diseases, this policy framework is not suitable for dealing with chronic and intractable mental illness. Hospital care is prohibitively expensive, and existing facilities do not reflect potential need. One major issue which has not been addressed is how to deliver mental health care to the majority of the population, who live in remote rural areas.

Overall, there were remarkable similarities between the patient sample from Guangzhou and that from Friern and Claybury. The Guangzhou population had spent longer periods in hospital, and had more recorded incidents of violent behaviour. Patient care practices in the Guangzhou Hospital were comparable with those in British psychiatric hospitals sixty or seventy years ago.

Written sources and empirical evidence from other psychiatric hospitals in China are adduced to suggest that the features studied may be typical of much Chinese psychiatric hospital care. Some of these practices may be due to the very low standard of nurse training in psychiatric hospitals and to the limited training of doctors.

There is a well articulated model of community care, but there are marked problems in operationalising it. Ultimately, there seems to be a lack of political and professional will to face the problems presented by serious mental illness in China.

FOR MY FATHER AND IN MEMORY OF MY MOTHER

relaxation. It has been both a comfort and a benefit to be able to share both feelings and academic issues with two such stimulating friends.

Finally, I would like to acknowledge the unfailing support of my supervisor, Professor Kathleen Jones.

To all of them, my sincere thanks.

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GLOSSARY OF TERMS

Since 1949, the official name for China has been the People's Republic of China. However, for ease of reference China, or the PRC, are used throughout this thesis.

Danwei - work unit

Dian lethargy, apathy, depression

Guangxi - literally 'connections' meaning the network of relationships which people build up, from whom favours, goods and services can be asked and demanded in return. Without 'guangxi' in China, it is almost impossible to get anything, from a railway ticket to a seat in a restaurant.

Hou kou - a residence permit

Jen - benevolence or human heartedness

Kai - a form of honorific family title given to someone with whom one has a close relationship. e.g. **kai ma** means a **kai** mother.

Kuang - acute, psychotic excitement.

Li - the rules of correct behaviour or propriety.

Mui tsai - a system of bonded labour of pre-pubescent girls who were sold into a household and might be taken as a junior wife or concubine by a man of the household, once they reached puberty.

Neibu - literally 'internal', normally referring to information or documents to which non-Chinese people are not supposed to have access.

Qi - vital energy

Qi gong - a form of exercise that combines spiritual and mystical elements

Qing lo - a term from acupuncture referring to the major energy meridians believed to traverse the body.

Saang - Mr.

Siu je - Miss

Tai - Mrs.

Wu lun - the Five Cardinal Relationships: emperor-subject, father
        son, older brother - younger brother, husband and
        wife, friends.

Yin-Yang - the two opposing, yet complementary, principles of the
        universe, from which everything else flows.

Money

The Chinese unit of money is the yuan. It is not helpful to give
English equivalents when sums of money are mentioned in the text,
because standards of living are so different as to render such
comparisons meaningless. Standards of living are very variable
across China. The average monthly income in the richer coastal
provinces is much higher than in the interior areas. Urban
residents have a greater disposable income than people living in
rural areas. A rough guide would be that in Guangzhou an average
individual income would be about 120 - 150 yuan a month. The
disposable income for an ordinary peasant family would be about
1,000 yuan per year. It is in this light that hospital fees of 200
or 500 yuan a month must be viewed.

Transliteration of Chinese Characters

Chinese words have been rendered into English using Pinyin rather
than the older Wade Giles system, which may be more familiar to
English readers. Thus Ching is rendered as Qin, Mao Tse-tung as
Mao Zedong, and Kwangchou as Guangzhou. Exceptions are made in the
cases of current authors who prefer to use the Wade Giles system
for their names, or where Wade Giles is used in the original
sources.

SCHEDULE OF VISITS TO CHINESE PSYCHIATRIC HOSPITALS

1983 - Shanghai Number One Hospital; one morning

1985 - Xiamen Psychiatric Hospital; one morning

1987 - The Guangzhou Hospital; one day

1988 - The Guangzhou Hospital; April   3 days
                               September 2 weeks
                               October   2 weeks

   - Lam Shek Hospital, Foshan, Guangdong: one day

   - Fong Tsuen Hospital, Guangzhou; one day

   - Anding Hospital, Beijing; one morning

1989 - Anding Hospital, Beijing; ten days

   - Heilonguang Hospital, Beijing suburbs; one afternoon

1990 - Shashi Psychiatric Hospital, Hubei; March   2 weeks
                                           July   2 weeks

   - Shashi Psychiatric Hospital, sub-unit for chronic patients
                                           one morning
   - Wuhan University Affiliated Psychiatric Unit   one day

   - Wuhan Civil Affairs Bureau District Psychiatric Hospital
                                           one afternoon

1991 - Shashi Psychiatric Hospital, Hubei; May   2 weeks

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HISTORICAL CHRONOLOGY

THE CHINESE DYNASTIES

Xia	B.C.	2205-1766
Shang		1766-1122
Zhou		1122-770
Spring and Autumn Annals		770-476
Warring States		476-221
Qin		221-206
Han		206 - A.D. 220
Three Kingdoms	A.D.	220-265
Zin		265-420
Southern and Northern		420-589
Sui		589-618
Tang		618-907
Five Dynasties and Ten Kingdoms		907 960
Song		960-1280
Yuan		1280-1368
Ming		1368-1644
Qing		1644-1911
The Republic of China		1912-1948
The People's Republic of China		1949

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INTRODUCTION

'Parents must be very sad when they face their crazy sons and daughters and find that they are helpless. Fortunately, the great, glorious and correct Chinese Communist Party, the great People's Republic of China, they loved and cared for the crazy sons and daughters down to the very last detail. They sent the crazy sons and daughters to the mental hospital for treatment'. (A patient in a Chinese psychiatric hospital, Appendix 1, Essay 29)

To suffer from mental illness in any society is a tragedy, usually compounded by stigma and a sense of shame for both the patients and their families. In China, as the quotation at the top of the page suggests, the position is no different from that in other countries. In some ways it is worse, because of the government's unwillingness to be open about the situation of the mentally ill. (Kleinman, 1986) Mental illness is not only shameful for the family but also for the whole country. There is even a fear about 'contagion'. Foreign visitors must fill in a health declaration form on entering China which requires them to reveal whether they are suffering from psychosis, leprosy or AIDS - in that order.

This official attitude of secrecy towards mental illness means that there is little reliable information available about what goes on in Chinese psychiatric hospitals, despite the numerous reports based on brief visits to Chinese psychiatric facilities by Western observers. Some of these are politically influenced. Others may lack sufficient background knowledge of the Chinese situation, and are able to do little more than report what they have seen and been told.

My first visit to a psychiatric hospital was in 1983 - the Shanghai Number One. At first, it was a delight to be able to

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visit any psychiatric facility in China on any terms. But gradually, these fleeting glimpses became profoundly unsatisfying. Surface impressions and stock answers only whetted an appetite to discover what really went on behind the walls - and outside them.

Clearly, there was room for a detailed empirical study that would give some sense of the realities of psychiatric care in China, although it would necessarily be geographically limited. At the time of my first visit, there seemed little hope of being able to do research because of the very restrictive attitude of the Chinese authorities towards contacts with outsiders; but as the 1980s progressed, the effects of China's 'open door' policy towards the outside world became apparent. There was a positive desire to learn more about Western ideas, not just in the area of business and investment but in science, technology and medicine. Opportunities for research in the field of mental illness became available, and I eagerly accepted them.

Anyone who wishes to study aspects of life in China quickly becomes aware of the vastness and diversity of the country. Officially, China has 1.16 billion people, although the real figure may be greater. The population constitutes about one quarter of the human race. Although to an outsider the Chinese people appear homogeneous, there are in fact many divisions. There are differences between the rural and urban populations, between coastal and interior provinces, between the minority peoples and the dominant Han Chinese. Even among the latter, there are many dialect groups and a perception of separateness between people from the various parts of China. The sheer size of the country

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means that any empirical work must take account of this variability. Nevertheless, a strong centralized administration imposes a degree of uniformity. The question is whether or not this is more apparent than real.

My commitment to the mentally ill was formed during the process of working in psychiatric settings, first in Broadmoor Hospital, then as an Adviser in Mental Health in Hampshire Social Services Department and finally as a Principal Psychiatric Social Worker in a teaching hospital in Southampton. Thus my practice experience spans 'grass roots' social work, policy formulation, hospital and personnel management and service delivery. It seemed very natural to transfer these interests to Hong Kong and thence to China on taking up an appointment as Lecturer in Social Work in 1981.

It is difficult, if not impossible, for research workers in the social policy field to avoid being influenced by the attitudes which they bring with them to their research. These attitudes influence both their choice of topic and the way they select and interpret data. What is necessary is for the reader to know what these attitudes are and how they were formed.

This thesis has been written from the standpoint that fate has dealt a cruel blow to those, both patients and their families, who suffer from major mental illness, particularly schizophrenia. It is to our shame that with the potential knowledge and resources at our disposal, what happens to them often exacerbates rather than alleviates their misery.

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Much of what follows is concerned with problems associated with schizophrenia. This is partly due to personal experience of people with this .chronic and disabling condition, but there are other reasons: first, the issue of the reliability and frequency of the diagnosis of depression and manic depression in China is very controversial, (Kleinman, 1986) while schizophrenia is generally accepted to occur in all societies. (Sartorius, 1986; Jablensky, 1988) It is easier to identify than other forms of mental illness and comparisons with the West are more reliable.

Second, it is seen by the Chinese themselves as the major problem facing psychiatrists and psychiatric services. S.M. Yan et al. (1980) and S.M. Yan and D.Z.Xiang (1984) confirm that over 80 per cent of psychiatric patients are given this diagnosis. Kleinman and Lin (1981, p. 139) point out that:

> 'With their practical concern for providing adequate care to the severely ill and minimizing the impact of mental illness on community productivity and social order, the Chinese psychiatrists have undoubtedly been more interested in schizophrenia than in other kinds of psychiatric affliction'.

Third, more than any other psychiatric illness, schizophrenia has profound consequences for sufferers and their families. The chronic, debilitating nature of the disease, its potential to disrupt social relationships and the limitations of chemotherapy and other medical treatments in mediating these features all put it squarely within the area of concern of social policy and social work.

Much of the approach in this study is implicitly or explicitly comparative. Comparison helps to illuminate by highlighting

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differences between two or more systems. It is frequently the dissimilarities rather than the similarities that are most interesting. (Higgins, 1981) Fielding and Fielding (1986, p. 16) put it more forcefully: 'the method is always comparative; there can be no explanations without comparison'.

In any comparative study, there is a need to find an analytical framework which does justice to individuality without forcing an alien construction or value judgment on a particular system; or treating each system as individualistic to the point of eccentricity or exoticism. This is even more important when the matters under consideration involve very different cultures. Anthropologists make a distinction between etic analysis (using an imposed frame of reference) and emic analysis (working within the conceptual framework of those studied). (Harris, 1979; 1987) Both modes of understanding are vital, if the unique qualities of the Chinese system are to be appreciated and yet placed in a wider context that permits more scientific analysis. Thus concepts from the West, for instance frameworks for social policy and organisational analysis, have been used to explicate the Chinese experience. It is unfortunate that no emic accounts of any depth have been written by Chinese psychiatrists. Even though the persecutions to which intellectuals were subjected during the Cultural Revolution have come to an end, scholars and practitioners are still very wary of committing to paper any views which might be considered controversial by those in power. I have therefore tried to construct both an emic and an etic account of mental illness in China, since the two should be complementary.

As the quotation at the beginning of the introduction shows, one of the unique features in the Chinese system is the overt involvement of ideology and politics in the thinking of ordinary people. As Higgins (1981) says, one of the requirements in comparative social policy analysis is to be able to ask good questions. To what extent do ideology, history and the economy influence the delivery of services to the mentally ill? Is there a wider 'truth' about societal reactions to mental illness that does not depend on ideology and may be found across cultures? Only a comparative framework will help to answer questions of this kind.

A full comparison of policies and services for the mentally ill in China and the United Kingdom has not been attempted. There is a considerable body of Western literature on the subjects of study; and data about China are much more difficult to obtain, and therefore deserve greater emphasis. Much of the material about China will be fresh to the reader. Consequently, it has been necessary to provide a good deal of background information to aid understanding. Many of the things which are thought in the West to be 'known' about China turn out, on closer inspection, to be misconceptions.

Part One deals with policy and practice relating to mental illness. It starts with an historical perspective, outlining the development of modern psychiatric services in China since the opening of the first psychiatric hospital in 1898, through the post-Liberation period after 1949, and the Cultural Revolution, to the beginning of the 1980s. Many of the ideas about the treatment

of the mentally ill were incorporated into China from outside; either from America and Europe before 1949 or from Russia after it. For the Chinese, there is a very uncomfortable tension between wanting techniques which are effective, and at the same time resisting the hegemony of Western psychiatric theories, as they try to develop 'psychiatry with Chinese characteristics'. Policy continuities and developments in both the health and welfare fields as they affect the provision of services for the mentally ill are discussed. A comparative framework is delineated in which Chinese and Western solutions to the common problems faced in the provision of welfare are examined.

The issue of culture and mental health cannot be ignored because it affects what is perceived as illness, explanations for it, and what treatments are accepted as efficacious. Indeed, culture forms the context in which illness is experienced and lends individuality to the universal phenomena of disease. Culture also frames the legal context of mental illness. There are no legal protections from involuntary admission for non-offender psychiatric patients. In China, the balance of concern about protection leans heavily towards society rather than the individual patient. This is entirely consistent with the overall collectivist orientation of Chinese society. On its own terms, Chinese law treats mentally ill offenders 'leniently', with a hospital disposal accepted as a more humane outcome than imprisonment.

Part Two is largely concerned with an empirical study of one psychiatric hospital in Guangzhou, mainly caring for patients with

chronic schizophrenia. Efforts have been made to examine the workings of the hospital from both the point of view of the patients and that of the staff. In order to evaluate the data concerning patients in the Guangzhou Hospital, comparative data was sought from a recent major empirical study of two psychiatric hospitals in London.

In Part Three the literature and empirical findings are brought together in a consideration of hospital and community care in China. While only one hospital was studied in detail, there is evidence that the hospital regime is not idiosyncratic. It is strongly affected by national policy directives, by the nature of the issue of power and authority in Chinese society and by national failings in training psychiatric doctors and nurses. Thus, an analysis of the Guangzhou Hospital has been used as a paradigm of Chinese psychiatric hospitals to attempt to throw light on the hitherto <u>neibu</u> (not for outside eyes) nature of those enclosed worlds.

The Chinese are aware of the advantages of providing care for psychiatric patients outside institutions, not least because it is held to be cheaper than providing beds for the millions of people suffering from mental illness in China. Although it probably would be fair to say that the Chinese would cite a lack of hospital beds as the major problem they face, there is, nonetheless, a clearly articulated model of community care. Unfortunately, as in most other countries, the gap between the rhetoric and reality of community care is enormous, with the heaviest burden falling on

families. Overall, despite cultural disparities, the problems faced by the mentally ill, their families, and the authorities in seeking appropriate caring mechanisms, are remarkably similar, East or West.

A common practice in thesis presentation is to start by generating hypotheses and to proceed to test them. After careful deliberation, I decided that this would be inappropriate to my subject, since it would have involved a purely etic analysis, imposing a Westernized framework. This could have led to the exclusion of key issues and important findings. This is not to say that the investigation was approached with a blank mind, or with no expectations at all, but it was necessary to recognise that the territory was largely uncharted and the whole exercise was a journey into the unknown.

The reader is invited to join in a voyage of exploration that includes an examination of the influence of history, culture, politics, economics and law on the experience of mental illness in China.

PART ONE:
POLICY & PRACTICE

CHAPTER ONE

THE DEVELOPMENT OF PSYCHIATRIC SERVICES IN THE TWENTIETH CENTURY

There was no tradition of institutional care for the mentally ill in old China. Nor did the Chinese pharmacopoeia have medicines that were effective in the symptomatic treatment of psychotic disorders, although there were, and are, preparations that have a sedative effect. It was not until the end of the nineteenth century that the first psychiatric asylum was opened by an American missionary.

Within the ancient medical literature, Chinese physicians recognised and described the aetiology and symptoms of mental disorder. (Xia Zhengyi and Zhang M.Y., 1981; Young Derson and Chang Mingyuan, 1983) However, the holistic form of Chinese medicine did not encourage the development of clinical specialities. Psychiatry in particular, based as it is on a dualism between mind and body, did not find fertile soil in traditional China. Thus the introduction of asylums for the insane and the various forms of treatment that were espoused from that time may be seen as alien forms grafted onto Chinese society rather than an indigenous product. The initial forays into formalised psychiatric care have to be seen through the prism of Western participants as there is very little other information available. From 1949 onwards, records also include material written by Chinese practitioners and this is drawn on in the latter part of this chapter.

'A party consisting of the doctor, a man carrying on his back an insane patient followed by the wife of the doctor, stood at the door of one of these buildings. A key was inserted in the door. It opened, and for the first time in the history of China a mind diseased patient was to receive special care'. (Selden, 1937, p 708)

The doctor was John Kerr and the year 1898. The buildings continue to be used for their original purpose and the hospital is now known as Fong Tsuen. Dr.Kerr was a missionary who for many years had been in charge of the Canton Municipal Hospital which was funded by the Board of Missions of the American Presbyterian Church. It was the first Western run hospital in China, established in 1835 by Dr. Peter Parker, another Presbyterian missionary, famous for his skill as a surgeon. (Tucker, 1983; Spence, 1980)

Although not a psychiatrist, Dr.Kerr had long recognised a need for a special institution to care for the mentally ill in China. He had lived in China for over 40 years, spoke the language with complete fluency and was very familiar with the problems people faced in their daily lives. Families suffered under the burden of caring for mentally ill family members and for some it was too much. Kerr observed that many of the street dwellers were psychiatrically disturbed and disowned by their families. Some families brought their mentally ill family members to the Canton Hospital where Kerr was unable to offer anything as the facilities were unsuitable.

His missionary board did not support him on the grounds that he already had heavy responsibilities. Indeed, not everyone agreed

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with him that such an institution was necessary. Dr. Wenyon, the senior British medical officer in Canton wrote to the <u>British Journal of Medicine</u> in 1891 saying that:

> 'Insanity is not nearly so prevalent in China as in Europe and America.....Owing to the simplicity of life here and the clan system of society, many persons thus afflicted are able to do something for their living and if not, they freely and safely go in and out among their relatives and are, with few exceptions, kindly treated. Asylums for the insane in China should be provided by themselves'. (quoted in John Kao, 1979, p. 24)

Kleinman (1986) has noted a similar sentiment in the report of Dr. John Dudgeon in 1871 on health problems in Beijing for the Imperial Maritime Customs annual medical report. Dudgeon claimed that 'nerves' and mental illness were not problems among the Chinese who, in the absence of the pressures of Western life had 'no worry' (sic). Kleinman attributes this to the racialist and paternalistic attitudes prevalent at the time which regarded the thought processes of indigenous populations as primitive, free of the worry and psychic discomfort to which more sensitive Westerners were prone.

Wenyon further opposed the idea of an asylum on the grounds that such medical work was not an effective means of propagating evangelism and warned of the potential dangers to the medical missionary community in general which might stem from potential misunderstandings on the part of the Chinese public concerning the activities at the asylum, which he claimed were the most exposed to 'obloquy'. He concluded that:

> 'It is especially to be hoped in the interests of the safety of European and American residents in China, that no foreign missionary society will be deluded into connecting itself with such an institution as that proposed'. (quoted in John Kao, 1979,

p. 24)

In a second letter he went on to say:

>   'A missionary lunatic asylum is more likely to be a
> hindrance than a help to the great results which it is our first
> business as missionaries to secure......It was necessary to beware
> of the false sentiment which would divert us from our true mission
> and by increasing popular prejudice against us would sacrifice the
> spiritual well-being of thousands for the physical comfort of a
> few'. (quoted in John Kao, 1979, p. 25)

Why these two doctors had such a different assessment of the
situation is not entirely clear. Wenyon, as the senior British
medical officer in Canton, may not have had as much contact as
Kerr with local people, although he was connected with a hospital
in Foshan, a city in Guangdong Province. Certainly he is most
unlikely to have lived in Canton for as long as Kerr. Families had
little choice but to look after disturbed family   members.
Depending on circumstances such as position in the family,
(husband or wife, son, daughter, or daughter-in-law), severity of
the illness, financial resources, this would have been done with
varying degrees of kindness.

It must be remembered that a common explanation for illness would
have relied on supernatural explanations. Mental illness was
frequently interpreted as a punishment for the faults of the
family ancestors. Such explanations are extant in modern China.
(Li and Phillips, 1990) Thus the family would have been aware of
the stigma that would have attached to mental illness. Wenyon may
have been more oriented to the difficulties of the missionary
effort being 'tainted' by the association with such a marginal and
despised category as the mentally ill, particularly since the
benefits (or 'cures') would by no means be as clear as they had

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been for surgery and a lesser extent medicine.

Kerr, on the other hand, seems to have been genuinely motivated by compassion for patients and families whom no one else would assist. Wenyon's view that 'asylums for the insane should be provided by the Chinese themselves' strikes a sympathetic chord today in the light of reservations about the medical missionary enterprise. To Kerr, occupying a different space, the answer was clear:

> 'So should hospitals and all other benevolent institutions, but how long would Dr. Wenyon have to wait for the Chinese to establish a hospital like his own in Foshan? Left to themselves when will they have surgeons and physicians qualified to manage such a hospital?' (quoted in John Kao, 1979, p. 26)

A Chinese psychiatrist who practised in China during the first half of the twentieth century concurs with Kerr's view about the neglect of mentally ill people:

> 'Psychiatry is a new line of medicine introduced only recently into China. It was not so very long ago that superstitious ideas and sentiment of aversion were still attached to psychiatry, while the insane were either kept in cellars restricted by iron bars without adequate medical attendance or just left at home in the care of their families'. (K. C. Wong, 1950, p. 44)

Whatever his reasons, Kerr was sufficiently convinced of the importance of his cause to use virtually his entire life savings to buy four acres of ground on which to build a psychiatric hospital. With the aid of an anonymous donation from a Chinese citizen, he was was able to build two structures. Thus 25 years after he first requested that such a service be provided, and well past his seventieth year, his hospital finally opened. Soon after its inauguration, John Kerr died, and his work was continued by

another medical missionary, Charles Selden.

Care By The Family

Given modern concern about the undesirable effects of institutionalization, and the belief that patients are better cared for outside a hospital, was Dr. Wenyon correct, were the Chinese better off without psychiatric hospitals? The quote that began this section is from a letter that Mrs.Kerr wrote and the next two lines are:

> 'In his home this man had been chained for three years to a stone in such a way that he could not take a single step and had lost his power of walking. The second patient, a woman, was found sitting on the floor of a hut with a chain around her neck, the end of which was fastened to a staple in the floor behind her'. (Selden, 1937, p. 708)

There are many descriptions written by missionary doctors of ill treatment by their families of mental patients. It must be remembered that Ching laws made the family responsible for the actions of disturbed people and families were supposed to register their mentally ill with the local magistrate who was empowered to issue chains for their restraint. (Ng, 1980) Kerr's view was that:

> 'A short method of getting rid of the hopelessly incurable has often been adopted in a country where the father holds the power of life and death over his family and death has been hastened among the poorer classes by the want of care and attention'. (Kerr, 1898, p 177.)

Ingram, from the Peking Union Medical College (funded by the China Medical Board, which was in turn backed by the Rockefeller Foundation), describes a situation where a young man broke down during his studies and was taken to a general hospital where it was thought the rest might speed his recovery. Instead he became worse and his father was asked to remove him:

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'The father felt it necessary to protect himself by drowning his son in the river, which was not far distant from his home'. (Ingram, 1918, p. 153)

The literature abounds with reports from missionary doctors of the poor treatment afforded to the mentally disturbed kept at home. Dr. Andrew Woods, a neuro-psychiatrist, was the first Westerner to teach psychiatry in China. He arrived in Canton in 1910 and transferred to the Peking Union Medical College in 1919, where he established the department of neurology and psychiatry. While working in the out-patient department of the Peking Medical College he was called to see a:

'... well-to-do merchant living in an iron cage built into the corner of his room. He had lived in it for six years and even during the lucid periods between his manic depressive attacks, his family feared to release him'. (Woods, 1929, p. 569)

Selden, (Kerr's successor in Canton, a missionary doctor but not trained in psychiatry) talks of patients being admitted with the marks of poundings and whippings they had received still very visible. Two came in with badly burned thumbs, from having lighted kerosene soaked wicks put under their nails. This procedure was supposed to drive out insanity or at least determine who was genuinely mad. (Selden, 1905, p. 4-5) A doctor who worked in Hankow, speaks of several reports of people being:

'... built into a small cell house, with no door and only a small window to admit food.....A mentally defective person is considered by his family as being lost to them and as long as he lives he is a burden to all concerned. The treatment is not always cruel but is rather that of neglect'. (McCartney, 1926, p. 621)

Sometimes traditional doctors would prescribe very powerful emetics in order to keep the mentally ill person debilitated and weak and therefore more easily handled by the family. (Selden,

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1909, p. 229; McCartney, 1926, p. 622) Selden also talks about

mentally disturbed people being mocked and laughed at on the

streets:

> 'There is in the Refuge now a woman who had been followed by
> street rowdies and stoned from one end of the street to the other,
> when, happily, she was brought to the Refuge by the district
> watchman'. (Selden, 1905, p. 5)

Others tell of police and sometimes relatives deliberately

breaking the arms and/or legs of mentally ill people in order to

keep them in one place. Thus:

> 'The case was that of a man who was violently insane. His
> mother hired ruffians to break a leg and an arm of her son, in
> order that he might not be able to terrorize the neighbourhood'.
> (Ingram, 1918, p.153)

The re-telling of these incidents is perhaps not wholly

disinterested on the part of the authors, who doubtless had their

own axes to grind. But even if only partially true, they still

speak of the misery and despair that was the lot of the mentally

ill and their families. This is of course something that they

would share with Western patients similarly afflicted.

Selden, particularly, also mentions families who are caring and

affectionate towards a mentally disturbed member but the

overwhelming impression from reading these missionary reports is

that the position is far from being the one claimed by Wenyon.

Hospital Care

International experience demonstrates that while care within the

family may not be very good, care within the institution is

frequently worse. For the pre-1949 period in China there is only

one hospital for which there is reliable information and that is the Kerr Refuge. Selden recommended kindness:

> 'The regular quiet life of the asylum; the absence of over-restraint; looking after the general well-being of the patient; occupation when possible for hands and mind; more than upon any drugs. As soon as we can manage it, we mean to make more use of the daily bath as a curative measure'. (Selden, 1905, p. 8)

Three principles were set forth at the Kerr Refuge as encouraging the right attitudes in the attendants;

1 - These people are ill. When they speak and act unreasonably it is not their fault.

2 - This is a hospital, not a prison.

3 - Although insane, these patients are yet men. (Selden, 1909, p. 222) Such guidelines would not be out of place in today's psychiatric hospitals.

Selden was a doctor and he clearly had no doubt that his patients were ill. At the same time, perhaps because of his religious convictions, (for he gives no evidence in his writings that he is aware of the principles of or literature on, moral management), he emphasises their shared humanity. Using this as a basis he points out repeatedly that if patients are treated with kindness and common politeness and provided with a structured existence, they are very likely to respond positively. Most patients were brought to the hospital in chains and fetters which were immediately removed and, except in unusual circumstances, the patients were given the freedom of the hospital grounds. (Selden, 1909) Entertainment and useful occupation were also recommended.

While there is no reason to doubt the sincerity of Selden's views, it would be wrong to assume that he found no necessity for

physical restraint. His articles are full of details concerning ways in which patients may be restrained with minimum discomfort. He gives the design of a sleeping cage covered in strong wire netting and features various types of restraining chair, as well as recommending the use of a strait-jacket. Indeed he seems to prefer physical restraint to chemical, and advises that while drugs must be used, it should be as infrequently as possible. The drugs he mentions include hyoscine, paraldehyde, and Ellenmeyer bromide. His discussion mirrors modern day concerns frequently expressed by psychiatric staff about the relative merits of physical and chemical 'straitjackets'. (Selden, 1909, p. 381) As we have noted, Selden had no psychiatric training, nor had he ever worked in a state or private psychiatric asylum in the United States before coming to China. Nonetheless, his attitudes toward restraint seem to reflect those of his countrymen who did specialise in psychiatry, in that he assumed that it was an integral part of treatment and did not imply lack of care or cruelty. (Tomes, 1988) This was to be contrasted with the view prevalent amongst British psychiatrists that moral management was to be emphasised and physical restraint to be avoided wherever possible. Selden's ideas about managing patients, whether by chance or design, seem to have combined aspects of both.

Patients, whenever willing and suitable, were put to work helping with maintenance tasks around the hospital, carrying water, gardening, sewing and so on for which they were paid a token amount. The regime at the Refuge does not seem dissimilar from what would have been common practice in psychiatric hospitals in

America or England at the same time. If Selden sometimes sounds patronising and superior, we should not judge him with the benefit of twentieth century hindsight.

It is clear from the response to the hospital by the citizens and officials of Canton that the hospital met a need. For the first six years of its life it operated as a private institution. However, at the request of the authorities, it gradually began to accept patients brought by the police whose fees were paid from the public purse. From a 30-bedded facility it expanded to over 700 beds by 1933. (Lamson, 1934) The different approach to treatment and most particularly the evangelism that went hand in hand with medical treatment did not appear to discourage local people from using the Refuge.

Evangelism and Medicine

Missionary doctors were always under some pressure to demonstrate to their boards in their home lands that the primary purpose of their work, evangelism, did not take secondary place to medicine. (Tucker, 1983) On the other hand, the patients and the community were much more attracted by the tangible benefits of alien medicine than they were by an alien creed. For Selden it was important to demonstrate that:

'The hospital gives more opportunity for evangelistic work than would be apparent at first thought....The best place to present the Gospel to our patients is in the wards and the best way is by personal dealing at the patients bedside...where the opportunity is unique....clinical evangelism, or buttonhole theology'. (quoted in John Kao, 1979, p. 33)

Selden's pragmatism is further demonstrated by his comment that:

> 'Many, it may be, get nothing from the service spiritually but it provides employment and entertainment for them in that length of time and who knows in whose heart there may not be a taking in of truth sufficient for salvation?' (John Kao, 1979, p. 33)

The tension between the medical and evangelical remained unresolved well into the twentieth century. A Report of the Appraisal Commission of the Laymen's Foreign Mission Enquiry On The Work of Medical Missions In the Far East stated in 1932:

> 'The use of medical or other professional service as a direct means of making converts, or public services in wards and dispensaries from which patients cannot escape is subtly co-ercive and improper'. (quoted in Hillier and Jewell, 1983, p. 19)

A riposte came from the Chinese Medical Journal's Medical Mission Council:

> 'The Council desires to express its conviction that the presentation of the full Gospel of the love of God as revealed in Jesus Christ to every patient in a Mission Hospital is part of the work of missionary physicians'. (quoted in Hillier and Jewell, 1983, p. 19)

Exposure to evangelism was one of the prices patients paid for access to treatment unavailable elsewhere, both in terms of treatment and as a way of disposing of problems for which there appeared no other ready answer.

Psychiatric Hospitals

Kerr's Refuge may have justified its existence in Canton but it did not lead to the establishment of similar institutions elsewhere in China. From an early stage there were pleas for the establishment of a hospital similar to the Refuge and run along modern lines in north China. (Editorial, The China Medical Journal, 1909: Ingram, 1918) Selden claimed that it was difficult

for him to accept patients from the north. Apart from demand from the Canton area he said that:

> 'We cannot understand their language when they would tell us their wishes, nor can we make them understand us, unless we can find an interpreter. They are surely sometimes lonely and this is not favourable to mental improvement. These people are larger also than our Cantonese and the latter [attendants] not being able to use either language to persuade, nor having sufficient physical strength, do not like these patients from the north'. (Selden, 1910, p. 326.)

Lamson reports that other than Kerr's Refuge, there were no other separate psychiatric institutions in China although there were psychiatric wards attached to general hospitals in Suzhou, Beijing and Shanghai. The Ministry of Justice announced its intention in 1930 to erect special reformatories and 'lunatic asylums' in various large cities. (Lamson, 1934) Lamson may not have been entirely correct in this assertion. Woods reports that:

> 'In Peking there is a place which is sometimes called a hospital for the insane but it is nothing more than a prison where 'psychopaths' are confined and sometimes put in chains. This so called hospital is in charge of a Chinese doctor who received his training in Japan. Also in Canton there is a municipal insane asylum in which two or three hundred patients are herded together. Christian missions are doing little more for these unfortunates. There is a small Roman Catholic hospital in Shanghai for twenty patients and two or three hospitals of Protestant missions set aside a ward for mental cases. Soochow boasts of a small 'insane asylum' outside the city under the charge of the Presbyterian mission but this institution has been rather unfavourably reported on because of its lack of scientific care. The Peking Union Medical College does not admit of any separate accommodation for mental cases, although it reports a goodly number of psychopathic [psychiatric] cases treated....the Hankow International Hospital has one room for mental cases'. (Woods, 1929, p. 570)

The hospital that Woods mentions in Beijing may well have been the one currently known as Anding, which opened in 1917 as a 'police' hospital. By the time of the Liberation (in 1949), T.Y.Lin and Eisenberg (1985) speak of five psychiatric hospitals and a small

core of psychiatrists in Beijing, Shanghai, Nanjing, Guangzhou, Chengdu, Changsha and Harbin. All of these are places that had large foreign populations or significant foreign influence. Xia Zhenyi and M.Y.Zhang (1981) reports that pre-1949 there were psychiatric hospitals in Guangzhou, Chengdu, Beijing, Shenyang, Suzhou, Dalian, Shanghai, Siping and Nanjing, a lengthier and slightly different list. In truth, it is probably impossible to know the precise extent of services for the mentally ill at that time. What is clear is that they were pitifully inadequate.

The Epidemiology of Mental Illness

As would probably be the case amongst modern practitioners, the missionary doctors tended to understand the causes of mental illness as a combination of factors including heredity and the social and physical environment. Many of them, based on the experience of their own practice with Chinese patients, came to be aware of the trauma suffered through some of the social customs.

Much mention is made of the practice of arranged marriages, the despotic and cruel behaviour of mothers-in-law, the pressure to produce a male heir, the mui tsai system of slavery for young girls, and the strains in a household caused by concubinage. (Selden, 1913; Ross, 1920; Lamson, 1934.) It must be born in mind that they may have been influenced by a sense of their own culture's superiority. Furthermore, they were seeing the casualties of the system, which may have influenced their view. But vindication for their opinions may be found in the fact that when the Communist Party came to power in 1949 they acted

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immediately to outlaw these 'feudal practices'.

In addition to that are the general social and economic circumstances of a country plagued by disease, poverty, famine, warlordism, civil unrest, occupation and finally civil war. Syphilis was rife so cases of paresis, or general paralysis of the insane were common and of course, incurable at that time. Even the strongest constitutions can be understood to have cracked under such an accumulated burden of adverse circumstances.

Following a survey questionnaire covering all China, McCartney (1926) came to the conclusion that the incidence of mental disturbance was also related to population density. It is hard to say how accurate his results were but it is the only information available. He found that the highest of mental illness was in Jilin, Shandong, Zhejiang, Fujian and Guangdong with Hubei, Anhui, Jiangsu and Hunan following closely behind. All those provinces had a population of over 250 persons per square mile, while Gansu, Yunnan and Guangxi had less than 100 per square mile and also had the lowest rate of psychoses in China. It is interesting that this finding is supported by the World Health Organisation studies on the differential incidence of schizophrenia in rural and urban areas. (Sartorius et al. 1986)

'It appears that psychopathology increases in proportion as the stresses incident in the struggle for existence become mental stresses, such as is found in the big commercial cities as Canton, Shanghai, Peking and Hankow'. (McCartney, 1926, p. 625)

Selden states unequivocally that 'insanity is inherited in its tendency'. (Selden, 1905, p. 14) Hoffman, his junior at the Refuge, supports this view claiming that:

'As to the causes of dementia praecox in South China, we find that the hereditary tendency is by all odds the greatest factor and this is especially true in the hebephrenic form'. (Hoffman, 1913, p. 372.)

He goes on to say that, while it is possible to extract information about the father's side of the family from the patient or his relatives, it is difficult to find out anything about the mother's side of the family, clearly a reflection of Chinese social customs. Selden says that in the case of women often not much can be known as many of them have been bought as children, sometimes changing hands several times, and no longer remember anything about their family of origin. Other families are simply reluctant to admit to a history of mental illness. McCartney expresses these doctors' general views most succinctly when he writes that the patient 'is the product of heredity and the victim of environment'. (McCartney, 1926, p. 626)

It cannot be claimed that $+$ $\mu \cap e$ of different mental disturbances were reliably established for this period. There a e no definitive epidemiological data for mental illness in China during this period. What follows is an indication of the attempts individuals made to provide a more systemacic picture of their work and to paint a broader view of mental illness in China.

It was the impression of the missionary psychiatrists working in China that the types and incidence of mental illness encountered among the Chinese population seem to have been quite comparable to those observed in the West. Hoffman thought that the types of psychoses seen in China circa 1912 were in accordance with Kraepelinian descriptions and similar in symptomatology. (Hoffman,

1913)

McCartney, following his survey of   mental diseases

in China, reported the following figures. (John Kao, 1979, p. 37)

Table 1:1: Incidence of Psychiatric Illness in China

Percentage	Disease
27.2%	manic-depressive psychoses
22.4%	organic brain syndrome psychoses
12.1%	general paralysis of the insane
11.1%	schizophrenia or dementia praecox (as opposed to the West where this disorder was said to be most frequent)
7.5%	paranoiac states
5.8%	pre-senile, senile and arteriosclerotic psychoses
3.4%	idiocy and imbecility
2.2%	toxic psychoses including addiction syndromes to alcohol and opium
1.9%	infections and exhaustive psychoses
0.4%	symptomatic psychoses including patients suffering from pellagra, multiple sclerosis, chorea, uremia, etc.

This table indicates that the occurrence of manic-depression is

greater than that of dementia praecox, at least in patients

receiving treatment in hospital. Why this should be so is

something of a mystery. Possibly, it may have been thought that

patients suffering in this way were more likely to cause damage to

themselves or others, or be much harder to contain at home. (The

figures do not say whether a depressed or manic manifestation was

more common.) However, it is in complete contrast to the situation

currently found in China where 70-80 per cent of psychiatric

hospital patients are diagnosed as suffering from schizophrenia.

(Phillips, 1990)

Writing in 1937 Selden says that in the first 29 years of its

existence the Refuge:

Table 1: 2: Admissions and Discharges at Kerr's Refuge 1898-1927

	Men	Women	Total
Admitted	4428	2171	6599
Discharged	4100	1813	5913

(Selden, 1937, p. 713)

One can see that men outnumber women by about two to one. Selden made no comment and offered no explanation for this himself. It is a pattern one also sees reflected in physical illnesses. In the First General Epidemiological and Morbidity Survey of China for 1933-34, the sex ratio in hospitals and in out-patients clinics was two males to one female. (Hillier and Jewell, 1983) As is discussed in a later chapter, this pattern continues today in Chinese psychiatric hospitals. It seems likely that pre-1949, there were a number of reasons contributing to this phenomenon. Primarily, families are probably less willing to spend money for hospital treatment on female members. Secondly, at least in the case of the mentally ill, women seem to elicit less fear in family and friends and are thought to be easier to physically control.

Psychiatric Training and Community Education

The Kerr Refuge had a policy of training local doctors from its inception following a tradition established by the Canton Hospital. In 1910, Dr. Woods was appointed a visiting neuro-psychiatrist to the Canton Hospital and then in 1919 became the first professor of neurology and psychiatry at the Peking Union Medical College, where he initiated courses in both subjects in

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1922. The first full scale academic programme in psychiatry was established at the Peking Union Medical College in 1932, by Dr. R. C. Lyman who was Dr. Woods' successor. Lyman stayed at P.U.M.C. until 1937, where he had a profound effect on the graduate training of psychiatrists. Many of China's current senior psychiatrists were students of Lyman's, or were taught by Lyman's ex-students. (Kleinman, 1986) Lyman encouraged the teaching of social work and sociology in his department at P.U.M.C.. (Lyman, 1937; 1939) It was the department at P.U.M.C. that was at the forefront of academic research of neurology and psychiatry in China before 1949.

But psychiatry was still an unpopular department. Kleinman (1986) points out that, despite Lyman's success in postgraduate training of psychiatrists at the P.U.M.C., only one graduate went into psychiatry out of the 116 graduates produced between 1924 and 1933.

The Chinese Society for Neurology and Psychiatry was formed in 1931 by two members of the Peking Union Medical College. (John Kao, 1976.) In Shanghai, 1934, the advent of Dr.Fanny Halpern trained in psychiatry in Vienna under Alfred Adler, led to new initiatives in teaching, research, and practice. (Westbrook, 1953)

The Mental Hygiene Movement, devoted to public education about mental illness and how to lead an emotionally healthy, life also had its adherents in China. Ross (1926) describes two occasions on which the grounds of the Kerr Refuge were thrown open for five days at a time. Entertainment was provided, a theatrical

performance was given to bring out mental hygiene facts for which they wished publicity. Apparently, 10,000 people attended every day.

The first mental hygiene clinic in Shanghai, and possibly all of China, was opened in 1939, under the direction of Dr.Halpern and co-ordinated by the Mental Hygiene Association of Shanghai. Much effort was put into training nurses, teachers and layman to work in this new setting. Dr.Halpern went on to accept a chair in neurology and psychiatry at St.John's University, Shanghai and established beds in the World Red Swastika Bhuddist Hospital for psychiatric teaching purposes. (Westbrook, 1953) However, all these efforts were brought to an end by the Japanese occupation of Shanghai. Although attempts were made to re-establish them after the war was over, lack of resources and the absence of trained personnel made this well nigh impossible.

Xia Zhengyi and Zhang Mingyuan, professors of psychiatry in Shanghai comment that in the pre-Liberation period in China:

'Psychiatry was influenced by foreign schools. At the time, exchange of experience within China was rare, so it was difficult to say which school predominated. For instance, north-east China was deeply influenced by the German-Japanese school, e.g. Kraepelin and other German classical psychiatric schools. In Shanghai, Dr. Su Zonghua had studied with Dr. A. Meyer, so diagnosis and treatment of mental disorders under him were based largely on the theories of the psychobiological school. In Nanjing, Beijing, Chengdu and other places, Freud's theories had considerable influence; but possibly because of the differences in social environment and economic status of Western countries, Freud's psychoanalytic therapy was never popular in China. (1981, p. 278)

Croizier makes the point that the philanthropy and humanitarianism of the best foreign medical institutions in China could not be

separated from the worst features of Western imperialism. Even when they were stripped of their formal religious character and administration placed largely in Chinese hands, general policy and financial support remained in foreign hands. Ultimately, he says, 'the whole missionary humanitarian effort in China fell before the rising tide of revolutionary nationalism'. (Croizier, 1975, p. 24)

In an address to the American Psychiatric Association in 1948 Dr.Karl Bowman reported on a three month visit to China which he had undertaken on behalf of the World Health Organisation to plan for the development of psychiatry and mental health there. He observed that China had very little psychiatry. By his estimates China at the time had approximately 600 psychiatric beds and less than 50 psychiatrists for a population of approximately 450,000,000 people. Treatment methods at the time of his report included insulin shock therapy, which he said was in use in virtually all psychiatric hospitals visited, as well as metrazol and electroshock treatment (which seems to be the first time that it is mentioned in any of the available literature.)

Bowman described China's psychiatric facilities in the following terms:

'The present psychiatric hospitals in China are poorly equipped and in a bad state of repair and are giving largely simple custodial care. Lack of money seems to be the most important reason for this condition and the psychiatric hospitals merely reflect the generally impoverished condition of China. The teaching of psychiatry in medical schools is badly handicapped by the fact that there are almost no teachers available. There is great interest in psychiatry and a desire to develop it in every way possible.' (quoted in John Kao, 1979, p. 47)

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T.Y.Lin (a professor of psychiatry at the University of British Columbia and, until recently, the Chinese government's honorary adviser on mental health) makes the point that Western style psychiatry did not take root in China in the same way that was true for surgery and medicine. He attributes this to the greater language skill needed in teaching and demonstrating the subject to would-be learners; the fact that at that time, there had not been similar breakthroughs in the treatment of mental illness comparable with the advances in the other branches of medicine; that psychiatry was more culture bound in its understanding of the human psyche and therefore less transferable. He concludes that:

'Few medical students chose to specialize in psychiatry and even some of those who chose to do so had to overcome the strong objections of their parents to enter the specialty, which arose from their families' fear that the stigma attached to mental illness would be transferred to their members who intend to enter psychiatry and become psychiatrists'. (Lin, 1985, p. 5)

Across the decades the ghost of Dr.Wenyon might well be nodding in agreement.

THE PEOPLE'S REPUBLIC; 1949-1966

The Communist government of the new People's Republic of China decided to sever all ties with the non-Communist countries of the Western world. The Soviet Union became the focus of scientific and cultural relations. Chinese psychiatry was cut off from the West at a time when radical improvements in psychopharmacology, diagnosis and neuro-biological research were being made. This was particularly difficult for the small core of psychiatrists all of whom were trained in Western theories and techniques.

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Soviet psychiatry exerted a monopolistic influence on Chinese psychiatry. Following an influential conference held in China in 1953, Pavlovian theory was introduced as the dominant theory for understanding human behaviour. A well organised nation wide movement was launched by the Ministry of Public Health and the Chinese Medical Association to encourage, or even coerce, all psychiatric professionals to learn Pavlovian theory, which dominated psychiatry until the end of the Cultural Revolution in 1978. (T.Y.Lin, 1985)

Psychology began to be viewed with suspicion as a means of accentuating individual differences. Intelligence testing and clinical psychology particularly were not encouraged. (Chin and Chin, 1969) As Breger comments, looking back on this period:

'Psychological testing points out individual differences and, according to the values of the Cultural Revolution, did not serve to integrate man into society'. (Breger, 1984, p. 128)

Sociology and anthropology were also banned. This, among other things, has permitted a predominantly medical model of psychiatric practice to develop with little input from professionals, like psychologists, social workers and occupational therapists with a background in the social sciences.

Perhaps reflecting the importance that the new government gave to improving the health of the people and possibly within the spirit of the times when almost anything seemed achievable in the new world, there appears to have been a great deal of enthusiasm amongst those engaged in psychiatric work. The Chinese Society of Neurology and Psychiatry was formed in 1954 and begun to publish The Chinese Journal of Neurology and Psychiatry in 1955. There may

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also have been an element of nationalistic pride in the determination to cast off Western 'superstitions' as Mao called them, and show what China could do unaided, exemplified by this statement from the deputy director of the Ministry of Health in 1958:

'Our goal was to reach a satisfactory level in patient management within one to two years and the world's advanced standards in the scientific and technological aspects of psychiatry within two to three years. In time, the number of psychiatric patients in China would decrease'. (Lin, 1985, p. 11)

Wu (1959) writes that especially after the Great Leap Forward in 1958 medical workers:

'Realized that it is their responsibility to serve the patients well. Therefore, there was a suggestion in many mental hospitals to let the mental patients enjoy the real humane treatment of socialism and they should live the life of normal people'. (quoted in John Kao, 1979, p. 113)

We have observed Kerr's Refuge through Western eyes at its inception and through its early years. The last published reference from its doctors was Selden (1937) who said that it had had to close due to trouble from the 'communistic labour unions'. We are able to meet it again, in the early 1950s, but this time from the point of view of the Chinese. The situation prior to Liberation in 1949 was described thus:

'The hospital had only very few workers, proper doctor and nurses were even less. The facilities were very poor, people were inadequately fed and had not enough warm clothes to wear, the food was poor and inadequate. Serious illness resulted due to cold weather and malnutrition. Hygienic conditions were very bad...the death rate once reached 36.5 per cent. We cannot really say there was any treatment for the patients, other than iron cages and iron ropes. The number of patients had once reached 1,000, even though only 300-400 could be accommodated. Many patients did not even have a bed. For many years there were only 3 or 4 doctors in the hospital. At one time, there was no doctor, only a general practitioner who came in when called'. (Mo Ganming, 1959, p. 310)

While conditions were doubtless exacerbated by the Japanese invasion, the civil war and so on, it would hardly be surprising if the Chinese felt no debt of gratitude to the foreigners who introduced the hospitals, or any desire to emulate their model.

Psychiatric Resources

To indicate the increase in facilities that took place between 1949 and 1958 two sources are worth quoting at length. A document was published in 1959 called a <u>Collection of Theses on Achievements in Medical Science in Commemoration of the Tenth National Foundation Day of China</u>. It contained an essay by Wu Cheng-I on psychiatry. He says that:

> 'Sixty two new hospitals were built throughout the 21 provinces and autonomous regions, with a total number of beds fourteen times greater than before Liberation. In 1950 the number of beds in the psychiatric wards was 1.1 per cent of the total capacity and in 1957 it was 3.6 per cent. There are now quite a few psychiatric sanatoriums in various areas for the chronically ill. The hospital staff increased as more hospitals and more beds became available. The number of doctors in 1958 was sixteen times that in 1949. The increase in the number of nurses was twenty fold'. (reproduced in Kao, 1979, p. 110)

If only he had mentioned his base line figures!

The next document is more specific, although the numbers do not entirely concur with those of Dr.Wu. It was the five year plan published in 1958 and known as <u>The Circular of the Ministry of Health Concerning the Issuance of the National Mental Illness Prevention Work Plan (1958-1962)</u>. It states that there were about 1,000 psychiatric beds at the time of the Liberation and 50 or 60 'mental disease specialists', although the document does not say

what training they had received, if any. It continues:

'According to incomplete statistics, there are now in China
46 mental hospitals and clinics with 11,000 beds in twenty one
provinces and municipalities and the number of professional
personnel for mental illnesses has been increased to 5,000 or more
among which some 400 are doctors (including some 30 doctors of
Chinese medicine). Ending in 1957, some 73,000 mentally ill
persons were treated and among them some 27,000 recovered'.
(reproduced in Kao, 1979, p. 122)

Ho (1974, p 624) quotes figures of 73,150 admitted and over 63,280

discharged but makes no mention of recovery.

There were very few resources to establish and fund new

facilities. The Chinese Journal of Neurology and Psychiatry from

this period carries an article describing how one hospital was set

up. (Zutangshan Care and Education Home staff, 1958) It may well

have been included as a model to encourage the others. It concerns

the establishment of a hospital for chronic mental patients who

were originally vagrants in Nanjing. The authorities took over an

old temple, 40 miles outside the city. There was no electricity,

no running water and no transport access. As the authors say, 'the

hospital was established with the spirit to conquer difficulties'.

(p. 259)

It seems from the article that none of the eight cadres were

doctors, although two of them were described as 'medical workers',

nor had they worked with psychiatric patients before. The rest of

the staff, described as 'care takers', were ex-residents of the

Civil Affairs Bureau's facilities for the poor and sick. Not

surprisingly, most of the 'care takers' were frightened and

reluctant, apparently armed for their task only with exhortations

to develop 'the spirit of running a hospital with hard work,

economization and the spirit to serve the patients with all your heart'.

The article, while extolling the virtues of socialism in helping to overcome difficulties, is also very forthright about the fleas, the incontinence, and the painful learning that brings them to realise that their patients are happier when meaningfully occupied, when their opinions are sought, and when they have cultural and recreational activities in which to be involved. Probably much of the increase in facilities that China saw between 1949 and 1959 w' along similar lines.

The Nanjing Conference

1958 saw another landmark event in the development of Chinese psychiatry with the calling of the First National Conference of Psychiatric Specialists at Nanjing. It was organised by the Ministry of Health and was attended by over 90 persons holding key positions in the field of mental health. (Ho, 1974) The conference was influential in setting directions for mental health policy.

Most particularly, it advocated a move away from Western domination of theory and practice and a move towards developing indigenous texts, expressed in the slogan 'destroy superstition, believe in ourselves'; it focused on the need for collective action to overcome the problems of mentally ill people, manifested in a willingness to move out of the urban centres and to provide services in the rural areas and condemned erstwhile

'individualistic' practices; it demanded that practitioners move away from the use of restraint and explore ways of implementing dialectical materialist thought in the treatment of patients. Above all there was to be 'no shrieking in the adult wards and no crying in the children's wards'. (Ho, 1974; Chin and Chin, 1969)

Not everyone agreed with the adoption of these new principles and apparently there were heated debates at the conference about the advisability of giving up the use of restraints and mechanical treatments. One had to bear in mind that at the time there was very little else, so it was tantamount to asking doctors to give up virtually all practices that were familiar to them and to substitute a form of political education in which none of them had experience and for which there was no existing proof of efficacy. These doctors argued that locking up patients was for their own good. This rationale was criticised as being 'capitalistic' in its orientation. Shen Yucun later wrote:

> 'After great debates...the restraining of patients was finally abolished; wards were completely opened, thus breaking the traditional system of locking up psychiatric wards of the past hundreds and thousands of years. Patients have been liberated'. (quoted in Ho, 1974, p. 633)

At the conference, difficulties impeding progress were discussed. It was apparently still difficult to employ suitable staff. There was an unwillingness to take up mental health work because it was seen as a low status job that carried a high risk of being attacked or verbally abused by patients.

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The Five Year Plan: 1958-1962

The <u>Five Year Plan</u> of 1958 turned out to be the only five year
plan and appears to be the sole policy document available in
English and quite possibly at all in any public forum. As such it
is worth closer examination. It began by stating:

> 'Mental illness is one in which the higher nervous
> activities of the human body are chaotic and there is a mental
> block. It brings not only pains and distress to the patient but
> also brings certain perils to industrial and agricultural
> production as well as social security'.

Thus, it adopted a quasi-Pavlovian explanation of mental illness
which did little to enlighten. It acknowledged the unpleasant
nature of the illness for the sufferer but was clearly also
concerned about the economic consequences for the nation and the
effect on public order and safety. It acknowledged that many
mentally ill people did not receive any or proper treatment and
were not necessarily well cared for at home. It estimated that 200
per 100,000 of population in China were mentally ill.

The <u>Five Year Plan</u> commented critically on the macro-level of
health organisation which concentrated too many resources on 'what
is new, what is big and what is regular', which is to say Western,
at the expense of looking at cheaper, more efficient and effective
solutions to service provision. The plan also pointed out that
such authorities focused too much on hospital based services and
too little on providing out-patient facilities and early and
preventative treatment.

Hospital managers were criticised for caring more about the
convenience of the staff than the comfort of the patients. *Some of*

them were said to have lacked professionalism, and claims that there 'are still some working personnel who dislike patients, discriminate against them and despise them'. The report suggested that managers should not automatically assume that patients cannot have an opinion worth listening to and should take their wishes and suggestions into account. It is impossible not to be struck by the relevance that these strictures have for many psychiatric hospitals in the West!

The report advocated;

1 three kinds of organisational pattern; a medical base, a preventive unit and sanatoria [for chronic care].

2 caring for people in their homes or sending them to rural areas where there was a need for labour [this idea seems to have been predicated on the notion that rural living would be less stressful, although it is hard to imagine that the patient used to an urban environment might find it so].

3 four kinds of cure; by Chinese and Western medicines and physical therapy; by proper labour therapy; therapy through organised sports and cultural amusements; and systematic educational therapy. These four principles continue to be the major therapeutic guidelines.

With regard to treatment, the plan emphasised the need to 'seriously summarize and propagate the clinical experiences of Chinese medicine'. It categorically forbade frontal lobotomy or other clinical methods that could 'injure the lives and health of

the patients....... binding or imprisoning of patients must be resolutely opposed'.

The plan advocated the establishment of mental disease sanatoria and mental disease convalescent villages, which at lest [a] by implication seem to be intended for chronic patients. These were expected to be at least partially self-supporting through agricultural, light industrial and handicraft work. These are also mentioned by Chao Yi Cheng (1965) but if they were established, they do not appear to have survived into the 1980s or '90s. Each province was supposed to establish a regional hospital centre, for the guiding of preventative work and the training of personnel. Joint planning involving 'three men small groups' were to be set up with representatives of local health, civil affairs and public security bureaux to co-ordinate activities.

The plan quite clearly did not envisage the building of more hospitals as the solution to problems of mental ill health. Consistency with the government's approach to physical ill-health may be observed in the encouragement to provide more outpatients' facilities and to provide some beds in local general hospitals.

Six regional collaborative centres were established in Beijing, Nanjing, Chengdu, Changsha, Guangzhou and Shanghai. These regional centres were to be responsible for training personnel, particularly at the middle levels to work in treatment and prevention of mental illness. They were also to train administrative cadres and to undertake research and in general to become centres of excellence. In their studies they were to 'adopt

the communist working style of imagination, outspokenness and daring'. While we may find ourselves out of sympathy with the political rhetoric that accompanies these ideas, the ideas themselves represent high standards of practice. It would, of course, be unwise to assume that these standards are necessarily translated into action, but this is only one more feature of common experience that China shares with the rest of the world.

THE CULTURAL REVOLUTION

The Cultural Revolution is generally dated as having lasted from 1966 to 1976, with the worst excesses in the first four years. Politics took command with a vengeance. Schools and universities were closed. Intellectuals and professionals were vilified and frequently sent down to work on communes, leading to the closure of some hospitals or a great diminution in the services they could offer.

Naturally, this had an effect on the psychiatric services although it is by no means easy to determine precisely what this effect was. Before discussing the detail of what is known the intellectual and political environment in which these reports were produced must be examined. Other than the documents mentioned in the previous section almost everything that is known about the Cultural Revolution period as it affected psychiatry is based on verbal reports given to visiting Westerners. There are no statistics, policy statements or research to guide us.

Consequently, it is imperative to distinguish between facts and normative statements made by Chinese colleagues. (T.Y.Lin, 1985) Kleinman points out that although it was widely reported that the use of binding and isolation had been banned in psychiatric hospitals he observed locked isolation rooms and patients bound hand and foot during a visit to a teaching institution (Kleinman and Mechanic, 1979). Careful reading of the literature also finds references to the continuing use of ECT despite its supposed ban after 1959; in Changsha (Brayfield, 1978); in Guangzhou (Kraft and Swift, 1978); in Nanjing (Walls, Walls and Langsley, 1975).

T.Y. Lin goes on to say that a model project is often mistaken by a visitor as a typical one, which he suggests may be due either to language difficulties or over-zealousness by the speaker in emphasizing points to the visitor. A third factor may also be involved; the visitor's willingness to believe what he is told because it is what he wants to hear:

> 'In Hangzhou a cadre explained how easy it had been in 1972 to convince me - as he himself had done - that all was well, even wonderful, in school, factory and commune. We 'foreign friends', plainly were sitting ducks. "I wanted to deceive you' he said 'but you wanted to be deceived"'. (Jonathan Mirsky, quoted in Brown, 1981, p 9)

This issue is important in looking at the reports by Western visitors that were published between 1964 and 1980. For a number of years, from 1949 to about 1971 reports by foreigners on China's psychiatric services based on an actual visit were extremely rare. (Lazure, 1964, Thomson, et al. 1967 and Chin and Chin, 1969) Cerny is much quoted, but he synthesized material from existing sources, including Russian, and does not appear to have visited China

himself.

It was only after the beginning of 'ping pong' diplomacy and the start of a rapprochement with the United States that foreign visitors again were permitted to visit. These visitors tended to be those like the Sidels who were known to have a sympathy towards communism, members of delegations who were known 'friends of China', like the Society for Anglo-Chinese Understanding (Adams, 1972), or academic visitors with a particular professional interest (Sainsbury, 1974) Reading through over 30 reports dating from this time it is quite clear that they are based on very restricted information and are biased either by lack of knowledge, which is hardly surprising considering the closed nature of the country in the previous 15 to 20 years, or are biased because of the writer's own political sympathies.

Again this is not surprising. China is ultra-sensitive to criticism and would be more likely to grant permission to visit to those who are likely to offer support. Even now, it is not possible to write about China without being aware of how what is published will be received by the Chinese authorities, and how this will in turn affect future access, not only for one's self but for others.

It is all too easy to be knowing after the event. Even so, reading some of these reports, it does seem that the writers left their critical and analytical faculties at home to an extent not called for by the circumstances. Leung, Miller and Leung (1978) comment that;

'If one took away concerns about money and debt, about success in the eyes of peers and parents, about love and jealousy, about the success of one's children and about 'what is the meaning of my life', caseloads in North America might drop considerably'.(Leung, Miller and Leung, 1978, p. 355)

If one were then to add the stresses of mandatory late marriages; in - law tensions; involuntary geographical separation of married people; allocated jobs rather than ones reflecting interest, ability or preference; fierce public criticism sessions leading to intense humiliation; being sent down to work in a commune and losing your right to live in your home town; to say nothing of the environment of chaos, suspicion and insecurity created by the Cultural Revolution, one might find caseloads rising again.

A close examination of the literature soon reveals that the vast majority of the foreign observers are reporting on the same two hospitals; the Shanghai Number One and the Beijing Medical College Third Hospital. The reports enjoy a certain consistency because they are based on the same statements by the same doctors.

Not only were these probably the top two hospitals in the country, but because of their location they were very close to the political heartland. Thus Brown points out that Shanghai was very much influenced by the Gang of Four, and this may explain why the policies reported at the Shanghai Number One Hospital may have so closely followed the official line about not using ECT, binding and isolation. (Brown, 1980, p. 22) The two most influential doctors at the Beijing Medical College were the professor, Wu Cheng-i and the psychiatrist in charge, Shen Yucun.

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Both of these were referred to in the previous section. It was Professor Wu who was selected to write the essay on psychiatry to contribute to the collection on China's medical achievements since Liberation, to celebrate the tenth anniversary of the founding of the People's Republic. Shen Yucun's impassioned celebration of the banning of inhuman treatments as the policy at the Nanjing Conference of 1959 would suggest that any hospital of which she was in charge would not feature these methods of restraint. Neither of them could be considered typical either in ability or influence of the doctors working in hospitals in more remote provinces and centres. Thus Ho's assertion that 'the Chinese have been able to put these ideas into practice on a massive national scale within a relatively short period of time' seems at best unproven (and possibly unprovable) and at worst inaccurate. (Ho, 1974b, p. 133)

The Socialist Model of Psychiatry

With these sizable caveats, what picture emerges of the state of psychiatry during the Cultural Revolution? Sidel, despite commenting that:

'The psychiatric hospitals were the only segment of Chinese life that we saw in which depression rather than exhilaration was the predominant affect', (1973, p. 732)

describes in some detail the principles of revolutionary optimism that govern psychiatry. These are:

1 - the belief in subordinating the feelings of the individual to the needs of the group of which he is a member - the family, the classroom, the commune, the entire

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society.

2 - the belief that the individual is part of something larger than himself, the revolution and that this revolution will ultimately be victorious.

3 - the belief that the participation in an ultimately victorious revolution gives meaning and joy to life, even if the road to revolution is paved with personal sacrifice.

4 - the belief in the infinite capacity of man to learn, to modify his thinking, to understand the world around him and to remould himself through faith in the revolution and for the sake of the revolution. (Sidel, 1973)

Karenga (1978) develops a five point model of Chinese psycho - social therapy. The first salient feature is the definition of the social dimensions of the problem. Thus the phenomena of mental illness are viewed largely as the product of the failure of the old political system. Solutions must be directed towards a sick society rather than a sick individual.

The second feature concerns the definition of the personal dimensions of the problem. Mental illness is seen as essentially problems in thought, and therapy as thought liberation. The individual expresses this as a rejection of reality and a refusal to accept the design and demands from a social context in which the patient feels alienated. At the same time, all individuals have the ability to learn and change both themselves and the world around them. Thus if the patient is informed of the correct way to view circumstances he can be encouraged to arm himself to fight his own illness. Ratner (1978), who visited the Shanghai Number

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One Hospital, quotes one of the staff there thus:

'Chinese psychotherapy does not focus on the patient's emotions or childhood experiences; it does not attempt psychological explanations. The main concern is for the patients to develop logical, rational thinking and to develop good social values of co-operation. Then the patients can come to have happy, fulfilled lives through their ordinary social activities. In other words because social life is fulfilling, the point is to participate in it and there is no need to engage in purely psychological, personal analysis'. (Ratner, 1978, p. 82)

The major technique to help patients develop rational thought was the study of Mao's works, particularly 'Where do correct thoughts come from?', 'On Contradictions' and the ones referred to as 'the three-constantly read articles'. These were; 'In Memory of Norman Bethune'; 'To Serve The People'; and 'The Foolish Old Man Who Could Move Mountains'. Staff were supposed to take the lessons contained in what are essentially allegorical tales and help patients to apply those lessons to their own lives.

In Western thought, this fits a model of cognitive therapy, couched in rational-directive terms. The political content is clearly a culturally specific feature. Because it seems such a strange way to approach the treatment of psychotic disorder to a Western observer, it has received much attention in the literature. Yet as a means of orienting the patient to a reality outside himself, of reminding him of a world other than his inner one and of reaching patients many of whom would have been illiterate, it may have had some effectiveness. Leung, Miller and Leung (1978) give an example from a session at which they were present when an ex-patient came back to talk about her experiences. She related her personal oppression and mis-treatment

by her in-laws which led to her breakdown. Through group discussions of Chairman Mao's writings, she came to realize while in hospital that in the New China there is a guarantee of equality of the sexes and protection of individual rights. She claimed such knowledge motivated her to re-assert her own individual dignity and led to her liberation from in-law domination.

Personal experience suggests that the success of any particular therapeutic theory or method does not always lie in the nature of the method itself but in the therapist's enthusiasm and faith in the treatment which conveys itself to the patient. It is most unlikely that Mao's thoughts did much to control acute psychosis but they may have had a part to play in what we would think of as the social rehabilitation of the patient.

Contained in this approach to the patient as a conscious being with a capacity to learn and change, is an ages old approach to human beings and their essential educability which is Confucianist in origin. People were essentially good but behaved wrongly because of faulty understanding. (Bodde, 1957) Thus they could be educated into better ways both by being presented with new ideas and with exemplars who would demonstrate the correct way to behave. This use of models is seen again and again in mass campaigns. (Burch, 1979) The archetypal model is Lei Feng, who died after an accident as a young man, but not before he had declared that he wished no more than 'to be a rustless screw in the machine of the revolution', and has been held up ever since as an exemplar of the model young citizen.

Hospitals in China since 1949 have tended to use the army as a model. Given that the concept of a hospital at all is a foreign one, a mode of conceptualizing its organisation and functions based on something that is familiar is almost certain to be sought. The political climate and the imagery involved in revolution made the use of a military model almost inevitable. Wards were divided into 'fighting groups' with the positions of corporal and sergeant being taken by the model patients - the Red Sentries - who are patients on the road to recovery who are expected to set an example and take care of newer and sicker patients. (Ho, 1974; Lu, 1978; Frears, 1976)

The third aspect of Karenga's model is that of the collective solution at the levels of construction, concern and execution. Ho (1974) points out that individualism has very different connotations for the Chinese. Whereas in the West, it implies dignity, freedom, and responsibility, the Chinese view it as selfish or undisciplined action divorced from the group. Clearly if mental illness is not seen as an individual problem then it is likely to be conceived as more amenable to a collective solution:

'The hospital becomes not only a battle ground for struggling against illness but also a classroom for learning and practicing socialism'. (Ho, 1974, p. 626)

The fourth feature is the collective implementation of therapeutic procedures, whereby the patient is not exempt from the responsibilities pertaining to an ordinary citizen, and is expected to contribute to national reconstruction through labour, and to take part in political study groups. The passive patient is supposedly transformed into the aware and active participant of

his own liberation and ultimately the liberation of society.

Finally comes the construction and maintenance of supportive relations. The focus is shifted from the individual to the environment in which he lives and works. A network of supportive relations are established and co-ordinated to keep the patient out of institutions where possible, and in the community where treatment and support can take place in familiar settings. Thus Rosner (1976) reports from the Peking Medical College Third Hospital, that staff teams make home and factory visits to prepare the way for the patient and to make sure that he is being offered suitable work on discharge.

Explaining Mental Illness

The aetiology of mental disorder contained some logistical problems for the Chinese during this time. As has already been discussed there clearly was a tendency to think of causation in terms of social and class factors, although I can find no reference to any public declaration that mental illness could be eradicated through the implementation of a socialist society. There was perhaps a tendency to think that there would be a diminution as shown in the previously quoted remarks by the deputy minister of health. (see also John Kao, 1974, p.90-96)

However, with the evidence before their eyes that the new China still had its quota of mentally ill people, social explanations of causation were hardly likely to be popular. It is one thing to argue that the injustices of capitalism drive people mad, but it

requires a different order of thinking to examine the flaws in the Cultural Revolution that might contribute to mental disturbance. As a consequence of this, notions about aetiology are not well defined during this period.

Frears (1976) quotes an article from the <u>China Pictorial</u> in 1971 which attempts to explain mental illness by saying that:

> 'A mental illness is different from an ideological illness. And to restore function of the cerebrum to normal, medicinal treatment is necessary. Although the cause of illness was different in each case most of the patients were in the grip of an intense mental struggle, or had lapsed into melancholia for a prolonged period owing to their inability to deal with the objective world correctly. Failure to free themselves of it caused the cerebrum to lose part of its function'. (Frears, 1976, p. 21)

On the whole, this contributes little to our understanding.

Kety (1976) asked Professor Wu Cheng-i to describe his concept of schizophrenia. He said that he saw it as a disease of the brain, biochemically and physiologically, but with important components determined by life experience. A colleague of Professor Wu, Dr.Yen, offered a very eclectic explanation that would be familiar to Western doctors. He said that he felt that schizophrenia is some kind of biochemical or physiological disturbance in the brain that also requires some experiential stress for its expression, but that stress is not enough since every one with the same stress does not develop schizophrenia. He also feels that genetic predisposing factors may exist.

In Nanjing, when asked whether they believed in the developmental theory of mental illness, (based on Freudian concepts), the psychiatrists there replied that they did not:

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'Under Chairman Mao's guidance, after Liberation everyone believes in dialectical materialism and everyone is happy. There is no conflict for our children'. (Walls, Walls and Langsley, 1975, p. 124)

In the same article, Shanghai psychiatrists were asked the same question and answered:

'We have not yet arrived at a unified explanation as to the causes of mental disease. Some people hold that the role is played by chemical changes in the brain or genetic factors. We think that a reasonable social system will reduce the environmental causes of mental diseases. But will it also be effective in reducing the occurrence of schizophrenia? Well, there are still some disputes'. (Walls, Walls and Langsley, 1975, p. 124)

An educational notice for patients posted on the wall in the same hospital says that:

'Psychosis is an illness which shows the abnormality of psychiatric activities. It can be brought on by various causes which have one thing in common, a functional disorder of the brain'. (Brown, 1980, p. 26. The entire notice is reproduced as Appendix 4)

There seems to have been a discrepancy in this issue when so much attention was paid in practice to social involvement and political understanding, while as Brown (1980) points out research focused (as it still does) much more strongly on biochemical issues.

THE EIGHTIES - SEEKING TRUTH FROM FACTS

The numbers of reports on Chinese psychiatry written by Western observers during the 1980s decreased markedly. This may have been because China had ceased to be quite so exotic to the West, so that the same intensity of interest was not generated by information on her psychiatric services and not so much material was offered or published. It may also have been balanced by the increasing numbers of articles available in English language journals written by psychiatrists from the People's Republic.

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Exchange projects like the one between the University of Washington and the Hunan Medical College in Changsha gave Chinese psychiatrists greater access to Western ideas and the chance to synthesize these ideas with their own experience.

Some of the characteristics that made China different, like the use of Mao's works in treatment, have clearly faded away. Masserman, (1980), Bloomingdale, (1980) and Achtenberg (1983) all comment on how this practice has ceased. There seems to be a greater willingness on the part of Chinese psychiatrists to speak frankly. On the subject of Mao's thought, Dr.Young Derson is quoted as saying:

'We do not believe that you can get a disease from a wrong idea - nor will a 'correct idea' cure a patient. We try to teach the meaning of illness, based on scientific knowledge'. (Actenberg, 1973, p. 373)

Some of the observers detect a lack of enthusiasm for the use of Chinese medicine in the treatment of schizophrenia. Parry-Jones says that its use continues:

'... but appears to be regarded largely as an adjunct to Western methods and its efficacy seems to be viewed with some caution'. (1986, p. 637)

Breger (1984) failed to elicit strong support for acupuncture, particularly from those doctors trained in Western medicine. Tousley (1985) found no psychiatrists who recommended Chinese herbal medicine for psychosis although some used it as a means to ameliorate side-effects.

Unlike the spirit of the 1970s when Western observers acted as ciphers of the official line, these newer reports have elements of

evaluation, or even oblique criticism of some of the practices of which they were made aware. Euphemistically, Parry-Jones (1986) describes as 'interesting' the practice in Szechuan of using a particular herb to induce vomiting and seizures in cases of schizophrenia. Thornicroft (1987) describes as 'novel' the use of intravenous hydrocortisone in the treatment of childhood schizophrenia. Wilson and Hutchison commented on high doses of chlorpromazine which:

'.... precluded any emotional outbursts or disruptive behaviour. Keeping patients well-behaved, busy and compliant was acknowledged as a legitimate therapeutic goal by the staff. Patients sat quietly at long tables most of the day putting hairpins and metal snaps on cards. These activities were viewed as productive contributions to society'. (Wilson and Hutchison, 1983, p. 394)

ECT is widely reported as being given in unmodified form. (Thornicroft, 1987; Parry-Jones, 1986; Tousley, 1985) The emphasis on physical treatment emphasises the lack of input from the social sciences that in the West has informed the treatment and understanding of mentally ill people and their families. This is demonstrated by the institutional nature of hospitals. They are bare, undecorated, completely devoid of any personal possessions of the patients. (Parry-Jones, 1988; Priemus-Noach, 1988; Wilson and Hutchison, 1983, Visher and Visher, 1979) Not even a photograph is to be seen. This is utterly unlike Chinese homes where even the poorer people still have family photographs displayed and a calendar hanging on the wall. Homes are cluttered and filled by the lives of their inhabitants. None of this is apparent in a psychiatric hospital.

CONCLUSIONS

1   Psychiatry in China began as Western psychiatry. Its professional development mirrored practices in the West, and its practitioners were either foreigners or Chinese people trained in Western medicine. It did not root in an alien climate with the same vigour shown by medicine and surgery. As the twentieth century progressed psychiatry was increasingly at the mercy of the vagaries of the continuously unstable political, economic and social environment.

2   There were efforts from the Liberation (in 1949) onwards to improve psychiatric facilities and to mould them into a more immediately recognisable Chinese shape. Politics intruded to interfere with what had been a promising beginning to lead psychiatry down a path that most would now seem to agree was a dead end.

3   The banning of psychology and sociology after the Liberation has had a long term negative effect on the way that psychiatric care is offered. It seems devoid of understanding about the way that the social milieu affects behaviour and pays scant attention to the personal psychological aspects which shape and form the experience of psychotic illness and give it an individual character for each sufferer.

4   The argument that the social system of the People's Republic reduces the incidence of mental illness is one that a number of Western visitors have found attractive. Armchair socialism is always a good deal more comfortable for Westerners than living the

reality. They seem to temporarily forget the freedoms, opportunities and comforts that make their own lives tolerable and instead transform them into a burden. Thus they are able to admire the deprivation in others' lives as a moral virtue. An appreciation of socialism can only be honestly achieved by an holistic understanding of all its facets, and not by a process of selective blindness or willful misunderstanding.

5   While the reports on psychiatry in China published since 1964 are of interest, they also reflect the drawbacks of one-off visits and in many cases, little understanding of China. Even those visitors who were on study tours that lasted six or eight weeks rarely stayed for long in one place. Informants were unlikely to see them again. There was no continuing relationship with the responsibility that brings or the trust that gradually develops, both of which are particularly important in the Chinese context. Without this on-going relationship and ability to carry out research these reports are curiously unsatisfying. They provide bulk but insufficient nourishment.

6   The overall impression is that psychiatry in China has lost some of its sense of purpose and direction. Having been deprived of its guiding force of socialism in the 1950s and the more concentrated form of Maoism during the 1960s and 1970s, it has lost its prime organising principle. In this, it mirrors the forces at work generally in Chinese society during this decade.

CHAPTER TWO

HEALTH AND SOCIAL POLICY

'Citizens of the People's Republic of China have the right to material assistance from the state and society when they are old, ill or disabled. The state develops the social insurance, social relief and medical and health services that are required to enable citizens to enjoy this right. The state and society ensure the livelihood of disabled members of the armed forces, provide pensions to the families of martyrs and give preferential treatment to the families of military personnel. The state and society help make arrangements for the work, livelihood and education of the blind, deaf-mutes and other handicapped citizens'. (Article 45 of the Constitution of the People's Republic of China, 1982)

China is capable of launching satellites and building Silkworm missiles yet rice is still planted and tended by hand and a water buffalo, and perhaps a donkey, are the closest many farms come to mechanisation. In a society of such contrasts between rural and urban, modern and traditional, ideology and practice, it is not surprising that expectations about policies and programmes based on the logic of what pertains elsewhere are constantly confounded. It is one of the aims of this chapter to test these assumptions against what is known of the Chinese situation.

China's psychiatric services do not exist in an historical or administrative vacuum. They are part of the overall structure of health and welfare services and as such have to be understood in the wider context of the forces that have affected the general development of such services in China. All societies attempt to make arrangements for the care of their sick, weak, vulnerable and dependent members. Out of the limited range of options those chosen will reflect the historical, cultural, economic, political and demographic imperatives of their time.

THE CULTURE OF WELFARE

While Western and Chinese cultures both admit the importance of relieving the plight of the needy, they have developed quite different ways of doing so. Chow suggests that this difference is based on a different consensus as to why help should be given and the results that should be expected. (Chow Wing Sun, 1987)

Western and Chinese cultures have very different ideas of man. The former see him as a separate and complete entity. For the latter he is part of a system that starts with the family and through them is connected to wider levels of societal organisation. The acceptance of the need to look after those who cannot fend for themselves is not because of a perception of shared humanity but stems from an extension of the rights and responsibilities that everyone should have as member of a family. Thus the Chinese have always emphasised the need to look after family members first. Caring for strangers is not a notion that sits very easily in Chinese culture.

Formal assistance from the state, as once from the Emperor, is not seen as a right, a means to achieve a just and fair society or greater equality but as a kindness expressed by a benevolent father. It is never intended to supplant the functions of the family. What social welfare in a Chinese context aims to achieve is a state of harmony and integration within the family and society, not the development and actualization of the individual. (Chow Wing Sun, 1987) Welfare provisions reinforce dependence

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rather than encourage independence.

The Tradition of Welfare

Little has been written about the efforts to ensure the livelihood and welfare of its population undertaken by successive Chinese dynasties and rulers. While such efforts might have been limited they most certainly existed and followed a pattern that would not be completely unfamiliar to a student of Western poverty relief.

The Confucian tradition in Chinese philosophy saw men as naturally good; benevolent, righteous, respectful and compassionate. Thus to care for the unfortunate, nationally or individually was laudable within these philosophical parameters. *The Book of Rites* (written sometime before 221B.C.) described the ideal state thus:

> 'When the word prevails, people seek the good of the whole society, select the wise to govern and stress trust and social harmony. As a result, people not only take care of their relatives and children but also work hard to ensure that all the elderly are well cared for, the strong have opportunities to put their energy to good use and the young can grow up in healthy ways. The widowed, lonely, disabled and sick should all be provided for....This then will be the ideal state'. (quoted in Chow Wing Sun, 1987, p. 35)

Natural disasters were frequently interpreted to be Heaven's revenge on an unjust ruler. Consequently, the Emperor had a vested interest in taking an active part in ameliorating the consequences of floods and earthquakes which might otherwise be all too easily interpreted as a sign of his careless stewardship and an invitation for another to contest the throne. Efforts to ensure social welfare thus had two sources; first as a function of the state and second from the initiatives of citizens to provide for the vulnerable and to protect themselves against times of

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hardship. Chinese officials had extensive experience of managing flood and disaster relief on a large scale. This often meant co-ordinating food, cash, medical supplies and building and agricultural rehabilitation involving very large areas of land and tens of thousands of people. (Yim Shui Yuen, 1978)

Orphanages and almshouses date from the Sung and Yuan dynasties. From the mid-Ching period China had a law concerned with the care of the 'deserving poor':

'All poor destitute widowers and widows, the fatherless and children, the helpless and the infirm, shall receive sufficient maintenance and protection from the magistrates of their native city or district, wherever they have neither relations nor connections upon whom they can depend for support. Any magistrate refusing such punishment and protection shall be punished with sixty blows'. (Tsu Yu Yue, 1912, p. 26)

Despite the threat of punishment, the law was never enforced because no central funds were made available and the local districts were already heavily taxed and unlikely to be willing to support charitable endeavours.

In 1805, the Hall of United Benevolence was formed in Shanghai, supported largely by private philanthropy. It provided support in their own homes to the elderly, and organised institutions for aged men and aged widows as well as providing coffins and free burial of the poor for both adults and children. Potential charitable institutions would include foundling hospitals, orphanages, public dispensaries, and 'asylums for strangers' which were hospitals where travellers in a strange city, without means to support themselves, might go should they become ill.

A guidebook to Canton written by John Kerr lists a wide variety of

charitable institutions. The Foundling Hospital:

> '... was established in 1698 and enlarged in 1732. Daily from six to ten infants (mostly female, a day or two old) are brought here and the most of them die. The place is in charge of a petty officer. There are usually about three hundred foundlings and one wet nurse for three infants'. (Kerr, 1904, p. 39)

The Home for the Blind:

> 'There are rows of one storey rooms on the north and south sides of the avenue which leads up to a temple. There are about five hundred rooms, to each of which four inmates are assigned. Six mace are allowed one person and what more is needed comes by begging or some kind of handiwork'. (Kerr, 1904, p. 12)

He also mentions a home for elderly women, another one for elderly men, a home for lepers, and a Roman Catholic orphanage staffed by Chinese nurses.

Much other welfare was provided through clan organisations and associations based on shared geographical residence. Of course this was very variable, but it was not uncommon for clans to set aside land, the grain and profit from which was to go to support clan members who were sick, widowed, orphaned or for some other reason unable to provide for themselves. With no system of state education clans might also provide other facilities such as schools for its young people.

Villages, which could be coterminous with one clan organisation, or might have several families living in them, also provided services. The headman and his helpers were responsible for public security, sinking wells, the upkeep of roads and bridges and so on. Villages might also provide for the poor and destitute and commonly would organise mutual loan associations and mutual providential associations to help cover members for large and

unexpected expenditures. (Tsu Yu Yue, 1912)

In large towns 'home place associations' were formed by people from the same place who were currently living among strangers. Members would be expected to assist fellow members in times of need on the basis of mutual aid. Trade and craft guilds sometimes provided and more often supported, charitable ventures for the poor and vulnerable. One such guild, when announcing to its members that it had decided on their behalf to provide regular support to the Hall of Universal Benevolence in Shanghai, justified it on the grounds that, among other things:

'It is our humble opinion that the promotion of good and bestowal of blessings tends to increase the prosperity of our trade'. (Tsu Yu Yue, 1912, p. 92)

Thus there were mechanisms for the provision of welfare in China that may be considered to be indigenous, pre-dating both the arrival of the missionaries and the Revolution. It is doubtful that in the case of institutional care very many people were touched by their services because they seemed to have been available only in cities. The link between the extended family, mutual aid and sharing risk based on proximity of residence were probably a good deal more relevant to the ordinary population and are still current features of welfare provision in China.

SOCIAL POLICY AND SOCIAL WELFARE IN CHINA

It is the 'how' of welfare provision that tends to elicit debate rather than the universal fact of it. This chapter began by saying that China confounds expectations and in this case it concerns the prediction of the structure of welfare provision. Convergence

theory suggests that as countries become increasingly industrial, the demands of technology and the forms of social organisation that it encourages lead to greater similarity between countries. As governments become more deeply and necessarily involved in encouraging and regulating industrial production, they become more and more responsible for providing welfare services to ameliorate the poor social conditions that are a product of industrialisation and for which they must bear some responsibility. Thus welfare arrangements become increasingly 'institutional' in character and are seen to be a right of citizens. As will become clear as this chapter develops, China does not conform to this picture at all.

Mishra (1981) has criticised convergence theory on several grounds. Most fundamentally a theory this deterministic precludes the possibility of choice about welfare policy, or indeed many other things. It minimizes the influence of other factors, such as history, culture, ideology, religion, elites and fails to account for the human and social processes involved in change and development. The state is not the integrative force that convergence theorists seem to assume and the process of social development is uneven, discontinuous and fraught with conflict.(Mishra, 1984) Mishra goes on to point out that it is possible to sustain a 'weak' version of convergence theory in that in all Western industrial countries the state has gone on to assume increased responsibility for meeting needs. However, why concentrate on the similarities between countries to the point where differences become unacceptable when it is the differences that are interesting and from which we learn most?

There are strong ideologically hegemonistic tendencies inherent in convergence theory. Because the industrial model is a Western one, to say that increased industrial development will lead to convergence is to say that the road to the future will be dominated by Western standards of culture and conduct. Furthermore there is an implied assumption that this will be the most desirable outcome. Viewed from an Eastern perspective this embodies a profoundly patronising set of assumptions and is unacceptable. It is also demonstrably incorrect. This denial of difference and inability to see beyond one's own cultural alternatives led Wilensky (1975) to view both Japan and America as welfare 'laggards' because they did not have a welfare state, not recognising that in those countries much welfare is provided through the workplace. Given that both are clearly industrial countries, that in itself must undermine the convergence theorists' position.

If we accept that the presence or absence of a 'welfare state' is not the defining feature it has been claimed to be, is there another model that permits the analysis of the provision of welfare needs that does justice to a variety of solutions to this shared problem without incorporating cultural bias?

<u>The 'Welfare Mix'</u>

The concept of a 'welfare mix' has existed in social policy for decades. Writing in the 1950s, Titmuss pointed out that welfare institutions could be grouped into three categories; those provided through central or local government, those financed

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through fiscal policies and those provided through the occupational sector. (quoted in Pinker, 1985, p. 105) Mishra (1981, p. 46) says in relation to state and occupational welfare:

'This still leaves scope for a great deal of diversity in welfare patterns, for example in respect of the mix between these two types of provision. And the mix matters unless we consider these provisions as functional equivalents (which clearly they are not)'.

Higgins (1981) pursues the idea of a 'welfare mix' further using Titmuss' three categories and differentiating between public and private welfare, the former being:

'... explicit, poorly funded, stigmatized and stigmatizing and is directed at the poor. The other practically unknown, is implicit, literally invisible, is non-stigmatized and stigmatizing and provides vast unacknowledged benefits to the non-poor'. (Tussing, 1974, quoted in Higgins, 1981, p. 135)

However, it was not until 1986 that this idea was fully developed by Richard Rose and Rei Shiratori in a book <u>Welfare States East and West</u>. They began from the proposition that:

'Definitions of welfare ..... do not vary greatly across national boundaries. The basic concerns of individuals and families are not derived from political values but from more pervasive human values. But the institutional mechanisms for delivering welfare, whether by government or independent of government differ greatly'. (Rose and Shiratori, 1986, p. 7)

They go on to define welfare as the product of the whole society, rather than of the market and the state and in this respect differ from previous authors. They propose that the total amount of welfare in any society will consist of a mix of provisions from the household, the market and the state. This mix will differ from society to society and within different programmes within societies as well. The three sources are complementary rather than

competing and an increase in quantity from one supplier may lead to an alteration in the components of the mix rather than any net gain to the consumer.

In considering the relationship between the level of economic development and the amount of welfare provision they make the point that the higher the per capita national product the higher the welfare quotient. But the economy is by no means the major determinant of a country's welfare profile. Rose and Shiratori (1986, p. 23) also warn that an explanation of variation in the 'welfare mix' between nations that is based on values:

'... comes dangerously close to inferring causation from consequences, assuming that the welfare mix of Americans, Swedes, English or Japanese must be what citizens want because it is what they get'.

Higgins (1986) goes on to identify six potential providers of welfare; the state, employers, Trades Unions, family, commercial organisations, voluntary organisations. Both Rose and Shiratori and Higgins make the point that the erstwhile fixation on defining the state as the main provider of welfare overlooked the fact that most care in any society is provided by unpaid female labour in the guise of mothers, wives, and daughters within the context of the family and the household.

The 'welfare mix' model has the overwhelming advantage that it is not culturally specific and that it provides a model in which most societies will be able to fit without doing unnecessary damage to their cultural and logical integrity. Certainly it is a model the use of which will greatly add to our understanding of how China copes with its citizens' welfare needs and avoid unwarranted

assumptions about the nature and finance of welfare in socialist countries.

The 'welfare mix' in China may be conceptualized as three concentric circles with the family at the centre, the collective (which may be represented by the danwei or by the neighbourhood organisation) in the next ring and then the state as the outer ring but encompassing the others. (Linda Wong, personal communication)

This dissertation is largely concerned with the role of the family, the state and collectives in providing welfare because they are all involved with the care of the mentally ill in some way. Other organisations do play a part, although not often in the case of the mentally ill. For instance, in some areas the All China Federation of Trades Unions provides sanatoriums for its members. They may also run 'people's palaces' where educational and recreational facilities are provided at subsidised cost. Mass organisations like the Women's Federation and the Communist Youth League and Young Pioneers are involved at grass roots levels in organising activities and providing educational or supportive services for their members. The new 'children's palace' in Guangzhou is run by the Women's Federation.

The Family

The centrality of the family in the lives of individuals and in the structural organisation of Chinese society is well known:

'Certain unique structural features of the Chinese family make it the deep structure of the society and, to a large extent,

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dictate the practices and behaviours of Chinese society and the Chinese'. (Lin Nan, 1988, p. 71)

Chapter Three offers more detail on this subject. It is sufficient for our present purposes to point out that the family is the first source of help for most Chinese people. Only if the family cannot cope will people turn to other bodies. However, the government does not encourage this, wishing people to be self-sufficient whenever possible to reduce the burden on the state. Families in turn are very often unwilling to seek outside help because it is viewed as demeaning and stigmatizing.

The Workplace

The primacy of the workplace in the lives of the majority of Chinese people is difficult to exaggerate. Jobs are not chosen; they are allocated or possibly inherited from one or other parent. Accommodation is arranged through the workplace. Your opportunity to start a family is decided by the workplace, according to the quota of new births they have been given for any one year. Health care, as will be discussed more fully later, is provided via the danwei either directly or indirectly. They may also provide residential facilities for their elderly, schools, kindergartens, recreational facilities and canteens. Food is sometimes bought in bulk and then re-sold at less than the retail rate to workers. Political education classes are provided via the danwei. It is currently impossible to go for further education, nationally or internationally, without written approval and support from the danwei. Recently, a charge has been introduced for publishing research articles in journals, ostensibly because they would not

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otherwise be able to finance the costs of publishing. The fee varies slightly but is approximately one and a half times the average monthly wage. Thus it is now practically impossible to have an article published in a journal unless the <u>danwei</u> approves the content and provides financial support. It is rare for people to change jobs and thus workplaces, although this does happen occasionally.

The Chinese Constitution reflects this emphasis on work. Article 42 starts by saying that 'citizens of the People's Republic of China have a right as well as a duty to work'. Article 6 concludes 'the system of socialist public ownership supersedes the system of exploitation of man by man; it applies the principle of "from each according to his ability, to each according to his work"'. This is a quotation from Engels which in the West is more often rendered 'from each according to his ability, to each according to his need'.

Mishra (1981, p. 133) claims that 'central to the socialist view of welfare is the notion "that to each according to his needs"'[my emphasis]. A little later (p.137) he goes on to say in relation to the structures in capitalist societies through which welfare needs are met, 'in the Soviet Union and in socialist societies generally, neither fiscal benefits nor occupational provision is of comparable scope and significance' [in comparison with the state]. In relation to China this statement is true of fiscal benefits but is grossly inaccurate regarding occupational welfare.

Again one is forced to examine previously accepted 'common wisdom'. It is supposed to be the exploitative capitalist system that is geared to let the weakest and most vulnerable perish and to define a man's worth by his capacity for work. If the Chinese truly enforce 'to each according to his work' then those who are handicapped or disabled to an extent that they cannot work are very severely disadvantaged in their capacity to claim the rights of citizenship. We should not be surprised to learn that one of the major emphases in welfare work is the provision of work for the handicapped. China has never developed for the mentally ill a system of community based accommodation as an alternative to living with the family. Rather, it has concentrated on developing welfare factories to provide gainful employment.

There are two major drawbacks to the provision of welfare benefits via the workplace. First, it discriminates against those who do not have work, who are arguably those who need welfare assistance most. In the last ten years, following the introduction of the 'open-door' economic policy, China has had a problem with unemployment and under employment. Many industries are grossly over staffed because of the state's responsibility to provide work for all. Once the emphasis turned to profit, enterprises became more cost conscious and tried to avoid carrying surplus employees.

Second, the 'open-door' policy has led to a division between the more prosperous coastal provinces, rich in resources and connections, like Guangzhou, Fujian and Zhejiang, and the interior provinces, like Gansu and Anhui, where conditions are very poor with little chance of improving them. Thus many people from the

interior provinces, despite official sanctions against such action, have taken to the road to search for work in prosperous cities. Unofficially, it is estimated that Guangzhou has over a million such people. They lack both a _danwei_ and a _hou kou_, or residence permit through which one obtains grain rations and other benefits. They are also cut off from any help the family might be able to give. Their new localities want nothing to do with them because they are not local people and are therefore not eligible for any benefits that might be had through street organisations. Their only recourse is to the government in the shape of the local Department of Civil Affairs, whose likely response is to be to send them back from whence they came.

THE STATE

This brings us to the role of the state in the provision of welfare. The profession of social work is more or less unknown in China today, although recently two university departments of sociology (in Beijing and Guangzhou) have begun teaching social work as one course within a sociology degree. However, many of the typical functions of social work such as the care of the old, young and handicapped who have no one else to care for them must still be performed. It was reported that in 1987 there were 37,368 welfare institutions of different sorts throughout the country, providing 650,000 beds. (_Beijing Review_, June 29th., 1988) The states' responsibility in this area is shouldered by the Ministry of Civil Affairs. It is relevant in our context because it provides a significant number of psychiatric beds and community

based services (where they exist) for the mentally ill.

The Ministry of Civil Affairs

The first such ministry was set up at the end of the Ching dynasty in 1906. Its functions were subsumed under the Ministry of Internal Affairs in 1912 and under the Ministry of Home Affairs in 1918. After 1949 civil affairs work was carried out through a department of the Ministry of Home Affairs which was disbanded at the height of the Cultural Revolution in 1968. At this time any form of assistance, even to the destitute, was perceived as being a way of seducing allegiance from the workers and thus tainted by capitalist 'economism'. (Dixon, 1981) Self reliance was to be the order of the day. The current Ministry of Civil Affairs was established in 1978. In 1989, its total budget was 459 billion renminbi, or 1.6 per cent of total national expenditure. (Chinese Society News, May 8th., 1990)

The Ministry's prime responsibility is to take care of the 'three have nots'; that is to say people who are without a home, without support and without a means of livelihood. This would include providing institutional care for the elderly, the physically and mentally handicapped of all ages, the mentally ill, children and infants. The decision that the Civil Affairs Department of the Ministry of Home Affairs, (as it was then), should provide psychiatric hospitals for 'three - no's' patients was taken at the Fourth Conference on Civil Affairs Work in 1958. (Chinese Civil Affairs Historical Records, 1986) The impetus for this decision seems to have come from the First National Conference on Mental

Health, held the same year in Nanjing. (Zhang Dejiang, 1987) Prior to that they had provided shelters for the destitute mentally ill who were found wandering in the streets. These shelters provided food and accommodation but little in the way of treatment. By 1964 there were 203 mental hospitals run by Civil Affairs Departments all over the country.

A system of 'out relief' is provided in the countryside by the 'Five Guarantees' scheme which guarantees food, clothing, medical care, housing and burial expenses to those who are otherwise without support who tend to be mostly but not exclusively, elderly people. This is funded through the collective finances of production brigades, although recently problems with this have developed as will be discussed in more detail later.

Civil Affairs Departments at the local level also organise and run productive welfare enterprises. In 1989, they were responsible nationally for 4,651, with a turnover of 48,000,000 renminbi. These enterprises employed 719,000 handicapped people. (Chinese Society News, May 8th., 1990) These small factories are supposed to provide productive work for the handicapped with some working ability but who would not be able to manage in open employment. In 1988, the then Minister of Civil Affairs declared that 'great efforts must be made for the development of factories employing the handicapped', which is entirely consistent with the emphasis placed on the obligation of the state to provide work and the duty of the citizen to perform productive labour. (Cui Naifu, 1988, p. 175)

In 1980, The Ministry of Finance and the Ministry of Civil Affairs issued a _Joint Circular On The Payment Of Income Tax by Welfare Production Enterprises Operated By Civil Affairs Departments._ This entitled any factory with more than 35 percent of disabled workers to be designated a welfare factory and be given certain tax benefits. A further circular was issued in 1984 by the Ministry of Finance concerning _Tax Exemption Matters For Social Welfare Production Enterprises Operated By Civil Affairs Departments._ Under the new policy, eligible units benefited from additional relief from product tax, value added tax and turn-over tax. (Wong and MacQuarrie 1986) It is these tax concessions that have been largely responsible for the increase in welfare factories and enterprises over the last ten years. In Guangzhou there are many welfare factories of different kinds and sizes. Those that make a profit subsidise those that do not.

The Ministry is also responsible for disaster relief and the direct relief of poverty. Small allowances may be paid by Civil Affairs Departments to the unsupported old, young or handicapped who are unable to work and who live in urban areas. On the whole, assistance in the form of loans to buy equipment or training in new skills is preferred to direct financial subsidy in order to make people less reliant on the state and productive. (Wong and Macquarrie, 1986)

The work of the Civil Affairs Ministry is sometimes described as involving 'the most honourable and the most pitiable'. The most honourable are veterans and surviving families of revolutionary martyrs and their families. The Ministry is supposed to guarantee

their livelihood and to find work, accommodation and so on for soldiers on their discharge from the army if they are not able to do this for themselves. One of the results of this is that many veterans are given jobs in welfare institutions as administrators or as party cadres. Another aspect of this close relationship is that welfare factories frequently engage in the making of prostheses, at least some of which are intended for soldiers invalided out of the army.

In a sense the Ministry needs the reflected respect that this association with veterans gives it. As in many other countries, government organs who work with the poor and disadvantaged become 'tainted' by the low regard in which such client groups are held. The Ministry of Civil Affairs is reputed not to wield much influence, nor its functions be given very much priority. As was noted earlier, it receives a minute portion of the national budget - 1.6 per cent. If it were not for its work for veterans, a group enjoying high social status in China, its position would probably be even worse.

The responsibilities of a municipal Civil Affairs Department may be roughly divided into: the alleviation of poverty; the protection of the vulnerable; and civil administration. Appendix 8, an interview with Mr. Zhang who is in charge of the Civil Affairs Bureau in Shashi, tries to give the full flavour of the range of their work.

While functions are essentially similar from area to area there are some variations. Shashi does very little for ex-psychiatric

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patients living in the community either in the way of providing
daily occupation or the provision of supervision and support at
home. Guangzhou is better in this respect. Also it is usually the
case that the Civil Affairs Department provides chronic care
facilities for psychiatric patients, leaving the acute care to the
Health Department. In Shashi, for reasons of what seem to be
historical accident, the Civil Affairs Bureau does both. Its
acute care facility was built in 1958, the year that the policy
decision was taken that Civil Affairs Departments could run
psychiatric hospitals. As the only hospital at the time, it
probably seemed most efficient and logical that it provided a
range of services, responding to consumer demand.

HEALTH POLICY

'The state develops medical and health services, promotes
modern medicine and traditional Chinese medicine, encourages and
supports the setting up of various medical and health facilities
by the rural economic collectives, state enterprises and
undertakings and neighbourhood organisations and promotes public
health activities of a mass character to promote the people's
health. The state develops physical culture and promotes mass
sports activities to build up the people's physique'. (Article 21,
The Constitution of the People's Republic of China, 1981).

In order to have a proper understanding of psychiatric care it
has to be seen within the wider context of general health policy
and care. The issues, (political, economic, historical) that
affected the broad spectrum of health care also influenced the
provision of psychiatric care. A sound understanding has in the
past been hampered by two factors. First, many of the reports by
Western observers in the 1960s and 1970s omitted to explain to
their readers that current policy in Marxist Leninist party

systems is most often a statement of policy goals and injunctions to act rather than a report of implemented policy outcomes. (Lucas, 1979) Archetypal examples of books of this sort are <u>Serve the People</u> by Victor and Ruth Sidel, (Sidel and Sidel, 1973) and <u>China's Social Policy</u> by Issac Ascher (Ascher, 1975)

Second, the Chinese had a vested interest in forgetting all that had occurred pre-1949 in innovative developments in health care. Thus there is a tendency towards 'historical amnesia' (Lucas, 1982) that leads to the pretence that the health policies that have come to be intimately associated with New China, for instance the development of 'barefoot doctors' in rural areas and 'red medical workers' in urban areas, were entirely the devising of the Chinese Communist Party in response to Mao's exhortations to 'serve the people'.

Despite the myriad reports by Westerners on psychiatric facilities in China, it was not until 1988 that any mention at all was made of the fact that it is not just the Ministry of Public Health that runs psychiatric facilities but also the Ministry of Civil Affairs. (Kleinman, 1988) In 1989 a more comprehensive analysis of the division of labour between these two ministries and the Ministry of Public Security in the running of psychiatric hospitals was published. (Pearson, 1989a) At least part of this problem stemmed from the Chinese authorities' reluctance to acknowledge that chronic mental illness existed or that there was a need for forensic facilities.

Even official reports of the number of beds and hospitals in China for the mentally ill are, in the author's opinion, not wholly reliable. There is good reason to believe, based on extensive discussion with Ministry of Civil Affairs officials that not all beds in their system are counted in published statistics. The 1989 Statistical Year Book of China claims that there are 414 psychiatric hospitals in China, providing 81,000 beds. But an internal document on rehabilitation says that the Ministry of Civil Affairs is responsible for 35,000 beds which constitutes over 33 per cent of all hospital beds and that 85 per cent of their beds are occupied by individuals with a chronic mental illness.

Obviously, these two sets of figures do not tally. The probability is that China has about 600 psychiatric hospitals with about 90,000 beds run by three different ministries, with different but overlapping functions. The exact division of responsibility is likely to differ from province to province and between cities and counties depending on custom and resource distribution. In my view, it is almost certain that nobody knows for sure quite how many hospital beds there are and what kind of patients are occupying them.

Themes and Continuities

In 1950, the Ministry of Public Health called the First National Health Conference which laid down the principles that still guide the provision of health services today. These were that medicine should serve the workers, peasants and soldiers; that preventive

health care should take precedence over therapeutic medicine; that Chinese medicine should be integrated with Western scientific medicine; that health work should be combined with mass movements.

When the Communists came to power China was known, accurately, as the sick man of Asia. The World Bank Study of China estimated that in 1950 the average life expectancy was 32. (World Bank, 1984) China was riven by the combined effects of ten years of Japanese occupation, a civil war, a disintegrating social structure, poverty, malnutrition, almost non-existent public hygiene, and endemic and epidemic parasitic and infectious diseases. However, by 1959 life expectancy was 59 for women and 55 for men and in 1985 it was 71 for women and 68 for men. (World Bank, 1989) By any standards, and whatever drawbacks can be detected in the methods used and priorities set, China's achievements in improving the health profile of her people have been remarkable.

The government's desire to see its people healthy was at least partly pragmatic. It believed that this would lead to greatly improved industrial and agricultural production:

'Health work must proceed with a view to developing production. The more intense the production, the more attention we must pay to health work; the better the health work is done, the higher will be the production level'. (Hsin Yun Pei, 1960, p. 49)

Given this commitment, it was always clear to the government that this could not be done by providing expensive curative health facilities. As Li Dequan, the Minister of Public Health, said in 1950:

'With China estimated as needing 5 million hospital beds, five hundred thousand doctors and three to four million auxiliary medical personnel of all kinds and with tens of millions of people yearly suffering from preventable communicable diseases and epidemics it is obvious that a short route must be found to the problem and it has: stop people from getting sick'. (Quoted in Hillier and Jewell, 1983, p. 151)

This emphasis on prevention and public health work continues today. At the 1990 National People's Congress the Prime Minister, Li Peng, declared:

'In the health field we shall further deepen the reform, ...We shall stress preventive health care and rural health work and do a superior job in the prevention and treatment of major diseases in order to further improve hygiene in both rural and urban areas'. (Beijing Review, April 17th., 1990, p.xix)

What facilities in terms of doctors and hospitals that China did have tended to be concentrated in the coastal provinces and in urban areas. The market forces of private practice favoured the wealthy cities. Shanghai was estimated to have 25 per cent of the nation's wealth and 22 per cent of its doctors and most of those were located in the International and French concessions. (Hillier and Jewell, 1983) Guangzhou was in a similar position. In 1934 it was claimed that:

'There are more than enough doctors and hospitals in the city to adequately care for the population but it does not follow that the population is adequately cared for....In Canton, wealthy as it is, hardly 10 per cent of people would be able to pay for good scientific medicine on a private practice basis'. (Oldt, 1931, p. 665)

Doctors of Chinese traditional medicine followed the same pattern of distribution as Western trained physicians so in effect the majority of the population had no access to professional health care of any sort. Shamans were viewed perjoratively. George Hatem in an interview with a Western journalist said:

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'The witch doctors are banned, they are dangerous. We got rid of them by introducing them in yangko plays so that the people laughed at them and we got them better jobs - gave them farms - anything as long as they would stop harming the people. The herb doctors, the acupuncturists and the midwives we kept but we gave them training in the essentials of Western medicine. Chinese herb doctors have done an enormous amount of good.' (Payne, 1947, p.358)

China then, as now, was faced with the question of limited resource allocation that bedevils all governments in the question of health service provision. All allocations of resources under these circumstances embody values that guide choices about what to fund. Davis and George (1988) argue that there are essentially four different schemes upon which choices may be based; meritocracy, where the social status, moral worth, or productivity of the person are most important; utilitarianism, where governments attempt to maximise the help provided to the largest number of people; egalitarianism, where all are equally deserving and access is settled by lottery methods or on a 'first come, first served basis'; and finally, the technical decision based on who has the best prognoses and who will benefit most.

Davis and George go on to argue that at least one of the problems that policy makers face is that there is no way of determining which of these strategies is the best. However, this may not be true for China, at least at the level of ideology as opposed to practice. Meritocracy clearly guided the decision that health services should be provided for workers, peasants and soldiers. Certain people, like ex-rich landlords and their families were deliberately excluded from receiving certain health benefits (like belonging to insurance schemes). (Vermeer, 1979; Lucas, 1982)

Utilitarianism dictated that resources should be aimed at public health and preventive measures rather than expensive curative services. Mass mobilization (for instance in the anti-schistosomiasis campaign, hygiene movement, and the eradication of pests) was not only ideologically preferable but the only financially feasible strategy for achieving these goals. Both meritocracy and utilitarianism were coherent with communist ideology.

Conflicts about scarce resource distribution are supposed to be correctly resolved through the Party via democratic centralism and articulated to administrators and people through the 'mass line'. Contrary to theory conflicts and competition continue between local and factional interest groups, even after official party policy has been formulated. (Lucas, 1979)

Without the authoritarian organisational structures that typify the Chinese Communist Party it is doubtful whether such strategies could be implemented elsewhere. Indeed efforts to copy the 'barefoot doctor' strategy directly failed in Iran. (Sidel and Sidel, 1982) Nonetheless, China's achievements in improving its citizens' health profile have generated much interest in both the developed and developing world.

Diffusion and Its Effects

'The multi-sectorial influences responsible for improving health conditions in China - as well as the emphasis within the health sector on prevention, on community mobilization and finance and on barefoot doctors - have strongly influenced the thinking of health care professionals throughout the developing world. Indeed the Alma-Ata declaration on 'health for all by the year 2000' through a strategy of primary health care was much influenced by

the Chinese model'. (World Bank, 1984, p.xi)

Midgley defines the use of the term diffusion in social science;

'... to connote the transmission of ideas, policies and practices in the welfare field between countries. Used in this way, the concept of diffusion may refer to the development of social welfare institutions through the exchange of information and views between policy makers or to the adoption of welfare policies or practices of one country by policy makers in another: it may result in the discerning adaptation of foreign experiences or the uncritical replication of alien welfare policies'. (Midgley, 1984, p. 170)

What is perhaps most interesting about Chinese health policy and its influence on other nations is that it is in fact, at least partially, a re-export. AnElissa Lucas (1982) in a major contribution to the field, points out that other authors have tended to accept China at its own evaluation and believe that China's contributions to the field of health care were largely original. Even a seminal study, like that of Lampton (1977), fails to link health care policies extant in China in the 1930s with developments after 1949. The Sidels go so far as to say:

'These principles were an amalgam of tenets adopted by Mao and his followers during the long period of revolution prior to 1949 and those prevalent in the Cultural Revolution'. (Sidel and Sidel, 1982, p. 5)

In fact, many of the health reforms introduced by the Communists were policies introduced into China by the League of Nations Health Organisation at the request of Chiang Kai Shek's Nationalist government. They were most particularly concerned with the lack of care provided in rural areas, bearing in mind that China's population was a largely rural one. Two experts in rural health care from Yugoslavia were asked by the League of Nations to

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advise China on establishing a system of health provision in rural

areas. What they advised relied on what was later to be known as

mass mobilization and self-reliance:

> 'Although the peasants have not passed through a technical
> school and though many are illiterate, they often realise their
> own needs better than people who come from the
> cities......Particularly in countries with predominantly peasant
> populations, there exist immense moral and physical resources that
> .... can make up for what agricultural villages lack in money'.
> (quoted in Lucas, 1982, pp. 66-67)

A model rural health project was established in Jiangning, outside

Nanjing. Another rural health demonstration project was

established at Dingxian, about 60 miles from Baoding. This project

was backed by the Peking Union Medical College and the Rockefeller

Foundation.

Both projects were organised around a county wide network of

medical institutions, which were staffed by different grades of

medical personnel from urban specialists down to basic grade

health workers. Each village health worker was selected by the

village's self government organisation for ten days to six weeks

of training at the sub-centre health station. Each sub-centre

health station was staffed by a physician and a nurse. The health

workers received additional training in public health at county

level hospitals. These attempts at rural reforms in health service

provision came to an end with the start of the Sino-Japanese war

in 1937.

Lucas (1982) points out that the village health workers of the

1930s differed little from the 'barefoot doctors ' of the Cultural

Revolution. If the barefoot doctors were more successful, it was

because medical technology had advanced so that they had more to

offer than the 1930s village health workers. Furthermore, these model rural health projects established the principle of referring difficult cases up to more specialised facilities at county, city and even provincial level, a policy which continues to this day.

Lucas even goes so far as to claim that the Yenan health reforms instituted by the Communist Party in their Gansu-Ningxia border region stronghold during their opposition to the Nationalists and the Japanese, closely resembled the reform policies recommended by the League of Nations advisers and pursued in Jiangning and Dingxian. The 'socialist newborn thing', as barefoot doctors were called, was not so much new born as adopted. More realistically, the contribution of the Communist government lies with successfully operationalising the policy nationally, which the government of Chiang Kai Shek was never able to do.

The Current Organisation of Health Services in China

Hillier and Jewell (1983) give the following summaries of the current structure of urban and rural health care.

Table 2:1:   Organisation of the Urban System of Health Care In
             the 1980s

Specialist   city   -   Teaching,   research,   specialist
              departments,   medical   hospital   and   surgery
              (100-700 beds) University trained doctors. State
              funded. Attached medical schools and research
              institutes. Serves national population.

Municipal/   - Teaching, research, specialist departments,
Provincial   medicine and surgery, obstetrics (100-500
                 beds). University trained doctors.   State
                 funded. Attached medical schools, colleges.
                 Large OPD. Serves population of 1 million and
                 one sector of a city.

District hospital - Training (barefoot doctors, red medical
                 workers, family planning workers), general
                 medicine   and   surgery   (100-200   beds).

State/city funded - Large OPD. Serves population of 200,000
                 (one sector of a city).

Factory/neighbour-   - General medicine and surgery (10-50
hood hospital   beds). Local/factory financed. Inter-
                         mediate level (sometimes   university
                         trained) doctors, worker doctors,
                         pharmacists, dentists.   Large   OPD
                         Preventive inoculations, obstetric,
                         family planning, abortion.   Serves
                         population of 10-20,000.

Neighbourhood   clinics - Run by street doctors (red medical
                         workers),   3-6   months   training.
                         Mainly family planning,   preventive
                         inoculations, care of chronic sick.
                         Serve population of 2-3,000.   Visits
                         from local hospital personnel for
                         antenatal, post-natal, and   family
                         planning.   Municipal   finance/local
                         finance.

Lane clinics -   Run by street doctors (part-time) and
                         part-time sanitary worker. Organise
                         preventive   campaigns   and   family
                         planning.

Source: Hillier and Jewell, 1983, p.139

Table 2:2:   Organisation of Rural Health Care In the 1980s

Provincial   hospital   -   Teaching,   research,   specialist
             medicine (5-600 beds). State funded, university
             trained doctors. Large OPD. Serves population of
           . 1 million.

County hospital   -   Training   (barefoot   doctors),   internal
             medicine and surgery.   State funded (40-100
             beds), university and intermediate doctors and
             technicians. Large OPD. Serves population of
             200,000.

 Commune   -   Some   training   (barefoot   doctors),   internal
             medicine,   hospital/clinic   simple   surgery,
             obstetrics,   abortions,   antenatal   care.
             State/commune funded (10-50 beds, often more).
             Large OPD, intermediate and barefoot doctors.
             Serves population of 12-50,000.

Brigade   clinic   -   Dentistry,   out-patient   treatment,
             preventive inoculations, antenatal care,   family
             planning, brigade/commune funded. 2-5 barefoot
             doctors. 2-3 part-time health workers.   Serves
             population of 2-4,000.

Production   team   -   Preventive   work   (organise   mass
             campaigns), family planning, basic first aid
             treatments, antenatal care, brigade funded, 1
             part-time barefoot doctor, 1-2 part-time health
             workers. Serves population of 200-500.

Source: Hillier and Jewell, 1983, p. 138.

On the surface, both urban and rural populations seem to be

reasonably well covered   by the health system. However, this

disguises the reality that rural areas are more poorly served.

They find it difficult to attract the better qualified doctors who

are reluctant to work in remote areas. Life is hard, education for

children is poor and there is little contact with colleagues and

less   opportunity to earn significant sums of money.   Furthermore,

care for psychiatric patients is very bed-dominated, with little

in the way of community care or training amongst paramedics as to

how to treat psychiatric illness. The logistics of providing

psychiatric care for a rural population are frightening. The Civil Affairs Department hospital in Shashi has 500 beds and serves an urban population of 270,000 and a rural population of 11,000,000. Physical distance and lack of health insurance usually mean that patients in rural areas consult the provincial and specialist hospitals less than their urban counterparts. Effectively, rural patients have far fewer choices open to them in seeking health related services.

Barefoot Doctors

Mao's strategy included 'walking on two legs', which meant giving equal emphasis to the 'treasurehouse' of Chinese medicine; changing the focus of practice to the rural areas; and training doctors with just three years of primary schooling. Barefoot doctors are first mentioned in 1955, in a commune in Henan implementing a co-operative medical system. (N.S. Zhu et al. 1989) The medical schools closed down in 1966 and many of the staff were criticised, beaten, imprisoned but mostly sent down to the rural areas. It was in the same year that an official report first mentioned barefoot doctors:

> 'A new type of peasant physician who is both a medical worker and a peasant is coming into being in every part of China. With a current campaign to extend the medical services....group after group of city doctors have been going into the countryside and large numbers of graduates of city medical colleges have been assigned to work in county hospitals or commune clinics. But this is only part of the answer and in order to ensure that adequate medical and health services become available to peasants everywhere part study part secondary medical schools are being set up to train secondary medical personnel amongst the peasants locally'. (quoted in Hillier and Jewell, 1983, p. 362)

Barefoot doctors had variable amounts of training that ranged from six weeks to 18 months (spread over a period of years). They were expected to be, at the least, responsible for sanitation and hygiene work, vaccination and inoculation, maternal and child health and treating common and minor illnesses. Much of their training was based at county level hospitals, which usually had an intermediate level trained doctor on the staff. Barefoot doctors were selected and financed by their production brigades and were expected to continue to work part time in the fields. The original idea was that they were a link in the referral chain but by about 1970 the press were lauding the feats of barefoot doctors who performed advanced surgery and treated difficult cases, which has to be interpreted as a sign of official policy. Between 1966 and 1976 over two million people were trained as barefoot doctors. (P.C. Chen and C.H. Tuan, 1983)

However, by the early and mid-1970s when people were more free to speak out, deep concern was expressed about the adequacy of the service provided by barefoot doctors. In 1973 Deng Xiao Ping suggested that barefoot doctors should 'go from barefoot to sandals and from cloth shoes to leather shoes'. (Quoted in Hillier and Jewell, p. 370). The Sidels report that Deng once walked out of a showing of a propaganda film on the work of barefoot doctors which he thought to be portraying them going well beyond their levels of competence. (Sidel and Sidel, 1982, p.40) The expectations of many of the people have been raised about the quality of care to which they are entitled and many are in a position to distinguish between good and bad value. Amongst other

things, it was the dissatisfaction of the ordinary people with the quality of the barefoot doctors that led to their upgrading in training, status and salary.

The National People's Congress held in 1980 passed a resolution that agreed that the name of the barefoot doctors should be changed to the Western term 'paramedic'. Since about 1978 the numbers of barefoot doctors have dropped significantly, partly due to problems in funding, lack of status and insufficient salary. Standards of training have been raised. By 1986, 40 per cent of barefoot doctors had attained the level of medical school graduates, and upon passing a qualifying examination were certified as village or country doctors. (N.S. Zhu et al., 1989; S.M. Huang, 1988)

Medical Training

Diffusion is also an issue that is relevant to the introduction of Western medicine and training into China. The desire for trade drove the West to open up China and in the wake of the merchants came the missionaries. Christianity did not find Chinese soil to be as fertile as Bhuddism had at an earlier time. One of the ways that missionaries found was effective in gaining an audience was to provide something that the Chinese could see was of practical value. Initially this was surgery. From 1835, Peter Parker at the Canton Hospital performed operations without benefit of anaesthetics or aseptic techniques with a skill that demands respect even today. One missionary doctor, commenting rather ascerbically on the new emphasis on public health, remarked that

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'China was opened with a lancet and not a fly swatter'. (Quoted in Hillier and Jewell, 1983, p. 41) It was John Kerr at the Canton Hospital who pioneered the first missionary medical school in 1866.

As the missionary hospitals began to train Chinese doctors, other overseas organisations started to take an active interest in sponsoring training institutions in Western medicine. In 1906 the Peking Union Medical College backed by the Rockefeller Foundation via the China Medical Board, was opened. St. John's College, Shanghai, incorporating St.Luke's Hospital, came to an agreement in 1914 with the trustees of the Pennsylvanian Medical School to link up. In 1913, Xiangya Medical College in Changsha, Hunan was founded as a joint project with the Yale-in-China Association. This started the trend towards what was called 'scientific medicine', with a strong bias towards curative medicine, courses of between six and eight years long and a major focus on research. Graduates from these programmes were often employed as faculty members, and if they did go to practice it was usually in the coastal areas and foreign concessions. Thus, these elite schools did little to improve the parlous state of health of the majority of the population.

The dilatory and ambivalent attitude of the Chinese government towards the provision of more medical training and health services at this time may be contrasted with that of the Japanese Meiji Emperor who declared that in 1870 'wisdom and knowledge shall be sought in all parts of the world'. To this end, the Japanese government sponsored students to study medicine, science,

technology and engineering in centres of excellence - wherever they might be.

Many of the medical students went to Germany where they came back impressed by the 'two tier' system of training that produced two types of doctor. One was the highly qualified university graduate. Another undertook a much more truncated form of training, usually three years, and was expected to be competent in the diagnosis and treatment of everyday diseases. Japan went on to copy this system. By 1913, Japan had graduated more than 15,000 practising state registered physicians from its two level, state regulated medical university and special college system. In contrast, there were reportedly only 500 Chinese medical students being given training in the variety of missionary apprenticeship programmes, hospital-schools, and union medical colleges operating throughout China. Even by 1934 it was estimated that there were only 5,390 physicians trained in modern medicine practising in China. (Lucas, 1982)

A number of Chinese students went to Japan to study medicine in the intermediate medical schools and staffed the provincially supported medical schools established under the Republic after 1912. Thus the various governments and policy makers of China had a variety of models to follow when they began to think about establishing a national policy. The 1931 League of Nations Health Organisation Report on Medical Schools in China recommended a two level system of medical education for China: national medical colleges to produce 'high grade physicians' and experimentally

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upgraded provincial level medical schools to train a larger number of medical practitioners. (Lucas, 1982)

This two `level system of education is still in place in China today. From its instigation, it has been the subject of a 'quality versus quantity' debate. It has been argued that with limited resources and a vast population, China could not afford to train all the necessary medical staff to the highest level. It was therefore better to have larger numbers, adequately trained to deal with common illnesses and who could recognize what was beyond their capacity, so that the patient could be referred to more sophisticated facilities.

The issue of equity and the rural-urban divide was of even more importance to the Communist government than it was to that of the Nationalists. Mao Zedong formed the opinion that the Ministry of Health was not doing sufficient to provide doctors and services to the rural areas. Furthermore they also represented an elitist bastion of medical power, favouring lengthy training, research and high technology. He issued his famous directive of June 26th 1965 which became the foundation of all policy initiatives in the health sector for the next ten years. It is worth quoting at some length:

'Tell the Ministry of Public Health that it only works for fifteen per cent of the total population of the country and that this fifteen per cent is mainly composed of lords, while the broad masses of the peasants do not get any medical treatment. First they don't have any doctors. Second they don't have any medicine. The Ministry of Public Health is not a Ministry of Public Health for the People, so why not change its name to the Ministry of Urban Health, the Ministry of Lord's Health, or even to the Ministry of Urban Lord's Health?

Medical Education should be reformed. There's no need to read
so many books. In medical education there is no need to accept
only higher middle school graduates, It will be enough to give
three years to graduates from higher primary schools. They would
then study and raise their standards mainly through practice. If
this kind of doctor is sent down to the countryside, even if they
don't have much talent, they would be better than quacks and
witchdoctors and the villages would be better able to afford to
keep them. The more books one reads the more stupid one gets....We
should leave behind in the city a few of the less able doctors who
graduated one or two years ago and the others should all go to the
countryside.....In medical and health work put the emphasis on the
countryside'. (Quoted in Lampton, 1977, p. 185-186)

Chen and Tuan discuss the question of people entering the health
care system with no training at all. They say that there are
essentially two reasons for this. First, that during the Cultural
Revolution many people with no training were given jobs because of
nepotism and factionalism. Secondly, since 1978 with increasing
unemployment, county and municipal governments have resorted to
the practice of letting children 'inherit' their parents' jobs.
Chen and Tuan claim that since 1966, 42 per cent of persons
recruited into the nation's health care system had no prior
training in health care whatsoever. In Jilin province, in 1980,
4,007 out of a total of 6,009 persons recruited into the
provincial health care system had no prior training.

In June 1981 the Chinese Communist Party Organizational
Department and the Party committee of the Ministry of Health
issued a joint statement calling on the CCP party committees at
all levels to 'strive not to or to appoint as few as possible'
persons without proper training to the health care system. They
were enjoined that in filling vacancies, graduates of the medical
colleges or the middle level medical schools should be looked upon
as the major source of candidates. Chen and Tuan emphasize that

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the position has improved somewhat since this circular was issued. (P.C. Chen and C. H. Tuan, 1983)

As far as can be ascertained there is not now and never has been any system of accredited post-graduate specialist training. There are doctors who specialise in psychiatry and who, at least in Beijing, study for a Master's Degree in medicine. Post-graduate training is reported to have been initiated in psychiatric hospitals in Shanghai, Changsha, Siping, Chengdu, Beijing and Nanjing. (Xia Zhengyi and Zhang Mingyuan 1981) This is likely to be no more than a drop in the ocean and the more usual system of training seems to be based on learning by observation, through apprenticeship to an older expert who in turn has learned what he knows through many years of practice. There are nationally accepted hierarchical grades for doctors and provincially organised exams must be passed before a doctor is eligible to proceed to the next grade. All exams have two components, one generic and the other in the doctor's specialism. In the late 1980s rules were promulgated to try and ensure that standards were even and procedures uniform from province to province.

A newly qualified doctor must spend seven years at the first level before he is permitted to take the first promotion examination. The exam to reach the third level requires another five years of practice to become eligible. Doctors are not allowed to enter themselves for the examinations and must be sponsored and nominated by their hospital. This obviously leaves room for favouritism and influence. The Ministry of Public Health and the Ministry of Civil Affairs set their own exams which are supposed

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to be equivalent. The status of each grade is the same in each ministry, although salaries may be generally higher in the Ministry of Public Health.

Passing the exam does not bring automatic promotion. Younger doctors often have to wait for older doctors to retire or to be promoted in their turn before a vacancy at their appropriate level of qualification becomes available. Thus expertise in any specialism tends to be acquired through self-study if the person is enthusiastic and motivated, or is assumed to exist if the doctor has worked in that area a long time. If a Chinese doctor begins a sentence 'in my thirty years of experience' it is expected to preclude further argument. And it usually does.

FUNDING

It is a common but erroneous impression that because China has a socialist/communist political system it upholds universalist principles of accessibility and provides services free to all its citizens. This is not the case:

> 'The social security system in China ......comprises two different parts: one for workers working in the cities and the other for those unable to fend for themselves all over the country'. (Chow Wing Sun, 1988, p. 30)

The Labour Insurance Regulations were first promulgated in 1951. Although amended in 1953, 1958 and 1978 their basic structure remains the same. The regulations cover all workers and staff employed in state operated, joint state-privately operated, privately operated or co-operative factories, mines and railways. The entire scheme is a non-contributory one and the enterprises

are responsible for shouldering the whole burden of sickness and disablement benefit, maternity leave and pensions.

The rules, which are still in operation in many places, entitled workers injured at work; to medical treatment at designated hospitals and clinics; wages in full throughout the period of treatment; and 60-100 per cent of wages when certified to be wholly disabled. Injury, sickness and disablement not sustained at work are also provided for, with 60-100 per cent of wages being payable for up to six months and in some places longer. Dependent family members of the worker would also be eligible for sickness benefits.

These regulations discriminate against urban workers who are not employed by large enterprises, as the regulations apply only to enterprises employing over 100 or more, and the vast majority of the population who are peasants. An additional problem of recent genesis is that of individual workers in the urban areas who have no labour insurance protection. One estimate puts their number at 20,000,000. (Wei Xing Wu, 1988) If the unemployed, also a recent phenomenon, were included this figure could quite possibly double.

Chow Wing Sun (1988) argues that the new Communist government considered generous welfare benefits for urbanites necessary in order to ensure the stability of the regime. The peasants had more to gain from the Communists because of the immediate land reform measures that were instituted and the Communists' major base of support had been amongst peasants. They needed to do something to demonstrate to urban dwellers that the new regime also had something tangible to offer to them.

Initially, the enterprises paid their benefit contributions into a labour insurance fund which provided some element of risk sharing. However, the labour insurance scheme ceased to operate during the chaos of the Cultural Revolution. In 1969 the Ministry of Finance issued an order that the relevant benefits would be paid directly by the enterprises as labour insurance expenses. This in effect discontinued the labour insurance funds and led to benefits being paid directly out of operating expenses. At the time this caused little concern because there were few retired workers.

However, now it is largely conceded to have been a mistake. Very few enterprises created their own benefits fund. Consequently, the longer established the enterprise, the greater the number of retired, disabled or sick workers whose benefits have to come out of the operating expenses. This puts the newly established enterprises in an advantageous position because with fewer retired, disabled or chronically sick workers they have more money to re-invest in equipment, research and so on. (Wei Xing Wu, 1988)

While in 1952 labour insurance expenditure was equivalent to 14 per cent of the payroll, in 1984 it was 24 per cent. Currently, enterprises are expected to put aside 11 per cent of the payroll to fund medical benefits plus other collective welfare schemes like homes for the aged and canteens. Chow Wing Sun (1988, p. 42) gives an example of one enterprise where medical benefits constitute 67 per cent of direct labour insurance payments made to workers in 1980 (excluding retirement pensions).

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Chow estimates that the benefits of the labour insurance programme are unavailable to at least 80 per cent of workers and their families in China. What arrangements then are made for the peasants who form the majority of the population? From the very beginning of the People's Republic there was never any question that medical services would be provided free to all citizens. Resources then and now do not permit it as a viable option. One way of approaching the problem was to establish that good health was not a gift that a caring government gives its people but a condition for which people must take partial responsibility themselves. But the best public health and preventive measures in the world will not obviate the need for some curative services.

The provincial governments took most of the responsibility for the provision of hospitals down to the county level. However, their plan was that the communes, first established in 1958, should be made responsible for the provision of health care at commune, production brigade and production team level. (Communes consisted of on average between 20,000 and 50,000 residents). The mechanism for doing this was to be co-operative health insurance.

As with the other 'socialist new born thing' this one was more truly adopted. Rifkin (1973) claims that this plan had first appeared in 1958 but did not become nationally established until 1968. In fact, a co-operative health insurance scheme seems first to have been proposed by the Nationalist government in the first Three Year Plan (1931-1934) for a Chinese national health service, although there is no indication that it was ever widely adopted. The talent of the Communist government lay with the

operationalising of these ideas.

Under the system, each commune or brigade member paid a standard fee which then went into a collective pool out of which medicines, a portion of hospital costs, equipment and barefoot doctors' workpoint remuneration were paid for. Using this method it was possible to finance local health care facilities and remove the burden on county hospitals. Being locally based and composed of individual contributions it was possible to control waste since people were more sensitive to abuses. Co-operative health insurance also fitted the emphasis on self reliance supported by the Communist Party.

There were problems. It did not contribute to the re-distributing of resources from the richer areas to the poorer ones. Healthier peasants within communes were reluctant to subsidise those who were heavier users of the scheme. Many of the schemes, particularly at the beginning had insufficient funds to meet the demands on them so that a small registration fee was introduced to try and reduce requests for payment. Certain groups, like ex-landlords, rich peasants and those who had committed political errors were specifically excluded from many brigade schemes despite the fact that through their labour they had contributed to the surplus that made the scheme viable.

Lampton makes the point that from 1958 onwards, anti-parasite campaigns, like the one to eradicate schistosomiasis, and the organisation of health services at commune level and below, became the responsibility of political cadres who were answerable to the

Party hierarchy, not the Ministry of Public Health. The Ministry had very different priorities involving education, research and curative programmes. Politically ambitious Party cadres wanted 'free' medical care in the communes as a tangible sign to leaders and followers that they were advancing towards socialism. Commune health centres had the appeal of providing an inducement to peasants to participate in the communization movement.

This splitting of responsibilities for the development of health policy minimized the capacity of the system to co-ordinate policy initiatives, creating unintended consequences. Thus when the commune health centres were expanding, creating a greater need for staff the Ministry of Public Health lengthened medical training programmes. There were problems in meeting the increased demand for drugs created by expanding health services into the rural areas in the late 1950s. Despite the intention that production brigade clinics and commune hospitals would be able to absorb most of the demand for services, in reality unprepared urban hospitals were swamped by referrals from the rural areas. In the late 1960s, barefoot doctors, instead of lightening the load as they were supposed to do, increased the burden on urban hospitals by finding more disease than many areas had resources to treat.

The success of the schemes always depended on the surplus generated by any commune or brigade in a year. Richer provinces could afford more than poorer provinces. Thus financing was forever uncertain. Co-operative medical insurance continues to be the way in which peasants are supposed to share the burden of

financing health costs.

From personal observation, which is confirmed by a number of
authors (Chen and Tuan, 1983; Hillier and Jewell, 1983; Chow Wing
Sun 1988; Henderson, 1990), the system of co-operative health
insurance has been severely undermined by the dismantling of the
commune system since the decision taken at the Third Plenum of
the Communist Party in 1979 to let peasants cultivate their own
plots in line with the 'open door' policy. It also allowed
villagers to mix agriculture with industry, thus fuelling the
major growth area of the Chinese economy in the last ten years.
Without the communally organised finances at brigade or commune
level there is no basis for co-operative insurance because, on
the whole, families prefer to bear the risk themselves. For some
families with children in Guangdong it has been estimated that
health insurance contributions will absorb ten per cent of their
yearly disposable cash income. (Hillier and Jewell, 1983)

'If the cost of using health services is high in relation to
their incomes, the poor will use them only when they regard it as
desperately important to do so. They will hope that illnesses will
cure themselves, as many do.' (Abel-Smith and Leicerson, 1978 p.
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In 1975 an estimated 84.5 per cent of the rural Chinese population
was covered by collective financing in health care. By 1985, this
had fallen to 39.9 per cent. (N.S. Zhu et al., 1989) The same
authors go on to point out that this cannot all be attributed to
the effects of the 'contract responsibility system', because the
changes in rural areas have not been uniform. They say that local
community leaders in their study feel that the government has

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stopped actively promoting communal health insurance and its barefoot doctors, and this contributed substantially towards the system's decline.

Private practice was strongly discouraged from 1949 onwards although at times it was the only way that a number of people, particularly in the rural areas, could gain access to any curative health care at all. In 1949 there were 6,669 private practitioners; 2,829 in 1956; 1,514 in 1965; 506 in 1981; 432 in 1984. (1985, China News Analysis, p. 51) Since the contract responsibility system was introduced private practice has gradually re-emerged. In 1980 the State Council approved a report of the Ministry of Public Health allowing doctors to practice privately. (People's Daily, September 6th., 1985, p.4) Judging from the aforementioned figures this seems to have had little effect until 1985 when 80,200 were registered (9,200 in the cities and 71,000 in the countryside, 78 per cent of whom were practitioners of Chinese traditional medicine. (China News Analysis, 1985, No. 1296; Hillier, 1988)

On April 25th, 1985, the State Council approved a Report of the Ministry of Public Health on Some Policy Questions Concerning the Reform of Health Work. Amongst other reforms, this permits individual health practitioners to open hospitals and clinics and practice medicine independently. This has even extended to the psychiatric sector. Doctors at Anding Hospital told me that there were at least two small private hospitals in the suburbs where the major qualification of the staff was said to be well-developed muscles. A more recent article in the China Daily (March 18th.,

1989) reports that there are 18 privately run psychiatric hospitals in Beijing providing 2,000 beds which constitutes 40 per cent of all available psychiatric beds in Beijing, according to figures given in the same article.

Hillier (1988) considers that there is increasing pressure from the state for new hospitals to be collectively owned and run and for all hospitals to be responsible for their own survival. The official view is that the state's responsibility is to provide basic preventive services while, curative health services should be paid for by the consumer.

In 1987 I visited a commune about 20 miles outside Kunming, the provincial capital of Yunnan. Commune leaders told me that their commune had previously been served by seven doctors (or possibly more appropriately, paramedics). Since 1986 only two doctors staffed their health clinic on a private practice basis. They were contracted to provide health care for all the commune children from the age of 0-6 years old. This cost two yuan per child per year and included immunisation. The two doctors bought medicine in bulk and then sold it to the villagers at a retail rate. Hospitalization was not subsidised at all. The average cost of an operation at that time was 100 yuan and if the family did not have it they had to try and raise the money as a loan from friends and more distant family members. This is, of course, only one example. P.C. Chen and C.H. Tuan (1983) and N.S. Zhu et al. (1989) outline a variety of ways in which co-operative medical schemes have adapted. But it is quite clear that the system is in disarray

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and that many families in China are left to carry the considerable burden of hospital charges unassisted.

Lampton, (1977), Hillier and Jewell (1983), S.M. Huang (1988), and Chow Wing Sun (1988) all comment that at various times and for various reasons the Chinese health system has been swamped with people way beyond its capacities to cope. For instance, Lampton (1977) points out that when the Labour Insurance regulations were first promulgated in 1951, four million urban workers, many of whom had probably never had access to a doctor before, suddenly found themselves eligible for free medical care. Not surprisingly, they flooded to the doctors and hospitals. Cadres, officially or unofficially, enjoyed special privileges and were particularly demanding. They were often entitled to better rooms in hospitals and wished always to have the more expensive medicines. Doctors were reduced to prescribing placebos or on occasion suggesting mental hospital admission as a deterrent to patients who were frequent, but healthy, users of the service. (Hillier and Jewell, 1983, p. 100)

Both Cui Naifu (1989) and Chow Wing Sun (1988) express the view that medical benefits available under the Labour Insurance Regulations are too generous and are open to abuse, both by patients and hospitals. At various times different rationing systems have been in force to control access to health care in China. In rural areas, the nearest hospital is often over 100 miles away and families find the journey on public transport a very difficult one, only to be undertaken in the most dire of circumstances. Once there, clinics are often full to over-flowing

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and being seen by the doctor entails joining a long queue. Most frequently of all there is the question of cost.

During more prosperous times, hospitals are able to charge large sums of money for in-patient care in order to reduce their waiting lists. The introduction of the contract responsibility system into hospitals in the mid 1980s has made bonuses (often making up 50 per cent of an employees 'take home' pay) dependent on generating fee income. Thus ever more imaginative ways are found to extract money from patients, often through the provision of dubious treatments which are charged for individually. Psychiatric medication which could perfectly well be administered by injection or orally is given by intravenous drip because it costs more. In some hospitals, individual doctors are given a target of a monthly income to generate. If they fail to meet their target all the staff on that ward are financially penalised. Thus peer pressure is brought to bear in order to maintain personal and hospital income.

A first class bed in the psychogeriatric ward of Anding Hospital costs about 1,000 yuan, which is approximately nine times the average workers take home salary per month. Admission to an ordinary psychiatric ward costs about 500 yuan a month and a month's deposit is expected in advance. If a patient is not covered by insurance supplied by his work unit, costs can be crippling. Much needed care may simply be unaffordable. Furthermore, in times of economic hardship the tendency is for patients who have comprehensive insurance to stay longer because

the hospital has no incentive to discharge someone who is a reliable source of income.

Where Do The Poor Go?

One of the major tasks of the Ministry of Civil Affairs is to provide a safety net for the 'three have nots'. One may ask, with the introduction of the contract responsibility system, where do the poor go? In a speech given at the Second National Mental Health Conference, the Vice Minister of Civil Affairs Zhang Dejiang (1987) argues that:

> 'We must face reality and develop self-pay care. With the increase in living standards of the people and the continuous development of society there are fewer and fewer mental patients who have no family to go to, no financial resources and no supportive network. There are more and more who are doing nothing productive for society but who dc have family support. To work with this reality and to cope with the need of society and expectation of the people we broke the old way of working and shattered the original idea of the 'three have nots'. This eliminates problems for society, the patients' families and the <u>danweis</u> and has got very good results. According to initial statistics, at present over 50 per cent of mental patients cared for by the Civil Affairs Ministry are self-funded. Experience illustrates that the advent of self pay care has been deeply welcomed by families and <u>danweis</u> and has made the hospitals full of life and activity'.

This is all very well for those who can pay. But it has changed the basis of hospitalization, bearing in mind that a psychiatric bed is a relatively scarce resource, from those who need it most to those who can afford it. It discriminates in favour of those who are covered by the Labour Insurance Regulations and against those who are peasants. It also does not address the question of what happens to those people who need long term care. The 'three have nots' are the totally destitute. But there are hundreds of millions of people in China who for various reasons have not been

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able to benefit from the economic reforms and who are just plain poor. They have families, means of support and a livelihood but that does not put them in a position to pay very high hospital fees. The Guangzhou hospital operated a system of fee remission for the poorer self-pay patients. This was not the case in Shashi. The introduction of a fee income system means better bonuses for staff and perhaps a pleasanter type of patient to treat. It may even lead to the upgrading of hospitals, which will of course benefit patients. But it is done at the expense of poor and chronic patients and to argue otherwise is to be dishonest.

A MEMORANDUM ON PSYCHIATRIC CARE

Contrary to experience in Western countries, it is very difficult to find material in either Chinese or English that concerns policy and planning directions in psychiatric care. My impression is that there is even less in this specific area than there is about health and welfare generally. What little there is is classified as neibu, which means internal and definitely not for the eyes of foreigners. Consequently, I have been extremely fortunate to acquire a policy document concerning the Second National Meeting on Mental Health which was held in Shanghai in 1986 and jointly called by the three Ministries most concerned with mental health work; Civil Affairs, Public Health and Public Security. (The First National Meeting was held in 1958 in Nanjing and is discussed at length in the chapter on the history of psychiatric services in China.)

The document is a memorandum to be circulated to all 'departmental

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officers concerned in local people's governments in all provinces, autonomous regions and municipalities, with copies to Public Health, Public Security and Civil Affairs Departments in all provinces, autonomous regions, and municipalities'. The memo is entitled <u>Opinions About Strengthening Mental Health Work</u>. It is accompanied by the message that it has 'been approved by the State Council and is now distributed to all of you. Please carry it out thoroughly according to the local situation'.

The first paragraph concerns the achievements in mental health work since the First National Meeting, but after that the memorandum is exclusively concerned with the problems and what to do about them. The problems are listed as follows:

1 - that there is insufficient understanding about the importance and urgency of mental health work and 'many comrades do not appreciate the internal relationship between mental health work and the construction of socialist spiritual civilization'. Insufficient emphasis is put on this work and it lacks support.

2 - there is an obvious increase in the occurrence of mental illness. Currently there are more than ten million mental patients in China. With industrialization and modernization psycho-social factors associated with mental illness develop continuously. The occurrence rate has increased from 0.7 per cent in the 1970s to 1.54 per cent in the 1980s and is growing. Nearly half of all psychiatric patients experience relapse and cause 'serious danger' to society.

3 - there is a serious shortfall in agencies doing mental health work, in hospital beds, funding and manpower. Mental hospital buildings are old, rundown and unsuitable and facilities are primitive. Many of them are built in remote areas far away from the city that they serve. This causes difficulties for patients and relatives and makes management of the hospitals awkward.

- the government allocates only half the funds to psychiatric hospitals that they give to general hospitals at the same grade. This means that necessary repairs and upgrading of old equipment cannot be carried out. Because of lack of financial support, community treatment and prevention which has been shown to be very effective cannot be implemented. The most pressing case is that of mental hospitals run by the Ministry of Public Security for those patients who have broken the law and urgently need treatment and confinement. More hospitals cannot be built because of lack of funds and as a consequence these kinds of patients continue to seriously endanger social order.

- there are insufficient hospital beds. At present there are only six beds for every 1,000 psychiatric patients. 80 per cent of patients are not able to receive treatment and 95 per cent of patients cannot be admitted to hospital. Some patients are chained up at home for years and treated very inhumanely. Some enterprises deploy production workers to watch mental patients twenty four hours a day in three shifts. Care for psychiatric patients has become a long term burden for society, enterprises and families.

- there is a serious lack of organization, training and

experienced mental health workers. There are only six psychiatrists for every 10,000 mental patients. The ratio between hospital beds and staff is only 1:0.6. The quality of work is poor. Mental health workers are not valued by society and are called doctors for 'nutters'. The heavy workload, high risk, low pay, and unfair assessment of professional requirements and poor promotion prospects make new staff reluctant to join and unsettles the existing staff.

4 - the lack of treatment facilities for mental patients mean that many of them are living in the community with no treatment or supervision where they constantly cause trouble. The danger caused is quite serious. According to a survey carried out in Jiangsu province, there have been more than 1800 crimes committed by psychiatric patients since 1985. Of these, 130 are murders; 189 people sustained serious injury; 209 cases of arson; 800 cases of robbery or theft. In many serious crimes mental patients occupy a considerable percentage of the offenders. A female patient from Heilongjiang province crept into the memorial hall to Chairman Mao in Beijing, trying to break the glass coffin. In the oil refinery at Daqing a psychiatric patient caused 100 million yuan's worth of damage by deliberately starting a fire. In Shanghai a patient knocked down and killed fifteen pedestrians when driving a car. Other cases involve psychiatric patients displaying their nude bodies, causing shame and trouble and damaging electricity supplies so that factories and mines have to stop work and production. These are common cases and these frightening facts are enough to illustrate that if we do not have active means to

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strengthen mental health work then even more serious social problems will occur.

The memorandum goes on to point out that China is in a new phase of economic development and that improving the mental health of the nation is very important to that and is 'related to social peace, the safety of property and the lives of citizens'. Mental health work needs to be put on an 'important agenda' and the following suggestions are made:

1 - a joint committee led by the Ministries on Public Health, Public Security and Civil Affairs should be set up to co-ordinate and guide national mental health work. Personnel from other ministries, such as education, personnel, and publicity should also be involved.

2 - mental health work should be incorporated into the construction of a socialist spiritual civilization and be included in all local plans for development. This would give it the recognition it deserves and the necessary support when the national budget permits.

3 - more effort should be put into training to solve the manpower problems. High level medical colleges should add courses on mental health to their programme. Training in prevention and treatment of psychiatric illness should also be encouraged. Efforts should be made to solve the problem of fair job evaluation and rewards for mental health professionals. Emphasis should be given to strengthening scientific research in mental health.

4 - mental health legislation and forensic psychiatric assessment and treatment facilities should be developed as quickly as possible. A forensic psychiatric assessment committee should be formed as soon as possible by the public security, health and judicial authorities.

5 - to exempt welfare factories and work stations for the mentally ill from tax and to encourage and support establishing mental health facilities by multi-channelled fund raising; to develop community prevention, treatment and management work; to accommodate, treat and manage mental patients.

6 - to strengthen publicity about the importance of mental health work and to spread scientific knowledge about mental health and illness; to ask for concern and recognition of mental health work from everyone so that all Chinese people can have a good working and living environment and to reduce social, familial and psychological factors which lead to mental illness; to create conditions which help to rehabilitate mentally ill people back to their own environments.

This is probably the most honest official statement available about the condition of psychiatric services. Clearly, the problems that are faced are similar to elsewhere; a lack of funds; discrimination against psychiatric hospitals in favour of general hospitals; poor training and an unwillingness to join mental health work; poor terms of service; concern about the potential of some psychiatric patients to seriously disrupt society; lack of understanding and stigmatization of the mentally ill from the

general public and government officials; a recognition that community services are important yet, a continuing policy emphasis on increasing beds. However, elsewhere no one is facing the sheer enormity of co-ordinating and providing services for 1.2 billion people, or as the memorandum says, ten million psychiatric patients.

Yet if this memorandum is supposed to serve as guidance , it can only be described as grossly inadequate. The recommendations constitute little more than a 'wish list', with very little in the way of pragmatic suggestions or operational plans to outline the necessary steps to be taken, people to influence and concrete goals to achieve. Most important, there are no detailed considerations for resource implications, of what the multichannelled sources of fund raising might consist, or how the burden of finance could be shared between national, provincial and local sources of funding. Other than saying that 'whatever it is, we need more', there are no guidelines as to what number of beds, out-patient facilities and so on there should be per head of population.

Furthermore, one is also left with the impression that the people involved in writing this memo were all urban based because there was no attempt at all to address one of the most serious problems in health service delivery; how to reach the 80 per cent of the population living in rural areas. Nor was there any discussion of how to regulate the supply of drugs in a rational way based on predictions of use so that the smaller and less well known

hospitals are not subject to interrupted supplies.

When I asked the Professor of Psychiatry at Anding Hospital who decided mental health policy in China, he told me that it was largely up to the Minister of Public Health, who is advised by 16 senior psychiatrists in seven subject areas; child, community, psycho-social aspects, geriatric, forensic, epilepsy and education. Tsung Yi Lin (1985) confirms that there is no office or officer in the Ministry of Public Health responsible for mental health. Professor Chen did not consider that psychiatry receives much priority. With only two national meetings to plan directions for the future since 1949 that seems an accurate assessment.

CONCLUSIONS

1 - From preconceptions based on assumptions about what welfare arrangements a socialist country would seek, it would not be possible to predict the arrangements that China actually has. Of particular surprise is the very high cost to the consumer of in-patient hospital treatment. A relatively small section of the population, urban workers in large or state owned enterprises, enjoys quite generous welfare benefits. However, the majority in effect have to fend for themselves. Thus rather than the 'institutional' system one might expect in a socialist country, the system in China for most people is very much 'residual'. (Wilensky and Lebeaux, 1965) The strategy emphasises the devolution and decentralisation of welfare responsibilities away from the state and towards the family, danwei, street organisation, and the production brigade. One of the mottoes of

the Ministry of Civil Affairs is 'self-reliance by the masses; mutual aid and dependency within the collective; state help as a last resort'.

2 - Despite the trumpeting about the 'socialist new born things' a careful reading of material shows quite clearly that there are policy continuities stretching back centuries that are both indigenous and influenced by Westerners. One cannot understand social policy in China without a lively appreciation of history. Traditionally, welfare was organised around the triple institutions of family, locality and work and it still is. Mutual aid through loan societies and locally based insurance was common, particularly in rural areas and it is still the government's preferred way to finance welfare. Paramedics and the two tier system of medical training may both be traced back to Western influences that pre-date the revolution.

3 - The rural - urban divide has bedevilled health policy in China since the beginning of the century. The difficulties of providing services to the rural population are of course shared with other countries with large rural areas. There is strong and deep seated reluctance amongst Chinese physicians to work in the countryside. The resources needed to send doctors to train rural based paramedics, or provide mobile clinics would be enormous. This is probably the most important issue facing the development of psychiatric services in China. In practice, it remains unaddressed and the disparity between urban workers with health benefits and the rural population largely without, has led to gross inequality in access to treatment.

4 - It is indisputable that China has had enormous success with its policy of public health, prevention and mass campaigns in extending the life span of its people. Yet there must be doubts about how appropriate this method is in dealing with mental illness. With major mental illnesses we are dealing with entities the cause of which is not known. We are by no means sure how people acquire the disease and have no idea how to cure it, although symptoms may be quite effectively controlled. Policies of prevention in mental health might more precisely be called early detection, for how can you prevent something when the cause is unknown? If ten million people are really affected by mental illness in China, then it must be counted as a disease with a strong potential to have a negative effect on the masses, just as malaria, schistosomiasis and so on. Possibly because it falls outside the usual parameters in which they have enjoyed some success, little concerted imagination at the national level has been brought to bear on the best way to deal with an illness with such intractable characteristics.

5 - It seems that health care is less a priority now than at any other time since the founding of the People's Republic. Much has been achieved but there is no longer a sense of vision about the path that health care is taking, either in general health or in psychiatry. Hillier and Jewell (1983) talk about a policy of gradualism being no policy at all because it reacts to events rather than decides them. Many of the issues which face China's health policy makers are to do with structural aspects of society

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rather than individual health promoting habits and thus require change at the economic and political levels. These are not likely to be forthcoming.

CHAPTER THREE

CULTURE AND MENTAL HEALTH

Understanding of the issues raised in this thesis will be enhanced by the provision of information regarding background material that is related to the Chinese context. At the same time, it would be a task of Sisyphean proportions, quite beyond the scope of this thesis, to attempt to cover all the issues that could be considered potentially relevant. Another difficulty arises in that in trying to cover a mass of material with brevity the tendency is to talk in stereotypical terms; the Chinese are this or do that. Clearly this is not true for the individual, who makes his decisions based on a variety of information inputs and personal preferences within the framework of the cultural context with which he is familiar. Consequently he may choose to act in ways that would not necessarily have been predicted by a knowledge of the ideal types of cultural behaviour. When you are dealing with 25 per cent of the world's population, it is very unlikely that they will all fit the same mould.

Nonetheless, in order to convey the flavour of a dish it is sometimes necessary to underplay the individual ingredients. Equally, there are times when we wish to compare one dish with another. The subject matter under consideration here is the broad issue of mental health in China and, because of the dominance of Western ideas in the field of psychiatry, it is inevitable that the comparison should be in that direction. This is not to be unaware of other Asian countries, their unique qualities and

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similarities and differences with Chinese culture. But such broad parameters are beyond what it is hoped to achieve with this work.

Not only are individuals affected by the culture in which they live. So is the medical system which, as Kleinman expresses it:

'Represents a total cultural organisation of medically relevant experiences, an integrated system of social and personal perception, use and evaluation. Medical systems are much more than particular kinds of medical facilities, practitioners and practices. They are cognitive, affective and behavioural environments in which illness and health care are culturally organised... They define a cultural trajectory for illness from naming and explaining to treating and evaluating'. (Kleinman, 1978, p. 413)

What follows is an examination of the micro and macro issues involving people and systems and the relationship between Chinese and Western systems of definition, belief and practice in mental health care.

The Individual, the Family and Society

In a review article based on both Chinese and Western sources, Yang Kuo-shu (1986) sums up what is known of the personality characteristics of the Chinese as having a social oriented character with collectivistic orientation, other orientation, authoritarian orientation, relationship orientation, and a submissive and inhibited disposition. He relates these characteristics to a predominantly agricultural subsistence economy that lasted for millennia; to a social structure that is hierarchical, collectivist, structurally tight and based on what he calls generalized familization; and to patterns of socialization which emphasise dependency, conformity, modesty, self suppression, and parent centredness. He also says that signs

of change are detectable. (Yang Kuo-shu, 1986, p. 162)

Francis Hsu (1985), in a famous thesis, denies that the concept of personality, as an expression of individualism, is applicable to the Chinese. He posits a model that sees man, culture and society as a series of concentric circles, the innermost circles being the unconscious and pre-conscious, the next two the inexpressible and expressible conscious, surrounded by intimate society and culture, operative society and culture, wider society and culture and finally the outer world. This system he calls psychodynamic homeostasis, represented by the Confucian concept of <u>jen</u> variously translated as 'benevolence', 'human heartedness' and 'humanity').

In some ways Hsu was ahead of the field, for he formulated his ideas at a time in Western psychology, the 1960s and 1970s, when the concept of personality tended to be construed as a static given, constant in many different situations and with many different people. His interactionist, flexible notion of the individual in relation to others behaving differently in different contexts has been adopted by main stream Western psychology as a more fruitful way of looking at all human beings.

One of Hsu's fundamental theses is that Chinese people do not have to go beyond the family to satisfy their intimacy needs, and that attachment to parents provides a stability and continuity that is lacking in Western people's search for intimate relations. He goes on to suggest that his PSH (psycho-social homeostasis) layers of intimate society and culture are not the same in

Chinese/Japanese as opposed to Western cultures. The former are characterized by more ritualization, role playing, hierarchical relationships, repression of negativity, repression of personal spontaneity when compared with Western ideals. These factors make it more difficult for intimacy as Westerners think of it to occur. Family stability and security are maintained at the cost of the Western concepts of intimacy and independence. But this is because the Chinese and Japanese are not seeking a conceptually equivalent type of intimacy. The stability and reliability of intimate relationships with others are a source of strength for the individual and the society. The question is how and whether different cultures provide for this need, and the tolerances and implications for differences in the experience of need.

'A child in China is born into a family and placed in a network of inter-related persons. The self does not develop in a process of gradual separation and individuation as is often conceptualized in Western psychological theories. We see instead a 'little me' maintaining its interdependency within the context of the 'big me' the family, the state and the world throughout the philosophical traditions of Confucianism and Taoism as well as present day socialist theory'. (Dien Shu-fang, 1983, p.284)

Others have been at pains to point out that there is room for individualism in traditional Chinese thinking. Kenneth Chau (1980) argues that Confucian philosophy did not intend that family consciousness take the place of social-national consciousness. Nor, while emphasising the importance of the family, did Confucius intend that the individual be subordinate to it. King and Bond (1985) argue that, while Confucianism as a social theory tends to mould the Chinese into group and family oriented, socially dependent beings, it also represents only part of the total complexity. The Confucian thrust is also to develop a person into

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a relation oriented individual who is capable of asserting a self directed role in constructing a social world. If this was not so it would make a nonsense of Confucius' ideal of a righteous man, who achieved this condition through self-cultivation, nurturing the values of jen, and being able to recognise what was morally correct and do it.

Confucius was writing at a time of great social upheaval and this may account for the emphasis he places on harmony as the most treasured social value. He argues that harmony may only be achieved by every one acting towards each other in a proper way. The proper way is defined by the rules of propriety (li). This defines correct behaviour in a series of social relationships, that will maintain harmony for as long as each person acts according to the rules. According to T.Y. Lin:

'In the Chinese view, a person is a relational being, living and interacting in a massively complicated role system'. (1983, p. 866)

The maintenance of harmony is so important that it takes precedence over the expression of one's own opinions or feelings. As many authors point out, external compliance should not be mistaken for internal acceptance. (Yang Kuo-shu, 1986; King and Bond, 1985; Pye, 1988) The ability to adjust oneself to the situation is greatly valued over the idea that the situation should adjust to you.

Most social relationships are seen in hierarchical terms, expressed by the Five Cardinal Relationships, the wu lun; the Emperor and his subjects, father and son, older brother and

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younger brother, husband and wife and friends. Only the last of these is based on anything like equal footing and even then friendships tend to be interpreted in terms of kinship relations, so almost inevitably friendships take on a hierarchical component, one or another of the pair tends to be the 'big brother' or 'big sister'. Hierarchies in the family are based on age, sex and generational position. Outside it, they are also based on status. (Baker, 1979; King and Bond, 1985) Filial piety is but an extension of this authority within the family and beyond to the individual's relation with the state.

'Filial piety begins with serving one's parents, leads to serving one's king and ends in establishing one's character'. (Confucius, quoted in Kenneth Chau, 1980, p. 6)

There are some fundamental differences in the way that Chinese and Western people view the family. To a modern Westerner, families might well be seen as a mixed blessing; nurturing but restrictive, hampering freedom and independence. There was even a time in the 1960s and 1970s when families were seen as positively bad for you! This perspective is rarely aired in public by Chinese people although there is no reason to suppose that the reality matches the ideal. As will become apparent later in the chapter, family conflicts abound. When one considers the poor and cramped living conditions, frequent lack of privacy (with two or three generations living in one room) and various other factors, it is not surprising that reality does not live up to the image. Two contrasting views are offered:

'For Chinese people, the importance of the family, the institution which has patterned the entire social matrix can hardly be over-estimated. It is the bastion of their personal and economic security; it provides the frame of reference for personal

and social organization; it controls all the behavioural and human relationships of its members through a clearly hierarchical structure and sanctioned mode of conduct; it transmits moral, religious and social values from generation to generation through role modelling, coercion and discipline. It offers a haven for safety, rest and recreation. The influence of the family on the lives of its mentally ill is no less profound than it is for anyone else'. (T.Y. Lin and M.C.Lin, 1981)

'The family, with its friends, became a walled castle with the greatest communistic co-operation and mutual help within but coldly indifferent toward and fortified against the world without. In the end, as it worked out, the family became a walled castle outside which everything is legitimate loot'. (Lin Yu Tang, 1935, quoted in Bodde, 1957, p. 67)

Based on their work in the Chinese community in Vancouver, T.Y.Lin and M.C.Lin have identified five stages of familial coping with mental illness;

1 - exclusively intrafamilial coping

2 - inclusion of certain trusted outsiders in the intrafamilial attempt at coping.

3 - consultation with outside helping agencies, physicians and finally a psychiatrist while keeping the patient at home

4 - labelling of mental illness and subsequent series of hospitalizations

5 - scapegoating and rejection

They say that the first three stages are characterized by 'tender loving care', protection and intense efforts to mobilise helping resources. Once the mental illness has been labelled a radical change in family attitude seems to take place and the family becomes less tolerant. Their guilt, frustration, fear and anger are directed at the patient and the tender loving care is replaced with tension, worry and desperation. It is difficult to know

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whether or not this is typical of family reactions in China. If the onset of mental illness is florid and sudden the family may be given little choice but to seek outside help as other members of the community may not be prepared to tolerate such behaviour. The potential for rejection in such a tightly knit, geographically immobile and poorly resourced country is limited.

What is known is that the decision to seek treatment, what kind of treatment, and the amount of money to be spent on it, are all family decisions over which the patient has little or no control. Once the person is accepted as mentally ill he is considered unable to have a lucid opinion on his situation. Family members will accompany patients to the hospital on most occasions and frequently stay with them once admitted. This is also seen in medical hospitals. (Henderson and Cohen, 1984)

The Communist Party's initial desire was to rid people of Confucianist thinking, seeing it in fundamental opposition to their own philosophy and as a potential rival to their own political control. Over the years, however, they came to realise (as the Mandarinate had done before them), that there was much about the structure (if not the content) of social relationships guided by Confucianism that was not only coherent with their own but useful to them. The reliance on higher authorities, the emphasis on obedience and acceptance of hierarchies and ultimately the ability of the family to control and order its members made China governable for millennia. And it does so still.

CHINESE CONCEPTS OF HEALTH AND SICKNESS

Chinese medicine has a history dating back many thousands of years. During that time theories were formulated about psychiatric disturbances and doctors treated them, leaving meticulously observed case histories for the edification of future generations. Many of the ideas on which Chinese medicine is based are still extant in the minds of mental health professionals and the layman, and are consequently influential in practice, if not in the higher echelons of the medical profession or with policy makers.

The Yellow Emperor's Classic of Internal Medicine, (Huang-ti nei-ching su-wen), compiled during the second and first century B.C. describes a condition known as kuang which is generally accepted as acute psychotic excitement although a differentiation between mania, schizophrenia or organic psychosis is not made:

> 'When the illness is grave the patient always takes off his garments and walks away, or ascends heights, chanting songs or even refuses to eat for several days. The patients can also climb over walls and roofs which were beyond his usual capacity'. (Tien Ju Kang, 1985, p. 69)

Another psychiatric disorder, dian, was also recognised, the associated symptoms being lethargy and apathy. Tseng points out that mental disorders in the East and West tended to be recognised in the same sequence, if not at the same time; epilepsy, then psychosis with excitement. Depression, dian, was not recognised until considerably later and W.S. Tseng (1973) suggests that this was because quiet people were well tolerated and accepted in China.

Unschuld (1987) speaks of Chinese medicine as a highly complex edifice of interconnected and heterogeneous influences and systems of thought, influenced by Bhuddism, Taoism and, more recently, by Western medicine. It is not one single structure but a broad range of ideas and practices related to health care. Only at the beginning of Chinese recorded history does it seem that ideas about the causation of illness were influenced by 'religious' notions concerning the spirits of ancestors or demon spirits. (W.S. Tseng, 1973) He sees this separation of the religious from the medical at an early stage as something which distinguishes Chinese from Western medicine.

'Medicine in a modern sense - health care based on a perception of natural, non-metaphysical laws and directed at issues that require specialists focusing their attention on the individual organism (and its relation to the social and natural environment) - only appeared in China at the end of the first millennium B.C.'. (Unschuld, 1987, p.1023)

While the formal system of theory concerning illness ('the great tradition') discounted ideas about causation that involved the supernatural, these have remained alive and well as folk beliefs (or 'the lesser tradition'). Most written records concerning medicine would be written by Confucian scholars and would thus embody 'the great tradition'. In the context of the legal codes and casebooks, Martha Chiu (1981) quotes the late Qing scholar Hsueh Yun-shen as admitting that they had deliberately omitted references to the spirit possession theory of insanity. The issue of the continuing influence of the belief in the supernatural causation of mental illness will be considered in more detail later in the chapter.

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Microcosm-macrocosm correspondences and the dynamic balancing of elements appear to be the two most central concepts of Chinese medicine. Human beings were seen as being part of the natural world and an elaborate system developed to describe the correspondences between astronomical systems, seasons, weather and time on the one hand; and the internal organs, functions, sensations and emotions on the other. This conception of the world was strongly influential in moulding Chinese medicine's holistic view of man in contrast to Western medicine's innate dualism.

'The concept of correspondence, of the affiliation of all tangible and abstract phenomena to certain lines of association enabled a seamless linking of the psychic with the somatic. The biological and psychological dimension of illness constituted here a complete unity; to see in this question two separate dimensions of existence was completely alien to the medicine of systematic correspondence'. (Unschuld, 1985, p. 216)

From this framework, three main themes of fundamental importance evolved; the yin-yang system, the Five Elements and the meridian system (qing lo). (K. M. Lin, 1981) Yin and yang are the two primary principles of the universe, eternally interacting with each other, yet at the same time eternally opposed. (Bodde, 1957) They represent qualitatively contrasting aspects inherent in the universe which are simultaneously contradictory yet complementary; the existence of one implies the other, as in darkness and light. The yang principle stands for brightness, heat, dryness, hardness, activity, masculinity, Heaven, sun, south, above, roundness, odd numbers. The yin principle stands for darkness, cold, wetness, softness, quiescence, femininity, earth, moon, north, below, squareness, even numbers. All universal phenomena result from the interaction of these two phenomena.

Although they complement each other, _yin_ is generally considered to be subordinate to _yang_:

> 'In this insistence on mutual reciprocity coupled with mutual inequality, we come upon one of the most conspicuous themes in Chinese philosophical thinking'. (Bodde, 1957, p. 35)

In Chinese medicine the _yin-yang_ construct details the nature and phase of the disease, as well as the categorization of medication, dietary considerations and other therapeutic measures. The primary concern of diagnosis in Chinese medicine is to delineate imbalance between _yin_ and _yang_ and treatment is aimed at restoring this balance. Judith Farquhar describes attending classes in Chinese medicine, (in China), based on the medical classics given by a young doctor who presented _yin-yang_ theory as a metaphor for natural phenomena. When another, older, doctor saw her class notes he was angry, insisting that _yin_ and _yang_ are things, not forms of thought. (Farquhar, 1987)

Through the interaction of _yin_ and _yang_, matter comes to be differentiated into the five elements, which in turn interact to produce the multiplicity of existing things. (Ho Peng Yoke, 1985) The theory of the Five Elements proposes that everything in the human body and in nature belongs to one of five categories which are represented by the five elements, fire, earth, water, wood and metal. The five viscera (liver, heart, spleen, kidneys and lungs) five emotions (anger, joy, worry, sorrow and fear), and five climatic factors (wind, heat, humidity, dryness and cold) all correspond to the five elements. Inter-relations of organs within the body are revealed by the relation of the elements to each other; wood creates fire, fire creates earth, earth creates metal,

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metal creates water, water creates wood. There is antagonism

between water and fire, fire and metal, metal and wood, wood and

earth and earth and water. (W.S.Tseng, 1973)

Table 3:1: The Five Elements and Their Correspondences

Five Elements	Internal Organs	Orifices	Tastes	Colours	Psychological Functions
Wood	liver, gall bladder	eye	sour	blue	anger
Fire	heart, small intestine	tongue	bitter	red	happiness
Earth	spleen, stomach	mouth	sweet	yellow	desire
Metal	lung, large intestine	nose	spicy	white	worry
Water	kidney, bladder	ear	salty	black	fear

'Madness is the result of too much mucus being produced in the heart. Since it is too dangerous to dissipate the flame responsible for this over production, it is necessary to strengthen the soil region of the body (stomach and spleen). According to the five phases, fire engenders soil, so that this therapy removes from fire its function enabling it to reduce itself. A restriction of fire, that is of the function of the heart, results in a decrease in mucus production and consequently the desired cure of the behavioural disturbance'. (Chang Chieh Piu, circa 1687, quoted in Unschuld, 1985, p. 222)

Qi is the vital energy for all parts of the body. It has its main

origin from the stomach which grinds foodstuff into minute

particles and transforms them into energy. When this energy is

combined with air from the lungs, qi is formed. Qi passes round

the body through the qing lo system of meridians. There are

supposedly 12 meridians and eight 'lesser tracts'. Since qi is so important to the maintenance of all vital functions and is virtually irreplaceable, any loss of qi or obstruction of its circulation is considered to have grave consequences. The system is not only important for acupuncture but is relevant to diagnosis, herbal remedies and other treatment methods. (K.M. Lin, 1981) The acupuncture needles stimulate qi and help to remove obstructions, so that it can flow smoothly again.

W.S. Tseng (1973) describes the attribution of causes of illness as passing through three phases. First, was the supernatural; second was natural elements like wind, or excessive heat or humidity; third was causes arising in the human body, like an excess of phlegm or other humours. There is an obvious likeness to Galen's humoural theory here. Tseng considers that is not due to any cross fertilisation of ideas, but to two cultures at a pre-scientific stage coming to the same conclusions faced with similar circumstances.

Internal organs within Chinese medicine are more than the physical entities that Western medicine recognises, although they are frequently that as well. But their functions are somewhat different. Farquhar describes them as 'systems of physiological effects extending beyond the physical boundaries of the organs'. (1987, p. 1018) Thus the 'heart' is regarded as the organ harbouring spirit or mind and is seen as the governing body of all the psychological functions. (In my experience it is common to hear psychiatric patients in China make an initial complaint of 'having an uncomfortable feeling in my heart'.) 'Kidney' is the

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reservoir of concentrated qi. The 'lung' is described as susceptible to worries and sadness, and the 'stomach' and 'spleen' to thinking too much. The 'liver' and 'gallbladder' are believed to be especially disposed to anger.

Chinese medicine does not differentiate between psychological and physiological functions. Any sort of emotional excess, even happiness, is considered to be pathogenic. Thus emotional containment is associated with maintaining balance and health. However, while acknowledging the effect of emotions on health, the Chinese emphasise somatopsychic effects. Once physiological functions are disturbed, the logical methods of treatment become physiological or pharmacological interventions even if excess of emotion is considered to be the original cause. ·

Unschuld (1987) describes Western psychosomatics, which in general terms tends to search for mental/emotional problems causing a somatic suffering, and seeks to change either the environment causing an emotional problem, or to change the patient's attitude towards his environment to eliminate the basis of his somatic ills. The Chinese somatopsychics orientation appears to have preferred to find out the somatic-physiological basis of mental/emotional disorders and then direct treatment - generally by means of herbal medication - at the somatic issue in order to reshape the patient's emotions - mostly regardless of the patient's environment.

It may be seen that the theory and practice of Chinese medicine precluded any specialist development in psychiatry. Although

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symptoms of psychiatric disorder that Westerners would recognise were also recognised in Chinese medicine, notions of causation were very different. Symptoms were classified according to whether they were yin or yang, exterior or interior, 'cold' or 'hot', and indicative of weakness or fullness. Patients were investigated by the four methods; observing, hearing, inquiring and pulse taking. (Liu Xie-he, 1981) As the result of all this, two patients with very similar symptoms might well be thought to be suffering from different illnesses and given quite different sorts of herbal medicine.

Liu Xie-he (1981, p. 432) gives an example of how acute psychosis and the chronic, withdrawn symptoms of schizophrenia might be construed within this system:

'An acute psychotic patient with violent behaviour, high fever accompanied by a chill, flushed face, a dry tongue coated with fur and fast pulse, will usually be identified as disease of Yang, Exterior, Hot and Fullness character.....chronic patients, withdrawing from their environment, with pale faces, slippery tongues and slower pulses would be identified on the opposite side and treated with different prescriptions'.

There appear to have been few or even no books on mental disorders. Tien Ju Kang (1985) says that one was written by Zhang Jinyue in the seventeenth century called Methods of Curing Mental Illness. Liu Xie-he (1981) says that a special manual of prescriptions for treating psychosis was compiled before the first century A.D. but was lost. Other than this, he denies the existence of any other books on the subject. Before the end of the nineteenth century and the introduction of Western medicine, psychiatric symptoms were seen as an integral part of general medicine as practised by general doctors.

The majority of treatment in Chinese medicine relies on herbal prescriptions. (W.S. Tseng, 1986) These tend to be combined by the doctor for each individual according to his particular combination of symptoms. Thus a herbal pharmacy will have many hundreds of individual items, (animal, vegetable and mineral), as well as a series of standard preparations. Tseng (1973) describes those for psychiatric usage as being for 'reducing internal heat', 'regulating vitality to relieve the liver', 'clearing sputum to invigorate vitality', 'inhibiting general prostration and generating bodily fluids'. This terminology clearly reflects the standard concerns of Chinese medicine with exhaustion, deficiency, and disharmony as the reasons for illness, and regulation, nourishment and vitalisation as the roads to recovery.

Liu Xie-he (1980) reports on a herbal drug used in the treatment of schizophrenia which induces three to five seizures with each dose and vomiting accompanying each seizure. He describes it as a form of drug convulsive therapy and says that it is effective but limited because of the side effects of excessive seizures and vomiting.

In another article (Liu Xie-he, 1981), he describes several types of treatment for psychosis; qingre xieho for 'clearing the heat and eliminating the fire' which involves administering herbs with a laxative effect to purge and quieten the psychotic patient; ditan kaiqiao for 'expelling sputum and re-opening the obstructed orifices' involving herbal medicine that will make a patient vomit; wenyang bushen, which means 'warming the positive functions

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of the body and recruiting the functions of the kidney' and relies on administering tonic herbs to chronic psychotic patients.

W.S. Tseng (1986) reports on large doses of radiz aconiti praeparata and herbs for 'regulating the vital function of internal organs' being given to schizophrenic patients suffering from symptoms of withdrawal. Acupuncture is commonly used to treat auditory hallucinations, the point located in the ear. However, as Tseng (1986) comments, although psychiatrists in China say that results of herbal preparations and acupuncture are encouraging there have been no scientifically controlled studies to validate this point of view.

One example may suffice to support this statement. In volume six of the Journal of Traditional Chinese Medicine 1986, an article on the use of acupuncture to treat schizophrenia was published. It was written by Shi Zhengxiu and Tan Meichun from the Shenyang People's Liberation Army Hospital. They claimed a 'total effective rate' of 88.4 per cent. Of the sample, 78.8 per cent were claimed as 'cured' or 'remarkably improved'. However, there were was no control group, no double blind assessment of improvement, and no mention of what other treatments might be being given simultaneously. Careful reading of the paper indicated that there were confounding effects from using chlorpromazine in an unspecified number of cases. For as long as research remains on this level it is going to be very difficult to convince anyone, other than the already converted, that Chinese medicine has anything to offer the treatment of severe psychosis.

Unschuld (1987) claims that Chinese medicine has always been characterized by the pragmatic utilisation of substances or techniques found to be useful in some way or another. Thus the theoretical approaches that inform Chinese medicine contain no in-built defence against adopting aspects of Western medicine that are seen to be useful. Unschuld characterises this as an 'as well as' approach, in contrast to Western medicine's 'either - or' stance to bodies of knowledge different from its own. Kleinman has called this ability to adjust, accommodate and internalize other systems of thought to its own purpose's syncretism.

Chinese medicine has remained very acceptable to lay people who make their own decisions about which practitioner is most suited to which disease. Overall, acute infections are thought to be best treated by Western medicine - antibiotics - but other diseases, particularly chronic ones, are considered more amenable to Chinese medicine. Western medicine is considered to be a blunt instrument that attacks symptoms, while Chinese medicine works more gently, takes longer, but cures the roots of the disease. (Kleinman, 1980)

At the same time, individual psychiatric practitioners are acutely aware that their system of diagnoses and treatment are considered by the West to be neither up-to-date nor good enough. (Kleinman, 1986) The situation is further complicated by the political overtones that are now associated with Chinese medicine, made very clear by Mao Zedong. Independent of any considerations of efficacy, it is patriotic.

Following Leff (1988), we may say that there are four issues that must be addressed in order to examine disease phenomena across cultures - in our case, schizophrenia. First, it is necessary to be able to identify a disorder wherever it appears. This entails establishing a core of culture free symptoms sufficiently characteristic to allow the illness to be differentiated from other similar illnesses. Second, do psychiatric conditions have the same frequency in different cultures? Third, do psychiatric illnesses run the same course? Fourth, are psychiatric illnesses treated the same way in different cultures? Although Leff does not consider the issue, the fourth question masks a fifth. What explanatory models are used, by medical and lay people, to explain causation?

To address the first question: do Chinese and Western psychiatrists mean the same thing when they diagnose schizophrenia? Or is the same label being used for very different diagnostic concepts? This is a problem that has bedeviled psychiatrists for many years and was first given major publicity with the publication of the U.S. - U.K. study that demonstrated that American psychiatrists used the diagnosis schizophrenia with a much greater frequency than their British colleagues and apparently meant something different by it. (Leff, 1988)

The peculiar difficulty that psychiatry faces is that there are no tests or markers that will confirm a doctor's diagnosis. The illness may only be construed from and detected in its symptomatic

manifestations. Jablensky, 1988; Leff, 1988) as Guimon says 'psychopathology cannot be described in terms of structural pathology'. (Guimon, 1989, p. 35) Thus attempts to set guidelines that will help systematize diagnostic practice have assumed great importance, with the development of the <u>International Classification of Diseases - 9</u> and the <u>Diagnostic and Statistical Manual III</u>

The World Health Organisation has been involved in a more or less continuous epidemiological research effort since 1966 to establish that schizophrenia is a world wide phenomena. (World Health Organisation, 1973 and 1979; Sartorius et al, 1986) Among what Jablensky (1988) calls their first rank findings is that the syndrome of schizophrenia is universal. Although no single symptom was invariably present in every patient and in each setting, the overall clinical configuration of the disorder was remarkably constant across cultures. Furthermore, the subjective experiences of individuals suffering from schizophrenia and the way that they describe it are remarkably similar in people of very different backgrounds and educational experience. (Jablensky, 1988)

The PRC did not take part in the World Health Organisation study, although Taiwan did. Nonetheless, it has been concerned to carry out its own epidemiological survey and to work on defining its own diagnostic criteria. In 1989 the <u>Chinese Classification and Diagnostic Criteria of Mental Disorders, second edition</u> (CCMD-2) was passed at a conference in Xian. This is an internal, <u>neibu</u> (forbidden to the eyes of an outsider) document which is not

available in the English language, so detailed attention will be paid to it here.

At the first national conference on the treatment and prevention of mental illness in Nanjing in 1958, a classification of mental illness was drafted but never published. In essence, the classification named 14 different kinds of mental illness. Twenty years later, the Chinese Medical Association called another conference where a special group was appointed to revise the 1958 draft. The revised document was sent all over the country and comments invited. It was formally announced in the <u>Chinese Journal of Neurology and Psychiatry</u> as the <u>Classification of Mental Illness (trial draft)</u>. This one divided mental illness into 10 types. In 1981 the trial draft was revised again, and called the 'Chinese Medical Association Classification of Psychosis - 1981'. Psychiatric workers all over China were requested to adopt it. This version included 13 types of illness.

In October 1984, at the National Special Conference on Affective Psychoses held by the Neurology and Psychiatry Association of the Chinese Medical Association, the formal classification announced in 1981 was revised again - back to 14 types of illness. It was felt that the classification system had gone through too many changes, had become difficult to publicize and use widely. Some of the revisions were only changes in name and had little to do with meaning. In June 1986, the Third National Conference on Neurology and Psychiatry was held in Chongqing. At this meeting, another working group was set up and it was agreed to produce diagnostic criteria for all mental illnesses within three years. ICD - 10 and

DSM 3 were translated into Chinese and published and these served as essential reference material in setting the Chinese criteria. A first draft was produced in 1988, and the fieldwork undertaken to test the usefulness of the criteria and revisions made. The final draft was accepted at the conference of the Chinese Medical Association in Xian in 1989.

The final result for schizophrenia seems to contains elements from both the DSM 3 and ICD 9 and 10 classifications. The Chinese classification recognises: hebephrenic (ICD 9 and DSM 3); catatonic (ICD 9 and DSM 3); paranoid (ICD 9 and DSM 3), undifferentiated (DSM 3); simple (ICD 9); residual (ICD 9 and DSM 3); atypical schizophrenia which is divided into two parts - schizophreniform psychosis, which is not recognised as a form of schizophrenia by either international classification system and post-schizophrenic depression (ICD 10); other types of schizophrenia, which are not included in either ICD 9 or DSM 3.

Schizophrenia is defined in CCMD-2 as a group of mental illnesses with unknown cause. Onset is mostly in adolescence and young adulthood and is associated with disorders of sensation, thinking, affect, behaviour and a lack of co-ordination in mental activities. In general, there is no disorder of consciousness or impairment of intelligence. The course of the illness is usually long.

Before a firm diagnosis can be made, at least two of the following symptoms should be present. If the existence of a symptom is unclear or not typical then three symptoms are needed: disorder in

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thinking; delusions; auditory hallucinations; disordered behaviour
(catatonia or foolish, childlike actions); the patient's belief
that they are being controlled by others; thought broadcasting;
thought blocking; disturbances of affect (apathy, giggling to
self). Doctors are also now required to diagnose by exclusion; in
other words they must state why the illness is not, for instance,
manic depression as well as say why it is schizophrenia. Doctors
say that the major difference between CCDM-2 and DSM 3 is that the
former permits a firm diagnosis to be made after three months from
onset, while DSM 3 requires six months. (Chen Deyi, 1984) This
probably reflects different attitudes towards labelling, with
Western doctors reluctant to confirm a diagnosis that produces
stigma and social handicap. The stigma and social handicap are
certainly no less in China, but doctors there say that they would
be thought to be incompetent by relatives if they took six months
to diagnose a disease!

Thus there can be little doubt that schizophrenia exists in China
and would be identified as approximately the same collection of
symptoms as recognized elsewhere. A trickier question remains to
be faced. How many psychiatric doctors in China use CCDM-2? It is
well documented that the tendency in China is to over - diagnose
schizophrenia and under - diagnose mania, or manic depression.
(X.E. Liu, 1983; S.M. Yan et al. 1982; X.E. Liu, 1980; Altschuler
et al. 1988; S.M. Yan and D.Z. Xiang, 1984; Chan Deyi, 1984; Yuan
Tinggua, 1987) My own observations reading through case files in
both Anding and Guangzhou tend to confirm this view.

But, as Leff (1988, p 41) says, with regard to the difficulty of persuading American doctors to change their diagnosing habits from their previous inclusive psychodynamic approach to the much stricter phenomenological guidelines of DSM 3, 'official policy is one thing and clinical practice is quite another'. If Chinese doctors are idiosyncratic, 'theirs is no unique condition'.

This brings us to the second issue of whether, if an illness can be shown to exist, it has the same frequency across cultures. Based on the WHO research, Jablensky's view is that:

> 'To date there is no evidence to refute the conclusion that in most human populations schizophrenia typically occurs at a rate between 1 to 4 cases per 10,000 population at risk per annum. Since this is a low incidence rate, the three to fourfold difference that may be observed between areas and populations (even if statistically significant, when based on large samples), could be regarded as trivial from an epidemiological point of view'. (1988,p. 26)

The most reliable psychiatric epidemiological data available for the PRC is contained in the Twelve Centre Epidemiological Survey which gives point prevalence figures. (Shen Yu Cun, 1986). For schizophrenia, these are 6.06 per 1,000 in the urban areas and 3.42 per 1,000 in rural areas. (Shen Yu Cun, 1986) Based on data from the WHO research, a rural-urban difference is to be expected. The size of this one, however, raises doubts about case finding in the rural areas. Leff (1988, p. 110) gives prevalence figures from a variety of countries. These vary from 0.9 to 8.0, suggesting that the Chinese figures do not fall outside the expected range. Schizophrenia was found to be the most common mental illness.

The WHO study would seem to demonstrate conclusively that the course of schizophrenia is much milder and the prognosis better in the developing countries. (Sartorius et al., 1986) Sartorius found that the patients with an acute onset had a significantly better prognosis, with a cumulative duration of psychotic episodes amounting to less than 15 per cent of the follow up period. On the other hand, the majority of cases of an insidious onset tended to be severely psychotic for more than 75 per cent of the follow-up period. Relatively few cases fell in between these two extremes. 52 per cent of patients from developing countries had an onset of psychotic symptoms lasting less than a week, compared with only 29 per cent in developed countries. The proportions for insidious onset were reversed.

Although more cases in developing countries had an acute onset, this relationship did not fully account for their better prognosis. A number of authors have suggested that this difference may be due to environmental factors. (Leff, 1988; LeFley, 1986; Jablensky, 1988) Two factors are given particular attention; namely larger, more accepting, less demanding and critical families; and the greater availability of ordinary and socially meaningful work within the capacity of someone with a vulnerability to psychosis.

'Of overwhelming importance is the recognition that large supportive networks mitigate family burden by providing multiple resources for caregiving, attention, economic sharing and buffering the effects of disruptive behaviour. These networks also are often capable of providing occupations for the patients that are appropriate for her or his own level of functioning, thereby assuring a productive social role conducive to the maintenance of self-esteem'. (LeFley, 1986, p. 54.)

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Unfortunately, there seems to be no reliable information on the course of schizophrenia in China, although Lin states that schizophrenia takes a more benign course in Taiwan. (T.Y. Lin, 1982; 1983) The Twelve Centre Epidemiological Survey in China did not include two and five year follow up as did the WHO study. As a predominantly rural society, we could hypothesize that the course is more likely to be benign, but the work remains to be done that would permit us to test the proposition. One finding from the epidemiological survey in China does suggest that large family size offers some protection against the severer manifestation of schizophrenia in that prevalence was lowest among large size families and highest in nuclear and medium sized. (Shen Yu Cun, 1986)

DOCTORS, PATIENTS AND FAMILY MEMBERS

Given the paucity of services available for mentally ill people and their families in China, an even greater significance is placed on family attitude towards the sufferer. LeFley (1986) contrasts the typical adversarial attitude towards families by mental health professionals in the West with the way that families in other parts of the world are welcomed as participants in patient care. What evidence there is does not support this optimistic view as far as Chinese cultures are concerned. Gale (1975) described a lack of information-giving to patients in Taiwan. Kleinman (1986) described the way patients and relatives were treated in the clinic in Changsha in which he interviewed as 'paternalistic, medical and interrogative'. Ahern found similar attitudes among her medical respondents in Taiwan, one of whom

told her:

'I hardly ever tell patients what I think is wrong with them. What I say might disagree with other doctor's opinions and besides knowing what is wrong won't help them get well at all. I think most doctors feel the same way'. (Ahern, 1978, p. 29)

On the other hand, out of 46 informants interviewed by Ahern about choosing a doctor, 40 indicated that being given an explanation was a significant factor. Nor does this view take into account the high level of stigma attached to mental illness in China. (Kleinman, 1977; T. Y. Lin 1982) Stress is experienced by families who are either trying to hide the fact of having a mentally ill member, and living with the fear of being discovered; or coping with the rejection and hostility that comes with openness.

Lin discusses the nature of mental disorder as a taboo subject in China and the unwillingness of lay people or the authorities to face the issue squarely. This in turn has led to a paucity of provision for treatment and support and an over-reliance on the traditional family centered approach:

'An approach that has long hampered the development of adequate and prompt care for the Chinese mentally ill'. (Tsung Yi Lin, 1984, p.373)

Of great interest in China, where families carry the major burden of care for the mentally ill, would be research based on the 'expressed emotion' work of Vaughan and Leff, where measures of overt hostility, criticism and over-protection shown by family members towards the patients proved to be an effective predictor of the likelihood of relapse. (Vaughan and Leff, 1976; Leff, 1985) It cannot be assumed that the measures would be relevant to China so work must be carried out to ensure their cultural

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compatibility. In particular, measures of over-protectiveness might be very different between China and the U.K.. The expressed emotion research has been criticised in the West as extending the adversarial relationship between doctors and families in another guise. (Falloon, 1986) It is hoped that research on expressed emotion will be started in China in 1991, and perhaps will be able to investigate the positive coping strategies of families as well as the more negative aspects.

Leff's fourth question was about treatment. This issue is sufficiently complex to require its own chapter and such it has been given. Suffice it to say that the vast majority of treatment for schizophrenia is based on drugs that would be wholly familiar in the West. (S.M.Yan and D.Z. Xiang, 1984; D.S. Young and M.Y. Chang, 1983) Indeed the positive response of schizophrenic symptoms to phenothiazines, and their virtual universal use for the treatment of the disease, is considered by Jablensky to be one of the 'first rank findings' of the WHO epidemiological research. (Jablensky, 1988)

Thus far we can claim with some certainty that China fits into what is known of the international picture of schizophrenia. But there are those who, while not denying a certain circumscribed usefulness for international epidemiological activity, would ask 'so what?' Both Kleinman and Tsung Yi Lin have expressed doubts along these lines. Kleinman is concerned about what he calls category fallacy, using the example of depression.

> 'Applying such a category to analyze cross-cultural studies or even direct field research is not a cross cultural study of depression because by definition it will find what is universal

and will systematically miss what does not fit its tight parameters. The former is what is defined and therefore seen by a Western cultural model; the latter which is not so defined and therefore not 'seen' raises far more interesting issues for cross cultural research'. (1977, p.4)

He considers that most transcultural research, because it ignores this issue, is no more than the application of Western psychiatric categories to non - Western societies:

'Although this type of research may hold importance for validating professional psychiatric constructs, by no means a trivial concern, we should not deceive ourselves that it is studying disease in relation to culture or that it represents real cross-cultural comparisons'. (Kleinman, 1977, p.4)

Kleinman differentiates between disease and illness. Disease can be thought of as a malfunctioning or maladaption of biological or psychological processes. Illness is the personal, interpersonal, and cultural reaction to disease. While social or cultural factors may affect disease, they always affect illness. Epidemiological approaches, by tearing disease from its cultural context, lose information about illness, and thus deny the investigator access to a whole world of meaning.

Tsung Yi Lin expresses concern about the ethnocentric attitudes and assumption of clinical universalism that he perceives in Western psychiatry. These:

'Originate in the belief that all human beings basically live, feel, think and behave alike so that the symptomatology, course and outcome of a disease as well as its methods of treatment and theories of causation should apply in all cases in spite of any individual, racial, ethnic or cultural differences. Modern psychiatry was born in the West and as it grew was moulded by specifically Western philosophical and scientific traditions. It developed as a child of the West'. (Tsung Yi Lin, 1982, p. 243)

He points out that using current psychiatric categories that originate largely from Western psychiatric theories and practice a

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comparable group of major psychoses can be found among the Chinese. However, these same categories when applied exclude large groups of people whose behaviour is judged to be abnormal in their own cultural contexts. It also excludes people who are not reported to the case finders in epidemiological surveys because the family perceive their illness as a physical rather than a mental one, despite the fact that, according to the Western based psychiatric categories, they should be included.

'Application of standard Western criteria and definition of mental disease yields interesting data, useful to a certain extent in a comparative study. It does not enable us to determine the breadth, depth and the nature of mental illness in a Chinese context'. (p. 243)

Yet, what might be interpreted as Lin's ambivalence about Western psychiatry in Chinese contexts is evident from another quotation.

'From my own perspective, the dominance of Western based psychiatry and mental health sciences will and should continue in the foreseeable future, since they provide the most powerful tools to further strengthen and expand our scientific foundation and also to assist in the training of others'. (1984, p. 371)

The emotional import of this issue is exemplified by a very senior psychiatrist in Changsha, in the hospital where Kleinman undertook most of his recent research on neurasthenia and depression, (Kleinman, 1986) although Kleinman's name is never mentioned.

'We do not see such changes in diagnosis in the fields of internal medicine or other non-psychiatric specialty areas. Changing the diagnostic label for malaria to pneumonia and vice versa after hundreds of years of clear diagnostic use of such terms would not even be considered. Regrettably this is a common phenomena in psychiatry. Examples of this kind might be seen with the change of hysteria (an old diagnostic term lasting thousands of years) to Briquet's disease, only 100 years old. Neurasthenia might serve as another example. This diagnostic term, first used in the USA by Beard, was later abandoned. At the present time it currently appears strange and anachronistic and perhaps foreign to most American psychiatrists. This trend which moves the mental sciences further away from their base upon general medical and

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natural sciences moves the field away from progress on a firm reliable base. We feel that such trends as deliberately changing the name of a diagnostic category or of subjectively deducing psychic mechanisms without some scientific support cannot lead to more knowledge in understanding either the aetiology or pathogenesis of mental disorders. Nor can it lead toward improved treatments. Such conceptualizations without a scientific data base only lead to confusion'. (D. S. Young and M.Y. Chang, 1983, p.436)

As Kleinman (1986) points out, the irony in this is that

neurasthenia is a Western concept adopted, and now wholly

identified, as Chinese, the prime example of what he calls the

syncretic abilities of Chinese medicine.

Themes in Young and Chang's quote exemplify some of the quite

radical differences in orientation between the Western and Eastern

traditions of medicine. These may be summed up as a reliance on

practice, experience and knowledge that has stood the test of time

on the Chinese side, as opposed to a more research based quest

for improved theoretical foundations and techniques on the Western

side.

'The origin of Chinese medicine is in the practice of preventing and treating disease. Experience accumulated from practice is supplemented and generalized to become medical theory. Theory in turn guides practice......the history of Chinese medicine is an upwardly spiralling process of practice - knowledge - again practice - again knowledge'. (Huang Jitang, quoted in Farquhar, 1987, p. 1016)

Similar views are expressed by Li Zhi Zhong (1984).These

principles have been applied to the practice of Western medicine

in China, and go at least part way towards explaining the problems

that young, gifted doctors have in obtaining recognition, and the

enormous power that the 'grandfather' generation of medics wields.

Overtly, Young and Chang are stating a case for the continuation of neurasthenia, not just as a label but as a recognized disease. It is also possible that it is a reaction against what Young and Chang interpret as cultural imperialism in areas of both knowledge and practice. Thus it represents the desire to be recognized as part of the international professional community of psychiatry, while maintaining the right to its own 'psychiatry with Chinese characteristics'. These two positions contain elements of conflict. This issue will be considered in more depth through an examination of explanatory models of causation.

EXPLANATIONS OF MENTAL ILLNESS

Explanations of the causes of mental illness are important to patients, relatives and medical professionals, albeit for somewhat different reasons. For each they allow the experience of illness to be given meaning. For the latter, they make treatment a more scientific enterprise, with a greater chance of therapeutic success; for the former, they affect the patients' and families' sense of culpability and control and mould the attitudes of the wider public. Explanations used by lay people and medical professionals do not necessarily follow the same paths, for reasons which should become clear. Nonetheless, they may be subsumed under the same schema.

T. Y. Lin and M.C.Lin (1981) offer a five category model for explanations of mental illness used by Chinese people, based on work in Taiwan and amongst Chinese communities in Canada. These are:

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1) the moral view

2) the religious or cosmological view

3) physiological or medical theories

4) psychosocial factors

5) genetic transmission

Young Derson (1985) also suggests that relatives of patients in China use three types of explanations; superstitious, psychogenic and somatogenic. However, as they correspond to three of Lin and Lin's categories they will not be dealt with separately.

Moral Explanations

The moral view emphasises misconduct as a cause of mental illness; deviation from socially prescribed behaviour especially in neglecting the respect due to the ancestors or violating the norms of filial piety. Lin and Lin say that it is a widespread practice for the head of the household, or other respected person (like a teacher), to exhort and lecture the sick person on the virtue of good conduct. The indigenous view is that mental illness necessitates 'correct' thinking and therefore requires rectification of personal errors. While 'correct' thinking no longer concerns strict Confucian codes, this attitude continues in mainland China, but with the strictures of the Party as the new orthodoxy. In the Cultural Revolution, psychiatric patients were occasionally pilloried for their improper political thinking which was assumed to be at the root of their illness. Western psychiatry also had its 'moral view', based on the ideas of R.D. Laing and others concerning the genesis of schizophrenia; the role of the

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family, particularly the schizophrenogenic mother, and the notion of the double bind.

Physiological and Medical Theories

The physiological or medical theory plays an important part in the Chinese view of both the aetiology and treatment of illness. This may be based on Chinese medical belief in the disturbance of the balance between _yin_ and _yang_ in the body through an excess or deficiency in physiological functions that lead to illness; or it may be seen in modern parlance as due to a lack of vitamins, hormone imbalance or brain dysfunction. There is an advantage to both patients and doctors in adopting a medical viewpoint. Many authors have pointed out that to see mental illness as a disease rather than adopt the Western 'moral view' that it is a problem in living, or failure in mastery over one's circumstances, relieves the patient and his family of the burden of blame or inadequacy. (Kleinman, 1986; Fanny Cheung, 1986; Tsung Yi Lin, 1981; Leff, 1988)

'It appears evident that contrary to the Western value system, a social ambience that externalizes causation of mental illness, subscribes to a disease model, views the afflicted individual as sick rather than a participant agent in his disability.... results in more benign family relationships and lower rates of hospitalization. (LeFley, 1986, p.53)

'Physical complaints have social cachet; psychological complaints do not'. (Kleinman, 1986, p. 54) If an illness can be categorized as physical, rather than mental, it may be possible for the sufferer and his family to avoid some of the stigma attached to the latter. Under such circumstances the increased likelihood of

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seeking somatic explanations is clear, reinforcing cultural tendencies towards somatization.

It is possible to see a change in the literature from the emphasis placed on class relations as a prime contributing factor in mental illness, to explanations which currently favour more genetic and biochemical causes. (Hillier and Jewell, 1983) In discussion with doctors, and in participating in clinical interviews with them, it is quite clear that their main explanatory paradigm is a physical, biological one. Personal experience confirms that of Kleinman and Mechanic (1981) who found that there was no psychosocial awareness by doctors in their assessment and treatment of psychiatric complaints.

Tseng confirms this in a review of Chinese psychiatric textbooks which he found to be characterised by a strong emphasis on clinical description and classification of psychiatric disorders, coupled with relatively abundant somatic, biologic explanations of aetiology. (W.S. Tseng, 1986) In analysing the 314 articles on psychiatry that appeared in the <u>Chinese Journal of Neurology and Psychiatry</u> between 1955-1966 and 1978-1984 he found that 21.7 per cent dealt with clinical description, psychopathology and diagnostic matters relating to functional psychoses; 14.3 per cent dealt with pharmacology; and 11.1 per cent with coma therapy and E.C.T.. The closest articles came to showing any psychosocial awareness were 11 that were published on community/preventive psychiatry (and nine of those were published in the earlier period).

Kleinman's view is that the materialist, somatopsychic position is more acceptable because it is supported by the shared physicalist value orientation of biomedical traditional Chinese medical and popular Marxist paradigms. This is probably also a major reason why Pavlov's theories were so acceptable to China. Pavlov saw himself as a physiologist rather than a psychologist, (and posited no separation between mind and body), a materialist viewpoint which was compatible with Chinese medicine and did not threaten Marxist social theory. (Robert and Ai-lin Chin, 1969; Kleinman, 1986) It is also, frankly, politically safer.

Genetic Theories

Associated with the physiological approach to explanations are ideas about genetic transmission. These are relevant to both medical and lay people. In my experience, it is common, even in the absence of any other data about the patient's family recorded on the file, to find an enquiry has been made concerning mental illness in the family back to the grandparents' generation. In the Guangzhou Hospital study reported in Part Two, it was found that 35 per cent of files examined mentioned whether or not there was a family history.

Two separate articles in the Chinese Journal of Neurology and Psychiatry give the rate of schizophrenic patients with a positive family history as 14.8 - 42.5 per cent (Liu Xie-he et al, 1983) and 28.4 - 42.7 per cent. (Xun Minlai, 1986) Xun's article expresses concern about the unwillingness of schizophrenic patients to accept birth control measures, even after their

illness has become apparent, and emphasises that the number of children schizophrenic patients have is marginally greater than that of a control group of non-mentally ill people. Fewer of them accepted the one child family planning policy. It seems from the article that it is a study of 250 schizophrenic patients, all of whom were sterilised. It is not clear from the article how voluntary this was, but it is said that all patients involved had at least one child.

Fang Yongzheng (1982) in another article in the same journal frankly advocates a eugenics policy, and placing legal restrictions on the right of schizophrenic patients to marry and have children. He says that 'sterilization should be publicized amongst the schizophrenics and they should be mobilized to undergo the operation'. (p. 206) Both Fang and Xun mention a common belief among lay people that if a young person has a psychotic breakdown then marriage will provide a cure. Thus parents are very keen to arrange marriages for them, compounding the problem in their eyes.

Lay people's concern with the hereditability of mental illness is expressed in issues concerning marriage. Great lengths are taken to hide a young person's mental illness because it not only affects their chances of marriage but also that of their siblings. Someone who is known to be mentally ill can probably at best expect as a marriage partner someone else who is in some way 'damaged goods'. An example from the psychiatric hospital in Shashi is given in Appendix Two which illustrates the kind of transaction that takes place.

Religious or Cosmological Theories

The religious or cosmological view of causation is described by
Lin and Lin as the wrath incurred by the patient or his family
members of gods and ancestors, in either present or former lives.
Bhuddist belief in reincarnation and Taoist as well as Bhuddist
beliefs in the supernatural play an important part in the Chinese
view of aetiology of mental and other illnesses. Prayers and
offerings at Bhuddist temples, calling on Taoist priests to
perform shamanistic rites, are common practices indulged in by
families. This view conflicts with that of W.S.Tseng (1973) who
claims that for the last two millennia supernatural causation has
not been a feature of Chinese medicine. Tseng's view contrasts
with that of Unschuld who writes:

> 'Until modern times the much older demonic medicine, among
> other approaches, remained a conceptual and as far as
> practitioners were concerned, a largely personal alternative.
> There are numerous indications that, in terms of numbers of
> patients, demonological healing was the more influential system.
> In China, as in the West, belief in the existence of evil spirits
> was by no means limited to the lower or uneducated segments of the
> population. Virtually all the best known authors of the Ming and
> Qing periods and numerous others, acknowledge the pathogenic
> influences of demons as a self evident fact.' (1985, p. 216)

A number of medical anthropological studies have confirmed a
continuing and lively belief in supernatural causation of illness
in Taiwan. (Ahern, 1978; Kleinman, 1980) They exist side by side
with standard medical practice, and patients and their families
experience no conflict in approaching doctors and faith healers
for the same illness episode. Shamanistic practices have been
outlawed in China (Hillier and Jewell, 1983) so information about
their continual involvement in healing is sparse. However, a

recently published article (Li Shengxian and Phillips, 1990) confirms that folk healing practices are flourishing in the countryside of Hubei province. As Ahern says:

'Unlike doctors, who often disregard a patient's request for an explanation, gods and their assistants are sought out specifically because they are able to tell the patient what is wrong'. (1978, p.30)

THE SHASHI INVESTIGATION

The discussion of the biomedical approach taken by most doctors suggests that they will rarely give credence to psychosocial factors in mental illness. Young Derson (1985), while acknowledging that stress may play a precipitating role in functional psychoses in 50 per cent of those cases where an important stressor may be found, considers that the importance of stress has been over-emphasised in history taking. In another article, he talks about aetiological agents largely in terms of 'infections and chemical and medical intoxications', which he says are infinite. (Young Derson, 1980) Whatever the reason, there is an obvious reluctance among doctors to acknowledge the involvement of psychosocial factors in the onset or relapse of schizophrenia.

What do families think? The question of the explanatory models that families use to account for mental illness has not been explored in the literature. What follows is based on interviews of 37 patients and accompanying family members who were interviewed by the author. The purpose was to discover what explanatory models were being used by families to explain the behaviour of the disturbed person. A semi-structured interview schedule was used that permitted the respondents to choose their own words and

featured open-ended questions that would be followed up with more detailed questioning where appropriate.

Twenty one of the interviews took place in the outpatients' department of Shashi psychiatric hospital; 16 took place on the wards. The people interviewed were not specially selected in any way. In the out patients' department, patients registered and then queued to be seen. Nurses directed them to one of the three rooms in which doctors were interviewing. The author joined one of the interviewing doctors, and asked that no effort be made to send her 'special' patients. Those seen may be taken as representative of the users of the service. Patients and families seen on the wards were those who were free at the time and had no objection to being interviewed. The purposes of the interview and my presence were explained at the beginning, and each interviewee was at that point given an opportunity to opt out. None of them took it.

On the whole, families had no doubts that most relatives were suffering from a psychiatric disturbance (whether or not they were). They differentiated between a milder form of 'thought disorder' and a more serious form of mental illness. It was often at the point when they considered that 'thought disorder' had tipped over the edge into mental illness that they decided to seek professional help.

The division of labour was such that I interviewed the accompanying family member(s) in the presence of the doctor and, usually but not always, the patient. After this was over, the doctor then interviewed the patient in front of the family member

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and myself. The whole process took on average one hour. The doctor and I had a prior agreement that we would be allowed to ask supplementary questions in the other's interview.

The Attitude of Doctors to Patients and Relatives

Earlier in this chapter, we looked at the idea that doctors in less developed countries adopted a more positive, egalitarian approach to families of the mentally ill, in comparison with the situation in the West. From observing these 37 interviews between a doctor, the patient and family member(s) in Shashi, and based on questions in my interview schedule concerned with how much information families had been given about the patients' condition, 'partners in care' did not describe the attitude shown towards the family by the doctor.

It was much more common for the doctor to assume that the family would continue to care whatever the cost emotionally and practically. Rarely were families informed of the diagnosis, and never were the features, symptoms and likely outcome of the illness explained to them. It was clear from the interviews that the families would have very much appreciated more information about diagnosis, prognosis and management but expected doctors to take full charge in deciding what treatment was appropriate, because they saw this as the doctor's area of expertise.

The rhetoric of the Cultural Revolution encouraged an egalitarian relationship between families and staff. However, it seems that politics are less important than traditional social norms of relationships with authority figures. This is not confined to the

psychiatric setting. Henderson and Cohen, in a study of a surgical ward in a Chinese hospital, summed up the expectations thus:

'Physicians and nurses expect patients to accept without question and quietly the treatment they are given....medical personnel believe that patients [and families] should know as little as possible about diagnosis, medication and treatment'. (1984, p.113)

Ideas About Causation

To establish explanations of causation each interviewee was asked an open-ended question as to what they considered to be the cause of the problem. Then a follow-up question was asked listing potential causes of a physical, somatic, supernatural, social and psychological nature. Out of 37 interviews, 28 (75.6 per cent) gave social reasons, 29 (78.3 per cent) named personality factors, 15 (40.5 per cent) named supernatural influences, seven (18.9 per cent) gave a somatic cause and three (8.1 per cent) said they had no explanation. Only one mentioned any possibility of a genetic component. It is hard to know whether this was because it was not part of their explanatory framework, or because their fear of the genetic taint was so great. The most frequent social reason given was family conflict followed by financial worries. Conflicts at work and school also featured as did problems in opposite sex relationships.

The Significance of Personality

Out of the 24 female patients, ten were described as having a 'strong' personality, being hot tempered or extrovert; six were described as introverted or isolated and three were not specified; one was said to think too much; and one described herself as

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wanting freedom and equality but was described by her mother as introverted. Of the 13 male patients, seven were described as introverted, gentle or isolated; one was described as irritable; and one as anxious and strong willed. No personality factors were ascribed to the other four. Only seven interviewees thought that somatic factors were involved in causation. One teenager was thought to have used his brain excessively in schoolwork; one woman was said to have generally weak health; another had a 'problem with her brain'; one was said to have had a very difficult delivery at birth; another's difficulties were associated with the onset of menstruation; another's by practising too much qi gong; the last was non - specific.

Supernatural Intervention

Supernatural intervention was the third most common cause that family members gave for the patients' illness (40.5 per cent). What follows are some examples from the interviews undertaken in the outpatients' department of the hospital in Shashi. All of those who had consulted a shaman or engaged themselves in shamanistic practices were from rural areas. Indeed, it was a common reaction among the urban based interviewees to scoff or laugh derisively when asked whether they had consulted a shaman. It was noticeable that patients were not involved in making decisions about their treatment. It was also obvious that in some cases there was dissent in the family, particularly regarding the consultation of the shaman. When this was the case, it tended to be the younger family members who were in disagreement, but were

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over-ruled by older members.

The Xiang Family

The patient was a young man, probably schizophrenic. The family had decided that he was mentally ill when during Spring Festival, he had convinced the entire village that they were being attacked by ghosts and had led all the other villagers in a ghost hunt. It was his girlfriend who had suggested calling in a very famous shaman from a village about 20 miles away. The shaman was a 50 year old female peasant. She rolled eggs over the patient's body and sang chants that nobody else could understand. The family considered that her efforts had been helpful. The patient could sleep better, and he stopped trying to drive the ghosts off. Cost unknown.

The Wang Family

The patient was a 24 year old female diagnosed as suffering from mild depression. The patient saw two shamans on at least ten occasions. One was her own father and the other a very famous one who lived 30 miles away. He burned paper money to the ghosts of the dead people who were afflicting her, lit incense and drew a circle in the centre of the room while chanting. They found the efforts of the shaman quite helpful. The cost of the one not related to the family was nine yuan, which was a discounted rate because of family connections.

The Guo Family

The patient was a 24 year old woman with a diagnosis of schizophrenia. The details in this case are less clear. Older female family members burned paper money to appease the spirits of the dead who were haunting the patient.

The Liu Family

The patient was a 42 year old woman with a diagnosis of reactive psychosis and it was the patient's mother who suggested consulting the shaman. The shaman was famous, living in the same village as the family and it is her sole occupation. The shaman burned paper money and paper with Bhuddist symbols on it asking blessings from Bhudda. The patient was then asked to drink water that had been covered with pictures of Bhudda. The shaman also danced and chanted. There were three consultations at a cost of 200 yuan. This was a family who could not afford the costs of admission, so 200 yuan must have been an enormous sum for them.

The Bian Family

The patient was a woman aged 30 diagnosed as suffering from psychosis and epilepsy. The attending relative was the older brother who was at pains to distance himself from having brought in the shaman. It was the patient's husband who had insisted. The

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shaman was an old peasant lady from a nearby village. She burned
paper money and made the patient drink the ashes in water. She
also took two swords and shook them. The family consulted her
twice. There was no cost because she knew how poor they were. The
family did not find that it helped much.

The Lin Family

The patient is a 26 year old male, diagnosed as schizophrenic. The
informant was the patient's brother who could not tell us
precisely what the shaman did because he was not present. The
shaman was a 50 year old, male peasant who charged 60 yuan. It was
the patient's parents who asked for his assistance.

Mrs. Zheng believed that the ghosts of dead relatives were

visiting her in her dreams and asked her husband to take offerings

of food to their graves. Her husband made it clear that he thought

this was a load of nonsense and only went along with it to keep

his wife quiet. The wife did not make a connection between the

ghosts and her problems, only that they disturbed her sleep.

Most of the shamans seemed to be ordinary peasants who were

described as undertaking shaman activities as a part-time job or

as a hobby. The ghosts usually did not seem to bear any relation

to the patients or their family members, and were most commonly

identified by the shamans as bodhisattvas, if the dictionary

translation is to be believed. They were described in a very non-

specific way, almost as though they were hanging around waiting

for an opportunity to cause trouble, because it was part of their

nature, rather than because of any personal grudge they bore the

patient, or because of any act of volition on the patients' part.

Mr. and Mrs. Wang (in the second example) thought that she had

been 'caught' by a ghost late one night on her way to the outside

latrine before going to bed. This corresponds quite precisely with

Ahern's respondents' descriptions of being 'hit' by malevolent

spirits as you might bump into someone in the street. (Ahern, 1978)

Summary

The sample is of course too small to do more than generate observations. Of some interest is the issue of which personality factors tend to be associated with psychiatric illness in women, and which with men. This is because it is possible to argue that they are indicative of role reversal of those characteristics typically considered desirable for the sexes. Thus 42 per cent of the women were described as having 'strong' personalities, but only seven per cent of the men (and he was a 15 fifteen year old); whereas 50.5 per cent of the men were described as introverted or isolated, but only 25 per cent of the women. The similarity to Broverman et al.'s well known research on the criteria used by mental health professionals to determine which characteristics were mentally healthy in both sexes is clear. (Broverman et al. 1970) They found that those characteristics which were considered to be healthy in men (independence, assertiveness, ability to make decisions etc.), were considered by mental health professionals to be mentally unhealthy characteristics in women. It might be hypothesized from this small sample that firstly, lay people are making the same kinds of judgments and secondly, the process works in reverse.

The second general observation to be drawn from the sample confirms the contention that Chinese people use a variety of aetiological explanations simultaneously when dealing with mental

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illness. (T.Y.Lin and M.C.Lin 1981; Kleinman, 1980)

'Empirical studies of patients and normal subjects have found that Chinese adopt multiple causal attributions and coping strategies in dealing with their problems. These cultural characteristics suggest the importance of an interactionist paradigm in which psychological processes, somatic factors and the situational and social contexts all contribute to an understanding of Chinese psychopathology'. (Fanny Cheung, 1986, p.212)

However, one aspect that needs further exploration is the issue of

somatisation. It tends to be held as a 'common wisdom' that

Chinese people express emotional pain through physical symptoms;

that they somatise rather than psychologise. If this is so, it is

quite surprising that the interviewees rarely sought somatic

explanations for the onset of illness. Somatic explanations of

aetiology and the expression of somatic symptoms may not be

closely related. This latter issue will be considered more fully

in the chapter that deals with approaches to treatment.

CONCLUSIONS

1 - The core characteristics of schizophrenia as a disease are

found in China as elsewhere. The way that the illness is dealt

with both by families, the afflicted themselves and medical

professionals is a product of cultural features involving internal

aspects, like culturally favoured personality traits, family

centredness and external factors including philosophical,

political, and economic institutions.

2 - Although in the case of schizophrenia Western chemotherapy is

the dominant treatment approach, the ancient and respected body of

knowledge of Chinese medicine co-exists alongside. Patients may

express their discomfort using traditional concepts like 'liver

fire' for anger, or 'kidney weakness' for sexual dysfunction, or a 'pressure on my heart' for unhappiness. Doctors see no conflict in prescribing Western and Chinese medicine simultaneously.

3 - Chinese medicine, more eclectic in nature, has had to carry the main burden of adjustment in this co-habitation. Consequently, the pressure from the demands of Western medicine and its practitioners in China to dominate have led to Chinese medicine and its practitioners feeling that they have been relegated to the position of second class citizens. Because of the nature of the historical and political environment, encroachment by Western medicine has undertones of imperialism and to defend Chinese medicine becomes a patriotic duty. An acceptance of and respect for difference is deemed an insufficient response; differences have to be ranked and it is resented that Chinese medicine is thought by many to occupy a lower rung on the ladder.

4 - One of the ways in which Chinese medicine, and to some extent wider aspects of the culture, are still seen to influence the medical system, is in the influence of age and the importance of knowledge gained from practice, rather than from book learning or experimentation. This places the elderly generation of psychiatrists in a position of great authority and power and reinforces an anti-scientific bias in medical practice.

5 - Aetiologies of illness reflect an interactional view of causation, at least on the part of families of the mentally ill. They appear to be more broadminded and pragmatic in their understanding of the combination of factors that may precipitate a

breakdown and willing to follow a number of strategies simultaneously, if they consider that they might lead to a successful resolution.

6 - Doctors on the other hand, while not unaware of severe family problems, tend to divorce such occurrences from their models of causation which rely heavily on biomedical and genetic factors. There are at least two reasons for this. One is almost certainly the pre-eminence given to somatic causation in Chinese medical theory which predisposes doctors to view events through this particular pair of spectacles. The second is more delicate, and concerns the politicization of personal and social life in China. If one does not attribute social or personal agency in the onset of mental illness, one is not then forced to apportion blame either to the individual or society for being in some way politically incorrect.

7 - The issue of decisions regarding treatment is very much family centered. The patient has little or no say in what happens to him. This has to be seen in the context of other kinds of general decisions affecting family members which would also be approached in the same way. Western authors have commented favourably on the way that doctors in less developed countries treat families as 'partners in care', in contrast with the more adversarial stance typical of the doctor-patient relationship in the West. This assumption does not characterise the interaction between doctors and families at the Shashi hospital.

CHAPTER FOUR

LAW, RIGHTS AND PSYCHIATRY

'In Western societies people struggle for rights, while in China, people are concerned with relationship construction'. (King and Bond, 1985, p. 41)

Little is available in English that examines the way that China has viewed the legal status of those regarded as mentally ill, or how such people are dealt with when they transgress. As the quotation which heads this chapter suggests, ideas about the rule of law, equality for all before the law, and even justice, have traditionally been very different in China from those in Western countries. (Hansen, 1985) Confucian thinking concentrated on the idea of li, proper behaviour, encouraging the belief that if every one knew his role and carried out the behaviour associated with it, then harmony would reign. This was tempered by the idea of jen, benevolence or human heartedness. If Western law tried to be guided by consistency and logic, then li and jen required that law was subsidiary to flexibly interpreted custom and moral tradition. (Bodde, 1957)

Citizens did not so much enjoy rights as hope to be ruled justly by a beneficent Emperor and his officials. When they were disappointed, as they frequently were, they had little official recourse. For millennia, the Chinese have lived with the knowledge that it is who you know that is truly important; thus the emphasis on building relationships.

An examination of Chinese material relating to law and the mentally ill, suggests a coherence with other facets of Chinese thought in the emphasis given to the importance of maintaining social order rather than the preservation of individual freedoms. The concern of mental health practitioners in the West with the human rights of psychiatric patients finds no echo in China. What is the historical relation between law and mental illness in China? What is the current situation? How do the Chinese look at the question of human rights? Do they use mental hospitals to incarcerate political dissidents? These and other questions will be discussed in the following pages.

THE HISTORICAL PERSPECTIVE

As one might expect in a civilization that stretches back thousands of years , the issue of the relation between mentally ill offenders and the law was considered early on. According to Liu Xie He, the first mention of psychosis in the law was by Han Fei Zi (280-233 B.C.) who wrote that 'psychotics cannot escape from punishment according to the law'. (1981, p. 429) From the later Han period onwards, representatives of the law tried to control psychotic outbursts. The first law directed at kuang sufferers was promulgated in 100 A.D. (Han dynasty). Such people were held sufficiently responsible for their actions to merit a penalty being set; but out of compassion for those who acted when they were not really themselves, the sentence was reduced. (Martha Chiu, 1981) However, it was only from the first half of the Qing dynasty that a sustained effort was made to eliminate such

disruptions of the social order by legislating on the responsibilities of family, community and officials towards the mentally ill. (Martha Chiu, 1981; Bunger, 1950)

A continuing theme of concern of authors writing on this subject is whether and/or why Chinese law showed clemency to mentally ill offenders. The legal tradition of clemency in China for certain categories of offender evolved during the Zhou period (1122-770 B.C.) when the concept of the 'three pardonables' was developed to ensure the lenient treatment of offenders who were very young, or very old, or who were 'mentally incompetent'. These ideas were embodied in the Tang Codes (618-907 A.D.) which provided for relatively light sentences for those who suffered incurable diseases or those who were seriously ill. The mentally ill were included in the latter category. (Vivian Ng, 1980) The Qing Code dealing with the special conditions pertaining to youth, age and infirmity is almost word for word identical to the relevant section of the Tang Code. (Bodde, 1980)

Why were these people treated more leniently than other offenders? Bodde suggests two reasons. First, on the pragmatic grounds that they were not considered to be habitual criminals and were thought less likely to offend again. Second, and perhaps more important, because of a tradition of humanitarianism going back to Confucius. The Tang code explains why, for instance, monetary redemption may properly be granted to wrongdoers who are aged, young or infirm by frequently introducing the words 'compassion' and 'love' into its discussion. The Tang commentary on the Code supports its argument by quoting a passage from the Book of Rites:

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'A person of eighty or ninety is called a venerable greybeard. A person of seven is called a child deserving of pity. A child deserving of pity and a venerable greybeard, even though they may have committed a crime, are not to be subjected to punishment'. (quoted in Bodde, 1980, p. 140)

The Tang Code gave legal recognition to mental ailments as a valid criterion for determining infirmity and incapacity. Two degrees are specified; 'feeblemindedness' under infirmity and 'insanity' under incapacity. In Tang times, the feeble-minded and the insane were not held legally responsible for their actions, a situation which apparently persisted at least through the Song dynasty (960-1279).

The Qing Code employs a single generalized term, mental illness, which is discussed in relation to homicide but no other crimes. (Bodde, 1980) The Qing homicide laws, which dictated lighter penalties for the mentally ill, at least in relation to single homicides, may be seen within this tradition of clemency. They represented the view that an insane person lacked the capacity to reason, and was not aware of what he was doing and could not therefore be said to be guilty in the same way as other offenders. The punishments regarding multiple homicides committed by insane persons were much more draconian. The tradition of clemency was overridden because the enormity of multiple homicide and the threat it constituted to social order demanded punitive action, whatever the mental state of the defendant.

Bunger (1950) and Bodde (1980) both point out that the emphasis on clemency fights a losing battle with the concern for social order throughout the Qing period. This is demonstrated by the

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registration and confinement laws for insane people that were introduced in 1689 (Martha Chiu, 1981, p. 81) Insane men were to be given into the custody of their families only if the authorities were satisfied that they could be locked up all the time. Insane women were automatically returned to their families after they had been registered. To assist families in their task, the government issued locks and fetters. Alabaster, writing in the late Qing period, says that:

'Relatives are bound to report cases of lunacy and exercise strict supervision over the lunatics, under penalty of eighty blows with heavy bamboo if the lunatic kills himself, and one hundred blows if he kills anyone else...Lunatics are required to be manacled and the relations must not remove the manacles without proper authority'. (1899, p. 53)

In practice, the registration law was difficult to enforce, because families often refused to register a mentally ill member, and neighbours and relatives were reluctant to intervene. The demand for registration contravened centuries of pervasive wariness of becoming entangled with the law and its officials. (Vivian Ng, 1980) There is little evidence that overworked magistrates gave the law much priority. Although the intention of the registration and confinement laws was to ensure public security rather than punish, it is unlikely that those affected by them were able to make such fine distinctions. The relevant sub-statute was repealed in 1908. (Vivian Ng, 1980)

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LEGAL DEVELOPMENTS IN THE COMMUNIST ERA

Jural Law or Societal Law?

S.C.Leng and H.D.Chiu (1985) distinguish between the jural
(formal), and societal (informal), models of law in China. Jural
law is represented by codified rules, enforced by a judicial
hierarchy. Societal law focuses on socially approved norms and
values, inculcated by political socialization and enforced by
extra-judicial apparatus consisting of administrative agencies and
social organisations. Leng and Chiu attribute the domination of
societal law to Mao's bias against bureaucratization. Others
(Nathan, 1986a; Copper et al., 1985) also suggest that Mao saw law
as a potential brake on the Revolution and an encumbrance to what
Baum (1986) recognises as his preference for 'the rule of Man'.
The concept of the rule of Man in China goes back to Confucius,
who advised that a ruler and his subjects should be guided by the
rules of li, ethics or proper behaviour, rather than by
codifications of law. Behaviour should be mediated by moral
principle rather than by the fear of punishment. In a different
context, Mao also espoused this dictum, in fact if not in
rhetoric. The principle is expressed in a 1960s Guangzhou Red
Guard Pamphlet:

> 'The principle of law is to develop fully the power of
> the proletarian dictatorship so that we can attack the enemy more
> effectively and more accurately; it may never be used to restrict
> the functioning of dictatorship. If we respectfully follow
> Chairman Mao's instructions, we are then following the highest
> principles of law'. (quoted in Baum, 1986, p. 83)

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Consequently, it was not until 1979 that China had a formal Criminal Code. Before 1979, it was impossible for the populace to know with any precision whether or not a particular action would be in breach of the law. The notion from the Napoleonic Code that there should be no crime without a law, (nullum crimen, nulla poena sine lege) adopted by Russia, found no supporters in China. Instead, the ancient Chinese principle of 'judgment by analogy' was reasserted in Article 79 of the Criminal Code. This stipulated that:

'A crime not specifically proscribed under the specific provisions of the present law may be confirmed a crime and sentence rendered in light of the most analogous article under the special provisions of the present law'.(Baum, 1986, p. 87)

The ascendancy of the societal model over the jural model of law led to the complete dominance of the Party and the police in the administration of justice. This habit was far too deeply ingrained to be very much affected by the Criminal Code or Criminal Procedure Guidelines of 1980. A 1981 law college textbook states:

'Legislation must take party policy as its basis and administration of the law must take party policy as its guide. When legal provisions are lacking, we should manage affairs in accordance with party policy. When legal provisions exist they should be accurately applied, also under the guidance of party policy... Policy occupies the leading position.... Law serves to bring policy to fruition'.(quoted in Nathan, 1986b, p. 133.)

In 1985 an article in the Beijing Review (Feb. 11th, p.4), by An Zhiguo bemoaned the fact that party leaders in many places continued to think that the Party exercised leadership over everything, substituting party leadership for administration and regarding their own words as law.

The police, in the form of the Public Security Bureau, take a much more proactive role in dealing with wrongdoers than is the case elsewhere. It is a tradition that Chinese people on the whole prefer to avoid the adversarial context of a law court, and are willing to accept mediation or other means of settling disputes or minor crimes.

The police have very wide ranging powers to deal with minor offenders, political dissidents and socially undesirable or disruptive elements not charged with felonies. (Baum, 1986; Copper et al., 1985; Edwards, 1986) Such people may be assigned to hard labour in camps for periods up to four years and as they are defined as being subject to 'education' they are not entitled to public trial or legal counsel because technically they are not being punished. Re-arrests and reassignments are permitted so that in effect this is indeterminate detention without trial and without necessarily having committed a crime.

There is no presumption of innocence. (Nathan 1986a; S.C.Leng and H.D.Chiu 1985)) Once an individual is in a court, he is almost certain to be found guilty. Baum claims that conviction rates are well over 90 per cent. (1986, p. 89) Copper et al., based on a review of sentences in cases reported in two national and two provincial newspapers between the years 1978-1983, say that the highest proportion to be acquitted was 2.2 per cent in 1981.

Currently, there is no comprehensive law for the mentally ill that covers all of China. The necessity for such a law is acknowledged. Wu Jia Sheng (1985) says:

'Legislation and regulation for protection of social order against mental illness should be formulated soon. It seems that at the moment, the most outstanding problem is compulsory custodial treatment. For example, there are no clear guidelines to define the boundary, operational procedures, treatment means, period of detention for compulsory custodial treatment. There are also no clear guidelines regarding rights of the mental patients. From the perspective of a healthy socialist legislation, it is necessary to formulate these regulations'.

Apparently, mental health legislation has been drafted and was expected to go before the 1990 National People's Congress. However, it seems to have become entangled in the political infighting of the psychiatric hierarchy, and it may be some years before such legislation is officially ratified. At the moment, laws affecting the mentally ill are scattered through a wide variety of statutes.

MENTALLY ILL OFFENDERS AND THE LAW

Criminal Responsibility

Forensic psychiatry does not seem to have received much official attention until about 1984-85. This view is borne out by a conversation with a forensic psychiatrist and the large increase of articles on the subject since that time.

The Criminal Code reflects the historic concern, with the issue of diminished responsibility and clemency. Article 15 of the Chinese Criminal Code states:

'A mental patient who caused harmful results when in a situation of being unable to understand or control his actions does not bear criminal responsibility. However, his family members or guardians should be instructed to keep close watch over him and give him medical treatment. A patient of intermittent insanity who committed offenses when he was sane should bear criminal responsibility. A drunken person who committed offences should

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bear criminal responsibility'.(S.C.Leng and H.D.Chiu, 1985, p.195)

Judging from the articles that could be found in the general subject area, the issue of what constitutes criminal responsibility, and how it is to be judged, is a very central issue for Chinese authors addressing the issue of the relationship between insanity and law. According to Li Cong Pei (1986), the offender's ability to understand his illegal act before and after the crime is committed does not pertain to the ruling of criminal responsibility, although it may have some bearing on the verdict. The decision as to whether the offender should bear criminal responsibility is based on whether or not he had the capacity to do so at the moment the crime was committed.

Although it is never stated as such, the question of intent, (mens rea), seems to lie at the root of the arguments put forward on the issue of responsibility. This means having the intention to commit an act which is legally forbidden. (Hart, 1968) For a crime to be committed there must also be an act or a commission; the actus reus. Hart argues that what is crucial is that those whom we punish should have had the ordinary mental and physical capacities for doing what the law requires, and avoiding what it forbids, and the opportunity to exercise those capacities. In determining the level of responsibility of an accused said to be suffering from mental disorder, two questions have to be asked. First, what would the reasonable man with ordinary capacities have done in these circumstances? Could the accused with his capacities have done that? (Hart, 1968, p. 155)

Article 14 of China's Criminal Code states that persons under the age of sixteen are assumed to have no criminal responsibility, except in the case of very severe crimes committed by fourteen to sixteen year olds, such as murder, arson, grievous bodily harm, robbery, or behaviour that seriously undermines social order. Below that age they are considered to be immature physically and psychologically, and not to have enough experience and knowledge to enable them to foresee the possible harmful consequences of their behaviour. Thus decisions about criminal responsibility for the mentally ill are related to equating behavioural responsibility with that of legal minors. (Li Cong Pei, 1986)

Two criteria must be used in a decision about criminal responsibility. (Li Cong Pei, 1986) First, the offender should be suffering from an acute, chronic or temporary mental illness. Second, this mental illness must be of such severity that the patient loses the capacity to distinguish right from wrong or to control his behaviour. Both criteria must be met simultaneously and both are equally important. Similarity to the McNaghten rules are clear:

'It must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong'. (quoted in Prins, 1979, p. 18)

Some authors on this topic ((e.g. Li Cong Pei, 1986; Zhang Hu, 1987) are familiar with the McNaghten Rules but there is no statement that the Chinese system is based on them.

While the 'not guilty by reason of insanity' verdict is relatively rare in the U.K., (Prins 1980; Chiswick, 1988) it is the logical consequence of being judged to have no responsibility in China, and is therefore the rule rather than the exception for mentally abnormal offenders. Officially, Chinese law only recognises an either/or position with regard to criminal responsibility but in practice in Chinese courts, partial or diminished responsibility is also accepted. (Zhang Hu, 1987) Unlike the U.K., China applies the concept of diminished responsibility to a variety of offences rather than just to murder.

Yu De Jiang (1987) argues that being mentally ill does not necessarily mean that the offender should escape responsibility for the crime. He suggests that if the offender knows that he has a psychotic illness; if he can objectively criticize his own psychotic symptoms; and if he knows that his psychosis affects his future, his family and society generally, then he can be judged to have sufficient self-awareness to tell the difference between right and wrong and to have controlled his behaviour. Thus he should be dealt with as an ordinary criminal.

There is extensive discussion, for instance by Li Cong Pei and Guo Jing Yuan, as to which mental illnesses should be considered to affect criminal responsibility. The general consensus is that someone in the grip of an acute psychotic episode should be considered to have no criminal responsibility. A patient who is clearly in remission should be judged to have partial or diminished responsibility, based on the reality of individual

situations. The very severely mentally retarded would normally be considered to have no responsibility while those with less retardation would be more likely to be judged as having partial responsibility. People with organic brain damage, for instance caused by arteriosclerosis or Alzheimer's Disease, would probably be considered to be able to exercise partial responsibility but the decision would be based on the circumstances of their case, and the severity of their condition. Generally, people suffering from neurosis or personality disorder are to be treated as normal offenders.

Zhang Hu (1987) explains it in this way:

> 'In serious psychosis the patient is normal before the psychosis is imposed on him without his being aware of it or consenting to it. When he is ill, his cerebral function shows quantitative and qualitative damage. If the psychotic commits a crime under these circumstances, logically the illness should be responsible, not the patient. The likely legal judgment would be that because he is infected with psychosis he loses the ability to judge between right and wrong and to control his behaviour, so should be deemed to have no responsibility'.

Zhang goes on to say that in the case of neurosis and minor mental retardation:

> 'The illness is the person himself and if there is criminal behaviour it results from the criminal's personality, in which case he should be treated like a normal person'.

What reasons are put forward to justify treating the mentally ill differently from other accused persons under the law? Guo Jing Yuan summarizes them:

> 'A mentally ill person is not able to assess or control his own behaviour which leads to self-destructive or other destructive behaviour. This is against the requirements of law and society concerning individual's behaviour and will seriously destroy public peace and order causing damage and loss to society,

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family and individuals. But from the point of law and medicine we should give more understanding towards criminal acts committed by mental patients and not judge or punish them by ordinary legal standards. The reasons for this are as follows. First, the behaviour of the mental person is a sign of their illness and they cannot control it. Second, people in society should be more understanding to mental patients and show them humanitarian concern. Third, we should give custodial and enforced treatment to the patient. Fourth, punishing a mental patient cannot produce positive results and will cause negative consequences, making their illness worse. Therefore, the law should treat mental patients differently when they have committed crimes'.

Zhang Hu (1987) comments on the paradox of the anti-psychiatry movement in the West that favours treating psychiatrically ill offenders as ordinary criminals, 'which would lead to the penalising of psychotics when they commit crimes'.

Neurosis is an integrated, if undesirable, aspect of the person who must needs accept responsibility for his or her actions. Psychosis exists separately from the individual who deserves pity for being so afflicted in a way that is beyond his control. Two authors discuss what should happen if the person is clearly psychotic, and yet the psychosis does not appear to be related to the crime. (Zhang Hu, 1986; Jia Yi Cheng; 1983) Both say that there is a controversy amongst Chinese psychiatrists on this point. Some say that if a direct connection between the crime and the illness cannot be shown, then the person should be treated as an ordinary criminal. Others say that the very fact of being mentally ill should mean giving serious consideration to permitting partial responsibility.

The Appraisal Process

Each provincial or city level Procurator's Department must

formally appoint an Assessment Committee on Forensic Psychiatry. (Wu Jia Sheng, 1985) The committee is supposed to consist of doctors with psychiatric experience, preferably with experience in forensic psychiatry. Their purpose is to conduct a psychiatric examination, and investigation to determine a person's level of criminal responsibility. This work is mostly done on an out-patient basis. The patient is rarely admitted to hospital. It is not clear from the available information whether most cases would be on remand in gaol, or on some form of bail at home.

A request for appraisal may be made by various people at various stages in the legal process. According to Article 75 of the Criminal Procedure Code of the People's Republic of China, neither the victim nor the accused may refuse to be physically examined. Zhang Xing Sheng (1987) reports research carried out in Hangzhou. 53.4 per cent of appraisal requests were made because public security officials detected mental abnormalities in criminals before or during the trial. Only 2.4 per cent of requests were made because offenders showed abnormalities during their imprisonment. 10.5 per cent of requests originated from the families of the accused, which the author suggests shows faith in the judicial system. 32.9 per cent of requests were made because the accused was known to have been mentally ill before committing the crime.

Appraisal may also be requested to be made of victims. In Zhang's research, all such cases occurred where the victim was the subject of rape or attempted rape and suspected to be mentally retarded. In Zhang's sample, 46.3 per cent of those appraised were

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considered to have full criminal responsibility, 29 per cent partial criminal responsibility, and 24 per cent no criminal responsibility.

The legal appraisers are considered to have a responsibility towards the people they are appraising, their own organization, and the government, as their work is related to safeguarding socialism's judicial system, and the rights and ultimate fate of the person being appraised. The appraisal is a group process by two or three panel members. It is considered that this gives a better result by balancing out individual biases and permitting more thorough investigation. The panel between them is expected to interview the accused, their family, the danwei, and any one else who may be considered to have useful information, as well as examining all relevant documents pertaining to the accusation and trial. At Anding I was told that it is usual for the patient to spend about four hours in the forensic assessment unit, during which time he will be interviewed and given various tests including an EEG, the Weschler Intelligence Test, the Eysenck Personality Inventory and the MMPI.

Li Cong Pei (1986) recommends the following areas should be followed in the preparation of a report for the court.

1 - general information: the name and age of the person being appraised; their relationship to the defendants, witnesses and other parties involved. The main points of the case and the reason for appraisal should be listed out, for example the mental abnormalities of the person being appraised. The method and timing

of the work involving appraisal should be listed.

2 - the medical and psychiatric history of the patient's family which is needed to arrive at a conclusion; a description of the lifestyle of the person being appraised, and their psychiatric and medical history.

3 - observations made based on the physical and psychiatric condition of the person being appraised.

4 - an analysis of the relation between the crime and the mental abnormality of the person being appraised: the appraiser should state the facts of the crime and the appraised's behaviour; he should state clearly the reasons on which he has based his decision in language that the court officials can understand, so that they can follow the logic of the arguments and conclusions.

5 - the conclusion: the appraiser should state clearly whether the appraised has criminal responsibility; ability to understand the proceedings of the court; whether or not the appraised is feigning mental illness.

The law requires that the accused be informed of the conclusion of the report. (Article 90, Criminal Procedure Code of the People's Republic of China, 1979) Article 90 also states that the person being appraised may request a new or supplementary report, presumably if they think the first one is biased or inaccurate in some way. The report is not legally binding. It is submitted to the court and they may or may not choose to accept its recommendations. Zhang Xing Sheng's research (1987) said that the

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conclusions of their written reports formed the basis of the court's decision in 91 per cent of cases.

It is interesting to note that Zhang talks about 210 cases being referred to his department for an appraisal, but producing only 121 written reports. This is despite the fact that the law requires written reports signed by the appraisers in all cases. (Article 89, Criminal Procedure Code of the People's Republic of China, 1979) Li Cong Pei also mentions that the appraisal can take place in court. It seems likely that there are major permitted variations in standards of practice, presumably according to availability of resources and accepted practices from area to area.

It is clear from the available literature that the appraisal doctors disagree with each other sometimes. Li Cong Pei says that when doctors on the panel disagree they are permitted to submit separate reports, and the court may choose the one that they wish. It is also said that if the family or the danwei are not satisfied with the way that the appraisal has been conducted, they are at liberty to request a second opinion. How many of them have the courage or resources to do this is not known.

More serious clashes of opinion occur, best exemplified in two attempted murder cases described by Guan Xin (1988) The first concerned a slightly physically handicapped man who formed an unreciprocated attachment to a girl. He went to her house one night and stabbed her and then himself , although both recovered. The accused's defender requested a psychiatric appraisal. The

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appraisal report concluded that the accused was suffering from paranoid schizophrenia. However, the court refused to accept this, saying that:

> 'It would not be objective if we said that the accused is deluded by love, just from his love for the victim, and has a delusion of jealousy, just from the fact that the victim has told the accused about her boyfriend. Similar situations happen to many people in real life. Does this mean that all of them are suffering from paranoid schizophrenia?'

So the court asked for another assessment from a different hospital. This reached the exactly opposite conclusion from the first: that the accused should bear full responsibility as he was not mentally ill. As a result this was adjudged a 'difficult' case, and was suspended for eighteen months. It seems that it was then referred to the provincial high court where the judges questioned the accused and his family, interviewed the victim, made investigations at the place where the offence occurred, and eventually concluded that they supported the findings of the second report.

The second case followed a similar pattern. The first assessment found that the accused suffered from schizophrenia. The second one disagreed. The third agreed with the second. Instead of referring the case to a higher court, the judges brought in a fourth set of psychiatric personnel who agreed with the view that the accused was not mentally ill. Thus he was sentenced to death, suspended for two years [which may be commuted to a life sentence if the prisoner shows sincere remorse and good behaviour during the stated period], and had his political rights removed for life.

These cases clearly indicate that the court is not obliged to accept medical opinion if it does not cohere with its own. One interpretation is that the court is able to seek several opinions, until it finds one which agrees with the already established opinion of the court. On the other hand, this view may be too cynical. At least in the two cases described, much effort seems to have been taken to be fair to the accused, and not to reach a hasty decision that was not backed by strong medical opinion. It is noticeable in the two cases that the psychiatric opinions were sought from institutions of increasingly higher reputation.

Material available on the kinds of crimes committed by those for whom appraisal is requested is scarce and incomplete. This is also the case for information concerning the frequency of each kind of diagnostic category. Zhong Xing Sheng (1987) says that in his sample, sexual crimes were the most frequent (35 per cent), mostly involving rape or attempted rape. It is not wholly clear from his figures, but it seems that the majority of victims and perpetrators were mentally handicapped. One wonders how 'rape' is being defined in these circumstances, and to what extent the term is being used to describe consensual intercourse between people who are not socially entitled to it.

Zhong's second category is a ragbag of murder, assault, theft, fraud, arson, framing others, anti-social and anti-political speeches and deeds. Of these cases, he says that in 1977, 54 per cent of crimes by those being appraised concerned anti-political actions. Now the figure has dropped to 6.7 per cent, which 'shows

that there is internal stability and unity in China'. There is no discussion of whether this is an absolute drop in numbers due to a decrease in that kind of crime, or whether the officials of the Public Security Bureau now only take notice of such behaviour if it is very extreme.

Zhong claims that in his survey, 30.9 per cent of those appraised were mentally retarded, 23.3 per cent were schizophrenic, and 7.2 per cent suffered from a personality disorder. Other studies found that the majority were suffering from schizophrenia. For example, a major study by Li Cong Pei (1987), of 865 cases of psychiatric appraisal found that 45 per cent were diagnosed as schizophrenic. Of those, 79 per cent were males, of whom 75 per cent were between the ages of 21-40. Among the victims of the people suffering from schizophrenia, 51 per cent were relatives. The appraisers of the schizophrenic offenders judged that 97.5 per cent were not responsible for their actions.

Ability to Stand Trial

This is outlined by Li Cong Pei (1986), who is the only source found to mention the subject. He points out that the capacity to stand trial needs to be distinguished from the ability to accept criminal responsibility. The latter refers to the accused's state of mind at the time of the crime. The former is only concerned with whether the accused is able to properly take part in court proceedings, by being able to understand the nature and process of the trial, and being able to co-operate with his lawyer. In some cases the accused may be exempted from both. If the accused is

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judged not to be capable of taking part in the trial, then he is to be 'convinced to take treatment', and the trial will be postponed until he is fit to stand. While not ideal, this has some advantages in comparison with the British system, where someone who is considered unfit to plead may be consigned to a secure hospital, and is effectively given an indeterminate sentence without having been found guilty or had the chance to present a defence to the court. Such cases are apparently rarely brought back to court. (Prins, 1980; Chiswick, 1988).

Li Cong Pei suggests that five criteria need to be met for the accused to be considered able to stand trial.

1 - Does the defendant know that he is on trial and what the charges are?

2 - Can the defendant describe his criminal act, how the crime takes place and the legal status of his crime?

3 - Does the defendant understand the proceedings of the trial, the function of the court, his own legal rights, the possible verdict and penalty?

4 - Can the defendant defend himself?

5 - Can the defendant within reasonable limits assist and co-operate with his lawyer?

The Disposal Of Mentally Ill Offenders

The articles that have been drawn on so far discuss the details of criminal responsibility in repetitive detail. However, they are noticeably silent on what happens to those who are found to be suffering from a mental illness, and who are consequently

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considered to have no responsibility and are therefore not guilty. Are they permitted to return to their families under strict supervision? Are they hospitalized in ordinary institutions? And if so, how is the length of their stay determined? Are there special institutions for the severely mentally ill offender, even if he has not been sentenced?

Two pieces of legislation give some guidance on this matter. The first is Article 37 of the <u>Act of the People's Republic of China for Reform Through Labour</u>, promulgated in 1954. This states that:

'A health examination shall be given to offenders who are committed to custody. Except for major counter-revolutionary offenders whose criminal acts are major, commitment to custody shall not be permitted in any one of the following circumstances...

1) mental illness or acute or malignant contagious disease....

Offenders who under the preceding items may not be committed to custody shall, after the organ that originally ordered their commitment to custody has considered the situation, be sent to a hospital, turned over to a guardian, or put in another appropriate place'. (S.C.Leng and H.D.Chiu, 1985, p. 253)

<u>Regulations of the People's Republic of China on Administrative Penalties for Public Security</u>, 1987, Article 10 says:

'A mentally disordered person who violates the administration of public security at a time when he is unable to account for or control his conduct, shall not be penalized, but his guardian shall be instructed to keep a close watch on him and subject him to medical treatment. (<u>China Law Year Book</u>, 1987)

Shanghai has produced its own 'mini' version of a mental health law, called the 'Regulations of the Shanghai Municipality on Guardianship, Treatment and Handling of Mental Patients Stirring Up Trouble and Causing Disasters'. (<u>China Law Year Book</u>, 1987)

This was adopted at the 23rd. session of the Standing Committee of the Eighth People's Congress of Shanghai Municipality, in August 1986. Article 8 defines 'stirring up trouble' as;

1 - committing assault or doing violence causing injury to others.

2 - insulting women

3 - damaging public or private property

4 - impeding the safety of communication

5 - other acts disrupting public order or hampering public security.

Article 11 authorises officers of the Public Security Bureau to remove by force to hospital for treatment someone whom they think is mentally ill, and who is stirring up trouble, with or without the relatives' permission. The same article says that the patient must be examined on arrival at the hospital by two doctors, one of whom must be on the level of physician-in-charge. If this doctor decides that the person is not suffering from a mental illness, then the Public Security staff will 'deal with him according to the law'.

Other articles deal with relatives who wish to discharge a patient without the permission of the hospital authorities; they are not allowed to do so. Under these regulations, if a patient's treatment is completed but his family are unwilling to accept him back, the Public Security Bureau are authorised to escort the patient from the hospital and deliver him to his relatives, whether they are willing or not.

The category of 'causing disasters' is more serious and includes, homicide, rape, arson, causing explosions, robbery, poison and other acts seriously endangering public security. These people must be examined by the expert appraisal panel. These patients need not only the approval of the hospital but also of the Public Security Bureau before they can be discharged.

There are at least two areas in which these regulations are different from common practice in China. First, they permit the wishes of the relatives to be over-ruled, albeit in cases which are considered to be serious. Second, for both categories of patient, the regulations, (Articles 11 and 14), say that the expert appraisal panel may be used as an appeal body by patients, relatives or victims not satisfied with the diagnosis or hospitalization. Because of the rarity and interest of the document, the Shanghai regulations have been reproduced in full as Appendix Six.

While these various laws and regulations give some idea of what happens in theory, and are coherent with the general notion of clemency towards the mentally ill found in Chinese law, it offers no clue as to what happens in practice.

When I read through files at the Guangzhou Hospital, it rapidly became clear that there were people there who had technically broken the law, been arrested or 'picked up' by the Public Security Bureau and taken straight to hospital. There seems to have been agreement between the Public Security Bureau representative and the family, or street organisation, responsible

for the patient that their behaviour was so clearly crazy that arranging an admission to a hospital was obviously the most sensible course of action. For instance one female patient with a history of criminal damage (not specified), scolding and hitting people in the street, and stripping naked in public and standing in the road stopping traffic was arrested and brought to the hospital, with her family's approval.

Another male patient disturbed traffic, destroyed his own clothes, attacked his father with an axe, assaulted women on the street, set fire to his house, and 'affected social security with very, very, bad consequences'. He was admitted through the Public Security Bureau at the request of his family. Similarly, a male patient, with no family to support him, was admitted at the request of his street organisation after he hit people and broke windows and the glass front door of a hotel, and was deemed to 'have seriously affected social security'.

Offences committed in public usually amount to no more than being a public nuisance when no member of the public is seriously hurt. More serious offences tend to be committed against family members. It is possible that psychiatric admission seems the most pragmatic of options to both the wounded party and the police, as they are unlikely to want to prefer charges. They may also consider it to be a more humane option than a trial, and a possible prison sentence; and perhaps less demeaning for the family, if for no other reason than it will be less public.

Prins (1980) points out that police in England will often unofficially screen out petty offenders whom they consider to be mentally disturbed, if other arrangements they consider more suitable than a trial can be made. Section 136 of the Mental Health Amendment Act (1983) permits the police to remove from a public place to a place of safety someone whom they consider to be mentally disordered. Often this place will be a psychiatric hospital.

Zhang Hu (1987) says that for those who are thought to be seriously psychotic, who have committed a dangerous offence, but who have been found to have nil responsibility, 'guardianship' may still have to be provided at the discretion of the court. There are special hospitals run by the Public Security Bureau for people who have been found to have partial responsibility and for those who are deemed to be very dangerous, even though they have been judged to have nil responsibility. Jia Yi Cheng (1983) mentions such institutions in Shanghai and Dalin, and I have been told of their existence in Beijing, Tientsin and Guangzhou, but have never been permitted to visit one. As far as can be determined there is no mention of them in the English language literature, nor is there any discussion as to how forensic psychiatry in China operates. Jia implies that those who were found to have partial responsibility by the court, and would therefore have received a sentence, would find that the time they spent in one of these special institutions counted towards their overall sentence when they were transferred to prison, presumably once symptoms were under control.

Wu Jia Sheng (1985) writes in some detail of these 'treatment and management institutes for mentally ill offenders'. Mentally ill offenders who require custodial treatment need a special case report by the local Public Security unit. This, together with the forensic psychiatry appraisal report, has to be evaluated and approved at the provincial or city level by the Public Security Bureau. Offenders should be given modern treatment for their illness, and once they have become stable they should be given appropriate cultural education and assigned some light labour work, so as to help them recover their ability to live in the community. Once the patients are definitely cured, then they can go back to their work units, or to the care of their neighbourhood committees. Wu also implies that the offender-patient will continue to receive money from his work unit during his stay, 'according to the Labour Ordinance'.

In discussion with a doctor at Anding Hospital, Beijing, who worked in the forensic assessment unit there, I was told that if a patient referred by the Public Security Bureau is found not to be able to bear criminal responsibility, then the Public Security Bureau is responsible for his disposal. They might let him return to his family, or they might decide to admit him to one of the special psychiatric hospitals. All of these Public Security Bureau hospitals are known as An Cun, e.g. Beijing An Cun Hospital.

It is unlikely that the police would return someone who had committed a felony to his family, but they would be more inclined to do so if the offence was classified as a misdemeanour. Once

admitted to such a hospital, the offender who has committed a more serious crime is likely to spend some years there. Someone with a less serious offence may be discharged once his mental state is considered to be stable.

Doctors working at An Cun hospitals will make a recommendation for discharge to the hospital leaders, who are Public Security Bureau officials and who take the final responsibility. The leaders take into account the patient's mental state, the family's willingness to look after the patient, but apparently most of all the current 'community atmosphere'. Patients are less likely to be released during times of unrest, or during an important event, like the Asian Games.

Offenders who are found to have diminished responsibility may also be admitted to an An Cun hospital, and in practice are treated no differently from those found to have no responsibility. There is also a psychiatric prison hospital in a county just outside Beijing, where prisoners go who become mentally ill in prison. Not all patients who offend are sent to an An Cun hospital. Some of them may be admitted to an ordinary hospital, if the hospital is willing to take them. This is not surprising when one considers that all hospitals are pre-eminently security conscious.

Within the prison and special hospital system in the United Kingdom, both staff and offenders are very aware of the concept 'time for the crime'. Personal experience of working in Broadmoor, led to the observation that there is a reluctance to discharge someone from a special hospital, even when the illness is under

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control, unless he has served as much time as he would have been likely to do if he had received a prison term. Mental illness is not an issue in deciding guilt or innocence in the United Kingdom, but rather disposal once guilt has been established. Within the Chinese system, a mentally ill offender is technically not guilty of the crime because of his insanity. Thus, while in effect 'sentenced' to hospital, (despite being innocent of the crime), he may spend less time there than he would have spent in prison. Certainly, the two doctors to whom I spoke on the subject did not emphasise the question of parity. Sun Jun Wen (1984) describes six cases of schizophrenic patients who, while in Zhejiang Provincial Psychiatric Hospital, killed fellow patients. Three of these patients were discharged; one within three and a half years of the murder; one within one year; and one within one month. All were described as responding well to treatment.

A case example may serve to illustrate some of the intricacies involved. (Li Cong Pei, 1986) In 1967 a man called Wang, with others, was implicated in a murder which was assumed to have happened after the supposed victim disappeared. Wang was asked to sign a letter of confession which he did, without the proper investigations being carried out. It is suggested in the article that this was at the height of the Cultural Revolution and political grudges were involved. Wang was a model prisoner, and although those convicted with him appealed against their sentences, he never did. No mental abnormality was detected until he had been in prison for a year or so, and he requested to join the Communist Party. He claimed that the party had appointed him

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its central investigator, number 808.

The authorities did nothing at that time, but three years later, when he claimed that the Party had commanded him, through a 'highly confidential television set', to commit the murder, they decided that it was time to have him appraised. The investigating psychiatrists discovered an encapsulated delusional system involving Wang's relationship, as he perceived it, with the Party, and his belief that his behaviour was completely controlled by television and an electronic man inside his body. They decided that his confession was part of his delusional system, and that he had never been involved in a murder. They recommended that he should be exempted from criminal responsibility. The various government departments involved ruled that the case had been wrongly decided, and reinstated Wang's reputation. They also provided him with work and treatment.

THE CIVIL LAW

Within civil law, there is an idea that corresponds to that of criminal responsibility, the ability to 'act' which is based on whether or not a patient is able to understand his civil rights and obligations and to carry them out. (Guo Jing Yuan, 1987) This largely affects marriage, entering into contracts and making a will. Once again the analogy is that with legal minors. Children below the age of ten are considered not to be able to enter into any legal agreement. (Article 12, General Principles of the Civil Code of China, 1987) Their rights and obligations are exercised on their behalf by their parents, who are also expected to protect

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their interests. Children between the ages of ten and 18 are considered to be partially responsible in this respect. (Articles 11 and 12, General Principles of the Civil Code of China, 1987)

The spouse, parent or danwei of an adult who is considered to be too mentally ill to handle his own affairs, can apply to the court to carry out an expert psychiatric appraisal to declare that the individual is incapable of doing so. This would be done by the same committee which is involved in appraisals for criminal responsibility. The court may appoint an agent ad litem on behalf of the mentally ill person, and officers of the court are expected to question the patient themselves. (Articles 136-138, Civil Procedure Law of the People's Republic of China, 1982)

The court is empowered to appoint a guardian, usually a relative, who will have similar rights over the patient to those a parent has over a child. If no relative is willing or able to act, then this role is expected to be taken up by the danwei, neighbourhood or village committee or local Civil Affairs Bureau, as appropriate. (Article 17, General Principles of the Civil Code of China, 1987) The person who has been deemed incompetent or his guardian, can apply to the court to have the judgment rescinded if the circumstances have changed. (Article 140, Civil Procedure Law of the People's Republic of China, 1982)

The guardian becomes responsible in law for the actions of the mentally ill person. Thus, if that person causes damage and compensation has to be paid, the guardian must pay it, unless the guardian can prove to the court's satisfaction that the person is

beyond his control. (Article 8, <u>Regulations of the People's</u> <u>Republic of China on Administrative Penalties for Public Security</u>, 1987) In turn, if the guardian through handling his charge's property makes a loss, he is responsible for repaying the money or goods so lost. (Article 18, <u>General Principles of the Civil Code</u> <u>of the People's Republic of China</u>, 1987) Any person who 'shares interests' with the mental patient may apply to the People's Court for announcements that the mental patient is incompetent for civil conduct, or is limited in such conduct. (Article 19, <u>General</u> <u>Principles of the Civil Code of the People's Republic of China</u>, 1987) The removal of civil responsibility would only be considered in cases where the mental impairment seems to be permanent and of long standing duration. It would not be considered in cases of temporary or intermittent disturbance of sanity. (Li Cong Pei, 1986)

Li gives the following examples. If a party to a marriage suspects the other party is mentally ill and he or she wants to nullify the marriage, it is possible to apply to have the partner's psychiatric state appraised by the court. Wills may also be challenged on the grounds that the deceased was not in his right mind at the time of drawing up the will. In this case, the appraisal procedure must be carried out using secondary sources of evidence. A contract is invalid if one of the parties to it is found not to have been able to exercise civil capacity at the time of the contract. If the person lacking civil competence suffers a loss as a consequence, the other party has to pay compensation. Parents who are severely mentally ill and lack civil

responsibility, may lose their parental rights. Nathan (1986a) says that the mentally ill are not permitted to vote. Article 37 of the <u>Criminal Procedure Code of the People's Republic of China</u>, 1977 forbids people who have physical or mental handicaps, who are too young to know right from wrong, or who cannot adequately express their own will, from being witnesses in court.

A case illustrating how this legal provision might be used is given by Li Cong Pei (1986) On several occasions a cadre in a rural area wandered away from home staying out all night and causing a search to be made for him. He was found dishevelled and apparently having been faecally incontinent. On the last occasion he stayed away for ten days, eventually returning by himself exhausted. On all three occasions he was unable to remember what had happened. People 'began to suspect that he was abnormal' and he was sent for a psychiatric appraisal. Although normal in every respect on a verbal examination he was given an E.E.G. and found to have abnormal brainwaves associated with epilepsy. On these grounds he was ruled to have neither criminal responsibility nor civil competence.

Involuntary commitment

However, losing one's civil competence not does not necessarily imply involuntary commitment to psychiatric hospital. It has been widely reported by Western observers either that there are no compulsory admissions to psychiatric hospitals in China or that they are very rare. Visher and Visher (1979, p.30) state that 'compulsory admission of patients does not occur in China except

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in criminal cases'. Bloomingdale (1980, p.23) asserts that:

'Forensic psychiatry does not exist in the People's Republic of China.... Chinese psychiatrists were puzzled about western insanity laws. In China the issue of legal sanity is not raised'.

Breger (1984, p.130) claims that:

'When hospitalization is deemed necessary, patients are admitted voluntarily, invariably persuaded and not forced to enter hospital. We saw no evidence of a civil commitment process'.

Breger is correct when he says that no process of civil commitment exists, but wrong to assume that there are no compulsory admissions. It is perhaps difficult for a Western observer steeped in the belief that it is necessary to protect individual freedom, to perceive that it is perfectly possible to put someone in hospital without their permission, and with no legal protection at all.

The Chinese view is more concerned with the patient's right to receive treatment, and doubtless with society's need to be protected. Thus Dr.Young Derson of Changsha Hospital says that 'you cannot ask a psychotic patient whose judgment is impaired whether he wants treatment'. (quoted in Achtenberg, 1983, p.373) Reading through the files at the Guangzhou Hospital it was very apparent that many people were brought to hospital against their will. One was admitted in chains by the Public Security Bureau. Another was tricked by her family into believing that they were all going on a picnic to the country. I was standing in the out-patients' department of Anding hospital when a patient was brought in sedated to the point of unconsciousness, and tied hand and foot to the stretcher. In Shashi, one patient from the rural area

was brought to the hospital by his family trussed up as thoroughly as a turkey ready for the oven. The only action still available to him was to spit.

It is not the individual who is consulted about his admission, but his family. If the family agrees to it, then he is admitted. If the family disagrees then he stays outside until such time as his behaviour comes to the attention of the Public Security Bureau, (if it ever does), or the family reaches a stage when it can no longer cope and changes its mind. Some of the cases cited earlier in the chapter are a testimony to the level of disturbed behaviour some families are willing to tolerate before taking action.

Marriage and the Mentally Ill

The 1950 Marriage Law forbade the mentally retarded, but not the mentally ill, from getting married. Over the years, attitudes changed somewhat, so that marriage was seen as a right whose benefits the mentally retarded should be able to enjoy. On the other hand, bearing children was a privilege and should be strictly controlled. The situation of the mentally ill in the new Marriage Law of 1981 has changed. Article 6(b) states:

'Marriage is not permitted in the following circumstances....Where one party is suffering from leprosy, a cure not having been affected, or from any other disease which is regarded by medical science as rendering a person unfit for marriage'.

Clearly, this leaves a great deal of space for individual interpretation by different provinces and municipalities. Palmer (1987) reports a case of a 35 year old woman who applied to the court for a divorce after six years of marriage to a man who

habitually beat and abused her, even following her to her workplace to do so. He was diagnosed as schizophrenic and she applied to the court for a divorce on the grounds that he was suffering from an illness 'regarded by medical science as rendering a person unfit for marriage '. The court refused her request, instead instructing her to 'go away and perform to the fullest extent the duties of a wife'. It appeared that her father-in-law had exerted influence with the court because he did not want to have the responsibility of looking after his mentally deranged, son and was afraid of losing custody of his grandson. There are similarities between this case and the one contained in Appendix Two.

An authoritative commentary on the Marriage Law (Ren Guojen, 1988), says the law is not clear and that the relevant judicial and legislative organs have not yet issued any interpretations. Based on judicial practice, the two most important illnesses covered by Article 6(b) are severe mental illness, (he mentions schizophrenia and manic-depression specifically), and mental retardation. Three reasons are given as to why schizophrenia and manic-depression constitute an obstacle to marriage.

1 - Both illnesses are contracted during youth

2 - Patients suffering from schizophrenia in particular are unable to take legal responsibility, suffer from a lack of self-control, and lack the ability to exercise civil competence. Consequently, they are unable to exercise marital or parental responsibilities.

3 - Both schizophrenia and manic-depression are hereditable diseases. Thus there is a danger of transmitting them to descendants, and the risk of spreading the disease through the population is very great. Ruo emphasises that this is the most basic reason.

There is no doubt at all that Chinese psychiatrists are very concerned about the hereditability of schizophrenia. (Fang Yongzhang, 1982; Liu Xiehe, 1983; Xun Minlai, 1986) Some see it as a justification for restricting marriage and childbirth. In such a populous nation, it is hardly surprising that attitudes towards controlling the birth rate are more stringent than are considered appropriate in the West. Both Fang Yongcheng (1982) and Xun Minlai (1986) are concerned with the higher birth rate among schizophrenics among whom, for a variety of reasons, birth control acceptance is not high. One reason is that birth control workers are afraid of them, and reluctant to approach them or 'mobilise' them in the face of resistance, in the same way they would other members of the population. Both Xun and Fang advocate using the law to restrict marriage and childbirth for people suffering from schizophrenia, and frankly advocate a policy of eugenics and compulsory sterilisation. Xun's research involved a population of 250 male and female schizophrenics who were sterilised in the Xiang Tan Psychiatric Hospital in Hunan Province, between 1972 and 1983. What is not made clear is whether these sterilisations were voluntary or not. Likewise, Fang mentions that 22 per cent of his sample of people with schizophrenia were sterilised.

In 1986, the Ministry of Public Health and the Ministry of Civil Affairs issued a <u>Circular Concerning Pre-marital Medical Check-ups</u> (Ming Zhi, 1991) The circular stipulates that the parties concerned can only complete the marriage registration formalities after they have undergone a medical examination, although there is the proviso that 'since conditions vary from place to place, no fixed time for implementing the circular has been laid down'.

The circular has three categories affecting marriage and childbirth. Marriage is prohibited between close relatives and between people who have very low intelligence. Marriage is to be postponed when one or both parties are suffering from schizophrenia, manic depression, or other types of psychoses. Marriage is permitted but childbirth forbidden:

'....where either party whose inherited disease, such as schizophrenia, manic-depressive psychosis, or other types of psychoses, as well as congenital heart disease is in a stable condition'. (Ming Zhi, 1991, p. 18)

In 1989, 113,000 people underwent the pre-marital examination and 1.4 per cent of them suffered from problems affecting their proposed marriage. Thirteen were prohibited from marriage, 1,479 had to delay their marriage and 29 were not allowed to get married. (Ming Zhi, 1991) The aim of this policy is quite clear:

'With the rapid development of eugenics, scientific research work into eugenics and healthier births broke new ground, and health care work in urban and rural areas greatly improved, thereby enabling eugenics to guide marriage and childbirth'. (Ming Zhi, 1991, p. 18)

Thus, although the Marriage Law is very non-specific, it does appear that there are regulations restricting marriage and

childbirth for people suffering from mental illness in China. What is completely unknown is how rigorously and universally these are enforced, and how many people are persuaded or forced to accept sterilization. Such policies are another manifestation of priorities that place the good of the collective higher than the wishes or rights of the individual.

HUMAN RIGHTS ISSUES

It is not possible to consider this specific issue without first looking at the question of rights in general. The phrase 'human rights' is an imprecise one. A definition in western eyes would probably be based on international agreements such as the the Universal Declaration of Human Rights, 1948, or the International Covenant on Civil and Political Rights, 1966; and on Economic, Social, and Cultural Rights, 1966.

The immediate history of human rights in the West goes back to the seventeenth and eighteenth centuries. Probably the most famous statement is in the American Declaration of Independence:

'We hold these truths to be self evident: that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty and the pursuit of happiness'.

Kamenka (1978) makes the point that this view sees society as a collection of individuals, founded - logically or historically - on a contract between them, and it elevates the individual human person and his freedom and happiness to be the goal and end of all human association:

'In the vast majority of human societies, in time and space, until very recently such a view of human society would have been

hotly contested'. (p. 6)

These original formulations of human rights assumed that rights were inviolable, pertaining to the natural condition of being human; that they were not granted but inborn. This view has retained its supporters to this day, (Henkin, 1986) and was challenged from its inception. Jeremy Bentham, the philosopher, called the idea of imprescriptibility 'nonsense on stilts'.

Cranston differentiates between positive rights, which are recognised by 'the actual law of actual states', and moral rights, which are appeals to justice and may or may not be supported in law. Kamenka sees human rights as 'a proposal concerning the morally appropriate way of treating men and organising society'. (1978, p. 12)

Although ratified by many nations, the international covenants and declarations do not have the force of law unless enacted as statutes in the individual countries. Walker sums up the position thus:

> 'There can be no dispute about the reality of man-made rights which are embodied in statutes, contracts or other documents with legal force; but the same cannot be said about 'natural rights', whose status is extremely debatable. As for rights embodied in international conventions or declarations, they are not so much rights as persuasive instruments for the creation of statutory rights, which is their intention'. (1980, p. 187)

Rights, wherever laid down, may also be seen as being 'rights for' or 'rights against'. The latter are less contentious, easier to agree on and, therefore, to put into practice; for instance the right not to be subjected to cruel and unusual punishment. 'Rights for', on the other hand, tend to be subject to cultural variation,

and more expensive because they require the provision of resources: for instance the right to receive humane treatment in the least restrictive circumstances possible, or the right to receive comprehensive care outside an institutional environment.

What is China's position regarding human rights? Two major strands of thought contribute to a complex attitude. First, is the historical and cultural experience of Imperial China. It is generally agreed that the question of human or civil rights did not feature in traditional Chinese moral or political philosophy. Hansen (1985, p. 360) claims that 'there is no discussion of "rights" - in fact no such term enters the Chinese vocabulary until comparatively modern times'. More thoughtfully perhaps, Wang Gung Wu (1979) argues that, at least initially, the presence of duties, particularly filial piety and loyalty, also implies the presence of rights. If a son is filial, he has a right to expect a mother to be loving and caring. If a subject is loyal, he has a right to expect the Emperor to be benevolent. However, these duties and implied rights were between unequals (father:son, older brother:younger brother, Emperor:subject,) which in turn led to an uneven distribution of both duties and rights. The resulting picture was one:

'... of a civilisation where all those below, the great majority, had only duties and the only rights were found among the small minority who held power above'. (Wang Gung Wu, 1979, p.14)

Despotism emerged gradually over the centuries, worsening steadily from the Han to the Tang dynasties and more rapidly after the Tang reaching new heights during the Ming and Qing dynasties. The

Confucian moral order contained no belief in the rights of the
individual as a limit on any kind of authority be it familial or
state.

Indeed, Kamenka comments that:

> 'The Great Code of Punishments of the Qing Dynasty was as
> complex and sophisticated an administrative document as any
> European lex or leges up to even the nineteenth century; but it
> was a code of punishments, addressed to officials and not to the
> citizens, providing administrative measures, imposing strict
> obligations while encouraging ad hoc justice and sub-legal
> settlement'. (1978, p. 8)

In the late nineteenth and early twentieth centuries political
reformers in China became interested in the question of rights,
many of them having been educated overseas, and rights became part
of the reformist agenda. However, they largely addressed the
question of rights and liberties from the perspective of what
would best serve collective goals and when they discussed
individual rights it was in terms of how best exercising such
rights could strengthen China, for instance by releasing
individual creativity and energy to be put to work solving China's
many problems. Such rights were not universal principles but
instruments towards a higher goal, that of strengthening China.
(Wang Gung Wu, 1979)

John C.H.Wu, a jurist responsible amongst other things for
drafting China's 1946 Constitution, expressed it this way.

> 'Westerners, in struggling for freedom, started from the
> individual. Now we, in struggling for freedom, started from the
> group....We wish to save the nation and the race and so we cannot
> but demand that each individual sacrifices his own freedom in
> order to preserve the freedom of the group'. (quoted in Wang Gung
> Wu, 1979, p.29)

The second strand in modern China's attitude towards human rights is the traditional Marxist distrust and ambivalence towards them. While human rights may have been instrumental in political change they were, at the same time, seen to be statements of the demands of the bourgeoisie, and of the necessary conditions of capitalism to own property and buy and sell freely. (Tay, 1978) For Marx, the ideal was not the individual man, but the social man subsumed into a collective unit. Furthermore, at least in their original formulation, human rights were seen as rights of citizens against governments, not a welcome perspective in any autocracy. (Minogue, 1978)

Since Liberation, China has had four constitutions: in 1954, 1975, 1978 and most recently in 1982. It is not necessary to examine the content in detail for the purposes of the present discussion. In many ways, the 1982 Chinese Constitution is a model of its kind. It guarantees equality before the law; the right to vote and stand in election; the freedom of speech; of the press; of assembly; of association; of demonstration; religious belief; freedom of correspondence; the right to make complaints against state organs or functionaries. At this point, it is essential to recall Cranston's injunction to 'keep in mind the distinction between what is and what ought to be, between the empirical and the normative.' (1973, p. 6)

In none of the constitutions were rights considered to be derived from human personhood. They were received from the state and were not considered to apply to all. Distinctions were made between

'the people', who were usually workers and poor peasants, and those with a bad class background like landowners, or those who were considered to oppose the purposes of the state and were dubbed counter-revolutionary. The rights in China's constitution are the rights of citizens, not of persons. Citizenship is not constitutionally guaranteed, so that a person who is not accorded, or is deprived, of citizenship is not promised any rights at all.

Chinese constitution writers had no inhibitions about changing provisions in the constitution quite dramatically to suit altered circumstances. What the state could dispense it could equally well withdraw:

> 'Rights are entrusted by society to the individual; society is the source of rights. The individual apart from society has no rights to speak of. Since society bestows rights, at times of necessity it can also remove rights; at least it can limit their scope'. (John C.H.Wu, quoted in Nathan, 1986b, p. 131)

Because rights are granted as part of being a member of society they cannot be enforced against society. There is no concept of the individual needing to be protected from the depredations of the state, or that government is other than positive. Peng Zheng, a Politburo member, told the National People's Congress that:

> 'We are a socialist country, in which the interests of the state and society are basically identical to the interests of the individual. Only when the democratic rights and basic interests of the vast masses of the people are guaranteed and developed will it be possible for the freedoms and rights of individual citizens to be completely guaranteed and fully realised'. (Beijing Review, 1982, 25(50), p. 13)

The Chinese constitutions were written as political programmes for the future, and presented as goals to be realised. Thus they mentioned rights which, in fact, could not be enjoyed. (Nathan,

1986a) These constitutions did not form a contract between the governed and the government, embodying sets of reciprocal rights and duties.. Their main function was to create a strong state, not to restrict the powers of the state.

In November, 1989 the Beijing Review carried an article entitled 'Opposing Interference In Other Countries' Internal Affairs Through Human Rights' by Yi Ding. This article denies that there are any universal or abstract human rights. It states that human rights are only those which have been recognized in law by the dominant class of a country; that there are no universal human rights which override the laws of various countries; that international documents relating to human rights do not supersede the laws of any country:

> 'The theory that human rights know no boundary is not only theoretically wrong, and legally groundless but also very harmful politically and practically'. (November 6th., p.11)

Recent Human Rights Formulations

The West's concern with the universality of human rights has extended more specifically to the rights of the mentally ill. If the advanced countries struggle constantly to guarantee basic rights for their mentally ill population, what chance is there of improving practices in countries that share neither the resources nor the concerns?

Statements about the rights of mentally ill people designed to delineate international standards have been produced by: the Minority Rights Group based in England (Heginbotham, 1987), the

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World Federation of Mental Health, (The Luxor Declaration) 1989, the United Nations (Daes, 1986) and the World Health Organisation (Gostin, 1987a).

The most succinct of these was written by Larry Gostin (1987b) and contains five broad areas. These are;

1 - the right to humane, dignified and professional treatment, (also mentioned by Daes, the M.R.G. and The Luxor Declaration).

2 - voluntary admission should be encouraged whenever treatment is necessary, (also mentioned by Daes).

3 - the right to a full and impartial judicial hearing before involuntary loss of liberty, (also mentioned by Daes, the M.R.G. and The Luxor Declaration).

4 - the right to a free and open environment and free communication, (also mentioned by Daes and The Luxor Declaration).

5 - the right not to be discriminated against on grounds of mental illness, (also mentioned by Daes, The Luxor Declaration and the M.R.G.).

On none of these standards does China score highly, although this does not distinguish it from many other countries in the world. Conditions may, on the whole, be better than those in Japan, (Gostin, 1987a) Russia (Wing, 1978) and Greece, if the island of Leros is anything to go by. (Mind Out, Nov., 1987) In China facilities exist for the provision of care at least to urban

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patients. However, the widespread, routine use of unmodified E.C.T., plus its use as a threat or a punishment and the apparently growing use of psychosurgery give cause for concern. (see Chapter Nine)

There are no involuntary committal proceedings for non-offenders, so in one sense all patients are informal as far as legal status is concerned. On the other hand, a doctor at Anding said that no patient in his hospital was truly voluntary. There are no protections at all against involuntary detention other than the permission of the nearest relatives, and no professional guidelines about how such a decision is to be reached and by whom. Virtually all wards are locked, and there is no way in which the treatment environment could be described as a free and open one. Patients are formally discriminated against, as already described, in ability to enter into contracts and so on.

There is also the issue of consent to treatment, particularly those considered to be hazardous and irreversible. This issue has been of concern in recent years both in the U.K and U.S.A., and protections against abuse were one of the changes written into the British Mental Health Act in 1983. (Part Four, Articles 56-64) It is also of international concern. Daes' Report states that every patient should have the right to refuse treatment, [Article 11(1)]; that every patient who has the legal competence to do so has the right to an informed consent, [Article 12]; that certain therapies and treatment, such as psycho-surgery and electro-convulsive therapy, shall never be applied without the patient's

consent or that of his legal representative, [Article 9(3)]. The M.R.G. report says that 'a person's individual experience, wishes and desires shall be given full and due consideration in the treatment and care process'.

It has to be said that these concerns do not reflect priorities in the Chinese situation, where informed consent and legal representation are almost unheard of. A Chinese response might well be that a mentally ill patient cannot be expected to know what is in his own best interests. If he refuses treatment, it is only another indication of how much he requires treatment. If he accepts treatment, it is an indication of his sincere desire to become well. The individual's consent to treatment is simply not an issue in China. Where any thought is given to the matter, it is considered to be a family affair.

All that stands between an unwilling patient and a locked ward is the opinion of a relative. Neither in reading Chinese material, nor in discussion with Chinese colleagues, is there any sense that the relatives' interests and those of the patient may clash. Relatives' motives may vary from the kindly to the pecuniary. A spouse may wish to have their inconvenient partner removed for a variety of reasons. But none of the financial, emotional or sexual undercurrents that may muddy the clear pool of familial harmony are allowed to disturb the belief that the family always knows and acts in the best interests of its individual members.

Writers like Gostin and Heginbotham advocate international standards of rights for the mentally ill. Heginbotham talks

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about a 'macro-morality', a refusal to accept treatments that are inhuman, degrading or damaging and refers to his code of rights as 'a universal yardstick against which to measure the provision of mental health care'. (1987, p.4) Gostin states categorically that 'mentally ill people, like the rest of us have inalienable human rights'. (1987b, p. 354)

The notion of the imprescriptibility of rights for the mentally ill certainly has an appeal to sentiment for those who care about the parlous conditions in which many of them spend their lives. Unfortunately, it is not an argument that appeals to reason. Many countries, (including China), will not guarantee basic human rights for their ordinary citizens. Why should they treat the mentally ill any differently, particularly when they are such a stigmatized group? Rights need to be written down and enforceable by law to carry any weight. Even then, in many countries where legal systems are not well developed, and most citizens view any form of officialdom with fear and distrust, this gives them little real protection. Thus the requirement that there should be a full and impartial judicial hearing before involuntary loss of liberty is unachievable in, probably, the majority of countries. This does not mean that such attempts to set international standards are worthless. As Walker pointed out, they are documents to persuade. And international pressure, as in the case of Leros, Japan and Russia, may sometimes bring a beneficial effect.

By international standards, the nature of some psychiatric practices in China is dubious at best. These include the lack of consent to treatment (particularly hazardous and irreversible

practices), the custodial nature of most treatment settings, the lack of any effective protection against compulsory detention, the summary removal of civil status, and the lack of an appeal mechanism. Of course, all these issues are consistent with wider societal practices and do not discriminate against the mentally ill as a special group. It is nonetheless surprising that China has been spared the attentions of the international community in this regard. China's well known sensitivity to outside interference in her internal affairs should not blind us to practices that in others we would find unacceptable. Nor should the issue become enmired in the 'developed versus developing world' debate. If a country has the professional and technological expertise to perform psychosurgery, it has the means to protect its citizens from its improper use.

Psychiatric Hospitals and Political Detainees

Reading through hundreds of case files, I have found no evidence that sane people are being detained for political offences. It might be suggested that these files had been carefully vetted to exclude such cases. However, as I discuss in Chapter Five, this seems unlikely. When the direct question has been put as to why this does not happen in China, the consensus is that there is no need. There are other ways of dealing with political dissidents that do not require the inappropriate utilization of a scarce and expensive hospital bed.

Other Westerners have also asked about this issue. Bloomingdale (1980) was told that political dissidents were sent to May 7th.

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Schools for intensive 'ideological education', not to psychiatric hospitals. Brown (1980) states that 'bad elements' are not sent to psychiatric hospitals. Achtenberg (1983, p.373) says that 'in response to our question we were told that mental hospital beds were too scarce to be used for political dissidents'. Kleinman:

'... looked for evidence that professionalization has led to tensions with political leaders over gatekeeping for determination of disability and eligibility for welfare support or to abuse of psychiatric hospitals to serve the state's social welfare needs (as in the Soviet Union) and we saw little in the way of conflict and abuse'. (1988, p. 26)

There are undoubtedly people in psychiatric hospitals whose breakdowns have been precipitated by political events, or persecution for political reasons, but that is a different matter. There is also a grey area where someone does something that is considered to be so foolhardy by others that the only explanation must be that the perpetrator is mad. For instance, Wu Xin Chen (1983), looked at the types of schizophrenia found in a sample of people who had been appraised, and the kinds of crimes they had committed. The most frequent crime was murder or attempted murder, (51.9 per cent), but the second most frequent crime was anti-social and anti-political actions, (33.6 per cent). Wu says that:

'Most of these cases involved purposeless scribblings, or sticking up posters which carried anti-revolutionary and absurd sayings, or chanting anti-revolutionary slogans'.

This kind of crime tended to be committed by those he describes as deteriorated schizophrenics or suffering from 'delusions of exaggeration'. Li Cong Pei gives as an example of a lack of self-control or judgment that typifies crimes committed by

schizophrenics, 'sending anti-revolutionary letters signed in their own name, or even giving their home address and the department they work for'. But these types of examples are isolated in the sense that abuse of the psychiatric system by the state has not become institutionalized.

CONCLUSIONS

1 - The tradition of jural law, including the separation between the judiciary and the state, has never been strong in China. Societal law, based as it is on moral precepts, lends itself to domination by a class of people or organization. At one stage, it was the Mandarin class. Now, it is the Party. Within this context, it is not always possible to know what the law is, or whether or not a particular action transgresses it. The Public Security Bureau are given wide-ranging powers to coerce socially and politically compliant behaviour, including detention without the formality of a court appearance.

2 - There are no legal protections for mentally ill people against involuntary detention or compulsory treatment. In a society where the rule of law is not well established it cannot be said that they are being singled out in this respect. There are few safeguards for anyone in China.

3 - By its own standards, China might be said to have a tradition of showing clemency to the mentally ill, at least as far as offending against the law is concerned. Traditionally, they were subject to lesser punishments and currently, for other than the

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most serious offences, they are likely to go to hospital rather than prison. There is also some evidence to suggest that they are likely to spend less time in hospital than they would have done in prison for the same offence, as treatment rather than punishment is emphasised.

4 - The civil law permits a form of guardianship for those people severely incapacitated by mental illness, and who are thought to be incapable of exercising their rights and responsibilities in law. No figures seem to be available to indicate how common this procedure is. The position regarding marriage is not entirely clear. While the law does not specifically limit the rights of those suffering from severe mental illness to marry and have children, supplementary regulations do. Once more, it is impossible to know with any accuracy how consistently, and with what severity, these regulations are carried out. Some psychiatrists are very concerned about the spread of schizophrenia in the population and frankly advocate a policy of eugenics.

5 - Legislation that concerns the mentally ill often represents an uneasy balance between the rights of the individual to freedom and the rights of community to protection. The position in China over the centuries reflects a concern with public order and security that dominates any consideration for the well being of the individual.

6 - It is very obvious that while the international community is prepared to publicly criticise Russia, South Africa, the United Kingdom, Japan and Greece concerning aspects of psychiatric care

China remains free of this sort of scrutiny, despite the fact that many of her psychiatric practices are unsatisfactory by international standards.

7 - There is no evidence that Chinese psychiatrists have perverted psychiatry for the purposes of incarceration of dissidents, as has been the case in Russia. (Medvedev and Medvedev, 1971; Cohen,1989) They have not invented a category of disorder that corresponds to that of 'sluggish schizophrenia' in the U.S.S.R. (Wing, 1978)

PART TWO:
AN EMPIRICAL INVESTIGATION

CHAPTER FIVE

PROBLEMS OF FIELD RESEARCH IN CHINA

This is a largely personal account of the experience of attempting empirical research on a very sensitive topic in the People's Republic of China. Most of the information presented in this dissertation was gathered at the Guangzhou Civil Affairs Bureau Psychiatric Hospital. Extensive use was also made of data and impressions gathered during visits to other psychiatric facilities in China since 1981. These include both hospital and community based facilities. A list of field visits has been included elsewhere, so will not be repeated here.

Triangulation

Frequently, distinctions are drawn between the 'hard' quantitative methods of data collection and the 'soft' qualitative ones. Research workers tend to line up on either side of a methodological chasm, although many seem to think that the 'heavy guns' are in the possession of the 'quantitative' camp. Consider, however, that if Jane Austen had been compelled to demonstrate empirically to the .01 level of significance that 'it is a truth, universally acknowledged, that a single man in possession of a good fortune must be in want of a wife', she might have preferred to lay down her quill and pick up her sampler. In which case, future generations would not only have been deprived of a source of considerable pleasure, but also of a unique fund of knowledge concerning life and customs of the eighteenth century English gentry.

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More formally, Zelditch puts it thus:

'If you prefer 'hard' data you are for quantification and if
you prefer 'real, deep' data you are for qualitative participant
observation. What to do if you prefer data that are real, deep and
hard is not immediately apparent'. (Zelditch, quoted in Fielding
and Fielding, 1986, p. 10)

The problem, in so far as there is one, is entirely man-made.

There is no reason why a research question cannot be approached in

such a way as to use a variety of theoretical and methodological

approaches to address the issue from different perspectives, in

order to build a more holistic view:

'We should combine theories and methods carefully and
purposefully with the intention of adding breadth or depth to our
analysis, but not for the purpose of pursuing "objective" truth'.
(Fielding and Fielding, 1986, p.33)

The perspective that this view leads to is known as triangulation,

an attempt to build a more whole, more complete picture by

combining 'hard' and 'soft' research methodologies; and by trying

to incorporate the views of all participants in a study. In the

case of the Guangzhou Hospital this included the official, staff

and patients' views.

Triangulation is not a scatter-shot technique to collect as much

data in as many different ways as is possible. The rationale for

choosing multiple methods and multiple theories emanates from the

view that life is also multi-faceted and understanding needs to be

built up by techniques that have a specialized relevance. Fielding

and Fielding (1986) advise selecting at least one method that is

specifically suited to exploring the structural aspects of the

problem, and at least one which captures the essential elements of

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meaning for those involved.

The study of the Guangzhou Hospital included quantitative methodology - completing questionnaires based on information from the patients' files. This was used not only to provide information on the Guangzhou patients, but as the basis of comparison with a similar sample of patients from two London hospitals. It is hoped in this way to demonstrate both the common and the particular, which would be impossible without a comparative perspective.

Attempting to explore the world of meaning for staff and patients was more difficult. It was approached through an essay competition for the patients and interviews of both patients and staff. It would be disingenuous to pretend that my previous experience of psychiatric hospitals did not colour my perception of the Guangzhou Hospital. At the same time, strenuous efforts were made to avoid imposing categories of cultural meaning derived from the West on the data.

Gaining Access

Contact was made with the the Guangzhou Hospital in May 1987, during a visit there with staff of the University of Hong Kong's Department of Social Work. The general attitude of the Medical Superintendent encouraged me to broach the subject of a possible reciprocal exchange between staff of his hospital and myself and unspecified others. Clearly, the Medical Superintendent was interested and personally willing to participate but both of us realised that much work had to be done in negotiation with his

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seniors in the Civil Affairs Bureau and, as it transpired, various organisations in Hong Kong.

Another meeting was arranged between the Medical Superintendent and myself at the end of 1987 after an exchange of letters. At this time we discussed the possibility of carrying out some research in the hospital, as part of the reciprocal exchange. Unofficially, the Medical Superintendent said that he could more or less guarantee access to patients' notes, to patients and staff but not patients' relatives. It was agreed that members of staff of the hospital would be invited to visit Hong Kong as the guests of the Richmond Fellowship of Hong Kong who would arrange a programme of visits to the full range of psychiatric services, expenses to be born by the Richmond Fellowship of Hong Kong. In his turn, the Medical Superintendent agreed that he would arrange for accommodation to be provided at his hospital for visitors from Hong Kong at no cost. Food expenses and other costs would be born by the Hong Kong guests.

The Medical Superintendent and I then agreed a skeleton proposal for this reciprocal exchange, and that a draft of this proposal should be sent to him to pass to his immediate superior. His prediction was that if it was accepted by his superior there was a strong chance that our plans could go ahead. If the draft was altered by the superior then this would give some clue as to how to phrase it for success. At this meeting the Medical Superintendent made it clear that he and his superiors would wish to decide who was selected from the Civil Affairs Bureau to take part in the exchange. I could only hope that it included a high

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proportion of staff with direct patient contact, and few high ranking bureaucrats.

This plan was adhered to and a draft proposal formulated and sent. Eventually, the draft was approved so a formal proposal was dispatched. Approval for this took longer than the Medical Superintendent had predicted, so that the schedule of visits was put back from April - June 1988 until August - October 1988. When one considers the route that the proposal took through the labyrinthine tunnels of Chinese bureaucracy, it is hardly surprising: to the Medical Superintendent's immediate superiors in the city level Civil Affairs Bureau, to the layer above, then over to the provincial level Civil Affairs Bureau, then to the Hong Kong and Macau Office, then to the Xinhua Newsagency in Hong Kong.

The latter is the unofficial Chinese government in Hong Kong, and its head of the social welfare section, (Mr. Chen), was asked to vet me and the Richmond Fellowship of Hong Kong and comment on our suitability for such a project. It was a great stroke of good fortune that only a few months previously I had joined a Social Worker's Association study tour to Yunnan Province led by Mr.Chen who consequently knew me. A visit to a Richmond Fellowship of Hong Kong facility was arranged for Mr.Chen and his staff, (although nothing so crass as a vetting procedure was ever mentioned), and a lunch given in their honour. Some two weeks later, approval was received.

A further visit to the hospital in Guangzhou was made in April 1988 for the occasion of its fifteenth anniversary. It became apparent that accommodation at the hospital was going to present some difficulty. Accommodation for guests existed, but because one of us was a foreigner the local Public Security Bureau and office dealing with external relations had refused permission for us to sleep there overnight, as it had not been approved as an area in which foreigners could stay.

During the visit we had more discussion about the detail of the exchange. My original idea had been for two groups of six people each to visit Hong Kong and spend a considerable proportion of their time working alongside Richmond Fellowship of Hong Kong staff for a month. At the request of the Medical Superintendent this was reduced to two groups of three people each, with the major focus of their visit given over to visiting a wide variety of facilities.

One of the most difficult aspects of the arrangements was that it was impossible for the hospital authorities to predict with any accuracy when permission would be given, or when visas and passports would be issued allowing them to leave. Visas tended to give only a week's notice and people were then expected to leave immediately. This was exactly what happened. After months of waiting, we received five working days notice in which to arrange a ten day programme for the first group. The six visitors were;

Dr.Tam   - Medical Superintendent
Miss Tsui - Supervising Civil Affairs Bureau Official

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Dr.Wong   - Administrative Director at the Hospital

Dr.Sheng   - Deputy Medical Superintendent

Dr.Lui   - Medical Director at the Hospital

Mr.Chan   - Senior Ranking Communist Party Official   in

           the Hospital

Initially,   the   plan had been that the Guangzhou   visitors   would
visit Hong Kong, then we would go to their hospital for two   weeks
and   the process would be repeated. This would have given me   time
to   digest   the   experience,   and   to   decide   what   aspects   of
information gathering to concentrate on during the second visit. I
was   also afraid that if all six of their staff visited Hong   Kong
first, they might withdraw their invitation for us to visit   them.
However,   the   Medical   Superintendent brought   a   great   deal   of
pressure to bear on us to agree to both groups from the   Guangzhou
Hospital visiting Hong Kong first, leaving just a week between the
two   visits.   He was clearly very concerned that   the   authorities
would capriciously withdraw their approval before the visits could
take place. The Medical Superintendent's unwillingness to let   the
matter   drop convinced me that it was of sufficient importance   to
him that it would be wise to acquiesce.

The   visits of the the Guangzhou Hospital staff to Hong Kong   went
well.   They were able to see the complete range of   treatment   and
rehabilitation services for the mentally ill that Hong Kong has to
offer. Although their schedule was busy, they were left sufficient
time   for   pursuing   their own agenda of   meeting   relatives   and
shopping. For five of them it was their first time   outside China,

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and for them the experience had particular worth.

At all times during their official programme our visitors were accompanied by myself and a senior member of the Richmond Fellowship staff. Although this was time consuming and exhausting, it allowed all parties to come to know each other much better and for trust to develop. There was also a nagging fear that our visitors might decide not to go back to China and 'disappear' into Hong Kong. This happens sufficiently frequently to make it a realistic concern. The Chinese authorities are, naturally, very sensitive to this issue and tend only to give permission to leave China to older people with families, and those who are Party members.

The Use of an Interpreter

My Chinese language skills are extremely limited and it was clear from the start that I would have to work through an interpreter/assistant. It behoved me therefore to find one who was reliable, competent and had an understanding of mental health matters. In this respect I was extremely fortunate in having the assistance of Rose Yu during the entire project, and for one week in China, Roger Kwan. Both were social workers employed by the Richmond Fellowship of Hong Kong, who had done their Master of Social Work degrees at the University of Hong Kong and had consequently been my students. Thus we had known each other for some years. This was hardly adequate preparation for what was to come. For a month Rose and I spent 24 hours a day together and for three of those weeks, Rose was the only person with whom I could

directly communicate. The consequences of such intense and enforced intimacy required great forbearance from us both.

Watching Rose work as translator/assistant I became aware of how very delicate a task this was. It was by no means a matter of simply translating what I said. She had to grasp my meaning and intent and then translate this into idiomatic Chinese. She felt acutely aware at all times of her responsibility for making myself and our Chinese hosts intelligible to each other, not just in words but also in spirit.

Not surprisingly over the month there were a few difficulties. At times Rose thought it appropriate to censor what I said. Sometimes, her judgment was correct, at other times not. Occasionally she also condensed a four minute response into a two sentence translation having failed to appreciate the nuances for me in the original. Sometimes after a 16 hour day she was just bone weary.

The experience also forced Rose to confront what her 'Chineseness' meant. She began to anticipate criticisms from me about things Chinese that in fact were not even in my unspoken thoughts. She was torn between what she saw as a personal loyalty to me (a foreigner) in the very significant teacher-student relationship and an idealistic, patriotic loyalty whose reality in daily life, relationships and conditions she was seriously confronting for the first time.

At the end of both our visits we presented our hosts at the hospital with a small memento. For the end of the first visit, I

chose a Wedgwood vase. For the second visit, Rose chose a painting of a rose. At the farewell dinner I made a brief speech of thanks and turned to Rose to translate it. She looked at me and said 'I'm going to do it the Chinese way', and spoke for four or five minutes. The non-verbal reactions from her audience were unmistakable. They clearly warmed to what she was saying and were greatly moved by it.

Later she told me that she had spoken about how the rose symbolized the friendship between our two organisations, starting as a bud and flowering into a full and beautiful blossom that we must continue to nurture. Such poetic images would have seemed overblown to me, but she had clearly judged her audience correctly. In this and many other ways my project benefited immeasurably from Rose's wisdom.

Collecting Data in Guangzhou

The heart of the data collection in Guangzhou took place in two fortnightly periods spread over five consecutive weeks, in September and October 1988. The original agreement was for myself and a research assistant (Rose Yu) to stay at the hospital but the Public Security Bureau still refused to give their permission. Consequently, we were housed in a Civil Affairs Bureau hostel in the centre of Guangzhou for our first two weeks.

Unwittingly, this gave us an insight into the daily routine of the hospital staff and particularly the centrality of the ferry schedule. In order to catch the 7.30 a.m. ferry to the hospital,

which arrived at about 8.45 a.m., we needed to get up at 6.00 a.m. and leave the hostel by 6.45 a.m. to catch a bus to the ferry terminus. The whole process had to be repeated at the end of the day when we, and most of the rest of the staff, caught the 4.15 p.m. ferry back to Guangzhou. All in all we spent four hours a day commuting. While it was possible to reach the hospital by road, it was not possible to get anywhere near it on a scheduled bus route. Thus the ferry was the only effective means of public transport.

Efforts were made by the Medical Superintendent to argue that we should pay for our own accommodation in Guangzhou. This had never been part of the original agreement, and I had brought the letter along with me to prove it. I resisted contributing to our accommodation costs on two grounds. First, I knew that if we agreed to pay then there would be absolutely no chance of staying at the hospital during our return trip. Second, their entire trip to Hong Kong including food, accommodation and all transport had been paid for by us. In addition we paid for all our own transport and food while in Guangzhou and it came to seem important to me that they should reciprocate, at least in the matter of accommodation. This strategy worked in that during our second visit, we were permitted to stay at the hospital for the first eight or nine days.

The heart of the various methods of data collection was filling in the data information sheets based on the contents of patients' files. The first version of such a sheet was prepared and 300 copies printed while in Hong Kong. Once we started reading the

files it became apparent that some expected information was not available, (for instance on the patient's family background), while unexpected data, (for instance on educational and occupational attainment), was there. Thus the forms were modified by hand during the first two weeks and re-printed to take account of this for the second research visit. All forms were completed in duplicate using carbon paper. It should be born in mind that the hospital had no photocopier, nor, for that matter, a telephone.

The Deputy Superintendent was asked to contact the ward staff for a list of all schizophrenic patients between the ages of 16 and 60. A list of 460 patients was drawn up. With our limited resources, this was too many files to examine in the time available and so a random sample of one in three was drawn from it, giving a total of 150 patients. At first, we were not permitted to take files from the wards and had to fill in data collection forms while sitting in the doctors' office. This had the advantage initially, while we were still unused to the layout and terminology of the files, of ensuring that there was always someone to ask when we were uncertain. It also permitted us to observe ward routines and interaction reasonably unobtrusively.

These advantages were soon outweighed by the disadvantage of constant interruptions from doctors wishing to help or discuss what we were doing. If more time had been available these attentions would have been very welcome but as it was, after the first few days, they were counter-productive. There was a further time constraint in that we were not permitted to stay in the

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doctors' office while they were absent from the ward. The office was locked at 11.45 a.m. and remained so until the end of lunch and afternoon nap at 2 p.m.. The office was again deserted at 3.45 p.m. as people prepared to catch the 4.15 p.m. ferry. This provided us with a window of opportunity from 9.30 a.m. (after the morning handover) to 11.45 a.m. and 2 p.m. until 3.45 p.m. - a working day of four hours!

Eventually, I managed to persuade the Deputy Superintendent that I was not going to abscond with the files, and we were permitted to sit in a room in the administration block where the files were brought to us. This enabled us to work almost without interruption and through the lunch 'hour' - a sacrilege in Chinese eyes. Even so, in order to complete the task we needed to work over several weekends. As much as anything else, it was this devotion to duty that persuaded our hosts that we were not simply idly curious, but for reasons that they knew but found puzzling, highly motivated and sincere in our interest.

We visited all wards for at least one morning each and some of them more frequently. Extensive ward observation to record routines and interaction between staff and patient were clearly desirable. Unfortunately, it proved very difficult. The majority of the patients had never seen a foreigner before and their lives were so boring that my arrival on the ward was a matter of great excitement. Patients would gather round, touching me and asking questions. It was not possible for me to become sufficiently unobtrusive not to disturb the dynamics of the wards by my presence.

It was possible to carry out some limited group interviews with patients, in order to form some impressions of their lives and experiences. The staff put no barriers in our way at all. Our major problem was time and we could only manage two group interviews. We asked members of the service groups on one male and one female ward to talk to us. The invitation stressed that attendance was entirely voluntary, and not all service group members who were invited, accepted. I decided not to be present so that translation would not impede the flow of communication. The interviews were semi-structured in that the interviewers had questions which they were to ask at some point in the interview. It was left up to them to decide how and when to put the questions and which areas it would be fruitful to pursue, depending on the mood of the group and the interests of the patients.

However, I was also anxious to reach more of the patients in a way that would permit them to say precisely what they wished, with little outside direction or structure. I devised the idea of an essay competition on the theme of 'The Story of My Life', as the broadest possible topic. In my mind was also the hope of encouraging the staff to see the patients in a more positive light and possibly to help them think of ways of enlivening the patients' environment. I provided paper and pens and all who entered were given a small token of appreciation (a packet of peanuts). There were five main prizes consisting of sums of money plus other small gifts. The judges consisted of my two research assistants and the Medical Director. Overall, there were about 30

entrants, and it was made very clear to both patients and staff that entry to the competition was entirely voluntary.

There were many opportunities to meet medical and nursing staff formally and informally. Not surprisingly, conversation during formal meetings tended to be more stilted and inhibited than at informal gatherings. We soon learned that certain combinations of personalities were not conducive to the free flow of information. Others remained silent in front of their seniors but talked animatedly when by themselves. Occasionally, unexpected conversations led to valuable insights which might not otherwise have been ours. This happened one evening when Rose Yu and Roger Kwan shared a table with the cook in the dining room. My absence in itself sometimes permitted more openness in conversations between Rose Yu and various staff members.

A persistent fear that came to the forefront of my mind as the end of our stay approached, was that I would be searched by customs and all the data forms and my priceless notebooks confiscated by a suspicious customs official, despite a letter heavily embossed with official stamps certifying that approval had been given. Two copies of each form were made. Rose Yu carried the carbons and I took the originals. Chinese and foreigners go through different gates to board the train to Hong Kong at Guangzhou station, so there would be nothing to connect us in official eyes. We hoped that if one was stopped the other would get through. Of course, our journey was entirely uneventful, but I did not stop hugging the bag with all the data in it until we had safely crossed the border.

At our request, our hosts at the Guangzhou Hospital arranged visits for us to two other psychiatric hospitals in Guangzhou and Guangdong. These were Fong Tsuen, the oldest psychiatric hospital in China and the one that performs the 'leading' role for the province, and Lam Shek which was an ordinary county level hospital run by the Medical Department. They also organised trips to neighbourhood and street organisations running day care centres for the handicapped (including the mentally ill) in Guangzhou. All this was deeply appreciated, as without their guanxi, (personal connections without which nothing works in China), access would have proven extremely difficult.

Reliability of the Data

To put it bluntly, can I believe what I was told? This question involves the issue of what is defined as confidential in a mental hospital setting. Problems were never raised over access to personal data in files. Ideas about individual privacy are so different in China that this was seen as quite normal. Thus what was recorded from the files is accurate in the sense that it is faithful to the information that was on the files. However, there is no way of assessing how correct or complete this information was. Files everywhere are susceptible to distortions and omissions but there is no reason to suppose that the ones in Guangzhou were deliberately distorted.

Dr. Judith Bannister of the China Branch of the U.S. Bureau of the Census, makes the following comment on the Statistics Law of 1984:

'While the law mandates regular publication of statistics, it also forbids the release of any data until political approval has been secured. In practice, the highest levels of China's government have had to give their explicit approval for the release of every national statistical figure in recent decades. The policy that every datum is a state secret until expressly declassified has stopped or greatly delayed the publication of most statistics. (Bannister, 1987, p. 15; see also Appendix 5)

Written documents are almost always treated as confidential, for instance those concerning policies or containing figures about the prevalence of mental illness. These are neibu, (internal) and not meant for outside eyes. Thus it was virtually impossible to collect hard data on matters like policy directives, job descriptions and so on. Policies had to be deduced from their implementation. Another difficulty arose concerning the figures for the number of psychiatric beds in Guangdong. I was told that these were very sensitive and not available. It may also be that the necessary epidemiological work has not been done, or records kept, and claiming 'sensitivity' is a way of disguising that fact.

It also became clear that as staff came to know me better and trust me more, less effort was made to mislead. One example of this concerned the use of E.C.T. From the beginning of my contact with the hospital very detailed notes were kept so I was generally able to check one answer against another over a period of time without relying on memory. During my first meeting with the Superintendent I asked whether E.C.T. was used in his hospital. The answer was a categorical no, because they did not have the necessary equipment. During their first visit to Hong Kong, on being shown modern E.C.T. equipment in one of the hospitals, the doctors exclaimed at how different it was from theirs and

proceeded to explain how. During a subsequent trip to their hospital, when E.C.T. was mentioned, the Medical Director told the assembled staff that it was permitted to be frank and discuss the matter openly with me.

On other occasions it was possible to check a piece of information with another source. Thus staff on a male ward were talking about the importance of patient outings. The impression was given that these had been going on for some while and happened several times a year. On examining a collection of photographs and a newspaper cutting displayed on the wall in the ward, it became clear to me that the ward outing rated a piece in the local paper because it was the first, and took place only three months earlier. Other examples could be cited.

Another question about which concern might have been anticipated was the political aspects of information. 'Politics taking control' is a Maoist maxim that has led to politics assuming a far more central position in the lives of individuals and institutions than would ever be considered appropriate, or even possible, in the West. Censorship of my access to data was mentioned on three occasions. The first time was in April 1988 when talking about file sampling procedure, when we were told that we would not be able to see the files of 'political patients' of whom there were two or three. I asked what political meant in this context and was told that certain patients had negative thoughts about senior leaders, (like Mao Zedong and Deng Xiaoping), as part of their delusional system.

When we came to do the sampling in September 1988 no more mention was made of this and there was no detectable attempt to censor the sample. It could have been that sensitive names were removed from the ward lists before we saw them, or possibly our selection missed them altogether, so there was no need for them to mention it. It is interesting to note, however, that the sampling frame came to within five digits of what, epidemiologically, I had estimated it should be. So if names were deleted from the sampling frame, the numbers must have been very small.

The second occasion was during the discussion about the possibility of setting up an essay competition. The Medical Director wanted to remove any that would be politically embarrassing before I received them. Naturally, I agreed to this without hesitation. Later when asked directly, the Medical Director assured me that we had received all entries without censorship, and patients had not been influenced by staff in what they wrote. Many of the essays were late and were handed in at the prize giving ceremony. They went straight from the nurses' hands, to the Medical Director's, to mine. He could not possibly have read them. The Medical Director wished to keep copies, but had no objection to me retaining the originals.

There was a point between my two visits to the hospital when the Medical Superintendent, in a phone call to Rose Yu, expressed concern that we might find political content in the files that would 'embarrass China', but no further mention of this was ever made. Part of the anxiety about political issues is to do with the

vulnerability of Chinese people who have extended contact with foreigners.

At the time of the research the door to China was fairly wide open but they are only too aware that, with China's history and long standing xenophobia, policy could easily change (as, indeed, it has done), leaving them open to attack on political grounds. Undoubtedly there were patients who had been caught up in the events of the Cultural Revolution, who had been Red Guards, who had suffered in a variety of ways. But it is sometimes difficult for an outsider to grasp the exquisite intensity of concern about how events in individual lives can be elevated to the extent of becoming embarrassing for China. Or to see how clearly delusional beliefs about Mao are going to threaten the position of the Communist Party.

Difficult though it is to grasp, the importance of these concerns must be conceded because they are part of the environment in which research has to take place. In the absence of documentation, many questions flood into the mind of the research worker. It is a sad truth that if she is wise, many of them will not be asked. Albeit in a peripheral way, I became involved in the social nexus of the hospital. As such I also had to become reasonably adept in juggling the realities of my inter-personal network so as not to cause offence and embarrassment, a skill at which Chinese people are expert.

It is a feature of communication in China that much is left unsaid and I had to accept that there were queries that could not be

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pursued because to have done so would not have been acceptable to my informants. My unquenchable thirst to understand had to be balanced against what was acceptable to them. I had no inalienable rights and ultimately was a guest in their house having to accept the limitations that imposed.

CHAPTER SIX

THE GUANGZHOU HOSPITAL

The Guangzhou Hospital is run by the municipal level of the
Guangzhou Bureau of Civil Affairs. It was built in 1973 and was
originally for patients who were classified as 'three have nots'.
It seems to have been anticipated from the start that the hospital
would accept long stay patients and its initial intake was largely
chronic patients with no financial resources from the provincial
'leading' hospital, Fong Tsuen, in Guangzhou. According to staff
at the hospital, nowadays 'three have nots' patients are more
likely to be 'two have nots' in that they frequently have a family
and possibly even employment, but do not have the financial
resources to be able to afford hospitalization.

Listening to the staff talk, the hospital as it is now is very
different from its beginnings. At that time it was known as   the
Number Two Care and Education Home and employed only one qualified
doctor. The staff and patients built the hospital together on the
site of a brickfield, an experience of camaraderie that both some
of the original staff and patients remember with   warmth.
Eventually the institution was promoted to being the Number One
Care and Education Home and finally at the beginning of the 1980s
was designated a Mental Hospital for Treatment and Rehabilitation.

In Guangzhou and Guangdong, psychiatric hospitals are run by both
the Ministry of Civil Affairs and by the Ministry of Public
Health. The leading provincial hospital, Fong Tsuen, is run by the
latter ministry. Within the same system are hospitals situated at

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city level in Guangdong at Fo Shan, Shantou, Mui Yuen, Siu Kwan, Kwong Mui, Cham Kwong, Siu Hing, Wai Yeung and Shenzhen. Under the city hospitals are smaller county level hospitals of about 100-200 beds. For instance under the city level hospital at Foshan are county hospitals at Guo Ming, Shunde, and Zhongshan. In addition to the Guangzhou Hospital, the Ministry of Civil Affairs runs two or three more hospitals in Guangdong but they are much smaller and according to the staff at the hospital 'not as good'.

If there are published figures for the incidence of mental illness in Guangzhou they are kept under lock and key. Verbally, officials at the Guangzhou Civil Affairs Bureau said that Guangzhou, with a population of 5,000,000, was estimated to have 5,000 mentally ill people. Similarly, Guangdong with 50,000,000 inhabitants, had 50,000 mentally ill. The Deputy Superintendent of the hospital told us, on hearing these figures, that they must also have included minor psychiatric disturbances.

Research in the hospital generated a copious quantity of notes but it was undertaken in an environment that to a Westerner was preternaturally sensitive to divulging any information that might be interpreted as of an official nature. The Statistics Law, mentioned by Judith Bannister (1988, see Appendix 5),is possibly a partial cause of this attitude but is also more likely to in itself reflect an already existing and widely held world view.

Thus while the hospital officials were very co-operative in providing information about and access to patients, they were much more circumspect about the running of the hospital or matters

concerning staff. This is not intended as a criticism. Within their world such caution is a matter of self preservation and must be respected.

The consequences, however, are that there are gaps in the data and that partial impressions must sometimes suffice where a more systematic approach would have been desirable. For instance, permission could not be obtained for us to read any written, official statements relating to policy or administration within the hospital. This situation has been compounded by the Tiananmen Square incident in June, 1989 which has made it impossible so far to visit the hospital again. Thus the information that is presented here is a record of one particular hospital, at one particular time.   .

The issue of time is important. China was at the height of its financial growth following ten years of the 'open-door policy' permitting greater economic freedom. Zhao Zhi Yang's strategy of developing the coastal areas first in the hope that there would be a trickle down effect that would benefit the poorer, interior provinces had led to Guangdong's rapid development. Many of the peasants had taken advantage of the new policies to establish rural industries, acknowledged to be one of the major engines powering China's economic growth. But as Deng Xiao Ping has always acknowledged, if you open the door to the aspects of Western technology that you want, some flies are bound to enter at the same time.

One of those flies was inflation. Another was the increasing disparity between the earnings of professional and white collar workers in the traditional organisations on the one hand, and individual entrepreneurs and peasants who were able to take direct advantage of the new economic policies, on the other. People inured to the common fellowship of deprivation found others' sudden wealth, through opportunity, talent or hard work, very difficult to stomach. There was also bitter resentment against the government concerning the rapidly rising costs of basic necessities, particularly food. This was most evident in people whose incomes were essentially fixed and were not in a position to avail themselves of new economic opportunities while having to pay the price for others' success. On a general and individual level this led to a widespread outbreak of 'red eye' disease as, jealousy is called.

This was also a time when the power of the Party to intervene in the running of enterprises and in people's lives was deliberately curtailed. The effects of this in the hospital will be discussed in more detail later. It was quite noticeable that, in comparison with reports produced by foreign visitors even in the late 1970s, there were no political study groups for staff, nor poster displays with any political content. In contrast, when I visited the Shashi hospital in March and July 1990, (remembering it is part of the same ministry as the one in Guangzhou), I was told that political study groups for staff were recommenced immediately following the Tiananmen Square incident and posters based on the 'Learn From Lei Fung' campaign were in every ward, department and

on every public noticeboard. All over the hospital were the sounds

of patients, led by staff, singing choruses from songs about Lei

Fung.

Thus, if we went back to the Guangzhou Hospital in 1991, we would

probably find that at least some of the 'process' issues in the

hospital have changed. However, other aspects are less likely to

change and we will begin with those.

LOCATION AND PHYSICAL ENVIRONMENT

The hospital is situated on a tributary of the Pearl River at the

very edges of the municipal administrative boundary of Guangzhou.

Indeed the border with the provincial administration of Guangdong

was formed by one of the hospital's perimeter fences. Thus the

setting is essentially very rural. The nearest market town is

about 35 minutes away by bicycle and the nearest large town around

45 minutes drive away. The hospital is surrounded by rice paddy

fields, worked by humans and water buffalo, and commercial

fishponds. It is possible to reach the hospital by road from

Guangzhou but it takes over an hour and is impossible without

individual transport as no bus route goes near the place. The

location of the hospital may be considered very typical of the

tradition of building psychiatric hospitals in isolated spots.

For those staff who enjoy the privilege of living in Guangzhou,

(awarded usually after many years of service), rather than in

quarters at the hospital, the day starts early. During our stay

there, when for two weeks we lived in the city rather than at the

hospital, it meant arising reluctantly at 6 a.m.,; a walk to the

bus stop during which we would consume breakfast of freshly steamed bread or a pork dumpling bought en route; a fight onto a bus whose passengers endured conditions that left them feeling envious of the luxury enjoyed by sardines; to be on time to catch the ferry that left at 7.30 a.m. and arrived at the hospital at 8.45 a.m. The senior management team of the hospital enjoyed the privilege of being able to sit away from the rest of the passengers on the outside of the boat at the front. Other passengers, at least 50 per cent of whom were hospital employees, sat in the body of the boat along with chickens, other assorted livestock and baskets of vegetables. They whiled away the journey chatting, playing cards and knitting.

Staff were expected to be on the ward by 9 a.m. or 15 minutes after the ferry's arrival, and since we survived this routine for two weeks it was not hard to be sympathetic with their sense of having had quite a hard day before they even arrived at work. Indeed the scheduling of the ferry and the sacrosanct two hour lunch break were the major factors structuring the working day, which consisted of two and three quarter hours in the morning and two and a quarter hours in the afternoon. Yet staff would not be back in Guangzhou before 6 p.m. and might well not reach home for another hour. All in all they felt as though they had had a very hard day.

The contrast between the 'outside' of the hospital and the 'inside' was very marked. The most remarkable aspect of the outside was the proximity of a holiday camp which shares grounds

with the hospital. There is no physical separation, like a wall or fence, between the two. This enterprise had been embarked upon by the previous Medical Superintendent. The hospital is rich in land, but little else. Originally, it had been negotiated as a joint venture with a Japanese businessman who had promised US$2,000,000, while the hospital would provide the land. He withdrew from the project but the hospital went ahead with it in a modified form.

The camp has not been as successful as they would like. The hospital authorities attribute this to the proximity of a mental hospital, poor quality facilities, and the presence in Shenzhen of a much bigger and better equipped holiday camp that attracts many people. Of the facilities available, it seemed to be the hostel accommodation that was most popular with holiday-makers. It is possible that with the very crowded living conditions in Guangzhou, where privacy is a scarce commodity, couples were using these facilities for romantic interludes. Thus the sign at the landing stage, rather than having the name of the hospital, says 'Welcome to the holiday camp'. Holiday-makers and patients, (those who have ground privileges and others being taken on escorted walks by nurses), are frequently within sight of each other. They seem to cope with this by ignoring each other; occupying the same space but different worlds.

Much thought and attention has been paid to landscaping the hospital grounds. There are traditionally-inspired water gardens with rocks and pagodas and a profusion of flowering shrubs, plants and mature trees. It is extremely pleasant to walk or sit in the shade in the grounds. This makes the contrast with the buildings,

particularly the wards and the staff residences, (which are the original wards built in 1973), even starker. The seven wards, built on the villa-system, are separately located around the hospital grounds. Many of them have been built in the last five years. Yet they are, on the whole, decrepit, poorly designed, poorly built and poorly maintained. That this is not an inevitable consequence of shoddy workmanship or inferior materials is demonstrated by the hospital's new administration block which, while not luxurious, is pleasant and adequately maintained; and by the buildings associated with the holiday camp, like the dance hall, some of which are really quite smart. While accepting that the conditions for the patients are not good, one of the senior doctors pointed out that those staff living in the original wards were even worse off. They share a standpipe outside the buildings and use the privies - ramshackle huts built over the edges of the numerous fishponds that are dotted around the hospital grounds.

Few facilities for staff or patients exist in the grounds. There are two small general shops or stalls, selling soft drinks, snacks, soap and so on. There is a staff canteen to provide the three major meals each day. Complaints about the standard of food are perennial, and the cook had recently been sent away on a course to improve his cooking skills. If asked, he might have replied to the criticisms with complaints of his own about the quality and paucity of the basic materials with which he was supposed to work. Vegetable sellers would come each morning, baskets perched precariously on their bicycles, to peddle their wares outside the canteen. Most of them were local peasants

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selling their own produce freshly picked that morning.

HUMAN RESOURCES

The Patient Population

What follows gives an overview of figures concerning the patients
at the hospital. Table 6:1 provides general demographic
information. Table 6:2 gives the numbers of patients in different
diagnostic categories. Table 6:3 shows the various sources of
payment and Table 6:4 the frequency of medical treatments being
used.

Table 6:1: Demographic Information

Total number of beds: 640

Total number of patients: 630

Number of discharges	Admissions;	Deaths
1988 - 25	77	n.k.
1987 - 24	135	10
1986 - 28	28	17
1985 - 23	38	10
1984 - 22	54	21
1983 - 16	37	36

Patients hospitalized for over one year: 97.6% (615)

Age:	Male			Female		
	%	n=415	(65.8%)	%	n=215	(34.2 %)
below 16	1	(4)		.9	(2)	
16-30	15.6	(65)		14.9	(32)	
31-45	38.5	(160)		37.3	(80)	
46-60	27.7	(115)		26.9	(58)	
61+	17.1	(71)		20.0	(43)	
	100%	(415)		100%	(215)	

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Table 6:2: Diagnostic Categories

Diagnosis;	%	n=630
schizophrenia	84.7	(534)
manic-depression	.4	(3)
neurosis	0	(0)
neurasthenia	0	(0)
organic psychosis	2.5	(14)
other psychiatric illnesses	1.5	(10)
mentally retarded	10.9	(69)
	100%	(630)

Table 6:3: Source of Fees

Source of payment:	%	n=(630)
veteran soldier	1.3	(8)
family or unit*	34.3	(216)
'three have nots'	64.4	(406)
	100%	(630)

*less than 30 are paid for by the family)

Table 6:4: Medical Treatments

Numbers receiving:

Western drugs	81.9	(516)
Chinese medicine	9.5	(60)
Acupuncture	1.5	(10)
E.C.T.**	2.8	(18)
No medication	not known	

Note   multiple responses were possible
       ** in the last 12 months

The wider implications of these figures will be examined where appropriate later. However, in sum they give us some core information about the hospital. It is quite large by Chinese norms

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for psychiatric hospitals and its population is primarily long stay. In 1987, admissions exceeded discharges/deaths by a very significant amount indeed. This is a reflection of a change of policy that encouraged the hospital to be more self-supporting. The easiest way for them to do this was by taking patients who paid rather than their traditional responsibility, the 'three have nots'. Nonetheless the hospital still has 64.4 per cent of this category of patient. There are very few of its other main responsibility, the veterans (1.3 per cent). 34.3 per cent are self-pay, most of whom are supported by their work unit.

There are no efforts to provide different conditions for the self-pay patients. They are kept on the same wards, receive the same food and suffer the same regime as the 'three have nots' group. Veterans are entitled to extra fruit and snacks at festival times. *Those who* served for a long time, or who gave especially meritorious service, also receive cash bonuses which the hospital put in a savings account for them.

The ratio of men to women is approximately 2:1, and for both sexes the majority of patients are over 30 years old. The largest diagnostic category is schizophrenia (84.7 per cent) and the second largest, mental retardation (10.9 per cent). Separate institutions for the adult mentally retarded are very rare in China. The treatment of choice is Western psychotropic drugs (81.9 per cent). In collecting information from the patients' files we found no instances where Chinese medicine was being prescribed to control a psychotic disorder. It was commonly used as a sedative.

<u>The Staff Population</u>

The following tables try to give an impression of the numbers and qualification level of medical, nursing and other staff. Table 6:5 deals with doctors; Table 6:6 with nurses and Table 6:7 with the total staff population.

<u>Table 6:5: Numbers, Training and Rank of Doctors</u>

Numbers of doctors: - 28

Training level:;
              5 years or more at university - 8
              3 years at university   - 4
              3 years in medical college - 16

Numbers of:	Western trained	Chinese trained
Chief Medical Officer	0	0
Assistant Chief Medical Officer	1	0
Senior Medical Officer	13	1
Medical Officer	8	1
Medical Assistant	4	0

Specialization:
specialized in psychiatry	8	2
specialized in other fields	18	0

Among those specialized in psychiatry, years of psychiatric experience:

                   <3 years - 0
                3-10 years - 5
                 >10 years - 5

Table 6:6: Numbers, Training and Rank of Nurses

Numbers of nursing staff: 126

Qualification: 3 years in college - 21
                   other or none   - 105

Numbers of:

    Chief Nurse   -   1
    Senior Nurse   -   11
    Nurses   -   52
    Nursing assistants -   62

Years of experience:
                 <3 - 37
               3-10 - 53
                >10 - 26

Table 6:7: Total Numbers of All Grades of Staff

Total number of medical and technical staff: 167
(these include doctors, nurses, pharmacists, X-ray and other technicians)

Number of other staff: 144

What is immediately apparent is that in terms of quantity, if not quality, the hospital is not especially understaffed. There is one doctor for every 22.5 patients and one nurse per five patients. The hospital conforms to the Ministry of Civil Affairs national guideline that there should be a staff-patient ratio of 1:2. This includes all staff, not just the doctors and nurses. Problems centre more around the question of training. It seems that by Chinese standards the doctors in this hospital have had adequate training, most of them at the lower level, and mostly in Western medicine. In informal discussion with the staff, there was a

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discernible feeling that Western training was better. One of the head ward doctors commented that the Medical Director, (who occupies the fourth most senior position in the hospital), only had a background in Chinese medicine, but his deputy 'was a proper medical man', i.e. had a Western based medical qualification.

Ten of the doctors have 'specialized' in psychiatry. In the context of this hospital that means that they have taken a six month course on psychiatry organised by the Guangzhou Bureau of Public Health, (chronic illness section), in conjunction with the Chinese Medical Society and the Association of Neurology and Psychiatry. Each relevant unit is given a quota and may send doctors on full pay leave but it is optional, not compulsory, and relies on the motivation of the individual doctors. Eighteen doctors in the hospital, approximately two thirds, have not elected to take this course, and are described as having specialisms in other subjects. This inevitably affects the way that psychiatry is conceptualized, leading to a very medical and somatic emphasis in treatment.

We may detect a similar but more extreme pattern among the nurses. They have very low levels of training. Only 21 out of 126 have had training in a formal institution. Others may have studied by themselves to take the provincial level exams, and there is a day release course. However, this involves working on a Sunday and in the evening, and is unsuitable for those who have to work shifts or, on a more personal level, those who have children. Indeed, one wonders about the effectiveness of a course aimed at a group who

commonly work shifts who are not able to enroll because of their shift work!

Furthermore, these examinations are of general, not psychiatric, nursing. Trained nurses may have a reasonable level of competence in the physical aspects of nursing, but there is very little of that which is appropriate or common in a psychiatric setting. The bulk of nursing staff consists of nursing assistants who have no formal training at all and who have learned what they know from watching others on the wards. The nurses freely admit that the nursing assistants do the same kind of work as full nurses, and that there is very little effective difference in their jobs.

It would be difficult to prove, but it seemed that some of the new doctors employed by the hospital had agreed to come and work there because it was the only way they could come back to Guangzhou. It was common practice in the past, when there were fewer universities or tertiary training institutes, to send fresh graduates to the remoter provinces. Thus many medical graduates from Guangzhou were sent elsewhere.

Most Chinese people have a visceral attachment to their 'home place', and if they cannot live there feel that they are in exile, even if still in China. Added to that, the standard of living and facilities in Guangzhou are much higher than in most other places. Once sent away it is difficult to arrange to come back. One newly arrived doctor had been a dermatologist in a hospital in an interior province for 20 years. Listening to her talk, it seemed evident that she had struck a deal by agreeing to work in a very

unpopular specialism in return for being permitted to live in Guangzhou. It is unlikely that she was the only one to employ this strategy.

ADMINISTRATIVE MATTERS

Remuneration is clearly a matter of great concern in any organisation for both management and workers. Trying to obtain information about wages was very difficult. Much of the information in this section was made available through the sympathetic co-operation of the Medical Director. In Chapter Two some information was given about the structure of take home pay, particularly the issue of bonuses. What follows is an example of how this works in practice.

Table 6:8: Salary Scales for Doctors and Nurses

Doctors	Salary entrance points
Medical Assistant	50-60 (yuan)
Medical Officer	70-80
Senior Medical Officer	117
Assistant Chief Medical Officer	130
Chief Medical Officer	180
Nurses	
Nursing Assistant	50-60
Registered Nurse	70-80
Chief Nurse of Hospital	117

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The highest increment in any grade is the lowest point of the next grade. The annual increment in any grade is 50 fen extra per month so that the maximum increment for seniority is about 20 yuan after 40 years of service.

These salaries are far too low to live on. Consequently, take home wages include a significant amount that is technically a bonus; or rather bonuses, as they are many and various. It is traditional in Chinese societies for workers to receive the 'thirteenth month', which is an extra month's pay at the time of the Spring Festival. At the hospital, 66 per cent of this is guaranteed but the other 33 per cent depends on performance. Every one gets a bonus of 30 yuan a month, and another one that is based on the cost of living in Guangzhou, which also comes to about 30 yuan a month. Working in the mental health field is considered 'high risk', so they receive an extra one yuan per working day as danger money. They are paid a travelling allowance of 20 yuan per month and a fuel allowance of 10 yuan. The hospital authorities also try to provide some benefits in kind for the staff like washing powder, soap, and soft drinks in the summer. Uniforms and shoes are provided and housing is subsidised. All staff receive the same bonuses from the superintendent to the gardener.

To give an example, the Medical Superintendent's basic salary is 100 yuan a month because he is a medical officer, and on the lowest of the three superintendent grades. Including the additional month's salary spread over the year he receives 126 yuan per month in bonuses, which is to say about 52 per cent of his take home pay. The issue of wages and their relation to status

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and authority is dealt with in more detail Chapter Ten.

Management Structure

There was no organization chart available in the hospital, and what was learned had to be pieced together. The five most important people in the hospital were the Party Secretary, the Medical Superintendent, the Deputy Medical Superintendent, the Medical Director and the Administrative Director (who was also a doctor, and in 1989 was promoted to become Medical Superintendent). Contrary to Western expectations, the most important, powerful person in the hospital was the Party Secretary, which was the case in any organisation or enterprise. All professional and administrative matters were subject to Party dogma and discipline. The effect of this on the hospital is discussed in more detail in Chapter Ten.

The position of the Party Secretary in the following chart is mentioned twice because a national decision was taken in December 1987 that the Party Secretary would no longer be the most senior person in any enterprise. Managerial and professional considerations were to take precedence in the selection of an enterprise leader. Thus during the period in which the research was undertaken, the Party Secretary was technically subordinate to the Medical Superintendent. However, this may be seen as essentially an anomaly. Following the Tiananmen incidents in 1989, the structure reverted to its previous position. More details are given in Chapter Ten.

Table 6:9: Management Structure

```
                        Party Secretary
                      (until |1-1-88 and since 5-6-89)
                              |
                    Medical Superintendent
   _  .  _   _   _   _   _  -|
          |                  |
Party Secretary              |
(from 1-1-88 to 4-6-89)      |
                             |
                    Deputy Superintendent
        ┌────────────────────┴──────────────┐
        |                                    |
Administrative   Director            Medical    Director
        |                              └──────┐
        |                                     |
     Deputy                               Deputy
        |                                     |
        ┌──────────────────────┐             |
        |                      |             |
Finance Department    Personnel Department   Head Ward Doctors
                                                  |
                                             Ward Doctors
```
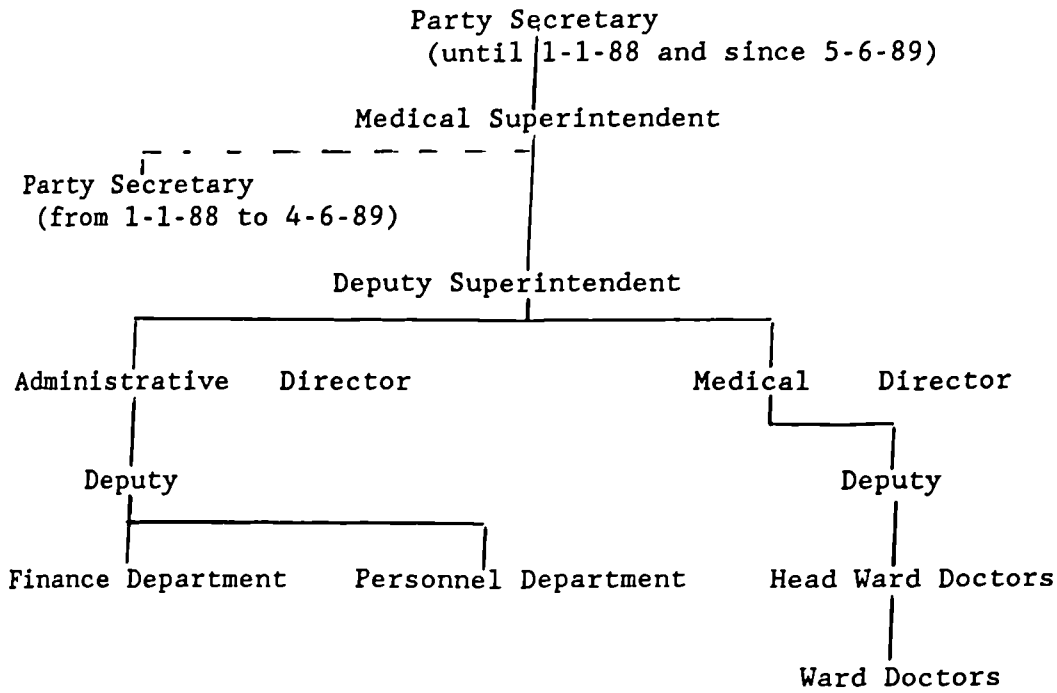
There is also a Chief Nurse who has not been included as it was not possible to ascertain where she would fit in, or indeed precisely what her responsibilities were. She was never included in any discussions in which I took part, unlike the other five. This could have been for a number of reasons; perhaps because she was a woman, and was not accepted by a predominantly male group, or that nurses were considered to be of lower status (even though in her case she earned more than the Medical Superintendent). What is also unclear is how the responsibilities of the Chief Nurse overlapped with those of the Medical Director. He described himself as being responsible for all the doctors and nurses on the wards.

The Administrative Director's job was described as being responsible for administrative work, drafting the rules and regulations, paperwork, writing reports. As well as the deputy, there is an assistant to the deputy and clerical workers.

Financing the Hospital

Finance was another delicate matter and one about which it was not easy to ask direct questions. The hospital's funding came from two sources. First, was a block grant from the municipal government. In 1988 this was 1.1 million yuan and generally increases each year to take account of rises in the cost of living. Grants for any capital projects had to be requested separately. The element of the grant that covers salaries is based on the number of 'three have nots' patients, of whom there are about 400. The official staff ratio is one staff to two patients, and they have 640 patients, so they have to raise the money for the other staff themselves. The grant also covers accommodation, meals and treatment costs for all patients but no extras. Renovations, repairs and environmental improvements cannot be financed from the grant. The total expenses of the hospital were 1.6 million yuan, so that left the hospital with 500,000 yuan to find.

They had various, (capitalistic), ways of doing this. Renting out the hospital's fishponds to commercial fish farmers brought in about 20,000 yuan per annum. The outpatients department generates another 20,000 per annum. Rent from the holiday camp managers contributed another 100,000. Self-pay patients were charged about

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200 yuan per month. The hospital is permitted to keep about 30 per cent of the fee income and uses it to fund staff bonuses. Among other things, bonuses are used to raise staff salaries to levels comparable with similar jobs in Guangzhou. They are subject to a departmental audit each year. Money from the block grant not spent in one financial year may be carried over to the next year.

Obviously, these figures do not entirely tally. Income from non-patient sources totals approximately 140,000 yuan per annum. There are 216 self-pay patients. Assuming they all pay 200 yuan a month that would give an annual fee income of 518,400 yuan. The hospital is supposedly permitted to keep only 30 per cent of the fee income, which would give a sum of 155,520 yuan per annum. This leaves a shortfall of over about 200,000 yuan. It seems safe to assume that we do not have the complete picture. If the grant and the total expenditure are correct, which seems reasonably likely, then the hospital is responsible for raising approximately 30 per cent of its yearly expenditure. It would be surprising if this did not loom large in the mind of the Medical Superintendent whose responsibility it is to find this money.

The Outpatients' Department

The main purpose of the Outpatients' Department is to service the ward areas with an X-ray unit, pathology department, sterilizing unit, pharmacy and discharged patients' records. Its secondary purpose is to provide a clinic for surrounding villages. The nearest other clinic is about one hour away. The majority of the patients are children with common childhood complaints, then

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adults with hepatitis, and thirdly people with minor mental disorders. Many of this last category are over 50 and suffering from depression or a neurotic disorder for the first time. Out-patients consultation is 30 fen plus the cost of the medication and 50 fen for a specialist consultation. The department has its own staff of 24 including a pharmacist and technicians.

The hospital authorities are well aware that having this clinic helps to improve relations with people in the surrounding countryside, who might otherwise resent having a psychiatric hospital in their midst. It provides a cheap, convenient, twenty four hour service, although most patients tend to come in the morning. About 30-40 people are seen each day.

LIFE ON THE WARDS

There are four male wards, two female wards and one which is mixed for patients suffering from infectious diseases. This latter is divided into male and female sides with the only possible connecting route being through the treatment room and doctors' office, which occupy a no man's land in the middle. In fact, most of the patients in this ward are not suffering from a current infectious illness but may have done so in the past. Many of them are over 50 years old. What follows will describe the general situation in the wards, highlighting differences between them where this is appropriate.

Physical Environment

The emphasis on security in the hospital is largely within the ward, not at the perimeter. All wards have only one exit to the outside which is constantly locked. The gate is either made from solid metal or metal bars. Each ward has a courtyard where, at least in the summer, most patients seem perforce to spend most of the day. Wards have either four, six or eight beds in them. Only the 'service group', (patients who do domestic work) in each ward are allowed to keep any individual possessions. Some of them are provided with a locker while others keep a bag under their beds. The majority of patients do not have a sheet on the bed; that is a privilege reserved for members of the service group. What sheets there are were obtained by the present Superintendent, second-hand at bargain prices, from a hostel in Guangzhou that was closing down. All the other patients have a rattan mat to cover the boards in an iron bedstead. Most beds seemed to have a mosquito net but there were no fans.

The wards, almost without exception, are completely bare of any decoration. There are no photographs, no calendars, no pictures cut from a magazine, no souvenirs of the patients' past life or individual identity at all. The only exception is that service group members sometimes have a potted plant by their beds, but that hardly provides any connection to a life outside the hospital. The doctors' room on each ward is slightly livelier, with the occasional calendar, picture, vase of flowers or potted plant. So the concept does exist.

There is one large room with tables and chairs, which doubles as a place to sit and a dining room, although not every ward has space for all patients to sit at the same time. Many take their meals standing or squatting in the courtyard. Most courtyards have no benches or seats which would probably be welcome, as this is where most patients spend a good part of their day. They have no choice but to sit or squat on the ground.

There is one exception to the general air of bleakness - male Ward 2's garden. This is quite clearly the pride and joy of a dedicated group of green-fingered enthusiasts among both the staff and patients of the ward, and without exaggeration may be described as magnificent. Patients are supposed to be able to sit out in it and receive visitors there, although instinct suggests that this might be a privilege for a favoured few. However, the staff said quite plainly that as patients had contributed to it, they should also be allowed to enjoy it. Another male ward had a roof garden mostly consisting of potted plants. However it had no wall or guard at the edge so only service group members were able to use it under supervision.

Even by standards of mainland China, the toilet and bathing facilities were basic. The toilets were concrete channels in the floor with the cubicles separated by half walls, and had no doors. This is not so unusual, but there were never more than six toilets for between 90 to 100 patients, and some of those were not accessible during the day. Bathing facilities varied slightly but normally consisted of cold water taps set about three feet up the wall opposite the toilet cubicles. There was absolutely no privacy

at all and the design clearly facilitated being able to wash a group of patients at the same time. Another version involved a bath large enough to hold seven people at once, with a large rubber hose lying inside, presumably to hose them down. It must be remembered that, as there is no occupational therapy department, most patients spend 24 hours a day on the ward.

Ward Staffing Structure

The numbers of staff on each ward is the same, 24. There are always three doctors, (one of whom is in charge), a head nurse, two workmen, and a general duties nurse. The balance in each ward is then split between nurses and nursing assistants with the latter always outnumbering the former. No significant difference could be detected between the wards in the distribution of nurses although there are minor variations. The general duties nurse covers tasks like keeping a record of patients' allowances, administering special food rations and other benefits for veterans, and controlling and dispensing toilet paper, soap, sanitary towels and so on. She is sometimes called the 'odd job nurse'. Patients wanting to use toilet paper, soap and so on have to request it from the nursing staff.

Nursing Regimen

It is a national policy in Ministry of Civil Affairs psychiatric hospitals that patients are divided into four nursing categories. (Ministry of Civil Affairs Encyclopaedia, 1987; Zhang Dejiang, 1986) It may also be true of the hospitals in the Ministry of

Public Health system. (Tousley, 1985) This policy is implemented at the Guangzhou Hospital.

Level 0 - refers to patients who require 24 hour a day bed rest and intensive nursing care. These patients are generally elderly.

Level 1 - all newly admitted patients, patients who are relapsing are allocated to this level, and any others who are considered to have a serious psychiatric problem. These patients are generally carefully watched and supervised by nursing staff.

Level 2 - the illness of patients at this level is considered to be under control, and the condition of the patient steadily improving. At this level patients may be expected to look after their own daily needs and basic hygiene with little supervision.

Level 3 - the Ministry's encyclopaedia defines these patients as having 'their mental illness syndrome basically removed' and ready to be discharged. In the context of the Guangzhou Hospital where discharge is a rare option these are patients who can go out without supervision and are generally independent. They are also in the service groups (see later section).

All staff are very aware of the necessity of maintaining the 'three preventions', that is to prevent suicide, prevent other destructiveness and prevent running away. Patients who are considered to be in danger of any of these three actions are dubbed a 'three prevention' patient and become the subject of very careful supervision. If a patient in this category did manage to

commit suicide etc., the staff would be subject to severe criticism. If a patient not in this category committed any of these acts, the staff would also be severely criticised for making a wrong assessment of the patients' mental state. Tousley makes similar observations, and comments on how stressful psychiatric nurses in China find the responsibility of preventing suicide. (Tousley, 1985)

Patient Files

Standardized ward files are kept on all patients. Information includes a record of nursing care, long and short term prescriptions, reports of accessory investigations and tests, a case record since hospitalization began, a record of mental condition, and temperature and blood pressure charts. It is a requirement that each patient must have a comment recorded on his file by one of the ward doctors each month, although some of these comments are perfunctory in the extreme.

The hospital has been making a great effort to improve the quality and organisation of the information on its patients' files. While we were there a lengthy series of meetings was continuing to try to decide on the changes. One that had been agreed was the need to include much more information about the patients' family and social background. There was also concern about the way that diagnoses were being reached. One of the new rules was that doctors should diagnose through exclusion, which is to say that they were supposed to state clearly on the file why they had excluded other diagnoses, as well as why they had reached a

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particular conclusion.

Having read through so many files it was hard to disagree with the hospital's assessment of where improvements were needed. It was also worrying to read a selection of the newer files on patients admitted after some of the altered procedures were supposed to have come into use, to find that they were just as bare as the old ones.

Daily Schedule and Activities

Patients are woken up about 6 a.m. and washing and toileting take place. Breakfast is at 7 a.m. followed by medications. Patients are supposed to make their own beds and keep their rooms tidy. The morning staff meeting takes place at 9 a.m., when patients who did not have a peaceful night are discussed, physical ailments reported on, and duties allocated for the day. Sometimes the doctor in charge will use this opportunity to issue a general instruction, like reminding staff to make sure that patients are warm enough at night, or to keep a special eye on those patients sad because they have no relatives to go to during festival times. (The major festivals are the Spring Festival, which usually falls in February, and marks the beginning of the new year according to the lunar calendar, and the Mid-Autumn, or Moon, Festival).

After this meeting all patients, and technically all staff, are supposed to spend 15 minutes engaged in physical exercises led by one of the staff. Having been present at several of these occasions it seemed that participation was largely perfunctory on

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the part of all participants. Patients are then mostly locked out of their rooms so they cannot go back to bed, and most frequently locked into the courtyard. Some are called to the treatment room to have their blood pressure taken, or escorted for an X-ray, or have small injuries attended to. This is also the time when hair and nail cutting takes place. Some nurses go round tidying patients' beds and rooms. About twice a week, those patients who are able are taken for a walk by the nurses. The destination is often the grounds of the holiday camp, but in fact most of the facilities there, like the swimming pool, or the small 'dodgems'), are defunct. There is an open air pool table which patients sometimes use. There are other facilities, like a dance hall, but these do not seem to be used by patients. The hospital has its own, rather decrepit, activities hall.

Lunch is at 11 a.m., followed by medications. From about 12.30 p.m. to 2.30 p.m. patients are allowed back into their rooms to take a nap. There appears to be very little activity on the wards during the afternoon. There is more medication at 3.30 p.m. and again at 8.15 p.m., before bed time at 10 p.m.. The final meal of the day is at 5 p.m..

It must be remembered that there is no occupational therapy department or activity centre at the hospital. Thus for most patients the ward is their entire world. The major occupational activity provided on the ward is pulling pieces of cotton apart in order that it may be rewoven. This is piece work and patients are paid a small amount for what they do. It is mind-numbingly boring work, although staff also claim that patients are not capable of

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anything more complicated. On some wards, patients engaged in this activity are permitted to watch television at the same time to relieve the boredom.

One ward (Male 3) was slightly exceptional in this respect in that staff had arranged for another money-earning activity for patients, sticking labels on packets. Staff had also spent bonus money, that they had earned helping to whitewash hospital buildings' to buy a table tennis table and equipment, and a badminton net and racquets for patients. Both activities took place in the courtyard. Ward 3 was also the only ward where both staff and patients smoked openly, and was in a number of respects atypical.

Each ward has a colour television and the hospital has a video player, (a sign of the level of affluence in the Pearl River delta area of Guangdong) so that films are also occasionally shown. There were no newspapers for patients on any of the wards, although a newspaper is an essential part of life for many Chinese people under ordinary circumstances. Only on one ward was one boardgame observed, Chinese chequers, and staff were never seen interacting with individual or small groups of patients on the ward in a 'recreational' way, other than occasionally to lead group singing.

While the lack of any meaningful daily occupation is one of the most obvious comments to be made about the daily schedule, a comment of the Physician Superintendent must be borne in mind that puts a slightly different light on the matter. He said that the

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previous Superintendent, under whom he had worked, insisted that

every patient do four hours daily labour unless they were so ill

or aged as to make it impossible. He felt this was an unreasonable

demand given the type of patients for whom they catered, and

stopping the practice was one of the first things he had done on

becoming Superintendent.

There is little effort made to orient patients towards the outside

world, unless it is through watching television. They have no

reminders of their own past life; no photographs of any sort, no

souvenirs, no treasured objects. Nor are they encouraged to take

any interest in what might be going on in the outside world.

Obviously there are resource constraints but opportunities that

would cost nothing are ignored.

An example

The period of research at the hospital happened to co-incide with
the 1988 Olympics. China has made marked improvements in its
sporting standards in recent years in a number of events and was
clearly in line for several medals. This would have been a
completely acceptable theme around which to build an interest
programme for patients, following the progress of China's
athletes, finding out more about other countries, monitoring
medals won with wall charts. Instead of which, on the afternoon of
the finals of the men's high diving competition, when China was
the only country that stood any chance of knocking the American
champion from the premier position he had dominated for years, the
patients were all locked out in the courtyard and all the staff
were gathered round the patients' television avidly watching the
event. (The Chinese contestant won the silver medal).

Most wards told us that they organised trips to Guangzhou once or

twice a year, (the zoo or the sports stadium were the two places

most frequently mentioned), and that they tried to take as many

patients on these trips as they possibly could. Such outings were

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very popular with the patients, and the staff reported that it permitted them to get to know the patients better because they opened up more. The implication was that this activity was long-established and regular. However, as Chapter Five recounted, on closer inspection of the evidence, this seems unlikely.

Visitors are encouraged to come at any time in office hours, 9 a.m. to 4 p.m.), on any day of the year although nurses prefer them to arrive after 9.30 a.m. when the handover is finished. They do not have to give notification of their intention to visit. The staff wish more relatives would visit the hospital, as nothing makes the patients unhappier than the sense that they have been abandoned by their families. However, very few make the effort. Visiting is difficult because of the remoteness of the hospital from Guangzhou.

The current ward environment can only be seen as grossly understimulating, even for the more deteriorated patients. For the majority of patients, there is almost nothing to do day in and day out. There is no provision for the encouraging of individual talents like painting, calligraphy, writing, knitting or sewing. There are no group activities or games, except on special occasions. There are no inter-ward table tennis contests on a regular basis, no Friday night socials.

Psychiatric hospitals in the U.K. used to be criticised for providing for all the needs of the patients under one roof, obviating the necessity for them to ever go out (for instance shopping, or to use local recreational facilities). But this

hospital provides for little other than patients' physical needs, nor are they able to go out. While the hospital is limited in what it can do to promote discharge for many of its patients, it could realistically humanize its own internal regime.

The Service Groups

Each ward has about ten patients who form the service group. They are under the immediate direction of the two domestic workers, and their basic function is to help with the cleaning, and to assist in looking after the more incapable patients. Their duties in the first respect are called the 'Three Front Door Responsibilities'; these amount to keeping the ward clean, and attempting to beautify the environment. In return they are paid a small allowance of 3-5 yuan a month, may keep some personal possessions, bath when they wish, go for walks unescorted, and have a sheet on their bed. Only one patient appeared ever to wear her own clothes occasionally. One ward permitted patients to have their own underwear as long as they took responsibility for washing it. Most patients had no underwear and were dressed in hospital pyjamas in varying states of dilapidation.

Admission and Discharge Procedures

The official way for a patient to be referred to the hospital is through the work unit or family. Whoever makes the referral contacts the hospital about a potential patient. The hospital sends a doctor from whichever ward has an empty bed to assess the patient. If the doctor thinks he is suitable for admission he

recommends this to the Superintendent, Deputy or Medical Department head. Relatives, work unit colleagues, or occasionally the police will then bring the patient to the hospital.

This seems to represent an ideal state rather than be an accurate account of what routinely happens. It was clear from reading the files that many patients were brought to the hospital to be seen for the first time, and were then admitted straight away. A number of the patients were tricked by relatives into thinking that they were going on a picnic, or being taken somewhere for a job interview. As one head doctor commented 'many patients arrive handcuffed and think they are coming to a prison. They wonder "what have I done wrong? Have I been anti-revolutionary"?'.

While we were travelling to the hospital on the ferry one morning we overheard a conversation between the ferry captain and the Medical Superintendent. The captain had a fifteen year old relative who was hearing voices and had attempted suicide, and he wanted to know how he could have her admitted to the hospital. Fong Tsuen had already refused to admit her, although no reason was given. The Medical Superintendent's answer was simple. A deposit of 500 yuan was needed and a document from the girl's work unit, or that of her parents, or her neighbourhood organisation, saying that they would take her back and be responsible for the fees. He appeared to be perfectly willing to admit the girl without ever having seen her. The captain asked if she would be admitted to 'one of the horrible chronic wards' and was told that she would need a period of observation before they decided. In fact, there are only two wards for women and placement rests on

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where a vacancy exists.

Discharge seemed to depend on a number of factors. The most important was whether or not the patient had a work unit or family willing to accept responsibility. The lack of either made the chances of discharge extremely remote whatever the condition of the patient. There may have been some liaison between the ward doctors and the relatives or work unit. One doctor described discharging a patient home without any warning to the relatives so that they had no opportunity to refuse to accept her. The doctor simply escorted the patient to Guangzhou herself, and then took her to the family home and left her there. There is no evidence to suggest that this is a common occurrence.

Some wards maintain contact with the patient after they have been discharged. Doctors in one ward claimed that they visited discharged patients once a month. Another ward said they paid them a visit once or twice a year. This does not form part of their official work and they do it out of kindness. They said that no fee was charged, but it would be surprising if the family did not offer some token of their appreciation.

Home Leave

A surprisingly large number of patients were permitted to go on home leave, particularly at festival times. In female Ward 1, they claimed 40 patients went home. Other wards routinely permitted ten or so patients to go home on leave. Some travelled independently, while others were escorted by their relatives.

Staff were aware that there were a number of patients who were quite well enough to live outside, but whose families were not prepared to have them on anything other than a temporary and time limited basis. Some patients were unwilling to be discharged because they felt that they were a burden on their families. One woman, who was described as 'very capable', used to go home at harvest time to help her family. But one year her brother died while she was there, and the next year her nephew drowned, and she now refuses to go home, although her family are quite willing to take her, because she feels she brings disaster on their heads.

Extended leave is also used more inventively;

- to send patients back to their work units, so that if they relapse there is a guarantee that the hospital will take them back again.

- to encourage patients to keep taking medication because they know they can be recalled instantly.

- to persuade a work unit to accept someone from the hospital, (who was not originally their employee), give them a job, and house them. In these circumstances the patient is on extended leave because of the advantages outlined above, and because the work unit is then absolved from paying the fee if the patient relapses.

The Use of Seclusion

Each ward has at least two, and sometimes as many as six, seclusion rooms. On the more modern wards, each room is entirely enclosed and the occupant is not able to see or hear anyone else.

The rooms are not padded, and are generally furnished with only a bed or sometimes a mat on the concrete floor. The doors are made from metal, and there is a small grille high up in the door that permits staff to look in. In the older wards the design is somewhat different. On female Ward 2 the seclusion rooms were by the main door. To enter them one went through a locked, barred metal door into a short corridor, on either side of which, facing each other, were three cells. Each was locked and had a barred metal door, so that occupants were visible to each other all the time.

The impression gained was that staff were not entirely at ease in talking about these rooms, or the uses to which they were put. On one ward we were told that they had not been used for over a year - but then at the handover, part of the discussion centered on the behaviour of a patient who had been in the seclusion room for some days. Some wards said they now only used them for patients who were physically ill; others that they were used for patients who were relapsing or misbehaved, but 'only for a few days'.

From what we were told and what we could observe, there are grounds for concern. There are no hospital guidelines for the use of seclusion, thus decisions about who goes in them, and the duration of their stay, remains at the whim of individual members of staff or shifts. Nor did there seem to be any requirement to inform the Medical Director if a seclusion room was being used. In female Ward 2 we were told of a patient who had been kept in seclusion for ten years because she bit other patients occasionally. She had only been released about four months ago

and had apparently not bitten anyone since then. When asked the reasons for this, one of the doctors who had been there for ten years, described the previous head ward doctor as very conservative, with only basic medical training, although she had worked in psychiatry for 30 years. It was she who had locked the patient up. The implication was that the regime had improved under the new head ward doctor. However, as the old one had retired in 1985, it had still taken them the best part of three years to release the patient. It may be worth mentioning that of all the seclusion rooms, those on this ward were in the worst condition, smelling very strongly like stables.

Another instance was given on male Ward 3 of a patient who had been placed in a seclusion room for 20 years because he was 'a severe sexual pervert'. His offences seemed to be masturbation, some form of sexual assault (but not rape) and writing political graffiti on the walls about national leaders. He has recently been released, and staff say that they successfully control his behaviour through medication and the judicious granting or withholding of cigarettes and favourite food.

The Deputy Medical Superintendent told us that there were rules to forbid staff hitting or shouting at patients and that the expectation was that staff would be able to control patients' acting-out behaviour within three days through medication. This ought to obviate the extended use of seclusion but the indications are that it does not.

<u>Staff Discipline</u>

According to the Medical Director, there is a code of practice for the whole hospital and his concern, as the person responsible for the maintenance of professional standards, is to encourage people to work according to these standards, rather than to punish them when they do not. He feels that some people criticise him for this view. Discipline tends to be enforced by manipulating the bonus element in wages, and by holding the entire staff of a ward or the whole shift responsible for mistakes committed by one person. This emphasis on collective responsibility presumably uses peer pressure to ensure that standards are maintained. If he considers that the head nurse and doctor of a ward have sincerely tried to rectify mistakes made by themselves or their staff, then the Medical Director will not penalise all the staff by reducing their bonus. It seems that if a member of staff makes minor errors, the ward may decide to reduce that person's bonus, awarding an equivalent amount to another staff member who has performed exceptionally well.

Regular evaluation is supposed to be carried out daily by the head doctor and nurse at the handover in the morning. Sometimes mistakes are pointed out publicly to increase the alertness of other staff. (see also Henderson and Cohen, 1984) Sometimes it is done individually. There is also evaluation from the Medical Department. They go to each ward to give supervision. Sometimes ward senior staff, but not the head doctor or nurse, will report mistakes direct to the Medical Department. Views about this vary as to whether the Medical Department should deal with this

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directly, or refer it to the ward's head doctor. On the wall of the doctor's office in each ward is a 'mistakes chart', with the name of every staff member of that ward on it, including the head doctor and nurse. Mistakes are publicly recorded and graded according to four levels of severity. There is also a 'mistakes book' on each ward and this is used at the end of each month to calculate the bonus for all staff members.

How this works in practice is demonstrated by the procedures invoked when patients run away. The ward reports the disappearance to the hospital office. It is the duty of the staff on the ward at that time to search for the patient. If they cannot find him the matter is reported to the public security bureau. According to new rules laid down by the Medical Department, all staff on that shift have to take the blame, whether they were directly involved or not, and all will have their bonuses reduced. Penalties are higher if the patient comes to any harm, or causes any harm, while out of the hospital. In that case a 'big, black mark' will be recorded on each staff person's file. Three of these administrative marks are supposed to lead to instant dismissal. No one has ever been dismissed from the hospital, and one wonders how effective these deterrents are. It is difficult to persuade people to undertake this kind of work and the Medical Director must be aware of this when he is disciplining staff. Perhaps that is why he tries to rely on persuasion rather than punishment.

On the evidence available from talking to staff, reading files and ward observation, it seems unlikely that the supervision

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techniques described by the Medical Director are effective in raising and maintaining standards of care. While the upper echelons of the hospital medical hierarchy may have had a clear idea of what they thought proper practice in the hospital should be, there seemed to be major problems in operationalising that throughout the hospital. The impression gained was that ward doctors were resistant to what they saw as interference. Nor did the head ward doctors seem to take much lead in monitoring professional standards in their wards, for instance by checking through files or ensuring that proper diagnoses were carried out. Good standards seemed to rely more on individual interest and diligence, which occurred in small pockets around the hospital, rather than being an agreed common goal.

The Contract System on the Wards

Since its introduction, the 'contract responsibility system' has tended to permeate every aspect of life. Within the hospital it is used in very diverse ways, from a basis for hiring staff to rationing soap. The idea behind it is to break the 'iron rice bowl', (a guaranteed job for life, independent of ability or motivation), and force people to accept responsibility for their own actions by setting quotas and making at least part of their salaries reflect their work ability. While it was effective in increasing agricultural output, 'contract responsibility' is not always suitable for the uses to which it is currently put.

Within the hospital the contract responsibility system is brought to bear in a number of respects. Various kinds of staff are

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employed on a contract including a few of the doctors. Mostly these terms are offered to nurses, maintenance staff, the carpenter and the cook although it is still more common for staff to be permanent and therefore allocated to the job. The basic salary for contract staff is what is in the contract, and it will vary in different areas of China according to living standards and from enterprise to enterprise according to the material wealth and workload of the unit. The contract is usually for two or three years and there is a probationary period of one year. After the probationary period the salary is increased. Once a contract is finished it may be renewed, usually at a higher salary. Contracts give more flexibility to both staff and management over choice of job, wage levels and personnel.

Although the hospital has never dismissed a member of staff, there have been times when a contract has not been renewed. If a contract is not renewed the government provides a proportion of the original salary, (but not including the bonuses), for six to 12 months to cushion the search for new employment. Both employees and the work unit pay into a contributory pension scheme for contract workers, which may be paid as a gratuity at the end of a contract if the person leaves, or as an old age pension on retirement.

Other areas of the hospital are also affected by the use of contracts. The workload of patients' laundry was too heavy to be dealt with through existing channels, so laundry work is contracted out to existing staff and their families. Security is semi-contracted out. Those working in that section were originally

staff members, but as a way of increasing their performance they are paid a bonus at the end of the year if there have been no cases of theft or untoward incidents. Equally, they are financially penalised if there have been.

The outpatients' department used to claim that it was too busy to perform routine urine, blood and stool examinations on in-patients. So the hospital authorities set up a total target amount for them and they now have to fulfil the target, with the usual rewards and penalties operating through the bonus system. It took two to three months to establish workload statistics, and to persuade out patients department staff to participate in the system. The Medical Director said that, while it is possible for the system to be abused by staff performing unnecessary tests, this does not happen very often and if they notice it going on, they talk to the staff, and in extreme circumstances deduct money from their bonuses.

The hospital authorities intend to introduce the contract system on the wards as a way to make staff be aware of the resources that they are using, and to ensure that they are not wasteful. This will affect the use of electricity, patients' clothes, soap, toilet paper and so on. The Medical Director does not think that this will lead to goods being unnecessarily restricted in order that staff may increase their bonuses by remaining below the target. On the other hand, there does seem to be space for abuse in such a system particularly since patients are not likely to be able to make effective complaints if their rations of toilet paper

and soap become too sparse.

Staff Attitudes Towards Patients

Information on this subject could not be systematically collected, and comment is based on observations of interactions between staff and patients, and staff's comments about patients over the month spent at the hospital. Only two doctors on the wards spoke about their patients as though they were human beings. One of these talked of lives 'full of blood and tears'. The others seemed either indifferent or were oriented to patients rather than persons. While the latter approach might have some place in the treatment of acute patients whose stay is brief, it is not appropriate for long-stay patients for whom contacts with staff are important in meeting affectional and reality needs. A significant proportion of the doctors seemed to be working in the hospital because they wanted to be in Guangzhou, not because they had any interest or experience in mental illness. However, none of the doctors showed any obvious sign of being unprofessional. At worst they were time servers.

The same could not be said for nursing staff. While the physical aspects of nursing seemed adequately dealt with, the nurses had little idea of what their role should include other than supervising the physical needs of patients. A significant contributing factor was their lack of any training in psychiatric nursing or, for many, of training in any kind of nursing. Some showed an apparent complete lack of ability to empathise with patients' feelings.

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<u>An example</u>

On the Mid Autumn Festival Day there was a show with performances by both staff and patients. Some of the patients taking part were not very able and in a group performance tended to move in the wrong direction, or sing the wrong words at the wrong time. A number of nurses in the audience found this very amusing and were doubled over with mirth, all the while pointing out the inadequacies of particular patients to their friends. The attitude of the more able patients to their less capable colleagues was in great contrast. They were kind and gentle with no hint of impatience or mockery in their demeanour.

It is, of course, possible to say that these events are being interpreted through Western eyes and may not contain the same significance for the actors themselves; but the fact that doctors and some of the nurses tended not to behave in this way, suggests that there are alternative models.

<u>Differences Between Individual Wards</u>

On the whole, wards were more alike than unalike. Groups of staff were subjectively certain that the administration favoured some wards over others. The staff of male Ward 4 were quite sure that the Medical Director's department sent them the patients who were the hardest to manage. Information from the data collection forms were analysed by ward but no reliable statistical differences were found, although efforts in this direction were hampered by the small number of cases in each ward. Some wards did have more self-pay than 'three have not' patients, and this may have made some difference.

The collective view of the staff was that the self-pay patients, being more acute, were more interesting and rewarding to treat. They also, on the whole, considered that standards in the hospital

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had risen since these patients were admitted, with more and better qualified doctors being employed. It is interesting to note that, while these patients may be considered to be more acute, this is not reflected in the discharge figures which have remained more or less the same for the last six years. This would suggest that they are needlessly being turned into long-stay patients, because they are reliable sources of income, because the staff find them more rewarding and are reluctant to let them go, or because relatives are reluctant to take them back.

Male Ward 4 staff reported that their ward had deteriorated over the years. During the late 1970s this was a rehabilitation ward with younger patients. Many of the patients worked in the grounds, and staff and patients played ball games together. Perhaps most significantly, the ward doors were open all day; now, as with all the other wards, they are permanently locked. As the patients have become older, they are not so lively, and the situation on the ward has deteriorated. This assessment is supported by the leaden ward atmosphere, and by the much heavier doses of drugs given to the patients on this ward than on others.

In contrast male Ward 3, while having similar physical conditions to male Ward 4, gave a very different impression. The staff here seemed to be the rebels of the hospital, for instance both staff and patients smoked quite openly. The ward office contained various charts, mostly pie and bar, of information to do with their patients, such as the numbers of 'three have nots' and self-pay, types of diagnoses, the numbers taking drugs. They were proud

of the fact that their patients earned the most money from pulling cotton threads, and it was this ward that had found another income source for patients, sticking labels on packets.

The staff were quite convinced that providing patients with occupation during the day prevented, or at least slowed down, deterioration and thought that the emphasis that they placed on this accounted for the better condition of their patients. This was in spite of the fact that over 90 per cent of their patients were 'three have nots', generally considered to be the least rewarding. This was also the ward where the staff spent some of their bonuses on providing extra facilities for patients. Whether or not their perceptions were objectively correct, the fact that they felt they were seemed to improve the staff 'spirit', and produce a discernible sense of camaraderie lacking on other wards.

In some ways, it was easier to grasp the differences between the female wards because there were only two. Female Ward 1, despite having the worst seclusion rooms, was a generally livelier place to be. All staff working on both female wards knew that Ward 1 had the 'better' patients. Female patients being readmitted routinely requested to go to Ward 1. Patients there would crowd around visitors asking questions and showing great interest in anything new or different. The hospital put only female staff on this ward, unlike female Ward 2 which had all male doctors, because it was felt that the sexual temptation for male staff working with younger and livelier patients would be greater. Female Ward 2 had older patients, and they certainly appeared less well-oriented than those on Ward 1, although there was no way of knowing whether

this was a result of longer hospitalization and greater institutionalisation, different ward regimes or the process of illness. Notes taken during an afternoon on this ward give a flavour of its atmosphere.

'The dormitories are locked to keep patients from lying on their beds, so most patients are in the courtyard. There are no chairs to sit on - a few courtyard walls. Most patients sit or lie on the ground. There is very little verbal interaction between patients. Nursing staff, other than performing 'treatment' duties, did not spend time with patients that I could observe.

There was some shouting and crying out, particularly one patient who was crying and sobbing apparently because the nurses did not take her out for a walk that morning.

Another patient, Patient X would scream intermittently and then would smack her own wrist quite hard. Patient Y found string and tied X's hands behind her back then stood behind X, wrapped her arms around her and rocked her forcefully. Occasionally Y would deliver a resounding whack to the side of X's head. X clearly did not enjoy this and struggled to break free. Y forcefully pulled down X's pants put both hands on X's head and forced her to squat. She then knelt on the ground and placed her head under X's bottom, withdrew and put her hand under and round to the front. Then Y seemed to stick a finger in X's rectum. My impression was that X did not enjoy these attentions and eventually struggled to break free of the string. Nurses were walking about during the interaction between patients X and Y but seemed not to notice and certainly did not intervene.

When Patient Y pulled down the pants of Patient X I was able to observe what looked like two red weals, one on each leg just below the buttocks. It might have been iodine, for instance on an insect bite, but they could also have been the marks of a cane. Another patient when she squatted down showed bruising on her lower back.

I observed at least four patients urinating in the open drain. The ward has three toilets for 87 patients - only one downstairs where the patients are during the day. It is in a very poor condition, dirty and foul-smelling, so from the patients point of view the open drain may well be preferable.

There was much aimless walking about by patients, some more able ones leading the less able'.

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This ward had a head doctor who spoke about his patients with care and concern. Perhaps he no longer noticed what the conditions on his ward were like; perhaps they had ceased to strike him as strange; or perhaps he felt impotent to change anything.

During discussion on the wards, all staff groups were asked in what ways they thought the hospital had changed over the years. The most common replies were improvements in the physical setting, and improvements in standards of staffing and quality of staff, and thus improvements in treatment and maintenance of files. There had been two medical superintendents before the present one. Both of them had been retired army veterans with no experience of hospitals or medical background. Some staff spoke quite openly of the conditions in the past, when both physical and mental illnesses went untreated, and patients were left to die with little intervention. Thus, whatever the conditions seem like to an outsider, the staff, using a different but no less relevant frame of reference, have a more positive sense of the hospital.

CONCLUSIONS

1 - The hospital is very physically isolated which reinforces the institutional ethos of the place and severely reduces the opportunities for community based treatment and rehabilitation. The distance from Guangzhou makes it difficult for relatives to visit, even if they wanted to, and many do not bother. The staff who live in Guangzhou, while seeing themselves as fortunate, pay a high price in the tiring journey that must be made twice a day. If it was ever intended that the holiday camp would overcome the

problems of isolation, it has not worked.

2 - The hospital seems in danger of creating new long-stay patients unnecessarily. If acute patients are to be admitted to what has been essentially a hospital for chronic patients, then thought needs to be given to how they are to be appropriately handled. Staff obviously think that accepting acute patients has brought benefits to the hospital. Little thought seems to have been given to what might be in the best interests of the patients.

3 - The lack of trained staff and training facilities has a damaging effect on standards of patient care. This is particularly true of the nurses, who are allocated to nursing, psychiatric nursing and this hospital. Choice and voluntary adherence to a professional ethos have absolutely no part to play. Under such circumstances, exhortations by the Party 'to serve patients with all your heart' are utterly ineffectual. Attempts to manipulate the bonus system to produce better levels of patient care do not appear to work because the amounts of money involved are too insignificant. It is also difficult to do anything more than discipline staff in a token way. First, it is almost impossible to dismiss anyone. Second, it is very hard to attract staff to work in any psychiatric hospital, let alone one that has the disadvantages this one does in location and type of patient.

4 - Basic physical needs are met as far as clothing, feeding and hygiene are concerned, at least by Chinese standards. The number of deaths each year, if accurate, do not seem excessive. There also seems to be an adequate, if basic, range and supply of

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psychotropic medication.

5 - There is little attempt at ward management regarding the social, psychological and rehabilitation needs of patients. No varying regimes for different groups of patients have been implemented. This could be done for the acute and chronically mentally ill, as well as the mentally retarded. At the moment, all wards have a number of mentally retarded patients who tend to respond better to a structured routine. This usually features opportunities for education concerning the skills of daily living. For this to be successful, such an environment would need to be created on one ward.

While there may be management reasons for keeping the more able patients scattered around different wards in order that they may help with cleaning and caring for less able patients, it would seem fairer for them if they could live in a more open and independent environment, even within the hospital.

CHAPTER SEVEN

THE PATIENTS' EXPERIENCE

Officially, hospitals exist to serve the patients. They are the justification for all action taken by the staff and the rationale for the entire organisation; yet such studies as exist of mental hospital services in China say little or nothing about the patients' perspective. Patients exert very little power and their voices go unheard.

To give patients an opportunity to express themselves publicly is difficult. Staff are wary for fear of what might be said about the hospital and the people who work in it. Patients are wary for fear of reprisals from the staff if they speak too freely. Sometimes they have been locked away for so long, and are so institutionalized, that they are not able to express their needs. Sometimes, but by no means as often as one might think, they are deluded and incoherent. None of these factors are sufficient reason for not trying.

A triangulated approach was found appropriate in trying to build as complete a picture as possible about the patients' lives and opinions. The ones selected were chosen because they were achievable.

1) data from patients' files; although these are not the authentic voices of the patients, they do provide a sense of both individual experience and how the wider political and social environment impinges on people's lives. The histories are taken

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verbatim from the files and are presented as found other than for a little grammatical rearrangement.

Information about the patient's previous life contained in a file is the product of at least two processes of selection. First, such information is based on interviews with the accompanying relative, or danwei representative, not the patient. So material provided relies on what the interviewee knows about the patient combined with what is thought to be important. Second, out of what is said by the relative the doctor taking notes is going to select what he 'hears', and what he thinks is important or relevant. The resulting story is very much a 'constructed' one.

It should be borne in mind that these are a selection of the more detailed histories and contain the sum total of knowledge remaining about the patients. For many patients, the files contained no background information at all. Comments on files since admission are usually restricted to phrases like 'poor hygiene', 'confused in thinking', 'will answer questions', 'hits and scolds other patients'. There is no further exploration of the self, feelings or experiences. The histories that have been chosen as illustrations have been selected because they are interesting and illuminate common experiences. They do not purport to provide explanations as to why patients became ill, or to be based on a random selection of histories

2) reports based on two group interviews: one with three female members of a service group, and the other with six male members of a service group. Attendance at the interviews was

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entirely voluntary, thus not all members of the service groups were present. Soft drinks and digestive biscuits were provided as a means of thanking the patients for their co-operation. These group interviews were jointly conducted by two research assistants, who were given guidance as to which areas to attempt to cover, but were asked to encourage the interchange to be as free flowing as possible. The research assistants wrote up their notes of the interviews immediately afterwards and this section is based on their notes.

The hospital put no barriers in the way of contact between patients and the research assistants. What constituted a severe restraint was the issue of time. It was hoped to conduct more interviews with patients on a third visit to the hospital at a later date. Sadly, this visit never materialised.

3) essays written by patients: The original intention of the essay competition was to provide all patients with an opportunity, if they wished to take it, to tell something of their lives. The title of the essay, ('The Story of My Life'), was left deliberately broad so that the patients could choose to write about those aspects which they considered important, without the imposition of someone else's categories or priorities. It also meant that they had the option to reveal or withhold as much or as little as they wished.

It was essential to choose a topic that would not appear threatening in any way to the staff, either professionally or politically. It was made very clear to the staff that patients

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should not be placed under any duress to participate. In discussion with staff beforehand we asked that they did not influence what patients chose to write about, emphasising that it was important, in order to understand more about the patients, that they were allowed to write what they wished. There were no obvious indications that influence was brought to bear on patients either to include or exclude certain things. However, this cannot be guaranteed. All essays are included in full in Appendix 1.

HISTORIES OF BLOOD AND TEARS

The Women;

Wong Tai

Wong Tai has been to hospital at least 11 times. The various hospitals would arrange to discharge her after the Trade Fair in the spring or autumn so that she would not give a bad impression of the city to visitors. Her misfortunes in life began when she was a child and her parents sold her to *an overseas Chinese couple* as an adopted daughter. She eventually returned to live with her real mother and started work in a sock factory weaving socks.

She made a free marriage and at first her marital relationship was good. Her problems started when her husband was sent away to another part of China to work leaving Wong Tai with four young children and her parents-in-law for whom to be responsible. In addition to this she had a very poor relationship with her husband's sister.

She started to hear voices and complained that someone put sand in her food. Wong Tai began to assault family members and destroyed furniture at home. All this culminated in her pouring petrol over her sister-in-law's house and attempting to burn it down. She was discovered, restrained and admitted to hospital. The ward notes say that she tends to hit other patients and shouts at them for no reason and describe her as having a poor attitude.

Yip Tai

Yip Tai suffered a high fever when she was 19, at the same time she was being courted by a boyfriend. She began to think about the boy too much, and the ward notes say that the combination of the illness and love affair triggered her first onset of schizophrenia. She received outpatient treatment, recovered but had several relapses. When ill she tended to scold heaven, hit other people, damage things and tear up clothes, which she would then mend when she recovered.

Yip Tai married, as she thought, and became pregnant but since her husband's danwei did not approve of the marriage they were not able to go through the official marriage ceremony although they lived together for three years. When she became pregnant the danwei leaders forced her to have an abortion at seven months. After that, she and her husband separated. Her mother also suffered from mental illness and was admitted to Fong Tsuen. On one occasion after discharge Yip Tai's mother wandered off, did not come back and was never heard from again. So once her father died there was no one to care for Yip Tai. She was having to live

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on welfare money from the government, and was therefore admitted to this hospital.

Ho Tai

Ho _Tai's_ illness was precipitated when her two children died within quick succession of one another, one from measles and the other from fluid on the lung; and her husband divorced her. She began talking and laughing to her self, behaving bizarrely, drinking dirty water, not eating properly and cutting her clothes down to a children's size. Ho _Tai_ had to be looked after by street level cadres, and as she was financially dependent on the government, she was admitted here.

Lai Siu Je

Lai _Siu Je_ became ill in 1966 with no apparent precipitating cause. She talked and giggled to herself and scolded others. She often deliberately harmed herself, beating her own head and chest. Sometimes she cut up clothes with scissors. She broke a window and a water standpipe, and frequently left home for ten days or more without telling any one where she was going. She would stand in the road and block the traffic. She began to have sexual relations with men and became pregnant twice. The street level association decided that she must have abortions. The patient was not co-operative during the operations and damaged the operating theatre equipment. Her mother died and her father was too old and weak to look after her, so she was sent to this hospital.

Poon Tai

Poon Tai's first episode of illness was in 1960. She married in 1963 and gave birth to a daughter. Then her husband disappeared and deserted her. In order to support herself and the child, she took a job in the market where she met a man. Their affair was discovered when she became pregnant and kept the baby. She was severely criticised by the leaders. She began to sleep all day and wander around at night singing loudly. She also started to assault others. Other than mentioning that her brother also suffered from mental illness, her file gives no more details.

Kwan Siu Je

When the Cultural Revolution was at its peak, the class background of Kwan Siu Je's family was investigated. She found this experience very stressful and became agitated and restless. She burned photographs and her Red Guard sleeve badge on her bed. Gradually, she became more and more withdrawn, refusing to eat or sleep and eventually was admitted to hospital for six months. Since then she has had eight admissions to hospital. Before her last admission to this hospital she became elated and sang lyrics of her own invention constantly, the contents of which were 'low taste and dirty'. She took knives and scissors from her factory which worried other people although she never threatened any one. Then Kwan Siu Je went back to her old school, saying that she wished to marry her erstwhile form master. Her family then applied for her to be admitted to this hospital.

The Men

Lo Saang

Lo Saang's illness started in the Cultural Revolution, although precipitating factors are not known. It began with him talking to himself, shouting revolutionary slogans, writing big character posters, talking about political matters the content of which was reactionary. He was taken to a psychiatric hospital by officers of the public security and treated for six months. After he was discharged, the patient refused to take medication and his mental state fluctuated. By 1979 he was quite stable, and was given a licence to open a stall in front of the city level Finance Department in Guangzhou mending metal utensils. When his mental state was unstable he would talk to himself as he sat by his stall, and write big character posters which he would stick on nearby walls, mostly concerning political events that happened in the Cultural Revolution. Lo Saang claimed that people put electricity in him and tried to persecute him. His business was not successful and closed down after several years, mostly because he lost people's pots and pans. After that, he lived on government welfare handouts. Because Lo Saang was acting strangely in front of the Finance Department, it affected the 'tidiness' of the street so the Public Security Bureau brought him to the hospital by force.

So Saang

In 1960, So Saang was sent home to his family from the university where he was studying because they said that he had become

mentally ill, although no details were given. He was admitted to Fong Tsuen hospital and, once discharged, worked as a teacher for two months. He could not cope with this job so he went back to live with his parents. So Saang relapsed and was admitted to Fong Tsuen again, and over the next few years was in and out of the hospital on at least seven occasions. Eventually, they pronounced him cured and he was sent to a village to work as a teacher, which he did for a year until he relapsed. He was admitted to hospital, treated and sent home.

This time he was sent to a village to work on a farm. He relapsed again, becoming incoherent, shouting reactionary slogans, saying 'down with ....' and naming political leaders at city and provincial levels whom he did not like. He claimed that he was a 'central' leader, and that he had authority over the city and district level leaders. So Saang also claimed that he had over 150 mistresses. He was very disturbed at night, shouting and gesticulating. He hit other people and damaged property and then tried to kill himself. He refused drugs, assaulted a female comrade and went into the women's toilet. All in all, his behaviour affected social security adversely and he was admitted to this hospital.

Ma Saang

The origin of Ma Saang's illness is not known but in 1975 his condition deteriorated and he wandered off to the main street, talking incoherently, hitting passers-by, halting traffic. He started fires at home and burned his own clothes and mosquito net.

Ma Saang also seriously wounded his father with a chopper. He wandered the streets begging for food and money, and then assaulted a woman. According to the file 'he affected social security with very, very bad consequences'. During the Spring Trade Fair, and at the request of the family, he was admitted through the Public Security Bureau into this hospital.

Keung Saang

During the period before 1949, Keung Saang was a leader of a sabotage unit fighting against both the Guomindang and the Japanese. In 1952 he began to work for the Land Reform movement. In 1953 he fell in love, but the Party objected to the relationship and he started to manifest abnormal behaviour, talking and laughing to himself, failing to look after himself properly. He managed to keep his job until 1960. Then he started to deteriorate further, refusing to bath, picking up food from the streets. However, he did not have his first admission until 1966 when he stayed in hospital for six months. After he was discharged, he refused to take medication and his symptoms returned. For the next 20 years he lived mostly on the streets, wandering from place to place in Guangzhou. Once his mother died he became even worse. As there were no other relatives he became the responsibility of the social security system and, as he was getting old, they decided to admit him here.

Chan Saang

Chan Saang married in 1973. Sometime later he began to suspect that his wife was having an affair which led him to request a divorce. Attempts at reconciliation on the part of the danwei leaders failed. Soon after the divorce Chan Saang started to behave strangely, crying and laughing loudly, so he was sent for treatment at Fong Tsuen where he stayed for two years. After discharge, Chan Saang went back to work at his previous danwei, where he showed a good attitude towards work and was responsible and efficient. In 1985 the man who lived on the other side of the partition in his room got married. Chan Saang was upset by this and within three days he relapsed, walking about the courtyard at night naked. The case record specifically says that he did not chase women, and also that he still continued to take notice of the danwei leader. He was treated at the danwei clinic with chlorpromazine.

In 1986 Chan Saang fell in love with a woman who worked in the same danwei. He bought her a pot of flowers and wrapped them up in a red cloth on which he had written 'I love you'. The woman refused to accept Chan Saang's gift, and he relapsed again. At this point he was sent back to his village of origin for treatment. Then, without permission, he left his village one day and went back to his work unit to request them to give him back his job. While in the office he began to stare at three women visitors and refused to leave when requested. That night he took off his clothes in public. The danwei decided that he could no longer be managed and he was sent to the hospital.

Lau Saang

In 1965 Lau Saang was 'mobilised' as part of the policy to send city youths down to the countryside to learn from the peasants. He had been an apprentice in a factory and was very unwilling to go and work on an orange farm. In 1968 his city residence permit was revoked and, with other city youths, he returned to Guangzhou to ask for the permits to be re-instated. This behaviour was strongly disapproved of by one of the local Red Guard factions who chased them.

When Lau Saang returned to his village he was speaking and behaving strangely. He was sent to the local psychiatric hospital for treatment and attacked a doctor. Later, the commune sent him back home to his family, at which time he was demonstrating flat affect and did not want to do anything. He refused to take any advice from his family members. Then he bought cartoon books and stuck them on the wall of his room, and hung posters of women inside his mosquito net. He started to laugh to himself and would cry out 'ghost'! very loudly two or three times in succession. He was admitted and discharged from Fong Tsuen three or four times, but would stop taking drugs once at home. After he was discharged in 1982, his family locked him inside the house because he caused such a disturbance in the neighbourhood, throwing rubbish into the next door neighbour's house and destroying property at home. The neighbours complained about him; Lau Saang started to talk about committing suicide, so his family brought him to the Guangzhou Hospital.

Fung Saang

In 1958, Fung Saang, a Guangzhou resident, was allocated a job on a farm in Hainan island. Initially, his work performance was good, and after work he took an active interest in sports, arts, music and cultural activities. After about two years of working on the farm, he and a female colleague were sent to Guangzhou to study. They fell in love, but in 1962 their friendship finished. Fung Saang's behaviour began to change. He started to damage other people's belongings, became hot-tempered and excitable. He talked and laughed to himself and thought that people were trying to harm him. Fung Saang often refused to stay in his quarters and would wander off. Often he walked quite far, trying to get back to Guangzhou. Whenever he visited his older sister he would scold her. He played with fire and was often involved in criminal damage and assault. Sometimes he was beaten up by others. Fung Saang's behaviour disturbed the neighbours. His illness fluctuated because he would not take medication, although he had been taken to the out-patients department of psychiatric hospitals in Guangzhou and Hainan. In 1975 he married a woman from Jiangxi province. However, the marriage only lasted two years because, when she found out that Fung Sang suffered from mental illness, she left him without leaving an address. Their son is now cared for by Fung Saang's sister.

The areas that the research assistants were asked to cover with patients were as follows:

- Have they been in other hospitals?
- How do the hospitals compare?
- Are they taking medication?
- Do they know what they are taking?
- Do they find it helpful?
- Have they ever had any other sort of treatment in this hospital or elsewhere?
- What sort of things do they do each day?
- Are there any special events during the week (e.g. a film night)?
- How has the hospital changed since they have lived here?
- Is there anything that they would like to see changed?
- What is the most memorable thing during their stay in hospital?
- Do they still have contact with friends and relatives?
- Do they ever think about discharge?

The first group to be held was the one with male patients. In retrospect, the dynamics of this group were agreed to be more difficult than those of the female group. A number of factors are likely to account for this. The two research assistants said that they felt more tense in the male group as it was the first one. At least two patients clearly did not like each other, which led to sharp interchanges and some silences. Two staff members, a nurse and the head doctor from the patients' ward, joined the group after it had begun, and it was also interrupted by the Medical Director coming into the room to search for his notebook.

There was a very dominant member (Lui Saang, see essay 1) whose admiration for the hospital, and constant defence of it, made it difficult for the others to express their opinions freely. Lui Saang was not popular with the other patients, many of whom remained very quiet unless directly addressed. Lui Saang and one

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other patient were two of the original patients, and had been involved in building the hospital and the holiday camp. The other patients varied in length of admission from 6 years to six months. The most recently admitted patient said that he had been tricked into coming to the hospital by his relatives, who had told him that they were going to visit a local beauty spot.

The jobs that they do on the ward mainly involve fetching water for collective bathing and ward cleaning. Almost all of them know what medication they are taking, (chlorpromazine), although Lui Saang said that doctors are reluctant to explain anything about medication to the patients. As for special events during the week, they reported that there were none and that, if you are in hospital, then there is nothing memorable to recall.

Many of them had also been in Fong Tsuen hospital at some time in their lives. They did not think that there was much difference between the two in terms of routines, but were agreed that the food in Fong Tsuen was better. One of the patients complained very bitterly about the food once the ward head doctor joined the group, saying that it tasted like grass. Lui Saang became visibly embarrassed and protective of the hospital. Lui Saang felt this hospital had the advantage of having more grounds, as there is no garden at Fong Tsuen.

All the patients were single, and five of them were 'three have nots'. One said that he had lived with his father and sister. Most of the patients said that they wanted to leave but had no plans for the future. One who was a teacher wanted to return to his

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danwei. He had requested discharge for a long time, but had not been granted permission. [It was not clear whether the problem lay with the hospital or the danwei].

Lui Saang had been discharged eight years ago. He enjoyed what was, to the other patients, the very dubious distinction of being the only patient to be discharged from the hospital who had voluntarily requested to come back, (because he thought that he was 'getting crazy' again). The other patients made it quite clear that they thought that for this reason, if no other, he was justifiably diagnosed as mad.

Lui Saang described his experiences outside the hospital. For five years after he was discharged, his neighbours called him a 'nutter', and were unpleasant to him. During the last three years this behaviour stopped. He is proud of being the only person ever to ask to come back.

The interview with the women was less constrained. This may have been because there were fewer of them, they were friends of each other and because this time it was decided to ask staff to leave. Two of the patients were self-pay and one was a 'three have not'. The first two had been in the hospital for two years and the latter for 15, since it opened. All had had experience of Fong Tsuen, or its subsidiaries, before coming to the Guangzhou Hospital. Keung Siu Je said that she had been tricked into coming to the hospital by the Medical Superintendent and another staff member, who told her that they were taking her to a factory to find work.

All three knew that they were taking chlorpromazine but had been given no explanation as to why by the doctors, other than that they must because they were ill. Keung Siu Je said that she did not like taking medication because, for her, the side effects were very burdensome. Consequently, she had relapsed six times and had spent most of the last ten years in hospital. Sometimes Keung Siu Je managed to throw her medication away, but if you refused drugs, or the staff discovered that you were throwing them away, they would insist that you take them. If you continued to 'stubbornly refuse', they would hold you down and force the medicine down your throat.

The patients reported that drugs are the most frequent form of treatment. Sometimes the staff will use electric-acupuncture for 'naughty' patients, although none of them had ever experienced it personally, but had seen it being given. Again, none of them had had ECT but commented that those who do say it is very painful.

As service group patients they are expected to work, which in their case means cleaning, sweeping and washing the rooms of the incontinent patients. Keung Siu Je said that she would prefer a lighter job, that she thought there was too much hard work. She would rather do without the one yuan she earns. Han Siu Je earns 5.50 yuan because she does more work. The 'odd job' nurse used to take them out once a month locally, which they enjoyed, but it is now more like every three or four months. They have had one outing to Guangzhou, (to the zoo), which they liked even though it was raining.

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They commented spontaneously on physical brutality, mentioning particularly 'Auntie Cheung', one of the domestic workers on their ward, who frequently hit patients with a broom handle or the cane attached to the duster. Yeung Siu Je had been hit by a staff member, a nurse, in the hospital because she had wanted to continue to watch television one night. They said that at Fong Tsuen staff did not beat the patients. Doctors were somewhat different, at least on their ward, where they were kind and showed care and concern for the patients.

They agreed with the men that the food at Fong Tsuen was much better. There they had soup twice a week and more variety of vegetables. Here it is mainly vegetable marrow in the summer and cabbage in the winter. Only those on a special diet receive soup.

Keung Siu Je said that there are fights between patients almost everyday on the ward. There was one incident where one patient hit another with a chair and the injured patient developed a hemorrhage and died. She thought that, if you were willing to give in, it was possible to avoid fights, especially if you did not care about getting food or medication quickly.

All three patients have relatives. Han Siu Je's parents are dead but she has five children, some of whom visit occasionally. Yeung Siu Je has a father and younger brother but they do not visit. She used to work in a textile factory. Keung Siu Je used to work as a clerk in the Bureau of Public Health and her family sometimes takes her for home leave. She feels very guilty about placing a burden on the family's finances because they have to pay her

hospital fees.

When asked about what changes they would like to see in the hospital, they could not relate this to the ward routines. The only improvement they could think of that had taken place in the hospital was that the appearance of the wards and the gardens over the years had improved. They all wanted to be discharged and go back to work, or in Han Siu Je's case, to live with one of her children. Keung Siu Je said that she was ready for discharge and the doctor had given permission. The hospital had written to her father and asked him to take her back, but he had refused. She supposed that this was because she relapsed so frequently.

THE ESSAYS

Given that the goal was to find out more about the patients' experience of life the results were somewhat disappointing. Out of 31 entries, 21 were short - less than 20 lines. Of these, about seven were very short, or about five lines or less. Nine were in the form of, or included, a poem. One was written as a letter to me. Only one was clearly based on phantasy (number 11), and another three, (numbers 31, 22, 25), one of whom signed himself Sun Yat Sen (number 31) showed evidence of mental confusion. All the rest, even if rather short in some cases, were coherent.

Only ten of the essays contained predominantly personal material that was not wholly centered around life in the hospital, for instance cataloguing schools attended or occupational record. Thirteen of the essays largely centered on matters to do with the

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hospital, although some of these were personal in the sense that they contained often poignant feelings about the individual's situation. One essay in this section (number 23) was entirely devoted to an enthusiastic description of the hospital gardens. Eight of them had nothing to do with the topic at all. Of these, one described the development of construction projects over the last 30 years in Guangdong (number 30); number 21 was a poem for National Day (Oct. 1st., a few days before the competition was held); number 12 was also a poem with no easily described theme; number 18 was largely a description of the hustle and bustle of Guangzhou; number 11 concerned a phantasy about a visit to America as an important diplomat. It was difficult to detect any special theme in numbers 25, 22 and 31. Clearly, for many of them the story of their life was the story of their life in the hospital.

EMERGING THEMES

The Patients and the Party

'We have turned a new page in our lives. Now we can lead a happy life. It is all due to the correct leadership of the government and the Party. I am thankful for the care and concern of the Party with all my heart. I turned out to be nothing even after years of cultivation by the Party. In contrast I became a burden to the country. I feel so ashamed of myself that I want to hide my face. I regretted that I didn't obey the assignment of the Party in the past. If I could work after discharge in the future, I will work hard and listen to the Party, serving the people with all my spirit....In doing so I could pay back the government, the Party and the people for their concern towards me'. (A female, divorced parent, essay 2)

'The great, glorious and correct Chinese Communist Party, the great People's Republic of China, they loved and cared for the crazy sons and daughters down to the very last detail. They sent the crazy sons and daughters to hospital for treatment'. (Essay 29, no biographical information)

'I am extremely grateful for the care given to me by the government and I will settle and recuperate without second thoughts'. (50 year old, single, male, essay 3)

For a Western reader, one of the more surprising features of the essays is the number that include some positive reference to the government and the Party, and a wish to contribute to building socialism in the country, or to contribute to the country generally. Politics is clearly a widely accepted reference point for these patients, whose conception of their government and the Communist Party is a very intimate one.

The immediate analogy that comes to mind is the one of a rather authoritarian, but benevolent, parent and a wayward child. The government looks after its citizens in a direct way and in return they are expected to contribute to the development of the country. It may be that because the patient population is predominantly middle-aged we are dealing either with people who saw the Communist Party make significant gains in improving the quality of the lives of the people; or who went through the period of the Cultural Revolution, where every effort was made to shatter familial identity and replace it with allegiance to the Communist Party. It is impossible to answer the question of whether or not the patients believe in what sounds to a Western ear like political jargon. They may say it because they genuinely believe it, or through intelligent self interest, or simply out of habit because that is how all people are expected to express themselves.

'In the hospital doctors and medical staff showed a lot of concern and care... from an unemployed youth, I became part of society. This is inseparable from the concern shown to me by Dr. Leung. He showed consideration to me in every aspect. He is really a doctor who treated patients with a parent's heart. (Young man, admitted because of family discord, essay 17)

'Celebrate the Number One Education Home
Praise our Motherland
The Number One Education Home changes every day
With green leaves that look like velvet carpets and pavilions
People coming and going. The air is fresh
To build the Number One Education Home as pretty as a picture
Our Motherland will be prosperous and strong'.(Essay 15, no biographical information)

'I really want to fly over the wall and go back home....I dare not think about my situation. How can I carry on with all this suffering? Alas nobody knows how I feel and understands my sorrow'. (A middle-aged female patient, who was one of the original residents transferred from another hospital when this one opened, essay 5)

'In the mental hospital doctors and nurses cared for us with serious words and thoughtful hearts. I heard and saw doctors and nurses call out daily 'take your medicine', 'take a bath', 'go to work', 'people upstairs come down to lay the table', 'room check'. Their voices were so cordial. They were really thinking of us'. (Essay 29, no biographical information)

One third of the essays either expressed liking for being in the hospital, gratitude towards the staff for the care they were shown or generally commented on the virtues of the hospital. This is a small number out of a total of 640 and is clearly not random. Even so, in comparison only two, (numbers 5 and 14), showed clear despair or despondency. One interpretation of the positive response to the hospital is that it reflects the level of institutionalization; that in Goffman's terms, patients are 'converted', (like Lui Saang) or 'colonised'. Yet, it is possible

that this is too cynical a view. For those for whom life has been
a constant struggle, somewhere that protects, feeds and clothes
them may be a preferable alternative to what they have experienced
outside the walls. And Lui Saang's evident unpopularity with his
fellow patients suggests a certain degree of scepticism among at
least some of the others.

The final extract quoted above gives the only example of direct
staff-patient communications as patients experience it. The
patient uses it as a demonstration of caring. Yet all the phrases
are commands and they all express the controlling function of
staff over patients' lives. Not one of them is an enquiry into
well being, either physical or mental. From a Western point of
view this appears significant, but perhaps the meaning is
different in the Chinese context.

Hospital Conditions and Work

'[My job included] cleaning several wards, single rooms,
toilets, intensive care unit and drains etc... I took the broom
and several other patients carried water. It was like this every
day.....It was hard work for me because I was not brought up in a
worker's family......At first we were allowed to go out to buy
things or to go for a walk with permission; that was a happy
thing. But it is not allowed any more. I don't know why. I saw
that patients were allowed to smoke in male wards but not female
wards. I am not happy at all..... I was just being locked up and
made to work hard'. (Essay 5)

'I feel better after coming to the mental hospital. I am not
as bad as I was at home. I had a good rest as well. I work in the
hospital and feel very happy'.(Essay 9, no biographical
information)

'I joined the service group in the hospital and did cleaning
every day which makes me healthy'. (Essay 13, a homosexual
university entrant)

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'Life was very simple in the hospital. It was not as good and refined as life at home'. (Essay 7, a woman who wishes to observe 'the five standards and the four beauties' - see Appendix 3)

'Work includes both mental and physical work. Personally, I think it is more appropriate for mental patients to engage in physical exercise'. (Essay 1, the only patient to ask to be readmitted)

'On both sides of the path there are many magnolias and you can smell the sweet fragrance of the blooming flowers. There is also a goldfish pond with pretty goldfish in it. It gives the hospital a feeling of tranquillity and elegance'.(Essay 23, wholly devoted to gardening matters)

'Once you get used to the food in the big cities, I found the food in the Number One Education Institute too bad'. (Essay 27, a menu from 40 years ago)

Patients rarely commented on the physical conditions of the hospital, possibly because in many ways they were similar to what they had been used to. The selected comments indicate that there is a range of opinion among patients concerning the regime in the hospital. Almost no one mentioned anything to do with direct treatment. What comments there were focused on issues to do with daily occupation, usually in terms of whether or not patients should work and whether, overall, staying in hospital was felt to be beneficial.

Family Relationships

'We had three adults in the household and my elder brother was the only breadwinner'. (Essay 28, a man with a very fractured work record)

'Parents must be very sad when they faced their crazy sons and daughters and found that they were helpless'. (Essay 29, no biographical information)

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'When my daughter was seven or eight years old, I couldn't earn enough by just selling junk. Hence I started to beg and sing on the street together with my daughter. When my daughter had reached the age of nine, we started to work as shoe shine and shoe repair workers. In the summer we sold newspapers. Later on I developed a tumour and had to depend on my daughter who carried on our trade repairing and shining shoes and selling newspapers.' (Divorced mother, essay 2)

'My family haven't visited me. They have not agreed to my discharge......I came from Guangzhou but I don't think the leaders here have tried very hard to find out the whereabouts of my family. If only I could go back home I would be grateful'. (Essay 5, a middle aged, female patient, one of the original residents, transferred from another hospital when this one opened.)

'I feel very sorry that I have been abandoned by people in the community and by my work unit'. (Essay 14, which expressed much sadness and despair)

Families do not constitute a lively presence in the pages of these essays. They are more remarkable by their absence. This may be accounted for by the many years that patients have remained in hospital; that most of them have had a long history of admissions to hospital, often under circumstances that will have created a burden for families, and would have broken or severely stretched all but the most resilient of family ties; and the remote location of the hospital that makes visiting arduous.

The essays indicate that some patients were aware and regret that they were a drain on family resources in a number of ways. For others the sense of having been abandoned is very acute, made even more so by the realisation that without family support they have very little chance of ever being discharged. For others, for instance the woman who left her husband to live 'in love and sweet happiness' with the 'most beautiful boy' in the district, (Essay

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24), it is as if the years have not gone by. This woman's hopes of living again with either husband or lover have not faded, even though there has been no contact for many years. There is probably little else than dreams to comfort her in her present situation.

Life Before Hospital Admission

'I became mentally ill when I started university. It was because of homosexuality that has ruined my life and made me spend a long time in hospital'. (Essay 13)

'[After discharge from the hospital] from a 'nutter' I became a normal person, an editor of the factory newspaper in the Guangzhou printing factory.....[to explain the relapse] I had been working continuously for three months, finishing duty after duty, for example preparing for inspection by the deputy mayor, working on the newsletter competition, preparing a bulletin board for festivals, organising a street exhibition etc. As a result my eating, sleeping and drug taking habits became irregular'. (Essay 1, the only patient to request re-admission.)

'After graduating from teacher training college I was assigned to work as a teacher for two years. I got neurasthenia and the organisation transferred a group of teachers suffering from neurasthenia to another danwei to work I was sent to work as a cashier in a Chinese herbal shop. At that time I was young and would just do things that pleased me. I refused to go as I thought it would be boring sitting down all day. Again I refused to go to work in the New China bookshop because I thought there's nothing technical to learn and the wage was low. And I refused to work in the kindergarten as well. The Education Bureau then transferred me to work as a temporary worker in the street service station. I lost my temporary job after I divorced my husband'. (Essay 2, a divorced parent)

'The Cultural Revolution started when I was in Form 2 of secondary school. I stopped going to school and stayed at home. Through the neighbourhood committee I worked as a temporary plasterer sometimes. I had not joined any Red Guard organisation. At the age of 18 I joined the call of the country to 'go up to the mountain and down to the village' and joined the Red Army production team of a commune in Hainan Island and participated in the construction of socialism. In 1970, I had an appendectomy in the commune hospital and after the operation had insomnia and was diagnosed as neurasthenic by the doctor. Because I didn't get proper treatment, it developed into mental illness'.(Essay 4, a

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male patient whose father was wrongly categorized as a rightist)

Patients' backgrounds are quite varied, and illustrate the ways that larger issues become entangled with individual lives. Many of the patients were 'touched' one way or another by the Cultural Revolution, although not many of them discuss its effects in their essays. The issue of the lack of life choices particularly over the matter of employment is very common. The woman quoted in the third extract paid heavily for her intransigence by eventually becoming a street sleeper. Many of the patients were sent from Guangzhou to rural areas to work on the communes. Some chose to go, most were forced. All were disrupted.

Hopes For the Future

'I want to be discharged soon. After going home, I will obey my father and my mother. I will not hit my grandmother or any one else. I will help my mother and father to do housework and will never go back to the hospital again'. (Essay 20 in its entirety)

'I saw on the television one day that the people and the street office of Bing Kong street take care of the invalids and can make them independent. My suffering is beyond expression when I saw this and compared it with my own dependency. I don't know when I can achieve the goal of being independent. I am not able to discuss this with either the hospital or the work unit. The committee of the work unit don't come to visit me any more....I can only see others successes with sorrowful eyes. I just wish God would let me die soon'. (Essay 14, a woman who describes herself as an unwilling invalid because of her illness)

'I am a lunatic. I am very careful at work. I've been waiting a long time for a job'. (Essay 6, an ex-model worker in a medical machine factory)

'When I am discharged I must treasure my own clothes and not destroy them, or I could give them away generously. If I could be discharged, then from now on I must respect my parents and younger sister. I have to strictly demand myself to have high expectations of myself'. (Essay 7, the 'five standards and the four beauties')

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The future is not the major orientation in these essays. Even those who mention discharge do not look far beyond the moment they are free to walk onto the ferry. I have observed the same phenomena with long term patients in Broadmoor Hospital and with prisoners. They have been too long away from the ordinary world to be able to conceptualize living in it realistically. Nor do they have access to the knowledge and resources they need to formulate realistic plans.

It is perhaps too much to expect the Guangzhou Hospital patients to have plans when they are very used to having others plan for them, as is the custom, mentally ill or not. Also they know that their fate does not rest in their hands and is, in a sense, independent of their behaviour, resting as it does on someone else's willingness to look after them and take responsibility for them. Most of them know that realistically there is no one there for them in that respect. Some look back to the past. For others that is too painful. The present, however imperfect, is probably the safest option.

CONCLUSIONS

1 - One of the themes that comes out very clearly is how little control people have over the course of their lives, at least in comparison with what would be considered normal in Western countries. Either families or officials make decisions about work, residence, fertility, marriage and opposite sex relationships generally. It is one thing to read about these issues as matters

in policy statements, but the histories give us information about the havoc such policies can wreak in, at least some, lives. When one combines this with the deeply institutional nature of the hospital, and the lack of knowledge that patients have about alternatives, it is unsurprising that some patients find it hard to think of improvements to the ward routines or think little beyond the day when they are free to leave.

2 - While it is possible that informally in their daily dealings with patients doctors behave differently, what they record in the files shows no psychological insight. The life histories indicate a singular lack of curiosity about clues to the issues that are important for individual patients. It would be accurate to say that the histories sometimes identify areas that one might, (in other circumstances), expect to be followed up either overtly in counselling, or at least to inform greater understanding of the individual. Ho Tai, after the death of both her children, begins to cut down her own clothes to children's size. Chan Saang is clearly affected by his inability to establish an emotional and sexual relationship with a woman. But their behaviour is treated wholly as part of their symptomatology, rather than as significant indications to important aspects of inner meaning, which in turn could be useful in the healing process.

3 - With some notable exceptions, patients tended to reveal little of themselves through the essays. Perhaps it was unrealistic to hope that they would. The expression of individuality is not encouraged in China and within the circumstances of the hospital it may well be a protective device

to keep feelings locked deeply inside. Others may have been in hospitals for so long that the process of the illness and institutionalization have gradually erased memory and identity.

4 - There is a very strong emphasis on the will of and control by the Government and Party. While this emphasis on the Government and the Party grates on the Western reader, particularly the patients' tendency to thank the Party and blame themselves, it could also be argued that there is a kind of respect demonstrated in treating psychiatric patients like every one else in terms of political indoctrination, and not using two different standards for the sane and the insane. Normalisation involves replicating conditions for the disadvantaged that bear the closest possible resemblance to normal life. In the Chinese situation, that includes the expectation of making politics part of your everyday thinking.

5 - The work ethos is very powerful in China. (see Chapter Two) This is not so much in the expectation to work hard, but that work defines a person and gives him access to a social identity and resources that he would not otherwise have. Some patients seem to value being able to work. Others view it as forced labour. Several of the essays mention a fear of becoming a 'useless person'. What are the ethics of the situation?

A number of the patients are being required to work as virtually unpaid cleaning staff, performing duties, like scrubbing out the rooms of incontinent patients, that are not popular with other staff. The hospital, if asked, would probably justify it in terms

of it being good for the patients' 'rehabilitation', and as a contribution to offset the money that the government is spending to keep them in the hospital. The hospital is there to serve the patients but the patients are there to maintain the hospital.

6 - Many of these patients would not need to be in hospital if community services existed. The evidence from the essays and the group members indicates that they are able to work, think coherently, write logically. This does not mean that they may not relapse for a time in the future, but the reason that they are in hospital currently does not rest with their mental state, but with the social and family conditions that pertain around them. Their continued incarceration is a product of a lack of supportive and responsive services for both themselves and their families, combined with the policy consequences of resting care solely on the foundation of family, at once immediately disadvantaging those who are effectively without families.

7 - The question is raised, particularly in the essays, but also to a lesser extent in the groups, as to what extent the patients are self-censoring. They were aware that staff would read the essays and staff were present in the male group. Thus some of the messages may have been for a staff audience. For instance, patients who are promising to respect their parents and not hit family members if discharged, or saying that the food tastes like grass are probably not primarily addressing the research worker!

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8 - The more difficult issue for the reader is the temptation to believe the negative things, like the brutality of some of the staff, the misery of some of the patients because it is what we would expect; to question the genuineness of patients' statements about caring staff or basic contentment with life in the hospital because to us it seems unlikely. Ultimately, we have to accept what we are told, while constantly bearing in mind that variable opinions are likely; that experiences vary from ward to ward; and that patients in their turn may be maximizing opportunities to influence. The research relationship is not a one way process.

CHAPTER EIGHT

A STATISTICAL COMPARISON

My research was never intended to be a full blown comparison of the English and Chinese mental health services. The English policy and services have been extensively reviewed and there seemed little point researching such well trodden ground. However, much less is known about the long-stay psychiatric patients in British hospitals. Thus comparing patients in my Chinese sample with patients in a similar position in the U.K., has the advantage of illuminating the situation of both, and giving a comparative perspective to the Chinese information. The original intention had been to find a hospital in England whose patients closely approximated the characteristics of those in the Guangzhou Hospital and to collect original data. This proved not to be possible in the time available. An unforeseen consequence of the policy of discharging the long-stay populations of psychiatric hospitals proved to be that the patients remaining in hospital tended to be much older than those in the Guangzhou Hospital, and were therefore not comparable.

With the kind co-operation of Professor Julian Leff, access was granted to the Team for the Assessment of Psychiatric Services (TAPS) database. While the concerns of the two projects were not precisely co-terminous, they were sufficiently similar to make comparisons possible on a number of significant variables. The TAPS data concerns the long-stay patients at Friern and Claybury Hospitals in London, both of which are destined for closure. The

purpose of the TAPS research is to evaluate the effect on psychiatric patients of this major change in their mode of care. In order to do this, baseline data had to be collected on each patient, and it is from this baseline that data has been extracted to be included in this current project. Both samples concern long-stay patients from a large metropolis, giving more point and reliability to the comparison.

Thus the data set out in this chapter is based on two data-sets of patients in psychiatric hospital aged 16-60, with a firm diagnosis of schizophrenia. One is drawn from the Guangzhou Civil Affairs Bureau Psychiatric Hospital and consists of a random sample of 147 patients taken from a population of 460 who fitted the criteria in terms of age-range and diagnosis. This data-set was collected by the present writer in September-October, 1988. The coding sheet is reproduced as Appendix Eight.

The data used for the purposes of comparison is drawn from the TAPS survey carried out, (between 1985-87), by a research team from the Institute of Psychiatry in Friern and Claybury Hospitals, north London. This comprises all patients meeting the selection criteria, a total of 271.

For ease of reference, the two data-sets will be referred to as 'GZ' and 'TAPS' throughout. Main figures given are in percentages of the samples, with actual numbers in parentheses. The mean and the standard deviation ʌ unavailable for continuous variables in the U.K. data. Thus it was not possible to perform the more sensitive T-tests and analysis has been restricted to chi square of grouped

categories, and the comparison of proportions. Statistical analyses were performed using SPSS-pc.

Table 8:1: GZ and TAPS:Gender of Patients

	GZ (n-147)		TAPS (n-241)	
	%	n	%	n
Male	66.7	(98)	63.47	(172)
Female	33.3	(49)	36.53	(99)
Total	100%	(147)	100%	(271)

No significant difference was found between the samples. It is immediately apparent that men predominate in both samples by a proportion of 2:1. Why should this be so? Williams and Spitzer (1983), the authors of DSM 3, have suggested three types of hypothesis to account for unequal sex ratios. Although their discussion involved depression their framework applies equally to schizophrenia. First, there may be a difference in true prevalence. However, it is generally accepted that this is not so. (Kendell, 1988) However, the 1986 epidemiological survey of mental illness in China consistently identified more women than men as diagnosed schizophrenic. (Shen Yu Cun, 1986) It seems unlikely that China differs from the rest of the world in this respect, but the issue requires further systematic study as to whether the difference lies in the true prevalence rate, or is being affected by other factors.

It is well known that there are certain differences between men and women in the way that they are affected by schizophrenia. It is quite clear that schizophrenia tends to develop up to six

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years earlier in men than in women and that more women than men suffer their first onset after the age of 40. (Loranger, 1984) Several studies have reported a worse prognosis, at least where hospital discharge rates are concerned, in men than in women (Kendell, 1988). Seeman (1982) reports that women have fewer relapses and are less likely to develop a chronic course. The International Pilot Study (Sartorius et al., 1986) found female sex to be the best predictor of a remittent, (versus chronic), course of illness and one of the five best predictors with respect to the percentage of follow-up time which the patients spent in a psychotic state. Overall, men do not respond as well to psychotropic medication, requiring higher doses of medication, which they do not tolerate as well as women; their long term adjustment as measured by such indices as social life, marriage, work record, suicide rate and general level of functioning is not as good as that of women. (Torrey, 1988)

To explain these differences, it has been hypothesised that estrogen may provide protection through a mechanism not yet understood, or that there may be two different kinds of illness involved, one of which tends to start later and have a more benign course and is prevalent in women; the other to predominate in men, with earlier onset and more damaging long term effects. (Seeman 1982; Torrey, 1988)

Williams and Spitzer's second hypothesis is that psychological variables affect the likelihood of seeking treatment and therefore being entered into the diagnostic data base. While this may be

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true the inclusion of only psychological variables is too narrow, when social ones would seem to provide more obvious explanations. This is particularly relevant if what we are trying to account for is an excess of men in the hospital, when according to Shen Yu Cun's research (1986), there is an excess of women in the population.

The role behaviour associated with being a housewife and mother is possibly easier to carry out than that associated with being a breadwinner, a success in the marketplace. Women's domestic survival skills outside the hospital are likely to be higher than those of men. Given the low rate of marriage amongst schizophrenic men, (see Table 8:3), once parents die men may have no effective family with whom they can live.

All these reasons probably hold true for the Guangzhou sample. In addition, there may be a reluctance to pay for medical care for women on the part of families in Guangzhou, who will keep them at home rather than pay for expensive treatment. Fewer women have the support of a danwei which might be expected to underwrite the cost of medical treatment. One Chinese doctor suggested that one of the reasons for the predominance of men over women, (a feature in all the hospitals I have visited in China), is that women feel a greater sense of responsibility towards parents, husbands, children and are consequently more reluctant to be admitted and tend to stay for shorter periods of time, (at least in the acute sector). Men on the other hand, are pleased to be relieved of work and tend to prolong their stays as much as possible. This may also have some relevance for the TAPS patients.

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William and Spitzer's third hypothesis concerns clinician bias in diagnosis. This is not an area that has been researched in China. On what is known, it is possible to argue that women, because they are less associated with violent behaviour may be more acceptable to families and after-care resources. Indeed, if aggression is one of the behaviours which is most likely to bring a person to the attention of the authorities, and lead to a diagnosis of schizophrenia, (as discussion later in this chapter suggests), it may well be that schizophrenia amongst women is consistently underdiagnosed.

Table 8:2: GZ and TAPS·Age Distribution

	GZ (n-147)		TAPS (n-271)	
	%	n	%	n
20<30	4.1	(6)	5.9	(16)
30<40	30.6	(45)	17.34	(47)
40<50	29.3	(43)	26.94	(73)
50>	36.1	(53)	49.82	(135)
Total	100%	(147)	100%	(271)

The age distribution for patients in the Guangzhou Hospital is significantly different from that in the TAPS data at the 0.006 level. Neither is a predominantly young population which is what one would expect in a hospital for chronically ill patients. The ages of the Guangzhou patients are quite evenly distributed between the 30s, 40s and 50s. The TAPS patients are bunched in the 40s and 50s. The major differences between the samples are in the age groups 30<40 and 50>. This presumably reflects different

admission practices, in that there may be a longer gap between the identification of illness and admission in the U.K. so that patients are older on admission. Another explanation is that the Guangzhou Hospital did not open until 1973 and while it accepted a number of chronic patients from the acute medical sector, there may simply have been insufficient time for its population to have aged.

Table 8:3(a): GZ and TAPS: Marital Status

	GZ (n=147)		*TAPS (n=270)	
	%	n	%	n
Never-married	61.2	(90)	76.58	(207)
Married	11.6	(17)	3.40	(9)
Widowed	2.7	(4)	3.69	(10)
Divorced	6.1	(9)	9.96	(27)
Separated	-		3.79	(10)
Not known	18.4	(27)	2.58	(7)
Total	100%	(147)	100%	(270)

* I case missing

Again the picture presented by the two samples is not dissimilar, and the similarity might be more marked if the numbers for whom there is no information were not so great in the Guangzhou sample. Clearly the majority of all patients are never married. Divorces are slightly under twice as common amongst the TAPS patients, and current marriage three times as common for the Guangzhou patients, although the figures for either marriages or divorces are very low.

Table 8:3(b): GZ and TAPS: Never-married and Ever-married

	GZ (n-147)		TAPS (n-271)	
	%	n	%	n
Never-married	75.0	(90)	78.71	(207)
Ever-married	25.0	(30)	21.29	(56)
Total	100%	(120)	100%	(263)
information unavailable		(27)		(8)

The people on whom there was no information in the Guangzhou sample are the truly sick and destitute for whom there may be a lesser likelihood of marriage. Thus the true never married categories could be virtually identical in both samples. A chi square test, computed with four cells, found no statistical difference. This picture is what one would expect based on international data on schizophrenia, which shows quite conclusively that patients suffering from this illness have a lower rate of marriage and fertility than in the rest of the population. (Kendell, 1988) The difference is more marked among men than among women as will be examined later in the chapter.

	GZ (n-147)		TAPS (n-271)	
	%	n	%	n
Parent	27.9	(41)	43.17	(117)
Sibling	19.0	(28)	29.89	(81)
Husband	4.8	(7)	3.32*	(9)
Wife	2.0	(3)	-	-
Other	2.0	(3)	10.71	(29)
Son/daughter	-	-	1.48	(4)
None	1.4	(2)	7.38	(20)
Not known	42.9	(63)	4.05	(11)
Total	100%	(147)	100%	(271)

* TAPS records refer to 'spouse' and do not differentiate

Both samples record members of the family of origin most commonly as next of kin; parents followed by siblings. This is to be expected given the low rate of marriage amongst patients. 43 per cent of the Guangzhou sample did not have the next of kin recorded on the file. There are two possible reasons for this. Either they have no one who can be named in this category, or the staff, for whatever reason, do not record it. There were a number of instances where some kind of information about a family member carrying out an active role vis a vis the patient was mentioned on the file, even though there was no recorded next of kin. It might also be that, on occasion, a family member accompanying the patient on admission refuses to act as next of kin and to give an address, thus effectively abandoning the patient to the care of the hospital. However, being given as next of kin is no measure of

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the amount of responsibility taken or care given to a patient. It

may simply be someone to inform in the case of death.

Indications of Chronicity

Table 8:5: GZ and TAPS: Current Length of Stay

	GZ** (n=146)		TAPS (n=271)	
	%	n	%	n
0<5	35.7	(52)	27.68	(75)
5<10	20.5	(30)	20.30	(55)
10<15	37.0	(54)	11.81	(32)
15+	6.8*	(10)	40.27	(109)
Total	100%	(146)	100%	(271)

** 1 missing case
* 15th. year only

This table reflects the fact that the Guangzhou Hospital opened in

1973. 64 per cent of patients in the Guangzhou Hospital and 72 per

cent of the patients in the TAPS project have been in their

respective hospitals for over four years, clearly an indication of

chronicity. While the distribution of patients through the time

bands in the TAPS project is fairly even, tapering off as one

would expect towards the higher ranges, the Guangzhou sample is

less uniform. This can most probably be explained in the context

of the history of the hospital. It opened with a limited number of

beds, which were gradually increased in the ensuing years, until

saturation point was reached. As patients were infrequently

discharged, the number of admissions dropped until a building

programme recently increased the number of beds.

Table 8:6(a): GZ and TAPS: Previous Admissions to Psychiatric Hospitals

	GZ (n=147)		TAPS (n=271)	
	%	n	%	n
No previous admissions	12.4	(15)	14.39	(39)
Second admission +	87.6	(106)	85.61	(232)
Total	100%	(121)	100%	(271)
information unavailable	(26)			

For 14.4 per cent of the TAPS patients and 10 per cent of the Guangzhou patients their current admission was also their first. Unfortunately, the figure for Guangzhou is not wholly accurate as there is no relevant data for nearly 18 per cent of the patients. A chi-square test computed with four cells, found no significant difference between the two samples.

Table 8:6(b): GZ and TAPS: Numbers of Previous Admissions

	GZ (n=147)		TAPS (n=271)	
	%	n	%	n
No previous admissions	12.4	(15)	14.39	(39)
1-4	71.1	(86)	46.85	(127)
5-8	11.6	(14)	26.19	(71)
9+	4.9	(6)	12.57	(54)
Total	100%	(121)	100%	(271)
information unavailable	(26)			

However, when the information was examined in more detail, (Table 8:6b), a significant difference at the .0001 level was found. The revolving door pattern of admission is common to both groups of patients, although those in TAPS perform more revolutions. 86 per

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cent of the TAPS patients, and at least 72 per cent of the Guangzhou patients, have had previous psychiatric admissions. For the Guangzhou patients the hospital was very much a final resting place. For 95 per cent of them their current admission to this hospital was also their first admission to this hospital. Thus all previous admissions had been to hospitals in the acute sector run by the Medical Department. Referral to and admission in this hospital was a clear indication that the acute sector no longer wished to have anything to do with them, and considered them 'no hopers'. This decision seemed to happen earlier in their psychiatric careers, judged by numbers of admissions, than for those in the TAPS sample. This may be due to both a lack of community facilities to care for patients who suffer frequent relapses, and a difference in attitudes towards permanent hospitalization held by medical professionals.

The TAPS data provided much more detailed information on the number of years spent in previous psychiatric hospitals and the total number of years in psychiatric hospitals. Unfortunately, this information was not available for 67 per cent of the Guangzhou sample so comparative data cannot be included here.

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Table 8:7: Length of Time In Psychiatric Hospital
            (TAPS Project Only)

Number of Years Spent in Psychiatric Hospital Prior to Current Admission (n=271)			Total Number of Years in Psychiatric Hospitals Including Current Admission (n=271)	
years	%	n	%	n
0-4	76.38	(207)	13.28	(36)
5-9	13.65	(37)	16.61	(45)
10-14	4.06	(11)	16.24	(44)
15-19	2.95	(8)	14.02	(38)
20-24	1.85	(5)	11.44	(31)
25-29	1.11	(3)	10.70	(29)
30-34	0		9.59	(26)
35-39	0		5.54	(15)
40-44	0		2.58	(7)
Total	100%	(271)	100%	(271)

The picture presented by patients in both samples is one of chronicity. What is not clear is whether their 'long-stay' character is due to the nature of their illness, the culture and expectations of the hospital, or the paucity of suitable resources and contacts outside it. For instance we noted in Table 8:5 that there was an admission bulge in recent years in the Guangzhou sample due to an increase in self-pay beds. Will these patients become long-stay because they have been admitted to a hospital that has low expectations about discharge? Would their career have been different if a place had been found for them in the acute sector? Had the acute sector already turned them down as not 'good' enough?

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	GZ		TAPS	
Aggressive behaviour	34.0	(50)	11.8	(32)
Transfer - psychiatric hospital	20.4	(30)	15.5	(42)
Suicidal	4.8	(7)	1.11	(3)
Transfer - general hospital	N.A.		9.96	(27)
Transfer - C.A.B. facility	5.4	(8)	N.A.	
Forensic	N.A.		10.33	(28)
Threat to public order	29.9	(44)	N.A.	
Confused	N.A.		36.16	(98)
Can't cope	N.A.		12.5	(34)
Trade Fair	3.4	(5)	N.A.	
Begging	.7	(1)	N.A.	
Shameless behaviour	15.00	(22)	N.A.	
Failure in family care	26.5	(39)	N.A.	
Failure in workplace care	5.4	(8)	N.A.	
Failure in neighbourhood care	1.4	(2)	N.A.	
Other	2.0	(3)	0.74	(2)
Not known	6.1	(9)	1.85	(5)

n totals greater than sample size because multiple reasons for admission were recorded for many patients

The categories under this heading reflect both commonalties and differences between the two samples as to the reasons why patients are admitted. Some of the differences reflect the concerns of the research workers; others are generated by culture. A remarkably similar proportion, 25.46 per cent in the case of TAPS and 25.8 per cent in the case of Guangzhou, were transferred from other

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facilities. Very few in either case were admitted because of a high suicidal risk.

Three times as many in the Guangzhou sample were admitted after acts of aggression than in the TAPS data. The difference between the samples was significant at the 0.002 level. This behaviour included aggressive acts towards family and non-family. It is impossible to know whether this measures a real difference in violent acts or whether aggressive behaviour, not well tolerated in China, is more likely to be commented on in the patients' notes and taken as an indication of mental illness.

Relatively lower levels of aggression may provoke a reaction from the Chinese authorities because of high levels of disapproval of such behaviour, which contravenes the norms of social harmony. Related to this is the 30 per cent who were identified as being a threat to public order in the Guangzhou sample. This might involve, among other things, disturbing the traffic, annoying the neighbours, setting fire to a house, or destroying property. Some of the events were trivial, others of sufficient severity that they might have led to a categorization as 'forensic' in the TAPS data. The legal system is much less formalized in China and these incidents were handled by the police as is permitted, without recourse to the judicial system.

Cultural factors are very much in evidence over admission because of the Trade Fair and in the display of shameless behaviour. Twice a year, in spring and autumn, Guangzhou hosts a very substantial Trade Fair, probably the largest and certainly the most lucrative

in China, which attracts businessmen and investors from all over the world. It is a time when the authorities of Guangzhou want the city to look at its best. Thus 3.4 per cent of the sample was admitted when the police were sweeping the city of vagrants and undesirables because, to quote from one set of casenotes, 'the tidiness of Guangzhou was being seriously affected'.

'Shameless behaviour' largely covers appearing naked in public and defecating and urinating in public. Both acts seem intended to shock in a society that is very modest about nudity and bodily functions. There is no dearth of public toilets in Guangzhou, where night soil is collected assiduously to supplement scarce agricultural fertiliser. The phrase most commonly used to describe nudity in the casenotes was 'taking off his/her clothes and shamelessly displaying his/her body in public'.

Again it is hard to know whether the occurrence is similar in the United Kingdom, but is not regarded as an issue: or whether there is an absolute difference in incidents of public nudity because of different attitudes to public bodily display. If so, this could be related to conservative attitudes towards matters defined as sexual (Ng and Lau, 1990) and reflect the emphasis still placed on propriety. (Bodde, 1957) Kraepelin used very similar terminology in describing behaviour he associated with schizophrenia, suggesting cultural explanations may be more applicable.

'The want of a feeling of shame expresses itself in regardless uncovering of their persons, in making sexual experiences public, in obscene talk, in improper advances, and in shameless masturbation'. (quoted in Barham, 1984, p. 5)

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It also seems that this kind of behaviour has been associated with 'madness' for thousands of years in China. As was mentioned in Chapter Three, the <u>Yellow Emperor's Classic of Internal Medicine</u> cites as one of the symptoms of <u>kuang</u> the patient 'always taking off his garments'. Nudity is also mentioned as a symptom by Li Cong Pei (1986), Francis Hsu (1939) and Lamson (1934), who writes about patients taking off their clothes and singing rude songs. (p. 426)

These findings on the prevalence of aggression and behaviour likely to offend against public standards of behaviour, support observations made in other developing countries. Leff (1988) reports on a study in Swaziland by Guinness that records stripping naked in public as a behaviour associated with psychosis. Gatere in Kenya (reported in Leff, 1988) tried to establish, both among lay people, doctors and traditional healers, the criteria on which they decided that people were mad. The four behaviours on which they agreed, in order of priority, were aggression (particularly attacking people), making a noise, walking naked and talking to oneself.

As Leff points out, in countries where psychiatric facilities are scarce, possibly expensive and access to treatment may mean a difficult and arduous journey, it is likely that only those patients found to be difficult to manage and very disruptive will be referred. Behaviour likely to lead to referral comprises violence to people and property and affronts to public decency. Altschuler et al. (1988), in relation to research that indicated that more manic than depressed patients were admitted to their

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hospital in China, write:

'The non-suicidal, withdrawn person is well tolerated in Chinese culture. Conversely, mania is not well tolerated by a community that greatly values conformity and obedience in its members'. (p. 874)

The greater acceptability of very quiet, withdrawn behaviour in comparison with excited, aggressive, bizarre and actively psychotic or manic behaviour in Chinese culture is confirmed by W.S. Tseng, (1973) and K.M. Lin (1981).

In China, as in the United Kingdom, care of the sick and handicapped is assumed to be a shared responsibility. In China, the neighbourhood organisation and workplace play a significant role. It is indisputable that the vast majority of people admitted to psychiatric hospital are mentally ill. However not all mentally ill people are admitted to psychiatric hospital, so what sort of events precipitate an admission? It may be a change in the mental state of the patient, but it may also be a change in the caring environment. Thus elderly parents die or a sister marries and there is no one left to care. Or more simply, the family are ground down by the patients behaviour over a period of time beyond their limit of toleration. An element of failure in family care was involved in about a quarter of the Guangzhou sample. It was also evident that workplace and neighbourhood organisation played little part in sharing the burden of care, judged by the small effect that failure in their involvement had on admissions. Another way of looking at this is to examine who provided the information concerning the patient on admission to hospital.

Table 8:9: GZ Sample: Person Providing Information on Admission

	n=147 % n
Family member	44.9 (66)
Work colleague	10.9 (16)
Neighbourhood cadre	4.1 (6)
Another hospital's notes	22.4 (33)
Public security	2.0 (3)
Not known/other	15.7 (23)
Total	100% (147)

The family has the major role. While work colleagues were responsible for escorting 11 per cent of the patients to the hospital, this does not signify a major commitment to their care so much as a decision that they are not prepared to take any further responsibility.

VARIABLES THAT WERE NOT INCLUDED IN THE TAPS STUDY

Education

While standard of education and previous employment were included on the admission form in the Guangzhou Hospital, this information was not routinely collected by the two hospitals in the TAPS project, and so is not available.

It was not always possible to tell whether a subject had completed schooling at a particular level, so figures refer to some experience at that level. Because of the nature of the hospital and its prime purpose of caring for the 'three have nots', it

might have been assumed that the standard of education would be very low. This was not the case.

Table 8:10: GZ Sample: Educational Level

	n-147 %	n
Tertiary	5.4	(8)
Senior secondary *	14.3	(21)
Junior secondary **	23.2	(34)
Primary or less	21.8	(32)
No education	5.4	(8)
Not known	29.9	(44)
Total	100%	(147)

** schooling to the age of 14/15
* schooling beyond the age of 14/15

'On the traditional scale of Chinese priorities, education ranked only one notch below rice'. (Bonavia, 1982, p. 174)

Information about educational level is routinely recorded on psychiatric patients' files in China, although it is not known whether this is for any particular purpose. The educational level of 30 per cent of the sample is unknown so the figures must be treated with caution. It should also be remembered that all schooling, (but particularly secondary education), was grossly disrupted during the Cultural Revolution (1966-1976). Schools were closed in 1966. Some opened after a year but others remained closed for several more years. (Gardiner and Idema, 1973) In this sample, 42.8 per cent of the patients had progressed beyond the primary level, 19.7 per cent had schooling beyond the age of 15, and 5.4 per cent entered the tertiary level.

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China does not appear to publish national figures concerning the level of education of the general population, or if so they are not within the public domain. Such figures may not exist, or the regional and provincial variations may be such as to render them meaningless. What national comparisons can be made, relevant to the years when many of the patients in the sample would have been at school?

Ensuring that children had access to basic schooling presented many logistical problems because of the size of the population and the scattered nature of the population in rural areas. In 1969 the Draft Programme for Primary and Secondary Education in the Chinese countryside was promulgated. This recommended a system of 5-2-2, or five years in primary school, two years in junior secondary school and two years in senior secondary school. Policy emphasis was placed on completing five years of primary school. A work forum from this time is quoted as saying:

'Manpower, financial and material resources allocated for the educational front by the state should be first devoted to ensuring the universalization of five year primary education'. (quoted in Gardiner and Idema, 1973, p. 262)

Bonavia (1982, p. 179) states that:

'While every child in China is supposed to receive five years or more of primary schooling, this is not so in practice. To score even 90 per cent of primary school attendance among children in the age group 7-12 is regarded as a really admirable achievement'.

64.7 per cent of the sample in the Guangzhou Hospital had received at least some primary education and most of them had substantially more than that. This is over 90 per cent when those for whom this

data was not known are excluded and compares favourably with what is known of national figures. Given that Guangzhou is one of the most developed areas in China, this is what one would expect. The World Bank Report on China (1986) reports that in 1977 46 per cent of the eligible age group were enrolled in secondary education, (an increase from 2 per cent since 1949). This compares with 42.9 per cent of our sample who had reached that level or beyond, or 61.2 per cent if those for whom data is not available are excluded. The level of illiteracy in the hospital sample is very much lower than the national average of 20.6 per cent. (Beijing Review, Sept.10th., 1990, p. 18)

These figures may only be taken as 'rough indicators', but they suggest that the Guangzhou Hospital sample's experience of education was the same, or better, than that of the national average.

Occupation

Occupations in China bear little relation to those used for classification purposes in the West. 80 per cent of the population is rural and work on the land. The majority of the town dwellers have little choice about where they work or live, as jobs are largely allocated. The majority work in factories, with relatively few having a professional or managerial post.

Table 8:11: GZ Sample: Occupational Level

n-147	%	n
Peasant	12.2	(18)
Factory worker	15.0	(22)
Trade or craft	4.1	(6)
Cadre	3.4	(5)
Professional	2.0	(3)
Other Job	4.1	(6)
None	41.5	(61)
Not known	17.7	(26)
Total	100%	(147)

The most remarkable aspect of these figures is the 41.5 per cent who had no job at all, in a society where everybody has the right and the duty to work. Some had never had work, particularly those whose age of onset was early. Others had not had a job for many years. Among the women, some had given up work to care for family and children.

The relationship between employment status prior to admission and other variables was explored. There was no significant difference between men and women as far as employment history was concerned. Nor was any difference detected on any of the treatment variables, confirming the view that whatever their payment status, patients are treated very much the same.

However, significantly fewer patients who had no job were married (p->0.0063) and there was a very different profile demonstrated on

who had accompanied a patient to the hospital on admission. In comparison with the employed, more unemployed patients were accompanied by relatives as opposed to work unit colleagues; well over half of the unemployed patients were admitted from another hospital or institution, through the public security bureau or neighbourhood office, (p->0.0000). This suggests a picture of a chronic course of schizophrenia with the concomitant psycho-social deficits that would be very familiar in the West.

It had long been observed in the U.K. and the U.S.A. that more than the expected number of schizophrenic patients came from the poorest levels of society. Attempts to explain this phenomenon led to the work of Goldberg and Morrison (1964), and Birtchnell (1971) in formulating the concept of 'downward drift'. Goldberg and Morrison compared the occupational class distribution of young male schizophrenics with that of their fathers, obtaining the latter information in most cases from birth registration sources. Whereas the social class of the patients at the time of admission showed the customary excess of unskilled and casual occupation, that of their fathers at the time of their birth was very close to the general distribution established for the male population at the 1931 census.

Birtchnell compared most recent occupation and parent's occupation in a large series of male psychiatric patients of a variety of diagnoses, and in a sample of controls drawn from general practice. He argued that, while the constantly increasing demand for trained workers had led in the general population to a steady movement out of the semi-skilled and unskilled occupations, the

psychiatrically disturbed have tended to be left behind and larger numbers have moved downwards into classes IV and V. The group classified as psychotic in his study showed both high downward mobility from white collar and semi-skilled manual origins, and lack of upward mobility from semi-skilled and unskilled backgrounds. Birtchnell suggests that either: these patients may have been prevented from realizing their full career potential due to the onset of a severely incapacitating condition early in adult life, or; they may have done reasonably well in their careers until overcome by the illness.

Goldberg and Morrison had no doubt on the basis of their research that the patients' social status had declined because of the incapacitating effects of the illness, rather than that their poor economic conditions had led to the development of the illness. However, they point out that:

'The unskilled worker, whether he is in this position from the beginning of his working life or as a result of occupational drift has little margin for manoeuvre and is thus at a much greater risk than a skilled worker of dropping out of the labour market altogether'. (Goldberg and Morrison, (1963, p. 801)

Birtchnell develops this theme by arguing that those who start off in the poorer classes will, on the whole, receive treatment of a poorer quality, less rehabilitation and will not have parents who are able to cushion them from the full hardships of their position. Thus those patients who start off in classes IV and V may have a qualitatively worse experience than those who arrive at it later.

To what extent does the concept of 'downward drift' apply in China? The idea of 'downward drift' is based on the notion that jobs are selected through talent and interest. In China, where jobs are allocated, or inherited, they frequently reflect neither. Before the introduction of the contract responsibility system to industry there was no particular pressure on factories to make a profit. Thus there was little concern about 'carrying' a number of workers, who for a variety of reasons, including mental illness, could not work as well as their colleagues. Now that financial conditions are much more stringent, factories are very reluctant to accept someone, either as a new worker or as a returning worker, whose performance is likely to be erratic. They are also very aware of the high medical bills the work unit will have to pay which is another stroke against a psychiatric patient.

It is possible that factory workers who become mentally ill may be allocated less responsible, less skilled and consequently less lucrative jobs within the factory. Certainly, this is an issue about which doctors in acute psychiatric hospitals are very concerned. They speak of the difficulties of persuading, (on the rare occasions they intervene directly), the patient to accept a drop in status and possibly pay, and of persuading the management to take the worker back and be flexible in job allocation.

Furthermore, in Maoist ideology peasants and workers were at the top of the status pyramid, although matters have altered somewhat in the last ten years. 'Downward drift' in China may lead to unemployability because of the reluctance to employ someone with a psychiatric history, and the lack of alternatives or a free job

market. As a concept, it may be too culture-bound to be of any direct relevance in analysing the careers of psychiatric patients in China.

Urban Drift

The hospital mainly serves Guangzhou and its suburbs, although much of the area within Guangzhou, but near the boundary of Guangdong, is very rural. This explains the comparatively low number of peasants amongst the patients. 85 per cent of the sample lived in Guangzhou, 5 per cent in Guangdong and the rest were not known. However, when one looked at the question of 'home place' the picture was different. The concept of home place for a Chinese person is important. It is the town or village from which their ancestors, or the founding ancestor of their particular branch of the clan, originated.

Table 8:12: GZ Sample;'Home Place'

n-147	%	n
Guangzhou	12.2	(18)
Guangdong	58.5	(86)
Another province	7.5	(11)
Not known*	21.8	(32)
Total	100%	(147)

* Most of the patients whose 'home place' and place of residence before admission were not known, spoke Cantonese. It can safely be assumed that most of them were, therefore, 'local'.

Table 8:13: GZ Sample: Payment Category

	All patients in sample (n=147)		Patients admitted 1987/88 (n=38)	
Veterans	2.7	(4)	10.5	(4)
'Three have nots'	53.8	(79)	34.2	(13)
'Self-pay'	27.2	(40)	31.6	(12)
Danwei	16.3	(24)	23.7	(9)
Total	100%	(147)	100%	(38)

As has been explained in Chapter Two, the Civil Affairs Bureau was set up to look after the poor, sick, handicapped and veterans. This goal is reflected in the first two categories of Table 8:13. The number of veterans is very small (and admitted in the last two years, although this is probably co-incidental). The major purpose of the hospital was to care for the 'three have nots'. In the figures given in Chapter Six for the total patient population, paying patients account for 64.4 per cent, while 34.3 per cent are 'three have nots'. These figures are at variance with those for the random sample - 53.8 per cent 'three have nots' and 43.5 per cent self-pay. The reason for this is not known.

However, if the random sample of patients is divided into those admitted before 1986 and those admitted afterwards, the picture presented is significantly different. Admission figures for 1987/88 demonstrate a change in emphasis. The number of self or danwei pay patients has risen to 55.3 per cent and the 'three have nots' fallen to 34.25 per cent. When tested the difference between the pre-and post-1987 figures was significant at the 0.04 level. It seems that the original function of the hospital is being

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clouded by the increased admission of paying patients.

One contributing factor is the new expectation that the hospital will work according to the contract responsibility system, and be at least partially self-supporting. Increasing the number of pay beds is an obvious way to do this. There may also be a decrease in the number of people who classify as truly destitute, so less call on the hospital from its traditional clientele.

Table 8:14: GZ Sample: Reasons for Onset of Illness

n=147	%	n
Medical illness	3.4	(5)
Study problems	5.5	(8)
Failed relationships	8.8	(13)
'Sent down youth policy'	4.8	(7)
Family stress	4.1	(6)
Work stress	9.5	(14)
Not obvious	10.2	(15)
Other	7.5	(11)
Not known	46.2	(68)
Total	100%	(147)

Information on this subject was taken from the file when such reasons were mentioned. The reason given on the file as being the major precipitating factor was the one recorded. A distinction was drawn between a classification of 'not known', in the sense that nothing was mentioned on the file about possible causes of onset, (46 per cent), and those cases where the question was asked but no particular reason for onset was discernible (10.2 per cent). This

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latter classification would correspond with the concept of insidious onset of schizophrenia.

Table 8:14 demonstrates that to a large extent the reasons that are attributed to the onset of schizophrenia are as many and various as they would be in the United Kingdom. Most of them are familiar. Work and family stress, problems at school, difficulties with failed personal relationships, are elements of a common human experience. The aspect that is different, and is of great interest to those outside China, is the effect of the Cultural Revolution. Did it cause people to breakdown? This question is largely unanswerable. Even where it can be shown that some aspect of the Cultural Revolution did have a deleterious effect on a person's mental state, it is impossible to say that the individual would otherwise have remained mentally balanced. Some other, more usual, but none the less very stressful event might have provided a precipitating factor. We can never know.

In the case of the Guangzhou sample, a specific event associated with the Cultural Revolution was chosen that affected a large proportion of urban young people and that many of them found very distressing indeed: sending youngsters from the town to villages and communes to learn from the peasants. In only 4 per cent of cases was it found to have been involved in schizophrenic onset and was not found to be significant in the age group affected. When this issue was discussed with staff at the hospital their view was that many people, including themselves, had been 'sent down youth', or in other ways suffered during the Cultural

Revolution, without developing major schizophrenic disorder. They concluded that there must have been a pre-existing disposition.

CONCLUSIONS

1 - The similarities between the two populations are more striking than the differences. This is most noticeable in the areas of gender and marital status and would suggest a commonality in the course of the disease, societal reactions to it, and male/female role definitions which transcend cultural boundaries.

2 - Although the age distributions are different between the two hospitals, (the GZ sample being somewhat younger), patients are predominantly a middle-aged and older population, each sample showing clear features of chronicity. Their history of psychiatric hospital admission is indicative of a different approach to treatment and service provision. Both sets of patients have experienced the revolving door phenomenon, but more chances to survive without long term hospitalization appear to have been given to the TAPS group. This is probably at least partly a function of a greater variety of treatment and rehabilitation modes available in the U.K.. Of concern is the relatively recent phenomenon of admitting paying patients to the Guangzhou Hospital. They receive the same treatment regime as the other patients and may well become long stay. (see Chapter Six)

3 - Significantly more of the GZ patients were aggressive before admission. They also flaunted standards of public decency and presented a threat to public order. The reasons for this are by no means certain but one hypothesis is that when facilities are

scarce, it is those patients exhibiting behaviour which brings them to the attention of the authorities, or endangers others, who will be hospitalized. This may be exacerbated by lay and medical 'working definitions' of schizophrenic symptoms including exactly those sorts of behaviours.

4 - It was not possible to make comparisons of the educational and occupational levels of the two samples as this information was not collected for the TAPS sample. The original hypothesis had been that the educational level of the patients would be low because of the 'three nos' nature of the hospital. This was not supported by the data. The educational level of the patients in the GZ sample compared favourably with what is known of the educational level of China's citizens. It should be born in mind that Guangzhou and Guangdong are advanced areas of China, and that one would therefore expect standards to be higher.

5 - As would be expected, the majority of patients who had jobs before admission were peasants or workers. The high number of people who had never worked, or who had been unemployed for a considerable time was not expected. It was not possible to identify the phenomenon of 'downward drift' in this population because jobs in China reflect neither preference nor ability. Patients who had been unemployed before admission were less likely to be married, and much more likely to be admitted through the Public Security Bureau, neighbourhood organisation or transferred from another hospital or Civil Affairs Bureau reception centre for vagrants.

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6 - Reasons for onset of illness were not available for the TAPS sample. When this was recorded for a GZ patient, it tended to show the commonality of the human condition: problems at school, in the family, at work, failed relationships with the opposite sex. Although a number of patients had been adversely affected by the events of the Cultural Revolution, there was no evidence, within the age group that would have been most involved, that this was a statistically significant factor in their illness. It is fair to say that on a general level, the GZ patients, as with every one else in China, have faced levels of hardship and chaos in their lives quite unknown to the English sample.

CHAPTER NINE

PSYCHIATRIC TREATMENT

Over the years of debate concerning the treatment of mental illness, particularly schizophrenia, it has gradually come to be realised that multi - faceted diseases require a multi - pronged approach to be effectively contained. This biopsychosocial model of cause and treatment attempts to aid the afflicted person in an holistic way with emphasis guided by individual circumstances. This is, of course, an ideal which is not always attained in practice but it nonetheless informs what might be called modern thinking in the area of mental health. This chapter attempts to review the position that Chinese psychiatrists have adopted in relation to how these issues affect treatment. Points are illustrated using data from a variety of hospitals that the author has visited.

Somatisation

An almost universal observation that is made about Chinese patients is their tendency to somatise. (Fanny Cheung, 1986; Kleinman, 1986; Unschuld, 1987; T.Y.Lin, 1983) Kleinman defines this as:

'The presentation of personal and interpersonal distress in an idiom of physical complaints together with a coping pattern of medical help seeking'. (1986, p. 51)

Unschuld describes both somatopsychics and psychosomatics as being based on an awareness of a unity between mind and body, that is a recognition of the fact that the former may cause illness to the

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latter and vice versa; or that illnesses in the former may be reflected by the latter and vice versa. Western psychosomatics in general tends to search for mental/emotional problems causing a somatic suffering, and it seeks to change either the environment causing an emotional problem, or to change the patient's mental attitude towards his environment in order to eliminate the basis of his somatic ills. Chinese psychosomatics, in contrast, appears to have preferred to find out the somatic/physiological basis of mental/emotional disorders and to direct a treatment - mostly by means of herbal drugs - at the somatic issue in order to reshape the patients' emotions, mostly regardless of the patients' environment. This unwillingness to differentiate between psychological and physiological function in Chinese medicine has, according to Lin, 'exerted a profound retarding influence on the development of psychiatry as a discipline or a profession in Chinese culture' (Lin, 1985, p.4)

Much of the debate surrounding the issue of somatisation has centered on depression and neurasthenia. (Kleinman, 1986) However, as a reaction to distress, it is also observable in patients presenting with other kinds of psychiatric disturbance. As Lin says:

> 'It offers an acceptable response against the shame and guilt associated with mental illness and represents an acceptable explanatory model to all concerned. Somatisation is not unique to Chinese but its intensity and pervasiveness are such that Chinese somatization has a unique quality'. (T.Y.Lin, 1983, p.866)

As we saw in Chapter Three, in the small study that was undertaken in Shashi, patients' families did not normally cite somatic reasons for causation. This did not prevent them from construing

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the complaint as an illness in many cases. It was also very noticeable that when asked the first open-ended question ('what is the problem that made you come to the clinic today?') the initial response was frequently in terms of a bodily symptom, like loss of appetite, sleeplessness or an uncomfortable feeling in the heart. However, further investigation almost always led to the description of a variety of social and psychological difficulties that were obviously of concern to the interviewees.

The question that is most frequently raised is which complaint is primary; the somatic one or the psychosocial one? It has been suggested by Western authors that the psychosocial complaint is primary and is 'masked' by the somatic complaint. Kleinman (1986) considers that assuming that overt somatic complaints are any less real than allegedly hidden psychological problems is an ethnocentric example of Western dualism. Kleinman goes so far as to say that it is not simply that individuals communicate in a somatic idiom; emotion is also experienced somatically. The feeling is part of the bodily process and of its communication to others.

So what might be the reasons behind this somatic approach? Without necessarily delving into layers of deep meaning, one contributing factor is immediately apparent; patients think that it is what doctors expect to hear. In research carried out in Hong Kong there is evidence that patients share their feelings quite freely with family members and friends. However, psychiatric patients' previous experience in medical settings, where they expected to

have their physical symptoms treated, may have led them to present somatic symptoms in these settings. (Fanny Cheung, 1986) Kleinman (1986) points out that doctors are trained professionally to somatise, in as much as they are taught to reinterpret, (medicalise), social and personal troubles as medical problems.

In addition, in the Chinese context there are other contributing factors including; valuing the harmony in social relations over the expression of potentially disruptive and ego-centered intra-psychic experience; strongly negative valuation of the open verbal expression of personal distress outside close family relations; and a desire to avoid the strong stigma that attaches to families with members labelled emotionally ill, among others. (Kleinman, 1986) Fanny Cheung (1986) suggests that Chinese people have a rich repertoire of subtle ways of communicating feelings, and that patients expect 'authoritative' doctors to be able to read the clues without recourse to speech.

The discussion about somatisation tends to be patient centered. The present author considers that this is too narrow a focus, and that the process of diagnosis and treatment is an interactional one in which insufficient attention has been paid to the role of the doctor. As we saw in Chapter Three, for a variety of reasons the medical approach tends to be biomedical and, as Guimon (1989) points out, the theoretical orientation of the doctor has a potentially profound effect on diagnosis and treatment. We have to recognise that what the doctor chooses to hear, what the doctor focuses on or ignores, what the doctor does not ask, reinforces the patient about 'correct' or relevant information or behaviour

in the interaction.

It was quite evident in the interviews in Shashi, (March and July, 1990), that the normal pre-admission interviewing procedure was perfunctory with interviews lasting perhaps ten minutes. While the doctors found the additional information generated by the research interview concerning the psychosocial problems of the patients interesting, they very rarely made any connections between them and the patients' psychiatric condition, (or the families request for admission), or used that information to formulate a treatment and rehabilitation plan. As one of them told me 'it is not our business'. Yet it is not necessary to accept that psychosocial problems have a causal relationship with mental illness to be able to accept that they exacerbate and precipitate episodes of illness, and have a debilitating effect on families' and patients' ability to cope.

If genetic and biomedical reasons for illness are being sought by doctors, and if doctors and patients have an expectation that illness is treated by mechanistic means, then it is not surprising that it is the physical treatments from Western medicine, that have been adopted into Chinese medicine rather than the psychological ones. Psychopharmacology, hydrotherapy, insulin therapy, prolonged sleep treatment, ECT, have all found a welcome place in the repertoire of treatments by Chinese psychiatrists. Both sources of influence will be examined.

Acupuncture has been used for millennia in China to encourage and strengthen the free flow of qi [life force] throughout the body. A lack of qi, or a blockage in its movement were held to be responsible for many symptoms. Practitioners recognised thousands of acupuncture points which were located on the 12 major meridians, eight extra meridians and a network of minor meridians which are said to traverse the body. Pressure is exerted on selected points usually through the use of needles. These needles are then turned by the practitioner to stimulate the qi. In recent times, electric-acupuncture has been developed. Needles are used in the same way but attached to a nine or 12 volt battery and a small electric current passed through them, thus removing the need for manual stimulation.

Hillier and Jewell chart the progress of the use of acupuncture in the treatment of mental illness over the last 30 years. It was popular through the early and mid-1970s, but doubts began o be expressed from the late 1970s onwards, and a more conservative policy of utilisation adopted. (Hillier and Jewell, 1983) From the author's observation it is still very commonly used to treat auditory hallucinations. It must be remembered that reports appearing in Western literature almost always concern those hospitals and psychiatrists who represent the leading cohort of psychiatric treatment in the People's Republic. Practice in the less well known hospitals will take longer to change. What follows is an account based on personal observations of the recent use of acupuncture.

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In the small psychiatric hospital at Xiamen, electric acupuncture was used regularly as a serious treatment in schizophrenia. One needle was placed above the centre of the upper lip and the other in the centre of the head. As described to me both points lie on what is known as the Tu-mai, (or governing vessel), meridian which runs from the anus, up the backbone, over the head and stops inside the mouth. This meridian is not associated with a particular organ, but with the treatment of metabolic disorders and psychic strain. There is a belief in its efficacy based on clinical observation of improvement in patients, without a very precise explanation as to how it works. I was told that this was the treatment of choice for patients who were subject to violent episodes, and was considered to be very effective. We were further told that patients found the treatment acceptable, were not afraid of it and suffered no after effects. This hospital had no access to ECT. On the other hand, the consultant at Fong Tsuen hospital, (a teaching hospital), expressed the view that acupuncture used in this way was not effective.

A further example of electric acupuncture was found at the Guangzhou Hospital, but used very differently. The equipment was the same and kept on each ward. The circumstances under which it was used, based on the examples we were given, seemed to be when a patient was being recalcitrant. Thus one patient who persistently removed the light bulb from a light fitting in the corridor was given electric-acupuncture in his hand, because his hand had been 'naughty'. The nurses said that all the patients were aware that

the electric-acupuncture equipment was on the ward and that sometimes threatening them with it, or bringing it out and showing it to them, was sufficient to ensure improved behaviour. The parallel with Galileo being shown the instruments is close. Furthermore, no special training seemed to be required in learning to give electric-acupuncture. The junior nurses watched the senior nurses and copied them in their turn. Whether or not one accepts the basis or potential efficacy of the treatment, to perform acupuncture well needs a high level of knowledge and skill. There was no indication at the Guangzhou Hospital that those administering the treatment had either the theoretical understanding, or practical skill to know what they were doing, other than attempting to control patients' behaviour.

During the Cultural Revolution, (particularly in the early years 1966-72), China became less accessible than ever. Those foreign observers who did manage to gain access reported that much treatment was based on the study of politics and in particular various works of Mao. (Sidel 1973) These were studied daily to help remedy incorrect thinking of patients and to help them determine objective reality as opposed to their subjective and, by implication, delusional thoughts. This has recently been confirmed by Young and Chang who say that:

> 'The ultraleft viewpoint regarding mental illness was due to faulty political thinking and that 'crazy' people were basically selfish persons who were severely in conflict with society. It was therefore believed that the cure involved political education. Thus standard treatments were abandoned'. (Young Derson and Chang Mingyuan, 1983, p. 433)

It became a matter of national and political pride not to use Western based treatments and doctors were urged to turn more to the use of Chinese medicine. One of the reasons for this may have been that, with the collapse of the economy during the Cultural Revolution, China was in no position to buy psychotropic drugs and her own production of them was grossly disrupted by the political, economic and social chaos. In retrospective discussion of those times, doctors say that political treatment was ineffective in controlling psychotic disorder and that wards tended to be chaotic, or as one of them said with a quiet smile 'very noisy'. They now also say they were aware that treatment based on politics and nothing else was going to be ineffective, but that given the times they had no choice.

It is also worth noting that the possibility of treating people with herbal medicine was also restricted. Herbal medicines are often expensive and need great care in collection and preparation. Many of them were also unavailable during the Cultural Revolution. Anarchy and chaos led to a drop in land use (Lampton, 1977) which, while largely affecting the food supply, also had a deleterious effect on the growth of medicinal herbs. According to one doctor, grass, leaves and twigs were used because there was nothing else. However, in recent years there has been no observable evidence that political study has any direct part to play in the treatment of psychiatric disorder.

Since the events in Tiananmen Square in 1989, political campaigns to increase patriotism and inculcate the correct, 'red' emotions of sacrifice and love of country have been re-introduced. Patients

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and staff in the Shashi hospital were subject to the 'Learn From Lei Fung' campaign. Although these sorts of campaigns are anathema to most Western people, it could be argued that if being involved in them is 'normal' for a society, then there is no reason why mentally ill people should be exempt from them, as this would only serve to emphasise their abnormal status.

Without a tradition of their own, psychiatric treatments in China were largely adopted from Western practices. By rejecting Freud and adopting Pavlov as a guide, it is perhaps not surprising that the treatments chosen tended to be based on mechanistic rather than analytic or social practices. Thus the literature based on Western observation contains references to insulin shock therapy (Sainsbury, 1974; Walls et al, 1975) a treatment discredited and in abeyance in the West for the last 20 years. From my own observation, insulin shock was still being used in the Shanghai Number One Hospital in 1983 and in the Xiamen hospital in 1985. Visits since then suggest that the practice is dying out. Chinese psychiatrists talk about the use of 'hydrotherapy' in years past, but there appears to be no evidence anywhere that this continues.

Electro-Convulsive Therapy

More contentious is the use of ECT. It has been the subject of great debate in Western psychiatry for many years. Having been possibly the first truly effective treatment for severe mental disorder, it was used extensively and inappropriately. Eventually, in some quarters, it fell into disrepute. ECT was the subject of a very thorough report by the Royal College of Psychiatrists

(Pippard and Ellam, 1980). Current opinion is that it is an

acceptable treatment in cases of severe and intractable

depression. It is generally considered to be contra-indicated for

schizophrenia except:

> '... in the treatment of schizo-affective disorders,
> where the treatment is directed primarily at the affective
> component of the illness and rare cases of catatonic stupor'.
> (Kendell, 1988, p.330)

At least part of the controversy surrounding ECT in the West lies

in the way it could be easily abused or used as a punishment.

Current practice demands that both a general anaesthetic and a

muscle relaxant be administered before treatment. Without the

latter, ECT is potentially dangerous, in that bones may be broken

during a severe convulsion, and intensely distressing to the

patient because of the fear beforehand and muscle pain that may

last for a week or more after the treatment.

It is not possible to determine when ECT was introduced into

China. It may have been used in the few psychiatric hospitals that

existed before 1949, run by missionaries or along Western lines.

In 1959 a senior Chinese psychiatrist wrote:

> 'In this country, specialists are divided in their opinions
> about electric shock treatment. They are generally quite cautious
> in its use. In recent years hydergine [used to ameliorate
> dementia] has shown obvious effectiveness and the use of shock
> treatment has been greatly reduced. It seldom is used alone and if
> it is used at all, it is in combination with other methods'. (Wu,
> 1959, p.601).

ECT is reported to have been banned during the Cultural

Revolution, or at least this is what the few Western observers

permitted to visit China were told (D.Y.F.Ho, 1974; Sidel, 1975)

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It is unclear whether this represented a central policy or initiatives at the local level and there is no evidence at all as to how widely it was enforced. At least one report from a visiting American team records ECT being used in 1973 in Nanjing 'if regular measures fail in a given case' of schizophrenia (Walls, 1975, p123).

Personal contacts with Chinese psychiatric hospitals indicate that ECT continues to be extensively used, and is not seen by doctors as being particularly controversial. In Guangdong province all three hospitals visited used ECT. Fong Tsuen, the 'leading' hospital where standards would normally be expected to be the highest, did not use an anaesthetic. Muscle relaxants were only given to elderly patients where the risk of broken bones was increased by a history of fractures or heart disease. The majority of patients receiving it suffered from 'affective psychosis', but it was also given to schizophrenics with severe delusions, hallucinations and excitation.

The physician superintendent admitted that the patients do not like it the 'traditional' way, but claimed it was simpler, needed fewer staff and was less expensive because no drugs were used. He claimed that three staff needed to be present when ECT was administered in the 'traditional' way, but five were required when muscle relaxants were used. ECT without a muscle relaxant costs five yuan and ten with one. A few years ago at Fong Tsuen, up to 60 treatments a week were given (in a hospital with 650 beds). As more drugs are used the number has dropped to 12 a week.

According to the physician superintendent at Lam Shek hospital
(the city level hospital for Fo Shan in the province of
Guangdong), ECT is mainly given to people who are 'relatively
manic' or who have 'adaptation problems'. No muscle relaxants are
used. The machine is of a type where the length of treatment is
determined manually, unlike more modern machines which deliver a
shock at fixed voltage for a pre-determined period of time. The
cost of each treatment at Lam Shek is two yuan.

At the Guangzhou Hospital the physician superintendent, during my
initial visit, denied using ECT at the hospital at all. He said
that his hospital was too 'simple' and did not have the necessary
equipment. As was recounted in Chapter Five, it was only during
one of their visits to Hong Kong, on being shown some modern ECT
equipment in a psychiatric unit attached to a general hospital,
that it became apparent that ECT was being used at the Guangzhou
Hospital. The machine is also a manual one. 80 volts of
electricity is given for one and a half seconds (as compared with
the Hong Kong psychiatric unit where 50 volts was given for three
seconds). The use of manual machines is generally considered
unacceptable by current standards:

> 'ECT should never be given with a machine that delivers
> an untimed stimulus and where the duration of stimulus depends on
> how long the operator presses the treatment button'. (Freeman,
> 1988, p.718)

The doctors freely admit that the patients dislike and are afraid
of the treatment and that they complain of pain for up to a week,
after the event. Consequently, it is given infrequently, 18

patients had received ECT in the past 12 months. Patients chosen

for this treatment are described as having symptoms like paranoia,

stupor, high suicidal tendencies, extreme agitation or aggression.

The course length varies according to the diagnosis and condition

of the patient. Treatments are usually given every other day but

occasionally every day, until the symptoms abate. When asked

directly why muscle relaxants were not used, the head of the

Medical Department said that if they used muscle relaxants they

would not be able to monitor the reaction of the patient to see

whether the fit had 'worked', or they might use more electric

current than was necessary. Freeman points out that it might be

safer to give ECT without anaesthetic than to have a psychiatrist

regularly giving anaesthetics in developing countries where

anaesthetists are unavailable. (Freeman, 1988) As muscle relaxants

also affect the capacity to breathe unaided, the patient may also

be subjected to the experience of not being able to breathe which

is potentially very frightening. (Dr.Bruce Ricketts, F.R.C.Psych.,

personal communication.) Phillips, working in China, has

demonstrated that schizophrenic patients receiving ECT tend to

have a shorter than the average stay in hospital. (Phillips, 1990)

<u>Psychosurgery</u>

The even more controversial treatment of psychosurgery was also

practiced at the Guangzhou Hospital, in collaboration with the

Number One and Number Two Affiliated Hospitals of the Guangzhou

Medical School. It is generally held that if psychosurgery is

going to be performed at all, then chronic, unremitting

depression, chronic severe anxiety and severe obsessional

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neurosis, are the three main indications. It is not a treatment

suitable for those suffering from chronic schizophrenia. (Freeman,

1988) Freeman goes on to point out that evidence of benefit

remains largely anecdotal and that:

> '... if the same stringent criteria had been applied to
> psychosurgery as were applied to new drugs before they could be
> licensed, all psychosurgery all over the world would be banned.'
> (p.723)

The information that follows is based on several separate

interviews with the medical superintendent and his deputy. The

psychosurgery programme was experimental, with five trial

operations performed in 1985 and a further 15 in 1986. No more

patients from the Guangzhou Hospital were selected after that. The

hospital was responsible for selecting suitable cases. The staff

said that the criteria involved a long history of schizophrenic

illness of at least eight years duration, with residual symptoms

like aggressive behaviour, that had not been amenable to other

forms of treatment. The operations were performed in the

collaborating hospitals and the patients then returned to the

Guangzhou Hospital.

Within the Civil Affairs Bureau system the Guangzhou Hospital is

the first in China to be involved in psychosurgery. After their

first five patients had the operation, a similar procedure was

performed on a Fong Tsuen patient, but the result was poor in that

the patient went into a coma for several days. This deterred the

medical staff at Fong Tsuen from continuing with this treatment.

Lam Shek hospital also tried psychosurgery with several cases, but

again with poor results. The staff at the Guangzhou Hospital said

that one of the problems was that the three hospitals were all using different selection criteria.

The physician superintendent claimed that as far as their 20 patients were concerned most results were satisfactory. Immediately after the operation they improved a little, then their behaviour deteriorated and recently some improvement was observed. It must be remembered that there is no requirement for patients to give their consent to treatment. Relatives and danweis must be consulted if the patients involved have a family or work unit. However, at least 30 per cent of the patients at the Guangzhou Hospital fall into the 'three-no's' category. Thus the hospital doctors are their legal guardians and are in a position to make an unchallengeable decision about whether to recommend someone for this type of surgery, against which the patient has no appeal. The physician superintendent also said that there was no difficulty in persuading relatives to agree to an operation. Families regularly ask the doctors to 'do anything' if they think it will help the patient. Some families request that the doctor give the patient a lethal injection, and in one of the sample files a form was found signed by the family requesting that the patient be allowed to die if he ever became seriously ill.

All the psychosurgery cases in the Guangzhou Hospital were selected from one male ward and several of the relevant files were studied. They contained no assessment records of any kind either before or after the operation. Nor was there any statement concerning the criteria on which the selection had been made.

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Consequently, there was no way in which an objective assessment could possibly be reached as to whether or not the patient improved as a consequence of having the operation. In a private conversation, the ward doctors expressed strong reservations about the efficacy of the operations. They considered that insufficient work had been done in finding the correct drug and dosage for the patients. Subsequent improvement in the years following the operation, they were convinced, was due to alterations in drug regime.

One particular case was discussed with us in terms of pride. While performing psychosurgery on a Guangzhou Hospital patient, the surgeons decided to remove some living tissue from another area of the brain to provide doctors at Fong Tsuen with a sample they requested for research purposes. This caused the patient to haemorrhage, and when the patient recovered consciousness he had lost the power of speech and was paralysed completely down his left side. He was left to lie in bed for two years receiving basic nursing care (and developing severe bed sores), until a new doctor arrived on the ward, trained in Chinese medicine. This doctor took a very active interest in the patient and treated him with a combination of massage, acupressure, Chinese herbal medicine and vitamin B-1 and B-12 injections in the dong gwai pressure points. Within three months the patient was mobile and when we were introduced to him six months after the treatment commenced he walked unaided, if with a slightly lopsided gait, and could speak, albeit a trifle indistinctly. We were also able to examine the file which verified the story as it was told. At no

point did any of the staff show any embarrassment at the ethical or professional issues involved. Rather it was seen as a matter of pride at the triumph of Chinese medicine.

Psychosurgery was amongst the treatments that were supposedly banned during the Cultural Revolution, (D.Y.F.Ho 1974; John Kao, 1979; Livingstone and Lowinger, 1983), and there is no mention in the literature of the last 20 years of such operations being performed. The Guangzhou Hospital doctors said that they were aware that the issue is a delicate and contentious one that would not normally be discussed with outsiders. It is impossible to know how wide spread this treatment is outside Guangdong province.

During a visit to Anding Hospital in December 1989, staff there told me that the senior psychiatrists in their hospital and in Nanjing were planning to begin psychosurgery in collaboration with a medical and surgical hospital in Beijing. Interestingly, the younger doctors were very much against this development. They had been promised a bonus for every patient they recommended for the procedure, but the majority had refused to have anything to do with it. Having found financial inducements to be ineffective, the senior psychiatrist issued an order that certain designated wards were to fill a quota of patients for psychosurgery. The ward doctors were trying hard to delay complying with the order, but were obviously concerned that they could not hold out much longer.

Pharmacotherapy

It is now very widely accepted that medication is the first recourse of treatment in schizophrenia, even by interested parties

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occupying very different philosophical positions. A special report

by MIND on major tranquillisers starts by saying that:

'Major tranquillisers are the single most important and effective treatment for serious mental disorders such as schizophrenia. For many people there is no alternative means of treatment to control the symptoms of serious mental disorder'. (MIND, 1985).

A chapter on drug treatment in a recently published book on

schizophrenia begins thus:

'Drugs form an essential part of all treatments for schizophrenia but it is only by taking advantage of all possible therapies - social, psychological and pharmacological - that the individual patient may minimize the handicaps of schizophrenia and reach the best possible level of functioning'. (Johnson, 1988, p.159).

Similarly, Kendell (1988) concludes that, although in the short

run phenothiazines have a much more dramatic effect on the

symptoms of schizophrenia than any other therapeutic measure,

there is a great deal more to treatment than prescribing

neuroleptics. He considers that in the long run other less

tangible social and psychological influences have a more powerful

effect on the final outcome than any drugs.

From this, a picture emerges of an ideal treatment regime for

schizophrenics based on a foundation of psychopharmacology with

the essential supplementation of therapies directed at increasing

the patients' behavioural and social skills and aiming to improve

his ability to mesh with the environment of family and work. This

high standard of care is probably rarely achieved, partly because

drug treatment is cheap and relatively less labour intensive, and

partly because of deeply entrenched attitudes concerning the

notion of what constitutes 'proper' medical treatment. To what extent does the treatment of schizophrenia in China fit this pattern?

Western derived drug treatments are extremely widely used in China. (Wu Cheng-i, 1959; John Kao, 1979; Livingstone and Lowinger, 1983; Parry-Jones, 1986; Young and Chang, 1983) However, doctors do not seem to have access to the same range that would be available to doctors in the West. To give one example, the most commonly used drug in China (and in the West) is chlorpromazine which has photo-sensitivity as an occasional side effect. The doctors in the Guangzhou Hospital seemed unaware of the cheap alternatives, (for instance, thioridazine), developed years ago, which overcome this problem.

During their visit to Hong Kong, the doctors from Guangzhou much admired the work of the New Life Farm in rehabilitating chronic schizophrenic patients. Although they had the land and, presumably, easy access to expertise on farming, they said that it would be impossible for them to set up such an operation as so many of their patients could not tolerate the sun during the day because they were taking chlorpromazine. This may or may not have been their real reason but further questioning elicited the fact that they seemed genuinely to be unaware that a cheap alternative existed, which did not carry this particular disadvantage. If thioridazine is universally unavailable in China, this seems a pity in view of the rural nature of the population who perforce spend a great deal of time outside.

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Their limited access to psychotropic medication may be due to the original ('three-no's') nature of the hospital. The doctors themselves say that they rely on 'simpler' drugs and treatments than are in use in hospitals run by the Medical Department. On the other hand, when asked which drugs were most commonly used in his hospital, the consultant at Fong Tsuen gave a list that was almost identical to those used at the Guangzhou Hospital, at least for the treatment of schizophrenia. Anding, as one might expect, had access to a much wider range of drugs. Doctors in the hospitals outside the major centres report that there are supply problems, even with the more common drugs.

Cost, of course, is an issue here. All the drugs used at the Guangzhou Hospital are produced in China and consequently are very reasonably priced. A bottle of one hundred 25mg tablets of chlorpromazine cost 1.50 yuan. Sometimes patients or their families think that foreign drugs must automatically be better and are willing to pay considerable amounts for them. China manufactures her own supplies of fluphenazine decanoate which consequently is cheap. However, it does not produce a closely related drug flupenthixol decanoate which is imported and consequently costs 66 yuan for 4cc, or half the average monthly wage in Guangzhou.

The following detailed discussion of drugs in use and prescribing habits is based on information recorded on the current medication cards of the sample of 147 patients at the Guangzhou Hospital. There is no reason to doubt the accuracy of the information, but practices in that hospital do not necessarily reflect practices

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elsewhere.

Table 9:1:   The   Guangzhou   Hospital: Drugs   Used   in   Order   of Frequency, Dosage Level and the Numbers of Patients Receiving the Drug at Each Level.

Drug   No. of Patients Receiving Dosage

	Low	Medium	High*
Chlorpromazine (n=62)	15	33	14
Perphenazine (n=30)	5	17	8
Trifluoperazine (n=17)	1	4	12
Clozapine ** (n=14)	ranges between 100-750 mgs. daily		
Haloperidol (n=10)	3	4	3
Diazepam (n=9)	9	-	-

* Dosages are defined thus in milligrams:

	low	medium	high
chlorpromazine	<100	<100 to <300	>300
perphenazine	<10	<12 to <24	>24
trifluoperazine	<10	<15 to <30	>30
haloperidol	<10	<15 to <30	>30
diazepam	<10	<15 to <29	>30

Dosages tend to be somewhat smaller for Chinese patients because of lower body weight. The advice of a lecturer in psychiatry at the Chinese University of Hong Kong was   sought   in   determining these levels.

** It was only in 1990 that the American F.D.A. approved clozapine for use. Prior to that it was banned in America and restricted in the U.K. because of the risk of acute agranulocytosis, a failure of white blood cell production that leaves the patients vulnerable to infections of all kinds and which can prove fatal.

It can be seen from Table 9:1 that the range of drugs used is very

restricted.   There is heavy reliance on two drugs,   chlorpromazine

and perphenazine. Chlorpromazine is still widely used in the West. It was found to be the most frequently prescribed oral neuroleptic in research carried out in two psychiatric hospitals in Oxford. (Michel and Kolakowska, 1981) However, perphenazine is no longer included in MIMS (April 1989). A study of in-and day patients in a Birmingham psychiatric hospital found that 49.45 per cent of patients were being prescribed either chlorpromazine or haloperidol. (Edwards and Kumar, 1984) This compares with 48.97 per cent at the Guangzhou Hospital. No comparative data are available concerning dosage, but with the exception of trifluoperazine, there is no concentration of patients in the high dosage levels.

Table 9:2: The Guangzhou Hospital Timing of Medication

Number of Patients

Twice daily	101
Thrice daily	12
Four times daily	6
When required	4*

* three of these were diazepam

All drugs being used are recommended by Kendell to be taken twice daily at 12 hourly intervals:

'There is no point in giving any phenothiazine, orally or intramuscularly, more frequently than twice a day.....three times a day or six hourly is simply a waste of valuable nursing time and an imposition on patients'. (Kendell, 1988, p.328)

Thus 68.7 per cent of all prescribed medication conforms to this pattern. This compares favourably with Edwards and Kumar's study

where 47 per cent of patients were receiving neuroleptics three or more times a day suggesting that in this respect the administration of medication is within international standards.

Polypharmacy

Kendell expresses his view on the matter forcefully:

'Most polypharmacy, like prescribing phenothiazines or tricyclic anti depressants three times a day, is simply a public display of pharmacological ignorance'. (Kendell, 1988, p329)

Polypharmacy, the concurrent administration to patients of more than one psychotropic drug, is generally not recommended because of increased risk of adverse reactions, and the lack of evidence for therapeutic advantage from using several psychotropic drugs instead of a properly chosen one. Given the sedative properties of neuroleptics, it is hard to justify the concurrent administration of minor tranquillisers and hypnotics. (Michel and Kolakowska, 1981) Various studies in the USA, UK, Finland and Israel have shown this to be a problem both in in-patient and out-patient care. (Tyrer, 1978; Hemminiki, 1977; Laska et al., 1973; Schroeder et al., 1977; Sheppard et al., 1969; Yosselson-Superstine et al, 1979.)

Comparisons were made between the prescribing habits extant in the Guangzhou Hospital and similar data obtained from the TAPS project in London. As the following table shows, within the populations of each hospital 17 per cent of the Guangzhou Hospital patients were in receipt of polypharmacy in comparison with 89 per cent of the TAPS patients.

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Table 9:3: Polypharmacy in the Guangzhou Hospital and TAPS

Medication: percentage of patients receiving	Guangzhou Hospital	TAPS
No medication	15.64% (23)	2.95% (8)
Oral neuroleptic	67.34% (99)	8.11% (22)
Oral neuroleptic + anti-cholinergic	4.76% (7)	26.19% (71)
Oral neuroleptic + anti-cholinergic + injected neuroleptic	00.00% (0)	49.81% (135)
Oral neuroleptic + anti-cholinergic + injected neuroleptic + benzodiazepine	00.00% (0)	12.91% (35)
Oral neuroleptic + benzodiazepine	2.04% (3)	00.00% (0)
Multiple oral neuroleptics	5.44% (8)	00.00% (0)
Oral neuroleptic + benzodiazepine + anti-cholinergic	3.40% (5)	00.00% (0)
Multiple oral neuroleptics + anti-cholinergic + benzodiazepine	0.68% (1)	00.00% (0)
Multiple oral neuroleptics + anti-cholinergic	0.68% (1)	00.00% (0)

(actual numbers in parentheses)

Clear differences in the use of medication are shown by this data. The most striking feature is the lack of use by Guangzhou Hospital doctors of the injectable depot neuroleptics. Only four cases of their use was recorded in the files. In comparison, almost 50 percent of the TAPS patients, (also suffering from chronic schizophrenia), received them. Without exception, the only time fluphenazine decanoate is used at the Guangzhou Hospital is for the immediate control of aggressive or difficult behaviour.

Thus the Medical Superintendent declared to us one day that his personal treatment methods were quite blunt. If a patient was 'relapsing' then his treatment of choice was a large shot of

chlorpromazine in one buttock and an equally large shot of fluphenazine decanoate in the other. The great advantage of the depot neuroleptics is the timed release of measured quantities of the drug over extended periods. This has clear benefits in terms of patient compliance and more efficient use of staff time. If a patient needs an immediate booster shot to control suddenly disturbed behaviour, then a depot drug would not be particularly effective. It would be necessary to give something that could be absorbed immediately. Thus Western practice would be, if depot neuroleptics were being prescribed, precisely the opposite. They would form the base of treatment and oral or intramuscular neuroleptics would be used to raise the dose at short notice if required.

A second clear difference in drug regime is that many more patients at the Guangzhou Hospital are on no psychotropic medication at all. A number of interpretations of this phenomenon are possible. Given the nature of the hospital, it might be a cost cutting exercise. In discussion with the staff, this is probably too cynical a view. Older patients whose symptoms are no longer active are considered not to need to take drugs unnecessarily. It is commonly acknowledged in the West that neuroleptics are more effective in controlling the positive symptoms of acute schizophrenia, rather than in assisting with the deficit states more commonly associated with chronic schizophrenia. Whether or not they know this, the doctors at the Guangzhou Hospital have possibly reached the same conclusions through clinical observation. An unwillingness to prescribe neuroleptics when it

was thought they were needed was certainly not observed.

The third discrepancy in prescribing habits observed in Table 9:3 concerns -anti-cholinergic, anti-parkinsonian drugs given to control the side-effects of neuroleptics. In the past these were given routinely, but more recently this practice has fallen into disfavour. It has been found that they alter the absorption of neuroleptics by changes in gut motility, thus reducing the therapeutic action of neuroleptic drugs. They may actually enhance the development of, and obscure the early stages of, tardive dyskinesia. Anti-cholinergic drugs may be abused for their euphoriant effect. Most crucially, patients maintained chronically on antiparkinsonian drugs and neuroleptics show little increase in side-effects when the former are withdrawn. (Loudon, 1988)

The medical staff at the Guangzhou Hospital were quite clear that they understood the dangers in the over-prescription of anti-cholinergic drugs, and that clinically they preferred not to use them, unless there was some clear indication that the patient was suffering from side-effects that could not be controlled by an alteration in dosage. Thus in terms of the timing of medication, less multiple drug use, less use of anti-cholinergics and a higher proportion of patients receiving no medication at all, the prescribing habits at the Guangzhou Hospital conform more closely to international standards than those at TAPS.

SOCIAL AND PSYCHOLOGICAL TREATMENTS

If Chinese medicine looks for both illness and cure in the body, it is hardly surprising that theories and techniques based on

seeking causes and remedies in the mind have not been widely

accepted. This traditional viewpoint has been supported by what is

seen as the innate opposition of psychodynamic and

psychotherapeutic theories to Marxist ideology:

> 'In China psychoanalysis is not a generally recognised
> treatment technique because it is based on the subjective rather
> than the objective. Psychoanalytic theories cannot be proved or
> disproved by experimental data or consistent clinical observation
> and, therefore, belief in such theories is thought of only as a
> matter of personal opinion'. (Young Derson and Chang Mingyuan,
> 1983, p. 435)

Freudian psychology, which was thought to base the origin of

illness on the 'physiological reaction to mysterious sexual

drives', was particularly unwelcome. (Ting T'san, quoted in R.and

A.L. Chin, 1969, p. 63) A more recent review article on Freud's

thinking is blunt:

> 'As an ideological set-up Freudianism is an extremely
> powerful corruptive agent in society..... The essential error of
> Freudianism lies in the fact that it does not use social-
> historical concepts to analyze psychological problems and
> questions; rather it uses theories of psychoanalysis to explain
> socio-historical phenomena. Hence it arrives at a counter-
> scientific result'. (Zhao Biru, 1983, p.69)

The reduced emphasis on psychologically oriented treatment is

exemplified in the psychiatry textbook edited by Beijing Medical

School, published in 1980 and 700 pages long. There is no section

devoted to psychotherapy, and psychoanalysis is briefly mentioned

in a section devoted to a foreign school of psychiatry. (W.S.

Tseng, 1986)

Tseng argues that individual psychotherapy was purposefully

suppressed by political ideology that criticised this product of

capitalism where therapists worked for the benefit of the

individual. Under socialism, therapy was supposed to cultivate revolutionary ideology in the patient who could then fight his illness. A theory of the human mind that regarded people as passive victims of an unconscious over which they have no control, was simply not acceptable in a society engaged in the transformation of human relations. This was particularly so when that theory was also seen to be an offshoot of bourgeois capitalist thinking, which in the process denied the reality of the class struggle that was at the root of mental ill health.

'Since this kind of theory was extremely well suited to the political needs of the ruling classes, it became used as a tool to screen the evils of an irrational system'. (Zhao Biru, 1983, p.76)

The debate about whether psychotherapy is applicable for the Chinese extends beyond the boundaries of the PRC, and it has been a commonly accepted wisdom that it is not. (T.Y.Lin, 1983; M.Tsai, S. Sue, N. Wagner, 1981; Kleinman and Mechanic, 1981) The grounds for this are usually cited as the resistance of the Chinese to talking about private, emotional matters; their inability to verbalize emotion; the strong sense of shame inculcated from an early age about discussing negative family matters outside the family; their dependent-authoritarian orientation. More recently, this view has been challenged. (Fanny Cheung, 1986; M.L. Ng, 1985; May Tung, 1984; David Chan, 1989)

In essence, what these authors say is that if there are no language or cultural barriers; if counsellors are trained; if the expectations and the needs of clients are taken into account and respected, so that the therapy adjusts to the client rather than

vice versa; then there is evidence to suggest that Chinese people find 'talking therapies' helpful and welcome them. This view is born out by the recent development of counselling services in some of the larger cities in China which are said to have been very well used. (<u>Beijing Review</u>, March 3rd., 1990, p.7; <u>Beijing Review</u>, Dec. 24th., 1990, p. 24-26) However, this has not meant that counselling has become more available as part of the services provided for mentally ill people.

Because psychotherapy is often seen as the defining aspect of psychiatry, (T.S. Lin, 1983), it is easy to forget that, while those practising it believe in its efficacy and those receiving it often feel that they have benefited in some way, it has remained remarkably difficult to demonstrate this scientifically. Furthermore, it is a form of treatment offered to only a small number. These tend to be the favoured few who share the same cultural and educational background as the therapist, and who frequently can pay for the privilege. The vast majority of emotionally disturbed people in Western countries receive precisely the same treatment as their Chinese counterparts; drugs.

As with most matters regarding views about treatment for Chinese people, (even those outside China), the issue of psychotherapy is underpinned by historical and political considerations. If we argue that psychotherapy is useful, is that an imposition of Western categories on Chinese beliefs and experience? If we argue that it is not applicable, is there an implied message of a less educated, less verbal, less developed society, somehow a little further down the evolutionary ladder?

Insight-oriented psychotherapy is not recommended for the treatment of people suffering from schizophrenia. (Kendell, 1988) But to assume that the doctor's, (or counsellor's), role extends only to the patient is to take a very narrow view indeed. Stripped to their bare essentials, most types of psychotherapy provide the opportunity to find relief from distress through talking, sharing, support, comfort and understanding. Families of the mentally ill, whatever their nationality, need help to deal with the practical and emotional problems to which the condition inevitably leads. Patients, while not needing insight necessarily, at least in Chinese cultures, require assistance to circumnavigate the emotional pressure cooker of the family from which there is no realistic escape. (Phillips, 1990)

But, as we have said before, this is not simply a matter of what clients or patients will or will not accept, but applies to medical staff as well. Until this latter issue is addressed, the reaction of patients and families to approaches other than drugs cannot be assessed. Informally, some of the younger doctors are showing interest in psychoanalytic works that are beginning to be translated into Chinese. Ironically, these are not the most relevant approaches for people who spend the majority of their time working with those suffering from schizophrenia. But it is a beginning.

Within the many schools of psychotherapy and counselling it is inconceivable that there are no approaches which would have something to offer Chinese psychiatric patients and their

families. Modification, adaptation and even invention by Chinese mental health professionals would undoubtedly be required. This is not an argument based on the 'West is best' orientation, but stems from the author's belief that there are aspects of human misery which are shared in common, and aspects of the psychological and social effects of schizophrenia on patients and families which are universal.

Interventions, for instance social skills training, or skills training in daily living, that focus on normalising behaviour rather than feelings are routinely offered in the more advanced hospitals in the West. Occupational therapy has become ever more central and sophisticated in the provision of experiences designed to keep even chronic patients more in touch with standard expectations of behaviour. These approaches are not apparent in psychiatric hospitals in China of which the author has knowledge. This is at least partly a function of the lack of differentiated personnel. There are few psychologists, and where they exist they are mostly involved in measuring and testing rather than treatment.

Anding Hospital in Beijing employed two fresh psychology graduates from Beijing University in the autumn of 1988, with an expectation that they would offer treatment. In discussion with these two, it became very apparent that they were having great difficulty with their role as they had had no training that would equip them for the task they were expected to carry out. Nor did they have any models to follow, or anyone to guide or supervise their work from

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a position of knowledge. Occupational therapists are non-existent, so that what is offered as occupational therapy tends to be restricted to some kind of work experience. This reliance on doctors and nurses, (many of the latter untrained), inevitably affects the way that treatment is defined.

It has been known at least since Wing and Brown's work (Wing and Brown, 1961) in comparing three psychiatric hospitals in southern England, that the course of schizophrenic illnesses and the resulting social handicaps can be affected for good or ill, by the patients social environment. (Kendell, 1988) Thus behaviour interpreted as symptomatic of the illness like head banging, posturing, talking to self, are as likely to be the product of a grossly deprived and non-stimulating environment as of a psychiatric illness. There appeared to be absolutely no awareness of the profoundly damaging effects of long term hospitalization among medical staff at the Guangzhou Hospital, and precious few doctors in other more advanced hospitals.

Without this understanding of behaviour, there is little reason to think of ways of treatment that go beyond the medical model. Thus everything tends to be reduced to a problem of medication and may be resolved through an alteration in dosage or type. Ultimately, if the problem remains intractable, then it is a measure of the severity of the illness, not a judgment upon the hospital regime. Walking through the female ward of an acute hospital at which we were guests, the Deputy Medical Superintendent of the Guangzhou Hospital pointed to the row of comatose bodies curled up on their beds at midday after lunch and medication, and wistfully said how

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much he wished his hospital could aspire to such 'scientific' practices. Behaviour which might be considered healthy and normal outside the hospital walls is defined as deviant and a sign of illness within it. Thus a male patient at the Guangzhou Hospital who was considered to be well enough to work on ground maintenance, asked to be introduced to a female patient whom he had glimpsed through the barred door to a female ward. He was immediately confined to his ward and his medication increased due to this evidence of a 'relapse' of his illness. Naive, perhaps, but hardly ill.

Formal occupational therapy is not well developed in China. In the smaller hospitals some activities take place on the wards. In the Guangzhou Hospital nurses supervised patients pulling apart cotton cloth to be rewoven. This is a very boring, low grade form of activity providing no intrinsic interest or stimulation. The work is provided by an outside firm and a very small amount of remuneration is given, perhaps enough to buy two packets of peanuts each month from the shop in the hospital grounds. As it is organised it gives no opportunity for patients to get away from the ward or to meet fresh faces.

Larger hospitals like Fong Tsuen in Guangzhou and the Shanghai Number One do have separate occupational and industrial therapy units which some selected patients are able to attend. They cannot cater for all patients in the hospital, however. At Fong Tsuen some handicraft work is possible, mostly sewing, and assembly work provided by outside factories. Fong Tsuen also has about 25 sewing

machines   which are used for the production of patient uniforms,
and other sewing jobs necessary in a hospital. Activities observed
at   other   hospitals   included   making   shoes   and   uniforms,
calligraphy, a newspaper reading room and, in some ways most
advanced of all - knitting. Almost every female old enough to hold
needles knits in China. However, the activity is not allowed in
most hospitals, (where patients are routinely deprived of all
their possessions except a toothbrush), because it is considered
that the needles could be used as a weapon against self or others.

At the Shanghai Number One Hospital (in 1983) much emphasis was
placed on 'heart-to-heart' talks which each patient would have
with their doctor about three times a week. These sessions were
used to help the patient and doctor to a greater understanding of
the patient's problems, and to discuss strategies for dealing with
them. It is the nearest to psychotherapy that treatment in China
comes and in Western terminology would probably be closest to
rational-directive therapy. The Shanghai Hospital was the only one
visited where communication between doctor and patient was
systematized in this way and was seen as a contributing factor to
the patients' recovery.

Most wards have more doctors on them than is common in the U.K..
At the Guangzhou Hospital each ward was allocated three who were
on the ward from 9 a.m. until 4 p.m., excepting a break for lunch.
Under those circumstances doctors inevitably come into contact
with patients frequently and, inevitably, some of them talk to the
patients, and see some value in patients sharing their troubles.
From my observations, this seemed to depend on the character of

the doctor rather than to be an expectation of the therapeutic task.

On the wards at the Shanghai Hospital we were told that there were also educational group meetings for patients to talk together about their illnesses under the guidance of staff, who would also give lectures on the nature of mental illness, symptoms, treatments and how best patients could help themselves. Discharged patients would be asked back to talk about life outside, how they had adjusted, what they had learned from their stay in hospital and so on.

In some ways, Anding on paper had the most impressive array of psychosocial daily activities. Patients seemed to be rarely left a free minute between sessions of music therapy, occupational and recreational therapy, psychological therapy. When enquiries were made as to what happened during these sessions, the picture was less positive. Music therapy consisted of listening to music through headphones, which was thought to have a soothing effect. One of the activities listed in occupational activity was taking a bath. Patients were charged separately for every session of such therapy and the costs were in addition to the 500 yuan a month hospital fee. Staff were open about working under the new financial guidelines that require hospitals to be partially self supporting, particularly in the areas of staff bonuses. Consequently it is hard not to draw the conclusion that the prime purpose of these activities is to earn money.

1 - The contribution of Chinese medicine exists on the periphery of available treatments for schizophrenia. The majority of doctors contacted were of the opinion that, at least in the control of psychotic symptoms, Western treatments were more effective. For many of them, their conception of treatment did not extend beyond drugs.

2 - The use of ECT gives cause for concern. It is frequently used to treat psychotic symptoms, a practice no longer recommended in the West. Attitudes among doctors in China towards ECT differ very markedly from those of their counterparts in the U.K. and the U.S.A.. From personal observation in China, it is also clear that ECT is used as a threat to obtain compliance from some patients and, on occasion, is actually used as a punishment. ECT is one of the reasons why Chinese patients fear hospital admission, and for as long as it is administered unmodified, it has to be admitted that they have much to be fearful about. The consequence of all of this, is that many people, particularly the severely depressed, are not receiving an appropriate and effective treatment. Families are very reluctant to give permission for such a distressing and painful procedure. For the same reasons, some doctors are reluctant to submit their patients to such an unpleasant experience.

3 - It has been widely assumed by Western observers that psychosurgery is no longer performed in China. (T.Y.Lin, 1985) There is clear evidence from this research that this is not so.

The idea of informed consent is non-existent. From examination of the files deepest disquiet must be felt about the assessment and selection of patients, the procedure itself and after-care.

4 - Western derived psychotropic drugs are the major form of treatment, partly because of their efficacy and partly because the requirement of a shared belief system is much less in psychopharmacology. The range used is restricted although in some respects remarkably similar to published data on British hospitals.

5 - Psychosocial models of care are not implemented in China and, where known, are thought to be of little importance. It is said that some hospitals are developing rehabilitation wards and that more effort nationally is now going into this area. Most places have some basic work therapy and some recreational activities but wards on the whole are unstimulating, oppressive places to be, particularly for long-stay patients. Despite the more obvious problems concerning psychosurgery and ECT, more avoidable misery is propagated on the wards of the Guangzhou Hospital by the mind-numbing boredom of the routine and the lack of contact with any semblance of normality.

6 - The real issue is not whether Chinese people are suitable for psychotherapy or counselling, but the resource implications of both training, and then providing, such counselling for so many people. It is ironic that the concept of holism which Western medicine has incorporated into its own practice, following the example of Chinese medicine, has become so narrowly defined in

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China as to largely exclude the psychological and social needs of

patients and their families.

PART THREE:
HOSPITAL AND
COMMUNITY SERVICES

CHAPTER TEN

PROBLEMS OF HOSPITAL CARE

There are always dangers in generalising from the particular and the detailed study of a single hospital in Guangdong Province may seem a very slender base for discussing 'Mental Hospital Care In China'. Enough has been said in earlier chapters about the dangers of stereotyping to emphasise the need for caution.

But nobody has a comprehensive and detailed knowledge of this subject. The sheer size and complexity of China is defeating, and few, if any, Western observers have had the opportunity to make a broad and informed assessment. Tours arranged for foreign visitors by Chinese officials are comparatively short in duration and tend to show only the best equipped hospitals and the most advanced practice. Those Western writers who have lived in and have more extensive experience of Chinese conditions, such as Altschuler, (Altschuler et al. 1988), Taylor, (Yan Shanming, Xiang Dezhao, Chao Yuzhen, Chen Deyi, Zhang Deqian, Michael Taylor, 1984), Kleinman (1986) and, most notably, Phillips et al. (1990) are all doctors. Consequently, they do not write about the management of hospitals and psychiatric resources generally, but are largely concerned with issues of diagnosis and treatment.

It is therefore proposed to take the problems of the Guangzhou Hospital as a paradigm of mental hospital problems in the PRC. The following considerations support this decision:-

1) Visits to other Chinese mental hospitals (Shashi and Anding in particular), suggest very similar problems in hospitals

under different jurisdictions. Two major reports in newspapers in recent years confirm this view. One concerned hospitals in Heilongjiang and Tianjin. (The Asylums of China, Independent Magazine, November 3rd.1990) The other concerned Dali Psychiatric Hospital in Yunnan Province. (In Search Of A Sane Society, South China Morning Post, November 19th., 1988) They are significant in that they were not especially chosen as suitable to be shown to professional guests from abroad and probably are much more typical of psychiatric hospitals in China than the ones written about in learned journals. Both articles described, if anything, worse conditions than those to be found in the Guangzhou Hospital.

2) Although China is vast and varied, there is very strict ideological control. Flexibility, imaginative improvisation and experimentation are not encouraged in this society, and indeed run the risk of being classified as 'deviationism'. The sort of small scale inspirational movement associated with the work of Maxwell Jones and Elly Jansen in the therapeutic community movement simply could not occur in the PRC. Nor could the criticism of a Goffman, or a Szasz, or the pressure group activities of a Larry Gostin or a Marjorie Wallace.

3) Goffman's analysis in Asylums (1961) was based on empirical observation in a single institution, and a somewhat atypical one: St. Elizabeth's Hospital, Washington DC. This analysis suggests that the pathologies of 'total institutions' may occur in all societies unless vigorously counteracted.

4) The previous discussion of stigma and shame in Chinese society (see Chapters One and Three) suggests that the concepts

proposed by Goffman are likely to be widely applicable.

5)   Certain aspects of policy making are national, for instance, the 'three preventions' and the 'four integrations' (see Chapter Six. Both Collins (1982) and Wilson and Hutchison (1983) mention the three levels of nursing care. Another aspect of national policy that is having a profound effect on psychiatric hospitals is funding. (see Chapters Two, Six and Eight; Zhang Dejiang, 1987; Wong, 1991) The drive to make hospitals less reliant on government money and instead to raise their own operating costs has affected length of stay, (Phillips et al. 1990), and access to care for all patients.

The analysis which follows is necessarily tentative, and may require revision if and when further empirical findings become available; but it is argued that in the present limited state of knowledge, the paradigmatic approach is justified.

THE GUANGZHOU HOSPITAL AS A TOTAL INSTITUTION

As an institution from the patients point of view, the hospital is a world enclosed upon itself. Goffman's analysis of total institutions has been part of the professional air we breathe for so long that it comes as a shock to find a place innocent of all notions about the iatrogenic effects of institutions and unaware that patients' behaviour is a product of environment as well as of the disease process. Indeed, such knowledge pre-dates Goffman. Henry Maudesley was well aware of the danger of creating 'asylum made lunatics'. (quoted in Barham, 1984, p. 5)

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According to Goffman a total institution is:

> 'A place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life'. (Goffman, 1961, p. xiii)

What features define total institutions? (Goffman, 1961, p. 17) To begin with they are isolated, either by geographical or man-made features. As we have seen from Chapter Seven, the Guangzhou Hospital certainly meets that criterion. All aspects of life are conducted in the same place and under the same single authority. Thus the nature of the regime is an encompassing one for patients. This is is true even for those patients who go on an occasional short home leave. Work and recreational activities, (what there are of of them), eating, sleeping, living are all conducted under one roof.

Each phase of the patient's daily activity is carried on in the immediate company of a large number of others, all of whom are treated alike and required to do the same thing together. This is what Goffman called 'batch living'. The routine requires that everyone get up and go to bed at the same time, shave at the same time, and bath publicly and simultaneously in the same bathtub, (one of which can hold seven to ten people), or under the same shower head.

All phases of the day's activities are tightly scheduled, with one activity leading at a pre-arranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. St. Elizabeth's

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seems to have had a more varied programme of activities than the Guangzhou Hospital. But in so far as the patients in Guangzhou have any activities, they are scheduled for the same time every day by the staff - morning exercise, for instance.

The various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution. Thus we have the 'four integrations'.

Goffman also describes a system of binary management where the world of the staff and the world of the patients co-exist side by side but rarely penetrate each other. The detail available to Goffman was not accessible to me in the same way because of language barriers and lack of time. It was, however, obvious that the staff occupied a position of authority and the patients were supplicants, for instance in the matter of being allowed to go for a walk.

One incident made an impression. On one of the male wards while standing in the courtyard, a doctor called a patient forward by barking his name, and pointing to a spot about three feet in front of his shoes where the patient was expected to stand. The doctor then gave an account of the patient's life and illness in front of all the other occupants of the ward, occasionally asking questions of the patient from whom the answers were a standard 'Yes, sir!', 'No, sir!' The expected salute did not quite happen. Many staff spoke about the patients as being able to do nothing, not even being capable of pulling apart cotton threads. Given the nature of the work and the pittance they were paid, it was impossible not to

wonder whether the patients were using the stereotype to their own advantage.

While it is possible to quibble over the details (for instance, the days' activities are not really tightly scheduled as there are very few activities) Goffman could have been describing the Guangzhou Hospital. There is no way of knowing how many patients were willing to come to hospital initially, but the impression from the files and the staff is that it would be very few. (see Chapter Four) From talking to the Medical Superintendent and the patients (see Chapter Seven), it became clear that Goffman's notion of the 'betrayal funnel' was also apposite to the Guangzhou Hospital. One patient was tricked into coming to the hospital by being told that they were going on a picnic; another thought she was going to be offered a job. There were doubtless many more and it is a pattern repeated at the Shashi hospital.

Methods of Adaptation

At least in the initial stages, until the patients learned to adopt the identity of a psychiatric patient, the 'mortification of the self' would have been acute. I was not able to witness an admission and do not know the precise detail of the admission procedures. The after-effects are quite visible; no personal clothes, no personal possessions, no personal space or privacy. (This also applies to the Shashi Hospital and Anding.) The staff preference for the 'inmate role' would be virtual 'invisibility', or in the patients' terms, withdrawal. Observation on the ward and information in the files suggested that this was an option for a

number of the patients, who had little verbal or emotional contact with the world around them.

By the time I had read through 147 case files, a picture formed of a truly 'three have nots' patient, based on the number of 'no information' boxes ticked on the data collection form. The more that was not known, the more 'have not' the patient appeared, until it seemed that for some of them only their physical form remained. The rest - their personality, their history, their family, their individuality, spirit - had all been erased by a combination of their circumstances, their illness and their sojourn in the hospital. There was neither written nor human record of their lives.

At least some patients, knowing no other home, feel grateful to the government for looking after them, feeding them and so on, and in Goffman's terms could be considered to have been colonised. Others are bitter about their wasted lives and pine for families long lost to them. A small number may be considered to be among the true believers who have internalized the institutional view of themselves, for instance Mr. Lui, (Chapter Seven) and have been converted. Goffman's fourth option of intransigence is harder to determine. The patients themselves reported that there was fighting on the wards (see Chapter Seven) and the existence of the seclusion wards and the fact that some, at least, were inhabited, suggests that there are those who resist. Whether it is the system they are struggling against is another matter. The major retaliatory weapon of the staff seems to be to define all such behaviour as a manifestation of the illness and treat it. To this

end, some patients may find themselves tied by all four limbs and around the torso to a bed and connected to an intravenous drip. Others may receive unmodified ECT or electric acupuncture.

As Jones (1984, p.25) points out, Goffman makes no allowances 'for the problem of severely abnormal behaviour or of running a stigmatised and underfinanced service'. Sedgwick (1982, p.63) makes very similar criticisms:

> '[Goffman's] method consists in a precocious sensitivity toward those elements of social living which involve face to face adjacency of persons. On all other aspects of the social process, that is to say, on any institution or happening that receives its meaning from outside this immediately shared space among individuals within shouting distance of one another, he is virtually silent'.

The point that Jones and Sedgwick are both making is that the distress and reality of mental illness are not figments of the imagination. Symptoms are more than behaviours that have slipped out of context. But within those confines, institutional care does not have to mirror the features of St.Elizabeth's Hospital. The shock in the Guangzhou Hospital is to see the ghost of St. Elizabeth's reflected so faithfully in the mirror.

ORGANIZATIONAL PERSPECTIVES

Scott (1987, p. 22) suggests that there are three paradigms to be used when looking at organisations; the rational, natural and open systems. Organisations following the rational paradigm are:

> 'Collectivities oriented to the pursuit of relatively specific goals and exhibiting fairly formal social structures'.

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Although organisations espouse specific goals the behaviour of participants is frequently not guided by them, nor can they safely be used to predict individual behaviour. Scott differentiates between the normative structures in organisations and the behavioural ones, or the difference between what is supposed to happen and what actually goes on. This is a common distinction made by writers in this field (Handy, 1985; Turner 1987)

This leads to Scott's second definition from a natural systems perspective that:

> 'Organisations are collectivities whose participants share a common interest in the survival of the system and who engage in collective activities, informally structured, towards this end'.(p.23)

Yet there is still a missing element. One of the most fruitful perspectives to be added to organisational theory over the last 30 years is the one that says that organisations cannot be properly understood out of the context of their environments. This perspective entered the social sciences from the natural sciences with von Bertalanffy's assertion in 1950 (p.70) that:

> 'Living systems are open systems, maintaining themselves in exchange of materials with environment [sic]....It is open if there is import and export and, therefore, change of the components'.

A number of authors, including Rice (1972) and Katz and Kahn (1978), have applied this input - conversion - output model to the study of organisations. Organisational activities and outcomes are strongly and reciprocally influenced by environmental factors. Thus Scott's third definition is based on an open systems paradigm:

'Organisations are not closed systems sealed off from their environments but are open to and dependent on flows of personnel and resources from the outside'. (1989, p.23)

Katz and Kahn (1978) advise that it is necessary to study the way that organisations are tied to other structures; not only those that provide material inputs, support and information, but also those that provide political influence and societal legitimation.

No organisation can be a closed system without eventually suffering from entropy and ceasing to function. Even our hospital, isolated and closed as it is for patients, is an open system from an organisational perspective. It is influenced by the political structure of the wider environment. There are inputs of policy directives from the Guangzhou Civil Affairs Bureau, as well as from national levels. It has _guanxi_ connections, debts and credits with various other institutions whom it helps out, and from whom it receives assistance in its turn. There are also the more obvious inputs of patients, staff, and other resources from the vegetable sellers to the companies supplying cotton to be recycled. Outputs are probably fewer. The hospital is a greater consumer than producer. Less than 30 patients are discharged each year and the hospital produces very little that is exported to the outside world except bags of cotton and the lily blossoms that the farmers pick.

Scott's argument suggests that all three perspectives are applicable in the analysis of organisations. One is not more correct than another, nor will only one be appropriate. This begs the question of whether some modes of organisation are more appropriate in some situations than others. Lawrence and Lorsch's

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contingency model (quoted in Scott, 1987, p. 96) suggests that the rational and natural paradigms should not be viewed as aspects of the same organisation but as different forms of organisation. From this position they argue that there is no best way to organize; but that different ways of organising are not equally effective; and that the best way to organise is defined by the nature of the environment to which the organisation relates.

Combining these notions leads us to the position that organisations may most usefully be viewed from three different perspectives simultaneously, but that one of these perspectives will dominate given the task of the organisation and the environment in which it finds itself.

Mechanistic and Organic Models

Burns and Stalker (1966) have characterised organisations as either *mechanistic or organic*. A *mechanistic* organisation is one based on the ideal type of bureaucracy, with a specialized division of labour and the rights and duties of each employee carefully defined. Tasks are co-ordinated by a management hierarchy which directs operations and takes major decisions. Communication is vertical with instructions flowing downward through a chain of command, and information flowing upwards processed by various levels of the hierarchy. This type of organisational structure is suitable for routinised tasks under stable conditions and fits within the rational systems paradigm.

An organic organisation does not rigidly define areas of responsibility and an individual's job is to further the goals of the organisation rather than simply carry out a pre-determined operation. When a problem arises all those who have knowledge and expertise to contribute to its solution will meet and discuss. Communication consists of consultation, not command. This type of organisational structure is more suited to changing situations where innovation and imagination are valued.

Handy (1985) expands on the idea of the mechanistic organisation with his notion of role culture as a Greek temple, with a narrow pediment of a small but controlling management group at the top supported by the pillars of different functions and specialities. The Greek temple design is suitable for organisations in a 'steady state'.

It is clear that the Guangzhou Hospital meets the criteria and conditions for a mechanistic model, incorporating Handy's idea of a role culture. Authority relations are rigid and hierarchical. There are few formal consultation channels with staff and little room for innovation or change unless introduced either from the management team or by outside forces, as when the hospital became responsible for raising some of its own funding. At the same time, as we saw earlier, it is not easy for the management to change the working habits and patterns of the staff who, presumably, are pursuing their own interests, which are not necessarily the same as those of the hospital's. And the hospital is responsive to the dictates of its environment not just in terms of policy directives but for example, in providing a health clinic for the local

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population.

Organisational Aims

As Katz and Kahn point out:

'The completely open organization would no longer be differentiated from its environment and would cease to exist as a distinct system'. (1972, p. 31)

One of the ways that organisations are differentiated and given a distinct identity is through their different purposes and objectives, frequently referred to in the literature as goals. (Katz and Kahn, 1978; Handy, 1985; Scott, 1989) However, as Hall (1972) says, the concept of goals is 'fuzzy'. The major criticism centres around the belief, in the 'rational' tradition of organisational theory, that there is only one set of goals articulated by the management or whoever occupies the higher positions in the organisation.

This view ignores the likelihood that different groups develop their own aims and objectives in working for the organisation that are just as real as the official goals. Thus the different groups involved in a hospital, (nurses, doctors, patients, administrators, ward orderlies, maintenance staff, ministry officials, neighbours), may be pursuing very different ends. From an analytical point of view no one group goal has a greater validity than any other, and all must be taken into account to achieve a proper understanding of the organisation. Scott suggests that rather than asking 'what are the goals?', a more useful question is 'who sets the goals'?. (Scott, 1987)

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Hall discusses the emergence of operative goals as official goals made more concrete. These may develop over time to reflect the objectives of other groups within the organisation, and, on occasion may be deflected radically from the intent of the original formulation. (Hall, 1972, p. 84) Thus they reflect the desired state of affairs, the modifications and subversions of these by personnel in decision making positions, plus the force of pressures from the environment.

Robinson argues that organisational goals are created by the interaction of participants in the course of their everyday work in the organisation. This again conflicts with the assumption of orthodox theories which tend to conceptualize organisational rules as decided on and structured, rather than a series of compromises between competing groups. 'It is the negotiated, informal guidelines to conduct which have the greater reality to those whose conduct they guide'. (Robinson, 1976, p.117;) Turner (1987) makes a similar point.

Nor does the classic account take into consideration the degree of conflict that may exist. Organisation members compete for status, power and resources in order to expand their own area of territory and control, or for career advancement. In pursuit of these aims groups are formed and sectional interests emerge. As a result policy decisions may serve the ends of political and career systems rather than those of the concern. (Haralambos, 1985)

The end result of this, as Hall points out, is that it becomes very difficult to determine when a goal has been reached, or how

effective an organisation is in achieving its goals. Moreover, in a situation with multiple goals, they may actually conflict with each other. The goal of cost-cutting may be achieved at the risk of jeopardising the goal of high standards of patient care.

Donnison and Chapman (1965) avoid the problems inherent in talking about goals and refer instead to organisational aims, which may be conceptualized from four different perspectives;

1 - manifest aims; what the organisation tells the rest of the world through policy statements, brochures etc..

2 - assumed aims; what the staff actually think they are doing.

3 - extant aims; what they are really doing.

4 - requisite aims; what the expert thinks they might be doing or adopt as a policy for the future.

The Guangzhou Hospital produces no brochures or publicity material so that policy statements have to be taken from national rather than local material. The Statistical Report of the Civil Affairs Bureau, 1987 (Sheshui Baozhang Bao, March 1988) starts in very general terms by saying that:

> 'Under the leadership of the Party and the Government and with the assistance of various departments, the Civil Affairs Ministry at all levels has persisted in the principles of reformation and openness and also launched the campaign of increasing production and income through cutting expenditure. The Civil Affairs Ministry has contributed to the development of a stable national economy, national economic reform and a stable society'.

Translated into local terms this refers to the alteration of policy regarding the 'three have nots', and the change to

accepting paying patients in order to become more self supporting and less of a drain on public expenditure. It is also reflected in the introduction of the 'contract responsibility' system within the hospital to reduce expenditure.

Secondly, there is a nationally stated policy about the regime in psychiatric hospitals run by the Ministry of Civil Affairs.

> 'The mental hospital run by the Ministry of Civil Affairs is using an integrative therapeutic treatment for the patients. This therapy includes medical treatment, work treatment, recreational treatment, and psycho-ideological treatment. These four treatments integrated together form the "four integration treatment". The medical treatment controls the relapse of mental patients, the work treatment trains the patients to adapt to social functions, the recreational treatment helps the patients to build up their physique, and the ideological education trains the patients to recover from mental disabilities and to improve their mental health'.

Interestingly, while the 'four integrations' was practised in the Guangzhou hospital, staff repeatedly said that it involved concentrating on drugs, occupation, recreation and physical exercise. They did not mention ideological treatment. They did sometimes say that it was important to educate patients about the facts of mental illness, but there was never any implication that there were political overtones to this. When specifically asked whether they thought that political education had any place to play in the treatment of mental illness the doctors were very clear that it was of little or no use. Thus it is probably justified to conclude that knowingly or not, the staff at the hospital have re-shaped the 'four integrations' to be more to their taste. Their version may be defined as an assumed aim.

Possibly the clearest assumed aim for the staff is that they are providing treatment and rehabilitation for the patients. Indeed, this is included in the official name for the hospital. They are also aware of improvements in the hospital in recent years. Mostly these include better trained doctors, improvements in the physical environment, more rewarding patients, and a wider range of drugs. The Deputy Superintendent was aware of the process that had gone into the change. He reported on the debate that had occurred among the staff in the early 1980s about altering the focus from, as he put it, 'feeding and housing' to treating. As more and more qualified doctors joined the hospital the importance of the debate diminished because there was no disagreement about the primacy of treatment.

Thus another assumed aim is to become more like a 'proper' hospital. Providing patients for psycho-surgery can be seen as part of this process, in the belief that involvement with the 'hard' side of medicine would improve their image. The Medical Superintendent was obviously proud to have been involved in what he called 'pioneer work'. This was not a view shared by the ward doctors who were more aware of the costs to the patient. A frequently expressed desire of the Deputy Medical Superintendent was for the hospital to be more 'scientific' in its approach to the treatment and management of patients. Thus at least one of the aims, albeit at a higher management level, was to do with moving closer to general medicine.

A delineation of extant aims tends to be based on observation rather than reading or listening. In a classic work, Parsons

defined the traditional goals of a mental hospital as custody, protection, socialization (which he defined as the internalization of the hospital's values) and therapy. (Parsons, 1957) Observation in the hospital leads inexorably to the conclusion that much of staff activity is directed towards maintaining custody and control:

> 'It has been argued that psychiatric hospitals have displaced their treatment goals in favour of custody and order. This argument assumes that it is realistic in the first place to suppose that psychiatric hospitals might actually achieve the goals laid down in formal policy statements....but it is more appropriate to regard the goal of treatment as of symbolic value only with custody and control as the real operative goals of the hospital'. (Smith, 1979, p. 58)

We have noted in other chapters the emphasis on control of the patient, for instance within the legal framework, and the principle that the right of the collective to be protected from the depredations of mental patients is more important than the rights of the patients to liberty. We have also noted the importance placed on the 'three preventions', and the sense of strain that is generated in staff by concern about the repercussions of patients' 'bad behaviour' on themselves. It is probably correct to assume that this focus on control has its genesis in the wider society, and its definition of the job of a psychiatric hospital.

This disparity between therapeutic and custodial aims is another instance of a problem shared with psychiatric hospitals elsewhere:

> 'Community pressure can affect what is already a built-in strain in the mental hospital, the conflict between the therapeutic and custodial functions....[this] conflict cannot be

fully understood unless the community orientation and the channels of its expression are studied'. (Etzioni, 1973, p. 85)

Etzioni goes on to argue that to some degree custodial activities are the means for therapeutic goals - if the patients cannot be kept in the hospital, they cannot receive its therapeutic service. This statement begs several questions. It presupposes an understanding of mental illness that suggests that treatment is efficacious independent of the human being, thus justifying enforced treatment on the grounds that the patient is incapable of having a rational viewpoint to which it is worth listening. This is a view to which many staff at the Guangzhou Hospital would subscribe. There may be legitimate occasions when a degree of custodialism is required, if someone presents a clear danger to themselves or others, but given the chronic condition of many of the patients at the hospital there is a stronger argument to be made supporting the view that custodialism is contributing to their problems.

Another area where it is possible to see an extant aim vying with manifest and assumed aims is in the conflicting priorities of money versus service. Now that staff and the hospital are being held to be financially accountable, the need to raise fee income looms very large. Some of the ward doctors were quite explicit that they were under pressure to prescribe more drugs than were necessary in order that higher fees could be charged. One of them said that it was easier for the better qualified doctors to resist such pressures but the younger and less qualified ones were very vulnerable to influence. (The consequences to treatment of changed financial requirements were much more noticeable at Anding

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Hospital and Shashi Hospital than at the Guangzhou Hospital).

Smith makes the point that:

> 'Within the ward as a front line unit nurses have control over the hospital's operative policy both in the tasks of patient care and, in the locked wards, in the task of custody and control. In particular, they control the flow of information with the ward as a pocket of communication'. (Smith, 1979, p.60)

The Guangzhou Hospital has many more doctors habitually on the ward than is common elsewhere, but they are still greatly outnumbered by nurses who have the most face-to-face contact with the patients. It is also likely that because doctors are seen as being further up the hierarchy, patients may use nurses to intercede for them, rather than approach doctors directly. We have already commented on the lack of nurse training. There is a consequent lack of professional orientation. To most nurses therapeutic aims have little meaning. They are much more concerned with whether a patient is 'good' or 'bad', and whether they cause the nurses more or less work. A 'good' patient is one who is quiet, obedient and causes no fuss.

One of the fundamental difficulties is that the nurses did not necessarily choose to be nurses but were allocated to the job. Almost none of then would voluntarily have chosen psychiatric nursing, and they were sent to the hospital independent of their wishes. Tousley (1985) in her visits to several psychiatric hospitals also reports this. One of the senior nurses told her that the young women eventually grow to like the job; but that may be a very optimistic statement. According to one of the senior doctors, newly graduated nurses, when told that they have been

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allocated to psychiatric nursing at Anding Hospital, are liable to burst into tears and beg to be sent elsewhere. He also said that they eventually get used to it. However, in such conditions it is hardly surprising that nursing staff pursue goals that are self protective as a way of defending themselves against a situation which, for many of them, is demeaning.

Some responsibility for the lack of effect that the 'four integrations' have on ward life must rest with the senior hospital doctors. The principles of treatment, occupation, exercise and recreation are sound ones to implement in a hospital mostly catering for long-stay patients. Yet little effort seems to have been made about devising ways of operationalising them at ward level other than the ten minutes or less of desultory exercise in the morning.

There are recreational activities to mark special occasions but these smack of Goffman's description of rituals to create a spirit of pseudo-community. Thus at the fifteenth anniversary celebrations of the hospital both staff and patients put on a singing and dancing show for guests, staff and patients. At Mid-Autumn festival a patient group from each ward performed for staff and other patients and then there was a tug-of-war between two different teams. But these activities seemed designed to express or generate solidarity with the hospital. Nothing in the way of normal recreational activities (knitting, reading, painting, calligraphy) is provided on a daily, routine basis to keep patients' brains active and functional.

Power and Authority

'Influence means the use of power; power means the resource behind it. Authority is used when the power is legitimate and has some recognized official backing. To say that someone has influence is therefore a shorthand way of saying power to influence. To say that someone has authority is a shorthand way of recognizing and accepting his or her power source'. (Handy, 1985, p.119)

One of the classic statements on the sources of authority comes from Max Weber. He identified three 'pure' types of legitimate authority;

rational - resting on a belief in the 'legality' of the patterns of normative rules and the right of those elevated to authority under such rules to issue commands (legal authority).

traditional - resting on an established belief in the sanctity of immemorial traditions and the legitimacy of the status of those exercising authority under them.

charismatic - resting on devotion to the specific and exceptional sanctity, heroism or exemplary character of an individual person and of the normative patterns or order revealed or ordained by him. (Weber, 1968, p. 46)

Within this typology, the Guangzhou Hospital is characterised by legal authority, bearing in mind that one of the immemorial traditions of Chinese society is to accept hierarchical structures with little question. Thus there is interplay between both legal and traditional authority within the hospital.

One of the aspects that differentiates a hospital from other organisations is that they have a dual system of authority, one from a body of administrators and the other from the professional

group of doctors. Hospitals are frequently characterized by the structural incompatibility between two competing systems of authority. (Turner, 1987; Robinson, 1976)

The official is obeyed first and foremost because of the position he holds. Professional authority is based on knowledge and expertise. The professional commands obedience because of this specialist knowledge rather than his position in a bureaucratic hierarchy. The autonomy, self-regulation, and individual decision making required by the professional conflicts with the hierarchical control and official rules of bureaucratic administration.

'The ultimate justification for a professional act is that to the best of the professional's knowledge, it is the right act. The ultimate justification for an administrative act is that it is in line with the organisation's rules and regulations and that it has been approved - directly or by implication - by a superior ranking official'. (Etzioni, quoted in Haralambos, 1985, p.306)

For the employee this can produce role conflict as professional guidelines and administrative procedures or orders from a superior may contradict each other. In some ways this is not as much of an issue for Chinese doctors as it might be elsewhere. This is not to say that it has no relevance, as we have seen in the matter of over-prescription of medication.

There is no universally accepted definition of the attributes that constitute a profession in the West, and the reasons as to why some occupational groups, but not others, either wish for or are granted this desirable status are complex and do not concern us here. What is important is that certain characteristics are

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accepted as defining a profession and with this appellation come certain responsibilities. Millerson (1964) distilled a list of attributes of professions from the writings of 21 authors. The characteristics most frequently mentioned were:

1 - skill based on theoretical knowledge

2 - the provision of training

3 - tests of the competence of members

4 - a professional organisation

5 - adherence to a professional code of conduct

6 - altruistic service

While a systematic body of psychiatric knowledge exists, Chinese psychiatrists are not required to acquire it. There is no standardised government licensing procedure, no professional body responsible for the setting and maintenance of standards, no code of conduct and no concomitant ability to sanction or disbar members not complying with them. The culture of altruism has been undermined by the 'contract responsibility' system. Ultimately, the Party has always been ambivalent about professions. First, it is suspicious of any loyalty which may challenge the power of the Party, and second, professions were identified with the bourgeois class and did not 'serve the people'. Thus all intellectuals, including doctors, were categorised as 'the stinking number nine class' during the Cultural Revolution, with well known results. Doctors in China do not enjoy the independence of action and respect that their counterparts in the West take for granted.

Another strand may be added to the rather complicated web of professional and administrative authority, and that is the role of the Party within the organisation. Just as the Party is paramount at the national level, it is also expected to be paramount within each unit, whether that is a government department, a factory or a village. (Madsen, 1984) When the manager of a unit and the Party Secretary of that unit were in disagreement, the Party Secretary would prevail and he had a license to interfere in any aspect of the business of the unit. To give a potential example within the context of the Guangzhou hospital, if the Party Secretary thought that insufficient time was being devoted to the political education of the patients, he could order the doctors to change the treatment regime.

In the Guangzhou Hospital, the Party Secretary was a veteran who had spent 18 years in the army and seen active service in the border conflict between China and Vietnam in 1979. One of his most treasured possessions was a white enamel mug, (from which he always drank his tea), that commemorated this event and had only been given to those who fought.

His official job description, (which hung on his office wall) said:

'1) under the leadership of seniors and the Party branch, constantly ensure that the policy and decisions made by the Party branch are carried out consistently. Also to understand and investigate into the policies of the Party.

2) act as leader to implement the Party's organisation and propaganda. Plan and organise political work and evaluate and assess it regularly.

3) work hard at learning the business of your unit. Act as a leader to cultivate the Party's good traditions and ways of doing things.

4) investigate and research thoroughly to obtain a complete understanding of the hospital staff's thoughts and work and to develop the political thoughts of the staff.

5) work fully as a staff member of the unit and help the superintendent to perform his role. Actively help and support their work.

6) do well in the personnel and security work. Also work with youth, workers and women.

The general impression was that the Party Secretary did not exert undue influence on staff. There were no political study groups, and political study was not seen as relevant for patients. During an informal conversation, the hospital cook said that people no longer wished to become Party members, and that the numbers recruited in recent years had dropped dramatically. As Scott says, power should not be viewed as a characteristic of an individual, but rather as a property of a social relation. For power and influence to be effective, A must have control of something that B finds desirable. 'Power resides implicitly in the other's dependency'. (Scott, 1987, p. 282) While the Party remained powerful, its pervasive influence in the lives of ordinary people in the hospital, and possibly the respect in which it was held,

had declined in the years prior to the events in Tiananmen Square in 1989.

The Thirteenth National Party Congress held at the end of 1987 adopted Zhao Zhi Yang's suggestion that the functions of the Party and government at all levels needed to be separated. (<u>Beijing Review</u>, (December 12th., 1987) So in the hospital in the summer of 1988, they were still grappling with what this meant for them. The Party Secretary said in one interview that the job description on his wall no longer applied.

Yet he clearly thought about and talked about himself as the major power in the hospital. He said that if there was a conflict between administrative and professional matters it was still his responsibility to resolve it. His major areas covered discipline, security and administration. Although the Medical Superintendent is now supposed to be responsible for personnel, the Party Secretary spoke about delegating this to him, and the Medical Superintendent coming to consult him before any decisions were made. He concluded that as far as he was concerned nothing much had changed.

In fact the four most powerful men in the hospital (all of a similar age, around 40) presented a collegiate picture of management. One of the reasons why it may have been difficult to persuade either the Medical Superintendent or the Party Secretary to clarify their respective roles to us was because it would have meant clarifying them to themselves. On a day to day basis, the contradictions that were inherent in the three strands of power

were probably best handled as part of the 'negotiated order'.
(Robinson, 1976)

Leadership

The issue of leadership, particularly as it concerned the Medical
Superintendent, is one that is intimately connected with power,
authority and influence. Handy (1985) reviews trait, style and
contingency theories of leadership integrating them into what he
calls the 'best fit' approach. This involves four sets of
considerations that the leadership must take into account.

1 - the leader and his preferred style of operating and his
personal characteristics.

2 - the subordinates and their preferred style of leadership
in the light of the circumstances

3 - the task , which involves the job, its objectives and its
technology.
These three factors and their fit will to some extent depend on

4 - the environment, which is to say the organisational
setting of the leader, his group and the importance of the task.

The Medical Superintendent was a man of 40, which is relatively
young for someone in a leadership position in China. He was also
unusually large (both tall and heavy) for a Chinese person and
seemed consciously to create a persona around this fact. Thus he
was dominating, energetic and forceful showing a hint of cruelty
to those he considered weaker than himself, like the doctor in
charge of administration, whom he teased mercilessly. His
entrepreneurial skills were evident; his professional skills less

so.

The impression gained in talking to the other staff, was that they respected him because he was someone who could 'get things done' within the hospital, and had influence and was well connected outside it. It was under his stewardship that the institution had evolved into a 'proper' hospital. He told us that one third of the Guangzhou Civil Affairs Bureau's annual budget was spent on the hospital, which in turn was seen by staff as a public affirmation of the work they did. However, he was not well liked. The kind face of leadership was worn by the Deputy Medical Superintendent. This man was convinced that he had been chosen for the job because, with a propensity to do what he was told (as he described it), he was one of the few people who could get along with the Medical Superintendent!

In a sense the Medical Superintendent had to make up in personal power what he lost in position and expert power. There are three grades of medical superintendent in China and the position at the hospital was graded at the lowest level. Despite the improvements that had been made, this was still an irksome reminder that the hospital was part of a low status ministry with a low status client group. Second, position within the medical administrative hierarchy was not related to seniority within the medical hierarchy. Thus, the most qualified doctor in the hospital was one of the head ward doctors. The Medical Superintendent is only a medical officer, close to the bottom of that particular hierarchy. Thus his source of expert power is low.

Neither the Medical Superintendent nor the Medical Director were accepted by other doctors as having advanced medical expertise. and were both aware that this constrained their ability to exercise influence over medical practice on the wards. Thus, at least some of the head ward doctors felt free to ignore politely suggestions or directives on medical matters, an example of what Handy calls negative power.

To confound the picture further, at least by Western standards, the Medical Superintendent is paid less than most of the other doctors. His grade of superintendent receive a salary of about 100 yuan a month, less than the senior medical officers and the chief nurse. The cook receives more pay than the superintendent, but the cook is aware of who wields the real power. As he said, 'I may earn more, but the Medical Superintendent could have me transferred anywhere in China tomorrow if he wanted'.

Hofstede, (1980) in a seminal work, identified a number of supra-national characteristics against which individual cultures could be compared in terms of organisational features. Relevant in our context is 'uncertainty avoidance'. This refers to the extent to which a society feels threatened by uncertain and ambiguous situations and tries to avoid these situations by providing greater career stability, establishing more formal rules, not tolerating deviant ideas, etc.. Second, is what Hofstede called 'power distance', which is the extent to which members of a society accept a hierarchical order in which every body has a place which needs no further justification.

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Bond and Hwang (1986) and Redding and Wong, (1986) have both argued that Chinese societies tend to prefer at least moderate power distance and uncertainty avoidance. The implication is that subordinates accept subordination as normal but at the same time have certain expectations of their leaders. Bond summarises the available research by saying that Chinese people prefer an authoritarian leadership style in which a benevolent and respected leader is not only considerate of his followers, but also able to take skilled and decisive action. Using these criteria, the Medical Superintendent would score high on decisiveness and authoritarianism but probably low on professional knowledge and consideration.

Followership is the obverse of leadership and that implies compliance. Etzioni defines compliance as:

> 'A relationship consisting of the power employed by superiors to control subordinates and the orientation of the subordinate to this power'. (Etzioni, 1961, p.xv)

Etzioni suggests that there are three kind of influence that a leader may wield: coercive, utilitarian and normative. (Etzioni, 1964) Coercive power is based on physical force, utilitarian on monetary and other tangible rewards and normative on the allocation of status and other symbolic rewards. The exertion of different kinds of power produces different sorts of response in followers. These Etzioni calls alienative, calculative and moral.

> 'The application of symbolic means of control tends to convince people, that of material means tends to build up their self-oriented interests in conforming, and the use of physical means tends to force them to comply'. (Etzioni, 1964, p. 60)

From the point of view of the subordinate, Handy (1985) discusses three psychological methods for adjusting to influence: compliance, identification and internalization. If the recipient complies with the influence attempt, it is because it is worth his while to do so and he defines the situation as offering him little choice. In the second case the recipient adopts the idea as his own because he admires or identifies with the initiator. If the recipient internalizes an idea or proposal, he adopts it as his own.

There seemed little identification or internalization involved in the attitude of the staff at the hospital towards the leaders generally, or the Medical Superintendent in particular. They complied in a 'calculating' way and in turn the leaders tried to guarantee their compliance through remunerative means. However, the system of pay and bonuses is quite fixed. There is a small amount of flexibility, for instance those staff who agreed to help whitewash hospital buildings received extra cash. But the bonus system is more usually used to threaten, (if not actually punish), than reward. Ultimately the difference in take-home pay may not add up to a significant amount either way, and is most unlikely to be enough to buy more than compliance.

Furthermore, the targeted behaviour is not normally dependent on the individual but the group. (see Chapter Six) The group in turn may have worked out standards of performance which they agree are reasonable and may use the power of peer group pressure, (which the hospital leadership is hoping to tap into to achieve the goals of the leaders), to maintain the standards of the workers rather

than those of the hospital. 'Subordinates are individually weaker but collectively stronger' than management. (Scott, 1987, p. 287)

It is generally not the current norm, at least with government employees in China, to maintain large differentials in pay or status. Rather, appeals are made to staff to build a 'socialist spiritual civilization', to 'learn from Lei Fung', to 'work for the glory of the Motherland and socialism'; or as Article 42 of the Chinese Constitution puts it 'work is the glorious duty of a every able-bodied citizen'. In Etzioni's terms, this is the attempted use of normative power. The underlying theme is that it is in the intrinsic nature of work that the job is worth doing. However, these kinds of appeals no longer have the power to facilitate the workers 'moral' involvement with the organisation. Maybe this approach was effective once, but people are now too disillusioned and cynical to believe any longer in these types of slogans.

Handy (1985) points out that if pay and status are rejected as rewards then the reward for effort will have to come from some sort of job satisfaction. The problem with this is that it tends not to last very long unless followed by a visible symbol of success. Without job satisfaction, or any other major form of reward, satisficing behaviour will become the norm. Individuals will perform well enough to get the compensation they are entitled to under whatever rules for equity apply. This seems to accurately describe the situation in the hospital for most of the staff.

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Some of these problems could be addressed by asking whether the goals and values of the individual are compatible with those of the organisation, and examining the match between the organization's culture and the cultural preference of the individual. But these are very Western notions and would be considered to be largely irrelevant in China. There it is assumed that the goals of the collective, which in turn are supposed to be a microcosm of those of the state and the Party are paramount and not accepting them brings into question the national and political loyalty of the individual.

LESSONS TO BE LEARNED?

The contract responsibility system was introduced in order to break the concept of the 'iron rice bowl' - a job for life however well or badly one performed. In a situation where the overall aim of the organisation is to provide a service rather than to produce a product, (unlike manufacturing or agriculture), there are problems of funding and motivation. In a sense, the government has replicated the 'iron rice bowl' through the bonus system. As Chow (1988) points out, most workers have lost track of what element of their take home pay is what and have grown to see it all, from bonuses to the medical insurance, as a package to which they are entitled. So despite all the adjustments and fiddling with the bonus system to try to improve 'productivity' and standards within the hospital, the overall impression is that it is not very effective. There is little intrinsic job satisfaction for many of the staff, the pay is low, pay does not seem to relate to status, pay differentials are not great, chances of promotion quite rare,

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and the perks of the job virtually non-existent. It is not surprising that in such an atmosphere it is hard to motivate staff or raise morale particularly when in addition to everything else they are working with patients most other people despise.

Such an environment produces satisficing behaviour and along with it a reluctance to be or do anything different on the part of the staff. For instance, returning to the example of the Olympic Games used earlier, if one ward had decided to use the event to try and animate the patients, the likelihood is that the staff from the six other wards would have been angry because it would have placed them in a poor light. When there is no reward or requirement to do better, and when it may provoke dissent, there is little incentive from the grass roots for substantial change, particularly when it involves them in more work.

Grass roots initiative is not rewarded and there does not seem to be any structural means through which all ward staff could feed back a collective view. Thus in the hospital, almost all impetus for change is from the top down. This is not ideal either because it almost certainly will meet resistance from many of the staff below, who identify change with threat or the requirement to make a greater effort. The perspective of the management does not necessarily represent what is best for the patients, as in the case of psychosurgery.

In a book devoted to examining the background to the various scandals that have plagued British psychiatric and mental handicap hospitals in the last 30 years, John Martin starts by posing a

question:

'How is it that institutions established to care for the sick and helpless can have allowed them to be neglected, treated with callousness and even deliberate cruelty? There is no simple explanation for this paradox. Individual psychopathology may have a part, but the issues are both broader and deeper. They are broader in the sense that much turns on the attitudes of society to its weakest members and the resources assigned to their care; they are deeper in that what may occur is a perversion of individual motives and social institutions'. (Martin, 1984, p.xi)

What Martin is doing is reminding us that it is all too easy to place the blame for failure to care on individual staff, when reality is a good deal less simple. The standards of care in any hospital are the end result of the attitudes of the wider society to a particular client group and the resources in terms of training, physical facilities and quality of staff that they are prepared to allocate. Operationalizing and maintaining proper standards of care are also the responsibility of the hospital management, not only the ward staff. If there are major problems they are likely to be structural rather than individual and therefore not solvable by tinkering with personnel.

He goes on to discuss six themes that emerged from the various inquiries. These were the need for inspection from an external body; a proper procedure for handling complaints; a desire to delineate and clarify responsibilities; concern about the way that communication between the central authorities and the grassroots staff could be handled; concern about the nature and content of care; and concern to explore alternatives to care in the large old institutions.

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China as a whole is not at a stage where it is able to identify the above issues as needs and requirements, and the standards of care in psychiatric hospitals have not yet been identified as a source of concern. The country has other (understandable) priorities. There are no complaints procedures, no independent inspection mechanisms; there is little communication between the top and the bottom of the hierarchies, and no sense that hospitals need to be radically rethought. At the same time, the lack of such mechanisms and procedures does not bode well for the patients.

CONCLUSIONS

1 - The Guangzhou Hospital comes very close to embodying the archetype of a total institution. It would be rare in the U.K. or the U.S.A. to find a psychiatric hospital, however deprived and institutional the environment, that was so socially, emotionally and therapeutically impoverished.

2 - The organisational structure is mechanistic and bureaucratic. Hierarchy is greatly emphasised and innovation and imagination are not well regarded. The authority structure is confused with the existence of professional, positional and Party hierarchies. The potential exists for an individual's position on one of those ladders to conflict with his position on another.

3 - Different groups of staff pursue their own aims, many of which are at variance with the official, stated aims of the hospital. Although there are policy guidelines set at national levels, help is not forthcoming in assisting staff to operationalise these at the local level. Staff have little idea about what a therapeutic

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regime would consist of, and even less about how to put it in to practice. Instead, they appear to judge the level of efficiency and success of the hospital on a series of negative measures, like how quiet the patients are, how few attempts to escape there have been. The only observable positive measures of success were certificates awarded for controlling and preventing infectious diseases in the hospital.

4 - The lack of training in psychiatry for doctors, and the lack of training of any sort among nurses had consequences, for both staff and patients. Among staff, it meant that they had no clear idea of what their role ought to be within a psychiatric setting, or what professional objectives they ought to be pursuing, other than the general ones set by the organisation. This was compounded by their unwillingness to work with psychiatric patients. Working with a stigmatised group, in a low status ministry, for poor remuneration, in a very isolated setting, with slight chances of promotion led to problems in morale. Inevitably, such feelings affected the ward environment.

5 - If the environment for the patients was an essentially punitive one, this was also true for staff. At least two issues raised their anxiety level. First, they believed that a significant number of patients were potentially violent and that they were working with dangerous people. Thus they feared for their physical safety. Second, rather than being rewarded for good work, they were punished for mistakes. They lived with the spectre of 'what would happen if...?', even if their worst imaginings were

rarely fulfilled.

6 - Not all the difficulties that have been described are attributable to lack of resources or a lower level of economic development in comparison with Western countries. This is demonstrated by the lack of interest among staff in taking the six months' training course in psychiatry and the unwillingness of the hospital authorities to make it compulsory.

RECOMMENDATIONS

Based on what we have learned of the Guangzhou Hospital, and assuming that its conditions are by no means atypical, what structural changes could be devised, with few resource implications, that would improve the standards of psychiatric care for patients generally in China?

In order for hospitals to fulfill their stated functions of treatment and rehabilitation of the mentally ill the following changes are suggested.

Medical Training

1 - increase the level of psychiatric input on basic medical training courses and, in the case of the Guangzhou Hospital, make the six month training course for doctors compulsory for all medical staff. Other provincial capitals and large towns and cities who generally have the highest proportion of well qualified staff, could consider developing their own 'in-house' training programmes for staff from more remote and smaller hospitals.

Ward Training For Nursing Staff

2 - attention must be given to improving the standard of nursing, not by teaching nurses to tie ever more complicated bandages, but by introducing in-service training that would concentrate on improving the therapeutic, social and emotional climate of the wards.

Activity Centres

3 - at present one of the most damaging aspects of the hospital for patients is the level of inactivity and boredom that many of them have no choice but to experience. Efforts should be made to develop activity centres outside of the wards so that patients do not spend twenty four hours a day in one place.

Ward Classification

4 - wards should be differentiated according to the needs of defined client populations. Keeping chronically damaged and acutely ill people on the same ward is disadvantageous to both. Almost certainly more care and attention is given to the acute patients who are more responsive and rewarding to the staff, leaving less time and energy for chronically ill patients. At the same time, the momentum does not exist within the current framework of chronic care for the rehabilitation and discharge of patients who do not need continuous hospitalisation.

CHAPTER ELEVEN

COMMUNITY BASED CARE

Unacknowledged in the hearts of many policy makers is a concept of a 'paradise lost': a time when people lived in small, geographically defined communities, self-sufficient and enjoying organically symbiotic relationships with each other and the world around them. The cash nexus barely intruded into this idyll, where welfare was provided by the family, each looked after their own and deviance based on mental disorder was generally tolerated. The time is long since past when this pretty piece of story telling should have been confined between the covers of a copy of Hans Anderson fairy tales, where it belongs.

As Bulmer (1987) points out traditional neighbourhoodism did not rest on some 'natural' tendency to be helpful or on generalized goodwill to others, but was a specific response to economic adversity and deprivation in which mutual aid was the only effective way of coping. While it may have been true that the mildly mentally handicapped could work relatively well in agricultural settings there is no reason to suppose that in these traditional village communities the more bizarre, and occasionally violent behaviour of the mentally ill, was well tolerated.

China is still a largely rural country where many people live out their lives in much the same way as their ancestors in previous centuries. Here is one account of how such a community dealt with a violent mentally ill member taken from China Legal News (Sept. 11 th., 1987):

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'Chinese newspapers announced death sentences for an assortment of criminals yesterday but warned people against taking the law into their own hands after peasants'executed' an insane man by drowning him in a manure pit. Three villagers in Hubei province had been arrested for inciting the kangaroo trial and execution. Mentally ill Zhu Anqing was judged by a court made up of twenty five village households after he beat and tied up several residents. The peasants unanimously agreed on the death penalty and threw their screaming victim into the nightsoil pit'.

Much as we would like to pretend otherwise, there is no real evidence to suppose that care in the community was ever the panacea it has been held out to be. What were the factors that led to this policy being adopted in the West? What are the services that have followed its implementation? What have been the consequences? Most importantly from our point of view, has China developed its own model of community care for the mentally ill and if so in what ways has it been shaped by the structural factors of economics, politics and culture that pertain in that society?

THE WESTERN EXPERIENCE

'When civilisation grew in the Western world, it grew behind walls - in castles and monasteries and small crowded cities; and the outcasts lived in the forests - madmen and idiots, lepers and escaped slaves, outlaws and felons, some victims and some predators. The gate and the drawbridge were signs of safety because freedom was dangerous. Then the position was reversed....and the victims and the predators were in their turn confined behind walls in hospitals and asylums, in poorhouses and workhouses, in gaols and bridewells'. (Jones and Fowles, 1984, p. vii)

By the 1950s, populations of asylums in the U.S.A. and Britain were often counted in their thousands, many of whom were very long-stay residents. This was the peak. Between 1960 and 1980 the population of mental hospitals in the U.K. had shrunk by 42 per cent and in the U.S.A. by 72 per cent. (Jones and Fowles, 1984)

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What factors account for this drop?

The most likely explanation involves the interaction of a variety of factors. The advent of the phenothiazines, in use by the mid-1950s, obviously had some effect. While by no means a cure, they did blunt the most bizarre symptoms and made patients easier to handle outside restrictive environments. However, as Scull (1984) and Wing (1979) point out, efforts had already begun to reduce the numbers in psychiatric hospitals in at least some of these institutions before the introduction of chlorpromazine. It could have been just as likely that hospital doctors and administrators would have used the new drugs to contain behaviour on the ward. There was no inherent logic in the situation that demanded that patients be discharged. Continuing this theme, Sedgwick (1982) points out that the de-institutionalization movement in Europe did not gather momentum until long after it was thriving in the U.K. and the U.S.A., despite equal availability of phenothiazines. So by itself, an explanation based on the introduction of new drugs is not sufficient.

Goffman was the first author to elaborate on the effects of the psychiatric institution on the behaviour of the inmates. The implications of Goffman's thesis was explored by Russell Barton in his book <u>Institutional Neurosis</u> published in 1959. This was the first work by a practising psychiatrist to try to demonstrate that while patients were admitted with one illness, the institution gave them another.

Alone, Barton's book might not have been sufficient to overcome the weight of hostility amongst doctors to the notion that hospitals could be iatrogenic, particularly since the symptoms he described were very similar to those of chronic schizophrenia. (Wing, 1967) However, Goffman's work was of a sufficiently seminal nature to enter rapidly into the professional collective consciousness - and conscience. Wing's own research on institutionalism (Wing 1962; 1970), provided the empirical evidence. It became very much harder to argue convincingly that a prolonged stay in a psychiatric hospital was beneficial.

Scull makes the point that whereas in the nineteenth and first half of the twentieth century institutions had been a relatively cheap option for the care and control of a large number of deviants, (at least in comparison with the alternative of 'out relief', which would have contravened the principle of less eligibility), this had become increasingly less so with time. Sizeable sums of money had been poured into developing these asylums:

> 'The amount of capital sunk in these costly palaces of the insane is becoming a growing impediment. So much money sunk creates a conservatism in their builders which resists change' (<u>Edinburgh Review</u>, 1870 quoted in Scull, 1983, p. 125)

As wages rose and as the buildings, many approaching 100 years old, became increasingly decrepit and in need of major repair to be even minimally inhabitable, maintaining institutions began to look less desirable. Furthermore, many of them were occupying prime building sites, whose value could only be realised as cash to the health authorities if they were sold without the impediment

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of their 'sitting tenants'.

Finally, the Zeitgeist was blowing in the direction of greater freedom and independence. If hospitals were not the solution, then perhaps the 'community', (whatever that might be) was. The community care movement may be traced back to the report from the World Health Organisation's Expert Committee on Mental Health in 1953. (Jones, 1988) Beds should be reduced and services should be provided in the community. In 1961, in the U.S.A., the Joint Commission on Mental Illness and Health advised that 'the objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner'. (Quoted in Mechanic, 1989, p. 155)

In the U.K., the 1959 Mental Health Act clearly embodied a radical break with the past. Whatever its operational shortcomings over the years, its emphasis on voluntary treatment except in exceptional circumstances, and the requirement on local authorities to provide facilities outside the hospital for the care and rehabilitation of recovering psychiatric patients was revolutionary for its time. The 1968 Seebohm Report popularized the idea of community care in social work generally.

With no major research into the best way of operationalizing the policy, with no major funding alternatives made available to provide alternatives to large institutions, and perhaps most important of all, no widely accepted definition of community care, it was almost inevitable that rhetoric was going to dominate over substance.

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'In Britain as well as in the U.S.A. the reduction in the register of patients resident in hospitals...has been achieved through the creation of a rhetoric of 'community care facilities' whose influence over policy in hospital admission and discharge has been particularly remarkable when one considers that they do not, in the actual world, exist'. Sedgwick (1982, p. 192)

Bulmer (1987) discusses various definitions of the term from the Seebohm Report to the Barclay Report to DHSS usage before concluding that the phrase lacks clarity and exactness because:

'It carries with it an aura, a sense of goodness... which refers to society as it is but also to social elements which are valued either in the past, the present or prospectively whether or not they exist'. (p. 26)

As a word, community never seems to be used unfavourably and is never given any opposing or distinguishing terms. This is significant for its use in relation to social care, for it carries the implication that association with 'the community' is good and favourable whatever the context in which it is used. Bulmer (1987, p. 35) suggests a working definition of community that involves 'identification of locally based informal social networks together with a sense of belonging'. Heginbotham (1985) argues that the term has become so debased as to be useless, and recommends that 'local mental health services' is a more appropriate term. Community care is a slogan without a programme.

Out of this chaos Bulmer (1987) has distilled four elements that are generally involved in community care services.

1 - they are provided outside large institutions

2 - they involve the delivery of various professional services outside of hospitals and other institutions

3 - they rely on 'the whole community itself', which includes voluntary and informal help from family, friends, and

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neighbours

4 - provision of care as close to normality as possible in the setting of ordinary life.

The kinds of services provided within this framework are oriented to attempting to maintain the normal semblance of life with decent accommodation in or outside a family, with daily activity centered around work whenever possible. Support services include hostels of various kinds, supported or supervised living arrangements and workshops or other occupation schemes. Medical services are provided, whenever possible, with the least disruption to ordinary life on an out-patient or domicillary basis. Services may be provided through a variety of types of organisation: statutory, voluntary, commercial and informal.

Jones (1988) has suggested five commonly held assumptions that lie behind the community care movement.

1 - everyone lives in a geographically definable community

2 - members of this community live in continuous interaction with one another

3 - communities exist by consensus and social exchange

4 - communities have strengths which can be utilised for assisting weaker members

5 - community support will be more flexible and more caring than that of official agencies.

While it may be true that everyone lives in a geographically definable community, the locational definition of community does not take into account the sociological aspects of community which

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are more to do with the quality and quantity of relationships available to individuals, and in modern life are not necessarily confined by distance. (Nassi, 1985: Bulmer, 1987) In the day of the car, telephone and job mobility supportive relationships are likely to extend beyond a geographical definition of community. (Hunter and Rieger, 1986) Thus people living in the same location are not necessarily going to have very much to do with each other.

The notions of consensus and exchange typifying communities are by no means supported. Disagreements between neighbours, between people forced to share and co-operate over joint resources can be intense. Those in need of long-term care may find that the supply of kindness and comfort available to them from others soon dries up. Furthermore, they may be burdened with a sense of 'debt', being unable to repay the favours in any reciprocal sense. These problems are compounded when those in need of care are discernibly different from their neighbours. One study in Toronto (Dear and Taylor, 1982) found that in principle people were sympathetic to the need for local facilities for the mentally ill, as long as they were 'not on our street'.

While it may be just conceivable that with sufficient organisation, resources and determination care for the mentally disordered in the community might be arranged, it is very much harder to devise ways in which care by the community might be achieved. Kin ties, particularly the nuclear family, remain the most important source of informal care for the majority of people. (Willmott, 1986) The sometimes strange and unpredictable behaviour

of the mentally ill do not make them a group that volunteers find very rewarding or feel very comfortable in supporting. The long-term nature of the disability, and the difficulties that people suffering from chronic schizophrenia have in making relationships with others, are not necessarily very suited to the often short-term time span of a volunteer. There is also the well known disjunction between the availability of volunteers in middle-class neighbourhoods and the need for their services in less salubrious settings, which would certainly apply to the mentally ill. (Abrams and Abrams, 1981; Pinker, 1987)

Equally, there are drawbacks for the mentally ill in assuming that neighbours will play a part in providing care by the community. Neighbours may be keener to erect social barriers rather than social ties in an effort to retain some semblance of privacy: the right to control information about oneself. Informal care, particularly if it does not involve close kin, may involve some kind of trade-off in privacy, having to share information about yourself you would rather keep secret. This is particularly true of those who have a stigmatising condition.

If community care involves the utilization of informal carers in a planned and purposeful, rather than haphazard, way - what is the role for professional carers? Baker (quoted in Hunter and Rieger, 1986) found that people who are less well integrated into family and friendship groups are more likely to use professional helping services, among whom one could count many of the mentally ill. However, the help rendered by natural care givers differs in significant ways from that provided by professionals. Patterson

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uoted in Hunter and Rieger, 1986) found that paid and natural
lpers differed in the types of helping approaches used, the type
· problem encountered and the type of relation between helper and
.ient. Professional helpers were more likely to use techniques
ich as clarification and information giving, while natural
ilpers used shared interchange and companionability and were most
ffective at giving emotional support. Thus functions were
lfferent, but complementary.

hat, then, have been the consequences of decanting thousands of
ong term psychiatric hospital residents, more or less unprepared,
nto a community equally unprepared to take them? What has
lappened to those patients who might otherwise have been offered
.ong-term hospital treatment, or at least frequent admissions for
)eriods of some months? The major bearers of the burden of
community care have been families. As Bulmer says 'the vacuum at
the heart of the community care policy is that in effect it means
unsupported family care'. (Bulmer, 1987, p. 212) Within families
it is the women who pay the highest costs, because of their own
and other people's expectation that they will take on their
traditional role of caring.

The situation of the family has been significantly worsened by the
attitude of mental health professionals. For many years, families
were seen as the source of the problem, being 'schizophrenogenic,'
and so were blamed rather than supported. Even when therapeutic
fashions changed, they were rarely treated as partners in a joint
effort, but as shadows in the background deprived of the

information and recognition that would have given them substance. When families can no longer cope, hospitals have abnegated their traditional role of offering asylum, and many patients survive on the margins of society: on the streets, in short term shelters, in prison. (Cohen, 1988)

Dear (1984) points out that the care and treatment of the mentally disordered have always proceeded from fundamental principles of isolation and separation of individuals in space. Initially this took place in institutions but, when these expelled their populations, strategies developed to extend this principle into the outside world. The power to exclude operates on two levels. First, the mentally ill person is subjected to a series of informal and formal exclusionary tactics as an individual in social and work settings. Second, come methods of group exclusion that permit residents to exclude undesirable categories of people from their neighbourhoods. De-institutionalization has led to spatial clustering in the community, confining many of the discharged mentally ill to the inner cities, or other clearly defined districts, away from desirable urban residential areas. In some ways these ghettos have become functional for discharged patients, because they are the focus for services and contain support networks of people in similar circumstances who can help a newcomer find his way.

This is not to argue that community based services as an alternative or supplement to hospitalization cannot work; rather that insufficient resources have been put into them to permit them to work. One review article (Kiesler, 1984) looked at ten articles

on the results of hospital care versus some kind of alternative care. The only criterion for inclusion in the review was that the research design randomly assigned patients to one or other of the two patterns of care. None of these studies showed outcome measures that were more positive for hospitalization than for alternative treatment, whatever it was. The authors are at pains to point out that the consistency of data across studies does not imply that almost anything would work. All the alternative treatments were active modes of care. However, they were also clearly untypical of the average pattern of care in that, to be researched, they are likely to have been 'pet' projects, with funding and enthusiastic, well trained staff.

As Jones (1988) and Mechanic (1989) point out, at least the psychiatric hospital provides a focus of organisation and care, research and training for services pertaining to the mentally ill. For community based facilities to provide and co-ordinate effectively the range of social, occupational, therapeutic, educational and basic feeding, clothing and hygiene functions that previously existed under one hospital umbrella, requires a level of investment and co-ordination between different bureaucracies that is simply not available in most places or for most people.

> 'Community life is no panacea unless the patients' suffering is alleviated and social functioning improved. We have learned that community life, without adequate services and supports, could be as de-humanizing and debilitating as the poor mental hospital. We have learned that if the patient is sufficiently disturbed and disoriented, as many schizophrenics are, residence in the home or community may cause innumerable difficulties for family and others and may result in an outcome inferior to good institutional care'. (Mechanic, 1989, p. 155)

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As we have learned from previous chapters, China has never been blessed or burdened with an inheritance of large psychiatric institutions. Indeed, if we are to judge from the policy paper produced after the Second National Conference on Mental Health in 1986, one of its major identified problems is a lack of psychiatric beds. Thus the differentiation between hospital and the community has never been quite the pivotal focus that it was in the West. Psychiatric hospitals were undoubtedly a Western import and family care the indigenous method for coping, for good or ill.

Care by the community, in the form of the immediate family, is taken for granted. Yet, as will become clear, China does have a quite clearly conceptualized model of care in the community, outside the boundaries of the family, despite the fact that, as Tsung Yi Lin says, psychiatric hospitals are the key facilities. (Lin, 1985, p. 21) What appears to be lacking are the mechanisms to disseminate this model throughout the nation in any consistent fashion. When one considers the vastness of the country, the decentralized and erratic nature of the funding, and the lack of centralized policy leadership this is hardly surprising. Mention must be made yet again of the urban/rural distinction. The model of community service provision that has been developed is essentially an urban, or at the most, suburban one. The logistical problems of delivering services to the remoter rural areas, particularly for those suffering from major mental disorders, are immense and have not really been properly addressed.

Many of the guidelines still in existence today were laid down by the 1958 <u>National Mental Illnesses Prevention Workplan (1958-62)</u> which incorporated the recommendations of the First National Conference on Mental Health held in Nanjing. It recommended the setting up of 'three man groups', (still the most common leadership and co-ordination mechanism,) consisting of representatives of the Departments of Public Health, Civil Affairs and Public Security. These groups were to be operational at provincial, municipal and district level, (in towns large enough to have districts). The workplan also recommended greatly expanding out-patient services, encouraging general hospitals to open out-patient clinics for psychiatric patients and designating a small number of beds for psychiatric patients. It also suggested dispersing chronic hospital patients with some working capacity to rural areas. It seemed to be assumed that this kind of work would benefit the mental state of the patient, while rural areas short of labour would welcome the addition to their work force. This policy does not appear to have ever been put into practice.

In comparison, the most recent policy document based on the 1986 Second National Meeting on Mental Health in Shanghai is considerably less trenchant. This document was discussed in detail in Chapter Two. Suffice it to say that community care is only mentioned three times. The preamble tells us that:

> 'Community prevention and treatment work is developing gradually. Some areas even have the innovative experience in implementing prevention, treatment and management in the community with close liaison with Health, Civil Affairs and Public Security Departments'.

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Second, that:

'Due to lack of financial support, the community prevention and treatment work which has proved to be effective does not have a good foundation nor can it be developed'.

The third time is towards the end when it is recommended that community prevention and treatment work should be developed. This could hardly be said to constitute a blueprint for the future development of community based services. Indeed, the overwhelming impression from this document is that the priority currently in mental health care is to increase psychiatric beds.

The Administrative Structure

The function of the work unit in the lives of its members was analysed in a previous chapter. Another administrative organ also has a vital part to play in integrating individuals into larger groups and providing an interface with higher echelons of the government: this is the neighbourhood. For someone without a job, who is retired, or is a full time homemaker, the neighbourhood performs many of the functions of control that a work unit normally carries out.

Figure 1: Urban Administrative Structure in China

```
Municipal Government
        │
 ┌──────┼──────────────────┐
 │      │                  │
D.G.   D.G.    District Government
                           │
                    ┌──────┼──────┐
                    │      │      │
                   S.O.  Street Office
                           │
                ┌──────────┼──────────┐
                │          │          │
               R.C.       R.C.    Residents'
                                   Committee
                                       │
                            ┌──────────┼──────────┐
                            │          │          │
                          R.S.G.     R.S.G.   Residents'
                                               Small Groups
```
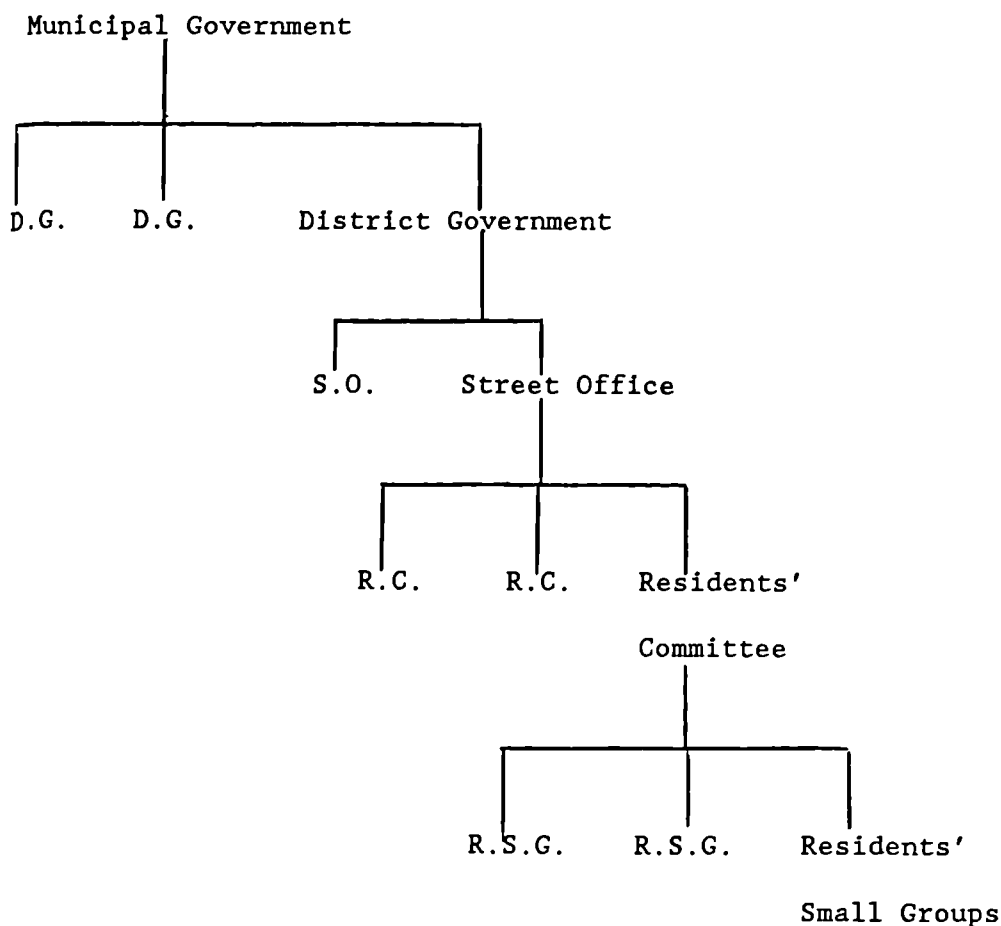
Source:- Linda Wong, 1990, p.6

The pinnacle of urban administration is the municipal government, elected by the municipal level people's congress. In large conurbations, there is a second tier at the district level which has its own government elected by the district people's congress. Below these two begin the levels that are most likely to impinge on the lives of families and individuals. The street office operates on authority delegated from the district level and, although not a government agency, wields informal influence over its jurisdiction which may extend from 1,200 - 5,000 households.

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Street office cadres are paid employees. Officials of the lowest two levels are generally unpaid volunteers, although they may receive something for expenses. Residents' small groups elect members to the residents' committee. Households elect members to the residents' small groups.

The organisation of street offices, residents' committees and residents' small groups is governed by state regulations. The residents' committee comprises of between 100-600 households while the residents small groups comprise between 15-40 households. These neighbourhood organisations are supposed to provide welfare services, mediate local problems, and reflect the interests of local people. They have a role to play in political surveillance as their boundaries are co-terminous with those of the public security wards. They are responsible for channeling government directives to local people and mobilising them in the frequent mass campaigns. (Linda Wong, 1990) Thus community in China still retains some sense of a geographical entity which is distinct from other similar entities. This is probably particularly true in the rural areas.

The services provided at street level are many and various. Some, like health clinics, nurseries, bath houses, reading rooms, repair stations and canteens are open to everyone. Others, (usually residential and day care services), are specifically for vulnerable groups, like the disabled, the destitute elderly and the mentally ill and handicapped.

If these are social services, what then of health services, in particular for the mentally ill? A previous chapter contained a diagram of the various levels of health provision. Standards are so variable it is impossible to predict with any certainty precisely what is provided in any town or city, without specifically finding out what that place has to offer. It may be said with a fair degree of certainty that psychiatric hospitals in towns and cities will include an out-patients department. The only one of which I have detailed knowledge is in Shashi. There, nearly all new patients seemed to be self-referred. Some families had consulted a doctor or paramedic at a clinic but most had made the decision that a family member was sufficiently mentally ill to warrant admission, and had brought him or her straight to the hospital. Knowledge of the hospital seemed widespread in the rural areas, with some families travelling four hours by bus to reach the hospital.

The interviewing doctor thus has no referral letter or background information about the patient. There is no system whereby a patient attending more than once sees the same doctor. The hospital authorities claim that 'it would be too complicated'. This means that the patient, or his family, must tell their story afresh each time they visit. If they forget to bring the small piece of paper they are given with the prescribed drugs recorded on it, the medical staff have no idea what previous medication was prescribed, or what the original diagnosis was. Ward doctors do not take out-patient clinics, so it is impossible for them to follow up patients on discharge or for the patient to see a

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familiar figure who is knowledgeable about his background. Nor is there any method of referring a patient on discharge to a doctor nearer his home for those who live out of town. Patients and families must come back to the hospital for further supplies of medication. One wonders whether the inconvenience of this contributes to the temptation to cease taking medication - invariably the most common reason cited by doctors for patients suffering a relapse.

It would be rare to find a psychiatrist, (even trained at the lower level), at any clinic or hospital below the level of the district or county in the rural areas. Some health clinic and health station paramedics may have a little training in psychiatry but it cannot be relied on. Nor may their attitudes and understanding be any more positive than those of the general public. Yao Chi Yu (1985) describes a model project for a rural area in Yantai county. There a county level mental health committee is responsible for planning, directing and co-ordinating the mental health service of the whole county. They are also responsible for mental health education to the public, and training and supervision for mental health personnel at the lower levels.

At the commune level the hospital provides mental health services through a psychiatric clinic run by a doctor who has received psychiatric training at the county psychiatric hospital for 6-12 months. This doctor gives guidance to the village, (barefoot), doctors. At the production brigade level, one of the village doctors is responsible for providing mental health services to

members of the brigade. Yao argues that the key to the development of mental health services lies in training mental health personnel at all levels. Through this scheme 610 commune doctors and 6,187 village doctors have received training.

Personal experience suggests that it is quite rare to find psychiatric in-patient facilities attached to general hospitals, although there may be some kind of psychiatric care available in the out-patients departments. Tsung Yi Lin (1985) expresses surprisingly open incredulity with the Chinese government, based on his time as their advisor on psychiatric care, because newly opened, modern general hospitals contained no psychiatric wing, clearly contrary to Lin's advice. This seems to be indicative of an unwritten policy, or preference, for keeping mentally ill people segregated within the health system and psychiatrists out of the mainstream of medicine.

THE COMPONENTS OF A CHINESE MODEL OF COMMUNITY CARE

Chinese people on the whole are not very much happier than Westerners at having mentally ill people located in their midst. Where the Chinese authorities have an advantage over their Western counterparts is that ordinary people's views do not have to be taken into account when planning non-institutionally based facilities.

Dear (1984) suggests that there are three major potential community attitudes towards the mentally ill: authoritarianism, which implies a view of the mentally ill as an inferior class

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needing coercive handling, benevolence, which embodies a paternalistic kindly view of patients, derived from humanistic and religious principles, and social restrictiveness, viewing the mentally ill as a threat to society. Elements of all three may be observed in the approach to community facilities for the mentally ill in China. It would, however, be fairer to say that the mentally ill are not necessarily seen as inferior, but as unable to control themselves and therefore in need of control by others. Benevolence, where it exists, is more likely to stem from a sense of being part of the same political community, and shared citizenship rather than religious or even humanistic principles.

A further point to be made is that in comparison with sources of help in the West there is little in China beyond what is provided through work or by government or other official channels, like the Civil Affairs Departments and the street organisations. We take for granted a network of voluntary, informal agencies, organisations or resources ranging from support groups run my MIND or the National Schizophrenia Fellowship, to the local Women's Institute, the British Legion and the local branch of the Round Table.

All in their various ways enrich the potential sources of help that are available to patients outside the hospital. They are a source of mutual aid and support, volunteers, drivers, social outlets, money (occasionally) and many other things besides. Nor should the efforts of some local churches in this area be ignored. Thus anyone involved in trying to construct a supportive network for a mentally ill person and their family usually has more than

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statutory services to which to turn, although this is by no means meant to imply that such an effort will always be possible or successful. In China this patchwork of potential aid is simply not there. Community care efforts, where they exist, are concentrated on: home beds, using medical staff at district or village level; work stations and welfare enterprises run by the street organisations or the Departments of Civil Affairs; liaison with large enterprises and factories; and nursing or supervisory care groups organised at the street and residents' association level.

Home Beds

Shen Yu Cun (1983; 1985) argues quite forcibly that caring for a mentally ill person at home is very acceptable to Chinese families, and is something that many of them prefer. Home beds is a phrase that refers to patients who are not well enough to attend out-patients or work on a regular basis, and yet do not need full time hospital care. In some areas such patients are visited on a regular basis by medical staff at home. The frequency will depend on the need of the patient.

Mention of home beds was first made in Wu Cheng-i's paper New China's Achievements in Psychiatry, published in 1959. Following the survey of 18,000,000 people, (the results of which were never written up), enthusiasm for developing services increased particularly in the major centres of psychiatric care. He reported that Nanjing had established 200 sick beds in patients' homes. Home beds are infrequently mentioned in the Western literature on

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China. (Allodi and Dukstza, 1978; Talbot, 1978)

The Chinese literature is more forthcoming, although judging from the paucity of written reports this form of care is not very widespread. The work of Shen Yu Cun (1983; 1985; see also Sophia Leung, 1978) documents the best known project in Beijing from its beginnings in the mid-1970s. Between 1976 and 1979, 211 schizophrenic patients were treated through the home bed scheme. She claims that 64.9 per cent had a good level of remission or showed much improvement. She lays much emphasis on their increased ability to work. At the beginning of treatment only 2.95 per cent were able to do normal farm work on a full time basis. After treatment, this rose to 47 per cent. Shen saw this programme as a way of solving problems of delivering care to a rural population rather than as an alternative to hospital care generally. However, Haidian district would be more aptly described as a suburb of Beijing and is certainly not typical of truly rural areas, although this does not detract from the feasibility of the project in a rural area with additional training for village doctors.

This is what Yao Chi Yu (1985) discusses in relation to Yantai county, (already mentioned), where the project provided 3,095 home beds. Yao made a comparison between the relapse rates of schizophrenic patients given home care and those treated in hospital. These were 24 per cent and 67 per cent respectively, significant at the 0.01 level. It took home bed patients 144 days to recover their full working capacity and 265 days for hospital

patients. However, impressive though those figures seem, patients do not appear to have been randomly assigned to either group, so these figures may only be reflecting different levels of severity of illness.

The following example is based on discussion with the medical staff of the Haidian district hospital, who run the home bed scheme, and a visit to one of their patients.

An example

The staff from the hospital explained that they work within a three tiered system. At the top is the municipal hospital, (in this case Anding Hospital), which is known as the first level. Then comes the district hospital at the second level. In Beijing every district has their own mental health clinic within the district hospital. At the third level are the danwei and street clinics. In Beijing every danwei health clinic has a doctor who has specialised in psychiatry [although this seems a little difficult to believe. There must be many hundreds of danweis in Beijing, some of which would be quite small.] The chain of advisory leadership goes from the first level, to the second to the third who in their turn liaise with the neighbourhood committees about mentally ill persons in their streets. The municipal level refers patients to their home area district level hospital for out-patient follow up on discharge. The municipal hospital will send a discharge paper to the district psychiatric centre who will follow up.

Home beds are for those who find it difficult to come to the out-patients clinic. The district staff then visit them in their own home and give the family advice on how to take care of the patient, explain the side effects of medicine, advise on how to prevent suicide, and give injections. The frequency of visits varies. It may be as often as once a day for the first three days, then weekly and then according to need.

The district hospital doctors said that they thought the advantages of home beds were that: they provide more and better care; the patient still enjoys family warmth and concern; they are not cut off from ordinary life and contacts; the staff have more time to give to the family on these visits so they are able to help them understand the illness better and take good care of the patients, unlike the hospital doctors who are too busy to have the time to give families the necessary support and advice; facilitating co-operation between the home environment and the doctor speeds recovery. Home beds are particularly useful for chronic care, but acute cases usually need to go to hospital.

Haidian district has slightly over ten home beds but other districts also use this form of care. In the past they did not charge for this service but since the open door economic policy they have had to improve economic efficiency. The first visit costs four yuan and subsequent visits two yuan. Drugs are charged separately. Even with the fee income the service is still subsidised by the government.

The patient whom we were taken to meet was a married woman of 56. Her first episode of schizophrenia occurred when she was 13 and was successfully treated by a herbalist with Chinese medicine. There was no relapse until the menopause, since when there have been three episodes of illness necessitating two admissions to Anding hospital. The patient was the gentlest, sweetest old lady it was possible to imagine, who assured us at great length that however disturbed she was, she had never been violent or shouted at any one! Rather, she became very silent and withdrawn, feeling muddle-headed and sleepy. Her home bed was set up four years ago and she and her husband say that they are very satisfied with the care that she has received. The reason given for having a home care bed was that her husband was too busy to take her to the out-patients' clinic.

The couple have two daughters and one son, and the patient's greatest pleasure in life is to play with her grandchildren. The husband has stomach cancer and said that he and his wife were well matched because, while he looked after her mental health, she cared for his physical health. They claimed never to have had a cross word in 40 years of marriage. It was an 'individual worker' household, and the husband made an excellent living as a meat grinder, working from a shed in the yard. The family had a car (to deliver the meat), a motorbike, a fridge, a washing machine, a colour television and a Sharp mini-stereo system. Clearly, the family was not typical and had been very carefully chosen for us both in terms of their economic standing, for the apparent success of the treatment and the lack of family problems. But who, under these circumstances, would not wish to show their best?

Work Stations

Work stations are a much more frequent, although by no means universal, form of provision. Their purpose is to provide some form of daily occupation for people of various handicaps. Thus it is very common to find people suffering from epilepsy, mental handicap, mental illness, cerebral palsy and other physical difficulties, all in the same station, being given the same programme. They are generally organised by either the street

organisation itself or by a Civil Affairs Department cadre in conjunction with street organisation officials. Liao Yikuang (1987), in a book called <u>A Review of Civil Affairs Work</u> points out that psychosis is a common problem with 10,000,000 people reportedly affected. Thus:

> 'if the Civil Affairs Department handles the problem correctly the mass will feel the care of the Party and the government towards people's hardships and this will generate a good political effect'. (p. 130)

There can be no doubt that these work stations are a blessing to families who are provided with a respite from care during the day, or fear of what an unsupervised patient may be doing at home while family members are out at work. They are variable in standard and in staffing. Some are staffed by retired workers (who may be paid a reasonable stipend); others by paid workers.

In some of them patients are paid a significant amount each month (30-50 yuan), while in others they receive only pocket money (5 yuan per month). Shanghai, while not apparently having a home bed scheme, has put considerable resources into developing work stations. Xia et al. (1987) say that there are more than a 100 of these work stations in Shanghai, serving about 2,000 patients. Activities are varied; usually there will be some kind of simple work like packing or assembling that does not require machinery; recreational activities like singing, playing games and doing physical exercises; and often, educational input such as practising writing skills. Of the patients in the work stations in Shanghai, Xia et al. report that of a sample of 153 patients with

schizophrenia who were treated in psychiatric hospitals, 95 had a relapse and 61 frequently caused public disturbances. After being a member of a work station group for three to five years, only 15 of these patients had relapses sufficiently severe to necessitate admission and only eight were guilty of disorderly conduct, (but there is no information about how this sample was selected). According to Xia et al., most of the patients improved sufficiently to be able to take up ordinary work.

A doctor in Guangzhou commented that recently Shanghai has ceased to place so much emphasis on these work stations. The reason he gave was that the community support services were supposed to provide care for chronic patients, and refer 'the acute and interesting' patients to the Shanghai Number One hospital. However, the community facilities reversed this process preferring to keep the 'interesting' cases for themselves and refer the chronic ones to the hospital. How reliable this information is is not known, but it certainly contains the germs of intra-service rivalry that would be familiar in the West.

The Civil Affairs Department run welfare enterprises which are a form of sheltered work between a work station and open employment. They are supposed at least to make enough money to cover their own expenses, although many do not. In Guangzhou, the profitable welfare enterprises are used to subsidise the unprofitable ones. Occasionally one comes across a report that indicates some enthusiasm and innovation within the rather tight constraints of the health and welfare system. Such a one is this project in Shenyang city in Liaoning province, reported in China Civil

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<u>Affairs</u>, (No. 9, September 1987,) as a model project.

One district in Shenyang with a population of 35,000 in which there were 153 mentally ill people, found that these patients 'could not control themselves and social stability is adversely affected. They disturbed the living of neighbours and became a burden to their families'. So in 1975 the Civil Affairs Department set up a 'prevention and cure psychiatric centre', Initially, they were surprised to discover that having work to go to helped keep people stable. At first they arranged some simple tasks. Then in 1979 they set up a welfare factory printing cinema tickets. This enterprise turned patients into consumers by giving them a wage, and from a burden to families to masters of their own lives. The factory subsidised the centre and its eventual reconstruction and re-equipping. When the centre began in 1975 it had four medical workers, one trolley and some simple equipment. Now it has ten medical workers, 50 rooms and a three storey, 900 square metres building. The centre provides an out-patients department, 22 in-patient beds and 204 home care beds. This would undoubtedly count as a model project.

An example: Beijing

In Beijing we were taken to visit a work station which was one of the poorest the city has. Patients live in the neighbourhood and attend daily. It was small, two rooms, and very basic. The room in which the patients worked was dark and bare, and equipped with only a trestle table at which the four patients sat. There are both mentally handicapped and mentally ill patients in the work station, although the staff said that they were aware that it was not very desirable to mix the two conditions. This work station has been in operation for six years and is run by the street organisation whose responsibility it also is to find jobs for the patients. Since opening, the work station has cared for 23

clients, three of whom have left because they found open employment. The work was very simple and consisted of assembling a packet with a children's book rest inside or tearing pieces of cotton cloth apart. Each patient, on piece rates, earns between 40 and 50 yuan a month. The two staff present in the work station were both physically disabled. One was blind in one eye and the other could only walk with the aid of crutches. This is almost certainly a case of killing two birds with one stone, as the Civil Affairs Department, (which has a 'leading and guiding' role regarding the welfare functions of street organisations) is responsible for handicapped people including finding them employment. They are also generally mindful that any enterprise employing more than 30 per cent of disabled staff is eligible for tax concessions.

An example: Guangzhou

Work stations in Guangzhou began to be established in the early 1980s but have become less rare only since about 1986. In Guangzhou, Hai Chu district has 19 street level committees, 16 of which run work stations for the mentally ill and mentally handicapped. They established the workstations on the principle that the mentally disabled in the community affect society adversely, disturb the traffic, upset social order and arouse prejudice if they are just allowed to wander about without supervision. In one work station the mentally ill members prefer to be known as mentally handicapped, as 'fools', because the mentally ill have acquired such a poor reputation in the neighbourhood after several incidents of stopping traffic in the road and dropping objects from high buildings. The community has been quite accepting of work stations because they can see that there is a reduction in undesirable incidents after a period of time.

Ji Li Street committee built a multi-purpose welfare building on land compulsorily purchased from farmers on orders from the government. [In fact, it was by no means clear whether the land was compulsorily purchased or compulsorily donated.] The ground floor is a work station for the mentally disabled; the first floor is an activity centre for retired workers; the second floor is a residential and day care centre for the elderly; and the third floor is a day care centre for mentally handicapped children. There are 20 mentally ill people in Ji Li Street but only five of them need to attend the work station. The others are retired or have a _danwei_ and are visited by psychiatric care units [see next section]. They define mentally ill people as those who have been to a psychiatric hospital, (usually Fong Tsuen), and are not fully recovered.

The work station is staffed by two full time staff who are retired workers (who receive 70-80 yuan a month) and a retired teacher, also paid an honorarium, who comes three times a week. Patients in the work station work for half the day and the rest of the time is given over to educational and recreational activities. They receive between 30 to 50 yuan a month. They are paid bonuses

according to punctuality, hygiene, attendance and so on rather than productivity. There are outings to local amenities two or three times a month and every year there is a 'grand event', like a visit to the sports stadium, that involves all the occupants of the building. Hai Chu street committee sent four people to the Seventh Olympic Games for the Handicapped in the U.S.A., where they won six medals.

The welfare activities of Hai Chu street are heavily subsidised by the Civil Affairs welfare enterprises in Guangzhou. These enterprises will not usually employ mentally ill people but otherwise exclusively employ as workers, but not necessarily management, people who suffer from a variety of handicaps. There are over 80 of these small enterprises, ranging from those that employ three to those that employ 60 workers. Many of them do not make a profit or even break even but a few do very well indeed, jointly netting 600,000 yuan profit in 1987. The enterprises cover a wide range of activities from decorating porcelain, to making axles for a fan company, sound-proofing machines, paper goods and coloured printing. And, of course, there are the tax concessions.

Psychiatric Care Units

The best description of psychiatric care units is given by Xia et al. (1987) in their analysis of mental health work in Shanghai:

'In some districts we have organized psychiatric care units consisting of patient's neighbours, retired workers and family members to assist in the care of mental patients. Their duty is to observe the patients' mental condition and report to relevant health personnel in case of disorderly conduct or breach of the peace. They help to guide and educate the patient, solve any psychological or social problems and administer drugs as prescribed. These care units meet periodically to exchange experiences. This arrangement enhances the efforts of aftercare of the patient and in addition, prevents or reduces the frequency of undesirable public behaviour. Over 40 per cent of neighbourhood committees have formed such care units, which now number more than five hundred. More than thirty thousand people participate in this kind of work and about ten thousand patients are under their

supervision and care'. (p. 83)

It does not appear that Shanghai has developed a home bed scheme, although it is not possible to be absolutely sure of this. To this observer at least, the most noticeable emphasis in this statement is the one on control. Most Western statements about looking after patients outside hospital are couched in terms of what will provide the most normal living conditions for the patients, increase his sense of worth and value and improve the quality of his life. This is not an issue in China. The major concern is how to stop the collective being disturbed by the individual.

An example

This information was supplied by a middle ranking Civil Affairs Department official. In Beijing, psychiatric care units are organised at the residential committee level. They are operated by the local chairman of the Law and Order Committee, the Chairman of the Welfare Committee, the basic level Civil Affairs cadre attached to the street and a family member. They are supposed to care for patients who are not well enough to go to the work station. In answer to the question 'what do care units do'? we were told that their job was to make sure that the mentally ill were kept off the street, stayed safely at home and took their medication. Some have to be locked in. If possible the care unit is supposed to provide some sort of occupation at home, for example simple assembly work.

The response was definitely one that emphasised the law and order concerns of those involved. Officially it is a requirement of the Mental Health Administration group that all street organisations run these psychiatric care units. This group is set up by the municipal government and consists of representatives from the Public Security, Public Health and Civil Affairs Departments. They make and enforce policies and have statutory powers but when the rules are not obeyed their only sanction lies in persuasion and education. The Civil Affairs Bureau requests that all neighbourhood committees run such care units but not all of them comply, although the majority do. Some care units do not operate very well, albeit they exist. Guangzhou also operates a system of psychiatric care units which are organised in similar ways and perform similar functions.

Factory Liaison Work

Some factories are large enough to provide their own services for mentally ill members of their work force. It is impossible to determine how widespread this practice is. In an article purporting to describe community psychiatry in China, Jiang Zuoning (1988) says that in such situations the factory forms a supervisory team consisting of the factory director, and supervisory personnel from the trade union and the factory hospital. A mental health group is formed under its leadership for prevention and treatment throughout the factory. This group is also responsible for visiting families and forming psychiatric care units. Their aim is to help the chronically mentally ill recover their working ability and resume production.

Lu Yi Chuang (1978) describes a close working relationship between Tientsin psychiatric hospital and a large factory which has about six psychiatric patients. Before 1969, the hospital waited for patients who were ill to come to them. Then they instituted a new system whereby members of staff went out to visit the factory to liaise with leaders there and to focus on prevention by educating factory workers about mental illness and teaching them to be able to detect the first signs of relapse in order that patients could be treated as quickly as possible and without having to be hospitalized. Both staff from the hospital and factory will visit patients at home to perform the functions of the psychiatric care units but also, according to Lu, to demonstrate their care and support.

<u>An example</u>

In Amoy Psychiatric Hospital, the medical staff were not able to provide all the aftercare support that they felt was necessary. As a response to this they had decided that they needed to work more closely with the health services in large enterprises. They quoted the Second Fishery Company as an example. This company provides health care for 200,000 staff and dependents. Medical staff of the two organisations regularly change places so that the doctors from the company can learn directly about mental illness and the doctors from the hospital are able to teach doctors and staff at the factory about the signs and symptoms of mental illness and how best to cope with staff who have been mentally ill. The hospital says that the main advantage of this programme is that symptoms are spotted earlier which means readmission is less likely.

The fact that a concept of a model structure for mental health services exists is demonstrated by an article in <u>China's Civil Affairs</u> (No. 9, September, 1987) This article describes Chongzhou city as a focus of experimental economic reform. As part of the Seventh Five Year Plan it has been decided:

'... to improve and socialize welfare provision using street and residents' committees as the backbone and various welfare enterprises as the foundation. The aim is to combine administrative and professional management with a socialized service'.

Among other things the intention is to restructure Chongzhou's psychiatric services. To do this the authorities intend to re-develop the psychiatric hospital into one which has specialized wards and an out-patients clinic, turning it into the city's headquarters of the psychiatric prevention and care administration centre. Hospital beds are to be increased to 500 and modern management and treatment methods for psychiatric patients are to be introduced. Home beds will be set up in households where patients cannot be hospitalized. Psychiatric care units will be established at the residents' committee level, and work stations will be established by street level organisations and in large and

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medium sized factories. Whether or not this happens it shows a clear conception of what ought to be in place.

COMMUNITY AND CULTURE

The major providers in the formal sector are the state, in the form of hospitals, and the collectives (danweis and street committees) in the form of work stations and clinics. There is also some fiscal involvement through tax concessions to welfare enterprises. The informal sector is very much narrower, resting largely on the family. No research has been carried out in China on the role of women as carers, but there is no reason to suppose that the position is substantially better, (and it may be worse), than that in the U.K. On those occasions when the neighbourhood is involved, for instance in the provision of psychiatric care units, it is doubtful whether it is truly voluntary based on reciprocity and social exchange. (Bulmer, 1987) Rather it seems an extension of a principle of social surveillance which extends into the nooks and crannies of everyone's existence, for instance in the person of the retired workers who act as street wardens, (wearing special armbands that identify them instantly), whose job it is to watch over comings, goings and doings in a lane or apartment building.

This brings us to the next issue, that of the right, as the West would see it, to confidentiality and privacy. In the question of informal versus professional care there is a strong case for saying that, particularly in the area of stigmatising conditions, professional help is more acceptable because it preserves the right to privacy and protects against neighbours' gossip. Pinker

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(1982, 255-256), in his minority statement in the <u>Barclay Report</u>
puts it well:

>'Respect for persons must entail respect for people's
>privacy and, in turn, for their right to confidentiality.....In
>totalitarian societies the imposition of community - in the form
>of a unified network of local loyalties which are subservient to
>the state - is one of the political aims of government.
>Democracies tolerate the co-existence of many different loyalties.
>It is important that the state is not allowed to intrude too far
>into the private worlds of individuals, families and local
>communities. The right to privacy in one's personal life is one of
>the hallmarks of a free society'.

Wu Cheng-i, (1959), Shen Yu-cun (1983; 1985), Xia Zhen-yi et al.,
(1987) and Yao Chi-yu (1985) all describe epidemiological surveys
carried out in what can only be described as a most exhaustive
manner. The typical method seems to be that a host of paramedics,
especially trained for that purpose, will descend on a locality,
having first informed and consulted local leaders. They check with
the local public security office, the residents' committees and
associations to find out all known cases of mental illness. They
then visit all families in the locality and interview them. People
who are suspected of being mentally ill are visited by a
psychiatrist to confirm (or not) the initial diagnosis. Those who
are found to be mentally ill are registered as a case, a file is
opened on them and to quote Xia Zhen-yi (p. 82) 'they are
treated'. Wu Cheng-i (p 616) adds that they took advantage of
these investigations to hold meetings with families, neighbours
and residents association members to educate them about mental
illness, 'so that all of them may not only take good care of the
afflicted but also report new cases quickly'.

It would be too cynical to impute sinister motives to these strategies, over and above the desire to maintain social order. There is almost certainly a large element of paternalistic benevolence involved; these people, (both individuals and families), need help, even if they do not recognise that fact. But such intrusion into the essentially private world of the family runs counter to millennia of expectations in China about the inviolability of the family. None of these reports considers family reactions to their privacy being breached in this fashion. The assumption is that they are grateful.

Yet outside the world of the published reports, there is a different kind of evidence. There is still a reluctance to interfere in family life. During a case consultation session with me in Shashi, a young doctor described a case of a male patient who had been in the hospital for well over a year. His _danwei_ paid his bills. Although the patient went home occasionally at festivals and weekends, his wife was very reluctant to permit him to be discharged. The doctor, through a friend who worked with the patient's wife, had very strong suspicions that the wife was having an affair. The doctor had interviewed the wife at the hospital on one occasion.

During our consultation session, I suggested to the doctor that she carry out a home visit and have further contact with the wife and teenage son. The reaction to this was very ambivalent. First, the doctor felt her colleagues would object because she had already done more work than most of them would feel was proper by seeing the wife, and her enthusiasm would put them in a bad light.

Second, was a very strong feeling that it was deeply inappropriate to intrude to the extent of visiting the family home. In similar discussions with doctors in Beijing and Wuhan the reaction was the same; the doctor's business was dealing with sick people in hospital. Their outside lives were of little concern because, in the essentially biological model of illness which most of them seem to espouse, messy matters like infidelity do not affect the course of the disease.

There is also considerable evidence to suggest that family members will go to enormous lengths to hide the mental illness of, particularly, a young person. First, this is because it affects their chance of finding a job if they are not already lucky enough to have one. Second, because it not only severely reduces the patient's chances of marriage but their siblings' as well. Parents sometimes split up, with one taking the mentally ill child and the other the rest of the children and going to live elsewhere, where the family is not known. In Shashi, one mother elected to pay all her daughter's hospital bills, (although the family was not well off), despite the fact that her daughter was entitled to danwei based medical insurance, in order that no one at work would find out that her daughter was in a mental hospital. As a 20 year old she needed to find a husband.

It is hard to believe that Chinese families and their patients do not value privacy as much, or even more than, their Western counterparts. Yet for those for whom the problem of a mentally ill family member is a chronic and debilitating, one the offer of

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treatment and neighbourhood support may be very welcome indeed. What obviously is not always available is a choice in the matter, whether it be to have treatment thrust upon one, or to be deprived of it entirely.

One facet of community care support services which has never been developed in China is that of alternative living arrangements. The vast majority of people live with their families; but there are a number of mentally ill people in any reasonably sized city who do not have family members to live with for one reason or another. In any hospital there will be a proportion of patients in acute beds who have been there for over a year because they have no one to care for them. The issue has been discussed in China at various national meetings but action has not been taken.

There are a number of possible reasons for this. The most obvious one is that it is against the family ethos. An infinitesimal number of people do not live with family members, and there is probably a strong feeling on the part of individuals that it is their right to be cared for within a family. Not to be would be a matter for shame and discredit and would bring further stigmatisation to the mentally ill. Remember that dependence between family members, rather than independence of them, is the dominant pattern in China.

From the point of view of officials, the financial consequences of accepting responsibility for housing mentally ill persons would be frightening, so they have every reason to avoid providing alternatives. They may well be concerned that if they did so, it

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would severely undermine family care and establish expectations that they would not be able to meet.

A precedent for so doing does exist in that there are many state and collectively run homes for elderly people in China. However, the situation of the elderly is very different. They are traditionally a highly valued group. Second, one of the main reasons why young married couples are so reluctant to adhere to the government's one child policy is because they are afraid of a destitute old age. One of the ways the government has of reassuring them is to make sure that childless elderly are seen to have a comfortable life. The cost of that is considered to be nothing in comparison with the cost of unrestricted population growth.

In structural terms, the provision of housing would cut across pre-existing administrative responsibilities. Outside the hospital, a mentally ill person is not the responsibility of any one by virtue simply of his illness. He is his family's responsibility because of blood ties; he is the danwei's responsibility because he is a worker; and he is the neighbourhood's responsibility because he lives there. There is no collective organisation based in the community that is responsible for looking after the mentally ill. Danweis do not have enough mentally ill people to provoke them into the search for alternative housing; likewise neighbourhoods. In both cases, there would need to be some way of generating the necessary finance to cover costs or even make a profit, and this is unlikely. At the collective levels at which services are currently provided it is

not sufficient of a problem to motivate a search for solutions.

It could be a source of difficulty for the hospitals but as long as the fees are paid there is no reason why they should trouble too much about a patient staying longer than usual. Indeed, they may even welcome it as a steady and reliable source of income. The iatrogenic effects of hospitals is not something that impinges greatly on the thinking processes of Chinese doctors. If patients are warm, clean, receiving medicine regularly and reasonably well fed there seems little cause for concern.

The only organisation that potentially has the resources and the responsibility for mental patients en masse is the hospital. It would be possible for at least some of them to establish hostels on their own grounds, for recovered patients without social support. At least the patients would live under less restrictive conditions. Again, however, who would pay the fees? And second, as a solution it does not fit very well into the existing collective structures. Would such patients become the responsibility of the hospital danwei or street organisation in which the hospital was located? How would such patients find work? Danweis would not want to take the risk of employing someone with a chronic illness for whose future medical fees they must assume responsibility. Nor, at least in Western eyes, would it be following one of the most important ground rules of community care: that services should be provided in the most valued and least stigmatising way possible. So, while all things are theoretically possible, alternative accommodation schemes do not seem very likely in the

near future.

It is worth noting, even if a wholly adequate explanation is not forthcoming, that there are obviously difficulties in disseminating reasonably well articulated government policies with regard to community care for the mentally ill in China. Part of this is to do with resource distribution. The national government does not have sufficient finances to centrally fund community care services. Instead it expects the provinces, and particularly the municipalities, to seek sources of finance according to local conditions. This also means that in the eyes of the local governments, Beijing has abnegated its right to lay down rules and expect to have them followed. It is frequently reduced to a 'leading and guiding' role. This is in essence what has happened to the 1987 policy document based on the Second National Mental Health Meeting, which asks nicely on the title page 'please carry it out thoroughly according to local conditions', which probably means not at all in many of the poorer provinces, like Gansu.

There are also problems with linkages within and between bureaucracies. China's enormous size both in terms of geography and population means that the vertical links in government departments are greatly stretched and have to take account of what makes sense in Szechuan having little relevance to Xinjiang. If vertical linkages are problematic, horizontal linkages between bureaucracies, in this case government departments, are almost non-existent. This is why the government places so much emphasis on the 'three man leading groups', consisting of representatives of the departments most involved with the mentally ill, in an

attempt to create such linkages. First hand observation suggests that co-operation is most successful when it is based on _guanxi_ and is thus essentially personal and idiosyncratic. There is much room for achievement based on one or two people's enthusiasm. Equally, bureaucratic inertia is hardly likely to cause comment.

How significant is the economic and political context in which community based care takes place?

> 'Some of the most basic needs of the mentally disabled, above all the needs for housing, for occupation, and for community are not satisfied by the market system of resource allocation under capitalism.....The crisis of mental health provision...is simply the crisis of the normal social order in relation to any of its members who lack the wage based ticket of entry into its palace of commodities'.(Sedgwick, 1982, p. 239)

But does the socialist system, or at least the version of it pertaining in China, do any better? China has substituted _danwei_ for wages but the effect is the same. Community is not necessarily something in which you participate, but instead performs essentially social control functions. We have already discussed the problems of housing.

It is really very difficult to sustain a thesis that socialism, because of its different economic substructure, produces a political superstructure that, in its emphasis on the grass roots and mass participation, produces an environment which is more accepting of mentally ill people.

To take another quotation, this time from Scull:

> 'As part of their drive to solidify their own political control, the central authorities sought to extend a single moral order throughout the state seeking thereby to homogenize the

domestic population and eliminate or greatly reduce the significance of purely local allegiances. In this respect, the state simply accentuated the tendency ....to produce a diminution, if not a destruction of the traditional influence of local groups (especially kinship units) which formerly played a large part in the regulation of social life....capitalism, which did so much to undermine and destroy traditional social restraints was at the same time far more sensitive than its predecessor to social disorder'. (Scull, 1984, p. 32)

Later, he states more baldly that:

'The asylum had become a museum for the collection and exhibition of the varied specimens making up the refuse of a capitalist society'. (1984, p. 106)

In the first quotation, if we did not know that Scull was referring to capitalism, we could substitute socialism without doing any damage to the logic of his argument. As for the second, the mentally ill all too frequently make up the refuse of society - any society. In this sense the political system is an irrelevancy and our tasks, if not necessarily our solutions, are held in common.

CONCLUSIONS

1 - There are no voluntary or informal sectors in China to provide support additional to that supplied by the state, the family and collective organisations.

2 - At the level of the family and patient, mental illness is still a matter of shame to be hidden, for the most part, from all but the closest of relatives. This attitude is in opposition to that of the government and health officials, who see the mobilisation of neighbours and co-workers as essential in providing community support and control, independent of the families' wish for privacy.

3 - Other than the psychiatric care units, community support initiatives are based on work. This is entirely congruent with the Chinese cultural ethos, and with what is known in the West about the importance of work in maintaining self-respect. What is obviously missing are alternative residential services. It is suggested that there are a number of reasons for this; it would be stigmatising in a country where the norm is to live with one's family; there are no administrative structures for whom the provision of such a service is a priority; the demand for such a service is relatively low, although not non-existent; it would be costly.

4 - The central government in Beijing expects the provincial and local governments largely to fund community services themselves. Thus, while it may issue policy guidelines, it takes only a 'leading and guiding' role because it does not provide the money that would give it the authority to insist on the implementation of certain practices. Meanwhile, at local level, the provision of community services are dependent firstly, on the wealth of a particular area; and secondly, the priority that is given to welfare issues generally and within that framework, the mentally ill in particular.

5 - Whatever the rhetoric - East or West - ultimately the care of the mentally ill does not rest on political ideology. Any society is restricted in what it provides by economic factors. Within that, choices are made about where and how to spend what is available. Seen from this relative perspective, the mentally ill

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are poorly served whether the country is China, the U.K. or the U.S.A.

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CHAPTER TWELVE

SOME FINAL THOUGHTS

'If I become a useless person after going into mental hospital then all my hopes and expectations will be dreams'. (A patient in a Chinese psychiatric hospital, Appendix 1, Essay 5)

This thesis has attempted to provide some new insights into policy and services for people suffering from severe mental illness in China, combined with a sense of what it is like to be one of those people. Underlying it all is the question 'how much is similar to, and how much different from, Western experience?'. By asking that question, we risk the accusation that 'the West' is being used as some kind of standard against which China should be compared. A Chinese person might well want to know by what right a Western observer considers herself able to pronounce on China's 'internal affairs' in the matter of psychiatry.

In sum, what can we conclude about psychiatric care in China? There is no doubt at all that major mental disorder exists in China. The tradition of hospital care for the mentally ill and the majority of drugs used in treatment have both been adopted from the West. The number of psychiatric beds, in comparison with the population, would suggest that hospital care is beyond the reach of many people.

Over the last six years access to formal treatment has increasingly been based on ability to pay rather than need. This has disadvantaged those in urban areas not covered by health insurance, and the vast majority of the rural population, where

the 'contract responsibility system' has seen the demise of the co-operative medical insurance schemes.

There is no national legal framework concerning the mentally ill. While no formal powers exist to admit patients against their will, there is no compunction about doing this when the family are in agreement. Police are empowered to admit people who have committed minor offences straight to psychiatric hospital, if they believe the person to be suffering from mental illness. This is thought to be a more humane course of action than arrest and a court appearance. Forensic psychiatry has also been developed, but it is impossible to know how it works outside the major centres. There are restrictions on the civil liberties of people with a severe mental illness, including the right to enter into contracts and the right to marry and have children.

A comparison of chronic patient populations in psychiatric hospitals in Guangzhou and London showed that in many ways they presented a similar profile, particularly in sex ratio, marital and parental status. The hospital in Guangzhou tended to have more patients with violent behaviour in their backgrounds. This may reflect the reality that, with fewer psychiatric beds available, it is patients who are hardest to contain outside an institution who occupy them. Families go to extreme lengths to hide the fact of mental illness in a family member. It is harder for someone with a mental illness to find work, particularly since the introduction of the 'contract responsibility system', when output and profit became much more important. Generally, it seems that mentally ill people in China suffer as much, if not more, stigma

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than in Western countries.

While caution must be exercised in drawing conclusions too broad to be supported by the available data base, there are reasons to believe that much psychiatric hospital care in China reflects some of the worst practices extant in the West 30 or 40 years ago. Hospital buildings and wards are severely impoverished and the lack of training for staff, particularly nurses, encourages punitive and damaging practices.

All of this has a distinctly familiar ring to a Western reader. There are differences, of course. The interests of the individual are given less emphasis than the rights of the collective. There are fewer community support services both for patients and their families. There is much less understanding and acceptance among workers in psychiatric settings of the social and emotional difficulties that contribute to the onset and maintenance of illness. It is true to say that overall China has fewer resources at her disposal to spend on the mentally ill, although one might dispute how they are used

So we are left trying to answer the question of why there are so many similarities in attitude and treatment of the mentally ill in China and the U.K., whose economic, political and social systems are so disparate. The answer almost certainly lies in the nature of the disorder and societal reaction to it.

In a book devoted to trying to prove that schizophrenia does not exist, Sarbin and Mancuso (1980) claim that rather than being a

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medical diagnosis, schizophrenia is a moral verdict. In reality, it is both. The handicaps of schizophrenia lie not only in the disease, but in other people's reactions to it.

The symptoms are frightening to many when in their florid form, and frequently take the shape of flouting concepts of public propriety. Although episodes of violence are not particularly common, they are common enough to create what feels like a realistic fear to bystanders. The negative symptoms are irritating rather than frightening, with apathy, neglect of hygiene and inability to tolerate usual social demands leading to condemnatory verdicts of the person being lazy, dirty, unfriendly. Status in any community is founded on the individual's ability to perform in appropriate age and sex related roles, maintain standards of propriety and modesty, and behave appropriately in kinship and social interaction. It is exactly in these areas that schizophrenic people do not conform. Failure to conform to these expectations will almost always lead to a social devaluation of the person involved.

Barham makes the point that all of us have to answer the question 'who am I?' as a more or less continuous, (and changing), process throughout our lives. To do this, we are involved in constructing a narrative of our lives which, because it has to take into account other people's narratives as they interweave with our own, can never be fully predictable.

'The agent lives out his life in relation to a conception of
a future, a conception which to be intelligibly held must partake
of culturally shared images of the future, but in virtue of the
dramatic character of social life, of the intermeshing of

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individual life projects and of the reflexive possibilities of which agents can avail themselves, the agent can never be certain how the plot is going to develop'. (Barham, 1984, p.89)

Whatever the nationality, the patient with schizophrenia has to construct a narrative for the future with a devalued identity, that takes into account others' hostile reactions to him in their narratives and a future that is unpredictable at best. This chapter began with an excerpt from one of the patients' essays that expresses very well the restraints that are placed on the narrative future by becoming redefined as a 'useless person'. Barham describes a very similar feeling among the patients in his study.

'Among schizophrenic people, loss of confidence in the viability and value of their life projects, and the reconstruction of themselves as useless, are as much as anything powerful determinants in the transformation of a potentially manageable disability into permanent social disablement and chronicity, and adverse secondary reactions like these are fuelled and aggravated by forms of contextual disadvantage such as unfavourable attitudes and expectations of others, lack of opportunity to practice social skills, isolation from everyday life and enforced pauperism'.

Thus both in China and the U.K., the terms of participation in social life which someone who suffers from schizophrenia is permitted are defined by others. It is not simply a question of setting a 'mental hospital', with connotations of degradation, against the 'community', embodying beneficence. Indeed, the concept of community as a site is not helpful. What is really under discussion is not the question of distance or proximity but the idea of a moral community, based on respect for the more vulnerable members of society and of the sorts of policies and practices that might be constructed in order to enhance the terms of participation in social life for such people. The issue is not

whether people live in hospital or outside it, but how they might come to live a valued life.

At the heart of the similarities in attitude toward people with schizophrenia in China and elsewhere is the convergence in the negativity of the moral verdict, and thus exclusion from the moral community and a valued life. The form of moral community and the content of a valued life are immaterial. The defining feature is to be excluded from them. Thus the universal reaction to schizophrenic disorder is almost always negative, superseding factors like political philosophy or available economic resources.

In turn, this negative reaction colours the way that the distribution of available resources takes place. It is true that the U.K. has a greater disposable national income, so that facilities for the mentally ill are more diverse and of better quality than they are in China. But comparisons of priorities within each country would show that the mentally ill are worse off in relation to other groups. The most socially valued group in China is the elderly. In the U.K. it would probably be children. In neither is it the mentally ill.

It would be illogical to criticise China for not spending what it does not have on the mentally ill. On the other hand, familiarity with the system leads inexorably towards the conclusion that there is also a failure of political and organisational will at both policy and grass roots levels that could lead to improved standards of care for mentally ill people. This is demonstrated by the paucity of national conferences to formulate policy

guidelines; the lack of a committee or section within the Ministry of Public Health to advise the Minister on the development of mental health services; the failure after years of work to produce mental health legislation. At grass roots levels, there are a number of improvements that could be made to hospital services and to develop community services, that would not be costly. In Guangzhou, there always seemed to be money for endless banquets, (costing three times the average monthly salary), but little to buy extra comforts for the patients.

Is this tantamount to saying 'the West is best'?. Anyone who has seen the video, (or read the book), Forgotten Millions (Cohen, 1988), or is familiar with the plight of the homeless mentally ill in London and other major cities would have to deny that proposition. Man's inhumanity to the mentally ill transcends national and cultural boundaries. What does distinguish the West from China is that there is a much greater awareness of the problems and a sense of shame, at least among some segments of the population, that we could do better and yet do not. The rhetoric is more humane, even if the practice leaves much to be desired. Furthermore, the political and social environment is one that encourages the formation of pressure groups, so that the views of patients, staff and families are all in the public arena. China is very different in this respect. Hsu (1985) argues that Westerners and Chinese have very different responses to the needs of outsiders. Chinese people, he claims, meet their need for intimacy almost exclusively within the family which is a stable and accepting edifice. Chinese people, Hsu says:

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'... throughout all of their history have developed few secondary groups outside of their kinship boundary. China... had no Florence Nightingales or Lawrence of Arabias. (1985, p.35)

Westerners develop many more significant relationships outside the family, which means they have to try harder in making and maintaining personal relationships. This in turn encourages them to be more involved in issues that extend beyond the boundaries of the family and people immediately known to them. This reaching out may in the past have gone as far as conquering, or through alternative means, subjugating other nations in the name of 'civilising' them. Understandably, this is a subject about which China is exceedingly sensitive.

What effect have these conflicting perspectives had on this research? Jonathan Spence (1980), in the conclusion to a book that examined the lives of a number of Westerners who tried, as the title of the book puts it, 'to change China', comments that they all had at least one motive in common. This was to help to bring either spiritual or material improvement to China, with the goal of making China more like the West. They were sure that their own civilization, whatever its shortcomings, had given them something valid to offer.

It would be dishonest to say that I do not think that, in comparison with China, the West has developed a greater range of knowledge about the treatment of mentally ill people in its broadest sense. Research, in my case, has not been 'pure'. I have never been able to look at what I was doing with the disinterest of a scientist examining molecules under a microscope. I wanted to

influence, and in turn was invited to influence, through the medium of arranging study tours, teaching two national courses on social work in psychiatric settings, and numerous personal contacts with practising psychiatrists, patients and relatives.

However, the influence process does not always produce the results desired. What happens is that a choice is offered to people, who, without that intervention, might not have known that there were alternatives - choice that they might not otherwise have had. They may exercise that choice in ways that are distasteful, as when the Medical Superintendent of the Guangzhou Hospital announced that, following the study tour to Hong Kong, he had advised the staff running a work station in Guangzhou to make the wearing of uniforms for patients compulsory - because it was more 'scientific'. It is hard to accept that people must invent the wheel for themselves and that learning from others' mistakes and experiences is no substitute for going through the process. Ultimately, psychiatric professionals in China must set their own goals and attain them at their own pace.

THE GUANGZHOU HOSPITAL PATIENTS' ESSAYS

ESSAY NUMBER 1 THIRD PRIZE

The Story of My Life

Autobiography of a Mental patient

Back to the Number One Education Home: allow me to call it this even though I know it is called Guangzhou Civil Affairs Bureau Mental Hospital now. On the one hand, this is a long name to write and on the other hand, the Number One Education Home is so deeply printed in my mind that I could hardly forget it. I lived here for five years from 1975 to 1980. At that time, it was just a young sprout coming out from the earth. Now it has developed in to a big tree. What big changes it has undergone! Now fruit trees and flowers are growing everywhere and it has become a holiday area!

The five years were a turning point in the treatment of my illness. I have grown into somebody who can cope with being discharged for eight years. I became a member of society. From a 'nutter' I became a normal person, an editor of the factory newspaper in a Guangzhou printing factory. How did I do this? One phrase - according to the principle policies of the 'four integrations' of the Number One Education Home. What are the 'four integrations'? New comrades may not know it very well but old staff should remember it well and fresh. That is integration in work, treatment education and recreation. I was treated according to the 'four integrations'. This is what I rely on after discharge

for eight years without relapse since 1980. I can maintain independent living and work. Even this time when I was admitted into hospital I was aware of my condition enough to write to the work unit leaders requesting hospitalization. I have some self-awareness. I would talk about the reasons for my relapse later. In the meantime, I would talk about my feelings towards the 'four integrations'.

The biggest fear for mental patients is that others say that you are ill. The first principle of the 'four integrations', education, is to make the patients aware and understand that they are ill. At the same time, the patient has to try to understand what is happening in the country, so that what they say and do can fit into social reality. It is like keeping in tune while you are singing. The song won't be the same if you are out of tune. If the patient doesn't understand social reality and doesn't understand what is happening in the country, then their behaviour and what they say will be different from other people. It is like a song that is out of tune. It won't be that song any more, and it is like somebody going crazy. If people with a history of mental illness act differently from others, people easily will think that they are having a relapse. This is the importance of 'education' and is the most important principle of the 'four integrations'. In addition, education also includes teaching patients not to do unlawful things. Patients would learn legal knowledge like every body else, as observing social order is one of the factors that can reduce the chance of relapse. That is what I learned from five years of hospitalization and eight years of independent living.

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On the other hand, work, treatment and recreation are very important as well. Work includes both physical and mental work. Personally, I think it is more appropriate for mental patients to engage in physical exercise. It can help to build up your body, can facilitate treatment and can reduce mental burden so as to avoid stress. Mental work is more difficult than physical work. Usually mental patients will find it more difficult to cope with. I can feel this myself.

As regards treatment, I take drugs according to doctor's prescription. I keep to it for the eight years I've been discharged. This is very crucial. You can't treat illness without medication. You have to admit that you are ill first and then take medication as prescribed by the doctor. This, together with appropriate recreational activities and adequate and regular sleep, are what I got and what I know about the 'four integrations'. I keep these principles myself as well. This helped me to remain stable for eight years after discharge.

But I forgot one point, that is what Dr.So told me, and is also what he expects from other patients, that is to do things within your capacity. This may sound abstract but it is concrete as well. It is not easy for patients to understand this and put it into practice. It needs a lot of experience to be able to do it. It is not an excuse for laziness and that is the tricky bit.

Now, let me talk about my relapse this time which is related to what I have just said. I had been working continuously for three

months, finishing duty after duty, for example preparing for inspection by the deputy mayor, working on the newsletter competition, preparing a bulletin board for festivals, organising a street exhibition, etc.. As a result my eating, sleeping and drug taking habits became irregular. Sometimes I worked overnight and went straight back to work the next day. This is what I learned from this relapse.

What I talked about just now may be superficial but they are my personal experiences. The reason why I feel the benefit of the 'four integrations' is because from 1960-1975, I've been in and out of Fong Tsuen mental hospital more than ten times. I've been through ECT, chlorpromazine, insulin shock, education through Mao's thoughts, electric-acupuncture, without getting the same results as in here. Here, I take mainly chlorpromazine since 1975. This proves the advantages of the 'four integrations'.

This time when I came to the Number One Education Home everything has changed so much. The environment has improved and facilities increased. People have changed as well. Old staff are more mature. New staff are enthusiastic. Everything seems so lively and joyous.

I may go back to my work unit after a short period of treatment. It is difficult to forget this place. Even though there's a lot of new staff and the environment has improved, I will expect myself to maintain what I got from this treatment. I will learn from their experience and try hard to be a good model. Lastly, I want to thank Dr.Yu of my ward for his earnest treatment, and all the hard work of the rest of the staff. It's like;

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> Leaving the Number One Education Home
> Eight years have gone by without a trace
> In the blink of an eye
> It is just like yesterday
> Now, trees have grown
> Like several decades have gone
> Here to work hard on treating my illness
> Strive on to go forward.

ESSAY NUMBER 2 SECOND PRIZE

<u>The Story of My Life</u>

After graduating from teacher's training college I was assigned to work as a teacher for two years. I got neurasthenia and the organization transferred a group of teachers suffering from neurasthenia to another <u>danwei</u> to work. I was sent to work as a cashier in a Chinese herbal shop. At that time, I was young and would just do things that pleased me. I refused to go as I thought it would be boring sitting down all day. Again I refused to go to work in the New China book shop because I thought there's nothing technical to learn and the wage was low. And I refused to work in the kindergarten as well. The Education Bureau then transferred me to work as a temporary worker in the street service station.

I lost my temporary job after I was divorced from my husband. No job was offered me by the street organisation and I couldn't get any charity money. In a nutshell, I have to put my daughter in a nursery, and earn my living by selling junk picked up in the street.

When my daughter was seven or eight years old, I couldn't earn enough by just selling junk. Hence I started to beg and sing on

the street together with my daughter. When my daughter had reached the age of nine, we started to work as shoe shine and shoe repair workers. In the summer we sold newspapers. Later on I developed a tumour and had to depend on my daughter who carried on our trade repairing and shining shoes and selling newspapers. Later, I cured my tumour by myself.

When my daughter was fifteen years old, somebody suggested that we could write to the City Women's Association to seek help regarding our living and the future. After the Women's Association received the letter, they contacted the Women's Association in our district immediately who then contacted the Civil Affairs Bureau in our street. They gave us some charity money and helped my daughter attend primary school.

Soon afterwards my daughter started school. She joined the Youth League and became a medium rank league leader and was holding other posts as well. She started in the second form of Primary 4 and finished her primary education with flying colours. She was even selected as a student with 'three good virtues'. Her story was published in the press many times. The civil affairs group of the Hoi Tung Street revolutionary committee let my daughter stay in my previous house without paying any rent. This year my daughter is in the first form of junior secondary school. She was elected as prefect immediately and was performing in other posts as well. With concern, both the teachers and her classmates showed her how to apply for the People's Scholarship.

When I was picking junk up from the street, out of grievance for not getting any charity money or being allocated a job I vowed that I would never go back home even if I was dying. Hence, when my daughter was aged between seven and 15 years old we were living in a small room under a staircase. After my daughter started school I stayed there until I was admitted into the hospital.

My daughter didn't come to see me for a long time after she had started school. I thought she had been abducted. I had no money for food. I could only eat the leftovers from nearby restaurants. I thought too much and became crazy. Later, my daughter gave me 10 yuan from her charity money of 40 yuan a month, since I haven't got any charity money of my own. She came to visit me once a month. Because the room was so small and there was no kitchen, I had to eat outside. I had to live on left-overs again once the ten yuan was finished.

Once I became crazy I started to hear voices. My head was wrapped up in a lot of white sponge I picked up from the street. A face basin was fastened in front of my chest with cloth. I often scolded others loudly on the road. Later, comrades from the street dragged me to F1 ward of the Civil Affairs Bureau Mental Hospital to recuperate. Here, it solved my problem of finding food and has cured my illness. I don't hear voices any more and don't scold others. Nevertheless, I would have insomnia sometimes and would feel restless during the day.

We, especially my daughter, have turned a new page in our lives. Now we can lead a happy life. It is all due to the correct leadership of the government and the Party. I am thankful for the care and concern of the Party with all my heart. I turned out to be nothing even after years of cultivation by the Party. In contrast, I became a burden on the country. I feel so ashamed of myself that I want to hide my face. I regretted that I didn't obey the assignment by the Party in the past. If I could work after discharge in the future, I will work hard and listen to the Party, serving the people with all my spirit. On the other hand, I will educate my daughter so that she could be a useful person and could serve the people with all her mind and spirit in the future. In doing so, I could pay back the government, the Party and the people for their concern towards me and my daughter.

ESSAY NUMBER 3 THIRD PRIZE

The Story of My Life

My Experience

I am [name], male and already nearly 50 years old. I started school after the liberation. When I finished my primary, junior and senior secondary school education the country was having economic difficulties. I stayed at home for four years without a job. In 1964, the country called her people to 'go up to the mountain and down to the village'. Under the influence of this historical trend, I went to work in a commune in the north of Guangdong. After working as a farmer for 12 years I became ill as well as having a problem with my eyes. My application to resign

through illness was granted by my seniors. I didn't want to work in a rural factory because there would be no good job opportunities so I went back to Guangzhou.

For five or six years the street organisation arranged temporary jobs for me both in the street and in large factories. The main reason why I became mentally ill was due to my superstitious thoughts. My brain was in a constantly confused and restless state, ever since my extreme superstitious thoughts were exposed. I felt that there was a great pressure on my head. This affected my social life and work. I was afraid to relate and get close to people. My work morale was affected and my work ability reduced. I was abnormal and others were dissatisfied. The street administrative office knew about my extremely superstitious thoughts which made my life and work abnormal. They applied for me to come to the Civil Affairs Bureau Mental Hospital for recuperation. I've been here for more than four years by now. After several years of recuperation, the psychological pressure on my head has decreased and I am a bit more normal. Still, it is difficult to keep in touch with the society. As time went by, the superstitious thoughts in my head were facing crisis and beginning to shatter, and I have to admit that these thoughts weren't real. I've been ill for more than 4 years. All along I was being cared for by the medical staff. They were very patient in treating my illness and they arranged my meals and accommodation. I'm extremely grateful for the care given to me by the government and I will settle and recuperate without second thoughts.

The Story of My Life

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My Experience

My father was wrongly categorized as a rightist. He died in December, 1974.

My mother was a housewife and died in April 1984.

My eldest brother used to work for the tin products factory in Guangdong. He is 53 years old and has retired due to renal disease. He is married.

My sister, 46 years old, works in the Guangdong iron and steel factory.

My second eldest brother, 44 years old, is a secondary school teacher in Dao Mun, Guangdong. He is married.

Younger brother is a cadre in Ling Nan rubber factory, Guangdong, and he is also married.

I started school when I was 8 years old and was studying in the primary school of Cheung On Dong Street, Sui Kong Road, Henan Province. I was transferred to the Kee Lap Road primary school in Primary 2. After finishing primary school, I was admitted to the Number 42 secondary school in Guangdong. The Cultural Revolution started when I was in Form 2. I stopped going to school and stayed at home. Through the neighbourhood committee, I worked as a temporary plasterer sometimes. I hadn't joined any Red Guard organization. At 18, I responded to the call of the country to 'go up to the mountain and down to the village', and joined the Red Party production team of the Cheong Wai Farm in Po Ling county,

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Hainan Island, Guangdong province, and participated in the construction of socialism. In 1970, I had an appendectomy in the commune hospital. After the operation I had insomnia and was diagnosed as neuraesthenic by the doctor. Because I didn't get proper treatment, it developed into mental illness. In 1972, I was sent to the mental hospital in Hainan Island for half a year, and was diagnosed as suffering from schizophrenia.

In the autumn of 1973, I went back to Guangdong to visit my family. During that time, my condition deteriorated and I was sent to the Guangdong Number 10 People's Hospital by my relatives. I stayed for treatment in Guangdong without going back to Hainan Island. In 1977, I went to the City Number 11 People's Hospital for follow up, and subsequently stayed there for three months. At that time, I was still in Hainan Island.

Spring 1978, I was 28 years old. I was discharged and went back to the city. But the street hadn't arranged any work for me. I could only earn my living by doing temporary jobs. Between 1978 and 1981, I worked as a dish washer, labourer and dug bomb shelters. I kept taking medication while I was working. In May, 1982 my relatives sent me to this hospital. I have remained here since. I am 38 years old already.

Under the care and concern of the comrade leaders in the hospital and the careful treatment of the medical staff my illness has improved. I feel so excited and so grateful for the concern and help given by the doctors. I have decided to try hard to learn and raise the awareness level of my thoughts. I would try hard to

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develop the function of subjective dynamics, and co-operate with the treatment in order to get well soon. I can prepare myself to go back to work and join in the construction of a socialist society.

ESSAY NUMBER 5   FIRST PRIZE

The Story of My Life

The Time Since I Have Been in the Number One Education Home

In June 1975, following the leader's recommendation, I was transferred to the female ward of this hospital together with some other patients. At that time Kam Sha Wai was still a very remote area, deserted without any buildings. My mind was unsettled and I wasn't used to the place. Luckily there was a woman doctor called Dr. Koo. I knew her and she showed a lot of concern towards patients here. Gradually I settled in.

I can't remember whether it was the first or the second day when the nurse, Ms.Lee, asked several of the patients to go outside and work. I thought, maybe I have to work here in the same way as we did at White Crane Cave Hospital. But perhaps it wasn't bad carrying on like this, I comforted myself.

Soon a patient called Ho was ill. The nurse asked me to take up her job. This included cleaning several wards, single rooms, toilets, intensive care unit and drains etc.. I took the broom and several other patients carried water. It was like this everyday.

Sometimes, we couldn't finish our work even by lunch time. It was hard work for me because I wasn't brought up in a worker's family. Still, I have to carry on. Doctors, nurses and other staff cared about me. They increased my bonus from two to five yuan. I was pleased about it. Later, staff told me that my relatives came to visit me. I was very excited about it, as since being admitted to White Crane Cave Hospital, I have had very few visitors.

Lunar New Year was near. Doctors and nurses requested my relatives to take me back for the holiday. Consequently, my second elder brother agreed, and took me home for Chinese New Year. Because of this, I am very grateful to the doctors, nurses and my second elder brother.

After I came back from my holiday, I still had no idea about when I could be discharged. I kept on working, took drugs and obeyed everything here. In 1980, we transferred to this present ward. Suddenly, everything changed again. We lived in new buildings, there were new beds, new mosquito netting and new blankets etc..

The Number One Education Home was gradually renovated into a beautiful place, like a garden. At first, we were allowed to go out to buy things or to go for a walk with permission; that was a happy thing. But it is not allowed any more. I don't know why. I saw that patients were allowed to smoke in male wards but not female wards. I am not happy at all. I didn't realize that I am already 53 until I saw what was written on my blood test report. I asked the woman doctor, Dr.Fu, to take me off medication which she did recently.

I was just being locked up and made to work hard. We were not allowed even to smoke or go outside. I really want to fly over the wall and go back home. My real family haven't visited me. The brother with whom I stayed at Chinese New Year is just a 'kai' brother [i.e. no blood relation but refer to each other as brother or sister because of closeness between themselves or parents]. They don't agree to discharge me. Disregarding the time I spent in other hospitals, I have been here for 14 years already. I don't think that I am crazy. I dare not think about my situation. How can I carry on with this suffering?

I came from Guangzhou but I don't think the leaders here have tried very hard to find out the whereabouts of my family. If only I could go back home once, I would be grateful.

I work very actively in my ward. When I am asked to do extra duties, I would try my best to finish them. Alas, nobody knows how I feel and understands my sorrow. Look, my hair has turned grey. It wasn't like this before.

I'm a Communist Party cadre and was working as a cadre before admission. I lived happily with my husband and children. But now I can't remember anything any more! I don't know what will happen if I go back? I miss my family very much. If I become a useless person after going into mental hospital then all my hopes and expectations will be dreams! Therefore I hope that the leaders, doctors, nurses and staff here will empathize with us patients more. We patients are useless. We can't even think about home or our country. We just want you to help and to care.

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ESSAY 6

The Story of My Life

I was very pleased when I was sponsored by the Guangzhou nitrogen fertilizer factory to the Nanking Chemical College in 1965. I learned a lot of new knowledge. My teacher, Kwok Ah Tse, was very good. She was able to explain the lecture clearly. Later on, Guangzhou nitrogen fertilizer factory lost its influence. I came back to work in the medical machine factory. After I came back in 1966, the Cultural Revolution started. I didn't join any mass action. I only worked on increasing production. I finished my production quota in eight years. I felt good about it because production is the main task for a worker. My responsibility was quite great at that time. After I finished my production quota I was very happy and was elected as a model worker. In 1972 I was sent to attend a scientific conference and then came back to the factory to fulfill my duties. On the 9th. September, 1976 Chairman Mao died. I felt very sad.

I am a lunatic. I am very careful at work. I've been waiting for a long time for a job.

ESSAY NUMBER 7

The Story of My Life

My day since I came into the hospital. I was not used to it at first. Later I got used to it after some days. After a period of hospitalization, life and everything changed gradually. Life was

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very simple in the hospital. It was not as good and refined as life at home. When I am discharged I must treasure my own clothes and not destroy them, or I could give them away generously. If I could be discharged, then from now on I must respect my parents and younger sister. I have to strictly demand myself to have high expectations of myself. I have to find my place in society. I have to observe the 'five standards and the four beauties'. (See Appendix 3)

ESSAY NUMBER 8

The Story of My Life

I am very happy during Mid-Autumn festival this year. The hospital's leaders have organised a party to celebrate the National Day. Dr.Tam, Dr.Sheng, Miss Pearson, and her interpreter from Hong Kong, also joined us. There were not many programmes but all the performances were good. The place was decorated beautifully with lights and ribbons. All the patients joined the party happily. Dr.Sheng and Miss Pearson talked to us as well.

ESSAY NUMBER 9

The Story of My Life

I feel better after coming to the mental hospital. I am not as bad as I was at home. I had good rest as well. I work in the hospital and feel very happy.

The Story of My Life

I feel restless recently, agitated and want to do some work but my physical health hindered me . I couldn't do much. I wish that somebody could help me and show me some concern. My sleeping pattern is the same as usual. But I could not do much. I wish that somebody would help me and show some concern for me.

My sleeping pattern is the same as usual. But I could not sleep in the afternoon. I was only able to have a nap after devising some special ways. But this was just a consolation. I couldn't sleep well. I can't eat and just play around with my food. I can sleep well at night. If I can't, then I move the bed or chat with other patients.

ESSAY NUMBER 11

The Story of My Life

In the autumn of 1975, I flew to New York with a worried heart. After getting off the plane, I got into a limousine which was sent for me by the U.N. and went directly to my mansion. Siu Lin and her younger brother, Cheong Nam, were also in the car. (Both of them were Americans). They were drinking soft drinks, eating ice-cream and chatting happily. Siu Lin asked, "husband, will you go to Washington as well? That is the capital city and is bigger than New York. I want to build a mansion there. You've got the money." (She means me). Little Kar Kin said, "sister, it seems that my brother-in-law was in a good mood last time he came to the US to

attend a conference". Without waiting for a reply he asked again, "will we be able to do some sight seeing?" I then said, "of course we shall go to every place of interest and we shall build a big house for your sister." While we were talking the limousine had arrived at Kau Tin mansion. President Nixon was already there, waiting for me. Kissinger and a group of foreign affairs officers were there as well. There was also Queen Elizabeth, and the President of Africa with his slaves. The banquet and flowers were already on the platform. On a noticeboard it was mentioned that Taiwan is a part of China. Foreigners who lived here, (including people from Hong Kong and Macau), were all Chinese alien residents. This is the theme of my talk for the U.N. this time. The scenery is very pretty here in autumn.

I was born in 1955, received my education in Lap Fung primary school, Number 54 secondary school, Guangzhou University, and Military and Political University. I am now the head of the Military Tactics Engineering Bureau. I have started businesses like the Friendship Store, the China Hotel, the Wah Ha Company, the underground mall of the Culture Garden and the Tai Pak Plaza.

ESSAY NUMBER 12

<u>The Story of My Life</u>

The sun is red and shining brightly in October. The beautiful sun is shining through the mountain, spring tide is coming. I am happy to recuperate here. The sun is shining all over the ground in spring. I decided to be as lively as a dragon after spring. Here

in the mountain I am with undaunted spirit.

ESSAY NUMBER 13

The Story of My Life

I became mentally ill when I started university. It was because of homosexuality that has ruined my life and has made me spend a long time in hospital. I joined the services group in the Civil Affairs Bureau mental hospital. I did cleaning everyday which makes me healthy. I feel happy that I could still try my best to make a contribution even though I am ill. I would try even harder in future to contribute to the development of socialism.

ESSAY NUMBER 14

The Story of My Life

I have seen the great changes in Kam Sha district with my own eyes [the area around the hospital]. Congratulations! It is something worth cheering and rejoicing over. But I have my worries. I don't know when I can achieve my goals. I don't know when I can express my sorrow.

Since I have been in this hospital, I see the changes in various aspects with my own eyes. It became a holidaycamp. It illustrates the great development of the party and the government and the contribution of the Civil Affairs Bureau to the community. This is something undeniable.

However, I myself have become an invalid. I feel very sorry that I have been abandoned by people in the community and by my work

unit. To shelter and treat invalids like us, the government has spent a lot of money, manpower, land and equipment, etc. However, I am already cured, but still cannot go back to the work unit. I just get the benefit without being able to contribute to the construction of socialism and the four modernizations. How detestable! How detestable! How I suffered to the utmost!

I saw on the TV one day that the people and the street office of Bing Kong Street take care of the invalids and can make them independent. My suffering is beyond expression when I saw this and compared it with my own dependency. I don't know when I can achieve the goal of being independent. I'm not able to discuss this either with hospital or the work unit. The committee of the work unit don't come to visit me any more. I just can't say what I want. It is:

> People would laugh when a crazy person speaks.
> I would face a lot of bad feelings, though I want to get myself organised.
> I could only see other's successes with sorrowful eyes.
> I just wish God would let me die soon.

ESSAY NUMBER 15

The Story of My Life

Celebrate the Number One Education Home
Praise our Motherland
The Number One Education Home changes every day
With green leaves that look like velvet carpets and pavilions
People coming and going. The air is fresh
To build the Number One Education Home as pretty as a picture
Our motherland will be prosperous and strong.

ESSAY NUMBER 16

<u>The Story of My Life</u>

Everyone calls me by the nickname 'Big Sister'. I have been treated for more than ten years after extreme mental suffering of losing my husband and children. I have created my life as a hard working, rational woman, using my own hands. The illness hasn't conquered me and I hope to be called the 'Good Sister'.

> The future is immeasurable
>   Maybe it is long, maybe it is short
> The hospital where I am living
>   Will give me a stable home

ESSAY NUMBER 17

<u>The Story of My Life</u>

Miss Pearson, how are you? My name is - - - . I was admitted into the hospital due to family discord. In the hospital, doctors and medical staff showed a lot of concern and care and I got better medical treatment. From an unemployed youth, I became a part of society. This is inseparable from the concern shown to me by Dr.Leung. He showed consideration for me in every aspect. He is really a doctor who treated patients with a parent's heart. I can feel the superiority of socialism. Now after rehabilitation, I have to improve family relationships, live with them in harmony, to learn and to improve myself. I wish that medicine in my country will continue to develop so that we patients can live under nature and be filled with love.

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ESSAY NUMBER 18

The Story of My Life

Memory of How I Spent Mid-Autumn Festival

This year I went to my sister's place in Guangzhou for Mid-Autumn festival. There were many new buildings in Guangzhou. Guangzhou is very prosperous. The market is busy and there are a lot of commodities for sale. At night, it is still bright and lit up, the roads are busy with traffic as well as pedestrians. They are talking and laughing and very happy. I can hear sounds of firecrackers everywhere and people are enjoying themselves during the Mid-Autumn festival.

ESSAY NUMBER 19

The Story of My Life

I am a mental patient. I became better after two months of intensive treatment. I am thankful to the doctors and nurses. After discharge I must work hard to show my gratitude for their care.

ESSAY NUMBER 20

The Story of My Life

I want to be discharged soon. After going back home, I will obey my father and my mother. I will not hit my grandmother or any one else. I will help my father and mother to do housework and will never go back to the hospital again.

ESSAY NUMBER 21

The Story of My Life

Poem for National Day

The Red Flag has been waving for 39 years. China has
    risen up with high spirit
The New China, standing upright and strong, has swept away all
    the Chinese and foreign evils
Thirty nine years is a long time, there has been thunder, rain
    and frost
Clearing thorns and going forward, our footsteps tell our
    strength
There are frequent obstacles in our way. Don't stop because we
    fall over?
Don't be afraid when clouds and fog are in front of us, the sun
    will rise to shine on our path
Clouds and fog will disappear when the sun comes out and we can
    go forward towards our goals
Difficulties can't stop us, the Red Flag is waving with the
    support of generations of hard work
If you are afraid of the long way ahead and the thunder and rain,
    remember that communism is our goal
Heroes emerge on our way and we walk our steps in blood
Which is the right step and which is the wrong step? We can only
    seek the answer from history
A word for the young generation of China; you must do better than
    your forefathers.

ESSAY NUMBER 22

The Story of My Life

The sky is covered with frost. You can see the sun set and hear
the birds sing.
Maple leaves over the lake were as red as fire
Sounds of temple bells outside the city can reach as far as the
river.

I am actually intended to be a health worker and am not as ill as

many other people.

The area of ward 5 is   91   ie-2.384848009(infinity)

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<u>The Story of My Life</u>

A Hospital With A Beautiful Environment

When you walk into the Kam Sha Wai Holiday Camp Civil Affairs Bureau sanatorium for the mentally ill, you can see beautiful environment with green leaves on both sides of the main entrance. At the back of the lawn is a beautiful administration block and a canteen. On both sides of the path, there are many white magnolias and you can smell the sweet fragrance of the blooming flowers. There is also a goldfish pond with pretty goldfish and white flowers in it. It gives the hospital a feeling of tranquillity and elegance. The artificial hill with creeping plants growing on it divides the pond up and makes it even more beautiful. There are also several Chinese pavilions where people can rest. It's cool inside and from there you can see the nearby scenery. People visiting their relatives like to take the patients there.

With the work of the staff, the garden in male ward 2 has improved every year. They have grown more varieties of flowers. Flowers in doctor's rooms are all from this garden. They grow some sweet asmanthus in the courtyard. In August, when the flowers are blooming, you can easily smell the fragrance that is carried along by the north wind. It will make your already rested brain even more healthy and refreshed. Ward 5 is very nice as well. They grow white magnolia. Some patients would give the flowers to friends so as to enhance their friendship.

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Staff in the hospital not only work to beautify the environment, they also integrate this with economic returns as well. They grow banana trees and sell the fruit to patients at market prices or sometimes even lower than the market price. They also reward some patients who have been particularly helpful with bananas. By doing this you can achieve several objectives with one scheme.

The environment of the staff family quarters is also very nice. Frangipane grow along the path and the fragrance is carried on the wind. The flowers are as red as fire, and are as pretty as a painting, and they also have a sweet fragrance. These will make your stay.

The hospital has really done a good job in beautifying the environment. But two points we have to remember. Firstly, beautifying the environment and getting economic returns should be integrated scientifically. Under the principle of beautifying the environment and benefiting patients' health at the same time (i.e. not polluting the air and not creating an environment where mosquitoes and flies will grow), we should grow plants that give an economic return. For plants that can grow easily, and are less precious, we can grow them in places where people can get in and steal the product easily. The more precious plants should be grown in places where thieves can't get in easily. People in the ward, from unit leaders to labourers, should be aware of their own responsibilities in relation to this scheme. There's no need to recruit special staff to do this job. With the permission of the doctor, the brighter and healthier patients can join in the work. Secondly, try to kill mosquitoes. Though flowers can make the

trees bloom and look pretty, it will also encourage the breeding of mosquitoes and flies. Some insects, although they eat mosquitoes, they don't stay in one place. Therefore, we should breed animals that will eat mosquitoes and flies and will stay in one place at the same time, for example, snakes and bats, etc. We can also keep more goldfish. In ward 3 they grow palm trees in order to encourage a particular type of insect that eats mosquitoes and there is an obvious decrease in the number of mosquitoes nearby. This is a very good example. I hope that ward 5 can grow some palm trees outside so that the insects that feed on them can kill the mosquitoes and flies. (There are too many mosquitoes in ward 5).

ESSAY NUMBER 24

The Story of My Life

In 1953 I graduated from Yuet Sau Teacher's Training college in Sai Village. I was then allocated a job in Pai Wan District Number 11 primary school and kindergarten. In 1956, I was transferred to Tong Shan district, Po On street kindergarten. In 1957, I was working in Sai village and there I met Liu Bun. In 1958, when I was 25, I married him. In 1963 I met the most beautiful boy in Tong Shan district who was called Wong Wah Ming. Then I spent one year with him in love and sweet happiness. In 1964 I went to Sha Pa commune and worked there for five years. I also worked as a wrapping worker in a Guangzhou candy factory. In 1972, I received news from my husband, Lin Bun. Then I started to have contact with Lin Bun again. Also in 1972, when I was 39, my mother died.

I went to see Wong Wah Ming often in Tong Shan. At that time our child was already six or seven years old. Then we lived together happily. But in 1977, I was sent to the Nan Hai County Civil Affairs Bureau Hospital by the police. 11 years have past. My child is already 17 years old. All this time I have thought about Wong Wing Wah and my child often. I also thought about Lin Bun because he had promised to marry me again. I suffered a lot in the hospital. I lost my freedom. But I write letters to Wong Wing Wah and Lin Bun often. Neither of them come to see me or take me home. Now I would like to re-marry Lin Bun, so that we could get together again as husband and wife and could lead a happy life.

ESSAY NUMBER 25

The Story of My Life

October, 1988

When one becomes old, one gets contented
One would have some request even died before others
Salvation was obtained rescuing the dying and helping the wounded
The responsible position has turned their heads. I looked back,
    turn the table
Experience in work, should be an old hand
It is reasonable to reduce troubles
Brightly, life improved.

ESSAY NUMBER 26

The Story of My Life

My Story

I was admitted to the hospital several years ago. Under the concern and care of the doctors and nurses, I have improved a lot

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mentally. I was studying in Yau Chai primary school when I was 7. Later, I was transferred to Chu Hoi district and graduated from Kai Lap primary school. Had my junior secondary school at 26 Middle School until form 3. I couldn't carry on studying at the beginning of the second term at form 3. My mind was at a dead end. Starting from 1973 until now, for more than 10 years, mentally I fluctuated a lot. After being admitted into hospital, thanks to the doctors and nurses' care I joined the service group. At the same time, I was able to go back home to see my family and other relatives.

ESSAY NUMBER 27

The Story of My Life

I was studying in Shanghai Chemical Technology College in 1952. The school fees and meal expenses were paid for by the government. The food there was very good. We had congee with fried peanuts and fried dough. In the morning, afternoon and at night we had meat balls with green vegetables, big pieces of meat with green vegetables. After I graduated from that college in 1954 I was allocated a job in the design school of the Beijing Chemical Technology Department. The food there was very good as well. We had beehive cakes and steamed buns, rice. We could choose whatever we wanted. There were three dishes and also Western food. For dish A we had chicken cubes in chili sauce or 'mak shui yuo' with woodear fungus, preserved chili vegetables, eggs and shredded pork. I forget what dish B was. Dish C was Chinese cabbage. For Western food, we had meat balls wrapped in egg and 'creamy balls'.

After the liberation leaders were concerned about the living of the people. In big cities we had a very good food supply. But once you get used to the good food in big cities, I found the food in the Number One Education Institute too bad. I wasn't used to it. I didn't think I would have to stay here for such a long time. I had such a good life when I was young. I should thank Chairman Mao and Zhou En Lai who raised the issue of concern for the people. They also did what they said.

ESSAY NUMBER 28

The Story of My Life

I have six adults in my family. After the land reform, I came to study in the school for the families of railway workers in Guangzhou. I graduated from primary school in 1957. Then I worked as an apprentice in a metal factory. I left in 1962 when the factory closed down. In 1963, I grew tea on Pak Wun mountain. Later transferred to the company for improvement of the environment and worked as a chemical technician. In 1969, I left the company of my own accord. I didn't work. I just stayed at home and played. In 1970, because young intellectuals had to go down to work on the land I joined the Sun Chow commune in Yeung Kong county. In 1973, because I was poor and couldn't find my place in the world, I became mentally ill. In 1973, because I was poor and couldn't work, I went back to the Shan Tsuen railway hostel and lived there. We have three people in the household and my elder brother was the breadwinner. It was impossible to live like that. The street level committee seldom gave jobs. I have nothing to do

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at home, and started to think nonsense. The illness started when I was on the street. I did silly things. Men and women on the street thought that I was a rascal. I was admitted into hospital in May 1981 for recuperation and joined the service group. Under the guidance of the doctors and nurses, I learned how to cut hair. Also I would call doctors and nurses when I saw that there was something wrong with other patients. At night, I went out and played in the holiday camp often. Now I'm happy with life and other aspects of life, and would be satisfied with spending the rest of my life in the hospital.

ESSAY NUMBER 29

The Story of My Life

My Thoughts and Feelings

Parents must be very sad when they faced their crazy sons and daughters and found that they were helpless. Fortunately, the great, glorious and right Chinese Communist Party, the great People's Republic of China, they loved and cared for the crazy sons and daughters down to the very last detail. They sent the crazy sons and daughters to mental hospital for treatment. In the mental hospital doctors and nurses cared for us with serious words and thoughtful hearts. They worked hard and concretely. I heard and saw doctors and nurses call out daily 'take your medicine', 'take a bath', 'go to work', 'people upstairs come down to lay the table', 'room check'. Their voices were so cordial. They were really thinking about us.

Their sense of responsibility is in their heart
No need to worry, parents of crazy sons.
The education sanatorium will take care of everything
They will take care of food clothing and accommodation
\ Sweating, work was taught
When the day comes for discharge
The soul will have a bright future.

ESSAY NUMBER 30

The Story of My Life

The Great Construction and Development After the Liberation

I came to Guangzhou from Guiyang City, Guizhou Province. At that time, the Guangzhou Kuang Sha Road was just a land of mud. Now it has become a wide road with scenery like a garden. After graduating from the Number One Teacher's Training School in Guangzhou, I worked in a primary school in Yuk Kai Sam Lane, Man Cheong South Road, Guangzhou. I saw the Pearl River Bridge and a bridge near the Yuet Sau highway where there were railways underneath and roads above. Before 1980, I saw a bridge built upon the river along road number 623. From 1980 until now, I saw a bridge built between road number 623 and Yan Tsai Road. I also saw a lot of flyovers built along Guangzhou People's Road.

These are developments made by the people of Guangzhou under the leadership of the Chinese Communist Party. This also reflects that the Chinese Communist Party showed concern about her people by improving the transportation system, so that transportation of material would not be blocked, and people could get their daily necessities on time.

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The Story of My Life

My native place in Guangzhou is Guangdong Province. I worked in the education field for more than thirty years. I was transferred to Gong Tsuen sanatorium, Foshan Tai Wu Hospital in Guangdong in 1940. I was a service group member and had played various roles. I am now a service group member in this hospital.

Nan Hai County

Kam Sha Holiday Camp

[Signed] Sun Yat Sen

[Note: there was also a piece written in English by this patient but it was very garbled and hard to decipher. This could have been due to his mental state or an incomplete grasp of the language. It has been decided to omit it].

A CASE STUDY

Mrs. Jin's story in many ways reflects the reality of life in China. She is 42 years old, has been married for ten years, with a daughter of six and is functionally illiterate. Originally, she lived in the countryside at a time when conditions in town were much better. Chinese people are not allowed to choose where they live, and the only way open to Mrs.Jin to move to an urban area was through marriage. At 32 she was already too old to be considered a 'good catch' so when the matchmaker told her there was something 'a bit wrong' with the prospective husband she probably was not surprised. Exactly what this was was never specified and she did not inquire. The marriage was agreed to without her meeting her future husband (not an uncommon practice in China even now).

Unknown to her, Mr.Jin had been diagnosed as suffering from schizophrenia five years before his marriage, and had been admitted to hospital after he attacked and seriously injured his father. Mrs.Jin claims that he beats her five or six times a year and, although not usually requiring medical treatment, the last time he knocked her to the floor and damaged her eye around which she now has a scar.

Mrs. Jin says that there has been no warmth between them since their marriage. They live in one room and perforce share a bed because of the cramped conditions. Mr.Jin has a job in a factory looking after the garden and the guard dogs. He used to work on

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the assembly line, but in 1985 was given his present job to reduce the pressure at work, an arrangement which was satisfactory for both himself and his employers. He earns 170 yuan a month, which is a reasonable wage in China, but gives none of this to his wife, preferring to spend it all on gambling and eating meals outside the house. Frequently, he does not come home at night. In order to support herself, her child, and maintain the household Mrs.Jin works as a street vendor and makes about 80 yuan a month. She cannot take a regular job because there is no one to care for her little girl. Her home is very poor, with none of the electrical appliances commonly seen in Chinese households, and the standard of living in the rural area she left is now much higher than her own.

Mrs.Jin has no one in whom she is able to confide. Her family is in the countryside and anyway, her parents are frail and elderly and she does not want to add to their burdens. It is also possible that having left home to 'make good' in the city, it would be too hurtful to tell her family that things have not worked out at all well. She has no friends or neighbours that she can talk to, particularly since her husband is well known in the area because of his tendency to become upset in the middle of the night, shouting and disturbing the neighbours.

Mrs.Jin wants a divorce, although her husband does not. She first applied for one in 1984. The court insists that before it will grant a divorce, one of Mr.Jin's remaining family (an elder brother and sister), must sign papers accepting responsibility

for him. Not surprisingly, they are not willing to do this; so no divorce. Mrs.Jin is now trying again but on hearing this, her husband relapsed and had to be admitted to hospital, which will almost certainly impede her request.

APPENDIX THREE

THE FIVE STANDARDS AND THE FOUR BEAUTIES

In February 1981 the Chinese Communist Youth Corps started a movement for the millions of corps members and youth pioneers to emulate the well known communist martyr, Lei Feng. The purpose was to set an example for all the young people and to establish a new code of morality, civility and courtesy according to the ideals of communism. Such a new code is considered essential to both economic development and the political stability of the country.

Shortly afterwards, nine mass organisations in China, including the All China Federation of Labour Unions, the All China Federation of Women's Associations and the Chinese Communist Youth Corps expanded it into a nationwide movement for all the people in China, with a particular emphasis on the *younger generation*. *The movement promoted the 'five standards and the four beauties'*. The five standards were: civility, courtesy, sanitation, orderly conduct and morality. The four beauties were:

1) 'Beauty in heart and spirit'; requires cultivation of an upright personality and ideology in support of the leadership of the Party and socialism. This beauty is to be demonstrated in patriotism, integrity and honesty. Any behaviour that blemishes national honour and personal dignity, or is self-centered and couched in falsehood, must be avoided.

2) 'beauty in language'; requires the use of polite language that is harmonious, graceful and modest rather than rude

and profane. One should not twist words and argue without reason.

3) 'Beauty in behaviour'; requires diligence, friendliness, discipline and behaviour that will not harm the collective interest but will promote the welfare of the people and society. One must not damage public property not violate law and order.

4) 'Beauty in environment'; requires sanitation and cleanliness in one's home, place of work and any public gatherings.

From Chu, Godwin (1985) 'The Changing Concept of Self in Contemporary China' in Anthony Marsella, George Devos and Francis Hsu Culture and Self: Asian and Western Perspectives p. 271

QUESTIONS AND ANSWERS ON PSYCHIATRIC ILLNESS FROM SHANGHAI NUMBER ONE PSYCHIATRIC HOSPITAL

Preface

To carry out the policy of 'putting prevention in the first place', and to produce more mass participation in the prevention and treatment of psychiatric illness, so as to achieve better results in this field, we think it necessary to give you a brief idea about the prevention and treatment of psychiatric illness.

What is psychiatric illness?

Psychosis is an illness which shows the abnormality of psychiatric activities. It can be brought on by various causes which have one thing in common, a functional disorder of the brain. The most prominent symptoms include: abnormality in the patient's sensation, thinking, emotion, will, behaviour, memory and intelligence as well as hallucinations of sound and vision, insomnia resulting from phantasies, abnormal excitement or agitation. But most of the patients are not aware of their illness, and therefore refuse medical treatment. This has a harmful effect to the society, as well as on the patients themselves and their families.

What are the factors that induce psychosis?

Psychosis can be traced to various causes. Violent and sudden 'mental stimuli', if not coped with properly, can induce

psychosis. Bereavement of family members, domestic disputes, great contradiction in work and study, and disappointment in love affairs may all become mental factors leading to a temporary disorder of brain function, which results in psychosis. Some cases are nevertheless due to physical factors, such as infection or poisoning. People differ in their cognition of, and attitude towards social events, and in the mechanism and the functioning of their nervous system. Therefore their responses to external stimuli differ. With the same external stimulus, those who are narrow-minded and unhappy and who have a weak nervous system, or those who are highly sensitive are most susceptible to psychosis.

What are the symptoms of psychosis?

The most common symptoms are as follows. Some patients are over-excited and agitated. They are identified by their disturbed behaviour, physical aggression or destructive behaviour. Some are sullen and pessimistic all day long, and are victims of self-condemnation. Some fancy that they hear voices that criticize, abuse, threaten them or give them orders, or that they see strange things, smell strange smells. Some are full of suspicion and feel persecuted, some regard themselves as having unusual talents and indulge in boasting and self-praise, some babble on endlessly, and laugh and cry alternately, some show signs of panic, make strange noises and do strange things. Some are still as statues, they neither eat nor drink and are unable to relieve themselves. All these clinical symptoms distinguish them from normal persons.

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How to deal with psychosis?

The mental activities of man are the reflection of the objective world in the brain. Although psychiatry is a branch of natural science, it has close and extensive ties with social science. Therefore treatment with medicine should go hand in hand with mental treatment or psychotherapy. The patients should make a serious study of Marxism-Leninism and Chairman Mao's works, remould their world outlook and apply dialectical materialism to their study, work and daily life, and make a sound analysis of the cause of their illness, to bring their initiative into full play, and adopt a correct attitude towards all kinds of contradictions, both in the subjective and objective world, so as to change and make a criticism of their abnormal thought and action. The patients should adopt three correct attitudes: (1) a correct attitude towards their illness; (2) a correct attitude towards their future life, so that they can continue to work for the revolution after they are cured; (3) a correct attitude towards their work and study, so as to raise their consciousness in class struggle, and in the struggle between two lines through practice.

What are the side-effects of drugs?

The combination of drug therapy and psychotherapy is an indispensable principle in the treatment of psychosis. There might be some side effects during the process of drug therapy, such as thirst, constipation, strong expression, slow movements and thinking, blurred sight, failing memory, general weakness, difficulty in swallowing, uncontrollable saliva, anxiety and

fidgeting. The use of traditional Chinese medicine might result in diarrhoea and vomiting. That is nothing to worry about. All these side-effects will be alleviated or eliminated and health gradually restored after the doses are properly adjusted.

Are there lingering symptoms after effective treatment? How are they identified?

There are some lingering symptoms with some patients after effective treatment. These symptoms might continue for a long time, although continuous treatment can get rid of them, and include lethargy or lack of sleep, excessive dreams, dizziness, headache, dullness, difficulty in mental concentration, bad memory, frequent fatigue, fluctuation of mood and touchiness. Some patients may have odd hallucinations or phantasies. Instead of getting bored and disheartened, the patients should strengthen their confidence in fighting the illness, and strive for an early recovery.

What is the correct view on hereditary factors?

Only a small portion of patients are influenced by hereditary factors. No hereditary factors have been found for the majority. Therefore psychosis cannot be analyzed solely from the point of view of heredity, much less can it be asserted that psychosis is hereditary. Given good education and influence in families, schools and the social environment, the second generation may be free from the misery of psychosis, even if there have been cases of psychosis in the first generation.

How to prevent the recurrence of psychosis?

1. To fight against this illness, the patient must first of all fight against his mental weakness and build up his courage in the fight against illness; he must make a serious study of Marxism-Leninism and Chairman Mao's works, use the view points and method of dialectical materialism to remould his world outlook, and adopt a correct attitude towards contradictions in his work and life.

2. Go for medical treatment in time, (when the doctor makes a longitudinal study of the patient), and take regular doses of medicine at the appointed times. Some patients may think that they are well on the way to recovery, so that it is not necessary to take medicine any more, or that they can reduce the doses by themselves. In such cases a recurrence of the illness very often results.

3. For those who can resume their work or take up jobs most suitable to them, it is preferable not to stay at home longer than necessary. Participation in the socialist revolution and in socialist construction, which are going on in full swing, will make a 'resurrection' of their old mental factors more difficult. Idleness and emptiness of mind only accelerate the revival of old things.

4. Keep to a regular time table. Apart from work, the patients should follow a good time table. A well-arranged time table will go a long way towards stabilizing the function of the brain.

5.   In cases with a recurrence of insomnia, excessive thinking, fluctuation of mood, inertia or illusions, the patient should tell his relatives and be taken to the hospital for timely treatment, so that the illness is checked before it is too late.

By the Department of Occupational And Recreational Therapy, Shanghai Psychiatric Institute.

From: Brown, L.B. (1980) 'A Psychologist's Perspective On Psychiatry in China' Australian and New Zealand Journal of Psychology Vol. 14, p. 21-35

PEOPLE'S REPUBLIC OF CHINA 1984 STATISTICS LAW

The law requires that statistics be published regularly, but it also forbids the release of any data until political approval has been given. In recent decades, people in the highest levels of government have had to give their express approval for the release of every national statistic. The policy that every datum is a state secret has stopped, or greatly delayed, the publication of most statistics.

Article 13

The State Statistical Bureau and the statistical organs of the people's governments of provinces, autonomous regions and independent municipalities are to publish their statistics periodically in accordance with state regulations. Statistical data to be published by all areas, departments and units must be checked and ratified by the statistical organs and the responsible statistical personnel....and the units must abide by the state stipulated procedure of requesting approval.

Article 14
Statistical data involving state secrets must be protected.

Article 25

Administrative disciplinary action is to be taken against those persons in positions of leadership, and persons with direct responsibility, when one of the following serious violations is committed.....

   6 - publishing statistical data without verification and approval in violation of the stipulations of this law.

   7 - violating the stipulation of this law concerning the protection of secrets.

From; Bannister, Judith (1987) <u>China's Changing Population</u>

Stanford: Stanford University Press

REGULATIONS OF SHANGHAI MUNICIPALITY ON GUARDIANSHIP, TREATMENT

AND HANDLING OF MENTAL PATIENTS STIRRING UP TROUBLE OR

CAUSING DISASTERS

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Adopted at the 23rd Session of the Standing Committee of the 8th

People's Congress of Shanghai Municipality on 29 August 1986.

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CHAPTER 1   GENERAL PROVISIONS

Article 1;   These Regulations are formulated in accordance

with the relevant provisions of the Constitution of the People's

Republic of China and other laws, in line with the actual

conditions of Shanghai Municipality, and with a view to

strengthening guardianship, treatment and handling of mental

patients stirring up trouble or causing disasters, maintaining

public order, safeguarding the security of life and property of

people as well as protecting the lawful rights and interests of

these patients.

Article 2;   Mental patients stirring up trouble referred to in

these Regulations, shall be those mental patients violating the

Regulations of the People's Republic of China on Administrative

Punishment for Public Security with comparatively serious

consequences, being unable to recognize or control their own acts;

mental patients causing disasters shall be those mental patients

violating the Criminal Law of the People's Republic of China or

seriously endangering public security, being unable to recognize or control their own acts.

Article 3: Guardians, family members of, or institutions employing, mental patients, the residents' committees, village committees of the residence of mental patients, and the departments in charge of health care, public security and civil administration shall strengthen treatment, guardianship and handling of mental patients so as to prevent them from stirring up trouble or causing disasters.

Article 4; Those who are determined by legal medical experts to be mental patients stirring up trouble or causing disasters, shall be subject to treatment under compulsory guardianship; those stirring up trouble shall be sent to the hospitals of the department of public health for diagnosis and treatment; and those causing disasters shall be sent to the hospitals for treatment of mental patients under guardianship to receive treatment.

Article 5; Mental patients from other provinces or municipalities stirring up trouble shall be brought home by their relatives in Shanghai, if any, and be kept under strict control and provided with treatment, or be sent back to their original places of residence; those without relatives in Shanghai shall be sent back to their original places of residence by the departments in charge of civil administration and public security. Mental patients from other provinces and municipalities causing disasters, shall be sent back to their original places of residence by the department in charge of public security.

CHAPTER II   GUARDIANS AND THEIR OBLIGATIONS

Article 6;   Mental patients unable to recognize or control their own acts shall be subject to the guardianship of their spouses, parents, grown-up children or other relatives capable of assuming guardianship in accordance with the law. Other relations or friends having a close relationship with them may assume guardianship as well, on a voluntary basis, with the approval of the institutions employing the mental patients, or of the residents' committees or village committees of their residence.

When there is a dispute over the assumption of guardianship of a mental patient, a guardian shall be designated by the institution employing the mental patient or residents' committee or village committee of his residence or from among his relatives. Those who are not convinced of the designation may appeal to a People's Court, which shall make a decision.

In case there are no guardians as defined in paragraph 1 of this Article, or the relatives are not suitable to assume guardianship, the institution employing the mental patients shall be the guardians; or the residents' committee or village committee or civil administration of the residence of the mental patients shall be the guardians, if they are not employed by any institutions.

Article 7;   Guardians should fulfil their obligations of guardianship, be responsible for keeping the mental patients under control and for their treatment, and safeguard their lawful rights

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and interests such as personal and property rights.

The rights and interests of guardians arising from guardianship in accordance with the law shall be protected by law.

In the case where the mental patients have stirred up trouble or caused disasters, inflicting economic loss or personal injuries on others, due to failure of obligations on the part of the guardians, the guardians shall be responsible for compensating for the loss or bearing the medical expenses; and if the cases are serious, they may be subject to investigation to affix administrative responsibility. Where a guardian has fulfilled his obligations, his civil responsibility may be mitigated accordingly. Residents' committees or village committees assuming guardianship shall not bear the responsibility for compensation.

CHAPTER III   HANDLING AND TREATMENT OF MENTAL PATIENTS STIRRING UP TROUBLE

Article 8;   Mental patients committing any one of the following acts of stirring up trouble shall be sent by their guardians or family members to hospital for diagnosis and treatment.   If the guardians or family members refuse to do so, the mental patients shall be sent by force by the public security organ of their residence to the hospitals of the public health department for diagnosis and treatment.

(1) Committing assault or doing violence causing injury to others.

(2) Insulting women.

(3) Damaging public or private property.

(4) Impeding the safety of communication.

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(5) Other acts disrupting public order or hampering public security.

Article 9; The hospitals of the public health department shall go through the hospital treatment procedure for those mental patients subject to enforced hospital treatment on the strength of notification of acceptance and treatment of mental patients issued by the public security organs of the city, district or county.

Article 10; During the enforced hospital treatment, mental patients may not be brought home by their guardians or family members before the illness is alleviated, stabilized or cured. The hospital shall notify the guardians or family members of those mental patients whose illnesses have been alleviated, stabilized or cured to go through the procedures for leaving the hospital for them. If the guardians or family members refuse to do so, these mental patients shall be sent home with the assistance of the public security organs of their residence. The civil administration organs shall be responsible for taking in and arranging for those mental patients without relatives and sources of living.

Article 11; Suspected mental patients stirring up trouble may be sent by force by the public security organs of their residences to psychiatric medical establishments for diagnosis. Those who are determined by two or more psychiatrists, (at least one of whom should be a physician-in-charge), to be mental patients shall be subject to enforced hospital treatment; those who are not mental patients shall be dealt with by the public security organs in

accordance with the law.

In the case of objections by the victims, the offenders and their family members to the diagnoses, they may apply to the leading group of medical jurisprudence for psychiatry for review.

Article 12; The medical expenses of mental patients stirring up trouble, during enforced hospital treatment, shall be settled in accordance with the regulations on labour protection and free medical service for those employed by institutions, and according to the relevant provisions of the state council for contractual employees. Such expenses shall be settled by the guardians or family members, if such patients are not employed; and shall be settled by the civil administrative organs, if such patients have neither family members nor sources of living.

Article 13; During the enforced hospital treatment of mental patients stirring up trouble, if their guardians or family members come to the hospital for wilful tangling and trouble-making, refusing to hear persuasion and dissuasion, these guardians or family members shall be subject, according to the seriousness of the cases, to investigation to affix their responsibility in accordance with the law.

CHAPTER IV TREATMENT UNDER GUARDIANSHIP OF MENTAL PATIENTS CAUSING DISASTERS

Article 14; Mental patients causing disasters with acts such as committing homicide, arson, blowing up objects, rape, robbery, poison or other acts seriously endangering public security, shall

be subject to treatment under guardianship in Shanghai hospital for treatment of mental patients under guardianship.

Article 15; Suspected mental patients causing disasters must be subject to examination by the medical jurisprudence for psychiatry. Those who are determined by examination to be mental patients shall be given treatment under guardianship, after the application form for treatment under guardianship of mental patients causing disasters, filled in by the public security organ of the place of disaster, is submitted to and approved by the city bureau of public security.

In the case of objections by the victims, the offenders and their family members to the expert opinion of the medical jurisprudence committee for psychiatry, they may apply to the leading group of medical jurisprudence for psychiatry for review.

Article 16; The medical expenses of mental patients causing disasters during treatment under guardianship shall be settled in accordance with the regulations on labour protection and free medical service for those employed by institutions, and according to the relevant provisions of the state council for contractual employees. Such expenses shall be settled by the guardians or family members if such patients are not employed; and the medical expenses and relevant expenses necessary for the municipal hospital for treatment of mental patients under guardianship of mental patients without family members and sources of living shall be settled by the municipal bureau of public security from the operating expenses of public security.

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Article 17;   During the treatment under guardianship of the mental patients, the public security organs of their residence may not cancel their residence registration; but the supply of grain and edible oil to their residence shall be suspended. The hospital for treatment under guardianship for mental patients shall be in charge of applying for their supply of grain and edible oil.

Article 18;   After treatment under guardianship, if the mental patients' illnesses have been alleviated, stabilized or cured, their mental status shall be determined by the hospital, and then they shall be brought home by their guardians or family members with the approval of the municipal bureau of public security to leave the hospital. In the cases where such mental patients are not brought home without proper reasons, reports shall be made to the public security organs which shall enjoin the guardians or family members to bring them home.

CHAPTER V   SUPPLEMENTARY PROVISIONS

Article 19;   These Regulations are approved by the Standing Committee of the People's Congress of Shanghai Municipality and shall come into force as of 1 October 1986.

Article 20;   The Interim Regulations of Shanghai Municipality on the Institution of Enforced Hospital Treatment for Mental Patients Causing Disasters shall be annulled upon the promulgation and implementation of these Regulations. Where there are contradictions between these Regulations and previous regulations

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in relation to mental patients stirring up trouble or causing disasters, these Regulations shall be applied.

Source: <u>China Law Year Book, 1987</u>, (1989) Publishing House of Law, Beijing (eds.) London: Butterworths.

DATA COLLECTION AND CODING SHEET USED AT THE GUANGZHOU HOSPITAL

Guangzhou Civil Affairs Bureau Psychiatric Hospital

Hospital Number:

1 Ward   1 2 3 4 5 6 7

2 Sex 1 male
       2 female

3 Age 1 16 < 20
      2 20 < 30
      3 30 < 40
      4 40 < 50
      5 50 < 60
      6 NK

4 Marital Status
      1 never married
      2 married
      3 widowed
      4 divorced
      5 separated
      6 other
      7 NK

5 Education
      1 primary
      2 junior secondary
      3 senior secondary
      4 tertiary - completed
      5 tertiary - not completed
      6 none
      7 other
      8 NK

6 Occupation
      1 peasant\farming   8 none
      2 factory worker
      3 trade or craft
      4 cadre
      5 professional
      6 other
      7 NK

7 Date of first admission to any psychiatric hospital
      1 < 1960   2 1960 < 1965   3 1965 < 1970   4 1970 < 1975
      5 1975 < 1980   6 1980 < 1985 7 1985 >   8 NK

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8 Years since first onset
  1 0 < 5
  2 5 < 10
  3 10 < 15
  4 15 < 20
  5 20 < 25
  6 25 < 30
  7 30 or over
  8 NK

9 Reason for onset
  1 medical illness
  2 problems in study (secondary level)
  3 problems in study (tertiary level)
  4 failed love affair
  5 'down to the village' policy
  6 family stress
  7 work stress
  8 not obvious
  9 other
  10 NK

10 Number of admissions to this or any other psychiatric hospital
  1 one
  2 two
  3 three
  4 four
  5 five
  6 more than 5
  7 not known; more than 1
  8 not known; no information

11 Date of admission to this hospital
  1 1973 2 1974 3 1975 4 1976 5 1977 6 1978 7 1979
  8 1980 9 1981 10 1982 11 1983 12 1984 13 1985 14 1986
  15 1987 16 1988 17 NK

12 Years spent in this hospital

13 Number of admissions to this hospital

14 Number of previous admissions to psychiatric hospital

15 Number of years spent in previous psychiatric hospitals

16 Total number of years spent in psychiatric hospital
  1 1   7 15 < 20   13 NK
  2 2   8 20 < 25
  3 3   9 25 < 30
  4 4   10 30 < 35
  5 5 < 10   11 35 < 40
  6 10 < 15 12 40 < 45

17 Place of residence on admission
        1 family of origin   9 another CAB facility
        2 siblings' family
        3 family of marriage
        4 housing supplied by work
        5 living alone
        6 no fixed abode
        7 other
        8 NK

18 Area of residence on admission
        1 Guangzhou   4 not known
        2 Guangdong
        3 other province

19 Next of kin
        1 mother   7 son-in-law   13 husband
        2 father   8 daughter-in-law   14 wife
        3 brother   9 other
        4 sister   10 none
        5 son   11 NK
        6 daughter   12 parents

20 Who provided information
        1 family member   9 another CAB facility
        2 work colleague
        3 another hospital's notes
        4 public security
        5 street\neighbourhood organisation official
      . 6 neighbour
        7 other
        8 NK

Reasons for admission
        21 failure in family care
        22 failure in workplace care
        23 failure in neighbourhood care
        24 danger to self
        25 threat to public order
        26 suicidal
        27 transfer from other psychiatric hospital
        28 transfer from other CAB facility
        29 shameless behaviour
        30 other
        31 disturbed\confused
        32 trade fair
        33 begging
        34 aggressive behaviour (family)
        35 aggressive behaviour (non-family)
        36 NK

Treatment

37 chlorpromazine		45 ECT
38 fluphenazine decanoate		46 neuro-surgery
39 haloperidol		47 acupuncture
40 trifluoperazine		48 other
41 perphenazine		49 anti-parkinsonian
42 clonazepam		50 vitamins
43 diazepam		51 cocktail
44 clozapine		52 none

53 Home place
    1 Guangzhou   3 other province
    2 Guangdong   4 other
                         5 NK

54 Payment category
    1 Veteran
    2 Three Have Nots
    3 Self Pay
    4 Danwei
    5 NK

55 Cultural Revolution involvement
    1 yes
    2 no

CIVIL AFFAIRS WORK IN A SMALL CITY

The information in this appendix is based on an interview I conducted with the head of the Civil Affairs Bureau in Shashi. Shashi is a small city, (by Chinese standards), about 270 kilometres away from Wuhan, the provincial capital of Hubei province. Shashi is situated on the banks of the Yangtze river. Its inhabitants generally seem to consider it a pleasant place to live, with good facilities and services, despite a very intemperate climate.

Mr. Zhang described his department's job as managing the social factors within the community. His department is responsible for: those who fall within the 'Five Guarantees' scheme; disabled people, (psychiatric patients, amputees, the mentally retarded, blind, deaf and mute); people who arrive from the countryside with no job and no place to live, who are fed, their details recorded and returned from whence they came; people visiting Shashi from elsewhere who fall ill or have their money stolen; orphans and abandoned, (mostly female), babies; arranging cremations for the destitute elderly; caring for old people with no family, either in an institution or providing the financial resources so that they can remain in their own homes, while mobilising neighbours to help with such things as carrying water and wood. Mr. Zhang commented that more elderly are being cared for by the state because their children are increasingly unwilling to look after them, and their danweis argue that they do not have the resources.

The Shashi Civil Affairs Department runs a factory that makes thermos flasks which has a special section for blind employees. Disabled employees are paid on the same scale as their able bodied counterparts. Another factory that employs deaf mutes produces batteries. When pressed, Mr. Zhang said that none of his department's welfare enterprises employed ex-psychiatric patients because 'there were insufficient ex-patients without work to make it necessary'. (This is likely to be at best only a partial explanation.) Such factories, in addition to tax concessions, are charged less for anything the government supplies, like electricity and raw materials. Bank loans are offered to them at a 20 percent discount on the interest rate.

The Shashi Civil Affairs Departments run a long stay care home for the elderly with 150 beds. This unit has a sub-unit attached for 20 disabled orphans who, if they improve, may be transferred to the orphanage for able bodied children. Every year about ten adoptions are arranged with couples who are over 30, and who have been medically certified as infertile. The largest institution run by the Civil Affairs Department in Shashi is an acute psychiatric hospital with 500 beds. A smaller psychiatric facility exists for middle aged and older patients, as well as the mentally retarded who have created social disturbances, like setting fires and removing their clothes in public, and cannot be managed at home. This institution has 200 beds.

A rehabilitation hospital with 100 beds is provided primarily for those who have had strokes and are paralysed. Many of the staff employed here are blind because they are well able to perform the

necessary physical therapy and massage, and this solves two problems at once. A reception centre is available for disaster victims, people wandering on the streets and those waiting return to their home areas. This place employs 20 staff and has over 100 beds.

Other responsibilities of the Civil Affairs Department include; the registration of marriages and deaths; running the municipal crematorium; keeping a household registry; making maps of the area for which they are responsible; the registration of community associations; deciding the boundary for the division of residents associations when one grows beyond the 700 limit permitted nationally; arbitrating between residents' committees over issues like disputed water rights.

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