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DELIVERY OF MENTAL HEALTH SERVICES IN THREE DEVELOPING
ASIAN NATIONS: FEASIBILITY AND CULTURAL SENSITIVITY OF
"MODERN PSYCHIATRY"

University of Hawaii

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DELIVERY OF MENTAL HEALTH SERVICES IN THREE DEVELOPING
ASIAN NATIONS: FEASIBILITY AND CULTURAL
SENSITIVITY OF "MODERN PSYCHIATRY"

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By

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ABSTRACT

A survey of mental health resources was undertaken in Taiwan, the Philippines, and Thailand. Three comprehensive questionnaires appraising psychiatric care, delivery problems, and staff attitudes were administered to 92 professionals at 31 agencies. The survey had two foci: first, to learn whether the standard of Western psychiatry is feasible as a model for service delivery among developing Southeast Asian nations. Secondly, to assess the degree to which Western-derived institutions are integrated into the sociocultural milieu of their intended recipients. A guiding premise was that continuity with client culture builds agency acceptability and establishes the cultural validity of mental health programs. On the issue of feasibility, the case studies compiled for each country are unequivocal. At national or even regional levels, these countries are unable (unwilling) to allocate economic, educational, administrative, research, and manpower resources to secure contemporary standards of mental health delivery. Extant psychiatric systems are capable of providing sufficient intervention resources to meet the needs of a circumscribed number of middle and upper class residents of these nation's capital cities. However, the question of cultural sensitivity of mental hospitals and clinics is less straightforward because community attitudes were not directly assessed. Nevertheless, staff perceive their clinics as alien

entities in the ongoing stream of community life. Psychiatric treatment is stigmatizing; it is unacceptable except at the last possible moment as a desperate gesture to relieve suffering. Yet, a tiny scattering of community based units--staffed mainly by non-medical personnel--are well-connected with diverse community groups. They appear non-threatening and acceptable, serving as smooth conduits into the mental health network. Theoretically, agency-specific practices of culture accommodation diminish community alienation by strengthening cultural validity. A full range of accommodation tactics were noted, but most tended to be informal and makeshift. Accommodation per se was not elevated to the level of policy or program objective. For example, linguistic matching was carried out whenever possible, yet policies of hiring staff based on background similarity with client populations were not considered. Moreover, accommodation undertaken at the initial point of agency contact was intended to win over family confidence and cooperation. Once staff secured the family's commitment to treatment, then clinic-preferred therapy modes were introduced. Traditional-minded patients were re-educated to acquire a more psychological view of their problems and appreciate the advantages of psychiatric methods. In brief, the sites visited were culturally insensitive and isolated in relation to the healing customs and beliefs of the general population. Their range of appropriateness and accessibility was narrowly

restricted to the urban elite. Services were unaffordable, far beyond the horizon in terms of manpower, and potentially destructive of integrated elements in the host culture. What is required is a treatment system continuous with cultural beliefs, values, and existing patterns of helping. Through a culture assessment, looking at the community definitions of problems, normality, ways and means of curing, and expectations of program performance, a clear understanding of appropriate intervention can be established. A procedure for systematically gathering and analyzing this information is proposed--the Ethno-Therapy and Culture Accommodation Scale (ETCAS). This scale assesses the congruity of an existing program with the expectations and preferences of the recipient community and serves as a guideline for introducing programs with a high level of cultural sensitivity. Furthermore, ETCAS identifies healing networks that may be strengthened by the allocation of additional resources. The end product in harmony with the aims of community psychology is to create competent communities capable of actualizing the values and goals they select for themselves.

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DELIVERY OF MENTAL HEALTH SERVICES IN THREE DEVELOPING
ASIAN NATIONS: FEASIBILITY AND CULTURAL
SENSITIVITY OF "MODERN PSYCHIATRY"

I. INFLUENCE OF WESTERN PSYCHIATRY IN SOUTHEAST ASIA

"Modern" psychiatry has a firm foothold in the developing nations of Southeast Asia. Western visitors are often surprised to find psychiatry practiced and taught throughout the capital cities of this region. This feeling stems from an assumption that traditional societies have less stress and hence, fewer psychological problems. It comes also from the incongruity that modern psychiatry could be readily exported to the non-industrialized world.

What accounts for the Western-derived treatment systems found in this region, and the continuing efforts to plan and expand such services? This chapter answers the question by examining both historical and contemporary conditions shaping psychiatry's development in Southeast Asia.

HISTORICAL FACTORS

The 15th-Century voyages of the Portuguese traders were harbingers of European domination in Southeast Asia which lasted until after World War II. Beginning in 1619, the Dutch exerted control over various portions of Indonesia while the Spanish, in nearby Manila, were transforming the Northern Philippines into a bastion of Catholicism. The British were late arrivals, establishing colonies at Penang

in 1786 and Singapore in 1819 at the expense of their Dutch rivals. English involvement in this region was initiated to secure the eastern flank of her Indian empire and protect the shipping routes to China.

Following the Napoleonic Wars, and spurred on by the Industrial Revolution, Europeans launched a political and commercial offensive in Southeast Asia, which brought most of the territory under their formal control by 1870. Through this offensive came the apparatus for public administration, technical skills, migrant workers, and a new world view (Steinberg, 1971).

However, the washing ashore of Western culture was by no means a new experience. Southeast Asia has interacted with a greater variety of external cultures for a longer period of time than perhaps any other area (Steinberg, 1971). The Portuguese, Spanish, Dutch, British, and French were merely the latest to leave their impression on a region already richly endowed with cultural strains (Neki, 1973a).

The colonial rulers placed their stamp upon all phases of human activity. Not only were systems of religion, economics, politics, and education transplanted, but European concepts of mental illness and its treatment were brought to the colonies (Lambo, 1978). At that time, the British, Portuguese, Dutch, and others incarcerated disturbed individuals along with common criminals. These Westerners had somewhat less sophisticated therapeutics than

native healers practicing a form of community psychotherapy. Indigenous therapists usually treated chronics among their familiar surroundings, avoiding isolation and stigmatization (Lambo, 1978).

With governmental concern for health needs came attention to the handling of psychiatric cases. Institutional and custodial care began in Southeast Asia and the United States simultaneously. For example, H. B. M. Murphy's (1971) search of records in Singapore yielded an 1841 decree to "lose no time in commencing the erection of an Insane Hospital (p. 14)." Twenty years after it opened, this hospital, accommodating 100 inpatients for a colony of 82,000, was providing Singapore with a higher psychiatric bed ratio than that of the United States. By 1829, nearby Penang had a "lunatic asylum" populated by Chinese, Portuguese, and Indians (Tan & Wagner, 1971). This preceded by a decade the opening of city mental hospitals in New York and Boston, and Dorothea Dix's quest to hospitalize every "insane" individual, ending "moral" treatment in the United States.

By the close of the 19th Century, colonial architects had created rambling, custodial enclaves--all remarkably alike--stretching from India, through Thailand, and down the Malay Peninsula to the Dutch-controlled archipelago of Indonesia (Haq, 1975; Setyonegoro, 1976; Tan & Wagner, 1971). These facilities, isolated and alien, represented the end

of the road for most referrals (Harding, 1975). This "last resort" image is a historical residue that even today shapes the perceptions of this region's people. The names of towns where large mental hospitals were founded are now synonymous with "madness." Their historical administrators are sometimes household names, who are jokingly threatened to be sent for when someone behaves oddly.

The colonial legacy of psychiatric treatment was institutionalization and custodial care, or no treatment at all. These foundations were not removed with national independence in the years following World War II, but carried over to undergird the present health system. This is not surprising. Just as the political institutions founded in the independent lands in the first 25 years after independence were derived from or were imitations of Western models (Butwell, 1975), so were the health and mental health apparatus of these countries.

CONTEMPORARY FACTORS

National independence did not end the pattern of colonial psychiatry in Southeast Asia. Instead, Western-inspired services have received national endorsement throughout the region. What contemporary forces perpetuate and expand the availability of these services? It appears that a number of factors combine to insure the continued importation and expansion of Western therapeutics. These include governmental request based on national development

needs, the unsettling impact of rapid modernization on mental health, the rationale that psychiatric medicine is trans-cultural and disorders uniformly identifiable, and the forces of international consultation and training which offer a standard for mental health planning. The following section examines these factors in relation to establishing a need, rationale, and means for psychiatric care.

Establishing a Need for Psychiatric Care

Governmental Request Based on National Development Needs

The quest for economic and industrial development is the principal organizer of national priorities in Southeast Asia. Nationalist leaders are ushering in modernization with breathtaking intensity to offset their countries' dependency on the world's more advanced states (Butwell, 1975). Modernization is also expected to bring a higher standard of living and a fuller life for the people through expanded educational and job opportunities and improved health conditions. To the extent that social welfare services and managing the psychologically impaired can contribute to these development goals, such services will be given governmental attention.

Several writers have sought to link psychiatry with national development. Among them, Kiev (1972, 1976) and Benyoussef, Collomb, Diop, and Zollner (1975) have made the strongest case for including mental health as a national priority. They use a cost-benefit logic to argue that

mental ill health is detrimental to socioeconomic development. Mental illness is depicted as a national burden because disordered individuals have a smaller chance of participating in the full range of employment roles and attaining job productivity. Kiev (1972) further points out the critical need for human resources and the unaffordable loss arising from mental problems among college students, technical specialists, and government leaders. In a struggling economy, there is also a disproportionately greater impact of such problems on absenteeism, poor motivation, and crime and drug addiction, as well as the economic strain of long-term patients. Kiev (1976) asserts that psychiatry is a valuable tool for development when its techniques can be employed to motivate and commit people to the development process and prepare individual initiative towards modernization.

The struggle to modernize and the need to prepare citizens for new social and economic roles has moved some governments to request psychiatry's participation in the process. In this respect, psychiatry has two functions: to set up a "modern" social institution supporting the philosophy of development and to alleviate its human consequences. Modernization is a two-edged sword, a topic considered next.

Stress from Socio-Cultural Change

Irrespective of present priorities, there is consensus

among indigenous professionals, international consultants, and researchers throughout developing countries that psychological problems are on the upswing and that modernization is clearly to blame (Burton-Bradley, 1973; Cawte, 1972; Kiernan, 1976; Marsella, 1978; Murphy, 1955; Sangsingkeo, 1966; Santoso, 1959; Wintrob, 1969). This belief has become a second prompt for health leaders to request and plan for a Western system of care. It is assumed to be the modern solution for meeting the increasing casualties of socio-cultural change.

Epidemiological evidence for rising incidence rates in Southeast Asia is sketchy and difficult to document (Hartog, 1972; Kapur, 1975). The World Health Organization (WHO, 1975) reports an estimate of 40 million untreated cases of mental illness in world developing regions; perhaps 200 million suffering from less severe disorders. Trends do show increasing survival rates for brain damaged children and disorders of the aged as a consequence of public health measures.

In Indonesia, Widjono (1975) reports an increase in drug abuse, a finding which he attributes to newly-found affluence among the youth. This concern has been recently echoed in Singapore, Malaysia, and Thailand with initiation of programs and public education campaigns (e.g., Ratanakorn, 1975). In Taiwan, Ko (1975) tried to establish rising rates for depression among urban dwellers while Lin, Rin, Yeh, Hsu,

and Chu (1969) carried out a 15-year longitudinal study revealing significant increases in the prevalence of all disorders, particularly among in-migrants there. Kiernan (1976) suggests that Thailand shares with other countries in Southeast Asia a rising prevalence rate due to continued incidence of traditional forms of illness and the appearance of newer patterns related to stress, over-indulgence, growing numbers of old people, and iatrogenesis.

In harmony with this, adjustment problems of adolescents at a mental health clinic in the Philippines were attributed to the new technological demands of society (Aragon, 1977).

Concern for the mental health effects of modernization, industrialization, and rapid social change among health professionals (e.g., Ignacio, 1976; Ko, 1975; Prasetyo, 1977; Sangsingkeo, 1966; Sanvictores, 1976) has been stimulated by extensive literature on this topic by Western writers. In particular, researchers have shown an interest in social change (Etzioni-Halevy & Etzioni, 1973; Marsella, 1977; Pizer & Travers, 1975; Shore & Mannino, 1975; Zollschan & Hirsch, 1976). Singled out for study are those instances where the fabric of a society cannot endure the pace of change; increased social pathology presumably follows.

Leighton and his colleagues began in the early 1950's to lay a theoretical foundation linking community disorganization with individual impairment (Leighton, 1959). They found data suggesting that when the socio-cultural

setting no longer met essential individual needs, and in fact disrupted patterns of personal striving for security, love, status, and so forth, rates of disorder increased (D. Leighton, 1963).

Wittkower is a second influential psychiatrist explaining the tie between culture and disorder (Wittkower & Dubreuil, 1973; Wittkower & Termansen, 1963). He identifies three pathogenic dimensions of culture: cultural content, including taboos, antagonistic values, and role deprivation; stressful social organization characterized by anomie or social rigidity; and social change, which becomes noxious with the accumulation of value diversity, role deprivation, and heightened anomie.

Undergirding all of these writings is an assumption about the functioning of cultures and societies. Namely, that cultures represent systems with mutually dependent parts. Kluckhohn and Leighton (1946) evolved this conception from their studies of Navajos undergoing acculturation stress. They found that, "instead of a patterned mosaic, Navajo culture is becoming an ugly patchwork of meaningless and totally unrelated pieces . . . [with] personal and social chaos as the byproducts (p. 237)."

Specifically, the complex systems of belief that people share in a society are core elements that hold people together and make life within a society possible. When the belief systems are threatened, the society is in danger of

becoming disorganized (Kunitz, 1970). This theme, promulgated by influential international psychiatrists, has become the explanatory framework used by mental health professionals for examining the rates of disorder in their rapidly acculturating and developing countries.

Echoing the culture disorganization theme, social observers in Southeast Asia lament and fear the passing of traditional cultural forms and institutions (Kiev, 1976). This change was initially restricted to the capital cities when Europeans began it two centuries ago. Now, however, it is spreading beyond its former enclaves to the 80 to 90 per cent of the people living in the countryside (Butwell, 1975). With the current widespread effects, Kamal (1975) notes the abandonment of the stable, traditional ways of life that gave people security, identity, and perhaps immunity from mental breakdown. He asks if it is possible to preserve spiritual elements of traditional life--community and family ties, religious convictions--without affecting the desired national progress.

Other writers have commented on the specific dangers of modernization and abandonment of old ways. Thailand's Professor Phon Sangsingkeo, an enlightened leader of psychiatry in his homeland, points to the effects of technological changes on interpersonal relationships. The extended family is dissolved as machinery makes farming less labor-intensive and young people move toward urban centers. No

one remains in the village to care for the old (Sangsingkeo, 1966).

Indonesian psychiatrists are concerned that the tremendous speed of change will significantly affect marital patterns, the household authority structure, and bind the family with conflicting values as children are socialized to old loyalties that have little meaning for them (Indries, 1971; Santoso, 1959). Widjono (1975) believes that the youth gangs springing up in Jakarta are a result of the breakdown in the family's ability to maintain the loyal ties of its younger members.

Urbanization has other consequences. Recent migrants are at "high risk" of disorder as they seek to adjust, usually without a firm economic base, to conditions of overcrowding, poor housing, status loss, sex role changes, depersonalization, crime, and drug addiction (Ignacio, 1976; Kiev, 1972, 1976; Widjono, 1975). The break in cultural continuity--from rural to urban, from traditional to modern--impacts especially child rearing patterns. The family network and value structure are thrown into confusion (Prasetyo, 1977). Moreover, emergence of the nuclear family under the pressure of urban living further reduces the family's capacity to care for its ill and psychologically distressed (Kiernan, 1976). Each member is now required to find work outside the home.

Along with socio-cultural disorganization, a second

factor, the revolution of rising expectations, has been identified as a determinant of disorder rates. Parker and Kleiner (1969), working with samples of American Blacks, and Marsella, Escudero, and Gordon (1972), studying urban Filipinos, provide a theoretical understanding of how an individual's aspirations, compared to what is actually achieved, lead to stress and psychiatric symptoms. As suggested by Sangsingkeo (1966) in Thailand and Sanvictores (1976) in the Philippines, widespread frustration accrues when people view the goods, services, and life styles of developed countries, yet lack the economic means for securing them.

Pressure on the poor intensifies as they perceive wider horizons through the mass media, only to find the fruits of national development reserved for the elite. Poor people, without the resources of a close-knit family, employment, or a philosophy of life to mediate the frustration, experience a rise in mental distress (Marsella, et al., 1972). As the gap remains unbridged between what is desired and what is obtained, the incidence of disorder theoretically increases along with pressure on the government to provide psychiatric assistance.

Some authors dispute the scenario just depicted. Murphy (1961) points out that mental health may be either worsened or bettered in some situations of change. Inkeles and Smith (1970), in their six-culture study of modernization

and personal adjustment, found that individual stress is not an inherent accompaniment of industrialization and urbanization. These authors concur with Lambo (1978) that village life can be just as stressful as the urban center. Some young migrants rushing from the countryside into towns are in fact escaping from an oppressive psychological environment--one with limited roles and individual opportunities.

Irrespective of whether or not modernization per se is related to increases in adjustment problems, mental health workers in the region believe this to be the case. This perception has led to the request for assistance from WHO and other international consultants for manpower training and expanded services (Hassler, 1971; WHO, 1977a).

Establishing a Rationale for Psychiatric Care

A third reason for the continuing exportation of psychiatry is the strong conviction that Western physicians have in the cross-cultural suitability of their methods and their belief in the uniformity of mental illness world-wide (Draguns, 1979; Draguns & Phillips, 1972). Some physician-investigators admit to cultural coloring of symptoms, especially for non-psychotic dysfunctions, yet they assume that the basic disease process is not culturally determined.

The epidemiological approach for measuring and comparing disorder rates is predicated on this assumption. A methodological drawback in the past to using this approach has been the lack of agreement among professionals on a world-wide

classification scheme and standard procedures for case finding. In the early 1960's, the Scientific Group of Mental Health Research of WHO (1964) made epidemiological research top priority and stimulated the development of the mental illness glossary for the International Classification of Disease (ICD) to alleviate this problem.

A major issue in culture and mental health research has been to demonstrate the universal invariance of disorder manifestations (Draguns & Phillips, 1972). This impetus has indirectly built support for cross-cultural application of psychiatry. Several studies are often cited as supporting this hypothesis (c.f., Draguns, 1979). Casual observation in Thai hospitals led Bowman (1959) to conclude that disorders in Thailand closely resemble those in the United States. Using the same method in Tahiti, Berne (1960) reported that cultural factors are of negative significance at the hospital level. More systematic in their method of inquiry, Murphy, Wittkower, and Chance (1970) found "primary" or universal symptoms of depression in their 30-nation survey of practitioners. Comparing Yoruban and Nova Scotian taxonomies of psychological disturbance, A. Leighton, Lambo, Huges, D. Leighton, Murphy, and Macklin (1963) found convergence on several criteria which these societies use for deciding disorder. This finding was later extended to an Eskimo group by Jane Murphy (1972). She reported that the same disorders were located in all three groups and were

recognized as such by culture members and psychiatrists alike.

Summarizing this body of research, and drawing upon anthropological findings from other cultures, Murphy (1976) recently concluded that patterns, rates, and causes of mental illness are more similar than different for all human groups. She thus rejects the notion that each culture independently shapes psychopathology.

The most ambitious project to address this issue, and one which has had a direct impact on international psychiatry, has been the International Pilot Study of Schizophrenia undertaken in nine countries by WHO (1973). This study yielded an impressive demonstration of similarity across facilities in terms of: 1) rank ordering of schizophrenic symptoms as measured by the Present State Exam (Wing, Birley, Cooper, Graham & Isaacs, 1967); 2) symptom clustering; and 3) the emergence of a core (concordant) group of schizophrenics with identical profiles of dysfunction. This monumental effort yielded two messages. First, international diagnostic instruments can be developed and interviewers trained to reliably code selected individuals. Secondly, the "disease" of schizophrenia is the same in Denmark and the United States as it is in India, Nigeria, and Columbia. Aside from methodological criticism that could be levelled against the results of this and other epidemiological and hospital record investigations (e.g., Margetts, 1965;

Murphy, Wittkower & Chance, 1963), the message for developing countries is quite clear. Namely, that the same mental illnesses exist everywhere and, by medical analogy, the same diseases deserve the same therapeutic interventions.

The studies just reviewed permit another assertion contributing to the exportation of psychiatry: treatment successful in one culture should be successful in another (German, 1972; Kamel, Bishry & Okasha, 1975; Kiev, 1972; Murphy, Wittkower & Chance, 1970). Giel and Harding (1976) echo the sentiments of a growing number of psychiatrists around the world that an expansion of psychiatric services is overdue, that such services offer viable care, and when provided, will be readily acceptable.

Spearheading the dissemination of mental health technology are psychopharmaceuticals. Psychotropic drugs are touted as an immediate solution to handling the heavy backlog of chronic cases and are seized upon by overburdened physicians (Giel & Harding, 1976). Kiev (1972) places high faith in this intervention mode. He urges that an active program based on drugs should be established at the earliest possible moment in developing countries. Among the benefits of drug treatment, according to Kiev, are: elimination of long hospital stays; dramatic effects that change family attitudes toward the patient; establishment of community programs based around drug care; and removal of patients' symptoms from his responsibility, relieving guilt and anxiety and creating faith in treatment.

Other intervention modes have been tried in Southeast Asia as well. Lubis (1975, 1977) has worked steadily to introduce dynamic psychotherapy to Indonesia. In his doctoral dissertation he found that highly educated clients with neurotic problems could benefit with this modality without modifications. The urbanized, educated Indonesian is seemingly more suited to psychotherapy than folk therapies (Lubis, 1975). Moreover, Indonesia does not have time for trial and error methods in developing its mental health system, so psychotherapy is perceived as a scientific, responsible, and economical choice (Lubis, 1975).

Psychiatrists in this region are also trying other interventions. For example, Chen and Yang at the National Taiwan University Hospital have adopted group therapy and behavior modification programs for adults and brain-damaged children. Deva created a day care and industrial rehabilitation program at the University Hospital in Kuala Lumpur. In Bangkok, Suwanlert operates a similar center for promoting behavioral adjustment among pre-schoolers. In the Philippines, token economy wards are beginning at the Philippine General Hospital and the Veterans' Administration Hospital. Drug abuse units are springing up within established psychiatric facilities throughout the region. In short, Western therapeutics, whether drugs, psychotherapy, special units, or behavior modification, are perceived as valuable tools for dealing with the mental health problems of Southeast Asia as defined by indigenous professionals.

Establishing a Means for Psychiatric Care

Once the need for intervention is established, and a rationale offered for the suitability of psychiatry, the next concern becomes the means by which psychiatric technology is transferred and the form it assumes. Several mechanisms have evolved to insure the transference of Western technology in the mental health domain. First, influential health leaders in Southeast Asia received most or all of their professional training in Europe or the United States. Second, international agencies like WHO provide ongoing consultation, coordination, and technical assistance to nations in this region. Through these mechanisms, models have been suggested and tried for assessing mental health needs and designing programs intended to meet those needs. This section details the consultation practices, service delivery models, and needs assessment found in these countries.

Western Training

International psychiatry is the comparative study of problems that arise in teaching, hospital administration, and treatment due to resource shortages in certain settings (Wittkower & Termansen, 1968). One solution to problems of this sort is to send trainees to resource-intensive centers in Britain or the United States, for example, to receive specialized instruction. Historically, WHO (1963) and the World Federation for Mental Health (WFMH, 1961) endorsed this practice, as did degree-granting facilities in the

United States (e.g., Lin, 1971; McDermott, Maretzki, Hansen, Ponce, Tseng & Kinzie, 1974), the Agency for International Development, and various governments (e.g., Australia Development Assistance Bureau, 1977).

The impact of this approach is considerable. The majority of national decision makers in medicine and psychiatry were educated under Western nation auspices. Supporting this point, Tan (1971) revealed that psychiatry started in Malaysia when the first psychiatrist returned from England. A WHO fellowship provided the first foreign certification for an Indonesian psychiatrist in 1956 when Professor Salan made his way to the Netherlands (Salan, 1970). As described later, the author found that among the 80 key professionals interviewed in 34 psychiatric agencies in the region, 50 per cent received graduate diplomas abroad. Surprisingly, the trend of sending physicians overseas for advanced instruction has not abated, although early returnees have built specialized courses within home universities and hospitals (e.g., Philippines, Indonesia). Without complementary programs for disciplinary research, knowledge and practice brought back quickly grows stale, necessitating further trips abroad for updating information.

Influence of the World Health Organization

The WHO is a significant influence in Southeast Asia as well as in other developing world regions. To understand its present role, four aspects of the organization are reviewed.

These include: evolution of mental health programs historically; current philosophy for developing countries; program implementation mechanisms; and present involvements in this region.

At its first meeting 30 years ago, the World Health Assembly approved in principle a set of recommendations from the World Federation for Mental Health (WFMH). These recommendations set in motion WHO's involvement in mental health which has grown steadily in recent years. Today this division enjoys the status of a "major program," involving interlocking projects, research centers, and collaboration on a truly global level.

The WFMH's guidelines proved enduring as a series of Expert Committees convened to steer the activities of the mental health division and make technical recommendations for programs of research, professional training, standardization of nomenclature, consultation, service delivery alternatives, and regional coordination. The organizing principle, as laid down in the 1949 Expert Committee meeting, has been to work toward the incorporation into public health work of the responsibility for promoting the mental as well as the physical health of the community (Hassler, 1971).

A watershed year for the mental health division was 1964. Work initiated by an Expert Committee a few years earlier, devoted to assessing the application of epidemiological methods to developing mental health programs, laid the foundation for a Scientific Group recommendation that a

full scale epidemiological research program be undertaken with the highest priority (Lin, 1967). This was to be the first major involvement in research and gave the Mental Health Division the visibility, direction, and energy it needed to establish parity with other programs within WHO. The long-term plan on epidemiology began in 1965 with a four-component research operation (Sartorius, 1971): standardization of psychiatric diagnosis; comparative research on specific diseases; epidemiological studies of diseases in geographically defined populations; and training in epidemiology and social psychiatry. Out of this undertaking came the well-known studies comparing diagnostic differences among American and British psychiatrists (Cooper, Kendell, Gurland, Sharpe, Copeland, & Simon, 1972), and the International Pilot Study of Schizophrenia (WHO, 1973).

More recently, mental health achieved higher prominence when the 1974 World Health Assembly urged the promotion of mental health within the general health services and requested WHO to promote the development of new, low cost treatments, collaborate in training specialist and non-specialist health workers, design information systems, and standardize the classification system in mental health (WHO, 1978). Mental health received the designation "major program" in 1977, further enhancing its status, with

budgetary levels proposed that would provide the basis for a further evolution of its work (WHO, 1977a).

The newfound prominence of mental health long considered low man on the medical totem pole, can be linked to a shifting focus in the content and philosophy of the Mental Health Division's activities, and a pioneering effort in formulating its program's organizational structure. In the former case, the new image of mental health eschews dependence upon the medical model of education, psychiatry as a specialized profession, and mental illness per se as its sole defining characteristics. Instead, stress is on the public health and social-psychological aspects of mental health and the "whole team" approach, de-specializing to involve other social services and the community. The multi-disciplinary framework gives new roles to sociology, psychology, and social work, with problems defined as psychosocial in character. Integration with existing health networks and movement of services and training into the community arena are core objectives.

Complimenting the new image in content is an experimental structure for defining and carrying it out--the Coordinating Group. Structurally there are coordinating groups at the national, regional, and global levels, linked to each other as mechanisms to insure coherence, social relevance, and coordination of all mental health activities (WHO, 1977a). This approach is aimed at establishing the

highest level of involvement from member states, as well as collaborating institutions, non-governmental organizations, and the social sciences. Coordinating these views and resources is thought to be the key to program effectiveness and relevance to the needs of developing countries.

The first meeting of the Coordinating Group in 1976 yielded the "Medium-Term Program in Mental Health" (WHO, 1976). Underpinning the new program is the desire to confront priority problems in developing countries with strategies that are simple, realistic, and culminating in fast results. The four main areas of activity include two new endeavors, psychosocial aspects of human environments and program coordination at all levels, plus two historical foci: development of services and manpower, and research to improve, prevent and treat specific forms of mental disorder.

The action arm of the Mental Health Program involves several mechanisms. First, in response to requests from member states, experts are sent for periods of from one month to four years (Hassler, 1971). Consultants sent to Southeast Asia have made a lasting impression with their advice and evaluations (e.g., Kiernan, 1976; Lin, 1964; Stoller, 1959, 1963). These experts draw upon the latest thinking of WHO and their own countries to recommend policies, projects, and education schemes. An excellent example is E. C. Dax, who in 1962 and 1969 filed assignment

reports regarding the proposed expansion of psychiatric programs in Malaysia. His recommendations were modelled after the service that he had established for the State of Victoria in Australia, where Dax was Director of the Mental Health Authority (Tan, 1971).

Interestingly, Alan Stoller, who followed Dax as Director for the Victoria Authority, was on assignment for WHO and gave a comprehensive set of recommendations for further planning and elaboration of mental health care in Thailand in 1959 and Indonesia in 1963. T. Y. Lin, father of Taiwanese psychiatry, visited Thailand a year after Stoller and established the framework for manpower development and teaching psychiatry to medical students there (Lin, 1964).

Secondly, WHO regional seminars and workshops are devices for implementing program goals. By 1975, five seminars on the teaching of psychiatry in the South-East Asia Region (SEAR) had been successfully held (WHO, 1975c, 1975d, 1978). Output from these events included specific recommendations and technical advice: for example, teaching methods and curriculum for providing personnel with skills for doing community mental health work. Surveys followed-up the recommendations to appraise progress made by member states in meeting the guidelines and noted the barriers that prevent attainment.

Improved coordination among national, regional, and

global levels of mental health action is the third mechanism. Following the leadership of the Coordinating Group, SEAR held its first inter-country group meeting in December, 1977, to set up its own regional level advisory and coordinating body. An important outcome of this meeting was the decision that each country should have a medium-term program plus an advisory group on mental health. This national group would be vested with the authority to establish priorities, re-allocate resources, evaluate and implement projects, and provide continuous input into the national health and social policy-making apparatus (WHO, 1978).

This second recommendation underscores WHO's present movement to build clout at the national level in its member states, and to bring into governmental awareness the new directions and opportunities offered by the Medium Term Program (WHO, 1977a). To insure this, a new project, "Mental Health in National Health Policy Formulation," is proposed to make sure that WHO plays an active role in the process of national policy formulation and cooperates with each country's health authority in the inclusion of mental health within the overall health planning. If WHO's mental health activities are not felt in the drafting of national policy, then their intended effect has been lost.

Fourthly, WHO collaborating and resource centers are planned for different areas. Resource centers are broadly based to concentrate on the diverse problems of developing

countries. They are intended to evolve appropriate technology for prevention and treatment schemes, insure that psychosocial input is felt in social action programs, and carry out WHO research as well as initiate local studies. Both collaborating and resource centers provide needed leadership for formulating and implementing policies, and offering health education training models (WHO, 1977a).

Lastly, WHO trainee fellowships and collaborative research projects form channels for implementing Mental Health Division objectives. Indonesia, Thailand, and Malaysia are presently cooperating in a project testing an epidemiological case reporting instrument for gathering data on drug users in contact with treatment facilities (WHO, 1978). Other projects include a review of mental retardation services in SEAR and prevention and treatment of drug dependency in Thailand.

Service Delivery Models

Mental health technology is skillfully being transmitted into Southeast Asian settings through WHO seminars, consultants, regional meetings, resource centers, and so forth. Yet what form does this technology assume when it reaches a non-Western context? What models of service delivery have been suggested or tried, and what data are amassed in planning for psychiatric systems? Characteristic approaches to needs assessment and treatment delivery are described below.

Needs assessment. Ideally, needs assessment is a systematic procedure for sampling problem domains within a population and deciding priorities for intervention. The process is problematic, however, because it must first be determined who decides what the problems are, the form of assistance necessary for their alleviation, and the type of information required to make these decisions. Potential participants in mental health planning include patients, their families, interested community members, professionals, outside consultants, politicians, and government administrators. The trend in the United States, and that used by WHO (1975a) to make services acceptable in the community, is toward an increasing degree of citizen involvement, either through surveys, interviews, forums, or citizen advisory groups (MacMurray, 1976; Milford, 1976).

Services now available in the region did not originate through such rational planning or surveys of user needs. Rather, they were derived from historical accidents of the colonial era, the orientation of visiting advisors, and the type of foreign education received by indigenous professionals. These factors, in combination with economic and political realities of developing nations, are the actual determinants of the scope and role of clinical psychiatry.

Given the above constraints, there nevertheless have been needs assessments undertaken to guide some phase of planning, or at least to record the existence of problems.

The most frequently used methods of case finding have been epidemiological surveys and descriptions of patients in contact with agencies (e.g., Jayasundera, 1969).

The epidemiological approach, where the incidence of new cases and prevalence of existing cases are estimated for a given population, was used successfully by Lin in the late 1940's to argue for the creation of psychiatric care and training in Taiwan (Lin, 1961). An important use of this method is to document the extent of untreated disorder, or "residual deviance," and thus provide ammunition for lobbying to secure more funds, manpower, and facilities. It may also give impetus to a "seeking mode" of therapy--going out to find clients where they live and work (Rappaport & Chinsky, 1974).

The most recent plan of action for Filipino mental health workers (Aragon, 1977) is predicated on a 1965 epidemiological survey that found a prevalence of 36 cases per 1,000 and a hospitalization estimate of 1.26 per 1,000. WHO efforts in SEAR take into account a population survey carried out in South India in 1972 (WHO, 1978). Carstairs and Kapur found that eight per cent of the adult population there were experiencing two or more mental symptoms which were sufficiently distressing to cause them to consult one or another of the local sources of healing. Rates of this sort are also used to assess the impact of a program, identify high risk groups, and link socio-cultural conditions with magnitude of disorder (c.f., Cooper & Morgan, 1973).

The second method of uncovering mental health needs is to tabulate detailed information on those people who find their way into the treatment system. Demographic data were found useful in Malaysia for learning which sex, age, income, and ethnic groups use facilities, and from which part of the country they are drawn (Hartog, 1972; Teoh, Kinzie, & Tan, 1972). Data for presenting problems and differential diagnoses are instructive to the extent that such indicators reflect the need for different types of staff, intervention techniques, specialized units, and programs. A variation of this method is the case register, a standard, pre-coded questionnaire administered to all new admissions or out-patients. Indonesia has pioneered in the case register approach at the national level. Computer assistance enables data collected from the General Purpose Questionnaire, administered to over 5,000 yearly admissions to Indonesia's 35 inpatient facilities, to be summarized and cross-tabulated (Salan, 1975; Setyonegoro, 1976; Tenny, 1971). Kiev (1972) and Tenny (1971) point out that monitoring such as this has direct implications for national budgeting, program development, and manpower deployment.

Although epidemiological and hospital case-counting approaches appear useful to planners, they have been strongly criticized on methodological and conceptual grounds (Dohrenwend & Dohrenwend, 1965; Draguns, 1973, 1977; Giel, 1975; Kapur, 1975; Mintz & Schwartz, 1964). This criticism will be taken up in some detail in Chapter II.

Treatment models. Programs and facilities implemented to handle psychiatric needs are the intended products of needs assessment research. Reviewing the reports of consultants and indigenous professionals, however, reveals an overall lack of clarity in program objectives and intervention strategies. These reports fail to conceptualize how systematic criteria (theoretical or empirical) are to be used to structure services and evaluate outcome (Higginbotham, 1976). WHO recently sought to deal with this confusion through the publication of guidelines taken from social psychiatry (WHO, 1975a, 1975b). Nevertheless, there remains an absence of systematic procedures for designing therapeutic programs appropriate to community problems. Reviewing the existing programs in the region, two basic models for service design do emerge. These are "traditional" psychiatry and the public/community health approaches.

The first model represents the extension of traditional North American or European psychiatry, unmodified, to non-Western settings. Typically, inpatient or outpatient facilities are added to existing hospitals, or present treatment centers are given consultation on "modern methods" (Dax, 1962; Lin, 1961, Murthy, 1977). Emphasis is placed on the development of institutional settings where the patients are removed from general populations (Baasher, 1975; Thong, 1976). The drawback is that expensive custodial care ties up personnel and resources; it perpetuates chronicity through lack of inpatient or follow-up care and long-term

confinement of cases thought too violent, unmanageable, or incompetent to release (Benyoussef, et al., 1975). This approach carries the legacy of colonial times. It is currently deemed an anachronistic and inapplicable element of modern psychiatry (Kiev, 1972).

Treatment within these settings ranges from custodial management only, to active programs of work "therapy": farming, woodshop, sewing, and daily chores around the hospital for life-long residents. For those newly admitted, or residing in "acute" wards, treatment often follows classic psychiatric formulae of psychotropic drugs-- chlorpromazine, resperine, lithium carbonate--and physical therapies like electro-convulsive shock (ECT) (Hartog, 1972a; Kinzie & Bolton, 1973). One-to-one psychotherapy is less commonly reported as a treatment modality. It is a luxury absent from the training of practitioners (Santoso, 1959). Recently, psychotherapy has become popular among those able to afford private sessions, as shown by Lubis' (1977) work in Indonesia. Seemingly more fruitful have been extensions from two contemporary psychiatric notions, group therapy and the therapeutic community (Chen, 1974; Lubis, 1975; Visuthikosol & Suwanlert, 1976).

Within this model, there are examples of accommodation to local social conditions and customs. Chen (1972), doing inpatient group psychotherapy in Taiwan, uses occupational and recreational activities as mediums to facilitate desired

patient interaction. Kinzie and Bolton (1973) describe a program where hospitalized Malaysian aborigines are accompanied by relatives who encourage them to carry on normal daily activities. Also, long-acting phenothiazines are administered to discharged patients in their West Malaysian jungle homes.

A second approach to the design of therapeutic systems, the public/community health model, is rapidly replacing "traditional" psychiatry as treatment of choice among workers in developing countries (e.g., Argandona & Kiev, 1972; Kiev, 1971; Harper, Shapiro, & Zusman, 1975; Sartorius, 1977). Community mental health programs in the United States are fundamentally derived from the public health model (Rappaport, 1977). Principles of community and social psychiatry evolved from community settings serving multi-ethnic populations with diverse problems. These principles are thus considered applicable across cultural boundaries. A key article by Mehryar and Khajavi (1974) delineates the features of this approach which are common to programs recently begun in Southeast Asia (e.g., Hsu & Lin, 1969; Kinzie, Teoh, & Tan, 1974): 1) emphasis on primary prevention; 2) training of paraprofessionals; 3) extension of professional resources through consultation and education activities; and 4) mobilization of community resources to maintain the patient outside the hospital.

To this list can be added WHO's new thrust to incorporate psychosocial factors in health delivery and training,

and its concern with the prevention of disorder among high risk participants in settings of social change, urbanization, and economic development (WHO, 1977a). Moreover, WHO planners have historically given strong encouragement to the integration of psychiatric with general health delivery (WHO, 1950). The full scope of this approach involves multiple levels of specialization and referral. A primary health worker at the village level would be trained to screen psychological disorders for referral to a nearby rural health clinic. There, the client would be attended by a nurse or paraprofessional with some psychiatric training under the supervision of a physician from the psychiatric unit of the district hospital. If the problem were unmanageable at the primary level, the client would be referred again, this time to the district hospital.

At the secondary level, psychiatrist and staff operate a small inpatient unit along with weekly outpatient clinic and consultation visits to rural health clinics. The regional mental hospital, the tertiary and final level, is reached only after efforts to manage the problem closer to home have been exhausted. This system is currently under testing in the Philippines (Ignacio, personal communication). In Sarawak, Schmidt (1967) pioneered in the creation of such a referral network to avoid hospitalizing his Chinese, Malay, Dyak, and Murato clients.

Establishing a Standard of Mental Health Intervention

The introduction of a public/community health type delivery system includes set criteria about its structure and characteristics. These criteria represent standards of mental health care desirable for the adequate coverage of a community. Standards for WHO member states are set forth in a recent publication, Organization of Mental Health Services for Developing Countries (WHO, 1975a). If these standards are adopted by member states, and the priority of mental health services reversed, WHO personnel like Harding (1975) believe that effective care can be brought to the 90 per cent who are without it.

According to the public/community health model of intervention, four components are essential to complete the system. First, the service should be comprehensive, with a diversity of treatments and units. Among them are emergency, outpatient, partial hospitalization, inpatient, rehabilitation, domiciliary, and after-care. Second, a preventive focus should guide the service activities. Primary duties are consultation with social agencies, other community services, and the public education system. Prevention includes the training of and collaboration with general health care workers. The third component of the model is continuity of care. Patients should be handled by a team of multi-disciplinary staff--psychiatrist, psychologist, nurse, social worker, occupational therapist--who share

continuous contact with their charge while hospitalized and during transition back into the community. This principle implies setting up an integrated referral network among different service agencies responsible for the client's welfare. Finally, the model mental health system should be accessible to the potential users. Accessibility can be defined in several ways. It can mean ease of referral, immediate attention without an appointment or long wait, manpower availability, or no educational sophistication required to successfully use the system (Quah, 1977). Sometimes it is viewed as a ratio of hospital beds per population, as in the 1953 WHO recommendation of one bed per 10,000 severely disturbed. More recently, accessibility has been defined as the extent to which mental health programs are integrated with primary health care (WHO, 1975a). Concern is with how best to intermingle mental with general health delivery, either through re-training health personnel or sharing their facilities. This effort is aimed at reaching more of the 10 to 15 per cent of the population who presently receive basic health care in developing countries.

These four standards, along with the recognition that the programs must somehow be acceptable to the community (WHO, 1975a), are lifted up as the attributes of a modern service. They are also criteria employed by the National Institute of Mental Health and the Accreditation Council for Psychiatric Facilities to evaluate the network of community

mental health centers in the United States (Errion, 1979; Windle, Bass, & Taube, 1974). International agencies, consultants, indigenous professionals, and visitors evaluate existing systems of delivery according to these standards. They are the foundation for recommendations about future development, allocation of resources, manpower training, national legislation, international collaboration, and research. Because of their profound significance, these criteria should be carefully analyzed and the full extent of their implications and suitability for these Asian countries brought to light.

This introductory chapter traced the historical and contemporary factors giving shape to the character and availability of psychiatric care in Southeast Asia. Upon a foundation of colonial making, modern psychiatry is nurtured by its perceived value to the modernization process, its transcultural applicability as claimed by its proponents, and international advisors who skillfully transmit to client nations contemporary models of service delivery. However, standards of therapeutic quality and efficacy accompany these treatment models which are based upon the resource and cultural conditions of Europe and the United States. Chapter II turns attention toward these standards for planning modern psychiatry, examines the array of problems that confront them, and questions their applicability to the nations of this region.

II. PSYCHIATRY AS A STANDARD FOR MENTAL HEALTH CARE IN SOUTHEAST ASIA

Chapter I described how Western psychiatry became firmly established in Southeast Asia. It also reviewed how intervention techniques are continuously updated through the efforts of indigenous professionals, consultants, and international collaboration. An enterprise of this magnitude and scope has far-reaching implications for these developing countries. It is essential, therefore, to inquire both as to the feasibility of following the Western model and to its responsiveness to non-Western cultures. Chapter II takes up these issues.

Considered first are the socioeconomic barriers limiting the feasibility of psychiatry's full development. Secondly, the sensitivity of Western therapeutics to Asian culture is discussed in terms of community acceptability and discontinuity with the sociocultural environment.

This discussion leads to a rationale for carrying out a survey of the mental health services in Southeast Asia. Namely, because of the resource investment and potentially disruptive impact of Western psychiatry, it is imperative to examine the current status of treatment delivery with regards to: 1) the ability of developing countries to attain the essential standards of modern care, and 2) community acceptability of facilities and efforts to accommodate to cultural needs and customs. Appraising the

mental health systems from these two perspectives yields information regarding the socioeconomic feasibility of the Western intervention model and its cultural sensitivity.

FEASIBILITY OF THE WESTERN MODEL WITHIN
THE CONTEXT OF DEVELOPING NATIONS

Socioeconomic Barriers

Observers in Southeast Asia recognize the immense difficulty of creating and implementing any therapeutic system. Failure to provide access to effective mental health care for the millions who are without it is part of a much wider failure to provide basic health services to the populations of developing countries (Giel & Harding, 1976). The socioeconomic context of today's developing nations precludes the possibility of meeting the four standards of modern psychiatry--comprehensive, preventive, accessible, and continuous care. Other constraints include politics, institutional underdevelopment, and the intensive demands of the Western model. This section reviews these prominent barriers.

A number of forces operating at the national level mitigate the feasibility of attaining the standards of modern intervention. The most critical of these is the low priority assigned social and medical welfare services in general, and psychiatric care in particular (Indris, 1971; Sartorius, 1977; Tan, 1971; WHO, 1975a). Meeting in New Delhi, prominent planners of the World Health Organization

South-East Asia Region (WHO-SEAR) termed this problem the "lack of national will" to elevate mental health concerns (WHO, 1978). Only programs for dental care receive less attention during national budgeting for health division items.

Projects for industrialization, rural development, and food production--not to mention "defense"--have top priority in settings where at present 70 to 90 per cent of the citizens reside in rural areas (Kiev, 1972; Neki, 1973a). Crisis in population growth, nutrition, internal migration, infectious disease, water purification, and education press more intensely upon the perceptions of national leaders (Harding, 1975; WHO, 1975a). Nevertheless, Neki (1973a) found that in 1970, public health funding was only .6 per cent of national expenditure for Indonesia, 2.7 per cent for Thailand, and 7 per cent for the states of India. Mental health was the lowest allocation within these expenditures. The money available went toward maintaining large custodial hospitals with their backlog of "incurables."

Political Constraints

The political aspect of establishing mental health care is a study in and of itself. Politicians are moved to address this need primarily in relation to political gain: as publicity during election time, when a mental patient commits a sensational crime, or scandal erupts at the national mental hospital (Sartorius, 1977; Tan & Wagner,

1971). With intense competition for scarce resources, general health providers, already entrenched in government circles, lobby against psychiatry as premature for areas where infectious disease remains unchecked (Harding, 1975).

Such competition fosters an unwillingness to coordinate with other agencies, leading to inter-departmental conflict and political turmoil that stalls mental health legislation (Dasnanjali, 1971; Kiev, 1972). National legislation, outlining precise mental health goals and policies for institutions, is clearly needed (Curran & Harding, 1977; Harding, 1975; Widjono, 1975). A permanent government body, situated at the directorate level, is recommended for giving mental health political clout (Kiernan, 1976; Tan, 1971; WHO, 1976). A directorate of mental health, such as the one in Indonesia, would be responsible for coordination and evaluation of services, planning, policy making, and manpower development. It would also serve as the focal point for collaboration with international agencies and research.

Limited Institutional and Organizational Development

Another characteristic of emerging nations, insufficient infrastructure, also impacts the health arena. The structure for making decisions and supervising their execution within institutions simply doesn't exist. Butwell (1975), a political scientist, bolsters this point by revealing that governments in Southeast Asia have generally been ones of men, not of institutions. Political, economic, or health

programs fall with the figures that proposed them when viable governing structures fail to develop.

For example, in some medical schools, there is still no teaching department of psychiatry; psychiatrists are subsumed under other medical departments. This becomes a barrier to the recruitment of able specialists--a paucity of leadership results (WHO, 1978). Mismanagement of resources by incompetent administrators within fledgling institutions is a related problem (Benyoussef, et al., 1975). Poor managerial skills prevent effective service utilization as drugs and equipment are stolen or lost. Professional time is wasted also through poor coordination, overlap, or involvement in non-clinical functions.

Foster (1977) adds an interesting anthropological insight into the functioning of these institutions. He observes that the culture of bureaucracies, and the psychology of the specialists operating within them, determines the shape of medical service delivery. Forces that determine how a professional actually acts within the system include his status and training, salary, personality, and convenience. As Carstairs (1973) notes, no one wants to work within the village. Therefore, 75 to 90 per cent of the mental health resources serve 10 to 20 per cent of the population--the urban dwellers (Kiernan, 1976; Kraph & Moser, 1966). On these occasions, Foster (1977) concludes, professional and client culture fail to overlap.

Intensive Technical and Economic Demands
of the Western Model

Actualizing the standards of modern care delivery requires an intensive resource investment for any country (Murthy, 1977). A delivery system that is structured to provide comprehensive, preventive, accessible, and continuous treatment, demands manpower, training programs, integrated facilities, and supportive research (Harper, Shapiro, & Zusman, 1975). Southeast Asia, and developing nations in general, are characterized by their acute lack of these resources (Kraph & Moser, 1966; Neki, 1973a; WHO, 1975a). The magnitude and implications of these shortages are described below.

Manpower

The shortage of manpower across all helping professions, especially at the supervisory level, is the most lamented scarcity (Benyoussef, et al., 1975; Carstairs, 1973; Chaudhry, 1975; Kline, 1963; Sartorius, 1977; WHO, 1975a, 1976; Widjono, 1975; Wig, 1975). Compounding the thinness of manpower is the uneven distribution of personnel (Kraph & Moser, 1966; WHO, 1976). Most are ensconced in a few urban inpatient facilities since general practitioners and specialists alike prefer to work and live in cities.

This manpower condition, more than the medical model itself, imposes a rigid stamp upon the nature of client care. Psychiatrists feel their treatment options constricted

when they face dismal manpower-to-client ratios. Sartorius (1977) estimates that there are approximately 700 psychiatrists for 800 million people in South-East Asia Region. Based on 1970 records, Neki (1973a) found ratios of .08, .05, and .34 psychiatrists per 100,000 population for India, Indonesia, and Thailand respectively. These figures are in sharp contrast with the First Report of the World Health Organization Expert Committee on Mental Health calling for one psychiatrist per 20,000 in order to provide satisfactory treatment (WHO, 1950). It is not surprising that patient management consists almost entirely of drug therapy and other brief somatherapeutic modes applied chiefly to acute cases (Leon, 1972).

Training

The source of manpower shortage lies in the absence of training facilities and university departments to prepare careers in the helping professions (Chaudry, 1975; Hartog, 1972; Kiernan, 1976; WHO, 1978; Wig, 1975). Settings which have initiated psychiatrist education may completely lack training opportunities for supporting professionals--social workers, psychiatric nurses, and psychologists. Psychology within these countries remains solely an academic discipline, unmotivated and unqualified to produce service providers (WHO, 1976).

Some governments, like Singapore, deny the need for training professionals in this field, although they could

afford to do so. The rationale offered is that society should progress through the hard work of its members without such crutches.

Prejudice within academic medicine and traditions of non-specialization in some countries are also curtailing influences (Carstairs, 1975; Maguigad, 1964). This distinct lack of interest by general medicine was documented by Kraph and Moser (1966). In a survey of 33 countries, they found psychiatric specialization unattractive to medical students because of poor quality courses, unattractive working conditions, low status, and low salary. Tan (1971) confirms this image, recalling that doctors assigned to work in mental hospitals by the Malaysian Division of Health, reacted as if they were being disciplined or outcast. The following actual conversation about one Malaysian psychiatrist communicates the attitudes of some physicians toward psychiatric hospitals (Wagner & Tan, 1968, p. 28-29):

First Physician: "Have you heard that Eng-Seong is now in Tanjong Rambutan (the large psychiatric hospital of 4,500 beds 150 miles north of Kuala Lumpur)?"

Second Physician: "Gosh, what happened to him?"

First Physician: "Oh no, he is there as a doctor, not as a patient."

Second Physician: "My God, that's even worse!"

This fear may not be unfounded. Besides the low financial and bureaucratic reward of being assigned to the

two Malaysian hospitals is the awareness that patients' relatives may threaten the lives of the medical staff when they are upset (Hartog, 1972). The prejudice and lack of support in general makes it difficult to get either treatment or training materials. Up-to-date journals, books, and reprints are as unavailable as newer drug therapeutics (Giel & Harding, 1976; Wig, 1975).

Specializing in psychiatry is just as difficult in Indonesia. To survive economically, psychiatrists employed by the government must do private practice in the evenings. Since most patients cannot afford the high fees of talk therapy, drugs are extensively relied upon. Frequently, the therapist finds it more economically rewarding to simultaneously carry on a general medical practice (Lubis, 1975).

Lubis (1975) laments that the introduction of newer modes, like psychotherapy, are hindered in Indonesia by traditional Kraepelinean teaching curricula and emphasis on drug management. Since the government supports medical training, it is only concerned with those problems which can be solved in large numbers. The restricted scope of individual psychotherapy is considered to be a poor dividend.

Training Abroad

The consequences of having few training opportunities at home is that those interested must seek advanced degrees abroad. Several problems are associated with this practice. Recently, sentiment has turned against offering overseas

fellowships. Regional experts agree (WHO, 1977a) that it is more useful to invite experts to their countries and train nationals in subjects identified as high priority by the government. Another preference is to send trainees to centers in nearby countries where psychiatric needs are relatively similar (Wig, 1975).

In the past, fellows have returned from highly developed countries with expertise inapplicable to the needs and resources of their home settings (Neki, 1973b; WHO, 1977a). Such "overtrained" professionals, with interests in esoteric therapies like psychoanalysis or gestalt therapy, face colleague resentment and may grow frustrated in their inability to incorporate new approaches (Kiev, 1972). Moreover, training in the West in a foreign tongue may inhibit communication with clients seeking care from the local community. Regional leaders are insisting that psychiatrists be trained within the cultural setting where the work is applied and in the language of the people served (Neki, 1973b).

Another problem is that foreign training frequently leads to a loss of manpower when trainees remain overseas. Their host country attracts them with higher paying positions than they would receive back home (Quah, 1977; UNESCO, 1975). Elite applicants, trained at home, often graduate only to slip away to jobs in more industrialized countries where their labor is also appreciated. The former

chairman of psychiatry and neurology at National Taiwan University, Dr. Hsien Rin, remarked that the mental health system in his country would be quite different if the numerous graduates trained in the last 20 years had remained at home (Rin, personal communication).

Approximately one-third of the psychiatrists, and many other medical specialists, have left Malaysia since 1976. Government policies of discrimination, politics at the national university, and the mood of the country, coupled with Australia's loosened immigration restrictions, are the key reasons for this brain drain.

Facilities

A number of deficits are found related to the nature and availability of facilities. Inpatient beds are particularly scarce (Benyoussef, et al., 1975). Industrialized societies make available anywhere from one to six beds per 1,000 population; for example, Japan has 1.8 and Finland, 4.5 (Kiernan, 1976). In 1959, WHO consultant Alan Stoller estimated that Thailand needed an additional 70,000 beds (Stoller, 1959). Twenty years later, follow-up consultant Kiernan (1976) estimated that a four-fold increase in beds was needed to bring the .2 beds per 1,000 up to acceptable standards. With referrals feeding into these limited residential facilities from police, courts, general medicine, and families, overcrowding reaches 50 to 250 per cent (Neki, 1973a).

There is an acutely felt shortage of comprehensive and specialty care (Kiernan, 1976; Kraph & Moser, 1966; WHO, 1975a; Widjono, 1975). The essential units for a standard comprehensive care system include inpatient, outpatient, partial hospitalization, emergency, rehabilitation, and specialized services for forensic, retardation, geriatric, child, and substance abuse cases (Kiev, 1972; Tjahana, 1976; WHO, 1975a). These are extremely rare and do not exist at all in rural zones. It is a common sight to see masses of patients, some having travelled quite far, waiting long hours for outpatient consultation which lasts a few brief minutes (Carstairs, 1973). Under these conditions, it is not surprising that psychiatry is used as a last resort.

Pressure on these facilities will only increase as public health measures enable brain damaged and senile populations to survive longer (WHO, 1971). Native healers will no longer shoulder the burden of care either, as modernization and official disapproval erode their prestige, and new trainees become scarce (Foster, 1977; Weinberg, 1970). Adding to this, WHO (1975a) foresees no prospect in the next 10 to 20 years of providing enough specialized workers to meet even the basic needs. For example, Wig (1975) notes that if India were to double the number of psychiatrists in the next 10 years, there would then be one psychiatrist for every 1 million population.

Two additional problems plague existing facilities.

First, despite efforts of WHO, mental health services remain isolated from the general/public health network. The absence of referral pathways linking the primary health worker with psychiatric units contributes to the lack of integration between the two systems. This fosters a related problem of wasted and misused resources: up to 20 per cent of those visiting outpatient medical units are potential psychiatric cases. Insufficiently trained health workers misdiagnose and mismanage these clients. This places an extra burden on the system and negates more appropriate treatment (Giel & Harding, 1976; Kiernan, 1976; WHO, 1975a).

Needs Assessment

The last component considered essential to the complete treatment system is evaluation research. It provides three functions: assessing community needs, deciding program priorities, and determining program effectiveness. Current delivery systems operate in an information vacuum, lacking data regarding mental health problems and intervention outcome (Murthy, 1977; Widjono, 1975; WHO, 1976). Knowledge relevant to community needs, essential for rational priority structuring, is rarely sought through epidemiological surveys--they are quite expensive and technically demanding (Giel, 1975; Kiev, 1972). Moreover, epidemiological data alone are useless for setting priorities and making other planning decisions. What these data cannot provide is a clear statement by the government of what they consider

proper mental health care and how this can be achieved (Giel, 1975).

Mental health priorities are ultimately value judgments superimposed on the survey process by observers with a particular orientation (Giel & Harding, 1976). These observers may also take into account evidence of community concern, perceived seriousness of problems, susceptibility to management, and their own therapy preferences as guidelines for priority setting (Morely, 1973). Giel and Harding (1976) undermine the fallacy that prevalence or incidence rates alone determine priorities. They show that the disorder with the lowest prevalence rate, functional psychosis, makes up two-thirds to three-fourths of those in mental hospitals and consumes the greatest proportion of health resources.

The outcome of research evaluating treatment may be slightly less expensive than full scale epidemiological assessment. However, the methodological sophistication essential to carry out valid systems evaluations is perhaps more demanding. Fine-tuning of mental health programs is clearly beyond the present means of developing countries.

Indeed, it is only just now emerging as an important aspect of funding for health care in the United States (e.g., Perloff & Perloff, 1977). It can be argued that evaluation is more important for settings where misdirected and ineffective programs are less tolerable economically. Even so, with

social science disciplines struggling for recognition vis á vis the heavier funded applied sciences, there is no one qualified to set up projects for systems analysis. Throughout all of Southeast Asia there are less than a handful of Ph.D. psychologists. Those having anything to do with mental health have difficulty gaining access to patients, even for personality and mental testing. The study of administrative decision making and the impact of medical staff and facility operations on patient change is unthinkable for both practical and political reasons.

In summary, it appears that the developing nation context affords little support at present for actualizing the requirements of the comprehensive mental health model. Its feasibility for these settings is hindered by forces at the national level, including socioeconomic barriers, patterns of political power, and limited institutional development. Furthermore, the psychiatric model makes demands for manpower, training, expertise, facilities, and research that at this time are too intensive to even partially meet. Beyond these problems of "national will" and economic resources lies a second set of concerns blocking the effective implantation of modern psychiatry. These concerns center on the concept of "cultural sensitivity," a topic explored in the next section.

CULTURAL SENSITIVITY AND THE WESTERN MODEL
OF HEALTH DELIVERY

Even if it were feasible to fully develop a modern mental health system in Southeast Asia, is it legitimate to do so? What are the implications for Asian societies? These are questions of cultural sensitivity and continuity. It is imperative to appraise the cultural sensitivity of any intervention system. Without it, the chances of community acceptability and utilization of the services are low, except under limited circumstances. Also, discontinuity of services with culture has far-reaching implications for social change, some of which may be undesirable. At minimum, thoughtful ethical consideration must be given to any tampering with the social fabric of a culture. Some calculation must determine whether the assets of innovation outweigh their potential liabilities.

Community Acceptance of Services

Acceptance of services by the community in Southeast Asia has been a problem historically. It is undoubtedly linked to the shortage of adequate resources. Yet, the negative evaluation of psychiatric care can be traced to a number of other factors bearing on the relationship between cultural traditions of the communities and the facilities placed in their midst.

Hospital Stigma

Mental hospitals have not transcended their historical stigma (Darmabrata, 1971; Carstairs, 1973; Tjahana, 1976). Organizationally they have remained a closed system to the larger community. Alien and isolated, their inhabitants--staff and patients--are cut off from the surrounding pattern of social life (Baasher, 1975). The perception of the mental hospital as a prison, a holdover from the colonial days (Tjahana, 1976), is coupled with the social stigma of seeking help. In Malaysia, it is considered by some as an admission of failure or irresponsibility and an invitation to family disgrace that psychological problems must be taken to others for help (Teoh, Kinzie & Tan, 1971). Rural people are especially remote from psychiatric clinics or hospitals. Yet for the above reasons, it is doubtful whether many would seek such help even if access were available (Giel & Harding, 1976).

A vicious circle operates to keep these mental hospitals isolated. Existing prejudice forces families to wait a long time before admitting the patient (Darmabrata, 1971; Draguns & Phillips, 1972; Quah, 1977; Neki, 1973a; Wolff, 1967). By then, the patient may have firmly established maladaptive behaviors (Bazzoui & Al-Issa, 1966; Neki, 1973a). The overburdened staff make little headway with these established patterns; chronicity and institutionalization gradually evolve.

When it becomes apparent that there is little hope for recovery, the family loses contact and abandons the patient. This is especially true if the person was violent or severely upset his family and community. Thus, the prophecy is fulfilled: the hospital becomes the institution of last resort, reserved for conditions of extreme disturbance for which rehabilitation back into the community is improbable. It remains an isolated entity, unacceptable except as a place of abandonment.

Patient Stigma

Another cultural factor influencing acceptance of psychiatry is the community's perception of deviance and behavioral disorder. Centuries-old beliefs about the causes of disorder involve notions of punishment for sin, violation of taboo, malevolent spirits, and witchcraft (Asuni, 1975; Baasher, 1975; Kiev, 1964; Murthy, 1977; Sethi & Lucknow, 1965). The traditional family reaction is to panic. They fear that the person has sinned, violated a taboo, or that someone else in the village is using sorcery to bring illness to their kinsmen (Lieban, 1973).

Being labelled "mad," orang gila, in Malaysia and Indonesia is a terribly shameful and humiliating experience for the person and his family. It is second only to having leprosy (Darmabrata, 1971; Hartog, 1972). Taking the patient to a psychiatric facility only reinforces this stigma. Moreover from this world view, such services have little to offer.

They ignore the real wellspring of suffering (Asuni, 1975; Neki, 1973b; Torrey, 1972). Indigenous healers are called upon to propitiate the malevolent spirit or cast off the malicious spell--returning the patient to his normal self without the stigma of institutionalization.

Professional Bias

The attitudes of other health workers toward psychiatry also determine its acceptance (Baasher, 1975). A number of sources report strong negative bias against mental health among other professionals (Baasher, 1975; Neki, 1973b; Tan, 1971; WHO, 1975a, 1976). For example, Carstairs (1975) sampled the attitudes of senior medical faculty in eight Southeast Asian countries. He found a high degree of prejudice and ignorance among professors of medicine, surgery, anatomy, and physiology. These medical leaders still maintained "outdated ideas about psychiatry, regarding it as exclusively concerned with the treatment of insane in mad houses (Carstairs, 1975, p. 109)."

WHO (1975a) regards negative attitudes held by health personnel, planners, and politicians as a major obstacle to the development of rational mental health care. Entrenched conservatism, with personnel favoring institutional treatment and resisting introduction of new, community-based methods, is also seen by WHO as perpetuating the negative, archaic image of psychiatry. Lastly, a new breed of indigenous professionals are beginning to challenge the

blind borrowing of Western patterns of training and intervention without testing their relevance to local conditions (Wig, 1975). Such challenges may play a larger role in the future acceptance of new psychiatric technology.

Discontinuity of Services with Culture

The second characteristic of a mental health service relevant to cultural sensitivity is the continuity of its goals and operations with the pattern of indigenous culture. This continuity is a critical feature which may be absent from modern psychiatry. There is a growing awareness that psychiatry is unacceptable to a traditional community--the assumptions underlying it are incongruent with cultural forms and beliefs. With incongruity comes impetus for culture change. However, the use of psychiatry as a force of innovation and change raises serious ethical questions when community members have no influence over the direction of that change (Neki, 1973b). The impact of innovation poses a threat to existing social relationships; it disrupts the integrated continuity of values and institutions. The cultural discontinuity and social change potential of psychiatry are described in this section.

Modern Psychiatry and Western Values

Visiting consultants and their in-country counterparts share a common education. Undergirding it are philosophical assumptions about the nature of man that are specific to the

cultures of Europe and America. These assumptions give shape to the course of psychiatric thought and action. Definitions of disorder, the curing process, and the ideal outcome of therapy are all determined by culture-specific values, just as they are in traditional societies of Africa and Asia (Collomb, 1974; Neki, 1973b). Many writers have commented on the cultural bias of modern psychiatry and psychotherapy (Kleinman & Sung, 1976; Meadow, 1964; Pande, 1969; Yap, 1968). They are viewed as social institutions seeking to meet the deficits in the Western way of life.

Values defining the process of psychotherapy in the United States were recently illuminated by Sampson (1977). For Americans, the end product of treatment is "self-actualization," autonomy, and mastery. The burden of attaining these criteria of adjustment is placed on the individual, who has within himself the source of cure. Therapy is designed to help the individual look inward to iron out neurotic wrinkles. The emphasis on individual growth at the expense of social interdependence is perhaps viewed as somewhat odd by members of kinship and group-centered cultures.

In broad terms, psychotherapy serves culture as a process of resocializing the person to expected norms (Draguns, 1975). To the extent that cultures differ, the goal and modality of resocialization differ as well. Draguns (1975) offers the following typology of culture and

therapy: internal locus of control societies practice insight-oriented, reconstructive, and open-ended psychotherapy; cultures preferring external control of its members employ authoritarian, directive techniques with focused outcomes. When indigenous professionals trained abroad in psychotherapy return home, with whom are their interventions appropriate? Kiev (1972) suggests that these returnees may have to unlearn newly-acquired methods and seek out other approaches more congruent with the needs encountered.

Modern Psychiatry Imparts Culture Change

The preceding paragraph noted that each system of curing is geared to fulfilling the sociocultural needs of its society. In doing so, that system becomes culture-specific. It cannot be transferred intact to another society (Asuni, 1975). With the transference well under way, though, something must be happening. Is the curing system being modified? Or are elements in the host society changing to accept a better fit? Societal elements at risk of change through health innovation include disease notions, behavioral values, social relationships, and patterns of power. These are considered next, followed by recent suggestions on how to modify psychiatry to make it acceptable (Asuni, 1975; Benyoussef, et al., 1975; Prasetyo, Humris, Hardjawana, Budiman, & Mangindaan, 1977; Schmidt, 1965).

Disease notions. A review of ethnographic and trans-cultural psychiatric literature suggests that prevailing

notions about disease in a culture may be replaced when new health technology is introduced (Kiev, 1972; Neki, 1973b; Wolff, 1965). Wolff (1965) underscores this point in viewing medicine as a potent agent of culture change on the Malay Peninsula: "For really good medical services to be established, it is necessary to acquaint the people with not only more modern tools, more efficient techniques, but with a new and acceptable way of thinking about disease, about causation of disease, about treatment of disease (pp. 344-345)."

The Western classification of diseases is intended to replace indigenous conceptions, including notions of behavior disorder. Making psychological evaluations from the standpoint of Western culture, Neki (1973a) argues, means holding Western criteria as essentially "normal" and assuming any departures from its prevalent pattern as deviant. This tendency runs counter to the assertion by ethnographers that diagnostic labels developed and employed in advanced countries are not applicable in divergent societies (Wittkower & Termansen, 1968).

Attitudes and values. Secondly, cultural values and attitudes may come under attack. Ari Kiev (1976) warns against "psychiatric imperialism." Yet, at the same time, he advocates psychiatry stepping into the political arena. Psychiatrists, armed with social science knowledge, should involve themselves in leadership selection, educational

planning, and suppression of tribal customs impeding the development of psychological autonomy among the young. Such customs, Kiev reasons, hinder modernization.

The role of psychiatrist as community educator and modifier of the "archaic" and "harmful" attitudes is a common theme in international psychiatry. Baasher (1975) sees the need to study communities intensively to identify incorrect attitudes, particularly the stigma of treatment, that need to be changed. In essence, psychiatry is value-laden (London, 1965), employs a single standard to establish deviance and normalcy (Neki, 1973b; Rappaport, 1977), and advocates making alterations in individuals' values and life styles. Thus, there is an ethical responsibility to gain community approval before it is introduced. At minimum, practitioners should clarify psychiatry's value system to those effected.

Social relationships. Social relationships are a third cultural element at risk of being altered. An established psychiatric service places explicit role demands on those involved. The medical system is hierarchical and prescribes role relationships among levels of staff, as well as among staff and patients, their families, and other involved community agents. In taking on the responsibility of caring for patients, the medical system competes with, and undermines, an intricate pattern of interpersonal relationships (Lewis, 1955).

Interpersonal contact with the identified client may be quite complex. The social matrix may include his immediate family, other kinsmen, village elders, religious leaders, teachers, local authorities, folk doctors, and so forth (e.g., Hartog, 1972b). Foster observes that changes in health behavior "almost always produce, or require, major restructuring of traditional and valued social relationships. When the 'social' costs of this restructuring [or any innovation] are seen as outweighing the potential advantage, the decision will be against change (Foster, 1977, p. 530)." (See also Fairweather, 1972; Lewis, 1955; Rappaport, 1977).

In particular, the family/patient relationship is most likely affected. The authority of the family, with its responsibility for making health decisions and overseeing their member's recovery (Kleinman & Sung, 1976), is often sacrificed for the sake of medical expediency (Clark, 1959; Prasetyo, 1977). This is especially tragic as maintenance of family contact--and involvement with the patient during admission--is an important determinant of early discharge.

Existing power structure. Fourthly, the introduction of mental health services has implications for strengthening or weakening prevailing patterns of power within a society (Lewis, 1955; Lieban, 1973). This issue has received prominence in the West. Some writers characterize psychiatry as a device for political and social control. They argue that as an institution, its goals are to maintain the status

quo or to discredit and silence opponents of those in power (e.g., Laing, 1969; Sue & Sue, 1972).

In Southeast Asia, the introduction of modern institutions has served to stratify communities into small westernized elites--those in leadership positions--and the vast majority of traditional farmers and peasants (Neki, 1973a). The former group is a separate class: a body of nationals different from the majority as a result of their acculturation. The domain of this class is government service, big business, education, the professions, communication, and the military. They have travelled abroad, gone to college, and speak English (Butwell, 1975). For the latter group, the village is their world and the focus of their identification and loyalty.

Historically, family ties and the welfare of the family business in the village were placed above that of the nation (Butwell, 1975). However, for convenience in administering public health, educational, and other social programs, villages are in the process of being rearranged. Although well-intentioned, newly-introduced programs of village welfare represent an unprecedented assault on the ways of village life (Steinberg, 1971). Older rulers had exploited but never intruded into village affairs. Contemporary governments have done so in drawing the peasants into new administrative frameworks (Steinberg, 1971). Administrative rearrangement of village units serves the needs of psychiatric delivery as well.

While the introduction of psychiatry adds to the rationale for political changes in these areas, authorities control how the treatment system will be introduced and used. This insures that, at minimum, it will not prove disruptive to the desired status configuration. Kiev (1972) warns international consultants that those in power may not be willing to help disadvantaged groups through the distribution of services. He encourages consultants to be watchful that authorities don't manipulate them into becoming a tool of their own political ends. In a similar warning, Westmeyer and Hansman (1974) add that authorities may try to limit direct consultant contact with clients and hold other paternalistic practices. These can only be overcome by ethically guided professional behavior that places the welfare of the target population first.

Indigenous healing. The final cultural element to suffer as a consequence of imported psychiatry is the system of indigenous healing (Draguns & Phillips, 1972; Kleinman & Sung, 1976; Torrey, 1972). The net result of introducing a modern, formal system for psychological problems may be less help for those in need. This situation arose for poor people in the United States with the development of comprehensive community mental health centers (Kelly, 1966). Rappaport (1977) explains that services to the poor were actually reduced when other agencies stopped treating them. Instead, these clients were referred to the new community mental health centers which also had little to offer.

Creating an ineffective new institution--like the alienated residential facilities described earlier--results in less support for the community. This occurs when legislation, official disapproval, and referral patterns combine to undermine the existing healing network.

Neki (1973a), Kleinman and Sung (1976), and Hartog (1972) found that traditional healers are extensively relied upon by all layers of Asian society. Native institutions are curative, serve important social functions, and assist in mediating the stress of rapid social change. Yet, folk healers, shamans, spiritualists, and other practitioners are dying out (Foster, 1977; Hartog, 1972; Weinberg, 1970). The formal programs intended to replace them are scarce, not well accepted, and suffer from the other deficiencies outlined earlier.

Cultural Continuity of Indigenous Healing

The critical feature of folk healing that Western methods lack is continuity with the values, beliefs, and customs of the local cultural setting. This points to the major deficit of modern psychiatry--cultural discontinuity. The repercussions of discontinuity involve disruption of the integrated set of cultural elements governing perception and response to mental health problems. It still remains, however, to articulate the specific ways in which indigenous treatment provides cultural continuity and modern medicine does not.

Treatment of Disease Versus Healing an Illness

Kleinman (Kleinman, 1977; Kleinman & Sung, 1976) is an astute observer of the cultural patterning of illness and healing. In his analysis of the cultural mechanisms governing the health care system lies a means for understanding the cultural continuity of folk healing. For Kleinman, there is a radical discontinuity between contemporary care and traditional forms of healing. While healing takes into account the control of sickness and provision of meaning for the individual's experience of sickness, modern health care attends solely to the former. While modern medicine is only interested in disease--the malfunctioning of psychological and biological processes--healers are interested in the patient and his family's psychosocial reaction to the disease.

Kleinman states his theoretical position as follows:

Healing is not so much a result of the healer's efforts as a condition of experiencing illness and care within the cultural context of the health care system. Healing is a necessary activity that occurs to the patient, and his family and social nexus, regardless of whether the patient's disorder is affected or not. The health care system provides psychosocial and cultural treatment (and efficacy) for the illness by naming and ordering the experience of illness, providing meaning for that experience, and treating the personal, family, and social problems which comprise the illness, and thus it heals, even if it is unable to effectively treat the disease. (Kleinman & Sung, 1976, p. 55-56)

In summary, to the extent that folk practitioners provide culturally legitimate treatment of illness, they must

heal. To the extent that professional clinicians focus exclusively on disease, they must fail to heal.

Folk Practitioner

Upon closer inspection, the cultural continuity of traditional medicine begins with the folk healer. His personal manner, style of speech, rituals, problem explanation, even style of dress and non-verbal messages, are all appropriate to the expectations of patient and audience (Clark, 1959; Draguns, 1975; Frank, 1974; Kleinman, 1977; Torrey, 1972). Meeting the patient's expectations of therapy, the healer insures mobilization of hope, faith, and expectancy of success, greatly increasing the chances of a positive outcome (Higginbotham, 1977).

The folk healer, working primarily at the psychosocial level (Kleinman & Sung, 1976), is an observant member of his community. He knows how to inspire group confidence in his cure and mobilize family and friends as resources for the distressed person (Clark, 1959; Dean & Thong, 1972; Marriott, 1955). Because he is so well acquainted with his patient's circumstances, the traditional doctor can provide what is desperately desired. He may offer firm reassurance of cure and absolute faith in the medicine prescribed (Carstairs, 1955; Marriott, 1955) or, an extensive community ceremony to solve interpersonal disputes, cleanse, and reintegrate a person alienated from his kinsmen (Chen, 1975; MacLean, 1971; Turner, 1964).

Unlike the generally individualistic and rationally oriented therapies of the West, folk doctors employ purposefully dramatic healing rituals. The patient, audience, and therapist are actively involved. These are public events; activities assaulting the sensory systems of patient and audience are intended to intensely captivate the patient or induce altered conscious states. The therapist, often with a supernatural connection and aura of wonder about him, creates a ritual structure that powerfully transmits the message of healing and change to the participants (Kennedy, 1973).

The folk healer's ritualized procedures can be interpreted at other levels. Broadly speaking, he is a medium for transmitting and integrating a diverse set of social values and customs. This is especially apparent in the face of modernization (Kiev, 1972; 1976). In Parson's terms, he is an important part of the social control system for society--judging who is truly sick and who is allowed to play the sick role (Parsons, 1957).

Traditional medicine maintains continuity with culture because the assumptions on which it operates are at the cultural core of society. Beliefs about mental illness are intimately linked with conceptions of religion, social values, norms, and ideals of human relationships (Cumming & Cumming, 1955; Kiev, 1972; Lieban, 1973). The shared belief system about mental illness determines the nature of

traditional medicine. It provides the medical framework for interpreting symptoms and guides social action in response to them and to the sufferer (Kleinman & Sung, 1976). Finally, the accepted explanation about the causes of disorders determines what people will do to cure them, the point of intervention, and how they will behave toward the sick person (Higginbotham, 1977).

In summary, the concept of cultural continuity is critical for understanding the disruptive potential and failure of Western psychiatry in Southeast Asia. When modern medicine is imported to traditional societies found in this region, it fails to provide ritual and philosophic basis considered necessary by members of these societies (Chen, 1975). Focusing exclusively on the disease process rather than the total human, villagers view Western treatment as depersonalizing, mechanistic, and fragmented. Scientific doctors seem aloof and uncaring of family and friends (Chen, 1975; Wolff, 1965). In short, scientific medical systems fail to satisfy neither all basic health requirements nor the social and metaphysical needs related to them (Foster, 1977; Kleinman & Sung, 1976; Lambo, 1978). Lambo, speaking from the African perspective, but equally applicable to Asia, makes a statement ideal for summarizing the cultural continuity theme:

The character and effectiveness of medicine for the mind and body always and everywhere depend on the culture in which the medicine is practiced.

In the West, healing is often considered to be a private matter between patient and therapist. In Africa, healing is an integral part of society and religion, a matter in which the whole community is involved. To understand African psychotherapy one must understand African thought and its social roots (Lambo, 1978, p. 32).

Culture Accommodation of Psychiatry

Recently, ethnopsychiatry has sought to come to terms with the cultural barriers inhibiting the introduction of modern care and, in the process, modify psychiatry to make it more acceptable (Benyoussef, et al., 1975; Collomb, 1975; Draguns, 1975; Kiev, 1972, 1976; Lebra, 1976; Leighton, 1969; Prasetyo, et al., 1977; Schmidt, 1965). This has been done successfully in Nigeria and Senegal through the village system (Collomb, 1972; Lambo, 1966; Osborne, 1969). Under this approach, psychiatric patients live with a relative in a traditional community especially provided to handle them close to the mental clinic. Treatment progresses through the natural therapeutic elements of village life, use of native healers, drugs, and group psychotherapy.

Other recommendations have been offered for accommodating to the unique cultural needs of Asia. In terms of training, Wig (1975) suggests that the best results arise when it is provided within the home country. If home training doesn't exist, then students should be sent to well-established centers in neighboring countries where the culture and problems are relatively similar. Furthermore, Wig (1975) feels that community needs call for a new type

of psychiatrist: one who serves as a community planner, organizer, teacher, and supervisor of non-professionals. Planning new services in strict collaboration with local leaders is an important recommendation (Asuni, 1975; Bhaskaran, 1975; Hassler, 1975). Moreover, making services accessible to users in terms of location, reduced waiting, and affordable fees increases acceptability (Foster, 1977). Programs become more desirable also when their personnel share a common background and language with the clients (Schmidt, 1965) or show the family dramatic results, quickly releasing the patient (Asuni, 1975).

Higginbotham's (1976) survey of the literature found three strategies for dealing with the problems of innovation. First, the Western trained professional is most successful as a consultant. In this role he offers indirect services of education, training, and support to existing caretakers. Consultants conceptualize prevention programs and suggest procedures for evaluating program effectiveness. Direct services are handled more effectively by indigenous caretakers (Kinzie, Teh, & Tan, 1974; Neki, 1973b; Santoso, 1959; Torrey, 1972; Vatanasuchart, 1971). Secondly, integration of new services with the present helping system appears advisable. This may take the form of collaboration with agencies in positive relation with the public, relying on traditional healers (Kapur, 1975; Prince & Wittkower, 1964; Wittkower & Warnes, 1974) or choosing the family home

as the site for care. In this regard, culture-specific concepts of disease and classification of disorder are treated with sensitivity and respect (Fabrega, 1971; Torrey, 1971). The third strategy is to use model projects for demonstrating the efficacy of new programs (e.g., Argandona & Kiev, 1972; Beaubrun, 1968; Chen, 1974). Experimental programs can be used to elicit community interest, train workers, convince government planners, and provide needed services.

What each of these strategies and recommendations have in common is an intention to modify the system of mental health delivery to make it more continuous with elements of the community and client needs. Culture accommodation efforts enable a closer fit between the treatment system and the cultural system which determines health behaviors in the community. Culture accommodation of programs permits cultural continuity; it offers relevant and viable services without adversely disrupting values, beliefs, and life styles--the essential fabric holding the community together. An accommodating program seeks not to replace existing patterns of helping, but rather to support and build upon them as resources aimed toward the same goal. Ideally, services are introduced where none exists and the community recognizes the value of a new program.

Very little has been written about the process of culture accommodation in Southeast Asia and the planning

necessary to insure it in the design of new services. Culture accommodation could well be a part of service operation in this region since facilities deal with a broad diversity of ethnic and income groups. This topic demands research attention because it is an important consideration in designing services in any community, including those for ethnic minorities in the United States (e.g., Kahn & Delk, 1973; Padilla, Ruiz & Alvarez, 1975; Sue, 1977). It would be valuable to have descriptions of the accommodation practices and dimensions of accommodation which Asian facilities have evolved in responding to the unique cultural demands placed upon them.

RATIONALE FOR THE SURVEY OF MENTAL HEALTH SERVICES IN SOUTHEAST ASIA

Two major points can be distilled from this discussion of international psychiatry. First, there is a clear doubt as to the feasibility of following the Western model of mental health care in Southeast Asia. Secondly, it is critically important for any helping program to accommodate itself to the surrounding cultural milieu in order to gain community acceptability and avoid cultural discontinuity. At this point, however, the methods and dimensions of accommodation remain speculative.

Presently there is little systematic information on the suitability of Western psychiatry from the perspectives of feasibility and cultural sensitivity. Gaining these

perspectives requires a survey of current services in Southeast Asia. The purpose of this survey would be to describe the status of mental health delivery in terms of:

- 1) their ability to successfully attain the criteria of comprehensive mental health care as delineated by the modern psychiatric model and,
- 2) the practices of culture accommodation within these facilities aimed at enhancing community acceptability.

Gathering information on these two aspects of mental health systems in the region furthers understanding of the transcultural validity of the Western intervention model. This information helps establish the feasibility of this model as a practical one for developing Asian countries and provides a means for gauging its cultural sensitivity to non-Western settings.

Placing the two perspectives in relationship terms enables the statement of the following assumptions:

- 1) To the extent that these countries are unwilling or unable to allocate the resources necessary to provide comprehensive, accessible, preventive, and continuous care, a model defining these as essential is inappropriate to the conditions found in these nations;
- 2) To the extent that psychiatric facilities in these countries are unacceptable to their communities, and fail to offer programs designed in continuity

with important elements of the culture, this model fosters inflexibility and insensitivity to indigenous conditions. It may also prove disruptive to host culture institutions.

The appropriate service delivery model based on the two perspectives is:

- 1) economically affordable, requiring a minimum of resources;
- 2) simple, requiring minimal organizational and institutional development;
- 3) continuous with the life needs and customs of its recipients; and
- 4) non-disruptive of the ongoing pattern of helping in the community--strengthening it when necessary and offering care where it is nonexistent but needed.

A survey assessing the possible limitations of the psychiatric model should focus on three aspects of current services in Southeast Asia. The first predicted domain of difficulty is limited availability of psychiatric resources. These include problems with providing comprehensive services, preventive programs, continuity of care, and accessible facilities. Secondly, the facilities may fail to integrate the community into its operations and experience low acceptability by the clients. Thirdly, programs may need to be modified in various ways to accommodate appropriately the patterns of health behavior found in the culture.

One method of learning about these potential problem domains is to interview mental health workers in the region. Several sets of questions could be posed:

- 1) What is the nature of mental health resources in the country? What types of services are rendered by each facility? By whom? For whom? And, how are they provided?
- 2) What problems confront practitioners in providing services to the community? Do staff perceive special problems in caring for "traditional" clients? Is community acceptance of agency a problem perceived by staff?
- 3) What particular practices and policies have agencies evolved to adapt to the distinct cultural characteristics of clients? What are staff attitudes toward such accommodation?

Chapter III describes the research instruments developed to assess facilities in these domains.

In summary, Southeast Asia is an ideal location for studying the feasibility of modern psychiatry in a developing nation context and understanding the importance of culture accommodation in mental health programs. In this region, systems for health delivery, while still at their initial stages of development, must serve an extremely broad array of people. Clients to a single facility may be drawn from both rural and urban areas, maintain traditional or

Westernized world views, and represent numerous distinctive linguistic, ethnic, and cultural groups. In the Philippines alone there are scores of major dialects and peoples of broadly contrasting racial and ethnic backgrounds. These conditions offer an exceptional opportunity for examining institutional development and adaptation vis á vis cultural values, customs, and expectations.

III. METHODS: FIELD INSTRUMENTS, PROCEDURES, AND SUBJECTS

DEVELOPMENT OF FIELD INSTRUMENTS

Purpose

The rationale for a survey of mental health resources in Southeast Asia was developed in Chapter II. To briefly recapitulate, the purpose of the survey is twofold:

1. to gather information on the feasibility of modern psychiatry--the potential for realizing its essential standards in the context of developing nations; and
2. to estimate the cultural sensitivity of the Western model of mental health delivery in these settings--describing aspects of its community acceptability and learning how it is modified, if at all, to accommodate to cultural patterns of health behavior.

Field Instruments

These two perspectives on psychiatry's suitability in Southeast Asia were approached through intensive interviews with personnel assigned to mental health agencies. Three interview schedules were constructed for this purpose.

They are Questionnaire #1: Administrator's Overview and Description of the Program, Questionnaire #2: Staff Perceptions of Agency, and Questionnaire #3: Staff Attitudes Toward Accommodation.

In conjunction with the interviews, written materials pertinent to agency operations were also collected. The research strategy was conceptualized as a case study approach integrating various sources of information. During the field work, the case study data were viewed as belonging to three domains of agency functioning: 1) agency services; 2) characteristic agency problems; and 3) agency considerations of culture accommodation. The specific procedures and instruments employed to generate the case study information for each domain are now described.

Overview of Services and Nature of Services Rendered

Questionnaire #1: Administrator's Overview and Description of Program. Questionnaire #1 covered:

1) services available; 2) funding; 3) staffing; 4) capacity; 5) clients; 6) staff training; 7) referral paths; 8) discharge rates; 9) primary prevention efforts; 10) therapies; 11) family involvement; and 12) community participation and control (See Appendix A). It was administered to agency directors and chief medical officers or other professional staff holding extensive and reliable information.

Written materials. Review was made of annual reports, government planning documents, legislative mandates, research publications, etc., providing additional documentation of the components detailed above.

Characteristic Problems Encountered by Agency

Questionnaire #2: Staff Perceptions of Agency was the primary data source for learning characteristic agency problems (See Appendix B). One component of Questionnaire #2 was designed to elicit from various personnel (doctors, psychologists, social workers, etc.) their perceptions of "possible problems encountered by the program." One open-ended and 31 scaled items were presented. Scaled items included problems with funding, staffing, professional support, treatment outcome, community acceptability, and other resource difficulties.

Considerations of Culture Accommodation Found in Agency Policies, Practices, and Personnel Activities

Questionnaire #2 contained several components pertinent to the culture accommodation domain. These include:

- 1) patient and family conceptions of disorder and treatment expectations;
- 2) nine items on "possible problems" component related to cultural barriers in using agency;
- 3) mental health criteria;
- 4) therapeutic goal setting;
- 5) staff accommodation to patient's conceptions of disorder;
- 6) adjusting inpatient services to culture;
- 7) accessibility of services;
- and 8) involving community helpers.

Designed specifically for this domain was Questionnaire #3: Staff Attitudes Toward Accommodation (See Appendix C). This questionnaire is a brief (16 item) attitude scale measuring the degree to which staff agree with specific

practices of culture accommodation. This scale, translated into Japanese and Chinese, was distributed to as many personnel as possible within each facility.

The final research method, involved consultation with agency administrators, staff, representatives from national health ministries, and authorities from academic institutions--anthropologists, psychologists, ethnopsychiatrists. Open-ended interviews covered: 1) culturally unique aspects of mental health problems and psychiatric care; 2) considerations given to gathering culture-specific information; 3) methods employed; 4) types of information sought; 5) degree of integration of this knowledge into services; 6) perceived value of culture accommodation processes; and 7) barriers to this approach. Findings are in the form of discussion notes.

Composite Variables for Case Study Analysis

To compose a case study from these diverse data sources, it is necessary to synthesize the information into a set of variables. They form a framework for integrating data from questionnaires, open-ended interviews, actuarial and published reports, and consultant evaluations. These variables, following the three domains of agency functioning, are shown in Table 3.1.

Origin of Instruments

Items for the three interview instruments originated from several sources. Questionnaire #1 is a straightforward

Table 3.1
Variables for Analyzing Case Study Data

Resource Variables

1. Comprehensive Services
2. Prevention Program
3. Continuity of Care Within Facility: Manpower
4. Continuity of Care into the Community
5. Continuity of Care: Inter-institutional
6. Accessibility of Facilities
7. Staff Evaluation of Facilities

Community Integration and Acceptability Variables

8. Community Involvement in Treatment
9. Community Integration via Review and Consultation
10. Staff Evaluation of Acceptability

Culture Accommodation and Continuity Variables

11. Institutional Practices
12. Culture-Specific Procedures Available and Stressed
13. Staff Attitudes Toward Accommodation

accounting of what services are rendered, by whom, for what types of clients, from which referral sources, and with what degree of involvement from the community. The items comprising Questionnaire #1 would be applicable to the description of a comprehensive community mental health center in the United States. The revised criteria for Federal funding of a mental health center are included. Standards call for 12 essential services: emergency, inpatient, outpatient, follow-up, child, geriatric, drug abuse, suicide prevention, consultation, education, diagnostic, and partial hospitalization. The community mental health approach--currently emphasized by WHO--is also included in other items assessing the availability of primary prevention, community consultation, involvement of the patient's family, and participation by the community in planning and directing program activities.

Questionnaire #2 has multiple components. One is an open-ended section asking the practitioner to report his experience with clients and their families regarding their conceptions of disorder. The questions constitute a domain definition interview except that the respondents are practitioners rather than knowledgeable community lay people. This interview elicits cultural beliefs about the types of psychological disorder, how they are classified, what causes them, expected therapies, and the anticipated goals of therapy. Each culture prescribes a set of expectations

relevant to the therapeutic process: the techniques, goals, and therapist manner seen as efficacious by culture members (Higginbotham, 1977). This component was designed to determine the practitioners' awareness of these cultural expectations and record the range of presenting problems brought to psychiatrists and professional perceptions of them.

Component two presents 31 potential agency problems to be rated as either "very," "moderately," or "slightly serious" or "not a problem at all." The items were culled from a literature review dealing with the issues of providing psychological services in non-Western countries (Higginbotham, 1976). Most of the problems found in this component are described in Chapter II. They deal with the full range of resource and facility deficits. Also included are items concerned with community rejection of agency and use of alternative (folk) health care.

The third component of Questionnaire #2 appraised agency accommodation practices. Suggestions for listing specific accommodation elements came from the literature review of psychiatric programs operating in non-Western countries (Higginbotham, 1976). Of particular interest were the more recent public/community mental health programs and Lambo's village treatment model (See Chapter I). Staff were questioned about who helped decide therapeutics, ways in which staff sought to accommodate to the patient's

notions of disorder, how inpatient services were adjusted to cultural patterns, agency accessibility, and community resource involvement in case management.

A third questionnaire was included to learn whether mental health professionals felt that culture accommodation was important for operating a successful facility. They were asked to examine 16 items which the researcher defined as culture accommodation dimensions. The task was to agree or disagree that each item would contribute to the success of a facility operating in a community where people maintained traditional beliefs and customs about mental disorder. The rate of agreement of a particular dimension yields an index of its perceived value as a practice for working with traditional clients. The overall pattern of endorsement reflects the extent to which the concept of culture accommodation is approved by regional practitioners. The items themselves were derived from a literature review of culture and expectancy in psychotherapy (Higginbotham, 1977) and the writings of public/community mental health workers cited earlier. The statements were written in a counter-balanced, "positive/negative" manner to avoid response bias. That is, sometimes the respondent disagrees with a statement to approve a culture accommodation dimension; at other times agreement with a statement indicates accommodation endorsement.

Pretesting

The researcher spent six weeks in Japan pretesting the three questionnaires prior to the survey in Southeast Asia. For several reasons, Japan offered a valuable opportunity for modifying and refining the instruments constructed in Hawaii. First, the profound language barrier forced the author to rewrite each statement into its simplest, most concise, and most understandable form. For example, the problem item "Under-utilization and lack of acceptance of programs by community members" was rewritten to "Community people have a bad opinion of the treatment program and use it only as a last chance." Items too obscure and abstract-- as "Difficulty of organizational structure of facility"-- were eliminated.

Another reason for Japan's value as a pretesting site was the status of psychiatry there and the basically "modernized" way of thinking about disorder among lay people. Psychiatry in Japan is still developing as a specialty. It follows the traditional Kraepelinean, descriptive school and is ensconced in conservative medical-academic settings. Except for two indigenous psychotherapies--Naikan and Morita--talk therapy and community based delivery systems are recent innovations that have yet to obtain respectability. A law suggesting that prefectures establish community mental health centers was passed more than ten years ago but this movement remains small.

The situation forced the researcher to recognize that no assumptions could be made about basic concepts like "psychiatrist," "psychotherapy," "family therapy," "community," and so forth. Dr. Masaaki Kato and Dr. Kazuo Yamamoto of the National Institute of Mental Health in Japan were extremely helpful in pointing out that these concepts were operationally defined in many different ways there. Their meanings did not necessarily overlap normal usage in the United States. For example, any doctor, irrespective of his formal training, may call himself a "psychiatrist" in Japan if he works in a mental hospital or is interested in psychological problems. There is essentially no formal training in schools of psychotherapy, like Freudian, existential, or behavior therapy. Respondents indicating that psychotherapy was carried out at their facility had to be questioned further about exactly what the activity entailed. This was a valuable lesson for the researcher. It was crucial to clarify the actual activities and behaviors of the practitioners rather than to rely on abstract labels of what personnel said they were doing.

The finding that Japanese living in urban areas held essentially "modern" medical notions of psychological disorder meant that the researcher had to look elsewhere for examples of the culture/beliefs relationship about psychopathology. Three lessons were learned: 1) "folk beliefs" must be defined narrowly for each setting--actual folk names

should be given as examples when talking with personnel; 2) agencies in rural, isolated, traditional areas must be visited for learning about culture accommodation; 3) the study of "lay" concepts of disorders (and inquiries about general complaints and presenting problems) would be more practical and understandable to practitioners in urban centers.

It was generally unproductive to simply inquire about "traditional" or "folk" beliefs. Aside from a few anthropologists and ethnopsychiatrists in Japan, no one is familiar with historical beliefs regarding mental disorder. This generalization does not hold true in Aomori Prefecture, however. Several practicing psychiatrists are quite knowledgeable of the folk healing shrines there. These doctors are interested in contacting the few remaining shamanistic healers in Japan--the Itako.

The instruments were formally pretested in Kaijoryo Hospital, a 200-bed inpatient facility in Asahi City, and in Tokyo Medical University. The psychiatric directors of these teaching and treatment facilities extensively reviewed the questionnaires, offered suggestions for modifications, and commented on the applicability of each item to their facility and the Japanese situation in general.

In short, the pretesting and the useful comments of these and other physicians and anthropologists permitted the refinement of the interview schedules. Wording was changed

throughout; concepts were better defined and the interviewer learned to obtain elaborations of treatment terminology. Moreover, the component on folk conceptions was made both more general--to include a question on "presenting problems"--and more specific--to offer particular folk names for psychological problems in each culture.

FIELD SURVEY PROCEDURE

Prior to the field trip, the investigator made a considerable effort to develop a network of contacts in each country. Psychiatric journals were consulted. Recourse was made to the four volumes of Mental Health Research in Asia and the Pacific and to knowledgeable faculty at the University of Hawaii and the East-West Center. A list was compiled of key psychiatric researchers, administrators, practitioners, and government officials in Japan, Southeast Asia (including Taiwan), and Australia. The Southeast Asian nations visited comprise the alliance "Association of Southeast Asian Nations" (ASEAN): the Philippines, Malaysia, Singapore, Thailand, and Indonesia. However, the case studies constructed for this report include only two of these--the Philippines and Thailand--plus Taiwan. The Culture Learning Institute of the East-West Center mailed more than 50 letters of introduction on behalf of the researcher. The letters to key personnel briefly mentioned the purpose of the project and requested permission to visit each psychiatric facility during a specified time frame

(See Appendix D). Approximately 75 per cent of those written to responded with letters welcoming the investigator. Some of them sent details about their facilities. Many suggested other psychiatric workers to be contacted and listed additional facilities that would be worthwhile to visit. Upon receipt of these letters, the investigator followed up with a personal letter to each correspondent. A two-paged, detailed explanation of the study was included along with a reprint of an article used as the foundation for the research--"A conceptual model for the delivery of psychological services in non-Western settings." (See Appendix E). Follow-up letters to the facilities and personnel recommended by the correspondents was done also.

It should be emphasized that this phase, "developing the network of contacts," is vitally important to the success of any similar survey. Before research can be rightfully initiated, one must learn who the key figures in psychiatry are and lay the foundation for a friendly and trusting relationship. Only through their consideration and assistance is permission granted to visit the hospitals, inpatient units, clinics, and departments of psychiatry to observe professionals carrying out their duties.

The investigator was fortunate to meet numerous helpful, generous administrators and staff in every country visited. They took time off from their pressing schedules to provide program orientations, appointments for the researcher with

other staff members, tours of the hospital wards, copies of annual reports, and access to records. These professionals spent considerable time explaining the local system of care. Without this level of support, the investigation would have been impossible. Moreover, it is essential for the visitor to have something to give in return. Lectures, reprints, books, and a promised copy of the final report--plus free-wheeling discussions of the latest thinking in psychotherapy in the United States--were among the "gifts" reciprocated by the researcher.

The ensuing chapters provide details of the survey procedures for three of the countries visited. Each setting was different: the survey procedures required tailoring to match the structure of its mental health system. It is necessary, therefore, to treat each country as a separate case study, approachable only on its own terms. Yet, there is communality in three basic processes which were undertaken to carry out the surveys in all countries. These processes are described below.

Entry into the System

Initial entry into the network of mental health providers, researchers, and trainers was perhaps the most difficult step. This is where the preliminary groundwork laid in Hawaii was first tested. Often, a note to key contacts was written to inform them of arrival dates just prior to landing. A preliminary grasp of transportation

and communication systems was obtained, which was no mean feat; contact was made with the researcher's "sponsor"-- someone who knew either the investigator or his dissertation advisor. The sponsor assisted by acquainting the visitor with the city and its transportation routes, indicating facilities and the best sites to visit. Depending on his knowledge, the sponsor might indicate important people to contact at each facility. He sometimes even provided introductions, set up appointments, and secured transportation.

Learning the System's Elements

The primary task after breaking into the psychiatry network was to learn its critical elements. That is, who are the national leaders of psychiatry? Who are the government decision makers? Who are central figures in mental hospital administration, in psychiatric research and education, and those collaborating with WHO personnel? Allied professionals peripheral to this network--clinical psychologists, social workers, etc.--along with ethno-psychiatrists and anthropologists specializing in traditional healing were also sought out.

The task was to develop an exhaustive overview of formal and informal care available to community members seeking help with psychological problems. In this vein, private, religious, and public sources of services alike were taken into consideration. On several occasions, visits

to healing shrines to witness shamanistic healing ceremonies were arranged. The investigator was accompanied to these shrines by psychiatrists and researchers. These cultural informants translated and explained the ceremonies taking place. In addition, university and commercial bookstores were visited to find publications related to psychiatry, ethnopsychology, and traditional medicine in each country.

Exhausting the System

To make the most of these month-long visits, the researcher had to move quickly to seek out and interview as many diverse elements in the network as possible. The principle was to interview multiple levels of staff within given institutions. The subjects themselves were not randomly selected. Randomization was impossible under the constraints of an operating treatment center. Rather, subjects represented the different disciplines found in these institutions: psychiatric supervisor, medical line staff, psychologist, nurse, social worker, occupational therapist.

Numerous and varied sites were sampled as well. Besides the major governmental inpatient facilities, a number of small, primarily private, counseling and social welfare agencies were visited. Also approached were local mental health associations and academicians in national universities who trained mental health manpower.

The purpose of this shotgun approach was to obtain

the broadest possible understanding of how the elements of the national delivery system fit together as a functioning whole. Each person had his own perception of what the system was and how it worked. It was necessary, therefore, to carry out numerous interviews with informants of varying orientations and levels to gain a balanced picture. This effort was intended to inject some degree of reliability into the data.

Several criteria operated as general guidelines for choosing sites to study once the overall network of facilities was known. These were: 1) position significance in the national delivery system (e.g., the Philippines' major inpatient facility, National Mental Hospital); 2) size and historical value (e.g., Thailand's first mental hospital at Dhonburi; Thailand's largest residential center, Srithunya); 3) innovation (e.g., National Taiwan University Hospital's day care and autistic children center); 4) contact with traditional patients and rural/urban balance (e.g., Chiangmai's Suang Prung Hospital housing patients from nearby Hill Tribes); and 5) accessibility to investigation within the time and economic resources allocated for the survey.

SITES SELECTED AND PERSONNEL INTERVIEWED

The measure of success in the investigator's efforts to carry out an exhaustive sampling of these national

networks of personnel and agencies is found in the following tables.

Inpatient Facilities

Table 3.2 indicates the extent to which inpatient facilities were sampled. Based on bed capacity, the facilities chosen for observation account for the majority of beds in the Philippines and Thailand, but not Taiwan. The highest percentage of national psychiatric beds visited, 62 per cent, was in Thailand. Only 11 per cent were sampled in Taiwan. Looking at the principal urban areas of these nations, we find that close to 100 per cent of the beds in Manila, Bangkok, and Chiangmai were located in sampled institutions. Clinics accounting for 40 per cent of Taipei's beds were studied. It seems safe to conclude that the interview data are highly representative of urban psychiatry and moderately exhaustive of the nations' inpatient resources in general.

Questionnaire Respondents

Selecting a site, the investigator would make an appointment with the hospital director. During the initial visit, the administrator would be shown the three interview forms and asked for suggestions on which staff members would be available to complete them. Efforts were always made to interview the administrator himself with Questionnaires #1 and #2. Appointments were usually made through the

Table 3.2

Extent of Inpatient Facility Sampling By Country and City

Country City	Total # of Mental Hospitals & Inpatient Beds Available	Total # of Mental Hospitals & Inpatient Beds Visited
<u>Taiwan</u>	+12 "Active" Treatment Facilities +3,000 beds	4 Facilities visited 323 beds (11% sampled)
Taipei	6 Treatment Facilities 774 beds	4 Facilities visited 323 beds (40% sampled)
<u>Philippines</u>	23 Treatment Facilities 6,500 official beds	8 Facilities visited 3,801 beds (58% sampled)
Manila	9 Treatment Facilities 3,831 official beds	7 Facilities visited 3,781 beds (99% sampled)
<u>Thailand</u>	14 Treatment Facilities 7,865 beds	7 Facilities visited 4,885 beds (62% sampled)
Bangkok	6 Treatment Facilities 4,290 beds	5 Facilities visited 3,990 beds (95% sampled)
Chiangmai	2 Treatment Facilities 865 beds	2 Facilities visited 865 beds (100% sampled)

administrator to interview several of the ward supervisors and at least one each of the psychologists, social workers, and psychiatric nurses.

There were far fewer ancillary psychiatric personnel so it was often difficult to include them. Their comprehension of the nature of the task and grasp of English was such that sometimes they were a little more reluctant to participate. Conversations with them were slightly more problematic. Many of the physicians had training abroad in English; some attended American universities. This was generally not the case for the other personnel. The investigator made appointments with as many professionals as possible, returning to the agency several times until the interviewing was complete.

The procedure for administering the interviews sometimes varied with conditions found at the institution. On occasion a single staff member was questioned; other times there was a room filled with people who gathered at the hospital director's request. Group questioning was rather difficult. One wasn't quite sure whom to address or which of the many conflicting answers to write down. In these situations, it was best to be quite cheerful and go quickly through only a few items.

The general format was for the researcher to sit with each respondent and read each item aloud. It was important to explain questions and terms, re-phrasing them as necessary

to insure comprehension. Through follow-up questioning on certain items and gentle probing for details, the investigator quickly judged whether the staff member provided answers accurately reflecting the meaning of the interview items. The interviewer soon learned which terms were understandable to the personnel in different countries; such terms were substituted to improve rapport and communication.

Questionnaire #1 was given to the director or his assistant along with the other two questionnaires if the director had time. Questionnaire #2 was administered to the other staff singly and was followed by Questionnaire #3. This last form was sometimes handed out to staff who were not interviewed with the other instruments. It was self-explanatory and simple. All interviews were carried out in English or with another staff member present to translate the items into the native language.

The following tables summarize the distribution of respondents to each questionnaire. Several variables were cross-tabulated: country, facility type, profession, and place of training.

Examining these five tables reveals several important facts about the sources for the survey data. In 22 facilities in the three countries, an administrator filled out the intensive overview questionnaire. An almost equal number of administrators from each country participated in the study. As reflected in Table 3.2, these sites account

Table 3.3

Respondents for Questionnaire #1: Administrator's Overview of Facility

Country	Number of Respondents
Taiwan	6
Philippines	8
Thailand	8
Total	22

Table 3.4

Occupation of Respondents for Questionnaire #2: Staff Perceptions of Agency

Country	Psychiatrist	Psychologist	Social Worker/ Occupational Therapist	Nurse	Total
Taiwan	6 (4) *	1 (1)	2 (2)	2 (2)	11
Philippines	12 (8)	5 (4)	2 (2)	3 (3)	22
Thailand	11 (6)	5 (4)	1 (1)	0	17
Total	29 (18)	11 (9)	5 (5)	5 (5)	50 (22)

*First number indicates the number of respondents; the number in parenthesis is the number of facilities from which they were sampled.

Table 3.5

Number of Personnel Completing Questionnaire #2
Within Each Facility Type

<u>Type of Facility</u>	<u>Number of Respondents</u>
Unit in University Department	9
Community Mental Health Center Outpatient Department	4
Large Government Hospital: >500 beds	17
Medium Government Hospital: 201-500 beds	2
Small Government Hospital <200 beds	14
Private Mental Hospital	2
Unit in Private General Hospital	2
Total	50

Table 3.6

Location of Professional Training for Questionnaire #2 Respondents

Place of Training	Number of Respondents
Home Country	29 (58%)
United States	18 (36%)
British System: England or Australia	2 (6%)
Total	50

Table 3.7

Occupation of Respondents for Questionnaire #3: Attitudes
Toward Culture Accommodation

Country	Psychiatrist	Psychologist	Social Worker/ Occupational Therapist	Nurse	Total
Taiwan	7 (3) *	5 (3)	5 (1)	3 (2)	20
Philippines	22 (8)	10 (4)	10 (3)	7 (5)	49
Thailand	10 (6)	9 (5)	3 (2)	1 (1)	23
Total	39 (17)	24 (12)	18 (6)	11 (8)	92 (24)

*First number indicates the number of respondents; number in parenthesis is the number of facilities from which they were sampled.

for 11 to 62 per cent of the nations' inpatient resources and up to 99 per cent of the capital city beds.

Table 3.4 offers a clear index of the survey's substantive depth. The number and diversity of staff answering Questionnaire #2 is especially important. It is the principal tool for gathering multi-disciplinary perspectives on the agencies' operations, problems, and community accommodation. Fifty staff from 22 agencies were interviewed with this instrument. Respondents are cross-tabulated by profession and country. The number of facilities from which the respondents were sampled is also indicated.

The questionnaire's strength lies in the large number of psychiatrists--directors ($n = 13$), supervisors and line staff ($n = 16$)--who were sampled with it. The psychologists ($n = 11$) and social workers/occupational therapists ($n = 5$) interviewed were far fewer, but were in proportion to their numbers. Few psychiatric nurses were obtained. On the average, 9.6 psychiatrists, 3.6 psychologists, 1.6 social workers/occupational therapists, and 1.6 psychiatric nurses per country were interviewed.

Based on these proportions, we may be highly confident that the data reflect the psychiatrist/administrator perspective in these countries. There is less certainty regarding the representation of psychologists and social workers/occupational therapists even though non-medical staff are numerically weak in these institutions. Furthermore,

there is little confidence that the data represent the nurses' perspective. Nurses, bearing the burden of day-to-day care for inpatients are the largest proportion of trained staff, yet only five were interviewed.

Tables 3.5 and 3.6 give additional data on the characteristics of the 50 staff administered Questionnaire #2. The first table shows that most respondents were from either large government hospitals with more than 500 beds or from small government hospitals with fewer than 200 beds. These two types of institutions, along with university psychiatric units, account for the vast majority of mental health manpower in the region.

Table 3.6 is noteworthy because it indicates the prevalence of foreign-educated professionals. Forty-two per cent of the respondents had specialty education abroad. Interestingly, Thailand alone accounted for 57 per cent of those educated overseas. Nearly all of the hospital directors and supervisors had overseas experience, but so did several senior psychologists and social workers. This points to the lack of training facilities in the allied disciplines in earlier years.

Finally, Table 3.7 presents respondents to the 16-item attitude scale on culture accommodation. Far more workers in all categories--especially the allied professions--were able to complete it. This brief scale was relatively easier to administer. With these fuller numbers, there is

more confidence that differences found in comparing attitudes across disciplines reflect variations in the perspectives of these workers. With a total number of 92 respondents from 24 agencies, there is also greater confidence that the attitudes expressed accurately represent the perceptions of Taiwanese, Filipino, and Thai mental health workers toward the value of accommodating programs to meet cultural needs.

ADDITIONAL SOURCES OF INFORMATION

To augment and add depth to the evolving picture of mental health delivery, two other sources of information were employed. The first of these was open-ended interviews with knowledgeable people in universities, government, private organizations, and international agencies. The questioning centered on the topic: "What makes psychiatry different in this country? Are there culture-specific or unique ways in which mental health services are designed to fit the expectations or life styles of the communities served? And how does the indigenous or folk system of mental health care influence the activities of psychiatric personnel?"

Additional inquiries were posed regarding "global" or national level variables affecting mental health services. These included questions about the availability of national health insurance, communication and cooperation among institutions, and mental health legislation. These open-ended items are given in Appendix F.

In addition, official documents and actuarial data were obtained relevant to agency operations and patient characteristics. These materials present the "official" picture of mental health resources and activities. They include hospital annual reports, public relations brochures, statistical yearbooks, national development plans, summaries of regional health activities, and legislation. Particularly valuable are a number of consultant reports and evaluations by WHO experts assigned to the region. Some of these documents were blueprints for establishing the current systems of care and training.

Professional Perspective Only

Before presenting the case studies, it is wise to keep in mind the bias and limitations which entered the data gathering enterprise. First, the case studies are restricted to the perspective of mental health professionals and administrators employed in various government and private institutions. The interviews and supplementary information collected represent as thorough an analysis as possible of what they say they are doing. This was accomplished by interviewing numerous staff occupying diverse agency positions. It is recognized that staff responses are influenced by their attitudes, prejudices, world view, and the desire to "look good." These aspects are part and parcel of the professional perspective under investigation.

From an anthropological perspective, it is just as legitimate to study the "culture" of the mental health provider and his setting as it is to do field work among the intended recipients of psychiatric services. It would have been ideal to do both. However, that option was closed off to the researcher when it was attempted. The community perspective enters the case studies through citations of anthropological and ethnopsychiatric writings and therapists' statements regarding client expectations and beliefs encountered in clinics.

Response Bias: The "Official" View
Versus Actual Practices

Secondly, it would be naive to accept the statements of these professionals at face value. Unquestionably, the desire for "impression management" motivates workers describing their facility to an outsider. Also, they are constrained to present an optimistic or "official view" of what they do and what the agencies' capabilities are, as opposed to what transpires "in reality." It must also be recognized that the investigator visiting these clinics represented a source of prestige. As a clinical psychologist, he was an "expert" in the American mental health industry. American standards of treatment are aspired to by those interviewed.

In Thailand, for example, it is culturally appropriate to tell such a visitor what the Thai think he would wish

to hear (M. Muecke, personal communication). This is not considered "lying." Rather, it is simply a way of making the guest feel comfortable, avoiding potential conflict, and "saving face." In other words, paying "lip service" is a modus vivendi among the Thai as it is among other culture groups in Southeast Asia.

The impact of this tendency to give socially desirable responses is mitigated in the case study analyses by several considerations. First, staff with diverse points of view were sought out to secure as many "biased" perspectives of agency functioning as possible. A more realistic picture emerged when these viewpoints were blended together. Second, the questionnaires were complex. They asked for specific examples of a certain practice and its availability and desirability. When inconsistencies in these three levels of appraisal were apparent, they were pointed out in the text. Third, with regard to staff perceptions of resource deficits (See Tables 4.13, 5.10, 6.10), a majority of respondents were quite open in revealing that many of the 31 items were indeed serious problems faced by their clinics. Interviewees responded differentially to these 31 problems. Some were deemed quite serious; others were not considered important deficits. This demonstrated an intention to fill out the questionnaire objectively.

Moreover, the interviewer worked hard to establish rapport and trust with these professionals. Anonymity was

promised to help create an atmosphere of open and honest exchange. The investigator sought to demonstrate an awareness of--and a genuine concern for--the problems of the care providers. It was felt that they responded, with few exceptions, with sincere answers. In fact, many interviewees were quite frank about the limitations they saw in their systems, especially those trained overseas. They seemed to welcome the opportunity to talk with a researcher interested in their opinions.

Another factor limiting response bias was that conclusions from WHO consultant surveys were compared with findings of this investigation and found to be compatible. WHO data were integrated into sections dealing with overviews of national service delivery.

Lastly, the case studies present descriptions of the structure and organization of psychiatric services. These data represent the potential resources for providing psychological care, not the actual quality of care provided. Thus, the information errs consistently on the side of optimism. It is a "conservative" or stringent test of the research hypothesis that Western standards of psychiatry are not feasible in these developing nations. In other words, if the systems fall short of the established criteria of "modern" psychiatry--even when given the benefit of the doubt based on available structure (i.e., number of hospitals, specialty units, manpower resources, etc.)--it strengthens

the conclusion that the Western model is inappropriate.

Sampling Bias: Only English Speakers
and Those Willing to Talk

Finally, there may be questions about sampling bias with regard to those interviewed. Indeed, there was an unmistakable tendency toward interviewing psychiatrists and those who spoke English. In fact, 42 per cent of the total Southeast Asian sample had received advanced professional education abroad, either in the United States, Australia, or Britain. These were a select group with regard to training experience, international perspective, and motivation to talk with a visiting psychologist. On the other hand, their opinions had considerable value. They appeared quite interested in discussing this topic and well-suited to critically evaluate the status of their facilities. Furthermore, these experienced professionals were able to quickly grasp the nature of the survey and formulate their perspective without difficulty. In essence, these persons are the transmitters of modern psychiatry in their home cultures. Their professional goals reflected that aim. Their experiences and dilemmas in the enterprise are the heart of the case studies.

SUMMARY

This chapter illuminated the interview instruments constructed for surveying the status of mental health

resources in Southeast Asia. Considered also were the procedures for discovering and making entry into the mental health networks of personnel and facilities. The investigator's guiding principle for selecting subjects was to "exhaust" the elements of the network. That is, to locate and interview many different knowledgeable sources-- practitioners, academicians, researchers, government officials, international consultants, and multiple levels of clinic staff. The intention was to gain a balanced, diverse perspective of psychiatry and folk healing in each setting. Tables 3.2 through 3.7 summarizes the extent to which the researcher was successful in finding multidisciplinary staff to interview with the three questionnaires. These tables also indicate the wide variety of agencies selected for survey work.

In addition, potential limitations of the questionnaires were aired. The survey perspective is that of institutional personnel only. It is predicated on the expressed perceptions and opinions of psychiatrists, psychologists, social workers, etc., regarding their work places. Sampling bias and the desire of respondents to "look good" or "save face" are potential threats to the reliability and validity of the information collected. However, interview procedures and principles of data interpretation were implemented to offset these limitations.

In the following three chapters, these various forms

of data are integrated to form case studies of Taiwan, the Philippines, and Thailand. While presenting an overview of mental health resource status, each case study addresses two issues: Is the Western model of modern psychiatry feasible for the region? And is the Western model culturally sensitive--acceptable and accommodating--from the standpoint of these Asian societies?

IV. MENTAL HEALTH SYSTEM OF TAIWAN

INTRODUCTION

Taiwan is a province of China separated from the mainland by the Taiwan Strait. Lying just 90 miles off the southeast coast, it is a mountainous island measuring 243 miles long, 88 miles wide, with approximately 14,000 square miles of area. Taiwan's population was 16,609,961 in April, 1977 (Europa, 1977). Its density of 1,186 persons per square mile is one of the highest in the world. While the Eastern portion of the island is mountainous with few inhabitants, the Western coastal plain is fertile containing more than 2,300 people per square mile.

Taiwan's history has been dictated by proximity to powerful neighbors and her position along the sailing routes of European traders. The earliest inhabitants, tribes of Malayan origin, saw Chinese settlers arrive in the fourteenth century. Spanish and Dutch settlements sprang up in the 1620's in the Northern and Southern parts of the island respectively. The Spanish were dislodged from Taiwan by the Dutch in 1642. Twenty years later the Dutch were driven from the island by the Chinese war lord, Coxinga, loyal to the Ming Emperor. An invasion by K'ang-hsi in 1663 ended a tumultuous century of struggle for the island. It became property of the Manchu dynasty until ceded 240 years later to Japan following the Sino-Japanese war of 1895.

The mid-twentieth century saw another series of profound changes for Taiwan. With Japan's defeat, the island was given over to the Nationalist Chinese Government in 1945 and became one of China's 35 provinces. Four years later, 2 million Nationalist government officials, soldiers, and their dependents--under pressure from the Communists--moved en masse to Taipei, Taiwan's capital. In one year, the population grew from 6 million to more than 8 million. The "indigenous" Fukienese, Hakka, and Aboriginal groups made room for the mainlanders who had abandoned their homeland provinces. The Nationalist authorities, under the direction of Chiang Kai-shek, quickly set up Taipei as provisional capital for the Republic of China. Chiang's government maintained theoretical sovereignty over the mainland provinces. Today, Taiwan is viewed by both the Communists and Nationalists as a province. Functionally, however, it is an island nation with both a national and provincial governing apparatus.

The post-war, post-migration evolution of Taiwan has been dramatic. Aided by an infra-structure left by the Japanese colonial administration and massive American aid in the 1950's, Taiwan has become an economic success story rivaling those of Japan and South Korea. Cut off from its former mainland market, the island turned toward the development of a modern industrial sector oriented toward world trade. The shift has resulted in substantial progress toward

prosperity. Today, Taiwan is the world's 22nd largest trading nation, exporting over 8 billion dollars worth of products in 1977. In the last 26 years, the G.N.P. has risen from a meagre 1.33 billion to 17 billion dollars; a rate of 8.3 to 11 per cent per year. Per capita income has increased seven-fold since the early 1950's to a respectable \$809 in 1977 and a projected \$1,400 by 1981 (Time, 1977). Other measures of success show Kaohsiung Port in the South as the world's 12th largest in total tonnage handled. Taiwan's manufacturers are leading suppliers of such diverse products as umbrellas, tennis racquets, and footwear. Moreover, the average Taiwanese has the highest caloric intake in Asia, 2,800 calories per day (Time, 1977).

Taiwan's economy has slowed little since her expulsion from the United Nations in 1971 in favor the the Peking government. the United States has more than \$500 million invested in the island's economy. In 1977 alone multi-national corporations like Union Carbide and Phillips have put up \$300 million (Time, 1977). There has, however, been a recent slowdown in domestic investment as Chinese businessmen, reacting to an uncertain political future, send their money abroad.

The shift from agriculture dependency to manufacturing for world export has stimulated a population re-distribution from rural areas to urban centers. In 1957, 29 per cent of the population lived in cities of 100,000 or more. By 1974

this percentage had increased to 42 per cent. This is in contrast to the Chinese mainland where perhaps 85 per cent of the population reside in the countryside. The five major cities include Taipei, the capital, with 2,108,193 inhabitants; Kaohsiung, the shipbuilding center, with a population of 1,028,334; Taichung and Tainan, port harbors on the Western coast, each with over half a million people; and Keelung, the northernmost city where a nuclear plant is being built. Administratively the island is divided into 16 counties and 345 townships.

HISTORY OF TAIWANESE PSYCHIATRY

Against the backdrop of Taiwan's dynamic post-war development, an equally ambitious scheme was created for a national mental health program. The person most responsible for laying the foundations of Taiwanese psychiatry was Tsung-yi Lin. A planner and administrator with remarkable vision, Lin has become an internationally distinguished leader of psychiatry through influential roles with the World Health Organization (WHO) and the World Federation for Mental Health (WFMH). Immediately after the war, however, Lin returned from medical training in Japan to inherit a psychiatric system devoid of personnel--all Japanese psychiatrists were repatriated--and consisting of a few buildings housing unattended psychotics.

Lin stepped into this vacuum at a time when the government was preoccupied with reorganizing the nation's

political, economic, and educational spheres. Fellow health professionals were burdened by the immediate tasks of combating acute infectious diseases and restoring public health services to the pre-war level (Tseng, 1975a). Besides being overshadowed by these national priorities, additional forces confronted Lin in the early days. Especially troublesome were the traditional indifference, ignorance, and prejudice among both professional and lay people about psychological care. In his favor, though, was the rare opportunity to begin carte blanc. He could create his own vision of a rational program of mental health care. There were no blueprints or other precedents available from the colonial past to mislead and bind the planner to the traditional, custodial trappings--the legacy in many South-east Asian settings.

Lin conceived the mental health program as a three-stage plan developing over 25 years (Lin, 1961). The first stage called for psychiatry's integration into medicine as a respectable discipline within a medical school curriculum. Secondly, mental health content should be integrated into general public health practice. Lastly, its principles should be instilled into the nation's educational scheme.

Clearly what is most striking about Lin's envisaged program are its guiding themes of social, community, and preventive psychiatry. Fifteen years later these became the new currency for the mental health movement in the United States.

From its early onset, Lin sought to mold a program oriented towards the community. Its services were to be dispensed through the public health system of general hospitals, health stations, or even schools. He emphasized day care, home care, and rehabilitation programs backed up with inpatient facilities. Concurrently, he focused on getting mental health education into the general medical curriculum for physicians and nurses, and on teaching to general practitioners as opposed to creating a few specialists. Lin's conception was to initiate a psychiatric system strongly formulated along non-custodial lines. Ideally it would be accessible to the public, diffused through existing health networks, and somehow responsive to Chinese patterns of health care attitudes and local problems.

Initial Foundations

The first task in generating Taiwan's mental health program was to develop a Department of Psychiatry and Neurology within the National Taiwan University Medical School Hospital (NTUH). The neurological component was essential to undermine opposition from the other medical branches and gain respectability. A psychiatric center was established at NTUH where Lin gathered a nucleus of colleagues. This center became the birthplace of modern psychiatry for the nation: the source of innovation in services, therapeutics, research and teaching.

The early duties of Lin and his core staff were threefold. First, a curriculum was set for educating psychiatric nurses and undergraduate medical students. After a modest beginning, two American consultants helped to launch the teaching component by making it a mandatory clerkship and having half of the students intern in psychiatry during their final year. The second function was to open an outpatient and small inpatient service to the public. According to Tseng (1975a), the center was quickly flooded with people requesting care. Lastly, a survey was undertaken between 1946 and 1948 to ascertain the magnitude of psychological disorder in the community.

The results of the prevalence study had enormous implications for planners. It found that 10.8 individuals out of a population of 1,000 needed some psychiatric attention, and that 95 per cent were without any modern treatment whatsoever. Lin used these data to both dispel the myth that Chinese culture moderates psychopathology and argue for the relevancy and continued expansion of his program. This was a rare example where needs assessment, through an epidemiological survey and study of existing community resources, became the basis for determining an educational and community mental health program (Lin, 1961). This research theme continued with epidemiological studies of Aboriginal mountain tribes, high blood pressure, and a 15-year follow-up of the original groups. Investigations

were also done of child development and the effects of family attendance on the psychiatric ward.

Bi-lateral and international input into the mental health program was another factor crucial to its development. A fully operational and modern Department of Psychiatry required upgrading the educational experiences of Lin and his colleagues. It became essential for teaching staff to secure advanced training abroad in different specialties then return to build a competent post-graduate program. Aid came in the form of WHO fellowships and assistance from the American Bureau of Medical Aid to China.

Seeking what he considered the best overseas training possible, Lin initiated ties with Harvard University. He went there in 1950 to study neurology. Upon his return other faculty were encouraged to develop their specialized interests within clinical psychiatry. Lin was enthusiastic about the conceptual orientation of the Boston group, which at that time included Harry Stack Sullivan, Gerald Caplan, and Erich Lindemann. Hsien Rin was sent to Harvard in 1955, and was soon followed by Chen-chin Hsu and Chu-chang Chen who studied child psychiatry and group psychotherapy respectively. More than a dozen trainees in psychology, psychiatry, social work, and nursing followed these initial sojourners over the next 15 years. They pursued studies in London, Boston, and elsewhere in the United States. Most were funded through WHO, but the United States Agency for

International Development (AID) and the Esst-West Center were also sponsors. Returning staff became graduate instructors and were called upon to direct new service projects within their specialties.

International assistance played other roles besides offering traineeships. As previously mentioned, consultants to the medical school lent their weight towards integrating psychiatry more firmly into the general curriculum. In 1955, Dr. Gundry carried out a WHO survey for Taiwan. He recommended that the child psychiatry division be enlarged to function as a demonstration center for child guidance: to serve as a teaching, training, and research center in child psychiatry (HSU, 1972). As a consequence, the Taipei Children's Mental Health Center (TCMHC), affiliated with the Department of Psychiatry and Neurology, was opened in 1956. Shortly thereafter Hsu spent two years training at the Judge Baker Guidance Center and Harvard University Children's Medical Center. Funds for the construction of TCMHC and for the building of a new 400-bed mental hospital in Kaohsiung and training its personnel were provided by the United States International Cooperation Administration Mission to China (ICA).

Expansion of Services

Taiwan's Provincial Health Department (PHD) drafted a Ten-Year Health Plan in 1964. In that report Dr. Lin summarized the mental health program's previous 18 years,

projected its goals for the next ten years, and described some difficulties. Mental health services and activities had expanded on several planes. Graduate education was organized in 1956 based on the themes of local training to meet the sociocultural needs of Chinese patients, theoretical eclecticism, and multi-disciplinary teams for service delivery (Lin, 1961). In 1954, the Child Mental Health Division began looking for ways of working with teachers in an early identification and primary prevention capacity. A mobile clinic begun in 1959 stimulated teacher interest in acquiring mental health concepts to deal with problem children. This interest grew into a series of seminars. One year later a special demonstration program, the East Gate Project, was set up with two objectives. The first was to teach basic knowledge and skills in mental health to all teachers of the school; the second part was to train leaders to establish counselor's offices (Hsu & Lin, 1969).

The pilot project brought governmental attention to the need for funding counselor training and work with learning disability children. By 1964 there were 26 schools affiliated with TCMHC receiving consultation in handling problem children.

On the research plane, the preliminary epidemiological survey (which had sampled 20,000 subjects in three communities) was replicated. New findings showed a significant increase in all categories of disorder except

schizophrenia. These were partially attributed to life stress associated with the massive arrival of immigrants from the mainland that had taken place since the first survey in 1946.

In 1964 Lin's perspective of the future called for intensifying University Hospital's use as a national training center for psychiatrists, psychologists, social workers, and nurses. Hopefully, teams of trained workers could be placed at key points in the existing public health system. Provincial general hospitals would add psychiatric units as personnel became available. These would function as centers for domiciliary, preventive, as well as clinical activities. Mobile mental health clinics would meanwhile serve the public through visits to general hospitals and health centers until specialized units could be added. Organizationally, the local health stations and public health centers would coordinate their services with the newly created acute care units in the general hospitals. Mental hospitals at Kaohsiung and Shikou would serve as regional centers to provide long-term treatment. Rehabilitation for chronic cases would be carried out at the 600-bed sanatorium to be built at Yu-li. A second children's mental health center was planned for 1972 completion in Kaohsiung. Like the TCMHC its focus would be on the prevention of disorder through programs in the schools and public health centers.

In general, the 10-year goal (1964-1975) was for a complete integration and expansion of mental health services into the public health program. The integration would accrue benefits to the entire population of Taiwan served by the provincial and local health systems.

Problems salient to Lin in 1964 were personnel and funding shortages and TCMHC's temporary status which made it difficult to carry out teaching and research duties there. More serious was the absence of a medical officer in the PHD to direct implementation of this plan. This shortcoming remains today. In his report, Lin urged the PHD to assume responsibility for planning and carrying out the program, training the various workers, and supervising direct services. He stated, by way of justification, that, "since mental health is a public health problem, PHD should be able to secure the funds required" (Lin, 1964, p. 177).

NATIONAL ORGANIZATION OF PSYCHIATRIC SERVICES

National Administration

In terms of administrative structure, mental health does not exist in Taiwan. None of the three levels of health administration for the country--National Health Administration, Taiwan Provincial Health Department (including county and city services), and Taipei City Health Department--contains an administrative bureau, division, or committee responsible for mental health programs. Responding to Lin's plea, the Department of Health did establish in 1968 a

Committee for Mental Health at the provincial level. Its aim was to undertake planning commensurate with the Ten Year Mental Health Project (PHD, 1970). The Committee, composed of PHD administrators, consultants from NTUH, and superintendents of the public mental hospitals, met occasionally until August, 1972. In fact, its main involvement was with training mental health personnel. In 1972, however, it was disbanded and its functions theoretically integrated into the operations of a related PHD department (National Health Administration, 1976).

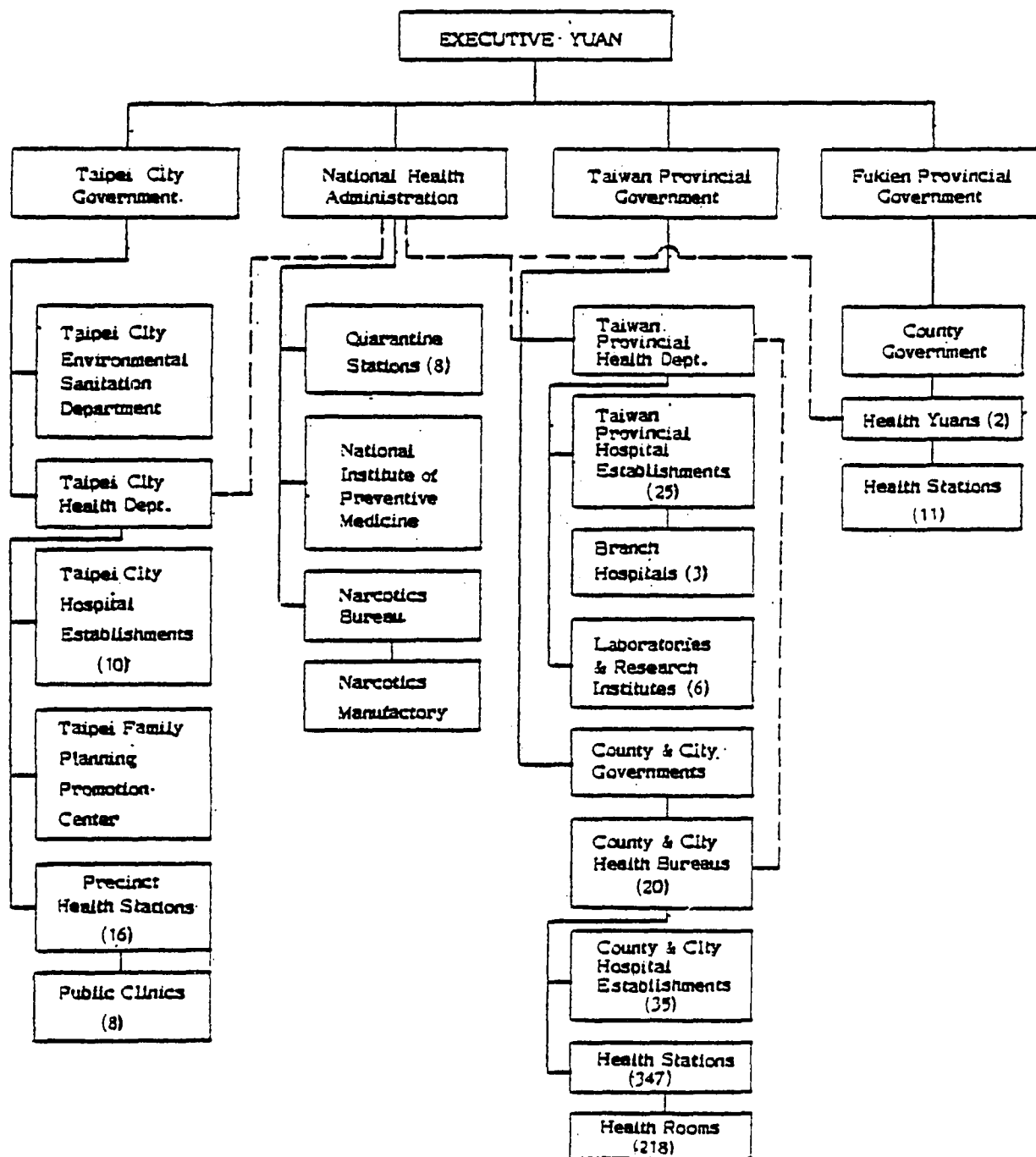
The low priority assigned psychiatric care is reflected both in its non-identity within the bureaucracy and the fact that it was the 11th and last priority item considered in the Ten Year Health Plan. Budget-wise it was 6th priority in relation to the other programs listed (PHD, 1964). Its total ten-year cost was estimated at \$5,762,736. This figure can be compared with the highest budget item, "Medical Care," predicted at \$27,091, 131.

The place of psychiatric care can be better appreciated by knowing the overall public health system in which it functions. Tables 4.1, 4.2, and 4.3 offer administrative overview charts of the three health organizations.

Table 4.1 shows that all health bodies are under the Executive Branch (Yuan) of the National Government. The National Health Administration (NHA) has a functional, although not directly administrative, relationship with

Table 4.1
Administration Set-up of Taiwan's Health Organization

June 1977



Key: ——— Administrative responsibility
 - - - - - Functional relationships

Taken from Health Statistics: General Health Statics, Republic of China, 1976. Taipei, Taiwan: National Health Administration, 1977.

both the Taipei City and Provincial Health Departments (THD, PHD). All three departments have separate budgets, although they share some sources of funding. It is worth noting that at the National level, health has a lower administrative position and less priority than, for example, education, which operates at the ministerial level.

Table 4.2 shows the principal service centers for the province. The delivery system components include 20 county and city health bureaus, 347 local health stations with 216 branch village health rooms, 423 mobile health units, 26 provincial hospitals, 18 county and city hospitals, and various disease hospitals and control stations. The Provincial bed capacity is 9,052; 3,700 (41 per cent) are situated in Taipei. Within this network, there are three mental hospitals located at Yuli, Taipei and Kaohsiung. Bed capacity for these three facilities is 2,600 or 29 per cent of the total available for general health.

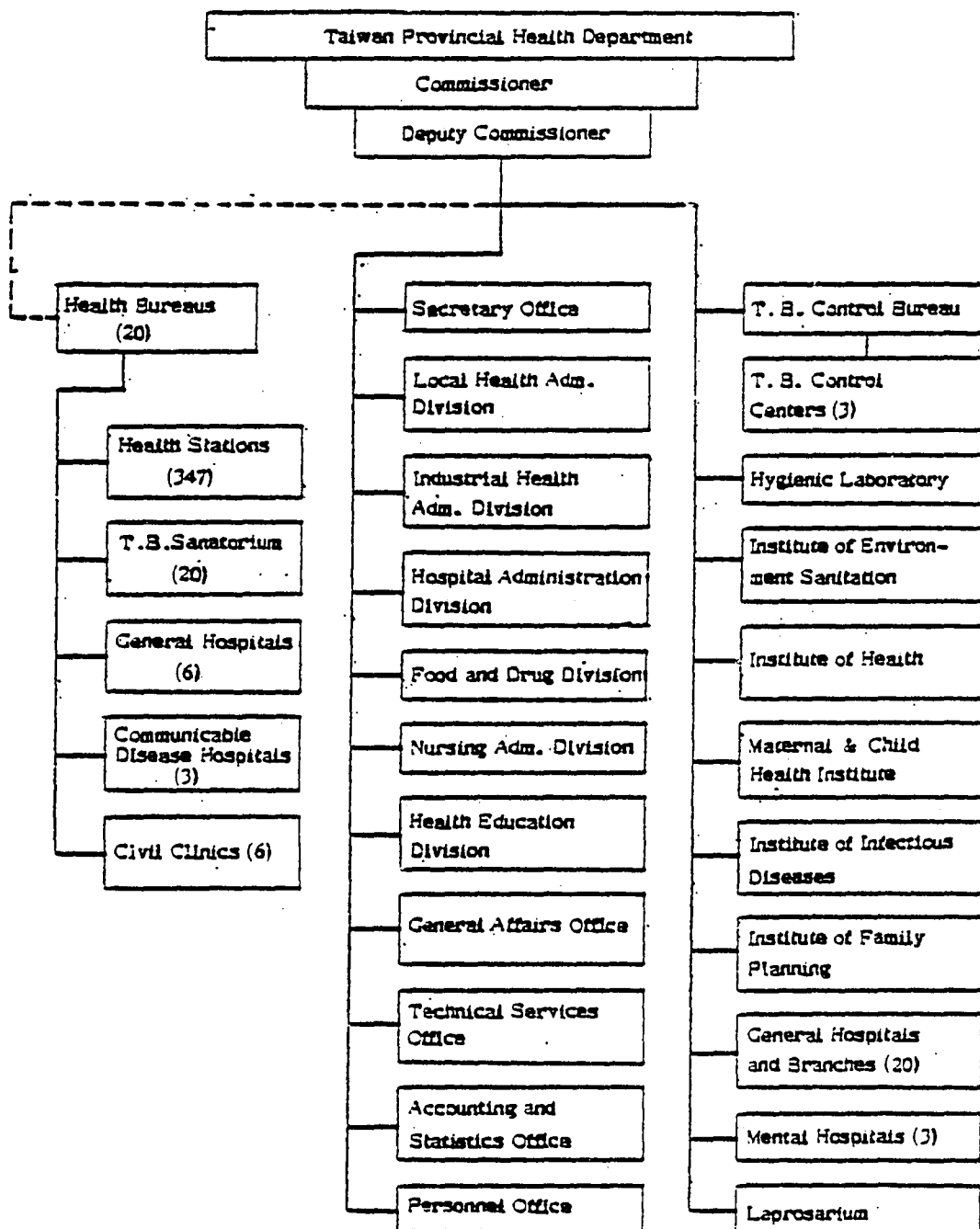
Health services for Taipei City are presented in Table 4.3. The city is divided into 16 districts and serviced by a health station for each area. Four general hospitals and four other specialty facilities serve the metropolitan area under city jurisdiction. Taipei sponsors one mental hospital, the 150-bed Taipei City Psychiatric Center (TCPC) plus the TCMHC which offers outpatient and day care services.

This public health program is by no means the complete health picture in Taiwan. The majority of people utilize

Table 4.2

Organization Chart of Taiwan Provincial Health Department

June 1977

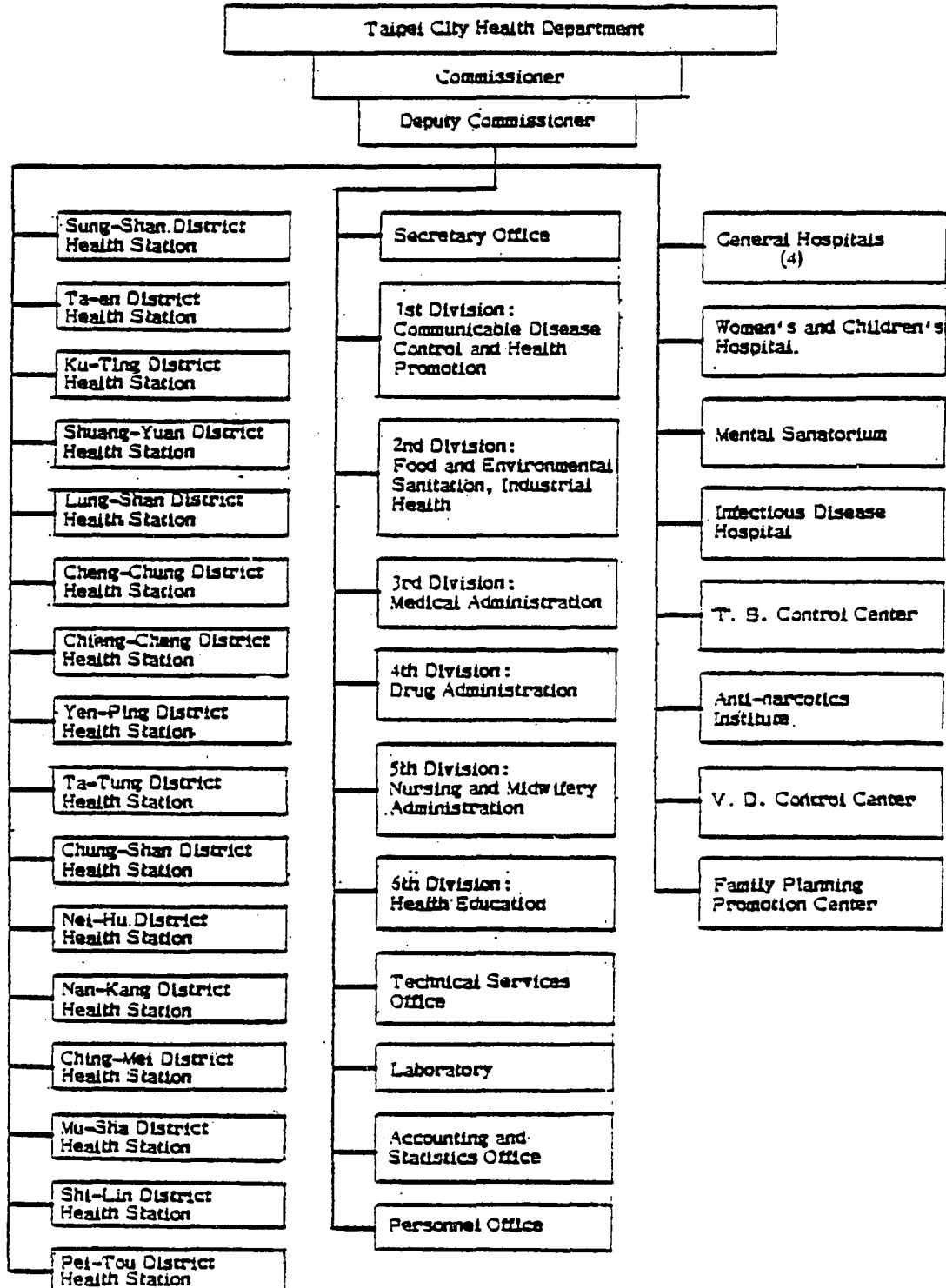


Taken from Health Statistics: General Health Statistics, Republic of China, 1976. Taipei, Taiwan: National Health Administration, 1977.

Table 4.3

Organization Chart of Taipei City Health Department

June 1977



Taken from Health Statistics: General Health Statistics, Republic of China, 1976. Taipei, Taiwan: National Health Administration, 1977.

private practitioners. There are approximately 8,563 hospitals/clinics in the private sector with over 18,600 beds. More than 2,000 private beds are in Taipei alone. In terms of psychiatry, 60 private mental hospitals and clinics exist with an accumulated 1,750 bed capacity. Moreover, the military operates 11 veteran's hospitals in affiliation with the Veteran's General Hospital, a modern and prestigious 1,500 bed compound in Taipei. Among the veteran's hospitals and the Army general hospitals, it is estimated that there are some 3,800 psychiatric-designate beds (NHA, 1975). Several of these facilities, notably at Puli and Pei-Tou, are used primarily as long-term care centers for chronic patients.

Health planners are very concerned about the typical maldistribution of services (e.g., Tsuei, 1978). Tsuei (1978) points to Taipei as the vortex of both general and specialty health services for the country--at the expense of rural areas. Not only are there 10 city and 5 large private hospitals concentrated there, but all three government medical schools (each affiliated with a large teaching hospital) are located in Taipei. Of the 32,452 medical beds in the country, 7,172 (22 per cent) are found in this one metropolitan area holding 12 per cent of the populace. In other terms, Taipei has 34.7 beds per 10,000 people. The rest of the nation has only 17.7. Analyzed geographically, outlying areas have access to 0.7 beds per square kilometer

while the capital enjoys 26.4 beds per square kilometer. These figures hold for physicians as well. Taipei has over twice as many physicians per 10,000 population as the rest of the country: 13.9 versus 6.0 per 10,000. Interestingly, 80 per cent of the population employ non-governmental physicians to treat their ailments (Tsuei, 1978).

From this brief sketch of the overall health system of Taiwan, it is possible to weigh the significance of its psychiatric care component. Mental health does not have an administrative identity within the three health departments. Hence, the design of a rational strategy for innovation, expansion, or evaluation, such as took place under Lin's participation in the Ten Year Plan, can only arise on an ad hoc basis. Lin's vision of adding new psychiatric units yearly to the general hospitals fell short. Only one such hospital in Tainan has established a fully staffed department.

In brief, there are three provincial mental institutions and one city hospital with a total of 2,750 public beds. The three major teaching hospitals in Taipei have approximately 100 beds altogether. There are perhaps just over 5,000 additional beds in veteran's hospitals and other private hospitals. Active treatment in these settings is marginal; drug/custodial management is the principal mode.

To summarize, about 3,000 beds are associated with active therapeutic intervention and 5,000 beds for managing

chronics. Translated into global population terms, there are 5,533 persons for each therapeutic bed and for all classes of psychiatric care, one bed per 2,075. In addition, about 100 trained psychiatrists practice within these settings. This contrasts with the almost 10,000 licensed general practitioners. Taiwan has only two Ph.D. level clinical psychologists. These figures strongly underscore psychiatry's tenuous position even within the government's medical service framework.

Budgetary Allocations

Another indicator of mental health priority is its monetary allocation within national and public health budgets. In 1975, the National, Provincial, and Taipei City budgets for public health amounted to 0.08 per cent, 4.03 per cent, and 6.03 per cent of their respective total budgetary allocations (NHA, 1976). The following year, a total of \$58,000,000 (including foreign aid contributions) was expended on health among all levels of government. The Taiwan Provincial Government--with \$38,000,000 to spend--has almost 60 per cent of the total health budget. This compares with an overall national budget of 4 1/2 billion dollars, including over 1 billion spent for defense alone. Therefore, about 1.29 per cent of the national expenditure went to health concerns (Europa, 1977).

Lin first calculated the Mental Health Program's budget in the 1964 Ten Year Health Plan. He saw an initial

capital outlay of \$350,000 for constructing a custodial care hospital at Yuli, setting up 15-bed acute care wards in provincial hospitals each year, and a new children's clinic in Kaohsiung in 1972. By FY 1975, the complete operating budgets for the mental health program were projected at \$810,000.

Health Statistics (NHA, 1977) gave details of money spent for four government mental hospitals in 1976. It showed that expenditures far exceeded these earlier estimates. For example, the Provincial Taipei Mental Hospital alone required \$3,626,000. Yuli and Kaohsiung Hospitals spent \$913,132 and \$725,649 respectively. TCPC, whose opening caused a cutback in expansion of TCMHC, expended \$365,187 during the same period. These four facilities account for a surprisingly significant 9.71 per cent of the overall health allocation.

What these figures reflect are both the extraordinary burden of long-term custodial care and the expense of operating teaching facilities--major functions of Kaohsiung Hospital and TCPC. Not included are NTUH, Tainan's Department of Psychiatry, and the community mental health centers at Taipei, Kaohsiung, and Tai-chung.

Other Factors Influencing the Delivery of Services

The status of psychiatric care in Taiwan has been considered in relation to the public health delivery system and the degree of financial endorsement given to major

inpatient facilities. Other factors at the national level are also associated with the nature and quality of mental health services. They involve availability of insurance, training opportunities, brain drain problems, and the visibility or perceived need of psychological resources identified through epidemiological surveys.

Insurance

Insurance or third-party payment governs the behavior of both health care providers and those seeking help. Insurance providers have the power to decide who the clients are plus which type of personnel receive payment for their services. A national health insurance for multiple categories of citizens is not available in Taiwan. People are generally responsible for their own medical needs except for "indigents" who receive government subsidized treatment (NHA, 1976). The other exceptions to this generalization are government employees and certain laborers. These individuals, amounting to about 10 per cent of the population, receive free medical attention as beneficiaries of two insurance plans. The remaining 90 per cent (excluding military personnel) must personally pay to visit a physician, including a psychiatrist.

Although the TCPC does have a new program to accept a few low-income patients, the specialized services of psychiatric hospitalization or consultation are restricted to the slim percentage who can afford them. Moreover, economic considerations dictate treatment policy. Those who pay can

only afford brief, drug-oriented interventions with minimal hospitalization. Repeated sessions for verbal psychotherapy are out of the question. Most clients reject talk therapy approaches because they are both too expensive and fail to fit Chinese conceptions of medical care.

Training Opportunities

Until the early 1970's, NTUH was the only training ground for Taiwan's mental health manpower. Its core staff was responsible for determining the country's course of action in this area: it researched program needs, conceived service delivery components and educated a multi-disciplinary group to operate the clinics.

The orientation transmitted by Taiwan's first psychiatrists to their students originated from contact with the social and community psychiatry formulations of Harry Stack Sullivan and Gerald Caplan. The educational relationship with American psychiatry, a source of advanced training, consultation, and funding, gave psychiatry at the National Taiwan University a "contemporary" character from the beginning. It was contemporary, that is, as defined by the American preoccupation with psychoanalytic theory and socio-cultural aspects of psychiatry. This contrasts with the Kraepelinean or "descriptive" approach adhered to by the European-influenced psychiatric educators throughout Asia.

NTUH continues to dominate psychiatric education in Taiwan although its early driving force, Tsung-yi Lin, departed for the director's position of WHO Mental Health Division in the mid-1960's. Now, however, psychiatric residency is available at the psychiatric unit of the Tri-Service Hospital (serving the Army, Navy and Air Force); TCPC, directed by a NTUH professor, Eng-kung Yeh; Veteran's General Hospital; and at the provincial mental hospital in Kaohsiung.

Even with these new training centers opening up, academic psychiatry remains tightly constricted. Critical problems arise because there are few positions and very little institutional pressures within the private and public sector to create new ones. Lin had sought to circumvent this problem through creation of psychiatric units in government hospitals but the idea never materialized.

The key question is where to place professionals when existing university departments are restricted in size and number by limited resources? The growth in the number of qualified individuals, some of them trained in prestigious schools overseas, creates the demand for assignment to responsible positions commensurate with educational status. Such opportunities simply do not exist for more recent graduates. Adequately funded positions in private hospitals or rewarding governmental assignments are also scarce because of psychiatry's relatively low priority. Under

these conditions it is more advantageous for qualified personnel to leave the country. In fact, many have left over the last 10 years.

Brain Drain

A number of factors have combined to make "brain drain," the loss of well-educated mental health workers, a severe problem for Taiwan. The lack of jobs within prestigious institutions like NTUH is a major one. Another factor is that almost a score of the brightest students were sent abroad. Many earned degrees qualifying them to work in their host country. Returning to Taiwan, they were sometimes placed in the awkward position of working under former teachers who were educationally less sophisticated than themselves. Yet, because of the age-related seniority system, the older staff were able to maintain their more powerful positions. Consequently, some returnees were frustrated in efforts to try out newly learned skills or teach their specialties.

On a different plane, Tsung-yi Lin's departure left a leadership vacuum difficult to overcome. He was a powerful, authoritative figure. Nationally and internationally recognized, Lin was capable of gaining support for the discipline's expansion within Taiwan. A successor had not been cultivated prior to Lin's departure. In the transition, the program's dynamism and attractiveness to new students began fading. Factionalism emerged over the question of

whether psychiatry and neurology should be split into separate departments. In this atmosphere, the opportunities overseas became more attractive. Especially vulnerable were those who felt their advancement chances limited and saw more possibilities for professional and personal freedom abroad.

A final influential factor is the political uncertainty of Taiwan in the face of withdrawal of political recognition by the world community. Taiwan's fading political position has pushed its professionals outside the circuit of communication and knowledge exchange fostered by international agencies. This lack of stimulation and support from abroad cannot help but reduce the development and innovation of its programs.

Needs Assessment

The last factor giving shape to the character and quality of Taiwanese psychiatry is the intensive survey documentation of psychological problems and research pinpointing the social stresses presumed to be their determinants. Taiwan, perhaps more than any other country in Asia, has made direct use of epidemiological findings to promote and plan its mental health program. This is attributable to the fact that Tsung-yi Lin, Hsien Rin and Jung-ming Chu, principal investigators in the three major epidemiological investigations, were also the key figures in conceiving and implementing the country's system of

mental health care (Lin, 1953; Lin, et al., 1969; Rin, Chu, & Lin, 1966).

In appraising the psychiatric needs of Taiwan, these researchers gave full attention to the linkage between the socio-cultural variables and patterns of disorder. The identification of high risk groups led them to closely examine the effects of migration stress, sex and sibling rank, rural versus urban residence, and the consequences of giving up traditional value orientations under pressure of modernization (e.g., Chance, Rin, & Chu, 1966; Chu, 1972; Ko, 1975; Lin, et al., 1969; Rin, 1969; Rin, et al., 1966; Rin, Schooler, & Caudill, 1973).

Several findings highlight the impact of culture on rates of disorder. For example, Rin (1969) found that the highest proportion of psychophysiological reactions were among youngest-born females, while the eldest sons were over-represented among psychotic inpatients. Extreme family role differentiation by age and sex were used to explain this phenomena. The youngest girls are the object of intra-familial tension and aggression. They are sometimes put up for adoption in times of economic hardship. Predictably female suicide attempts account for 77 per cent of the total cases at Taipei's suicide treatment center (MacKay Counseling Center, 1976). Older brothers, on the other hand, enjoy the most privileged offspring position. Encouraged to be dependent, they are pampered, over-indulged and unprepared

for later high pressure situations. School competition is the first major stressful experience for males; entrance into a good university insures subsequent attractiveness to employers.

Rin, Schooler and Caudill (1973) summarized other findings from the NTUH epidemiological studies. These showed that groups undergoing rapid social change did have elevated rates for psychoneurosis, although no positive correlation emerged between change and psychosis. Comparing those individuals who fled to Taiwan during the mass migration of 1949 with native Taiwanese Chinese, the former group showed more susceptibility to neurosis. The Taiwanese had a greater proportion of mental retardation. For the migrants, being a female and dramatically losing one's socioeconomic status were strong predictors of neurotic symptoms. Also at risk were men who abandoned their traditional value system for identification with modern modes of thinking without sufficient knowledge of modern social life nor inter-cultural contact. Men with modern values plus higher inter-cultural contact, or men who clung to a traditional value core although interacting with modern society, fared much better.

Another cultural element derived from the current political climate has been identified by Yeh (1972) from his clinical work with Chinese students. Apparently, the strict security control and prevailing tensions associated

with the omnipresent "threat" from the mainland fosters a social norm of defensive and distrustful behavior. Psychological security is found only within family and primary kinship groups. Insecurity is felt with most "outsiders." "One must be cautious about his own behavior and be vigilant against others to keep from being cheated," is a typical attitude. Yeh sees this as generating a "paranoid society." It is particularly evident in the delusional--yet somehow real--themes of students in therapy.

Taken together, these studies served both to advance the disciplines of transcultural and social psychiatry and form the basis for requesting new treatment programs for high risk groups. In recent years, programs for counseling college students, adolescents, and suicidal individuals have joined the already operating adult and child treatment centers in Taipei (Tseng, 1975). The provincial government has also begun three community mental health centers. The first one started in 1974 at Hsin chuang, Taipei County. Taipei City has initiated a mental health project to deliver services through the city's health stations. It is under the supervision of staff from five psychiatry departments. From the perspective of rational planning, the direct link between research and services found historically in Taiwan is both exemplary and rare.

PSYCHIATRIC RESOURCES AVAILABLE: SELECTED EXAMPLES

The preceding sketched Taiwanese psychiatry at the national level. The place of mental health services within the public health system was described in terms of administrative structure, facilities, and funding. Other variables of national significance influencing the nature of psychiatric care were mentioned. These included health insurance, training at NTUH and the important changes that have taken place there overseas, departure of professionals, and the role played by needs assessment data.

In this section, the focus of analysis shifts to a lower level. Services actually undertaken at selected sites are reviewed. A framework is introduced for describing the resource potential of sampled facilities. The framework variables are: 1) comprehensive services; 2) prevention programs; 3) continuity of care within facility; 4) continuity of care into community; 5) inter-institutional continuity of care; 6) accessibility of facilities; and 7) staff evaluation of resource strength.

The rationale for choosing these seven variables was given in Chapter III. Basically, they describe the components of a modern mental health delivery system as planned in the United States or recommended by WHO experts. These variables will be used to provide a framework for portraying therapeutic resources among all countries investigated in this study.

Overview of Taiwan's Mental Health System

Table 4.4 gives a summary of major residential treatment centers in Taiwan. Private as well as city and provincial funded facilities are included along with their approximate size. The word "teaching" indicates those sites providing training for psychiatric manpower..

Table 4.5 gives a list of important outpatient and counseling centers. Most are situated in the Taipei area. An asterisk (*) preceding the name shows those centers where staff were interviewed for this survey. The list given in Table 4.5 is not exhaustive. It does, however, account for those well-established and publicly visible counseling services on the island.

Resource Potential of Selected Sites

Sample

Intensive interviewing using Questionnaires #1, #2, and #3 was undertaken at TCPC, NTUH, TCMHC, Northern Area Community Mental Health Center (NACMHC), Tri-Service Department of Psychiatry (TSP), and Jen-Chi Charity Mental Hospital. Visits were also made to the Taipei City Community Mental Health Project, Professor Chang Counseling Center, Hua-Ming Counseling Center, and MacKay Hospital's Life-line Suicide Counseling Center. At these agencies, additional interviews were conducted and materials gathered describing their services. Data from the questionnaires and other information from these visits are synthesized to make

Table 4.4
Major Residential Facilities in Taiwan

	<u>Size</u> (beds)
<u>Government</u>	
Provincial Taipei Mental Hospital	900
Provincial Yuli Mental Hospital	1,400
Provincial Kaohsiung Mental Hospital (teaching)	200
Tainan General Hospital Department of Psychiatry	100
Veteran's and Army General Hospitals with Psychiatric Units (throughout Taiwan)	3,800
*Taipei City Psychiatric Center (teaching)	150
*National Taiwan University Hospital (Taipei, teaching)	40
*Tri-Service Hospital Department of Psychiatry (Taipei, teaching)	25
Veteran's General Hospital (Taipei, teaching)	20
<u>Private</u>	
MacKay Hospital Department of Psychiatry (Taipei)	50
*Jen-chi Charity Hospital (Taipei)	182
Yu-shan Hospital	50
Jen-ai Charity Hospital (Taipei)	230
Chu-Huei Charity Hospital	200
Other Private Hospitals	<u>1,038</u>
Total	8,375

(* = interview sites)

Table 4.5

Major Outpatient and Counseling Centers in Taiwan

Government

- *Taipei Children's Mental Health Center
- *National Taiwan University Hospital Children's Day Care Center
(Taipei)
- Veteran's General Hospital Adolescent Mental Health Project
(Taipei)
- *National Taiwan University Hospital Psychiatric Day Care Program
- *Northern Area Community Mental Health Center (Taipei)
- Kaohsiung Community Mental Health Center
- Tai-Chung Community Mental Health Center
- *Taipei City Community Mental Health Project
(via 16 District Health Stations)

Private

- *Professor Chang Adolescent Counselling Center (Taipei)
- *Suicide Life Line; MacKay Hospital Counseling Center (Taipei)
- *Hua-ming Counselling Center for Family and Youth (Taipei)

(* = interview sites)

descriptive statements following the mental health resource framework.

Table 4.6 describes the personnel interviewed with the three questionnaires and the number of open-ended discussions held with various staff. In brief, the case study is based upon recorded conversations with eight physicians, four psychologists, three counselors, three social workers, and two psychiatric nurses from ten diverse agencies.

Framework for Mental Health Resource Status

Comprehensive services. The first attribute of a mental health system is comprehensiveness. The variable "comprehensive" refers to the availability of diverse services, specialty units, and treatment modalities covering the entire spectrum of client population needs. Community mental health programs in the United States are required by the 1975 Public Law 94-63 and National Institute for Mental Health policy to provide 12 essential services and support functions. These define the concept of "comprehensive" for federally-funded facilities. Table 4.7 lists these criteria plus additional supporting functions related to agencies: research, evaluation, planning, and teaching.

Specific treatment modalities that may be drawn upon for case management are listed in Table 4.8. These two lists are complementary: the first reflects the breadth of client populations served; and the second shows the depth of therapies available to them.

Table 4.6

Personnel Administered Questionnaires #1, #2, #3

Questionnaire:	Number Staff Completing			Open-ended Interviews
	#1	#2	#3	
<u>Facility & Staff</u>				
T.C.P.C.				
Psychiatrist	1	2	2	1
Nursing Director		1	1	
Social Worker		1		
N.T.U.H.				
Psychiatrist	1	1	3	2
Social Work (Director)		1	3	1
Psychologist			2	1
O.T.			2	
Psychiatric Nurse			2	
T.C.M.H.C.				
Psychiatrist	1			1
N.T.U.H. Children's Day Care Center				
Psychologist (Director)				1
T.S.P.				
Psychiatrist	1	2		
Jen-Chi				
Psychiatrist (Chief)	1	1		
Psychiatric Nurse		1		
N.A.C.M.H.C.				
Psychologist (Chief)	1	1	2	
Professor Chang				
Psychologist			1	2
Life-Line				
Social Worker				1
Hua-ming				
Counselor				2
Veteran's General Adolescent Mental Health Project				
Physician				1
TOTAL	6	11	18	13

Table 4.7

Availability of Comprehensive Services

Service Function	NTUH Complex	TCPC	TSP	Veteran's General	Jen-chi	NACMHC	3 Counseling Centers
Inpatient	+	+	+	+	+	-	-
Outpatient	+	+	+	+	+	+	+
Emergency	+	+	+	+	-	-	+
Partial Hospitalization	+	+	-	-	+	-	-
Transitional Living	Planned	Planned	-	-	-	-	-
Follow-up	+	+	-	-	-	+	+
Children's Service	+	+	-	+	-	-	-
Geriatric Care	-	Planned	-	-	+	-	-
Drug Abuse	-	-	-	-	+	-	-
Diagnostic	+	+	+	+	+	+	-
Neurological	+	+	+	+	+	-	-
Suicide Prevention	-	-	-	-	+	-	+
Educational	+	+	+	-	-	+	+
Mental Health Research	+	+	+	-	-	-	-
Program Evaluation	-	-	-	-	-	-	-
Teaching/Training	+	+	+	+	-	-	Inservice Only

+ indicates available
- indicates unavailable

Table 4.8
Treatment Modalities Available

Modality	NTUH Complex	TCPC	TSP	Jen-chi	NACMHC	3 Counseling Centers
ECT	++	+	+	+	-	-
Physiotherapy	+++	-	-	-	-	-
Drug	+++	+++	+++	+++	++	-
Psychotherapy	++	+	++	++	+++	++
Behavior Modification	++	+++	+++	-	+	+
Group Therapy	+++	+++	+++	++	+	++
Family Therapy	++	-	-	++	++	++
Occupational Therapy	+++	+++	+++	+++	-	-
Work Therapy	+++	-	-	+++	-	-
Other	Ex-patient club play therapy	milieu therapy	recreation	dancing needlework cooking	home visits	crisis intervention

+++ often
++ sometimes
+ seldom
- never

Are the mental health centers in Taipei, as shown in Tables 4.7 and 4.8 offering comprehensive psychiatric care? The answer appears to be a qualified "yes." The full range of care is available but only if the various programs are taken together as a composite system. The question of integration and referral among these centers is complex. It is reviewed later under the rubric "Inter-institutional Continuity of Care." For discussion purposes, the patterning of services can be analyzed as though there were some degree of integration and wholeness to the system.

Several striking features emerge from a review of these two tables. Regarding strengths, the prestigious NTUH complex and the more recently developed TCPC are by far the most comprehensive care providers in Taiwan. These two key teaching hospitals are identical regarding what they do and do not offer. All inpatient facilities visited had outpatient departments, neurological assessment, and--except for Jen-Chi--carried out consultation and education functions. TSP was the only site without a day care program. NTUH's day care center is the most developed. It was initiated in 1952 by the present Chairman of the Psychiatry Department, Chu-chang Chen (1971).

Neurological and diagnostic assessment are well-established at the teaching centers. The Department of Psychiatry and Neurology at NTUH devotes half of its beds to neurological cases, continuing the historical association

of these two disciplines. Training, education/consultation, and research are active components of the hospital departments. NTUH coordinated the mental health personnel development project planned by the Committee for Mental Health in the early 1960's. Staff were also assigned to educate elementary school teachers in early identification and management of behaviorally dysfunctional and mentally retarded pupils. Recently, public health nurses and social workers received specialized instruction for manning Taipei's 16 health stations. Research has ranged from the seminal investigations of psychopathology in selected towns, to more recent studies of cortical lesions and malformations, drug trials, suicide, effects of acupuncture on neurotic disorders, and assessment of developmental disabilities in children (c.f., Bulletin of Chinese Society of Neurology and Psychiatry, 1975, 1(1) for full listing of research).

Consultation is an important link between the psychiatric departments and a number of counseling centers and education agencies in Taipei. The community mental health centers are mandated to conduct education seminars within community organizations and at public meetings in their areas.

Evidence of strength in clinical tasks was found in the areas of occupational therapy (OT), group work, and chemotherapy. Chemotherapy is by far the most widely employed intervention modality and is usually expected by patients. Besides drug treatment, ward activities appeared well-

structured. The patients are kept busy with such OT tasks as folk dancing, singing, arts and crafts, calligraphy, recreational sports, and making small objects for sale. NTUH has some patients in clerical tasks or gardening assignments around the hospital prior to discharge, enabling them to gain pre-vocational work competency. Belonging to a group is an important and reinforcing facet of Chinese socialization, so this format has been seized upon for therapeutic talk sessions by ward psychiatrists. C. C. Chen and Agnes Wu at NTUH facilitate an ongoing encounter group whose members include day-care and former inpatients.

Limitations among these agencies are also apparent. There were no geriatric, transitional living, or substance abuse units. Jen-Chi Hospital did, however, house many older patients and some drug dependents. The City of Taipei manages an Anti-Narcotics Institute, but no information was found on its operations. Informants did not view narcotics addiction as a significant problem: it is discouraged by a mandatory death sentence for those found selling heroin.

Psychological assessment other than elementary differential diagnosis is conspicuously absent since very few psychologists work within the medical teaching centers. Applied behavioral analysis is done only within the Children's Day Care Center (NTUH). Neuropsychological test batteries for assessing cortical dysfunction have yet to be developed. The three community mental health centers do give their

outpatients psychological tests. Therefore, some use is made of personality, intelligence, and aptitude scales, and especially Ko's Mental Health Questionnaire--T. H. Ko's modification of the MMPI.

Follow-up services are restricted to those who make return visits to hospital outpatient clinics. Manpower numbers prevent home visits or active efforts to initiate contact with discharged patients. One suicide prevention program in Taipei operates out of MacKay Memorial Hospital and has telephone, walk-in, and emergency counseling functions. This center appears to have a well-trained and enthusiastic staff. It is linked to other city facilities through a referral network--and has close contact with the other hot-line group, Professor Chang. Lastly, program evaluation, a function of recent prominence among American care providers, has not gained the attention of Taiwanese professionals. Nor is therapy outcome research regularly undertaken in these settings (e.g., Ko, 1974).

Chemotherapy, previously mentioned as a clinical strength, can also be viewed as a limitation of the system. Drug assignment dominates to the point of excluding alternative forms of therapy. Except for the private counseling and community mental health centers, the traditional medical approach is stressed. It emphasizes physical interventions--drugs, shock, and hospitalization.

The contravening option, considering client psycho-

social conditions and using a social-influence or educative model, is to some extent offered by the counseling centers. This difference can be attributed to the types of patients seen since these centers work with less impaired individuals. Behavior therapy, as practiced by British and North American professionals, is represented only by Yang's work at the Children's Day Program NTUH and a simple token economy system on one ward at TCPC. Although families frequently participate in case management and are encouraged to maintain close contact with doctor and patient during hospitalization, nothing akin to the Family Therapy Movement exists in Taiwan. On the other hand, several faculty at NTUH are interested in this approach and it may achieve popularity in the future (C. C. Chen, Wu, Huang, & Hsu, 1975).

In summary, the sites visited do offer "comprehensive" care, but only if viewed as an integrated network. Inpatient and outpatient units are plentiful, yet specialty departments for unique problems or diverse client groups (e.g., children, adolescents, elderly, or discharged patients) must be sought at various locations. Substance abuse and transitional living units are extremely rare. Program evaluation functions are still undiscovered. Chemotherapy predominates in Taiwan, but in comparison with most other settings in the region, is well balanced with practitioner interest in group work, talk therapy, OT, and attention to family involvement. Ties with overseas

educational programs have stimulated some interest in work with alternatives to a strict medical regimen, including behavior modification, insight psychotherapy, and conjoint family therapy.

Preventive orientations. The second mental health resource variable concerns the presence of prevention programs. A preventive orientation moves beyond the strictures of direct services. Instead, programs are aimed at eliminating conditions adverse to "normal" psychological functioning and securing coping resources for individuals at "risk" of disorder. Prevention is a theme of the community mental health movement; it removes practitioners from their offices and employs their skills in changing stressful elements of social grouping and institutional life. Prevention usually takes the form of consultation, education, and experimentation in settings like schools, social welfare agencies, prisons, primary medical care clinics, parenting groups, and so forth. Theoretically, action at this level mitigates the pressure for direct services as the rate of disorder declines. In short, successful prevention reduces and ultimately eradicates psychological disabilities resulting from social, emotional, intellectual or biological disorders. However, this endeavor requires additional personnel to cover both clinical and educational functions.

Preventive services expected at accredited mental health programs cover five areas (Errion & Moen, 1976).

Public Information dissemination requires the use of news media and public forums to motivate people to take responsibility for their own health and the health of others. Public Education is more specific; it is aimed toward risk groups, such as expectant mothers, instructing them in approaches to avoid psychological problems. Organizations or agencies dealing with large populations are offered Public Consultation services. Somatic Intervention involves quickly handling biogenic sources of mental disorder, such as syphilis and PKU, before their degenerative effects occur. Lastly, Ecological Changes are those activities focusing on peoples' interaction with their environment. The level and magnitude is significantly enlarged to include action at the social, economic, and political systems level. Action here would include efforts to assist groups to achieve political power, the development of neighborhood and community organizations, or work on poverty relief projects to stem the dehumanizing effects of economic uncertainties.

Prevention services undertaken among the sites visited are displayed in Table 4.9. It is difficult to accurately use this schema because it requires much finer discrimination among types of prevention work than those made by professionals in Taiwan. In fact, although some projects may be conceptualized as preventive, they may not actually be labeled as such and are included here only by investigator inference.

Table 4.9
Availability of Prevention Programs

Prevention Type	NTUH Complex	TCPC	TSP	Jen-chi	NACMHC	3 Counseling Centers
Public Information	+	+	-	-	+++	+++
Public Education	++	++	-	-	++	+++
Public Consultation	+++	+++	+	-	+++	+
Somatic Intervention	?	?	?	?	?	?
Ecological Change	+	+	-	+	+	-

+++ often
++ sometimes
+ seldom
- never

Inferences are unnecessary, however, regarding the work of the community mental health center and the three counseling clinics. Their expressed objectives are public information, education, and consultation. The NACMHC is most strongly associated with these service areas. It has a public education specialist (a B. A. psychologist) who plans lectures on such topics as family and inter-personal conflict, problems of adolescents and child rearing, and development of self-concept. In one month alone (June, 1977), there were seven community lectures with 600 people in attendance. In 1976, 128 families comprising an entire village were individually contacted for mental health discussions. Offers for intensive help and education were not well accepted, so staff decided that approaching the community through such structures as the schools was more fruitful.

Targets of consultation by NACMHC include factories, neighborhood groups, public health nurses, as well as school teachers. Parent education contacts form a major service area. An annual publication by the center is sent to the Department of Public Health for teacher education. Additional educational materials are planned for distribution among the public. Most clients are attracted through newspaper advertising and community lectures.

Professor Chang and the Suicide Life-Line are also active in educating the public about their services. Each

targets its own high risk population, either adolescents with problems or those contemplating suicide. These centers are less involved in educational work with other agencies or community groups.

NTUH and TCPC have strongly emphasized consultation with organizations in contact with potential cases. NTUH began over 20 years ago to send its mobile clinic out for guidance sessions with public health nurses. It was soon broadened to include school teachers through the East-Gate Project. Now, other educational programs, the police department, and the pediatrics section of NTUH are involved. NTUH has roots in nearly all social welfare/counseling centers in Taipei. Its staff either developed or now offers regular consultation to NACMHC, Life-Line, Professor Chang, and the Adolescent Mental Health Unit at Veteran's General Hospital, and others. TCPC, under Professor Yeh's guidance, has helped train 200 public health nurses and social workers as mental health specialists. These workers now occupy the Taipei district health stations and operate a small community mental health clinic within one of them. Specialists are trained to direct attention toward schools in particular. They also assist social welfare workers and private general practitioners. This program has continued the community extension service that was previously carried out by TCMHC.

Additional observations can be made regarding prevention

actions among these facilities. Jen-Chi and TSP concentrate completely on direct services, although TSP does send personnel to the surgical departments of its hospital for selected cases. Ecological change as a service area is weakly developed. The only evidence of institutional change as a function of intervention were efforts to make teachers more sensitive to the psychological needs of children and access given poor families to the resources of Jen-Chi and TCPC. Projects for social action, economic or political change among risk populations are not considered within the purview of mental health care.

Finally, it should be noted that the "somatic intervention" category does not exist as a discrete prevention component of any program visited. Disease entities that lead directly to psychological impairment are probably screened out through the primary care network. Child-oriented staff at NTUH, however, are working on tests for revealing developmental lags in children for purposes of early identification.

In review, the five-area scheme for accrediting prevention programs in the United States shows that Public Consultation is well represented in Taiwan, especially by the two major teaching departments and the NACMHC. Public Information and Public Education are slightly less available, in comparison. Somatic Intervention and Ecological Change are not found at all. Prevention services, the major

responsibility of the NACMHC, can be expected to increase as the number of community mental health centers increase.

Continuity of care within the facility: Manpower.

This resource variable focuses on manpower strength and the capacity for multi-professional "team" contact with clients. The full team approach to staffing--including psychiatrist, psychiatric nurse, psychologist, social worker, occupational or rehabilitation counselor--provides a continuity of care within the agency. A multi-disciplinary team is better suited for meeting the diverse and changing needs of a patient: beginning with initial contact, through periods of stabilization, behavior change and termination.

Continuity is evidenced in the smooth intra-team referral process, and a well-coordinated plan of treatment for each individual. A simple measure of manpower contact availability is the ratio of therapeutic personnel to inpatients and outpatients.

Table 4.10 depicts the clinic's manpower situation. All categories of staff are well represented at TCPC and NTUH, but present to a lesser extent in the other settings. Psychiatrists are numerically the strongest of the treatment staff. After a large drop in numbers, social workers and occupational therapists appear to be second. Psychologists are least employed. Nurses are found in varying ratios to patients, from 1:2 to 1:6 in residential facilities.

The concept of multi-disciplinary team involvement is

Table 4.10

Multi-Disciplinary Teams and Manpower Availability: Staffing Numbers and Staff Ratios to Patients

Profession	NTUH Psychiatry	NTUH Child Day Care	TCMHC	TCPC	TSP	Jen-chi	NACMHC	Total
Psychiatrist (including residents)	15	1	2	15	5	4	.5	42.5
Psychologist	1.5	1	1	3	1	0	2	9.5
Nurse	15	1	1	50	9	22	1	99
Social Worker	3	0	1	5	1	1	1	12
Occupational Therapist	3	1	0	10	0	4	0	18
Beds	26			250	25	180		
Daily Outpatients	60	26	10	50	20	20	<u>+7</u>	
Total New Outpatients Per Year	3,434		673	581			<u>+250</u>	
Total Outpatients Per Year	17,394			8,063			1,393	
Inpatients Per Therapeutic Staff	1.8			7.5	2.85	20		
Outpatients Per Therapeutic Staff	4	8.7	5	3.3	4	5	1.75	

most developed within the NTUH complex and TCPC. Both have emphasized training non-medical professional staff for support roles. However, these "ancillary" personnel remain in a somewhat secondary position vis á vis the psychiatrist. Intake interviews, treatment plan formulation, and most major decisions are left to the physician. He brings ancillary personnel into a case as he sees fit. Typically, a psychologist is called in if a question of testing arises. The patient's family is occasionally referred to the social worker. OT staff become involved before discharge, or run day-care and rehabilitation activities under supervision.

The few highly trained social workers and psychologists are given teaching roles within the hospitals. Outside the medical structure, they become extremely active in counselor training, group psychotherapy, designing new services, and consultation to a wide range of social service agencies. TCP and Jen-Chi rely far less on multi-disciplinary staff although the former does provide a practicum for psychology students. Jen-Chi has an active occupational rehabilitation program with four OT staff, but is without the services of a psychologist and has no capacity for follow-up care.

The manpower potential, as defined by contact possibilities between staff and patients, is reflected in the figures at the bottom of Table 4.10. Staff/patient ratios index the system's capacity for giving patients access to care providers. NTUH and TSP with their small inpatient

wards obviously maintain the highest potential for staff availability. Jen-Chi has the lowest ratio of inpatients per therapeutic staff with 20 to 1. The other set of ratios examines the daily outpatients in relation to manpower (primarily psychiatrists). These numbers all seem satisfactory. Even NTUH with its enormous yearly attendance, 17,395, still has ample staff capacity for seeing outpatients. NTUH averages one psychiatrist per four clients per day.

However, these figures are extremely conservative. On any given morning, one therapist may see between 10 to 30 patients since outpatient duty is taken on rotation by just a few physicians. The majority of senior personnel are in resident supervision, outside consultation, research, administrative tasks, and pursuits other than outpatient care--a task assigned resident psychiatrists.

In conclusion, manpower strength is found principally among the ranks of psychiatrists directing the programs visited. Continuity of care, produced through treatment plans integrating the involvement of a multi-disciplinary team, is limited. Factors responsible for the limitation are the lack of qualified non-medical team members and hospital traditions which harbor responsibility for intervention within the physician domain. In contrast, NACMHC and other non-medical counseling settings appear to operate with more shared responsibility among their social worker, public health nurse, and psychologist team members. In

terms of patient/staff contact potential, the sites studied all enjoyed satisfactory ratios. These numbers are only a rough index, however, since staff rotate clinical duties and are often required to see dozens of people within the space of one morning. Nevertheless, compared with the large residential institutions outside Taipei where only a small handful of therapeutic personnel are available for hundreds of patients, the ratios for the hospitals visited appear adequate.

Continuity of care: Inter-institutional. A second continuity of care resource variable involves the coordinated linking of services among different agencies. Continuity of care is achieved when a common relationship is maintained with an individual throughout an uninterrupted sequence of services (Errion & Moen, 1976). The referral process within a facility, among different care providers, or between agencies, should always aim for a standard of continuity. Strong linkage among institutions establishes a well-integrated referral network when all necessary elements are merged into a unified service system. This is termed synergy: the ability of system elements to work cooperatively.

One means of examining inter-institutional continuity of care (synergy) is to study a program's relationship with other psychiatric or social/medical institutions. The goal is to uncover the referral network and determine its scope and diversity. Information on referral sources and

consultation/referral relationships is found in Table 4.11 and Figures 4.1 and 4.2.

A survey of sites showed that family and friends were by far the most frequent community referral source, followed by schools, the public welfare agencies, general practitioners, and employers. Police and priests were listed as "seldom" or "never." Referrals from the folk system were also extremely rare.

Figure 4.1 shows these community sources feeding into the five major city hospitals. These hospitals, in turn, supervise clinical services within their five respective catchment areas of the newly founded Taipei City Community Mental Health Project (TCCMHP). The duties are performed by psychiatrically trained social workers and public health nurses within the 16 health stations. As shown by Figure 4.1, the health stations not only receive consultation from their supervising hospitals, but have a working channel of communication for referring cases. Professor E. K. Yeh at TCPC has spearheaded the effort to unify the five hospitals as a formal supervisory unit for the TCCMHP.

Figure 4.2 attempts to capture the complex relationships among the major centers and give the visible lines of referral. NTUH occupies a central position in this schema of relationships based on its historical role in the evolution of Taiwan's programs. NTUH personnel maintain active consultation responsibilities at the four counseling

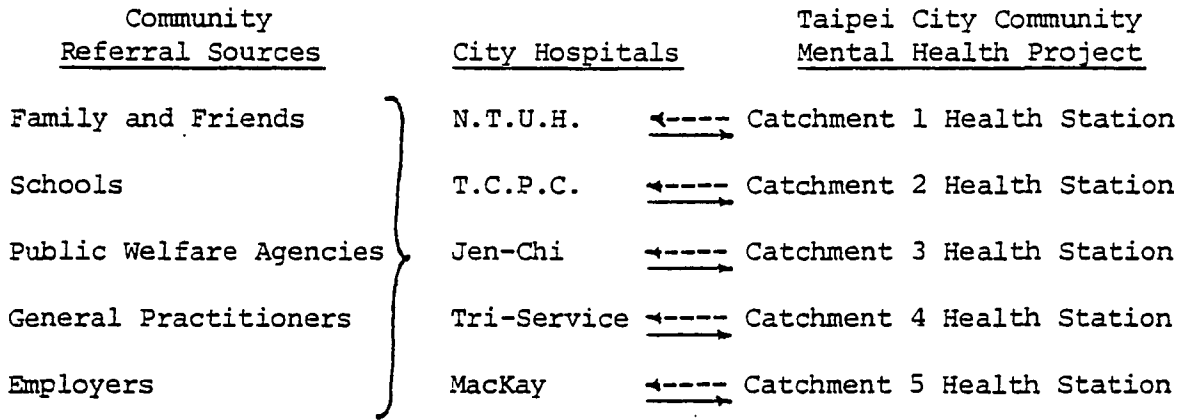
Table 4.11

Frequency of Various Referral Sources

<u>Source</u>	<u>Frequency</u>			
	<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>Never</u>
Physicians		TSP, NACMHC NTUH, TCPC, Jen-chi		
Mental Health Professionals		NACMHC, NTUH		Jen-chi
Mental Health Agencies	Jen-chi	TCPC, NACMHC, NTUH		
Social Welfare Agencies	Jen-chi, TCPC	NACMHC	NTUH	
Schools	TCPC, NACMHC	NTUH		Jen-chi
Police	TCPC, Jen-chi		NACMHC, NTUH	
Priests		TCPC, Jen-chi	NACMHC, NTUH	
Traditional Healers			TCPC Jen-chi, NTUH	NACMHC
Family/Friends	NTUH	NACMHC		
Employer	TCPC	Jen-chi, NTUH	NACMHC	

Figure 4.1

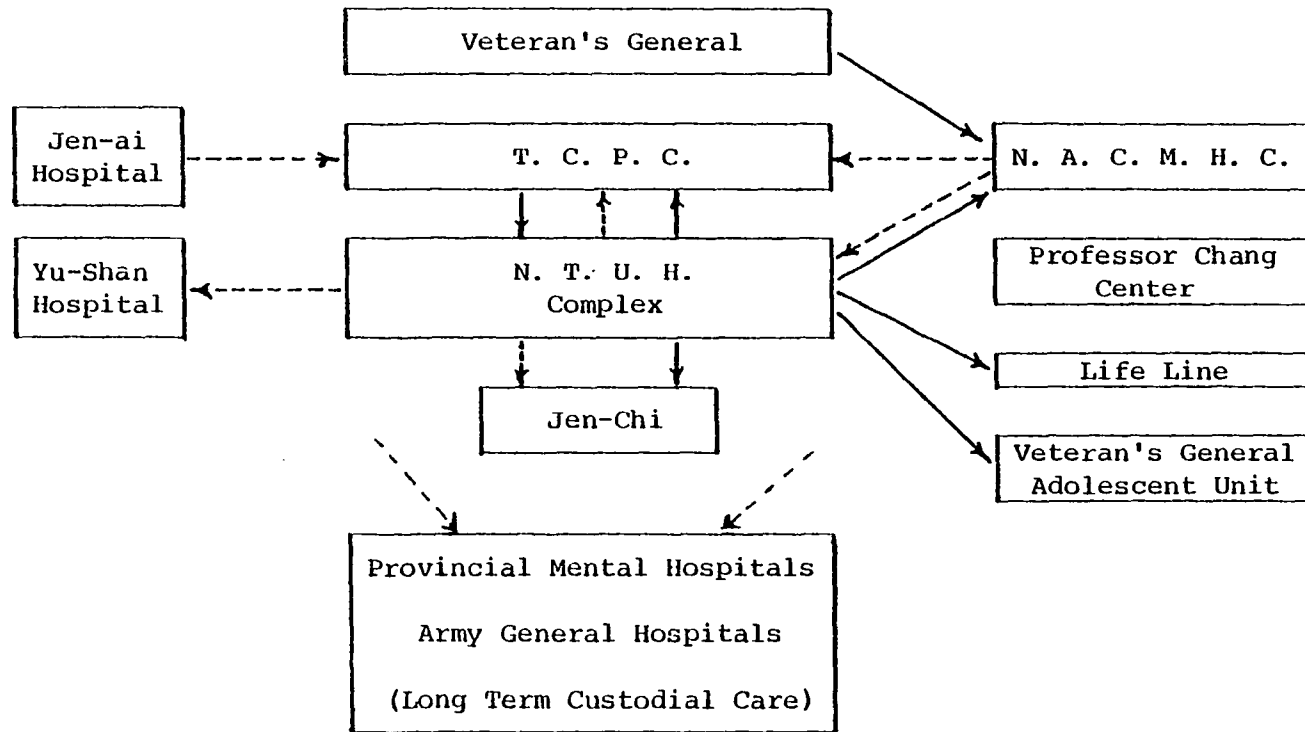
Taipei City Referral Pathways



Key: ———→ = consultation & supervision
 ←----- = referral

Figure 4.2

Referral and Consultation Relationships Among Taipei Psychiatric Centers



Key: - - - - -> = referral of patients
—————> = consultation

centers listed, several of which they helped to create. The NACMHC was founded by two NTUH psychologists, Y. H. Ko and S. K. Yang, among others. It refers clients for additional treatment to either TCPC or NTUH and has a part-time psychiatrist consultant from Veteran's General Hospital. NTUH, with its small inpatient ward, must rely on other residential institutions for long-term patients and those who are uncontrollable. Yu-Shan, a small private mental hospital occasionally houses obstreperous patients under the care of NTUH doctors. Jen-Chi and TCPC are sometimes given long-term referrals.

The provincial mental hospitals and army general hospitals are the last stop for chronic, unresponsive patients coming out of Taipei clinics. TCPC has a substantial number of yearly admissions referred from another private hospital, Jen-ai. It receives fewer referrals from NTUH but maintains an extremely close working relationship with that department since E. K. Yeh retains a professorship there. Also, several NTUH residents are assigned to TCPC. Its child program is being assisted by Professor Hsu from the TCCMHC.

The relationship patterns and channels of communication which have evolved historically determine to a large degree the referral pathways just cited. These channels are conduits for institutions to assist one another in expanding and strengthening their respective programs and passing

along those clients whose needs are more effectively met elsewhere. Personnel from the major city hospitals have come together since 1975 to work as a supervisory unit ensuring a viable mental health program through the health stations. This feat is based on personal relationships and a prevailing spirit of cooperation and identity. The hospitals involved range from a private charity institution to facilities under the administration of the national and city governments and the armed forces.

It is difficult to judge whether an individual client is able to transverse the various components of Taipei's mental health system in a smooth and well-connected fashion at all times. But given the relatively large number of links among these diverse institutions and their professionals, it seems credible to suggest that an individual has a good chance of moving through the system with an uninterrupted sequence of appropriate services.

Continuity of care into the community. Continuity of care into the community refers to the relationship between the service agency and those individuals who assume primary responsibility for the patient in his home or work environment. Typically, these individuals are family members, friends, employers, or community agents such as school teachers, police, village officials, and religious leaders. Their involvement with the service system may be prior to, during, or after the patient's direct contact with agency

personnel. This variable seeks to determine the ways in which the agency makes use of community persons during intervention and their degree of involvement. The assumption is that greater involvement of significant others and community agents permits a smoother transition for the patient back into his social environment after discharge. By extending its treatment effects into the community through the assistance of significant others, the agency promotes continuity of care.

Six alternatives for providing continuity of care into the community were found in Taiwan. These are presented in Table 4.12. The first of these is the active follow-up of discharged patients. Follow-up takes two forms: either the client maintains contact with the agency as a regular outpatient or a public health nurse/social worker makes home visits to check progress and offer support. NACMHC was the only agency where home visitation was a major treatment policy. NTUH complex and TCPC sometimes followed-up their former inpatients but only through outpatient clinics. Jen-Chi lacked personnel for an active follow-up program. As a military hospital, TCP found it impractical to maintain contact with patients since they were either sent back to their bases or discharged from the service and returned home. Follow-up programs were especially difficult for those clinics with clients coming from distant parts of the island. These individuals were usually discharged into the care of doctors in their home towns.

Table 4.12

Six Alternatives for Providing Continuity of Care into the Community

<u>Alternatives</u>	<u>NTUH Complex</u>	<u>TCPC</u>	<u>TSP</u>	<u>Jen-chi</u>	<u>NACMHC</u>
1. Active patient follow-up especially by social worker	++	++	-	-	+++
2. Educate or utilize family members as part of treatment plan	++	++	+	+	++
3. Relative stays in hospital with patient	+	+	+	+	N/A
4. Treatment within home or village setting	+	+	-	-	+++
5. Community agents assist in treatment (teacher, employer, village leader, M.D., police, etc.)	++	+	+	-	++
6. Participation in community activities during hospitalization encouraged	++	++	+	++	N/A

+++ always
 ++ sometimes
 + seldom
 - never

A second means of promoting continuity of care into the community is to invite relatives to participate in the treatment process. This is accomplished by educating relatives in how to help deliver care. Sometimes family members assist by living in the hospital. All four residential facilities made some provisions for family members to stay with the patient. They requested this if the patient were critically ill, suicidal, senile, or uncontrollable. NACMHC was particularly interested in carrying out family educational activities and focused on parent training for child rearing problems. The child division of NTUH is also interested in parent involvement. Child therapists there model techniques of behavior modification for home use by the parents. Sixty per cent of the parents meeting with therapists are mothers while 20 per cent are fathers.

Social workers at TCPC work with the family to find mutual treatment goals. Often this comes only after the family's confidence has been won by the physician. At Jen-Chi, some effort is made to educate family members about the patient's condition, although their active involvement in case management is rare. This is also the situation at TSP where education is done through informal interviews and discussions. Even though family participation at TSP is problematical because patients come from outlying areas, visitation is strongly encouraged.

Treatment within the home or village setting after

discharge or in lieu of hospitalization is perhaps the clearest example of continuity of care. It is, however, quite rare except at NACMHC which provides active outreach into homes, schools, and neighborhoods. In general, manpower is too precious for home treatment, and it is out of the question for areas outside of Taipei. The newly established TCCMHP is bringing services a little closer to the neighborhood level. NTUH's long-standing school consultation is aimed towards the same goal, but on a limited scale.

Staff at the two teaching hospitals and NACMHC report using community agents to assist in treatment. Those who do cooperate with the agencies are public health nurses and social workers at the district health stations, teachers, and occasionally the general practitioners who initially referred the patient. Employers, village leaders, or the police are seldom called upon to work with the agency.

Lastly, continuity of care in this domain is thought to be promoted by encouragement given inpatients to participate in ongoing community activities, celebrations, or through trial home visits. Except for TSP, staff do report occasional encouragement to keep patient attention on events outside the hospital. At TCPC home visits are used as reinforcers in a kind of token economy system. Outings are made once per week at Jen-Chi to various points of interest in Taipei, such as fairs or temples. TSP has an option of giving recovering patients a week-end pass.

In summary, the agency most concerned with continuity of care into the patient's home environment is NACMHC. Performance of this function is usually carried out by social workers assigned the tasks of follow-up and liaison with the family on treatment and education matters. The best example is family member participation in care while the patient is hospitalized. It is done either by having a relative stay in the hospital or through family counseling regarding patient problems and how to handle them at home. This occurs more typically with children than adult clients. Staff in general regard their institutions as permeable: regular efforts are made to get clients out into the community for special events and home visits. On the other hand, domiciliary care and well-instituted programs to work through family or community agents are rare.

Accessibility of facilities. Accessibility is measured by the ease with which an individual in need may successfully use psychiatric services. This is accounted for by a number of factors. The most important one is simply the existence of facilities handling particular problems. Other factors include cost to clients, agency location, whether or not there is a waiting list, availability of outreach or domiciliary programs for those who cannot journey to the clinic, and the integration of mental health programs within well-dispersed primary health units.

Many of these questions were covered through the

previous description of Taiwan's mental health resources. It was noted, for example, that active inpatient treatment is available on the basis of one bed per 5,533 persons. Accessibility is quite good within Taipei and Kaohsiung, even for specialty care, but practically non-existent throughout the rest of the island. Moreover, except for government employees and certain laborers, insurance reimbursement is unavailable for those requesting psychiatric consultation. Accessibility is being strengthened in Taipei with the training and supervision of district health station workers by TCPC and the other supervisory hospitals. Similarly, the numerous private counseling centers, phone-in services, and community mental health centers strive toward ease of access for clients. However, once again, these programs are restricted to a few urban enclaves.

Staff perceptions of their agencies' accessibility can also be cited. TCPC patients are seen to have difficulty getting to the facility primarily because it is on the outskirts of Taipei and the road leading to the hospital is under construction. The outpatient clinic is located more conveniently at a general hospital near the center of town. There was only a short wait to get into the hospital at the time of the survey. The government recently initiated a program to provide funds for the treatment of indigent people.

Staff interviewed at NTUH saw the long waiting list for hospitalization and the cost to the client's family as a

"moderately serious problem." NTUH is conveniently situated in the heart of Taipei. Therefore, location accessibility is good except for those who travel from outlying counties. Jen-Chi also has an excellent location. As a charity hospital it does serve poor clients but there is a moderate problem with a waiting list. Access to the NACMHC is seen by staff to be quite good on all dimensions except cost--viewed as a "moderately serious problem." TSP staff do not view accessibility as a major concern either: the military personnel are simply assigned there for treatment.

There appears to be two principal accessibility issues for Taiwan. First, the fact that the average citizen must pay for mental health care out of his own income. Secondly, there are only a few highly desirable and respected inpatient facilities. These institutions (NTUH, TCPC, Veteran's General, and a few others) each contain very limited bed space. All are located in Taipei. Outpatient and counseling services for certain problems are becoming generally more available and are well attended. However, they operate on limited funding, with limited manpower, and they serve only a few urban areas. It is obvious that most Taiwanese who may be judged in need of therapeutic assistance, receive such help from alternative sources.

Staff evaluation of resource strength. The final resource variable attends to staff perceptions of resource strength. Twenty-one potential resource problems were

listed and staff were requested to make judgements about the seriousness of each problem. These global evaluations may be used to confirm or qualify previous statements about Taiwan's mental health resources based on other data. They are useful for learning staff priorities and perceptions of their working situation.

Table 4.13 presents responses from ten professionals interviewed using Questionnaire #2. For details of who these respondents were, see Table 4.6. Grouping together the five treatment centers and the multi-disciplinary staff results in the dispersal of responses across items. Nevertheless, some trends can be seen, especially by dichotomizing the items as either problematic or non-problematic. In cases where most of the response variance can be accounted for by one institution or one discipline, these relationships will be highlighted.

A number of resource deficits are confirmed by the results in Table 4.13. First, the overall sense of low national priority and lack of budgetary support for present and future programs are found in items 1, 2, and 3. In terms of manpower, there is clear agreement that trained administrators and follow-up personnel are lacking. There is slightly less agreement that serious problems arise from lack of diagnostic and treatment staff. TSP and Jen-Chi are the only institutions indicating no problems in this area. The lack of integration with other institutions and

Table 4.13

Staff Perceptions of Resource Deficits (N = 10)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Lack of help from Government		30%	50%	20%
2. Not enough money for present treatment program		60%	30%	10%
3. Not enough money to develop future treatment programs		40%	20%	40%
4. Not enough trained administrators	30%	50%		20%
5. Not enough diagnostic staff	10%	30%	20%	40%
6. Not enough treatment staff	20%	30%	10%	40%
7. Not enough follow-up staff	50%	40%	10%	
8. Lack of relationship with other institutions	30%	20%	10%	40%
9. Other professionals don't support the program	20%	30%	20%	30%
10. Long waiting list		50%		50%
11. Not enough rooms to separate different kinds of patients		40%	20%	40%

Table 4.13 (continued). Staff Perceptions of Resource Deficits (N = 10)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
12. Lack of building space	20%	10%	20%	50%
13. Too many patients	40%	20%		40%
14. Lack of money for equipment and research	20%	30%	30%	20%
15. Library is not good enough	20%	20%	30%	30%
16. Little information about new treatments and new research findings	10%	10%	50%	20%
17. Lack of epidemiological data regarding mental problems	10%	40%	50%	
18. Staff relations are not good			30%	70%
19. Not enough treatment supplies		20%	40%	40%
20. Lack of transportation services	10%	40%		50%
21. Low success rate of treatment	10%	20%	60%	10%

poor support from other professions are less uniformly problematic. Yet, at least 50 per cent of those interviewed saw them as very or moderately serious.

Another dimension involves crowdedness and space restrictions. Staff at TSP, NACMHC, and TCPC tend not to view these as problems. The other institutions report waiting lists, patient load, lack of building space, and not enough rooms to separate different types of patients as "very" or "moderately serious" concerns. Research resources is a fourth dimension showing clear deficits. There is a consensus that research equipment, library materials, research findings about new treatments, and epidemiological data of community disorders are unavailable. Problems of this sort may be a consequence of personnel and funding shortages. Moreover, direct services take precedence over research and Taiwan is cut off from the information flow of new therapies evolving in other countries.

The four remaining items deserve comment. Few workers admitted any difficulty with staff relations. Interestingly, two of the three respondents who did indicate it as a "slight problem" were chief administrators. An absence of treatment supplies was not view as too "serious," except by a NACMHC psychologist and by a head nurse at a teaching hospital. It may be that personnel carrying out non-medical activities feel an absence of supplies which they deem important.

Except for Jen-Chi and TSP respondents, the lack of

transportation services was viewed as a "serious" issue. Transportation availability relates to agency accessibility. Having buses or cars available permits staff to make home visits, agency consultations, and assists patients in getting to the clinic. Lastly, 90 per cent of the subjects indicated their frustration with the system by reporting that low success rate of treatment was to some extent a problem. This finding may be the most important indicator of staff attitude toward the resource deficits found in their work settings.

To summarize, earlier statements about resource deficits in the system of mental health delivery were supported by a survey of staff perceptions. Low national priority, and lack of funding, space, manpower, and access to research findings were the major complaints. The most revealing finding, which sums up the respondents frustration with the resource picture, is the uniform complaint that treatment is unsuccessful. Presumably, with an adequate structure for intervention, this opinion would be less uniform.

Community Integration and Acceptance of the Mental Health System

Another key characteristic of a mental health system is its acceptance as an integrated part of the recipient community. Measurement of acceptance is ideally carried out through community survey techniques. Attitudes toward the agency, consumer satisfaction, and knowledge and use of agencies are general indices of community acceptance.

Unfortunately, this avenue of data collection was unavailable in the context of this study. Community acceptability was therefore measured through the opinions of staff members: perceptions of how acceptable their programs are to the areas served. Examining the variable of community integration was done by looking at instances of community involvement in patient treatment and their participation in the review of clinic objectives and procedures.

Community Integration through Involvement in Treatment

One means of integrating a service into the community is to involve relatives and friends in the intervention process. The clinics could structure their programs so that family or community people play active roles in goal setting, treatment selection, service delivery, and rehabilitation. Interestingly, these items clearly overlap with elements of the "continuity of care into the community" variable reviewed earlier. Services which actively involve individuals from the patient's social group profit from care continuity and integration. Theoretically, they achieve higher levels of acceptance.

To reiterate the findings of Table 4.12, several instances reflect community participation in service delivery and rehabilitation. This occurred most often with child cases: parents and teachers were taught improved ways of handling behavior problems. On some occasions, family members "live in" with hospitalized relatives, assisting

in daily care. Assessment of client problems through family interviews is common; intervention plans using family therapy is rare. At NTUH the family is requested to assist in getting employment for day-care clients as the goal of rehabilitation. NACMHC is most active with indirect methods: parents, community agents, and others are used as sources of social influence for the client.

Selection of therapy and goals of treatment are additional ways in which relatives and others could participate in therapy. Staff were asked to indicate which persons helped in treatment and goal selection. Not surprisingly, the power for making these decisions rests almost completely with the physician. Other professional staff add their opinions upon physician request. At TCPC, staff report that oftentimes they do try to involve family in the treatment selection process; this never occurs at Jen-Chi. NTUH and NACMHC report some involvement of family, friends, and teachers. Folk healers, policemen, clergy, and priests were very rarely mentioned as invited participants. It appears that intervention is viewed primarily as the domain of professionals--primarily physicians. Community members close to the patient are useful in some phases of assessment and their cooperation is seen as important for success, but there are few formal ways in which they are brought into the decision-making and service delivery process.

Community Integration Via Agency Review

Besides giving case management input, community decision making could also entail participation in planning program policies and goals. Community integration is thought to be enhanced by formal avenues of agency accountability to the opinions of social leaders. This may take the form of having interested community leaders consult with administrators about their perceptions of local needs or establishment of a formal community advisory board. Advisory boards are empowered to shape the direction of agency development: to structure its goals and determine the target problems.

There was no evidence of formal or informal input from non-governmental sources into the operations of public mental health facilities. Agency development and direction appears to be in the hands of the chief administrators who work arduously to maintain funding options for their current operations and future plans. Private counseling services, like Life-Line, are more responsive to community-expressed needs. Their governing bodies are a mixture of laymen and medical personnel.

Staff Evaluation of Acceptability

Another way of looking at an agency's integration with its social context is to survey staff perceptions of agency acceptability. Six items on Questionnaire #2 ask staff whether or not their clinic is viewed as a treatment place

of choice by potential clients. Table 4.14 presents a summary of staff responses to these six items.

It is clear from Table 4.14 that community acceptability is a critical issue recognized by all staff interviewed. There is strong agreement that mental health services are outside of general community awareness and that agency functions are a mystery. This lack of knowledge is coupled with a strongly held opinion that psychiatric clinics are stigmatized and used only as a last resort--after other avenues of help have been exhausted. Moreover, once the patient is brought in for help, there is a sense that patients and their families have little faith in treatment efficacy. Only the Jen-Chi group maintain that this community attitude is not a problem. However, item 4 responses project the uniform assertion that hospitalization and psychiatric treatment results in patient stigmatization. Ninety per cent of all respondents saw this as a "very" or "moderately serious" problem. Clearly, this consensus is one of the strongest for any question in the survey.

Items 5 and 6 reveal why staff feel that their programs are not accepted: individual's maintaining traditional beliefs about mental problems eschew modern clinics and prefer folk doctors. It may be that folk healing, available in the neighborhoods or local temples, does not carry the stigma of being a "psychiatric treatment for the insane." Perhaps folk medicine is more closely interwoven with the

Table 4.14

Staff Perceptions of Their Agencies' Acceptability (N = 10)

Questionnaire Item	<u>Seriousness of Problem</u>			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Community people don't know about or understand the treatment program.	30%	60%	10%	
2. Community people have a bad opinion of the treatment program and use it only as a last chance.	50%		30%	20%
3. Patients and their families don't believe the treatment will help.		20%	60%	20%
4. Patients returning home have problems because people know they were in a mental hospital.	50%	30%	20%	
5. People with traditional beliefs about mental problems won't use the treatment program.	30%	60%	10%	
6. People go to "Folk Doctors" instead of using the treatment program.	20%	70%	10%	

individual's life style--more clearly understood and less threatening. Regardless of the rationale, however, 90 per cent of the staff deem these two problems as "extremely serious": 1) tradition-minded patients turn to folk services for assistance; and 2) families avoid any sort of contact with the mental health system until their member becomes violent or unmanageable.

In brief, respondents uniformly agree that mental health services are stigmatizing and generally unacceptable except when all other avenues have failed. Ways in which these institutions have tried to make their programs more acceptable are considered in the next section.

Culture Continuity and Accommodation of Mental Health Services

Selected Examples

The third key characteristic defining the status of a mental health system is culture accommodation. To some extent, unique cultural patterns demand the modification of psychiatric services serving members of that culture. Accommodating elements of the service delivery system to attributes of the recipient community builds cultural continuity of care and insures greater therapy acceptance. In Taiwan, culture accommodation appears to proceed along five lines. These include staff recognition of the Chinese family's supremacy, adjusting to traditional conceptions of illness, special ward activities, appropriate professional

role behavior, and meeting specific expectations about therapeutics. Specific instances involving these five dimensions are presented.

Recognizing the supremacy of the Chinese family.

Taiwanese psychiatrists recognize the pre-eminent position of the Chinese family group in the lives of its members. When there is a psychological problem, the family takes charge of securing assistance and decides whom to consult. If professional help is desired, relatives bring the patient to the clinic and take an active role in the interview and subsequent follow-up visits. Without the family's cooperation and commitment to the therapy plan, professional efforts would remain ineffective.

In recognizing the family's central role, the agency worker must have a strategy for insuring its cooperation. TCPC psychiatrists work to gain rapport and trust by first relieving the unspoken fears that treatment involves shock, punishment, and a shameful public record. The physician takes an authoritative yet understanding position. He explains the nature of therapy and promises not to divulge family secrets.

The resistance to intrusion by others, like the therapist, is sometimes overcome by first gaining family confidence through a demonstrable improvement in the patient and then inviting the relatives in for a conference. At TCMHC behavior modification and medication are quickly

applied for immediate results. The parents' confidence is secured before moving into family-assisted modes of intervention. TSP staff find that relatives may ultimately interfere with therapeutic instructions. Psychiatrists reported that some Chinese mothers are especially over-protective of their servicemen sons. They bring them "charms" to wear and give advice contrary to doctor's orders. On these occasions, relatives are asked to stop their visits unless willing to cooperate.

Accommodation response to popular traditional conceptions of disorder. An important issue recognized by staff is how to deal with relatives and patients who maintain a dual belief system regarding disorder. Clients frequently enter the agency with problem explanations involving both superstitious terms (e.g., ghost fright) and modern attributions (e.g., brain damage). Maintaining such contrasting beliefs about causality apparently do not evoke a sense of cognitive dissonance. Families will often take their "ill" member to practitioners with divergent orientations to insure a cure.

Physicians at NTUH feel that it is important for professionals to be aware of the circuitious route traversed by some patients before reaching their clinic. The psychiatrist may just be one in a series of "healers" seen by the patient. One NTUH professional suggested that to establish rapport in such cases, it helps to assure the

family that they have a right to do what they feel is best. They are given permission to take the patient to folk healers if they so choose.

When patients are brought to modern clinics, conceptions of disorder which they bring with them are often a mixture of traditional and popular notions. Often, the problem is viewed as biogenic. The relatives report that there is something wrong with the patient's brain, or he has "weak nerves." An enuretic child is thought to have weak kidneys or bladder; "elevated liver fire" evokes tension and agitation. Tseng's (1975b) research showed that 70 per cent of NTUH's outpatient population complained chiefly of somatic symptoms which are socially recognized and accepted signals of illness. Emotional problems in contrast are much more difficult for Chinese to openly discuss (Tseng, 1975b). Moreover, following from these organ-centered notions of disorder is the expectation of a quick, physical cure. The family will frequently list the problems as they define them, then turn the patient over to the doctors expecting a 100 per cent cure that will enable the person to return to work. Neurologists are chosen over psychiatrists. Demands are made that EEG readings or a brain scan be performed to find the locus of damage.

Culture accommodation responses to these conceptions of psychopathology were noted. The most common strategy is a resigned acceptance of the fact that families mix therapeutic

resources. Under these conditions, it appears wise not to take a negative view of folk practices or confront patients who hold traditional or biogenic explanations of their problems (Tseng, 1975b, 1976). Psychiatrists at NTUH and TCPC agreed that to directly deny the veracity of patient beliefs was counter-productive. The attitude was to either ignore such ideas or to gently educate patients about the differences between modern and folk medicine and get them to consider psychological roots of behavior.

If the medical regimen was interfered with by folk practices, or they appeared to be harming the patient and draining his finances, then staff felt compelled to encourage the patient to stop visiting native healers. The more seasoned professionals recognized that, at minimum, knowledge of folk conceptions and cultural expressions of disorder such as culture-bound syndromes is useful in working effectively with traditional clients (Chang, Rin, & Chen, 1975).

Accommodation in ward activities. An important way in which inpatient treatment adjusts to Chinese culture is to allow relatives to reside on the hospital ward near their ailing family member. Tseng (1969) reported that up to one-fourth of the inpatients at NTUH were attended by relatives, either full or part-time. Taking advantage of this situation, staff at NTUH studied family attendants. Such factors as family interaction with the patient during

treatment and their attitudes toward psychiatry were examined (Rin, 1972). This practice sometimes results in a very close working relationship between staff and family. At most of these hospitals, elderly, ill, or unmanageable patients will have an "amah" (female attendant) stay with them 24 hours per day.

Another approach to accommodation is to make ward activities similar to important social functions outside the hospital. TCPC initiated a self-governing system where patients establish the rules of the ward and assign jobs to each resident. Since economic productivity is a critical social role, TCPC has a contract with a private company for making plastic toys. This gives patients the opportunity to earn money through occupational rehabilitation. NTUH's day care program focuses on developing similar skills. It offers pre-vocational guidance. Patients are assigned hospital jobs such as typist, clerk, gardener, or plasterer and earn a small income. Day-care staff encourage families to find suitable jobs for patients ready for release. Of the first 22 patients released from the program, 50 per cent were able to find some sort of job through their family's assistance (Chen, 1971). OT at NTUH also includes familiar Chinese pastimes such as calligraphy, tea-making, and landscape painting.

Accommodation through staff qualities and mannerisms.

Certain staff attributes and personal manners were reported

as important for gaining patient and family cooperation. For example, a consideration for hiring personnel at the NACMHC was their fluency in Fukienese--the dialect of native Taiwanese. Linguistic matching was also considered important at NTUH Child Division where the two psychiatrists had competency in three major Chinese dialects plus Japanese.

The therapists' manner is considered critical for evoking confidence and reducing client resistance. Therapists are expected to be figures of authority, actively dispensing fatherly approval and disapproval (Hsu, 1976). They must be direct in their explanation of the problem, offering specific formulae for curing. Assurance and hope are especially looked for from doctors, along with a proclamation that treatment will completely cure. Scientific modesty and honest doubts about efficacy disappoint the patients and their relatives.

Furthermore, the Western psychotherapeutic goal of encouraging open and direct expression of feelings and desires is inappropriate in the Chinese context (Tseng, 1975a). Chinese are not taught to openly express their personal feelings in public--particularly negative emotions like hostility or anger--or sexual desires (Tseng, 1975a). Tseng (1975a) advises that the first goal is to make the client feel comfortable in relating to the therapist; then gradually begin an inquiry about his life, environment, and past history.

Another cultural attribute which is a part of the accommodating therapist's repertoire is sensitivity to non-verbal communication. In American and European cultures where psychotherapy developed, verbalizations are deemed the most mature and successful avenue of human communication. People are socialized to express themselves somewhat freely since childhood. This contrasts with Chinese norms where non-verbal, subtle, and reserved self-expression are considered virtuous (Hsu, 1972). The therapist's techniques and approach to clients must be suitably modified to account for these preferences. Along similar lines, use of local or slang terms indicating "madness" is strictly taboo; it is considered insulting by patient and family.

Providing expected therapeutics. The final domain of culture accommodation involves staff efforts to provide treatment modalities expected by recipients. Since many complaints are couched in somatic terms, physical/somatic interventions are the client's treatment choice. Problems are viewed as "illnesses;" they are not environmentally or psychologically determined. Nor do patients see talk as a form of therapy. Certainly it is not something which requires payment. If patients receive talk therapy only, then they are reluctant to pay and have little confidence in its success. This forces psychiatrists to use drugs or vitamins and placebos--even when they would prefer not to--to make the patients feel satisfied.

Recently, traditional Chinese medicine and pharmacopoeia have been given governmental attention through the support of the China Medical College in Taipei. As part of this renewed interest in Chinese medicine, researchers have begun to look at the effects of acupuncture on hospitalized psychiatric populations. At TSP patients with clinical depression were administered acupuncture treatment. There is no information on the efficacy of this approach nor whether or not patients view it as a desirable therapy.

Staff Perceptions of Culture Accommodation

Questionnaires #2 and #3 recorded staff perceptions of clinic accommodation practices and their attitudes toward various accommodation dimensions. Tables 4.15 and 4.16 summarize this information. In the first table, respondents from five sites estimated the frequency of nine institutional activities related to culture accommodation. Results show that staff see it as fairly common to give inpatients the opportunity to make choices and to participate in outside community activities. Respondents also feel that the inpatient setting is structured to include elements of community life and that family often help on the ward. These findings add weight to the previous descriptions of ward events.

However, staff report an even stronger effort to adjust their personal manner to fit client expectations and to accept the beliefs of tradition-minded patients. This is

Table 4.15
 Perceptions of Institutional Accommodation Practices
 (N = 8)

Accommodation Practice	Percentage of Staff Endorsing Accommodation Item	
	Always/Sometimes	Seldom/Never
1. Native healer involvement in patient care		100%
2. Staff accept beliefs of traditional patients	57%	43%
3. Staff adjust their personal manner to fit patient expectations	71%	29%
4. A policy exists to find staff whose backgrounds are similar to those of the patients	33%	66%
5. Inpatient activities are similar to their activities outside the hospital	66%	33%
6. Patients make choices about their daily activities	66%	33%
7. Patients are encouraged to participate in community activities outside the hospital--work and recreation	83%	17%
8. Patient's family helps with hospital care	20%	80%
9. Problems occur because patients and staff have different social backgrounds	50%	50%

Table 4.16

Staff Endorsement of Culture Accommodation Dimensions (N = 20)

Accommodation Statement	% of Staff Endorsing Statement
1. Staff should know the traditional names for mental disorder	100%
2. Staff should adjust their personal manner to fit the expectations of patients from different social backgrounds	100%
3. While in the hospital, patients should remain isolated from activities in the community	100% disagree
4. Staff should know the traditional healing practices for mental disorder	95%
5. Community leaders should help in planning and directing facility activities	95%
6. The patient and his family should help choose the type of treatment given	95%
7. Patient activities in hospital should be similar to their activities in community	90%
8. Patients should go to larger central hospitals for their treatment	90% disagree
9. What is considered the appropriate outcome of treatment should be different for different cultures	85%
10. The doctor alone should decide treatment outcome goals	85% disagree
11. What is considered "normality" is the same for all cultures	85% disagree
12. It is useless to consult with native healers since most cannot help people with mental disorders	80% disagree
13. It is best to hire staff whose social backgrounds are similar to those of patients	65%

Table 4.16 (continued.) Staff Endorsement of Culture
Accommodation Dimensions (N = 20)

Accommodation Statement	% of Staff Endorsing Statement
14. Only those trained in scientific treatment techniques are qualified to help people with mental problems	35% disagree
15. Staff should try to correct or re-educate patients who maintain traditional beliefs and customs about mental disorder	25% disagree
16. It is useless for staff to know the traditional beliefs about causes of mental disorder	5% disagree

congruent with the results of Questionnaire #3 (Table 4.16) showing 100 per cent endorsement of the statement that "staff should adjust their personal manner to fit the expectations of patients from different social backgrounds."

In contrast, accommodation practices such as hiring staff with certain social backgrounds and involving native healers rarely occur. Interestingly, 50 per cent of the respondents reported problems arising because patients and staff differ in their ethnic backgrounds. NACMHC is unique in that staff are hired based on their linguistic ability to relate easily with their clients through the Taiwanese dialect.

Table 4.16 adds further insight into the relevance of accommodation. It reports staff endorsement of 16 statements dealing with various accommodation dimensions. The data are from 20 professionals representing all disciplines at the different clinics (See Table 4.6). It is remarkable that even with such diversity, three-fourths of the accommodation statements were endorsed by 85 per cent or more of the respondent.

Many of the items given uniform endorsement are consistent with previous descriptions of clinic accommodation, for example, items 2, 3, 6, 7, and 10. However, some interesting discrepancies emerge. Although 95 per cent agreed that community leaders should help in planning and directing facility activities, this policy did not exist

anywhere. Staff also disagreed that it is useless to consult with native healers. However, folk healer involvement was a practice alien to modern medical settings. Moreover, with respect to therapeutic modalities, the ultimate decision making rested with the physician. This contrasts with the expressed sentiments that the patient and his family should help choose the treatment type (item 6) and strong disagreement with the item stating that the doctor alone should decide treatment outcome (item 10).

Four culture accommodation dimensions were not endorsed as favorable. The issue of hiring staff whose social backgrounds are similar to patients did not seem that important except at NACMHC. Only 35 per cent disagreed that scientifically trained workers were the most suitable practitioners. Those expressing the strongest disapproval of this conclusion were nurses, occupational therapists, and social workers. Furthermore, only this same small group failed to support the notion that patients maintaining traditional beliefs should be re-educated. Finally, all except one psychologist agreed that there is no value in knowing the traditional beliefs about the causes of disorder. This seems incongruent with other responses showing full agreement that staff should know traditional names of disorder and folk practices. The wording of the item may have elicited a response bias. On the other hand, knowing conceptions of causality may genuinely be seen as less

useful than knowing folk names for psychopathology and folk interventions.

In brief, accommodation by the mental health system to elements of Chinese culture appears to have more endorsement in professional attitude than in actual practice. Adjustment to the expectations and demands of the Chinese family as it relates to the psychiatric care of one of its members is the most active accommodation dimension. Professionals recognize the family's supremacy in the life of the individual. It holds firmly rooted expectations about the best places to take the patient for help, what problems will be tackled (e.g., weak nerves), which medical interventions will be applied to the physical symptoms, and what type of recovery is anticipated.

In accommodating to the patient and his family, staff report trying to gain confidence and cooperation by avoiding the denial of folk beliefs, starting out with medical applications that are expected, and playing the role of an authoritative yet assuring expert. When confidence has been won, then divergent professional beliefs about the best therapeutics and suggestions for change are recommended. Accommodation for inpatients focuses on allowing family residence on the ward and emphasizing rehabilitation involving skills for economic productivity. This focus strengthens the individual's position within the family.

INDIGENOUS ALTERNATIVES TO MENTAL HEALTH CARE

Lin's epidemiological studies were interpreted to indicate that 95 per cent of those needing some form of psychiatric care were without access to modern treatment (Tseng, 1975a). However, it is erroneous to believe that most of those needing assistance are without any mental health resources. On the contrary, there is an elaborate system of alternative therapeutic interventions to choose from. Anthropologists and ethno-psychiatrists have delineated the system of folk therapy viably carrying out its function in modern day Taiwan (Ahern, 1975; Hsu, 1976; Martin, 1975; Tseng, 1976). The major forms of traditional psychological care are briefly sketched below in order to put modern psychiatry into perspective.

Families choosing traditional healing methods may employ four health resources: self-treatment, folk practitioners sacred or secular, and Chinese medicine. Generally speaking, the first resource considered is some form of family based or self-treatment (Kleinman, 1975). Here, secret prescriptions handed down from family ancestors are administered to the ill person. If this fails, then folk practitioners, either sacred or secular, are visited. The tang-ki, or Taiwanese shaman, is an example of a sacred folk practitioner available in both rural and urban areas.

Since the 17th Century when the Fukienese established settlements in Taiwan, there have been tang-kis in almost

every Taoist or folk temple (Li, 1976). The shaman's role is to become possessed by the temple god and convey instructions to worshippers and clients. While in trance, the tang-ki diagnoses the problem, explains its cause, and offers treatment through an elaborate ritual of spells, paper charms, or herbs (Li, 1976). Tseng (1976) reported that their clients were mostly women with low educational status. Kleinman and Sung's (1976) outcome study of shamanic curing found that the majority of problems seen were health-related. The remainder were divided between personal and family problems and business worries. In fact, with 800 tang-kis in Taipei alone, most seeing between 5 and 50 clients per day, Kleinman and Sung (1976) see these folk healers as playing a major role in general health care, psychiatric help, and crisis intervention. Tang-kis appear to treat most of the cases of sickness that move beyond the family context.

Tang-kis and village temple cults offer sacred medicine for more serious problems such as illness, fright, bad luck and bad fate. They do so by restoring harmony to the individual's life and "patching" his fate (Martin, 1975). On the other hand, divination is used to reveal a person's nature with the thought that such feedback will enable him to maximize talents and make up for predisposed shortcomings (Tseng, 1976).

Traditional Chinese medicine is the final source of

indigenous mental health care described. Kleinman (1975) found that Chinese and Western-style practitioners were generally called upon after unsuccessful results from self-treatment and folk healers. Chinese medicine involves an elaborate pharmacopoeia consisting primarily of herbal potions. But it also includes certain animal tissues thought to have healing and potency qualities. Acupuncture, acupressure, massage, and body manipulations like Kung Fu and Tai Chi are additional aspects of traditional medicine.

Chinese medicine has remained popular despite the Nationalist Government's 1929 endorsement of Western medicine (Gale, 1975). As opposed to the five medical colleges supported by the government, there is only one college of Chinese medicine, the China Medical College. This institution was regarded as a quaint but dying cultural element until 1974. At that time, a policy shift took place within the National Health Administration and a committee was set up to develop traditional Chinese medicine, pharmacy, and acupuncture. Funds became available to build a modern teaching hospital at the China Medical College. Money was given for acupuncture research and for herb cultivation. The intention was to find the benefits of herbal medicines for reducing hypertension and as anti-carcinogens (NHA, 1975).

Popular reliance on Chinese medicine was largely unaffected by lack of official support. According to Gale

(1975), there were at least 1,106 licensed Chinese traditional doctors in 1970. A brief walk through city neighborhoods in Taipei is enough to reveal the abundance of both herbal pharmacists and traditional doctors. At the personal level, those brought up relying on herbal medicine continue to do so as a matter of course in a culture which values the traditional. Furthermore, it is widely believed that scientific medicine, although rapid and dramatic, sometimes has harmful side effects. Chinese medicine is seen as gentle and effective (Tseng, 1976). It restores harmony without damaging body organs. The notion that prescriptions are transmitted secretly from ancient times adds mystery and faith to this form of medicine and appeals to many, especially those suffering from chronic illnesses (Tseng, 1975a). At a more abstract level, Chinese medicine is a symbol of traditional values giving reassurance in the face of dramatically changing times.

To review, indigenous therapies with relevance to psychological problems co-exist with psychiatric care in Taiwan. Actually, folk healing forms like shaminism and divination may be the only mental health resources available outside of a few urban centers. Preliminary studies by Kleinman (1975) suggest that families first turn to self-medication when a relative is defined as ill. Except for modernized urban citizens, who do rely exclusively on scientific doctors, most Taiwanese would next visit folk

practitioners--sacred and secular--before finally turning to Chinese or Western-type physicians. In reality, the referral pattern is even more complex, since families employ diverse health resources simultaneously.

Understanding the relationship among the folk system elements is also important. Tseng (1975) reports a functional difference between the healing systems based on problem type. Fortune tellers and physiognomists are typically confined to psychological problems of living and perform counseling rather than healing functions. Herbal medicine, on the other hand, is pharmacy oriented and related primarily to somatic concerns. The role of modern psychiatry in this context is to handle those cases with major psychotic disorders, but is less well suited for advising on problems of everyday life. It may be that these healing systems are functionally specialized, each with its own problem-specific territory. Rather than being in competition with one another, they may instead form a mental health resource network that services the broad spectrum of individual and social needs.

V. MENTAL HEALTH SYSTEM OF THE PHILIPPINES

INTRODUCTION

Geography and Population

The Republic of the Philippines is comprised of some 7,100 islands forming a 1,000-mile land chain between the South China Sea on the West and the Pacific Ocean on the east. This multitude of islands forms part of the great series of island arcs fringing the East Asian mainland. To the north are Japan, the Ryukyus, and Taiwan; extending south are Sulawesi, Irian, and the remaining Indonesian archipelago.

The combined surface area of the Philippine Islands is 115,831 square miles, just slightly larger than Arizon. Luzon in the north (40,420 square miles) and Mindanao in the south (36,537 square miles) account for two-thirds of the country's land area. The remaining one-third is mostly accounted for by nine other islands--Samar, Negros, Palawan, Panay, Mindoro, Leyte, Cebu, Bohol, and Masbate--which form the Visayans regional grouping.

The dominant geographical feature of these islands, and the Philippines' greatest natural liability, is their mountainous interior sections. The uplands comprise 65 per cent of the total land area with volcanic activity found at more than a dozen sites throughout the chain. This reduces the readily-cultivated farmland to a few narrow strips of coastal plain. The unique central plain of Luzon, the most

extensive lowland in the country, has enabled this island to play a dominant role in the life of the Philippines. The capital city of Manila is located in the heart of this important agricultural area.

Another critical feature of the archipelago is its climate. Lying completely within the tropics, the lowlands have a year-long warm and humid climate with an average mean temperature of 80° F. Rainfall is generally adequate, although the trade winds have variable effects due to the mountains. Lying astride the typhoon belt, the Philippines is buffeted by these climactic hazards on an average of 15 times yearly. Cyclonic storms affect the country with at least heavy rainfall and perhaps one-third of the time with destructive winds and torrential rains. The most severe storms are commonly felt in eastern Luzon and Samar.

The Philippine people are mostly of Malay origin, descendants of Indonesians and Malays who migrated long before Western contact. A tiny minority are Negritos, the first people among contemporary populations to inhabit these islands. They are believed to have come more than 30,000 years ago from Borneo and Sumatra across then-existing land bridges.

The Chinese are a small (1.25 per cent) but significant ethnic minority. They first arrived in the Ninth Century as traders and have played an important role in commerce and national affairs. Many Filipinos have Chinese ancestry due

to historical intermarriages. Approximately five per cent of the total population are Muslim Moros. Islam's northward spread from Indonesia was halted in the Sixteenth Century by the Spanish conquistadores. The Spanish cultural legacy is Christianity; Catholicism claims about 90 per cent of all Filipinos.

Linguistically, some 87 native languages and dialects are spoken; all belong to the Malayo-Polynesian group. Eight of these dialects are spoken by 86 per cent of the people; the three principal ones being Cebuano (Visayas), Tagalog (Central Luzon), and Illocano (northern Luzon). To promote national unity, the government has promulgated the use of Pilipino as a common language. Tagalog-based Pilipino is taught in all schools and is gaining acceptance as a second language. English, however, is spoken by 40 per cent of the population, including most professionals, academicians, and government workers. Pilipino is replacing English as the medium of instruction and writing in the universities as part of the political push toward Filipinization of the country.

The population of the Philippines in mid-1977 was 44,660,000. This yields a density of 149 persons per square kilometer, nearly double the average for Southeast Asia and only exceeded in this region by Singapore. The scarcity of lowlands means that the bulk of these numbers are squeezed into a relatively small area, particularly the food-producing Central Luzon plain. In fact, one-tenth of the nation's

people reside in the Metro-Manila area, giving it a concentration of 8,200 persons per square kilometer (NEDA, 1977).

Present population density, coupled with an extremely high growth rate (2.85 per cent annually), makes population pressure one of the most serious problems facing the nation today. From 1950 to 1970 there was a 70 per cent increase in population, not surprising given that the total fertility rate for all women is 5.8 offspring and for married women is 9.63 (Concepcion & Smith, 1977). At current rates, the 30 years between 1970 and 2000 will result in an increase of 162 per cent (U.N., 1975).

In 1971, however, the government officially recognized this problem with a law on national population policy and the creation of family planning clinics. The United States Agency for International Development (AID) has been a major force providing family planning assistance (Woolley, 1972).

History

Patterns of contemporary Philippine life can be traced to key historical influences. Pre-colonial Malay society was organized around small, autonomous kinship groups called barangays (Constantino, 1977). The scattered barangay communities--primitive economic units relying on subsistence agriculture--were ruled by appointed chieftains known as datus. Because these communities were loosely associated, they offered little resistance to subsequent waves of settlers

and conquerors. In the Ninth Century, Chinese merchants and traders arrived. They were followed by Arabs (Moros). The arrival of Spanish conquistadores, spearheaded by Ferdinand Magellan's initial landing in 1521, halted the movement of Islamic influence beyond the Sulu archipelago and Mindanao. Thus began a 350-year era of Hispanic cultural domination (Phelan, 1959).

The Spaniards came to Christianize and Hispanize island inhabitatns and build a base for converting China and Japan to Christianity (Phelan, 1959). The colonial power also desired a share in the lucrative spice trade and hoped for discoveries of gold and silver. Disappointed in the absence of these riches, they nevertheless extracted tributes, commodities of produce, and conscription labor to bolster the Spanish navy and army. Agricultural and economic development was neglected for 200 years while Manila became a major port for galleon trade between China and Mexico. While the economy lay stagnant, profound social changes began to take shape. The Catholic friars, holding administrative power, rearranged the scattered barangays into controllable communities around the church as their central foci. Henceforth, art, education, and entertainment centered on religious themes channeled through the offices of the parish priest. The impact of this cultural stamp is clear: the Philippines is presently one of the most "Catholic" nations in the world.

The late 1700's marked significant political and economic developments. First, an upper stratum of prospering

elite emerged from among the barangay chieftains. This new class, the "principalia," later merged with the Chinese mestizos (native born, catholicized Chinese with part-Filipino parentage) who ascended to prominence under a liberalized economic policy.

Under the imperatives of expanding world capitalism, Spain was forced to open its colony to import-export trade. The Chinese assumed the much needed middle-man position gathering sugar, indigo, rice, tobacco, and other produce for British traders and selling back to the people the goods which these traders brought with them. Under these favorable conditions, the mestizos joined the principalia as community leaders and landowners.

It was from this elite stratum that Philippine nationalism germinated after educational reform permitted principalia to send their offspring to Manila and Spain for higher education. These newly-educated youth, known as ilustrados (enlightened ones), agitated for better treatment for the colony, social rights, and a voice in the government. They pushed toward parity as a province of Spain. However, reformists like Jose Rizal were superseded by revolutionaries demanding separation rather than assimilation.

In August, 1896, a revolution was launched and General Emilio Aguinaldo emerged as leader of the revolutionary government. Two years later, all except Manila and Cavite were in the hands of the nationalists.

Modern nationalism arose in Southeast Asia for the first time with the collapse of Spanish rule in the Philippines and indigenous efforts to create a Filipino government. The first Philippine Republic was a completely ilustrado government. It inaugurated Aguinaldo as its president in January, 1898. However, the Spanish-American War brought American intervention on the side of the revolutionaries. Spain ceded these islands to the United States a year after independence had been declared. Despite initial resistance, and perhaps with a few qualms of conscience, the Americans set up a colonial administration employing a core of ilustrados who had declared their loyalty to the new rulers.

The United States' 50-year domination of the Philippines has clearly left its cultural imprint upon the social institutions and values of the nation. Americanization was channeled through a public education system using English as the language of instruction and standard American curriculum as learning content. By 1935, economic dependence on the United States was almost total; it handled over 70 per cent of the nation's exports and an even greater percentage of its imports (Constantino, 1977).

William Howard Taft engineered the transplantation of an American-type political process to the colony with the ideal of "popular self-government" (Steinberg, 1971). Idealism was compromised, however, as reliance on ilustrados to end nationalist resistance strengthened the prevailing

land tenure system. It concentrated large holdings in the hands of a few and permitted this aristocracy political control which has persisted to the present.

In 1916, the Jones Act facilitated Filipino control of their legislature. The Nationalista party, led by Osmena and Manuel Quezon, became the dominant political framework of the country. With pressure from American farm and labor interests, the Philippines was finally granted a 10-year commonwealth status leading to independence under the provisions of the 1934 Tydings-McDuffie Act. Quezon and the Nationalista party dominated political life up until World War II. This era saw striking increases in the number of people participating in urbanization, education, voting, and modernization. Philippine nationalism was in full bloom. People of all economic and social strata could at last identify with their homeland as a unified, self-governed politic (Steinberg, 1971).

The Japanese occupation delayed independence until July 4, 1946. The period post-war and post-independence saw a continued reliance on the United States. Free trade was granted and Congress appropriated \$144 billion for Philippine reparations. However, this was tied to a parity agreement whereby Americans had equal rights with Filipinos in natural resources and public utilities. Long-term leases for American bases were signed. The Philippines sought to make an American-style democracy work for 25 years. A two-party

system was developed (although politicians moved quite freely between them) along with a presidential office, judiciary, and congress.

During this time, Presidents Roxas, Magsaysay, and Macapagal were favorably disposed to American ties and interests. The Philippines joined SEATO and extended parity into business; American corporations purchased floundering industries when the economy sagged. American investments increased even sharper during Ferdinand Marcos' first term in the late 1960's.

During his unprecedented second term, Marcos ended Southeast Asia's longest experiment with democracy by declaring martial law in response to threatening incidents he had apparently staged himself (Botwell, 1975). In doing so, Marcos shattered seven decades of parliamentary government and joined the company of other regional leaders who placed personal power above all. Since 1972's declaration of martial law, the Philippines has moved from its strongly pro-Western stance toward a policy of non-alignment. Regional involvement, once overlooked in favor of association with American and European cultures, has been greatly stepped up through participation in the Association of Southeast Asian Nations (ASEAN) and a desire to establish closer ties with Viet Nam, Cambodia, and Laos. Problems plaguing Marcos' administration today include periodic outbreaks of resistance to martial law, armed insurgency among the Moros in Mindanao seeking

greater autonomy, and communist rebels in Luzon--the New People's Party.

Economy

The Philippine economy is characterized by relatively slow and irregular growth. Yet definite expansion in industrialization, agriculture, and mining sectors has appeared in recent years. Sluggish growth is reflected in the ten-year (1965 through 1974) averaged rate for Gross National Products (GNP) of 5.7 per cent. Gross Domestic Product (GDP) declined from 7.3 per cent in 1976 to 5.8 per cent in 1977, reflecting slower growth in agriculture, manufacturing, and construction activities and continued low prices for some important export products (ADB, 1977).

Agriculture, forestry, and fishing are the largest and most critical sectors of the Philippine economy, employing 57 per cent of the work force and accounting for 27 per cent of the GDP (Burley, 1977). Thirty-eight per cent of the land is given over to agriculture. The primary cash crops are sugar, molasses, coconut oil, copra, pineapple and tobacco. The Philippines is also one of the world's leading exporters of forest products. The manufacturing sector accounts for 24 per cent of the GDP, yet employs only 11 per cent of the work force (ADB, 1978b). Light industry products center on processing and assembly operations involving food, beverages, rubber products, textiles, plywood, etc. Heavier industries include cement, glass,

fertilizer, and industrial chemical production. While Philippine exports rose in the last six years at a healthy 18.7 per cent, imports increased at an even higher percentage. Unlike her neighbors Indonesia and Malaysia, the Philippines has no oil production, necessitating 100 per cent importation of petroleum products along with heavy equipment and other industrial products vital to development.

The balance of trade deficits, historically reaching into the hundreds of millions, has been a major problem resulting in the shift to a floating currency, massive International Monetary Fund loans, and government efforts to encourage industries. Economic development has also been encouraged through government policies stimulating foreign investment. United States investment was estimated at over \$1 billion in market value in 1975 (United States State Department, 1977). In 1976, the total new flow of resources from various funding agencies and countries amounted to \$2.35 billion, making it the second highest recipient country among the Asian Development Bank members (ADB, 1977).

Other indices may be cited to complete the economic picture. The inflation rate tapered off to a reasonable 7.9 per cent in 1977 (ADB, 1978b), from a high of 40 per cent in 1974 triggered by the world oil crisis and recession. Unemployment is presently about five per cent of the total work force (ADB, 1978c). More significantly, underemployment is widespread: 25 per cent of college graduates are unable to find work and only

17 per cent gain jobs in their fields of training (Woolley, Perry, Gangloff, & Larson, 1972). With a GNP of approximately \$15.4 billion in 1975 (United States State Department, 1977), the per capita GNP is only \$410 and per capita income \$370. Only Thailand and Indonesia have lower rates in South-east Asia. Infrastructure development--transportation, communications, power--has picked up since 1973, but still requires a great deal of more spending to provide a firm footing for the other areas of economic expansion.

To this description can be added pertinent social indicators to more fully portray the status of national development and quality of life in the Philippines. A residue of colonial times is the relatively high level of popular education: there are over 40,000 public and private schools, enrollment in secondary schools is 49 per cent, and the literacy rate is a very respectable 83 per cent (ADB, 1978b). Technical industries have a well-educated pool of indigenous manpower resources to draw upon, although, surprisingly, the supply may outstrip the demand. In fact, the Philippines has been exporting technicians overseas, especially to the Middle East.

Moreover, a chronic brain drain problem exists in the professional fields with a steady outflow of health workers to Western countries in search of higher paying positions.

In terms of health, the average Filipino consumes 1,960 calories per day (one of the lowest consumption rates in Asia

and the Pacific), although his life expectancy, 61 years, is fairly respectable. Infant mortality is 74 per 1,000 live births (DOH, 1978). This is quite high in comparison with Singapore, for example, which has an infant mortality rate one-sixth as large (ADB, 1978b). On the other hand, the ratio of physicians per population (1:2,000), is actually on par with Singapore.

The last indicator to consider is urbanization. Over 35 per cent of the population are now in a few concentrated urban areas. Metro-Manila is the major metropolitan center with approximately 4.5 million. Cebu and Davao, the next largest cities, have about 10 per cent of that number. A critical problem is in-migration into urban systems ill-equipped to serve the influx (Woolley, et al., 1972). Moreover, the uneducated migrant is a burden to development. Unable to fit into technical, industrial positions, his absence from the agricultural sector cuts production since there is no mechanization to make up for losses of manpower.

The Context for Mental Health Development and Delivery

The foregoing description is the backdrop against which health and mental health services have developed. Geography, history, culture and economy are the molding forces for all social institutions including those dealing with health. These elements give rise to the health problems confronting social welfare institutions.

Of special interest to keep in mind during the following

characterization of mental health in the Philippines are:

1) the effects of island geography on transportation and communication; 2) the multi-ethnic nature of the islands, a consequence of geographic isolationism; 3) the impact of Americanization on institutions, especially education in the health fields; and 4) the constraints of politics and economics.

The last point bears elaboration. Woolley and his co-workers (1972) found a profound interaction between health and socioeconomic development in their case study of Philippine health. Historically, politicians have kept the public sector purposely small--private interests produced 90 per cent of the goods and services. Efficient, long-range planning for national development concerns are crippled: politicians tend to focus on highly visible "pork barrel" projects that elevate their personal status with the voters and maintain the status quo.

Without revenues and capital formation in the public sector, infrastructure components like roads, airports, railroads, and the full breadth of public services suffer. Until recently, government expenditures were accounted for almost entirely by salaries for civil servants. In this political-economic atmosphere, the position of social welfare, health, and mental health matters is tenuous at best. It may be expected that public revenues for this domain are minimal and taken care of more by non-governmental agencies. What

official attention given to mental health matters may follow the cultural form of "window dressing." That is, a conscious effort to project an image of good will and concern for individual well-being, motivated as much for political reasons as genuine desire to solve social ills.

FACTORS INFLUENCING THE NATIONAL ORGANIZATION OF PSYCHIATRIC SERVICES

The purpose of this section is to identify major influences on the system of psychiatric care in the Philippines. An historical sketch is followed by an overview of national mental health activities within public and private sectors. To conclude this section, attention is given to miscellaneous influences such as the role of international consultation, research, migration of professionals, and national health insurance.

History of Philippine Psychiatry

Unlike Taiwan, there is no central figure in the evolution of Philippine psychiatry. An absence of published materials makes it difficult to trace the forces responsible for contemporary mental health care. In fact, the author found no governmental document delineating the nation's mental health program: its infrastructure, lines of administration, manpower, training requirements, facilities, expenditures, service statistics, etc. Nevertheless, from the writings of several authors are gleaned a summary of

what were the significant historical events (Aragon, 1977; F. C. Castaneda, 1974; J. Castaneda, 1974; Berne, 1950; Escudero, 1972; Maguigad, 1964).

In December, 1928, thirty years after American colonization, the Insular Psychopathic Hospital was established in Mandaluyang near Manila. It was built to house the "insane" from throughout the Philippines (J. Castaneda, 1974), replacing the "Insane Department" of San Lazaro Hospital. In 1935, it became the only government treatment facility when the Manila Sanitorium closed. The initial bed capacity of 400 was quickly exhausted, an event which was to become often repeated, requiring the construction of more and more wards.

By the time World War II came, there were 3,000 in-patients. Harsh conditions under Japanese rule--starvation and mistreatment--led to hundreds of patient deaths and their removal by families. By the end of the war, only 445 remained. Eric Berne (1950) visited this hospital two years after the war and found the population up to 1,813 patients cared for by 10 physicians and 20 nurses. He reported electro-convulsive shock as the principal therapeutic modality applied via an "outmoded" Japanese apparatus. At that time, there were no psychiatrists outside of government employment.

By the mid-1950's, it became apparent that the psychologically impaired could not be handled in one institution.

The solution to ease overcrowding was to build branches and extension clinics in other parts of the archipelago. This approach continues today, although it has never achieved its mission because of lack of support and resources (J. Castaneda, 1974).

A reorganization in the Department of Health (DOH) during 1958 led to the creation of the Mental Hygiene Division (MHD) within the Bureau of Disease Control. The intended purpose was to formulate policies, develop plans and programs, and carry out research germane to mental hygiene. Then, in 1962, bolstered by the presence of DMH, a national mental health program pushed in earnest for the decentralization of the National Mental Hospital (NMH) at Mandaluyang. The principal objective of this plan was regionalization of services, placing the burden of distribution on the eight Regional Health Offices (RHOs). This move was in line with a general DOH effort to integrate public health services with hospital-based care so it was natural to include mental health in the overall integration scheme (Aragon, 1977).

Decentralization, aimed at realigning the inefficient centralized administration of psychiatric treatment, resulted in NMH losing its executive control over mental hygiene units. These became the responsibility of the eight Regional Health Directors (RHDs). A five-year program was initiated following a set of recommendations to: 1) limit the number of inpatients to a maximum of 2,000; 2) transfer

out select patients to general hospitals near home; and
3) establish a series of regional mental hospitals, psychiatric units in general hospitals, half-way houses, and mental hygiene clinics. The DMH was to provide technical support by training physicians and nurses to work in these new services and facilitate decentralization through coordinating contact between NMH and the DOH Bureau of Medical Services.

The plan to phase out NMH congestion through the integration of mental health care with the public health system has been slow in its implementation and is far from successful. Presently, NMH, with an official bed capacity of 3,500, houses some 8,000 inpatients. Reasons for the failure of the national mental health program are taken up below.

While the public sector was beginning to experience the massive overburdening of its lone residential facility, a private agency was formed--the Philippine Mental Health Association (PMHA). PMHA's goals are to promote mental health activities, educate the public on the issue, and provide a wide range of clinical services. In 1951, it pioneered a nationwide educational movement through promotion of the first annual National Mental Health Week. This became an official yearly event in 1957 through Presidential decree. It also initiated the first community mental health clinic in the Philippines in 1951, later adding both rural and urban-based rehabilitation services.

PMHA provides the main stimulus for mental health research through the publication of two periodicals and since 1965 has awarded about 20 research grants. Several grants have gone to the DMH to assist them in their mandate to carry out epidemiological surveys. The first DMH epidemiological field investigation was followed up six years later through a PMHA grant to examine the status of 86 identified cases. These two field surveys, pointing toward an incidence rate of 36 per 1,000 (including mild dysfunctions), are heavily relied upon by government planners in discussions of psychological impairment and service needs for the country. In addition to research support, PMHA has sought to coordinate its educational and clinical activities with the DMH and aid that government unit with training professionals for public health psychiatric projects.

To review, the history of Philippine psychiatry was marked by an initial build up of a highly centralized, congested, and ineffectual custodial institution in Central Luzon. It was followed by a weak governmental effort to decentralize services through regional facilities and incorporation into the public health system. Within the DOH, the DMH was created in part to facilitate the decentralization of treatment. But it was only given "technical assistance" status with no form of administrative control or policy implementation power. In essence, the existing

public health system is being asked to cooperate in taking on mental health workers at various levels of service delivery.

The tenuous nature of this plan is revealed by several facts: 1) there are very few of these specially trained workers; 2) their role at the local level is nebulous; 3) they are quite often health officers who return to old jobs without concentrating on psychiatric problems; and 4) the success hinges on RHDs who may have little knowledge of, nor give much attention to, mental health concerns.

PMHA began in the early 1950's and quickly established itself as the strongest voice for mental health promotion and community-based care. To a certain extent, it coordinates its activities with the DMH and the NMH and has lent its support to the program of decentralization. The existence of a dynamic private sector influence in national mental health development is well within the Philippine national pattern of reliance upon this sector for national progress. The public versus private dichotomy, with private groups taking a leading role in institutional development, is expanded in the following section detailing the country's overall health and mental health resources.

The Two Sectors of Philippine Mental Health Delivery:
Public and Private

The DOH envisions its national mental health program as part and parcel of the public health system. In order to appreciate what this entails, it is necessary to sketch an overview of the public health program and its position within the government. This is followed by an elaboration of the mental health program as defined by the activities of the National Mental Hospital and the Division of Mental Hygiene.

Public Sector

Department of Health. Medical care in the Philippines is provided by the DOH, the Philippine Medical Care Commission, and chartered municipal and private agencies. The DOH, located in Manila, has responsibility for all public health services and additionally supervises and consults with private care givers throughout the country. Since the majority of Filipinos cannot afford private care, concentrated exclusively in urban centers, the burden of health delivery falls upon the DOH. At the time of this 1977 survey, the DOH was operating under a 1973 organizational scheme consisting of 16 Divisions under the Secretary of Health and his Under-secretary. One division, the Bureau of Health and Medical services, contained the Disease Control Unit under which the Mental Hygiene program operates. Curative and preventive services are administered

through 11 regional offices headed by the RHDs. Each of these supervises provincial health officers under whom are a number of municipal health officers and rural health workers. The rural health units (RHUs) and municipal clinics form the base of the health delivery system.

The most recent Health Plan (FY 1975-1978) lists as its priorities the increase in life expectancy, reduction in population growth and infant mortality, upgrading nutrition, expansion of the national insurance program, and a focus on health disabilities associated with growing urbanization (DOH, 1975). These goals are to be met through a concentrated effort to expand and upgrade the rural health infrastructure (NEDA, 1977). This means building scores of new RHUs, revitalizing existing ones, and creating neighborhood level "barangay" health stations on a massive scale with community, emergency, and regional hospitals. Integrated into these units from the barangay to the central level are the three principal programs of health, nutrition, and family planning. Presumably, a mental health program is included also, yet it is not mentioned in the national development documents (e.g., NEDA, 1977), nor did psychiatric specialists serve on the national health planning committees.

Manpower targets to operate the rural health system in the immediate future call for 2,300 physicians, 2,300 nurses, 9,300 midwives, and the training of 3,102 family

planning outreach workers. Eventually, 54,365 barangay level workers are also to be added (NEDA, 1977). One measure to fill the manpower gap is the Rural Health Practice Program instituted in January, 1974 (Pilar, Boncaras, & Santos, 1976). It requires medical and nursing graduates to serve in rural areas for six months; it is expected that some of them will choose a career in rural health care. In essence, the current theme is on greater health coverage to low-income rural, depressed, and slum regions with an expressed interest in community participation and reliance on local resources. Additionally, the government policies call for a strong involvement of the private sector in the same processes (Pilar, et al., 1976).

Funding. National health development has never been a priority consideration in the Philippines, as reflected in financial allocations. From 1970 to 1976, the DOH's share of the national budget decreased from 4.5 per cent to 3.05 per cent. Public spending on health as a proportion of the GNP has also declined from 0.40 per cent in 1974 (Europea, 1977). Although the expenditure has gone up numerically (\$96.5 million in 1976), this is offset by population growth, inflation, and the devaluation of national currency which has resulted in the scarcity of medical supplies and equipment (DOH, 1975). Health ranks fifth behind other government functions such as defense, education, agriculture, and infra-structure expansion. According

to the latest five-year development plan (FY 1978-1982), 21 per cent of the national budget in 1978 goes to social service considerations: education and manpower; health, nutrition, and family planning; housing; social welfare; and community development (NEDA, 1977). Approximately 15 per cent of this allocation (1.5 billion pesos) is earmarked for health, nutrition, and family planning; half will go toward curative and preventive services. In the context of these expenditures, it is interesting to note that funding for the national mental hospital was 37 million pesos in 1977--about five per cent of the total health budget.

In short, all social service programs in the Philippines compete for a relatively small (\$870 million) national budget. The share given DOH, projected at almost \$200 million for 1978, must go toward infrastructure development, new RHUs, barangay health stations, regional hospitals, etc.; manpower training; salaries for professionals to fill new positions; and special projects for nutrition and family planning. Mental health considerations fall secondary to these priorities with very little trickling down except for maintenance of existing facilities, employee salaries, and some re-training of public health workers in mental case management. Under these conditions, the burden falls upon the private sector for active promotion and expansion of treatment centers.

Service delivery components and network. To complete the picture of Philippine medical care, it is important to review certain health statistics and note the operational structure of the public health system. Characteristic of developing nations, ratios of physicians and hospital beds to population in the Philippines are one-third and one-fifth, respectively, of those typically found in developed countries. Specifically, there are approximately 13,480 physicians, or one per 3,150 population in 1975 (WHO, 1977), and 68,000 beds, or one per 662 population in 1977 (DOH, 1978). 1977 statistics showed a total of 1,027 hospitals (356 public; 671 private) which evenly divided between them the 68,000 beds (DOH, 1978).

Total health manpower--including M.D.'s, nurses, dentists, midwives, traditional birth attendants, etc.--make up a force of some 42,523 workers (WHO, 1977). Professional training takes place in the country's nine medical schools: five in Manila and four in Cebu City. There are approximately 24 schools offering a B.A. in nursing while 44 hospital programs exist for nursing degrees (Diesfeld & Kroger, 1974). Dispersion of these professionals and treatment centers is a critical problem. Almost 22 per cent of all hospital facilities, including the largest ones, are centered in Manila. An estimated 37 per cent of all physicians and 46 per cent of all nurses are located in this same area (Vreeland, et al., 1976).

Based on this estimated maldistribution of personnel, Manila would have one M.D. per 600 citizens, while rural areas maintain a ration of 1:9,000 (Vreeland, et al., 1976).

In some rural districts, however, 1974 manpower ratios held one M.D. per 30,264 and one nurse per 32,529 (Pilar, et al., 1976). RHU personnel in 1977 were estimated at 2,152 physicians and 2,810 nurses; 17,898 nursing and medical students were assigned to the Rural Health Program (Pilar, et al., 1976). Psychiatric specialists number approximately 180. Most of them practice in the Metro-Manila district. The NMH is the country's single largest employer of psychiatrists..

Originally, the DOH conceptualized health delivery in terms of preventive services, to be undertaken by the RHUs and curative medicine handled through hospitals of varying size and specialization. In practice, the RHUs and the nearly 2,000 city health department clinics offer both preventive--community disease control, environmental sanitation, maternal and child health, health education, etc.--and general clinical care as recommended by WHO guidelines.

The health teams that operate within these basic local units are generally comprised of four types of workers--midwife, sanitary inspector, rural health physician, and public health nurse (Woolley, et al., 1972). The recent trend is to add family planning, nutrition, and

(possibly) mental health workers to the roster. RHUs (primary level) are intended to be the initial entry point in the public health system, screening and referring to city or provincial hospitals (secondary level) those patients needing hospitalization.. More specialized care is available upon referral from these facilities to regional hospitals (tertiary level) in the 11 health regions. At the apex of the referral system are specialized treatment units in Manila associated with university medical schools (World Bank, 1976). Once inpatient care is terminated, the patient is supposed to be referred back to the RHU level for follow-up care.

A number of problems beset this public health structure. First, administration communication is quite difficult. It originates at the central level in Manila, and travels down through the 11 RHOs to the 65 Provincial Health Offices before reaching the RHUs and barangay health stations (Pilar, et al., (1976). Secondly, the referral process doesn't work smoothly since patients would rather return to the hospitals which treated them for outpatient care than to the local RHU. Moreover, patients and their families complain of shortages of personnel, beds, and medication, asserting that clinic hours are arranged for staff convenience and are irregularly met. Private clinics are preferred but unaffordable (Vreeland, et al, 1976).

A 1973 survey found severe deficiencies in the infra-

structure and resources available to the RHUs (World Bank, 1976). Vacancies were noted in 23 per cent of the M.D. and 46 per cent of the nursing positions. Lack of interest in rural care was blamed on unsatisfactory working conditions: lack of supplies, physicians having to carry out non-professional level functions, low salaries (earnings one-half of what was possible in private practice), and the lack of cultural amenities in rural zones.

Other problems plague the Philippine health situation. The medical training available in Manila is inappropriate for patterns of rural disease. There, workers confront pervasive communicable illnesses (gastro-enteritis, TB, etc.), malnutrition, poor environmental sanitation, malaria, schistosomiasis, and so forth. The teaching orientation of the North American-educated faculty, however, emphasizes high technology and hospital-based, uneconomical curative medicine. The majority of graduates go abroad for specialized training, viewing as uninteresting the simple tasks required of a rural physician. Perhaps fewer than 50 per cent of the trainees return as the country can only support a limited number of specialists (World Bank, 1976).

A statement by Woolley et al., (1972) expresses a gloomy summary of the health picture:

It appears that that Philippines is losing ground in meeting the health needs of a rapidly growing population. The situation presented by rising costs and the need for continuing expansion of facilities would be difficult under the best conditions. These

problems are greatly aggravated, however, by misallocations of resources, lack of logistical support, ill-defined programs, overlapping and ill-defined responsibilities of health workers, lack of usable data with which to establish priorities, and particularly the lack of an overall policy in the health sector (Woolley, et al., 1972, p. 57).

Mental health provisions within the Department of

Health. Mental health provisions offered by the DOH include two separately administered delivery systems. One is under the auspices of the National Mental Hospital. The other is provided through the RHOs and its office for technical assistance, the Divisions of Mental Hygiene. Before describing the present status of these systems, it is useful to examine writings of DOH professionals regarding their ideal image of Philippine psychiatry, as well as recent official policy statements.

In 1974, DOH sponsored the First National Workshop in Community Mental Health Nursing with WHO assistance. The director of NMH reviewed its existing treatment measures and called for a new direction that would not limit care to institutions alone, but include contact with patient communities and family support environments (J. Castaneda, 1974). F. C. Castaneda, Chief Nurse at NMH, expanded upon this notion. She urged serious consideration of the model under which she had recently trained in the United States--the Comprehensive Community Mental Health Center approach. Noting the absence of a comprehensive program, Castaneda strongly encouraged consideration of the

community mental health model as a tool to redevelop services in the Philippines. A preventive orientation would help reduce the caseload at NMH. Various national and international allies were thought necessary to evolve such a program. DOH should cooperate with other government agencies (education and social welfare), international agencies (WHO, AID, UNESCO), and PMHA in the private sector. Under new coordinated direction, all existing service units would be linked and mandated to deliver care at the neighborhood level.

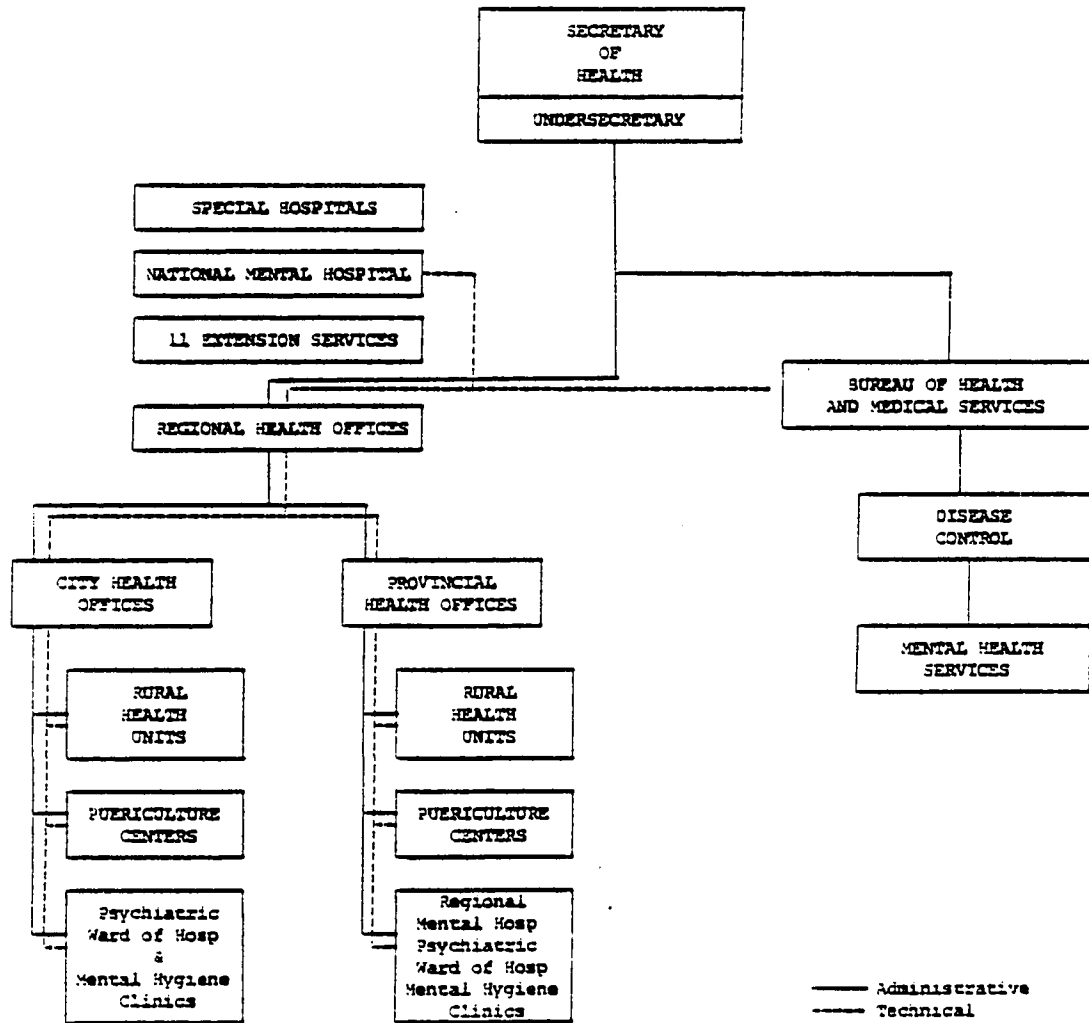
Other concrete recommendations were formulated for DOH consideration: 1) inclusion of psychiatric services in the National Health Plan; 2) integration of these services into basic health care given by RHUs and provincial general hospitals; 3) community mental health training for physicians in the rural and provincial health system; and 4) creation of a mental health specialist position within the administration of each RHO.

DMH's official orientation to service delivery is contained within its recent publication, Manual of Operations on the Control of Mental Disease (Aragon, 1977). Recommendations from the National Workshop on Community Mental Health are reflected in portions of the manual. For example, it suggests case management strategies that avoid closed institutional care, focusing instead upon outpatient departments linked closely with life in the

community to provide continuous care. This is termed a "new direction" in case management--away from simply adding beds and toward strengthening outpatient and domiciliary modes. Hospitalization will be short-term and only as a last resort. To maintain the patient in the community and prevent relapses, conjoint involvement of the family, rural health unit, and Department of Social Services and Development are stressed. Ideally, the patient would be followed up with a coordinated program of drug therapy and vocational, social, and educational rehabilitation (Aragon, 1977, p. 9). The economical advantages to patient containment within community environments is stressed. Also, the manual briefly outlines programs for preventive health education (mental illnesses should be taught along with other diseases) and training psychiatric personnel, nurses, and rural physicians. A significant point is the proposed assignment of a Mental Health Consultant to the RHOs to be responsible for coordinating these activities.

Department of Health direct services. Psychiatric treatment under the DOH is delivered either through the NMH and its extension facilities or by psychiatric units under the administration of provincial and city health offices ultimately responsible to the RHOs. Figure 5.1 provides an organizational chart of these systems, showing the lines of administrative and technical support. These two systems receive separate funding. In 1977 they were

Figure 5.1
Organizational Chart of the Bureau of Health and Medical Services



After S. Aragon, Manual of Operations on the Control of Mental Disorders. Manila: Department of Health, Republic of the Philippines, 1977.

each allocated 35 million pesos for operating expenses (E. Aragon, personal communication).

Although a national program presumably began in 1958 with the order to decentralize NMH, it wasn't until almost 20 years later that the DOH officially spelled out through a departmental circular (Department Circular, No. 35, January 20, 1977) what the agencies' functions were in the "Control of Mental Disorders Program" (Aragon, 1977, Annex 2). In that circular, it was specified that the NMH shall "...provide services for the prevention, treatment, and rehabilitation of the mentally ill; conduct case studies on the nature and treatment of mental disorders and shall serve as a center for manpower training of mental health workers in the government service (Aragon, 1977, Annex II, p. 3)." Presently, NMH has branch hospitals and clinics in 11 locations throughout the Philippines with bed space for approximately 2,500 patients (See Table 5.1). NMH in Mandaluyang has an official bed allocation of 3,500 (actual occupancy 8,000), bringing the total public psychiatric beds to roughly 6,000 with well over 100 per cent overcrowding.

These numbers suggest public psychiatric bed availability at a rate of one per 8,800 population. The number of psychiatrists working in these settings is uncertain, although figures for NMH alone show 60 physicians and 35 psychiatric residents. Neki's survey (1973) found a ratio

Table 5.1

Major Residential Facilities in the Philippines

	<u>Number of Beds</u>
<u>Public Funded</u>	
*National Mental Hospital, Mandaluyang, Rizal (teaching)	3,500 (officially)
<u>NMH Extension Services</u>	
Marivales, Baatan	850
Davao Regional Mental Hospital	600
Camarin Branch, Caloocan City	300
Tuguegaro Hospital, Cagayan	200
D. S. Rodriguez Hospital, Caddan, Pili, Camarinos Sur	200
Batangas City	200
Andres Bonifacio Hospital, Cauite	150
Southern Islands Hospital, Cebu City	60
Zamboanga City	20
Tagbilaran, Bohol	5
Davao Medical Training Center, Nervous Disease Pavilion	?
Baguio City Psychiatric Unit	?
*V. Luna Medical Center, Quezon City	81
*University of the Philippines, Philippines General Hospital, Manila	15
Laguna Provincial Hospital, Sta. Cruz, Laguna	?
Rizal Provincial Hospital Mental Hygiene Unit	?
Total	<u>+6,300</u>
<u>Private Funded or Non-Department of Health Facilities</u>	
St. Lukes Hospital, Quezon City (teaching)	50
*University of the East, Ramon Magsaysay Memorial Medical Center, Quezon City, (teaching)	15
*Veteran's Memorial Hospital, Quezon City (teaching)	90
*Medical City, Rizal	44
*University of Santo Tomas Hospital, Manila (teaching)	36
*Philippine Mental Health Association, Half- Way House, Pinagpala, Dasmarianas, Cavite	20
Cebu Community Hospital, Neuropsychiatric Unit	?
Total	<u>+ 336</u>

(* = interview sites)

of five psychiatrists per one million population, placing the total specialist population at 200. A large portion of these are engaged in private practice and university teaching.

The second DOH system of psychiatric services is administered through the public health organization. According to DOH Circular No. 35, the RHOs are "...To administer, direct, coordinate, and implement the policies and plans of the Mental Health Program through the field health agencies and to report thereon and make recommendations with respect thereto." The administrative officers under the Directors, the Provincial City Health Officers, "...shall be responsible for the administrative direction, supervision, coordination, and control of the plans and policies of the Mental Health Program within his province or city as the case may be (Aragon, 1977, Annex II, p. 3)."

Presumably, assigned to each RHO is a Mental Health Consultant. His position is to assist the RHO in implementing the "disease control program;" "supervise the psychiatric units, hospitals, and outpatient clinics; participate in training new workers; conduct pertinent research; and, in general, coordinate all mental health activities within the region (Aragon, 1977, p. 4)."

An important function of the RHO is to make arrangements to provide technical training of public health workers in the discipline of psychiatric treatment. The training

officers of the RHO Training Centers are pressed into service for this function.

A number of mental hygiene clinics, psychiatric outpatient clinics, and day care units are under the jurisdiction of the Provincial Health Offices. Manila has one mental hygiene clinic; Quezon and Pasay City, also within the Metro-Manila region, have four such centers. All three of these districts use NMH for inpatient requirements. Scattered throughout the rural areas, there are seven mental health clinics and psychiatric outreach programs attached to general hospitals (See Table 5.2). The regional mental hospitals and psychiatric wards that serve as extension services for NMH also receive administrative direction from the RHOs. These mental health units and wards are instructed through DOH Circular No. 35 to only take psychiatric emergencies and those needing short-term hospitalization.

Mental hospitals are to provide transitional services for long-term patients--half-way homes or sheltered workshops. Under this scheme, the RHUs are expected to cooperate and coordinate their activities with the mental health program. RHU duties include receiving discharged patients from NMH or regional hospitals and providing follow-up and crisis intervention aid. Other functions include keeping an updated registry of all cases in the district, engaging in casefinding via school examinations

Table 5.2

Major Outpatient Facilities in the Philippines

Public Funded

1. Jose R. Reyes Memorial Hospital, Manila
2. Manila Health Department, Mental Hygiene Clinic
3. Pasay City Health Department, Mental Hygiene Clinic
4. Quezon City Health Department, 14 District Mental Hygiene Clinics
5. Palomar Health Center, Department of Health, Manila
6. Rizal Provincial Hospital, Pasig
7. Calcooan City Health Center
8. Tacloban City Outpatient Clinic
9. Bohol Outpatient Clinic
10. Cagaya de Oro Outpatient Clinic
11. Legaspi Extension Services, Albay Provincial Hospital
12. Camarine de Sur Provincial Hospital Outpatient Clinic
13. Iloilo City Mental Health Unit, Pototan
14. Batangas Outpatient Clinic
15. Cabanatuan Outpatient Clinic

Private Funded

- *1. Philippine Mental Health Association, Clinical, Diagnostic and Research Center, Quezon City
PMHA Chapters with Clinical Services: Baguio, Cebu City, Butuan, Davao, Dagupan, Zamboanga, Cabanatuan
2. Drug Abuse Research Foundation, Quezon City
- *3. Institute of Maternal and Child Health, Manila
4. U. S. Veteran's Administration Outpatient Clinic, Ermita, Manila
5. Various university student counseling centers

(* = interview sites)

or clinic consultation, health education campaigning, and assisting in the transportation of patients needing short-term hospitalization to the nearest psychiatric ward of a general hospital or regional mental hospital.

While this integrated system of referral, treatment, and follow-up is outlined on paper, its implementation is still sparse and incomplete. One instance where it was begun on an experimental basis in 1968 is Davao City. The regional mental hospital there has been able to successfully link itself with various RHUs to coordinate patient release and supervise follow-up intervention.

The DMH was given the task of overseeing the nation's mental health program and rendering technical assistance to the aforementioned dual systems of treatment delivery. Specifically, the DMH has four functions: 1) develop policies, plans, programs, and operational procedures relevant to the control of psychological disorder; 2) conduct research to determine its nature and causes and to minimize psychiatric morbidity and its disabling effects; 3) coordinate the implementation of the national program in its technical aspects, focusing on the integration of mental health care into general health services; and 4) train personnel assigned to the program in collaboration with the Office of Health Education and Personnel Training.

Curiously enough, however, once given this mandate by the DOH, the DMH was never given the funding, logistical support, nor administrative power to actually carry out its role. Research surveys undertaken by the Division have relied upon PMHA for their funding. In 1972, this state of affairs prompted one official to remark in the DOH Annual Report; "Since there is no money to set up field mental hygiene services, the activities of the Division staff had been concentrated on continuous planning, clinical consultation in conjunction with research activities, evaluation and improvement of the very limited existing resources and facilities, limited training activities, advisory and consultative services, and active coordination with various agencies (DOH, 1971)."

The influence of the DMH for the development of a governmental therapeutic program is questionable. It took DOH 20 years from the inception of DMH to come out with a manual of operations stating specifically what its duties are and the responsibilities of the other public health officials to the mental health program proposed by DMH. The RHOs, under the provisions of Department Circular No. 35, are hence forth expected to carry through the policies and plans promulgated by the DMH. Gaining the full cooperation of the RHDs and officials at the provincial, city, and barangay level is another matter altogether. DMH has no direct authority over these individuals.

The regional Mental Health Consultants are the instruments of program implementation, yet their numbers are few and, as yet, they have very sparse manpower and resources to work with. Moreover, it may be that health officials in general are not only apathetic to the program but actively reject it. This is based on the negative connotations of the subject matter and their fear of dealing with the "mentally ill." Supporting this, one study of general health workers who had been given special training in psychological treatment showed that most did not employ this knowledge once they returned to their jobs (Manapsal, 1974).

On the other hand, certain DMH accomplishments can be noted. The manual of mental disease control, written by DMH staff, compiles most existing information pertinent to the historical development and current conceptions of treatment delivery. It includes several officially drafted policy statements regarding decentralization, disease control, and guidelines for handling psychiatric emergencies in general practice.

The DMH has perhaps worked the hardest in developing training seminars for educating general health personnel in psychiatry. Its guidelines for physicians suggest a six month to one year course beyond psychiatric residence to prepare the trainee not only in diagnosis and treatment, but also epidemiology, the organization of mental hygiene

services, ward activities, and the overall national program. The community mental health nursing course is recommended for four weeks emphasizing the more practical aspects of psychiatric diagnosis, treatment, epidemiology, and a practicum in an outpatient service.

For rural health physicians, lectures should be incorporated into their regular training, focusing on early case finding, prevention, and rehabilitative aspects. Week-long community mental health courses are recommended for the other disciplines; namely, social workers, psychologists, and occupational therapists. The DMH has structured, in addition, a two-day course for Provincial and City Health Officers and their key staff. The content of the seminar is community mental health aimed toward enabling the participants to understand their role in this domain, identify opportunities for primary, secondary, and tertiary prevention, and utilize existing community resources for its promotion (Aragon, DOH worksheet).

Lastly, the Division has detailed avenues through which personnel should work to identify potential cases. Among them are school children screenings, visits to guidance clinics in puericulture centers, and contact with crisis intervention and drop-in centers. Examination of Mobile Mental Health Clinic reports is recommended to locate where families have hidden impaired relatives. Finally, referrals from concerned citizens and barangay

officials is a useful avenue for identifying clinical cases.

Private Sector

Private psychological services, concentrated in Metro-Manila, are available to the 20 per cent of Philippine society who have the economic resources to use them. Economic parameters are important determinants of the system of private psychiatric care. Professionals are permitted to practice their specializations only to the extent that the local economy has the strength to support them. This problem raises the spectre of brain drain as professionals move from saturated markets. This significant issue is discussed more fully later.

Mental health care within the private sector is characterized by the clustering of small psychiatric inpatient units in university and general hospitals in Metro-Manila and the expanding system of outpatient clinics offered by Philippine Mental Health Association chapters. The PMHA is an example of a non-governmental institution offering social services on a national scale. There are 14 PMHA chapters, nine of which render some degree of psychological counseling, testing, and intervention (See Table 5.2). The Association operates on a budget of one million pesos (FY 1976). Funds are secured through the charity sweepstakes, national membership dues, client fees, and sales from its rehabilitation centers.

The national headquarters in Quezon City offers the fullest range of clinical services including an industrial therapy program drawing day care patients from NMH. In the early 1960's, a rural-oriented rehabilitation center was built in nearby Cavite; it offered released NMH patients both half-way house accommodations and training in agricultural work skills. An early evaluation study of the Cavite program by Reyes (1970) showed that almost 25 per cent of the residents left "completely recovered," while another 50 per cent showed definite improvement on behavior rating scales.

A focal point of PMHA chapters is education. An estimated 190,000 people were reached in 1976 through 280 programs: press releases, radio, workshops for youth and professionals, film showings, lectures, and a national conference on urbanization and mental health (PMHA, 1976). Aggregate statistics for 1976, combining chapters, showed 4,192 psychodiagnostic tests, 2,293 psychiatric consultations, and 1,587 clients given social work assistance. The two rehabilitation centers each had about 30 monthly trainees, altogether serving 146 clients.

PMHA operations in the same year included consultations to government and private groups to assist program planning; development and support of 12 student mental health clubs in Metro-Manila; creation of an outreach program for high school dropouts; and funding of four research projects on

such topics as aggression and the effects of television viewing on children.

In sum, PMHA appears to be the most dynamic agency in mental health promotion in the Philippines. It has active ties with governmental efforts in this domain as well as other private agencies. PMHA has sought to build a foundation of services at primary, secondary, and tertiary levels of psychological intervention.

One service area that PMHA has not endeavored to provide, however, is hospital-based treatment. Patients requiring hospitalization must turn to a number of small inpatient units situated in private general hospitals and university medical centers. If eligible, they may use non-DOH governmental facilities like V. Luna Armed Forces Hospital and the American-funded Veteran's Memorial Hospital (See Table 5.2). Altogether, there are six such facilities in Metro-Manila with a combined bed allocation of about 350. There is, moreover, a special "pay ward" at NMH housing up to 200 more patients. While few in number, these units represent the best psychiatric care available in the Philippines, extending to "acute" cases a reasonably up-to-date regime of medical intervention and rehabilitation. Section III below details the specifics of these hospitals.

Other Factors Influencing the Delivery
of Psychiatry in the Philippines

Up to this point, we have looked at the national organization of Philippine psychiatry from the perspective of historical influences and its bifurcation into public and private delivery systems. A number of other factors impinge on the character of mental health services as well. These include the role of research findings, societal attitudes toward psychiatric contact, the Americanization of psychiatry as a profession, the brain drain issue, and health insurance.

Epidemiological studies

It seems fair to conclude that the planning and operation of psychiatric services has been carried out with very little direction from empirical data. To date, the DMH has undertaken only one epidemiological survey in a Central Luzon barrio (Manapsal, 1969). Six years later, a team of DMH investigators returned to follow up the progress of the 86 cases identified earlier from the sample of 2,360 residents (Manapsal, et al., 1974). This single survey has become the basis by which planners have set the prevalence rate for disorder at 36 cases per 1,000 population,¹ or conservatively, 1.4 million affected

¹ These figures are a far cry from Sechrest's (1969) estimation of 1:1,000 based on his own observations of rural areas.

persons nationwide (Manapsal, 1974). Diagnostically, the following incidence rates were reported per 1,000 population: psychoneurosis, 15.2; psychosomatic disorders, 6.8; mental retardation 5.9; psychosis 3.9; personality disorders, 2.5; and epilepsy, 1.8 (Escudero, 1972). Females outnumbered males 2.5:1, but were classified as primarily neurotic. Males were given more severe diagnoses of mental deficiency, personality disorder, and schizophrenia.

Identified cases primarily express their problems through somatic complaints; 44 per cent had gone to general practitioners, five per cent native healers, 15 per cent saw both types, and only ten per cent had sought assistance from a psychiatric specialist. This last figure is not surprising as it required a journey to Manila to attend the nearest mental hygiene clinic. The only other relevant information comes from a handful of studies describing the presenting problems of two mental hygiene clinics (Aragon, Annex VII, 1977), monthly admissions to NMH (Sena, 1974), and the progress made by residents at PMHA's half-way community in Cavite (Reyes, 1970).²

² For a list of psychological investigations done on topics concerned with mental health in the Philippines, see Virgilio Enriques, An annotated bibliography of mental health works in the Philippines, and Shiro Saito, "Philippine Ethnography: A critically annotated and selected bibliography", Honolulu: University Press of Hawaii, 1972.

It is imperative, as Escudero (1972) indicates, to continue the epidemiological investigations in other selected rural and urban settings. A more representative perspective of the country's mental health problems could then be acquired. From this, planners would have stronger evidence for proposing the integration of mental health into public health practice. These data would help establish guidelines for training new workers and gain a clearer understanding of where to direct public education. Another issue requiring empirical documentation concerns negative public attitudes toward psychological disorder, a problem identified by Manapsal (1974). Her initial impression is that families' feelings of shame toward disordered relatives and their belief that the illness is "incurable" results in abandonment of members in mental hospitals even when the person could be adequately treated as an outpatient. This certainly bears research attention. Moreover, the finding that 50 per cent of NMH's 400 monthly admissions are previous patients deserves explanation (deGuzman, 1974). These figures could either reflect family reluctance to commit themselves to home care or be an indictment of follow-up services. There may be a breakdown in the referral system whereby the local RHUs are failing to pick up discharged patients.

Influence of Overseas Training

International contact is another factor which has played a part in deciding the nature of Philippine psychiatry. The Americanization of professional training is perhaps the most obvious example. Most of NMH's first psychiatrists and the founders of psychiatric instruction at the University of the Philippines Medical School-- Horacio Estrada, Baltazar-Reyes, Lourdes Lapuz--received their specialist training in the United States. Maguigad (1964), in his summary of Philippine psychiatry in the mid-1960's, noted that 35 of the 167 psychiatrists were certified or eligible for certification by the American Boards Examination. Moreover, the predominant theme running throughout the National Workshop on Community Mental Health Nursing in 1974 and articulated most forcefully by F. C. Castaneda (trained in psychiatric nursing at the University of Maryland) was how to best adopt the principles of community mental health evolving in the United States.

Participation by the WHO Mental Health Division in the Philippines has been somewhat limited in comparison with nearby countries. This is surprising since the headquarters for the Western Pacific Region are located in Manila. Manuel Escudero, one of the first Regional Advisors, sought to introduce changes into the pattern of administration, diagnosis, and recruitment of personnel

at NMH, but met with little success. An attribute of NMH which made it less amenable to constructive change was the practice of appointing its chief administrator based on political merit rather than knowledge of the field.

WHO has, however, provided fellowships for specialist training abroad and gotten involved in several research projects. The most recent one, entitled "Collaborative study on strategies for extending mental health care," is headed by the Chairman of Psychiatry at the University of the Philippines, Lourdes Ladrido-Ignacio. This project is worth noting because it tests the feasibility of giving mental health training to barrio-level workers including such paraprofessionals as "hilots" (traditional birth attendants). The purpose is to make service delivery more deeply community based. Other Philippine projects, part of the WHO 1977 Mental Health Programme (WHO, 1977b), address the topics of prevention and control of drug abuse, mental health in national health policy formulation, and teaching of psychiatry in medical schools. In late 1977, a WHO technical advisor assisted DMH to evaluate the state of Philippine services including psychiatric staffing patterns and training facilities.

Brain Drain

WHO and UNESCO have chronicled another factor which impacts national psychiatry among other health professions. That is, the exit of health manpower from the Philippines

to employment in developed countries. UNESCO estimates a departure rate of 40 per cent of those physicians registered during the past 10 years (UNESCO, 1975). The migration phenomenon is governed by a complex set of factors, according to an investigation by Mejia and Pzurki (1976). They describe the Philippines as a major "donor" country which has "suffered heavy net losses of physicians (outflow minus inflow). The percentage ratio of losses in relation to the "stock" or total number of physicians remaining, was 67 per cent (Megia & Pizurki, 1976)."

Several conditions are responsible for this: 1) The Philippines has a higher level of M.D. and nurse "stock" than is the average for its level of GDP per capita and is producing more than the economy can absorb; 2) The focus of the medical system is on the private sector--government services are an insignificant employer of physicians; 3) Health education is in English with employment opportunities available in English-speaking nations; 4) Training is geared to disease patterns found in affluent societies, quite dissimilar to local conditions, thus credentials are more useful for work abroad; 5) Given the country's low economic capacity, it is unlikely that many more people could afford to use the services of these health workers had they remained at home; and 6) The government has shown little interest in stemming the flow of

these professionals to distant shores.

Medicare Insurance

A final influence on the provisions of psychological services is the Philippine National Health Insurance scheme. In 1969, the first phase of the Medicare System came into existence through passage of the Philippine Medical Care Act. It covered all employees under the Social Security System and Government Services Insurance System. In 1974, Medicare was extended to employee dependents, comprising almost 50 per cent of the population. Provisions of this coverage included periods of medical confinement and surgical expenses, but completely excluded psychiatric care. Such exclusion underscores and reinforces psychiatry's position of alienation, both within the medical context and the society as a whole.

Insurance coverage of psychological care would serve to boost the interest of care providers in the discipline while permitting greater access to existing private clinics by middle-class families who presently cannot afford them. As it is, the intensive treatment opportunities provided by a handful of private practitioners and private residential settings in Metro-Manila will remain the exclusive domain of the well-to-do Filipinos.

PSYCHIATRIC RESOURCES AVAILABLE: SELECTED EXAMPLES

The preceding section traced historical and contemporary factors determining the national organization of Philippine psychiatry. After an initial period of concentrating all psychiatric patients in the custodial enclave at Mandaluyang, begun during American occupation, the trend in the last two decades has been to seek avenues for dispersing and decentralizing services throughout the provinces. Today, the nature of service delivery is shaped both by Department of Health action, slowly incorporating mental health into the public health system, and by efforts within the private sector. Non-governmental agencies, like the Philippine Mental Health Association, are the most dynamic forces in promoting mental health care and education and providing consultation for planning services.

University psychiatric units and special private hospital wards in the Metro-Manila area are the vortex of active drug and rehabilitation treatment in the Philippines.

Conditions which combine to place limitations on service development include the powerless position of the government's agency for planning services (DMH), the low priority given public health in general, lack of epidemiological research data, limited involvement of WHO in this domain, exodus of professionals to countries with more favorable employment opportunities, and the exclusion of

psychiatric care from the newly-introduced National Medicare Insurance Program. In this section, focus is shifted from these global concerns to an analysis of selected institutions representative of Philippine mental health delivery. The seven variable framework for describing resource status is employed to analyse the mental health potential in the Philippines.

Overview of the Philippine Mental Health System

Public and private residential treatment centers in the Philippines are summarized in Table 5.1. Their approximate size and regional location are shown and whether they are teaching facilities. Table 5.2 lists major outpatient clinics including DOH administered mental hygiene clinics and the various chapters of PMHA rendering clinical services. An asterisk (*) preceding the institutions listed in both tables shows those centers where staff were interviewed for this survey. Although these lists do show major treatment centers, they are not exhaustive. Information is least available for private clinics and wards outside of the Metro-Manila district.

Resource Potential of Selected Sites

Sample

Intensive interviewing using Questionnaires #1, #2, and #3 was done at National Mental Hospital (NMH), University of the Philippines, Department of Psychiatry Unit at

the Philippine General Hospital (PGH), Victoria Luna Armed Forces Medical Center (VL), Veterans Memorial Hospital (VMH), University of the East, Ramon Magsaysay Memorial Hospital (UERM), University of Santo Tomas, Department of Psychiatry Unit (UST), Medical City General Hospital (MC), and the Philippine Mental Health Association, Quezon City Clinic (PMHA). Visits were also made to the PMHA half-way house rehabilitation center in Cavite, the Region III Provincial Hospital and PMHA chapter in Cabanatuan, the Comprehensive Community Health Center in Bay, Laguna, and the Department of Health in Manila. At these sites, unstructured interviews and program descriptions were also gathered. Table 5.3 lists personnel responding to the questionnaires and those given unstructured interviews.

Looking at the totals, the Philippine case study is based upon recorded conversations with 13 psychiatrists, five psychologists, two social workers, and three nurses responding to Questionnaires #1 and #2. Questionnaire #3 was completed by 21 psychiatrists, 10 psychologists, 10 social worker/occupational therapists, and seven nurses. Interviews were recorded in 13 settings, all but three of them in the Metro-Manila area. Twelve informants were sampled through open-ended discussions. Thus, the Philippine data are derived from contact with approximately 50 mental health professionals from diverse disciplines working

Table 5.3

Personnel Administered Questionnaires #1, #2, #3

Facility & Staff	Questionnaire:	Number of Staff Completing			Open-ended Interviews
		#1	#2	#3	
NMH					
Psychiatrist (Director)		1	1	1	1
Consultant Psychiatrists			2	3	2
Psychologist			1 (chief)	4	
Social Worker			1 (chief)	3	
Nurse			1		
UPPGH					
Psychiatrist		1	2	7	1 (director)
Nurse (chief)				1	
VL					
Psychiatrist		1 (chief)	1 (chief)	2	
Psychologist			1 (chief)	2	
Nurse				2	
VMH					
Psychiatrist		1 (chief)	2	4	
Psychologist			1 (chief)	2	1
Social Worker			1	2	
Nurse				2	
UERM					
Psychiatrist (chief)		1	1		
Psychologist			2		

Table 5.3 (continued). Personnel Administered Questionnaires #1, #2, #3

<u>Facility & Staff</u>	Questionnaire:	Number of Staff Completing			<u>Open-ended Interviews</u>
		<u>#1</u>	<u>#2</u>	<u>#3</u>	
UST					
Psychiatrist		1	1	2	
Chief Nurse			1	1	
MC					
Psychiatrist		1	1	1	
Chief Nurse			1	1	
PMHA					
Director/Social Worker/Psychiatrist		1			
Psychiatrist			1		1
Psychologist				2	
Social Worker/OT				5	1
Department of Mental Hygiene					
Director				1	1
Region III Provincial Health Center					
Regional Director					1
WHO Regional Headquarters					
Regional Adviser for Mental Health					1
Bay Laguna Comprehensive Health Center					
Physician					1
PMHA Half-Way House, Cavite					
Social Workers					3
TOTALS		8	22	48	14

almost exclusively in the major psychiatric centers in Metro-Manila. Data from workers in the rural areas providing care via the provincial city health facilities (\pm 25 per cent of inpatient services) were not collected, thus limiting generalizations beyond this one urban region.

Framework for Mental Health Resource Status

Comprehensive services. The first resource variable in the framework examines the comprehensive service potential of the Philippine system: the degree to which it provides a full spectrum of clinical programs and units to handle the complete needs of the population. These data are displayed in Tables 5.4 and 5.5. The first table lists service function criteria for special groups; the second introduces the types of therapeutic modalities available at each site.

A careful inspection of Tables 5.4 and 5.5 suggests a pattern of strengths and weaknesses in the availability of full treatment functions and modalities. Strengths are considered first. Given the assumption that there is fluid referral among the programs, an "average" adult psychiatric case who can afford private care has access to almost the entire spectrum of services expected from a "modern" comprehensive system. Readily available among the eight settings are inpatient, outpatient, emergency, diagnostic, neurological, and to a lesser extent, partial-

Table 5.4

Availability of Comprehensive Services

Service Function	NMH	UPPGH	VL	VMH	UERM	UST	MC	PMHA
Inpatient	+	+	+	+	+	+	+	-
Outpatient	+	+	+	+	+	+	OT ⁺ only	+
Emergency	+	+	+	+	+	+	+	-
Partial Hospitalization	-	+	-	+	(referral)	-	+	+
Transitional Living	(referral)	-	-	-	(referral)	-	(referral)	+
Follow-up	+	+	-	+	+	-	-	
Children's Services	+	+	-	-	planned	-	-	+
Geriatric Care	-	-	-	-	-	-	-	-
Drug Abuse	-	-	planned	+	-	(referral)	-	+
Diagnostic	+	+	+	+	+	+	+	+
Neurological	+	+	+	+	+	+	+	formerly
Suicide Prevention	-	-	-	-	formerly	-	-	-
Educational	-	-	-	+	-	-	-	+
Mental Health Research	-	+	+	+	-	+	-	+
Program Evaluation	-	-	-	-	-	-	-	sometimes
Teaching/Training	+	+	-	+	+	+	-	+

+ indicates available
 - indicates unavailable

Table 5.5

Treatment Modalities Available

Modality	NMH	UPPGH	VL	VMH	UERM	UST	MC	PMHA
ECT	+	++	+++	+	+	++	++	-
Physiotherapy	++	-	++	++	-	+++	+	-
Drug	+++	+++	+++	+++	+++	+++	+++	+++
Psychotherapy	+++	+++	+	+++	+++	+++	++	+++
Behavior Modification	+	-	-	+	-	Planned	-	-
Group Therapy	+++	++	++	+++	Formerly	++	++	+++
Family Therapy	++	++	+	+++	+++	++	+	+++
Occupational Therapy	+++	+++	-	+++	+++	+	+++	+++
Work Therapy	++	-	+++	+	-	-	+	+++
Other	Milieu	Milieu	Work on Ward	Assertion Training	Hypnotherapy		Milieu Attitude	Home Visit

+++ Often
 ++ Sometimes
 + Seldom
 - Never

hospitalization and follow-up care. Entering one of the centers, a patient can expect to be given chemotherapy, occupational therapy, and individual, group, and family therapy on an "often" or "sometimes" basis.

General ward milieu and various work assignments around the hospital are other therapeutic components frequently cited. Psychotherapy is either supportive or follows a psychoanalytic orientation, given the American ego-psychology training of the professors of psychiatry in the university departments. UERM, however, practices Integrated Medical Psychology, a school of thought founded by former director, Professor Zaguirre.

Family and group work is surprisingly popular. Its form ranges from ward community and patient government sessions at NMH and UST to drug dependency groups and youth-parent relationship training at PMHA. Routine screening at PGH enables social workers to assign appropriate families to therapeutic sessions given by experienced resident psychiatrists. UST staff take advantage of family members staying with their relatives (so called "watchers") to conduct family discussion and education groups.

Interestingly, psychodiagnostics (termed neuro-psychological testing--N.P.) has grown extremely popular since the early 1970's. Government agencies and private companies are routinely requesting psychological testing

for personnel hiring, placement, and promotion. UERM and PMHA psychologists are frequently called upon to administer these tests. Partial-hospitalization usually takes the form of a day-care program where outpatients return to participate in sheltered workshop and occupational therapy projects. Follow-up services are generally extended via regular outpatient contact, NMH has activated a mobile unit to extend domiciliary care in the Manila area. On a limited basis, home visitation is also a part of the social workers' schedule at VMH and PHMA.

Finally, characteristics of institutional care can be compared. It should be noted that although the small private teaching units like UST and UERM do offer reasonably intensive therapeutic contact, they are not necessarily comprehensive. VMH, on the other hand, has the greatest capability in terms of function and treatment types. This might be explained by the fact that it was set up as an American Veterans Administration hospital in 1955 and receives its budget from the U.S. Federal Government. Except for the absence of acute inpatient care, PMHA has more depth than other facilities sampled. It alone has developed an extensive half-way house rehabilitation program, child and youth development services, and undertaken program evaluation. In contrast, VL and MC are the least comprehensive of the centers visited. VL is the only psychiatric facility for active military personnel.

It caters to the restricted needs of soldier-patients and has no intention of offering teaching, educational, geriatric, child, etc., programs. MC is ostensibly a ward for private practitioners to hospitalize their patients. It does have an active day-care/occupational therapy program. But unlike PMHA's clinic, is not set up to provide comprehensive services catering to the general public.

Limitations in efforts to provide comprehensive services are also discernible. First, there is no program for the elderly, nor for autistic or mentally retarded children. NMH's three wards for adolescents and PMHA's recently-initiated Children and Youth Development Center are the only intervention services addressed to childhood populations. Private programs for the mentally retarded are, however, found elsewhere.¹ Suicide prevention or telephone "hot line" services were not a part of institutional operations. Nor could any be located in the descriptions of the other programs available in the country (See footnote 1). Only two sites were involved in drug abuse treatment: PMHA had a counseling group and VMH offered detoxification services. Interestingly,

¹Five private agencies dealing with mentally retarded children were found in Focus on Mental Health Resources (a directory edited by Bonifacio Amor; published by PMHA: Manila, 1975): Elks Cerebral Palsy Rehabilitation Center, Makati, Rizal; Special Child Study Center, Cubao, Quezon City; St. Joseph of Cuperino School, Foundation for Retarded Children, Quezon City; Brent School, Baguio; and St. Martin de Porres School, Cebu City.

when MC's psychiatric unit first opened, its population was 90 per cent drug abuse patients from upper class families. VMH was planning to begin a drug rehabilitation program once its staff received training from Clark Air Force Base personnel who presently operate this type of service. The other facilities sometimes receive consultation from and refer drug cases to the Drug Research Foundation of Quezon City.²

Transitional living units are another scarce resource. PMHA's half-way house in Cavite, Pinagpala, draws referrals from the other institutions, especially NMH. It has a capacity for about 50 men and 20 women. A handful of private transitional living units, plus the Department of Social Welfare's Halfway Home for Released Prisoners and Recovered Mental Patients, are scattered around the Metro-Manila area. These, however, are simply boarding homes without active rehabilitation objectives.

Other deficits are apparent in the areas of mental health education, consultation to other social service agencies, research, and program evaluation. Consultation and education action is restricted to VMH and PMHA. The

²Other drug treatment programs listed in Focus on Mental Health Resources are: Silliman University Drug Education Center, Dumaguete City; Shalom House, Inc., Baduio City; National Bureau of Investigation, Narcotics Sections, Manila; and Philippine Constabulary, Anti-Narcotics Unit, Manila.

former gives consultation to the VA clinic and homes for disabled children and the elderly; its clinical psychologist supervises psychologists at PMHA. The latter allocates the largest portion of its budget (25 per cent) to education and information programs. PMHA has also developed extensive consultation relationships with social service groups: the Department of Local Government and Community Development, the Institute of Labor Relations, Education and Manpower, the Division of Mental Hygiene, the Department of Education and Culture, and the Juvenile and Domestic Relations Court. Relationships are also maintained with the Philippine Guidance and Personnel Association, Public Schools Guidance Services, and various private schools. From time to time, the other sites are called upon to give outside educational lectures or consultations, but do so only upon special request.

Research inquiry is peripheral to the function of these programs and evidence of formal ongoing program evaluation was absent. Research undertaken is usually drug trials or "end-of-the-year" studies turned in by psychiatric residents. Exceptions to this were investigations at PGH concerned with the adaptation of hemodialysis patients, malnutrition in child development, and the collaborative study on strategies for extending mental health care. PMHA has sponsored a series of research projects. Ones not previously mentioned are on such topics as parent's atti-

tudes toward their children's disabilities; parameters of aggression in the Philippines; evaluation of WISC, Children's Apperception Test, Edward's Personality Inventory among Philippine populations; Marsella's studies of dwelling density and socio-cultural stressors on psychopathology and so forth.

All of the major treatment modalities are well represented among the sites visited, with the exception of behavior modification. As in Taiwan, chemotherapy is the foremost treatment of choice, used "often" in all settings. Moreover, there is some reluctance to use ECT. Nevertheless, it remains a relied-upon option in all facilities except PMHA. It seems curious that behavior modification has not become an established treatment regimen. The long-term Chairman of the Psychology Department at the University of the Philippines was one of B.F. Skinner's early students at Harvard and participated in the original experiments laying down the principles of operant conditioning. However, Professor Lagmay focused his curriculum on experimental psychology. Eschewing applied clinical training, he focused instead on training academicians.

VMH recently began looking into the use of token economy on one of their wards. While visiting VMH, in fact, the author was invited to give an in-service training consultation on this topic. The Chief Psychologist at Jose Reyes Memorial Hospital has been spearheading the move-

ment to introduce token economy at UST, VMH, and other residential treatment centers. Finally, it is apparent that work therapy is not a therapeutic component drawn upon the three university teaching units--PGH, UERM, and UST.

In perspective, the potential for comprehensive care is fairly good across most service functions and intervention modalities within the settings sampled. An individual able to afford private care in Manila has access to a good selection of private practitioners, outpatient clinics, and if necessary, small inpatient units in university and general hospitals. Transitional living and day-care programs are also possibilities, but exist in limited numbers. Individual, group, family, and occupational therapies are prevalent; work-skills training and behavior interventions are much more scarce. Clients who must rely on public services cannot combine the diverse elements of the private mental health network to meet their unique needs. They are restricted to the handful of municipal mental hygiene clinics in Metro-Manila. If hospitalized, these persons are sent to NMH or, much less often, to PGH. Suicide, geriatric, mental retardation, and substance abuse needs are less provided for regardless of patient economic status.

In summary comprehensive care is available with only a few restrictions, but access to it is contingent upon

economic situation and proximity to the Metro-Manila delivery network. Peripheral service functions, like research, program evaluation, and education/promotion are carried out only by one or two institutions, most notably PMHA.

Preventive orientation. The presence of preventive mental health programs is assessed by the second resource variable in the framework. Preventive services are "pro-active;" they are aimed at eliminating conditions suspected of fostering psychological impairment rather than reacting to the problems once they emerge. Table 5.6 lists the four key prevention components--public information, education and consultation, and ecological change--and indexes their presence within the institutions.

Half of the institutions make some formal effort toward disseminating "Public Information." They use the media and various gatherings to motivate people into becoming concerned about mental health issues which may affect them. When such action occurs at NMH, PGH, and VMH, which is "seldom", it typically involves staff personnel being invited to community seminars as resource persons or staff may become involved in workshops designed for workers from other social agencies. PMHA expends 25 per cent of its budget on Public Information and Education, the most highly developed and longest standing components of its program. In its 1976 annual report, PMHA detailed

Table 5.6

Availability of Prevention Programs

Prevention Type	NMH	UPPGH	VL	VMH	UERM	UST	MC	PMIA
Public Information	+	+	-	+	-	-	-	+++
Public Education	-	-	-	-	-	-	-	++
Public Consultation	+	+	-	+	-	-	-	+++
Ecological Change	-	-	-	-	-	-	-	+

+++ Often
 ++ Sometimes
 + Seldom
 - Never

the extent of its information dissemination. Through 280 organized meetings, 109 press releases, radio broadcasts, and bi-monthly publications, it was estimated that 290,000 people were reached.

National Mental Health Week is a highlight during the year for PMHA. It is a time during which a series of seminars, workshops, and press releases are used to direct national attention toward this area. The theme of the 1976 Mental Health Week was "Mental Health and Economic Growth." Presentations on this topic were collected in the Philippine Journal of Mental Health, 1976, Vol. 7, No. 1. At other times during the year, PMHA organized orientation lectures, forums on approaches to psychiatric treatment, film presentations, and presented its annual national conference. In 1976, the conference considered "Urbanization and Mental Health." PMHA also supports and participates in other public information forums such as the National Workshop on Preventive Education of Drug Abuse.

Public Education is the second type of prevention activity listed in Table 5.6. It goes beyond Public Information in aiming instructional experiences at identified high risk groups to assist them in avoiding psychological impairment. Except for PMHA, none of the sampled sites had ongoing Public Education programs. This condition is also reflected in Table 5.4: suicide prevention services are unavailable from these agencies.

PMHA uses several formats for offering Public Education. Through the Pangkalahatun Center in Quezon City, a series of Life Enrichment Seminars are held for Out-of-School-Youth. The Problem of an excessive number of high school dropouts was recently given a high priority by Philippine political leaders including the Mayor of Metro-Manila, Imelda Marcos. The PMHA seminars, accredited by the Department of Education and Culture as official non-formal education curricula, are aimed at assisting those in this "risk" group to recognize and development their individual potential. Through group dynamics training, social values are transmitted to the youth, encouraging social responsibility and service. The overall goal is to get them employed or back into school. Along similar lines, at least 12 high school mental health clubs have been established in Manila. These utilize peer counseling and leadership training activities. Another project aimed at this population is the PMHA workshop offering Youth-Parent Relationship Training. Finally, under consideration is a "hot line" for runaway youth to broaden the crisis intervention services for these children and their families.

Those institutions offering Public Information also offer Public Consultation, rendering advice and technical assistance to other social agencies dealing with large populations. NMH offers to non-health workers--schools,

police, local governments--one-month seminars on mental health. It also supported the National Workshop on Community Mental Health Nursing and follow-up sessions called "Echo Seminars." The psychiatry professors at PGH are well-known throughout the Philippines and are called upon for consultation on their own. Recently, however, four psychiatric residents went to a regional hospital in Takloban, Leyte, as consultants to educate other residents. VMH provides regular visitations to at least three agencies: the outpatient clinic of the Veterans Administration, Golden Acres home for the elderly, and a residential treatment facility for developmentally disabled children.

The extent of PMHA Public Consultation goes beyond that of these other institutions. Besides its assistance to government groups, schools, and private organizations, trainers from the Education and Training Committee organized quarterly training sessions for the different PMHA chapters as well as other community mental health workers in the provinces--rural health physicians, nurses, teachers, etc. The trainers are also called upon to give in-service training to guidance counselors and school physicians at city schools.

Ecological Change is the final type of prevention action engaged in by social welfare agencies. It consists of diverse efforts at the social, economic, and political systems level to introduce changes that enhance psychological

functioning. As a rule, the institutions visited did not envisage their role as change agent for socio-political institutions. Nor were they concerned with enhancing the status of poverty-stricken peoples or assisting in the building of neighborhood and community groups which could mobilize their members' resources.

In certain respects, however, PMHA is concerned to a limited degree with ecological change. In 1976, through public forums and publications, PMHA sought to bring into public consciousness the relationship between national economic growth and psychological well-being, and the implications of increasing urbanization (e.g., Faraon, 1976; Ignacio, 1976). Oftentimes, though, messages regarding optimum mental health conditions communicated by PMHA extol values and ideals reflecting the vision held by present political leaders; i.e., Marcos' "New Society". The national development value of considering psychological conditions was spelled out by one speaker at the National Mental Health Week seminar series:

If the New Society is to succeed, economic planners and policymakers must be reoriented in their thinking so that they can see the importance of providing for the development of good mental health hand in hand with their plans for the development and growth of the economy because mental health is the most effective answer to the dangers posed by the revolution of rising expectations in the overall development effort (Sanvictores, 1976, p. 21).

Furthermore, PMHA may be viewed as contributing to ecological change, albeit on a limited scale, to the extent

that it seeks to develop high school clubs, recruits Manila dropouts, and works through the barangay organization (the neighborhood political unit seen as the foundation of the New Society) as its primary community contact.

In review, programs aimed at the four basic types of disorder prevention are unavailable at half of the sites visited. Prevention is assigned a low priority in three of the remaining four institutions. PMHA is by far the most active promoter of Public Information, Consultation and Education regarding mental health as a whole. In general, Public Information and Consultation were the most frequently found preventive services while Public Education (focusing on high risk groups) was less available. Efforts aimed at Ecological Change were practically non-existent. It seems reasonable to conclude that mental health providers have neither the political position to suggest changes in the country's social, economic, or political institutions nor the inclination to do so. By and large, they align their goals and values with the country's current political philosophy.

Continuity of care within the facility: Manpower. The next resource variable examines the manpower availability within these institutions and the extent to which they are able to deploy multi-professional teams to handle the full range of client/patient needs. Presence of various professional categories as well as ratios of these to

patient populations are rough indices of intra-institutional continuity of care. They denote the agency's potential for smooth patient referral among professionals at different stages of contact.

The manpower situation found among sampled sites is presented in Table 5.7. The different categories of professionals are unevenly distributed. Numerically, psychiatric nurses far outnumber other staff types. They are especially noticeable in high concentrations at NMH. Nurses were more numerous than other professionals in the majority of inpatient facilities. Their ratio to beds ranged from 1:20 and 1:16 at VL and NMH respectively to 1:1.2 at PGH. Psychiatrists were the second largest group, appearing in adequate numbers across most facilities except perhaps at PMHA and NMH. The ratio of inpatients to psychiatrists at NMH was 1 per 86. Occupational therapists are the third largest group. This finding is misleading, though, since more than 90 per cent of these workers are employed at NMH, two sites have none, and the rest have only one or two at best. Social workers and psychologists are numerically the smallest categories of staff. VL, UST, and MC are without the services of social workers. The latter two private institutions also do not have staff psychologists.

However, it should be recognized that the number of occupational therapists at NMH who actually have specialized

Table 5.7

Multi-Disciplinary Teams and Manpower Availability: Staffing Numbers and Staff Ratios to Patients

Profession	NMH	PGH	VL	VMH	VERM	UST	MC	PMHA	Total
Psychiatrist (including residents)	95	12 (10 PT*)	3 (3 PT)	7	3 (5 PT)	11	5	1 (1 PT)	137
Psychologist	20	(2 PT)	7	3	2	0	0	2	36
Nurse	500	12	4	11	6	16	13	0	562
Social Worker	26	2	0	2	2	0	0	5	37
Occupational Therapist	100	2	0	1	1	0	2	3	109
Beds	3,500 (8,227 patients)	15	81	90 (45 pts)	15	36	44 (31 pts)	None	
Monthly Outpatient Contacts	60/day	65	32	93	180	80	None	450	
Total Outpatients	3,500							1,055	
Inpatients Per Therapeutic Staff	11.11	.47	5.06	3.60	.88	1.33	2.20	41 (out- patients)	

(*PT refers to part time staff)

training in that discipline are far fewer than the 100 listed. Given this consideration, it becomes clear that each facility employs psychologists, social workers, and occupational therapists--if they have them at all--in approximately equal numbers.

The concept of multi-disciplinary contact with inpatients is well-established at NMH, PGH, VMH, UERM, and PMHA. Hence, the likelihood of continuity of care within these settings is good. Division of labor and assignment of responsibility follows traditional medical setting lines for the multi-disciplinary team members. The exception is PMHA where non-medical professionals have full authority over their respective projects.

Typically, psychiatrists (usually residents) screen for organic conditions, prescribe medication, diagnose, carry out individual and group psychotherapy, and are sometimes involved in family education sessions. Psychologists are primarily involved in psychological testing. (I.Q., projective, personality, aptitude) to support physician diagnoses. This activity has dramatically increased the caseload recently as companies and government bodies have begun to rely upon psychological screening for hiring and promotions. However, in some places, like NMH, UERM, and PMHA, psychologists are running individual, group, and ward community psychotherapy sessions by themselves and as co-therapists with residents. At PGH and

and UERM, psychologists are given teaching roles. They explain the use of tests to residents, consult on group psychotherapy, and supervise psychology interns.

Social workers enact a broad variety of roles across agencies. Some coordinate discharge and follow-up patients through home visits, make referrals to the Provincial Health Offices, or help patients find jobs. Others are active on the wards, doing intake interviews, case histories, screening for family therapy, guidance counseling, and offering education services for families with inpatients. At PGH, social work consultants supervise residents in family therapy. PMHA social workers run the outreach center, design and run the educational seminars for mental health workers, handle the youth programs, and engage in individual, group, and family counseling at the rehabilitation centers.

Occupational therapists are active on the four rehabilitation wards at NMH, run the outpatient program at MC, and of course, are responsible for the two well-used rehabilitation centers administered by PMHA. The residential treatment centers which operate on a multidisciplinary team basis--NMH, PGH, VMH, and UERM--also call upon team members to assist in discharge decision-making. This is in contrast with MC, where the admitting psychiatrist alone decides whether his patient has improved enough for discharge.

The conservative estimate of manpower potential for these settings as reflected in the contact possibilities between staff and patients is shown at the bottom of Table 5.7. Unfortunately, data are only available for inpatients. Information on daily numbers of outpatients treated were unavailable. In most instances, these ratios are extremely small, suggesting a good chance for contact and continuity of care among team members. They range from 1:0.47 at PGH to 1:11 at NMH, with 1:3.5 as the average. The size of these ratios is attributable to the numbers of available psychiatric nurses and adequate supplies of full and part-time psychiatrists working in small university teaching units.

In contrast, NMH is grossly understaffed when nurses are subtracted from the totals. With only one psychologist per 400 patients, one psychiatrist per 80, and social workers in a ratio of 1:310, it is assumed that active team care is restricted to a small percentage. Indeed, the hospital is organized into sections that include the acute and first admissions (treatable) and the continued treatment or chronic, long-staying patients (untreatable). The latter constitute the overwhelming majority of residents.

Under these conditions, it is difficult to imagine individual psychotherapy undertaken with any but a handful of highly selected (and paying) inpatients. Social work

efforts to provide follow-up care, do home visitation, and check the progress of trial home stays, are perhaps merely token gestures in light of the total needs. It is this set of circumstances which has brought forth the 20-year plea for decentralization of this facility: the largest mental hospital in Asia.

Continuity of care: Inter-Institutional. The inter-relationship among Manila psychiatric facilities is the second continuity of care variable studied. Well-established referral pathways among these agencies afford the individual an opportunity to maximize his contact with diverse services. Continuity of professional care is achieved for clients when the different clinics, securely linked with one another through referral and consultation relationships, function as a unified service system. A mapping of the referral process and the linkage patterns among selected sites in Metro-Manila are presented in Table 5.8 and Figure 5.2

Community sources referring patients initially into the mental health network are shown in Table 5.8. Ten referral agents and their importance for each facility are listed and rank-ordered at the top of Figure 5.2. These data suggest that family/friends and employers are the most active of community referring agents. Traditional healers, priests, and police are least frequent. It is important to note that physicians and other psychiatric

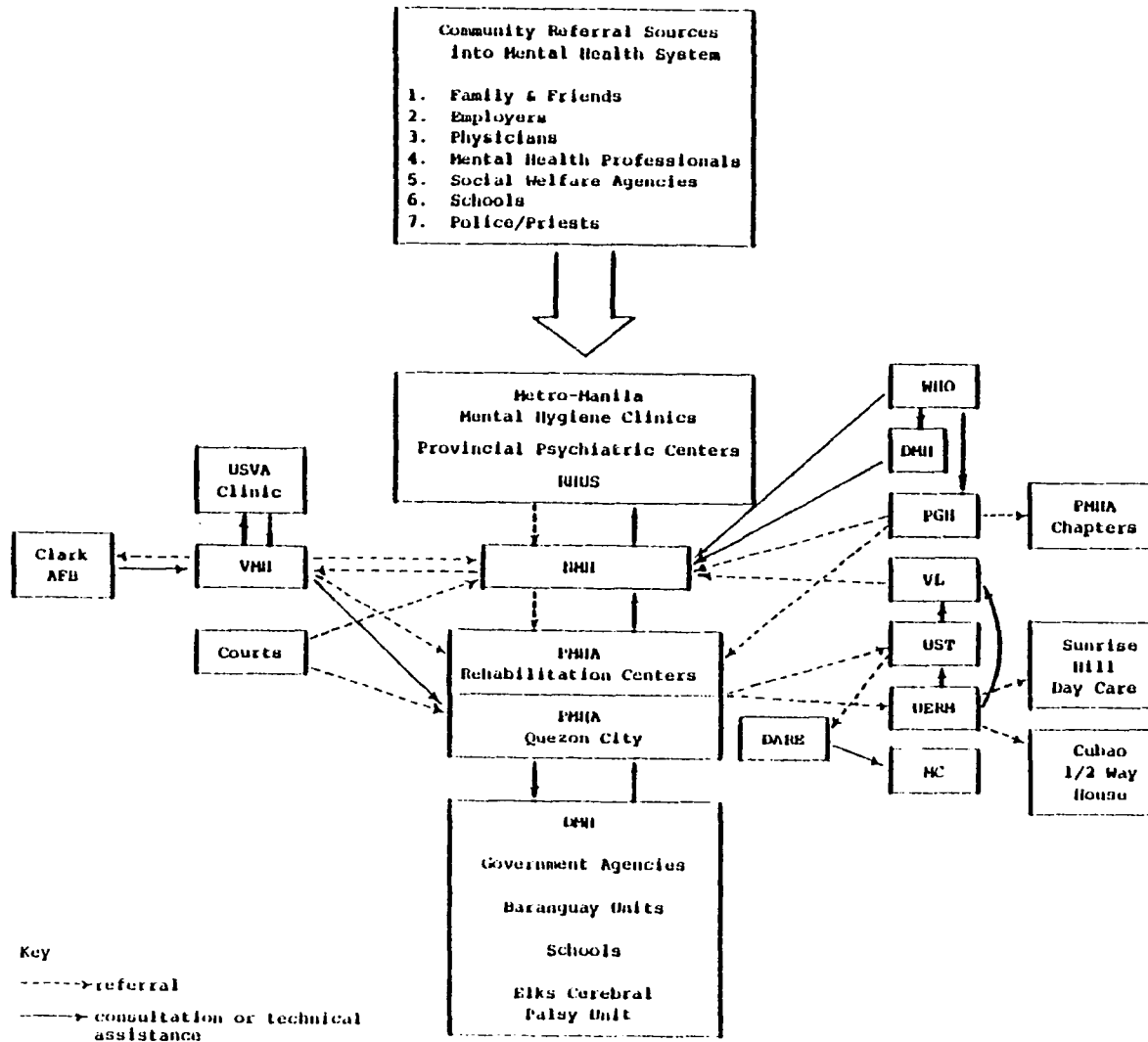
Table 5.8

Frequency of Various Referral Sources

<u>Source</u>	<u>Frequency</u>			
	<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>Never</u>
Physicians	MC, VL VMH, UST, UERM	PMHA	NMH, PGH	
Mental Health Professionals	NMH, VMH, UST	PMHA	UERM, MC	
Mental Health Agencies		PMHA, PGH, VMH UST, UERM, MC	NMH	
Social Welfare Agencies	PMHA	PGH, VMH UST, UERM, MC	NMH	
Schools	NMH, UERM	PGH, UST, PMHA	MC	VMH
Police	NMH, PMHA	VMH, MC	PGH, UST, UERM	
Priests		PMHA, NMH PGH, UST, UERM	VMH	MC
Traditional Healers		UERM	PGH, UST	NMH, VMH, MC, PMHA
Family/Friends	UERM, MC, PMHA NMH, PGH, VMH, UST			
Employer	NMH, VL, UST, UERM	PGA, VMH, MC, PMHA		

Figure 5.2

Referral and Consultation Relationships Among Metro-Psychiatric Centers



personnel and agencies are also important sources. This suggests viable ties to both allied medical workers and among fellow mental health professionals. Clearly certain sites like NMH and PMHA have strong ties with the police and school systems while others do not. None of the agencies reported receiving direct referrals from traditional healers like herbalists or shamans.

A complex picture indexing the potential for cooperative unity among the various settings is presented in Figure 5.2. The top of the figure lists in rank order the community agents which usher service users into the system. The two foci of this network are NMH and PMHA, although for somewhat different reasons. Considering NMH first, the reason for its overcrowding is strikingly apparent. It is the recipient of referrals from a host of sources: numerous Department of Health Clinics--rural as well as urban, the courts, private hospitals, and the military hospital. In essence, NMH is a dumping ground for long-term, chronic-type patients who cannot be handled successfully among the acute, intensive, and short-term units. Clinics referring inward their long-stay cases include the municipal and provincial mental hygiene units, VMH, PGH, VL and the prison system.

Conversely, according to decentralization, NMH is supposed to be discharging patients back into facilities being developed in their home provinces. Moreover, it uses

the PMHA Cavite facility for patients suitable for rural, live-in rehabilitation. Others are sent to the day-care industrial rehabilitation program at the Quezon City site. The technical capabilities of VMH are utilized for EEG and EKG assessment of certain NMH patients. Consultation ties exist between NMH and PMHA, the DMH, and the WHO Regional Office for the Western Pacific. These latter two organized with NMH the 1974 workshop on community mental health nursing and subsequent follow-up sessions.

PMHA, the second focus of the system, has an elaborate set of linkages not only with other psychiatric clinics but with government agencies, schools, courts, and community groups. Their rehabilitation programs are the targets of referrals from VMH, NMH, and PGH. In provincial areas, PMHA chapters are the only sources of clinical intervention and are relied upon by local physicians. PGH makes referrals to such chapters when they discharge inpatients living in these areas. From time to time, PMHA makes use of the small, private units at UST and UERM for hospitalizing referrals. Furthermore, its key function of consultation and technical assistance can also be noted in channels of communication between it and the host of other groups including DMH and NMH. Interestingly, VMH psychologists supervise the psychologists on staff at the Quezon City national headquarters.

Other active centers in the relationship network are apparent. Besides its contacts with NMH and PMHA, VMH gives drug referrals to Clark Air Force Base Drug Treatment program. VMH receives technical assistance from Clark on this topic and takes referrals from the U.S. Veterans Administration clinic in Ermita, Manila. The two university units, UERM and UST, have a consultation relationship with one another; both assist VL, the Army psychiatric program. UERM makes use of its psychiatric director's day care facility, Sunrise Hill, and also the Department of Social Welfare's Halfway Home in Cubao, Quezon City. UST refers drug cases to Drug Abuse Research Foundation (DAR), which has several day care and one residential program. DAR is working closely with MC to prepare its staff for treatment of substance abuse clients. Lastly, WHO's consultation relationships are shown. Over the years it has tried to advise NMH administrators--beginning with Manuel Escudero's efforts--as well as work through DMH. At present, WHO contact has been mostly centered on PGH and the collaborative research being done through University of Philippines psychiatrists.

These lines of communication and referral are the only evidence available for assessing inter-institutional continuity of care. Does this collection of agencies and programs function as an integrated unit? Do they effectively pass along clients whose particular needs are more appro-

priately met or followed up by allied institutions? In terms of NMH and its interchange with the general health system administered by municipal health offices, this continuity is what is expected, but it may be lacking in most instances except in Davao. Getting into NMH appears to be a lot easier than getting out; the sources for inward referral are more numerous than those receiving patients being referred out. Like the wards of NMH, the rehabilitation opportunities of PMHA seem quite visible among different sectors of the network, private and public, and are well used, although not to their maximum.

U.S. military-connected Filipinos have access to perhaps the most comprehensive care available via VMH, USVA clinic, and their relationship with Clark Base and PMHA. Those who can afford the private university units or are able to be seen at PGH can take advantage of these adequately developed programs. Those with adequate incomes are apt to receive proper referrals, either to drug abuse, day-care, or half-way care programs. Those without adequate incomes have the handful of mental hygiene clinics to facilitate. But, referral options are restricted to NMH or one of its extension facilities. On the issue of consultation, there is a small core of recognized, long-standing experts who move fluidly among several institutions. They assist in the development of specialized care and strengthen the staff capacity of these sites. Moreover,

PMHA and groups like the Philippine Psychiatric Association and the Division of Mental Hygiene have sought to bring the professional community together through annual conferences, workshops, seminars, joint research projects, special celebrations, etc.

However, a formal organizational connection among the institutions--as found among Taipei's five major psychiatric hospitals--and their attempt to create a community-wide treatment project has not coalesced in Metro-Manila. DMH, the most plausible proponent of such an organization, is without the power base to suggest it. PMHA, which has the viability to suggest more formal ties among the service providers, has no administrative access to the public health system. Public health would naturally need to be included to make such an organizational set up of value to the general public.

In short, there are certain well-worn patterns of interaction among certain institutions which may guarantee select clients the opportunity for smooth referral and hence, continuity of their psychiatric care. Yet, these channels are not system-wide and, for the most part, will not include low-income patients. A positive sign, however, is the presence of links between NMH and several privately administered agencies.

Continuity of care into the community. The previous resource variable dealt with continuity of care in the

patient's movement between institutions; the present one looks for continuity in movement from the institutional setting back into community environments from which the patient came. Such continuity is heightened when the service agency encourages or relies upon the participation of various community agents (family members, teachers, employers, religious leaders) in the treatment and discharge process. It also arises to the extent that agency personnel carry out their therapeutic and support functions in those actual settings where the patient lives and works. The six alternatives for providing continuity of care into the community for the agencies studied are summarized in Table 5.9.

The first alternative concerns agency provisions for maintaining contact with patients once they are discharged. In some instances, the family is given the responsibility for bringing the patient back for periodic consultations at the outpatient clinic. This is the case for NMH, PGH, and UERM. When this is not possible, NMH has a mobile unit for Metro-Manila offering domiciliary service. This service, like the one at VMH, is manned primarily by social workers. However, for both institutions, the professional time permitted for doing this is restricted. The scarcity of manpower versus need makes the task seem almost futile. VL, UST, and MC don't offer this alternative. VL either sends the patients back to their military units,

Table 5.9

Six Alternatives for Providing Continuity of Care into the Community

<u>Alternatives</u>	<u>NMH</u>	<u>PGH</u>	<u>VL</u>	<u>VMH</u>	<u>UERM</u>	<u>UST</u>	<u>MC</u>	<u>PMHA</u>
1. Active patient follow-up especially by social worker	+	+	-	++	+	-	-	
2. Educate or utilize family members as part of treatment plan	+	+++	-	++	++	+	+	++
3. Relative stays in hospital with patient	-	+++	-	-	++	-	+	
4. Treatment within home or village setting	++	-	-	+	-	-	-	++
5. Community agents assist in treatment (teacher, employer, village leader, M.D., police, etc.)	+	+	-	+	+	+	-	++
6. Participation in community activities during hospitalization encouraged	+	+	+	+	++	++	+	

+++ Always
 ++ Sometimes
 + Seldom
 - Never

discharges them from the service, or places them for long-term care at NMH. UST simply refers their discharged cases back to the admitting physicians.

The next two items involve family participation in the actual therapeutic process during hospitalization. A characteristic of these programs was their intention in one form or another of getting the family involved in patient care. Another was their working against what was perceived as a natural tendency for the families to turn over complete responsibility for patient improvement to the medical personnel. A number of different strategies appeared with differing levels of formality. PGH and VMH were perhaps the best organized: In the former, all families are screened for suitability of family therapy and often permitted input into treatment decisions. VMH has routine weekly family education sessions as well as social worker-led groups for parents, spouses, and full family participation to discuss patient behavior and assist in problem solving in home situations. Family "watchers" who stay 24 hours with most cases at PGH--and selected ones at UERM--are keys to relative-assisted treatment. Watchers are educated by psychiatric residents and nurses through group meetings in how to assist in the intervention process while on the ward and how to handle the patient upon return home.

Other less formal involvement of families was also

noted. At NMH, they were sometimes given specific information regarding home care as part of the discharge plan. Staff encourage family visitation only after the hostility toward the admitted member dies down. Visitation is also encouraged at VMH, where picnics with relatives on hospital grounds are frequent. MC sets aside one hour per day for visitation. PMHA attaches significance to family education and therapy with its clinic clients and employs this approach as an integral part of its two rehabilitation programs. Only VL, which by necessity must start treatment of military patients in the absence of contact with family (which may reside anywhere in the country) is unable to draw upon familial assistance in the treatment regimen.

Intervention involving professional services carried into the home or village settings was rare. Only two residential programs gave examples of such action, which was infrequently carried out. NMH, through its mobile clinic, sends social workers into the homes of patients in nearby neighborhoods who are unable to come to the outpatient department at the hospital. Social workers at VMH are allotted four hours per week to use hospital transportation to do home visitation and keep watch on trial home stays of recently discharged cases. At PMHA, home visits for the full range of clinical care offered by social workers is a routine service.

In short, the extension of treatment into the living

places of people in need is generally unavailable. Since it is a function apparently assigned exclusively to social workers, its absence may be tied to the scarce number of these professionals. On a more global plane, the addition of NMH extension services and the expressed desire to include mental health components in RHUs and provincial hospitals is a step toward placing such services closer to the home environments.

Getting community agents like teachers, employers, general practitioners, etc., is another alternative which is available but used only on a "seldom" basis. If any community agent is used, it is likely to be a public health nurse or school teacher who was involved in the referral of the patient to the institution. PMHA, more than any other site, draws upon such individuals in treatment planning. In addition to teachers and public health nurses, PMHA has sought to work closely with school counselors and clergy when making referrals. Moreover, it has begun to set up peer counseling programs for high school youth--a delivery system which has good potential for having an impact on that population.

The last alternative examines the extent to which the residential programs encourage their patients to participate in various community activities, whether work or recreation. Although this is done at all sites visited, it is not done with any regularity. Perhaps the most common outing would

be to attend a dance or fiesta. Staff at VL did report that some of their patients participated in a kind of Olympic sports meet for disabled and handicapped persons. While many staff reported that "sometimes" patients did go out and participate in community events, the existence of a program for regular off-grounds excursions for recreation, religious worship, or work was not mentioned.

Overall, the facilities visited appeared less able or willing to deploy manpower in activities aimed at working extensively with individuals from the patient's natural social environment. Training, educating, or planning with such persons took place almost exclusively with those family members who accompanied the patient into the hospital, stayed there as watchers, or were willing to come back for periodic group meetings with staff. Except for PMHA, there were few efforts by staff to make liaison with community agents encouraging them to take responsibility for assisting patient rehabilitation in the community. Sending staff beyond institutional walls to ease re-entry and assist adjustment was equally rare, although trial home visits were one step taken in this direction. Speculation regarding this deficiency would focus on three reasons: first, an absence of personnel with competency or interest in this activity, such as social workers; second, the fact that in many cases the patients reaching these clinics are from remote areas; and third, prevailing attitudes among

family members that the hospital alone has responsibility for curing their "sick" relative.

Accessibility of facilities. Availability and ease of access to existing mental health resources are the two components of the "accessibility" variable. As earlier noted, psychiatric services exist in the public sector via the National Mental Hospital, its 11 extensions, the municipal mental hygiene clinics, and whatever care is able to follow from specialized training filtering down to the public health worker. The private sector has its own system comprised of self-employed practitioners, small units in general and university hospitals, assorted specialty clinics, and the 14 chapters of the PMHA scattered about the islands. A PMHA directory of Philippine agencies engaged in the promotion and development of mental health lists 117 programs, touching on various aspects of therapeutic assistance (Amor, 1975).

However, the utilization potential of these sites for those in need is governed by its own set of factors. The major ones include the agencies' proximity to their users, cost, hours of operation, whether there is bed space available, and policies regulating admissions.

Staff perceptions of their agencies' accessibility were studied using these factors. The first one, agency location, is generally considered as a "slight problem," except in reference to those patients who must travel from

outlying areas to seek assistance. Excluding those at VL and VMH, who are drawn from throughout the Phillipines, the majority of inpatients live in or near Metro-Manila. NMH does have a sizable minority, however, who are referred from the provinces. This problem has prompted DOH intentions to establish one mental hospital in each region and a small (10 to 15 bed) inpatient unit in each Provincial general hospital. Because of the lack of such facilities at present, NMH staff label "location" as a moderately serious problem.

Cost is the second major ease-of-access factor. National health insurance, Medicare, does not extend to psychiatric treatment. Thus, private treatment is restricted to those who can afford it. There is a requirement, however, that private hospitals allow 10 per cent bed occupancy for charity cases. The extent to which this is adhered to is not known. UERM was the only private facility visited which reported service delivery to low income patients. The expense of private care varies among settings with the most expensive found at MC. Daily costs there ranged between \$14 and \$17, depending on dormitory versus semi-private room status. While PMHA charges a nominal fee for clinical care, NMH is required to accept all those needing institutionalization. Families sometimes contribute for medicines not supplied by the hospital. PGH, VL, and VMH are also without fee requirements. Because of the possibility of receiving some charity cases, most staff felt that it was "often" or "always"

possible for people with little money to use the treatment program.

Other factors included restrictions due to waiting lists or certain limitations on facility use. The consensus among staff sampled was that long waiting periods were either not a problem or only an occasional "slight" problem. Even PGH with its 15-bed capacity for the entire University of the Philippines did not complain of pressure for bed space. In fact, the impression was given that the services were under-used. VMH was only half full at the time visited; neither was MC at capacity. PMHA's half-way house was operating well below its size capabilities and awaiting more referrals. In contrast, NMH, functioning at 200 per cent overcrowding, is required by policy to intake those needing hospitalization immediately without waiting for vacancies. NMH is uniquely open to overcrowding, as suggested by Figure 5.2.

Other institutions have screening criteria or certain conditions which limit the flow of users. VL and VMH take only military personnel. The former receives men who are routed there from unit commanders while the latter only take in those enlisted in the American Army prior to Philippine independence. Both sites are only interested in short-term, acute cases. PGH admissions come only from other sections of that hospital, especially the emergency room. UST and MC cases only have access to the ward through their own private physician who has a relationship with those units.

In review, these findings suggest differential ease of access based on facility characteristics and the client's status and residence. Well-to-do Filipinos, who regard professional help as desirable, can visit the PMHA clinic in Quezon City or a score of private psychiatrist offices in Metro-Manila. These practitioners usually have some tie with one of the private general hospitals. They can easily hospitalize more severe cases on a psychiatric ward without the worry of a waiting list. Low-income individuals in need can choose from five municipal mental hygiene clinics in Metro-Manila or a dozen NMH extension services in the outlying health regions. Although some charity beds are available in several of the small private units, most who require hospitalization end up in the grossly over-crowded and under-manned NMH system. Only Filipino men who gave service to the United States Armed Forces are eligible for the most comprehensive psychiatric program available, operated and funded by the Veterans Administration.

Specialized psychiatric resources are overwhelmingly concentrated in Metro-Manila with a scattering of clinical opportunities through public health channels and PMHA chapters in provincial capitals. Rural people unable to either journey to Manila or find whatever psychiatric intervention is offered through their Regional Health Office have no access whatsoever to professional therapeutics. RHUs are criticized for not actually reaching rural

populations; most are situated in large towns or cities. It is obvious that care for psychologically impaired is even more remote for provincial citizens since it is seldom, if ever, even a part of RHU operations.

Staff evaluation of resource strength. Staff judgment of resource strength is the final resource variable studied. Examining staff perceptions of the seriousness of 21 potential deficits adds perspective to previous statements regarding resource limitations based on other data sources. It also adds insight into staff evaluations of treatment facilities and priority arrangements.

Table 5.10 lists 21 possible resource deficits (taken from Questionnaire #2) and the percentage of professionals endorsing the different categories of problem seriousness. Twenty-two staff were sampled (See Table 5.3) and responses across institutions were grouped together. Trends in these data can be heightened by dichotomising the items as either problematic or non-problematic and noting those instances where response variance is accounted for by one or two institutions.

The result of Table 5.10 suggest a moderate amount of diversity in staff opinion, not only across the sites visited but among workers within the same settings. The first grouping of items taps budgetary support for current and future programs and the sense of national priority assigned to mental health services. It seems clear that

Table 5.10

Staff Perceptions of Resource Deficits (N = 22)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Lack of help from Government	19%	33%	14%	33%
2. Not enough money for present treatment program	23%	32%	32%	13%
3. Not enough money to develop future treatment programs	32%	36%	27%	4.5%
4. Not enough trained administrators	40%	10%	15%	35%
5. Not enough diagnostic staff	24%	19%	14%	43%
6. Not enough treatment staff	27%	27%	14%	32%
7. Not enough follow-up staff	27%	23%	18%	32%
8. Lack of relationship with other institutions	14%	18%	23%	45%
9. Other professionals don't support the program	27%	9%	23%	41%
10. Long waiting list	45%	4.5%	36%	54%
11. Not enough rooms to separate different kinds of patients	41%	18%	18%	23%

Table 5.10 (continued). Staff Perceptions of Resource Deficits (N = 22)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
12. Lack of building space	32%	9%	23%	36%
13. Too many patients	41%	14%	23%	23%
14. Lack of money for equipment and research	54.5%	14%	23%	9%
15. Library is not good enough	36%	14%	4.5%	45.5%
16. Little information about new treatments and new research findings	9%	13%	14%	64%
17. Lack of epidemiological data regarding mental problems	27%	32%	18%	23%
18. Staff relations are not good	9%	4.5%	27%	26%
19. Not enough treatment supplies	27%	32%	32%	9%
20. Lack of transportation services	27%	14%	18%	41%
21. Low success rate of treatment	4.5%	14%	54.5%	27%

there are worries for future funding, although worries for present monetary insufficiencies appear slightly less intense. Governmental uninvovement is given as a problem by just half of the respondents, most of those who view it as unimportant are employed by private clinics like UERM and UST.

The next grouping, items 4 through 7, concern manpower. Once again, no clear pattern unfolds: responses are almost evenly divided problematic/non-problematic for each item. A careful examination of individual institutions, however, tells a different story. NMH and VL, both government facilities, consistently report manpower shortages, especially among administrators, treatment, and follow-up staff. These perceptions are congruent with the actual manpower numbers reported in Table 5.7. PGH, VMH, UERM, and UST, on the other hand, consistently report minimal or no problem in these same areas. These perceptions are congruent with their therapeutic staff per inpatient ratios (Table 5.7). But, they are still out of line with reality in the area of follow-up care, in which each is extremely understaffed. Interestingly, PMHA and MC follow NMH and VL in complaining of severe understaffing.

Linkages among institutions and acceptance of mental health programs by other personnel are not viewed as difficulties by a substantial majority of respondents. Apparently the multiple ties as found in Table 5.2 are satis-

factory to most workers with the possible exception of those at NMH, PGH, and the one physician interviewed at PMHA. Moreover, VL staff felt particularly alienated from their fellow professionals. This may reflect how their unit is viewed within the context of the Army hospital.

The fourth grouping concerns perceived space restrictions anywhere. This feeling of space availability carries over consistently for VMH, UERM, UST, and MC. Complaints of overcrowded buildings, lack of special quarters, and generally too many patients are voiced by the three governmental sites--NMH, VL, and PGH. NMH staff are particularly homogeneous in their perceptions of overcrowdedness.

The final grouping, involving perceptions of research resources, show that the existence of only a few cursory epidemiological studies of psychiatric disorder is indeed noted as problematic. About 70 per cent are concerned also with the absence of any money to carry on research. Poor library facilities are not bothersome except at NMH and VL. All respondents with five exceptions (two of them at VL) do not see being out of touch with new therapeutic innovations or research data as troublesome at their clinic.

Finally, we note the remaining four resource items listed separately. Clearly, staff relations are seen as good--or mostly all right--across the eight locations. Supplies sufficient enough to carry out treatment intervention (medication, O.T. equipment, psychological tests) are

somewhat unavailable as judged by at least one respondent from each clinic. Transportation services provided by the facility is not an issue except, once again, for the government-sponsored programs. In particular, NMH mobile clinic and home program rely upon the availability of transportation for home visits. Staff there are thus more sensitive to the need for transportation availability.

The concluding item is held to be an indicant of staff general attitude toward the resource deficits perceived in their work settings. Presumably, if the professionals felt frustrated in their efforts to provide an adequate structure for intervention due to the limitations of resources, it would be reflected in their judgment of a low success rate. In the case of the Philippines, unlike that of Taiwan, fewer than 20 percent viewed low success rate as more than a "slight" problem; 27 percent saw it as no problem at all. Understandably, several NMH staff identified this as a problem for their facility. Yet, PGH and PMHA personnel also responded in this manner. It may well be that these latter two cases were a function of heightened sensitivity on the part of respondents to what an idealized therapeutic outcome should entail, at least according to the standards of contemporary psychiatry.

In review, a strong consensus emerged that funding for future treatment programs and research was problematic. There was also agreement, although less uniform, that

treatment supplies, epidemiological data, and rooms to separate different types of patients are all in short supply. Of the remaining 16 potential resource deficits, 10 showed divided opinion between and within institutions on whether they presented difficulties. Six appeared not to be problems as viewed by staff.

Looking closely at the answer patterns for individual sites, staff at NMH, PGH, and VL often accounted for the responses given at the "very serious" end of the scale. This pattern reflected their overworked, yet precarious position within the government-funded system.

The private facilities--including the Veterans Administration hospital--tended as a whole to deny experiencing these items as critical problems. Such denial seems incongruent with previous deficit analyses. However, it may make sense for a number of reasons: the private facilities are not dependent upon the government for their well-being; they feel that they have sufficient manpower; they do enjoy decent relationships with other health and psychiatric institutions; they are not overcrowded as are the public clinics; and they do feel that they are in touch with new treatment techniques while realistically recognizing that research is not one of their priority functions.

This generalization does not hold true for PMHA, however, which expresses its problems in a pattern similar to the government agencies. This finding may follow from PMHA's

orientation to serve the general public for a comprehensive scope of mental health needs much like the mandate of the public agencies and in sharp contrast to the restricted service scopes of the other clinics found in the private sector.

Community Integration and Acceptance
of the Mental Health System

Having analyzed the resource potential of the Philippine mental health system, attention is now shifted to appraisal of its integration into the recipient community and its degree of acceptance.. Integration is examined by recording instances of community involvement in patient care and community action in review of agency objectives and operations. The perceptions of staff members are relied upon for determining the extent to which their programs are accepted by clients.

Community Integration Through Involvement in Treatment

Institutional ties to the community are strengthened through involvement of community agents, particularly family members, in various aspects of intervention. Community agents could assume specific roles in the areas of goal setting, treatment selection, service delivery, and rehabilitation. Clearly, these processes of community integration are isomorphic with several alternatives for providing continuity of care into the community as shown

in Table 5.9. Encouraging participation of persons from the patient's social network simultaneously provides enhanced continuity of care, integration, and hopefully community acceptance of agency programs.

A distinct pattern of community involvement in agency therapeutics is derived from Table 5.9. Non-relatives from the patient's immediate social environment are seldom brought into case management. On the other hand, agencies do apply a host of methods for getting family members to take some form of responsibility for helping in the patient's recovery. Family therapy, counseling with spouses, weekly family education sessions, and reliance on relatives to report problems and improvement at home are frequent methods used. However, the family "watcher" system, involving the overnight stay of a member who has a positive relationship with the patient, is perhaps the most dramatic penetration of the community into residential treatment.

At PGH in particular, the watcher has been recognized as a vital force for assistance. Staff take time to train, educate, and offer professional support to those accompanying an admitted relative. Visitation is encouraged in all settings; staff sometimes take advantage of family presence to gather information, offer suggestions, or encourage activities such as picnics or outings.

However, for the most part, family input into the selection of therapeutics and specific goals of treatment

is seldom sought out. The power for making these decisions-- as in the case of Taiwan--rests almost entirely with the psychiatrists. In some instances, other professionals like social workers, psychologists, and O.T. personnel are called upon to make team judgments. Yet, it is the physician in the standard medical tradition who is the final decision maker and authority. This is not the case in only one instance: PMHA's non-residential programs. There, the social workers and rehabilitation specialists carry the burden of client contact and consultation. Not surprisingly, PMHA is noted for its emphasis on the family unit in therapy, education, and research.

Community Integration Via Agency Review

A second measure of integration entails agency openness to community input at the level of program policies and goals. Formal agency accountability to local leaders may assume many formats including surveys of consumer needs and expectations of treatment or creation of advisory boards with community representation.. The conception of community consultants or an advisory board empowered to assist in program development was alien to the Philippine programs as it was to those in Taiwan.

The one exception was PMHA. It has its basic policies and orientation guided by a National Board made up of well-known professionals--lawyers, physicians, psychiatrists--representatives of the business world, and government. The

recent President of PMHA was a former Chief Justice of the Supreme Court. PMHA chapter offices are also directed by local boards comprised of community persons. They are usually volunteers: both professionals and members of higher social classes. Although neighborhood or barangay level political leadership is not formally represented in PMHA administration, certain PMHA programs are directed toward cooperation with these local units. There is a professed sensitivity to their expressed needs.

Perhaps of more direct consequence, however, is the voice of higher political authority, especially Imelda Marcos. She recently began a campaign to assist out-of-school youth which was taken up by PMHA. In short, PMHA is substantially tied to local interests in its orientation, although those interests are perhaps most closely associated with the values, attitudes, and beliefs of the educated elite of the country and its current political leadership.

Staff Evaluation of Acceptability

Staff opinion is the third element in the description of the agencies' integration with their consumer communities. Table 5.11 lists six items from Questionnaire #2 aimed at staff perspective of their clinic's degree of favorable status among potential clients. A firm hint of agency alienation is expressed in the first item. Less than five per cent of the respondents found no problem in the commun-

Table 5.11

Staff Perceptions of Their Agency's Acceptability (N = 22)

Questionnaire Item	<u>Seriousness of Problem</u>			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Community people don't know about or understand the treatment program.	23%	32%	41%	4.5%
2. Community people have a bad opinion of the treatment program and use it as a last chance.	18%	27%	41%	14%
3. Patients and their families don't believe the treatment will help.	4.5%	4.5%	50%	41%
4. Patients returning home have problems because people know they were in a mental hospital.	32%	32%	32%	4.5%
5. People with traditional beliefs about mental problems won't use the treatment program.	14%	14%	64%	9%
6. People go to "Folk Doctors" instead of using the treatment program.	14%	32%	50%	4.5%

ity's level of knowledge or understanding of their program. The sense of alienation is reinforced to a moderate degree by the view of just under half of those sampled that people hold negative opinions of psychiatric facilities and use them only when forced to. None of the sites reported being completely free of this problem, although VMH, UERM, and UST saw it as a minor issue.

Concern for the stigmatizing effects of psychiatric contact has the most agreement among respondents. Only one staff (at PGH) did not see stigmatization as a problem; a clear majority saw it as moderately serious or worse. In fact, staff firmly believe that their treatment carries the burden of social ostracism for patients. Those who come do so only as a last resort when other alternatives have failed. Yet, personnel feel quite certain that those who arrive bring with them a certain amount of faith in the treatment itself. The act of seeking help may require faith by those participating, a faith not shared by non-participating observers. Faith in psychiatry is evoked at the point when other intervention avenues such as general practitioners or folk methods have failed.

An interesting response difference emerged when personnel were asked to rate problems associated with tradition-minded persons (those whose beliefs about disorder might be incongruent with modern psychiatry's) and those who prefer to use "folk doctors" instead of clinic

services. More staff rated "folk doctor visitation" as more of a problem than the simple reluctance of people with traditional values to attend their clinics. It may be that staying away because of traditional-mindedness is only a minor difficulty, at least in regards to urban Manila. It may also be that the highly visible, dramatic, and well-publicized spirtualists and faith healers of the country--including the internationally known psychic surgeons who practice in Manila--are perceived as threatening by certified personnel. This could explain the finding that only one respondent did not label folk doctor's attractiveness to patients as problematic.

Taken as a whole, these three sources of evidence regarding integration suggest that a community penetration of agency functioning is limited to a few key points of contact involving the family. Furthermore, staff do recognize a modicum of alientation. But this is by no means thought of as overwhelming or severly isolating of extant programs.

Cultural Continuity and Accommodation of Mental Health Services

Selected Examples

The pursuit of cultural continuity in the delivery of psychiatric services is the third attribute of a mental health system investigated. Instances were sought depicting accommodation of psychiatric practice and procedure

with patterns of recipient culture. It is assumed that such accommodation fosters cultural continuity of care and enhances patient acceptance of intervention. Five dimensions of Philippine cultural accommodation, similar to those of Taiwan, were observed.

Prominence of Philippine kinship ties. A force requiring recognition in any designated therapeutic encounter is the Philippine family structure within which each patient lives. The family's prominence is seen in its functions as a source of individual identity, behavioral regulation, and recognition of deviance and its role in interaction with a helping agency for the enhancement or interference of patient recovery.

In terms of defining individual identity, nothing is more significant for the Filipino than kinship ties (Shakman, 1969). The eminent Filipino anthropologist, F. L. Jocano, supports this notion. He emphasizes the cultural ideal that an individual's most important duty and responsibility are to his close kin, doing nothing to bring disgrace to the family. In short, kinship ties prevail over all other kinds of relationships (Jocano, 1973, p. 34). Extreme loyalty demands by the family are presumably compensated for by its extensive support of each member and its function of satisfying emotional and dependency needs (Sechrest, 1969; Shakman, 1969).

The point of this cultural phenomena, which must be considered by helping professionals, is that the patient's interpersonal world is his primary source of emotional gratification. Reassurance is derived through successful negotiation of interpersonal affairs with family and friends (Lapuz, 1972). In Bulatao's (1969) analysis, only family members are to be trusted and no one else. Getting along successfully in the world depends upon emotional ties such as those binding the family, rather than a system of reasoning. Mental health institutions must key their intervention approaches to take into account an individual's psychological dependency upon his family and its traditional role in caring for the patient's well-being and social adjustment.

A second aspect of family influence which should be acknowledged by agency workers is its role in recognizing deviance and deciding upon some treatment action. A host of etiological and causal explanations are held regarding perceived illness (Jacano, 1973) and determine family reaction to it (see discussion below). What is significant to the agencies, however, are those behaviors which lead to a psychiatric referral by relatives. It appears that as long as the behavior dysfunction is passive in nature--the person quiet and manageable even though actively hallucinating--he will be maintained in the home.

Professionals complain of a general inability to recognize the cues of an impending disorder (Sena, 1974) or simply a high tolerance of mild psychotic symptoms (Santiago, personal communication). Supporting this latter point, Maguigad (1964) reports that family and friends may not actually consider visual hallucinations as unnatural. Jocano (1971) recorded in his visit to Panay that hallucinations are one method of social control used by the people and are an established part of the peasants' "idiom of cognition."

On the other hand, violence or threat of violence to family members and neighbors is definitely intolerable. In a culture where modesty in speech and actions are highly valued, where public display of feelings are discouraged (Jocano, 1973), and hostility toward parents is never legitimately expressed, severe social sanction is likely to befall the member who acts violently toward his kinship group. It is often under these conditions that a person is finally brought to the attention of a psychiatrist. At this extreme point of alienation from family, a person is hospitalized. It becomes the challenge of the agency worker to recognize the severance in the relationship and set in motion ways to begin a rapprochement. Without family support and cooperation, the agency will end up being long-term caretaker for the patient.

The point of initial institution contact is critical

for establishing a cooperative link between the staff and family of the patient. Relatives' initial expectations of treatment function are dominant and must be considered. Frequently, they expect a quick, complete cure, regardless of the patient's condition. They look around for the "best" healer--someone who can demonstrate quick results. The family may demand to have the patient released by a certain time, tell the staff how to handle the case, or remove their patient against the physician's advice when these expectations are unmet.

In accommodating to this situation, facilities work to get the family's commitment for a full treatment program. For example, at UST the patient is admitted with perhaps the whole family in attendance. They are interviewed and the program is described to them; ECT is explained and consent for its use is sought. Personnel noted that if the physician explains the significance of the treatment modalities the family is easily convinced of its value and is satisfied with the treatment program. At PGH, it was stressed that it is important to deal immediately with reduction of patient overt symptoms which the family fears. Rehabilitation involving broader treatment activities and family participation is discussed later.

The tendency to abandon the patient to residential care, especially those alienated from kin through acts of violence, is the greatest challenge to agency professionals.

It requires culturally appropriate procedures to counteract. Families eschew responsibility for rehabilitation. They prefer to have their patient remain in the hospital forever, even those cases who the psychiatrist advises can be treated on an outpatient basis (Manapsal, 1974). This may be related to fear of being harmed again, a sense of hopelessness, or to notions of illness incurability and a desire to avoid dealing with the stigmatization and shame that a discharged mental patient may bring to the family. At NMH it was remarked that if a patient is not completely recovered although functionally improved, the family still wants him to remain in the hospital employed in menial labor rather than returned home.

A variety of accommodation measures in response to this attitude of alienation between family and patient were found. These were efforts by the facilities to keep the family engaged with the patient, avoid abandonment, and facilitate the recovery process. These measures all entail encouraging different levels of family participation in treatment. NMH staff wait for the hostility to die down before asking the family to make regular visits to their relative. They are allowed to bring a supplementary diet to the patient. This not only promotes health but is a concrete expression of affection between family members (Jocano, 1973).

Of course, the watcher system is another example of how

agencies can rely upon existing ties of emotional dependency and support to provide intensive treatment contact for a case. This is especially true at PGH and UERM where the watchers are educated and trained to be maximally useful to the patient. Parent and spouse groups and family education sessions with treatment staff at VMH are examples of responsive efforts to exploit kinship structure for rehabilitation goals. These methods insure that the patient maintains his position safe within the family.

Accommodation response to popular/traditional conceptions of disorder. In the course of patient interaction, Filipino mental health workers confront an array of traditional and popular notions regarding illness. They are called upon to handle cases with long histories of contact with local healers. To gain patient and family confidence, it is sometimes necessary to act in a sensitive, accommodating way toward these folk beliefs and unravel the patient's previous means of attempting to solve his problems. Personnel in those institutions with greater contact with less-educated and barrio populations revealed a certain awareness of folk explanations of disorder.

Filipinos recognize two broad categories of illness. (Lieban, 1967, p. 81). First are those maladies attributed to physical or psychological causes not associated with sorcery or witchcraft. This class includes illnesses brought on by incorrect personal habits such as taking a nap after

a bath, bathing during the menstrual period, getting caught in the rain, or neglecting to eat meals on time (Sena, 1974). Common ailments like colds or stomachaches are attributed to an unbalanced relationship of elements inside the body due to overconsumption of "cold" or "hot" food (Woolley, 1972). Injury, infection, vulnerability arising from previous sickness, and hereditary transmitted ailments are also viewed as "natural" in etiology (Lieban, 1967; Sechrest, 1967). Moreover, disorder may be thought of as social in its origins. Interpersonal conflicts are frequently cited by respondents--abandonment by loved ones, quarrels in the family or with employers--as well as unbearable frustrations like death of a close relative, inability to find work, over-studying or failure of an exam, and financial problems.

The second illness category involves the widespread belief in supernatural cause of psychological impairment. These conceptions pose the greatest challenge for culture accommodation. Barrio people cling firmly to notions of devil or man-eating spirit possession (answang) sometimes caused by the malign magic of sorcerers (Jocano, 1971; Lieban, 1967; Sechrest, 1967; Shakman, 1969). Loss of soul and taboo violation as well as personal encounters with answang are also thought to bring about illness.

The consequences of these beliefs on patient and family behavior must be considered by treatment staff.

First, it is not uncommon to encounter shared "delusional" ideation among an entire family, a condition termed "Follie a Familia." An NMH psychiatrist reported cases where a husband and wife thought that their child was changing into a monster. They put a cross into the child's mouth, causing death through asphyxiation. Secondly, the notion that illness is caused by evil spirits leads families to choose spiritual or faith healers over psychiatrists. The latter are geographically and socially remote from them anyway (Manapsal, 1974; Shakman, 1969). Professionals complain, however, that local healers doing exorcism rituals employ sadistic procedures, such as burning the flesh of disturbed people with cigarettes, and delay proper medical attention (Sena, 1974). In contrast, Sechrest (1967) found in Negros Oriental that there was an intentional lack of treatment given certain cases. There was not even contact with native healers as it was deemed futile and thought unnecessary.

Accommodation to indigenous notions of psychopathology follows the general lines found in Taiwan: provisions of special ward activities, assumption of certain expected role behavior by treatment staff, and inclusion of therapeutic modalities demanded by community recipients. These are discussed below. However, specific examples of responses to popular belief systems are described first.

Psychiatrists at PMHA and PGH were most articulate on this point. The first strategy is to teach the family to view the problems in psychiatric terms, educating them to psychiatric methods. PGH staff found analogies useful in communicating concepts of disorder, such as the image of an overflowing or cracked clay pot when describing emotional repression.

Second, veteran professionals agreed that direct confrontation of "superstitious" beliefs and use of local healers was ineffectual. For example, saying that consulting a herbalist was a waste of time only leads to resistance. Often, herbalists enjoy patient trust, which remains to be won by psychiatrists. It was thought best to try and remain non-judgmental although professionals usually asked their patients to try their therapy as an alternative and avoid seeing a herbalist while under treatment.

Generally, staff attitudes toward folk healers were that they interfere with proper care, confuse patients, and may cause more anxiety than they dispel. One PMHA staff member, however, felt that it was best to try to make herbalists more scientific in their approach: to invite them as allies rather than antagonize them. This approach has been used for 20 years with hilots by public health administrators with established success (Mangay-Angara, 1977; Del Mundo, Morisky, & Lopez, 1976).

In essence, the accommodation strategy for handling clients with "unscientific" ideas regarding dysfunction is to either gently ignore them or to persuade them to acquire an alternative conception--one that is more "psychological minded." At least one staff member at PGH, however, expresses frustration that the Western theories studied so diligently are inapplicable with many patients who hold folk conceptions. Thus, therapists are forced to simply look at the individual's life situation and give small, realistic assignments that are aimed at helping them secure a better adjustment.

Accommodation in ward activities. Elements of accommodation in ward organization and events were observed in many institutions. A common practice was linguistic matching. Having so many major dialects and serving patients from throughout the islands necessitated assigning patients to treatment personnel or aides who could understand their dialects. Attending to sex role differences was recorded at NMH. Efforts were made there to try simulating a home-like atmosphere for certain female wards. Male programs involved a strong work orientation--learning work skills and even being sent out on weekends for part-time jobs. PMHA's rehabilitation program catered to cultural background in the employment domain: patients could be referred either to an industrial or farming training center. Another procedure to reinforce the

patient's sense of community was the establishment of ward self-government organizations by PGH and VMH. The VMH patient government met several times weekly, elected its own officers, discussed problems, and had a definite impact on ward policies such as food choice, TV usage, and resolving peer conflicts. Ethnic minorities were given some attention within these institutions. At NMH there are two pavilions set aside for Chinese-Filipinos. The buildings were donated by the Chinese Chamber of Commerce. The unique needs of Muslim patients at VL were somewhat addressed by recognition of food restrictions, acceptance of certain religious rituals, and permission to wear necklace "charms" believed to protect the person against evil (anting-anting).

Perhaps the most concrete institutional recognition of the need for culture accommodation was found at UST and VMH. UST has sought to remove the stigma of psychiatry by calling its unit a "Community Center." The hope is to create the image of a community-based service like a boarding house or general ward. Pleasant eating quarters and the absence of uniforms are intended to add to the atmosphere. Similarly, VMH is hoping to remove its out-patient clinic from the ward to reduce the stigma and apprehension evoked by clients visiting the hospital for consultations. Finally, it can be noted that MC seeks to keep a lively and "normal" atmosphere by including such

events as bingo socials, cook-outs, parties, films, marketing, and garden strolling as essential components of its therapeutic regimen.

Accommodation through staff qualities and mannerisms.

Agency personnel delineated three personal and interpersonal qualities thought to be prerequisites for securing a therapeutic relationship with Filipino patients. The major attribute expected of a therapist is authoritative stature, he or she should have an air of almost "godlike" authority and fit a "father" image. As an omnipotent expert in command of the situation, the physician should give assurances that the treatment will help. Lesser-educated persons simply turn over responsibility to the physician with complete trust. More educated clientele at the private clinics usually expect some sort of explanation of what therapeutics entail.

Along with the fatherliness, however, there is an expectation of allowance of dependency and emotional closeness between patient and staff. They look for the physician's human side and ask about his personal life in order to feel comfortable in the relationship. Patients seek security in physician acceptance, patience and understanding. They hope for a supportive and family-like emotional relationship with the nursing staff. Besides an emphasis on tender loving care, staff also recognize that delicacy with individual feelings is essential.

To avoid "shaming" the patient or violating his self-respect, it may be necessary not to go directly to the "point" in problem solving. Rather, therapists should send out "feelers" and use gentle suggestion. In short, fatherly and warm emotional approach is generally recognized by therapeutic staff as the basic approach to developing a good working relationship with patient and his family in these settings.

Providing expected therapeutics. A final instance in which accommodation is deemed essential involves catering to expected modalities of intervention. As was the situation in Taiwan, physical forms of treatment have the highest credence since more presenting problems are expressed in somatic terms. Lapuz (1972) listed the most frequent complaints from her clients: males generally reported poor balance, eye pain, low back and groin pain, and urinary disturbance; women complained of numb feelings, tremors, tingling hot and cold sensations, and body weakness. The most often reported symptom mentioned by agency respondents was disturbed sleeping patterns and loss of appetite. Lapuz (1972) also notes that for Filipinos, such physical ailments are readily given credence and are greatly effective in eliciting concern from others.

In correspondence with bodily complaints are expectations from the patient and his social group for physical treatments aimed at alleviating these symptoms. Those with

undifferentiated perceptions simply want the person hospitalized with a physician to care for him. However, many others specify that drug injections should be given. Remarkably, many staff report that families specifically asked that electric shock be administered as preferred treatment. Shock was seen by some as an immediate curing device preferable even to drugs. Some families insisted on taking their member elsewhere if shock wasn't provided. Except among the sophisticated few, talk therapy is disregarded as anything of curative value. Nevertheless, several therapists at PMHA and elsewhere expressed their faith in the use of group dynamic approaches. They felt that group interaction has more impact and a deeper effect on Filipino patients than do one-to-one therapies.

Staff Perceptions of Culture Accommodation

Agency respondents were also asked to state their perceptions of the availability of certain accommodation practices and their attitudes toward various accommodation dimensions (Questionnaire #3). These data are found in Tables 5.12 and 5.13.

From Table 5.12 it is evident that only two practices-- "Staff adjustment of personal manner to fit patient expectations" and "Patient's family helps with hospital care"--are clearly seen to be part of clinic routine. That staff indeed do adjust their personal manner in relation to patient expectations is suggested by very strong

Table 5.12

Perceptions of Institutional Accommodation Practices (N = 20)

Accommodation Practice	Percentage of Staff Endorsing Accommodation Item	
	Always/Sometimes	Seldom/Never
1. Native healer involvement in patient care	5%	95%
2. Staff seek to re-educate those with traditional beliefs about mental problems	100%	
3. Staff adjust their personal manner to fit patient expectations	95%	5%
4. A policy exists to find staff whose backgrounds are similar to those of the patients	40%	60%
5. Inpatient activities are similar to their activities outside the hospital	57%	43%
6. Patients make choices about their daily activities	63%	37%
7. Patients are encouraged to participate in community activities outside the hospital--work and recreation	68%	32%
8. Patient's family helps with hospital care	89%	11%
9. Problems occur because patients and staff have different social backgrounds	5%	95%

Table 5.13

Staff Endorsement of Culture Accommodation Dimensions (N = 49)

Accommodation Statement	% of Staff Endorsing Statement
1. While in the hospital, patients should remain isolated from activities in the community	98% disagree
2. Staff should know the traditional names for mental disorder	96%
3. Community leaders should help in planning and directing facility activities	96%
4. Patient activities in the hospital should be as similar as possible to their activities in the community	96%
5. It is useless for staff to know the traditional beliefs about the causes of mental disorder	90% disagree
6. Staff should adjust their professional manner to fit the expectations of patients from different social backgrounds	90%
7. What is considered as "normality" or "good personal adjustment" is the same for all cultures	86%
8. Patients should go to large central hospitals for their treatment	85% disagree
9. Staff should know the traditional healing practices for mental disorder	83%
10. The doctor alone should decide what the appropriate treatment outcome will be	83% disagree
11. What is considered the appropriate outcome of treatment should be different for different cultures	83%
12. Only those trained in scientific treatment techniques are qualified to help people with mental problems	63% disagree

Table 5.13 (continued). Staff Endorsement of Culture
Accommodation Dimensions (N = 49)

Accommodation Statement	% of Staff Endorsing Statement
13. It is best to hire staff whose social backgrounds are similar to those of the patients	52%
14. The patient and his family should help choose the type of treatment given	51%
15. It is useless to consult with native healers since most of them cannot really help patients with mental problems	43% disagree
16. Staff should try to correct or re-educate patients who maintain their traditional beliefs and customs about mental disorder	4% disagree

agreement with item #6, Table 5.13. This is further supported by the examples of staff offering physical treatments and explicitly desired emotional closeness or fatherly relationships mentioned in earlier sections. Examples of family participation which correspond with endorsement of item 8 were also noted earlier.

Staff were much more reluctant to describe their agencies as creating living environments which approximate the "real" outside social world. This is somewhat surprising as it is at variance with the unanimous attitude stated in item #1, Table 5.13, that patients should not remain isolated from activities in the community when hospitalized. The accommodation component regarding hiring staff whose backgrounds are similar to those of the patients appears to have meaning in the Philippines only in regards to linguistic matching. As noted in section "c," when language problems occur, patients are assigned to professionals who can speak the same dialect. Otherwise, social background differences will not be thought of as a problem, as reflected in the last item in Table 5.12 and the minimal endorsement of statement 13 in Table 5.13.

It was brought out in section "b" that staff accommodate patients with folk beliefs only to the extent that they gently re-educated them to alternatives and avoid direct confrontation of traditional notions. Item #2 in the first

table and #16 in the second show unvaried intention among all respondents toward correction and re-education of folk beliefs when they intrude upon the treatment setting. Lastly, there is neither perception of native healer participation in these clinic sites nor more than minimal endorsement of the statement that such healers should be consulted in some aspect of treatment (See item #1 in Table 5.12 and item #15, Table 5.13).

Looking now at Table 5.13 alone, we find a summary of Filipino mental health workers' attitudes toward 16 culture accommodation dimensions (Questionnaire #3). Like the response pattern found among Taiwanese professionals, almost three-fourths of the 16 accommodation statements are positively endorsed by 80 per cent or more of those interviewed. From the results, we find an almost unanimous agreement among these diverse personnel on three issues: 1) the folk names and causes of disorder should be known by staff; 2) professional manner should be flexible; and 3) the barriers between the hospital and community should be minimal both in terms of making the hospital environment similar to what is outside and allowing community input into agency programs. This last point is worth commenting upon. Although 96 per cent agreed that community leaders should help in planning and directing facility activities, in only one instance--the Board of Directors for PMHA--was such community involvement noticed. Cultural relativism

received over 80 per cent approval (items #7 and #11) as did the opinion that others besides the doctor should help decide treatment outcome.

However, only about half of those sampled thought the patient or his family should be involved in decision-making in terms of treatment per se. Finally, although most would agree that it is important for staff to know about traditional healing practices, far fewer were comfortable with the notion that non-scientifically trained people are qualified to help those with mental problems. Sixty-seven per cent agreed that it is useless to consult with native healers as most of them cannot really help patients with such problems. Apparently, it is thought good for mental health workers to have knowledge of what indigenous healing entails, but actual involvement of folk healers is not endorsed. This antagonistic attitude toward non-professional therapists was described earlier on page 325.

In conclusion, accommodation to distinctly Filipino cultural patterns by the mental health system appears to move along several lines simultaneously. Broadly speaking, these efforts are threefold: engage the patient's family in a cooperative relationship with the clinic (to avoid patient abandonment); gently orient them to the merits of a psychiatric approach (dispelling myths); and make the institution more attractive (lowering stigmatization) to

the community as a whole. Accommodation practices intended to carry this out included the 24-hour watcher system; involvement of the whole family during the intake interview; NMH encouragement of families to bring in food; the parent, spouse, and general family group sessions at PGH, PMHA and VMH; staff willingness to provide the close, emotional, and dependent relationships expected by patients; and attempts by PMHA, MC, and VMH to create the image of community-oriented services casting off the trappings of highly stigmatized and isolated psychiatric treatment.

In examining these practices and reviewing the perceptions and attitudes expressed in Tables 5.12 and 5.13, it seems apparent that culture accommodation within Philippine agencies is primarily an initial effort to gain confidence and cooperation until education and persuasion can coax the uninitiated into accepting an established psychiatric regimen. Families are invited to visit and get involved in inpatient care, but in a circumscribed manner, under the supervision of treatment staff. Their input into decisions about therapy or outcome goals seem rather restricted. Such decisions remain the medical staff's prerogative, specifically the attending physician's--a practice fundamental to Western medicine.

This concludes discussion of formal psychiatric resources in the Philippines. The final section below mentions the types of nonformal care for mental health

problems available to Filipinos. In fact these may be the only resources in outlying provinces.

INDIGENOUS ALTERNATIVES TO MENTAL HEALTH CARE

The final component in this case study of Philippine mental health resources touches upon healing alternatives outside the realm of modern psychiatry. Philippine folk medicine has been aptly described in recent years by anthropologists (c.f., Jocano, 1973; Lieban, 1967). It is beyond the scope of this study to do more than briefly mention the current status of indigenous healing and report the distinct types of indigenous specialists. This description is gleaned from the anthropological literature and remarks of psychiatrists regarding folk practitioners. The author had no direct contact with these providers.

Persistence of Folk Healing

Shakman (1969) remarked ironically that indigenous healing appears to thrive in the Philippines in spite of the fact that its medical schools produce roughly as many physicians in proportion to its population as does the United States (Shakman, 1969, p. 279). The persistence of folk healing and the cultural conditions responsible for its perpetuation are issues of special theoretical interest for anthropologists and are briefly covered below. However, from the perspective of this study, it is also important to establish the use patterns of native

healers for psychological disorders and draw out the implications these patterns have for acceptance/utilization of modern psychiatric care.

The first question concerns the extent to which folk practitioners are relied upon for patients with behavioral problems. Evidence on this point is rather sparse. Sechrest (1967) observed in a Negros Oriental barrio that the "modal" treatment entailed the use of the local native healer. Still, a surprisingly large number of cases that were judged in need of care intentionally received none. Escudero (1972), reporting on the 1963 epidemiological study of 2,360 persons in Central Luzon, found that of those 86 active cases located, 10 per cent received psychiatric help, 44 per cent consulted the general practitioner, five per cent saw native healers, 15 per cent went to both types of practitioners, and 25 per cent received no help at all. In the follow-up investigation of this same community a few years later, Manapsal et al. (1974) noted that herbalists and fortune tellers received only 15 per cent and nine per cent endorsement respectively as coping resources used by family heads in response to times of psychological crisis. Reliance upon religious avenues such as prayer and seeking the counsel of friends were named the major coping strategies by these respondents.

The Escudero (1972) and Manapsal, et al. (1974) estimates of folk practitioner use appear somewhat low. It

would seem logical to assume that those presenting psychiatric complaints would be taken to native specialists at least as often, if not more so, than persons experiencing physical illnesses. And the indications by Jocano (1973), Lieban (1967), and Shakman (1969), are that herbalists are in many instances the only practitioners within easy access to those in need. Moreover, they frequently have quite lively and demanding caseloads and may have a greater proportion of clients visiting them from outside the district than do nearby licensed physicians. It may be, therefore, that the figures of five per cent to 15 per cent use of folk specialists are underestimates of actual involvement. Perhaps informants interviewed by psychiatrists are unwilling to admit making use of neighborhood healers for psychological problems.

The actual pattern is undoubtedly complex. Patients whose impairments prove refractory to the healing power of folk specialists and general practice physicians may finally be referred to a psychiatrist and hospitalized. In the course of this referral process, perceived cause of the problem may change for those experiencing treatment failure. This in turn dictates selection of a different type of specialist. In general, however, the decision between folk and modern doctor is based on the recognition of natural or supernatural causes (Manapsal, 1974). A scientific doctor is assumed to be inadequate if a diagno-

sis of sorcery or encounter with a malevolent spirit is suspected. Modern medicine, in contrast, is given first priority for certain "naturally-caused" physical conditions like diarrhea or when the herbalist has proven ineffective (Woolley, et al., 1972).

Knowing that indigenous specialists play an active role in handling many psychiatric cases in some phase of their treatment course, it also becomes apparent that certain cultural factors serve to preserve the traditional Philippine system and detract from utilization of modern psychiatry. The first factor, found in Jocano's (1973) ethnography, concerns the high esteem that healers are able to enjoy within their community. These specialists, competent in the art of healing, carry out their work without asking for payment. They are thus respected for their convictions and high sense of civic duty to community and fellowmen (Jocano, 1973, p. 126). Incompetent or unethical healers are socially censured by withdrawal of patronage and repudiation of confidence.

A second factor contributing to folk medicine's persistence is the undying belief of rural (and some urban) people in the supernatural etiology of certain illnesses such as malign magic which are the exclusive domain of shamanic healers and sorcerers (Sena, 1974; Woolley, et al., 1972). Lieban (1967) points out the relationship between the belief in sorcery and the perpetuation of

folk medicine which is required to combat it. By providing an etiology, diagnosis, and treatment for sorcery, indigenous medicine stimulates and reinforces beliefs in magical causes of illness (Lieban, 1967, p. 87). Jocano (1973) describes the core of the Philippine belief system as an understanding of human existence as a configuration of harmonic relations between the physical body and the spiritual well-being of man.

Illness and misfortune are brought about by the disruption in the relationship between man's organic and spiritual duality. Hence, curing involves attention to both pharmacological techniques and ritual symbols--such as prayer -- directed at the metaphysical aspects of disease. In fact, Jocano (1973) notes that prayer is the most important part of healing as it serves as the link between a practitioner and the supernatural power which does the healing. This aspect is hardly attended to by scientifically trained doctors. Furthermore, the pervasiveness of these beliefs are indicated in a survey by a Filipino physician, R.V. Guiang, in 1960 (Shakman, 1969). Interviews of "provincial school teachers revealed that 50 percent believed in anitos (small anthropomorphic spirits believed to cause disease in some circumstances), 33 percent believe that indigenous healers can cure disease before which physicians are helpless, and 20 percent believe in the power of witches to inflict illness (Shakman, 1969, p. 280)."

Folk medicine also continues to thrive based on the culturally expected relationships, ceremony, and faith inducement it provides. Dramatic supernatural rituals of entranced healers--such as the bulo-bulo sleight of hand techniques of magicians and the miraculous surgical procedures of psychic surgeons (spiritistas)--captivate and reinforce the pre-conceptions of patients and onlookers. Moreover, the healer-patient relationship factor is especially critical. First, the overall physical milieu where the healer operates has the social class and economic characteristics which patients easily identify with as opposed to the doctor's offices and hospital clinics (Lieban, 1967; Shakman, 1969). It may be that the personal relationship offered by the folk specialist is greatly preferred over the sometimes rude, impersonal, and bureaucratic treatment associated with medical personnel, rather than an actual disbelief in the effect of modern medicine (Woolley, et al., 1972).

The key to the folk healer's acceptance, however, is rooted in the faith that they do, in fact, heal (Lieban, 1967)--a faith which has some empirical justification in certain instances (Kleinman & Sung, 1976; Lieban, 1967; Shakman, 1969). This factor beyond all others listed here accounts for their continued use. Moreover, according to Jocano (1973), both the healer and the patient must have faith in the healer's prayers or they will not work. In essence, "it is in this reciprocal faith that healers and

patients have that folk medicine finds appropriateness, strength, and continuity in the lives of the peasants... It may be lacking in all that scientific medicine has to offer, but certainly it is an unquestionable source of assurance--assurance that a sympathetic hand is zealously doing something to relieve the pain and the anxiety that accompanies it. Thus, even if the patient suffers more because of the procedure intended for his relief, the folk healer is still looked up to with respect, hope, and gratitude (Jocano, 1973, p. 195)."

In passing, it can also be noted that the geographic and economic remoteness of modern psychiatry (and public health in general) is an additional factor which supports the maintenance of local healing. Outside the sphere of wealthy urban dwellers, psychiatric agencies are almost unavailable. Lieban (1967) observed in Cebu that the facilities located in urban centers are not only difficult but actually dangerous to get to, given the status of rural transportation. Moreover, he reports a discrepancy of costs between the two medical systems. The folk system is usually much cheaper. In short, convenience and accessibility are generally on the side of indigenous medicine for the majority of Filipinos living in the provinces.

Types of Indigenous Specialists

There are several distinct categories of folk specialists practicing medicine in the Philippines. Two types of

specialists--the midwife and masseur, or specialist in broken bones, sprains, and other discomforts related to muscles--are not described. Their practices are not associated with helping those with psychological dysfunctions. Better known for dealings with psychiatric cases are shamans, the general practitioners of folk healing, sorcerers, diviners, and spiritistas or psychic healers.

The Philippine shaman, known in Central Luzon as arbularyo (herbalist) and in the Visayas as mananambal, is the folk practitioner most closely associated with the treatment of psychological disorders. Like all healers, the shaman is thought to have access to supernatural power (called bisa in Central Luzon). But, unlike the others, his power is not restricted in the types of illnesses that it can cure (Jocano, 1973).

According to Jocano, bisa is believed to be an unseen power that flows from God. Therefore, most healers feel the burden of responsibility to follow the will of God in using their "gift" or curing and do not charge for their services. Presumably, these God-given powers cannot be employed for evil purposes such as causing sickness. Most report being called to the profession through a dream or contact with a supernatural being. Through a trance state, the shaman is able to consult with his "not-human" patron when someone is ill, learning both diagnosis and knowledge of how to cure (Jocano, 1973; Woolley, et. al., 1972). Benefactors of the

Cebu mananambal may include spirits of deceased mananambal, saints, Christ or God (Lieban, 1967).

Jocano found other preconditions for arbularyo stature besides visitation by a supernatural being. The person must have a shaman in his family, undergo long training under the direction of an experienced arbularyo, memorize prayers and ritual procedures, and master the techniques of pulse-taking. In particular, he must become an expert in the use of medicinal plants. Knowledge of the available pharmacopoeia is the arbularyo's recognized forte. These causes--physical and organic etiology like indigestion, worry, or sprains--or supernatural origins--sorcery, witchcraft, and harm derived from (anitos) earth dwellers (Jocano, 1973).

The list of treatment modalities offered is extensive, including decoctions, poultices and other herbal preparations, fumigation, anointing, cupping, incantations, and various magical procedures (Lieban, 1967). Jocano (1973) asserts, however, that the specialist's most potent antidotes for serious illness are religious prayers, Holy Water taken from the cathedral, and objects of religious significance.

The mananambal and arbularyo are defined by their intentions of positive service to the community and by the folk medicine ideal of not profiting from the aid rendered (although commercialization is evident in urban practices). The sorcerer, on the other hand, is hired by clients to use

his destructive supernatural power to inflict illness or death upon persons who are presumably guilty to some transgression against them. Sorcerers motivated by economic gain derive their power from the manipulation of resources outside of themselves. These include magical operations or an established relationship with a supernatural spirit and are usually seen as evil (Lieban, 1967). In this regard, Lieban (1967) differentiates sorcery from witchcraft, in which supernatural power is rooted in the individual as a constitutional resource.

Although sorcerers may initiate malign magic against those who have antagonized them, their procedures are usually carried out at the bequest of a client who presumably has a legitimate grievance against another member of the community. Typical points of conflict include unfaithful spouses, personal insults, stealing food, or disagreements over land ownership. Its use is thus a sensitive measure of social conflict within the community (Lieban, 1967). Presumably, though, sorcery cannot have an effect on "innocent" persons so the sorcerer is supposed to check out each intended victim thoroughly or risk having the magic boomerang onto him.

In essence, Lieban suggests, sorcery is impotent in the control of future social decisions. It is restricted to the punishing of past alleged transgressions. In this regard, sorcery is not easily converted into social power. In fact,

unlike the aforementioned shamans, sorcerers are feared in the community; they must carry out their magical attacks in complete secrecy. Besides sending sickness on the wind to penetrate victim's bodies, they are also thought to be able to make people lose their minds or cause women to become pregnant and give birth to fish or lizard babies (Jocano, 1973). Sorcerers by necessity must carry out their procedures in strict secrecy and isolation from others, unlike the community participation nature of shamanic rituals. The redemptive function of the sorcerer lies in his perceived ability to cure the illness which he has inflicted.

In Central Luzon, diviners (magluluop) and medicos are other practitioners akin to the arbularyos. The diviner specializes in diagnosing illness through an elaborate ritual known as "luop." Symbolically significant paraphernalia such as the kalanghuga, a kind of shell, are passed over the body to give visible form to those unseen things that cause the patient's illness (Jocano, 1973). At the end of the luop ritual, the diviner declares what ails the person, the best medicine for promoting recovery, and which type of specialist is most appropriate for healing. When a diagnosis of sorcery or other supernatural etiology is made, the arbularyo's services are deemed essential.

Medicos, reported in Jocano's ethnography of Central Luzon, are local healers who have combined the traditional medical system with modern drugs in their practice. Perhaps

through their own reading of medical books and trial-and-error experience, they have acquired some knowledge of modern medical techniques along with a supply of syringes and various drugs. Their combination of medical with folk procedures has earned them the attention of the Philippine Medical Association and official censure for malpractice.

The final type of Philippine native practitioner having contact with psychiatric cases is the spiritista or so-called "psychic surgeon." Genuine anthropological data on these faith healers are unavailable. Popular books on this subject abound with the rising interest in psychic phenomena (c.f., Nolan, 1974; Sherman, 1967; Valentine, 1975). William Nolan, an American surgeon, did observe several of his spiritista counterparts in Manila and Baguio who were internationally known for their "miraculous cures" of foreigners seeking their treatment (Nolan, 1974).

Most of the faith healers belonged to a Christian religious sect, the Espiritista Church, and claimed divine intervention by Christ as the source of their healing power. With a heavenly protector to guide their hands, they plunged fingers into patients' abdomens, legs, backs, teeth, and even eye sockets, to remove alleged blood clots and tumorous tissues. Sometimes they used their fingers like syringes to inject health-giving spiritual energy into "run-down" patients. Amazingly, there is not evidence of incision at the site of the surgical removal. Like the shamans, psychic

healers handle diseases caused by natural and unnatural agents, the latter requiring an exorcism ritual.

The rationale given by Espiritista Church members of why there are so many psychic surgeons in the Philippines (Nolan reported there to be approximately 20) was that Christ wanted a sign of the Second Coming to appear among the poor--a qualification fitting the people in the Philippine lowlands. Several of these healers have become extremely wealthy in their ministrations to the monied ill who travel from the United States and Europe seeking treatment. One specialist in particular is reported to charge a \$200 donation for his chapel per patient. Based on the estimated number of patients he treats, the amounts to more than \$40,000 per month.

Nolan's close scrutiny of the psychic surgeons' procedures through witnessing the handling of numerous patients, as well as his own submission as a patient, revealed the operations to consist chiefly of sleight-of-hand techniques. A piece of sharp mica was secretly used to make a shallow incision "miraculously" appear in a procedure that drew blood out into an inverted glass jar (cupping). Cotton soaked in red dye or betel-nut juice and animal entrails were covertly palmed and then triumphantly pulled out at the conclusion of the operation and declared an appendix or cancerous tumor. One particularly dramatic operation involves pulling the patient's eye out of its socket

and polishing it with cloth. An animal eye and hand trickery are used to give it a very real appearance.

Organized psychic surgery is a relatively recent phenomena in the Philippines. Its practice is probably restricted to the major urban areas where the healing churches are located. No descriptions were found of procedures used for psychological problems, although psychosomatic complaints are undoubtedly a large portion of the clientele seen. Shakman (1969) suggests, however, that the spiritual surgeons with their florid techniques probably see more mental illness than do other native healers.

In summary, traditional beliefs and folk remedies exist side by side with modern medical care in the Philippines. Suspected sorcery victims or those taken ill as a consequence of encountering a supernatural agent are taken to shamans, diviners, faith healers, and allied native specialists. Modern medicine, which does not make allowances for the metaphysical component of man, is at a disadvantage in curing many perceived illnesses. Moreover, families are even willing to travel long distances, bypassing medical personnel, to bring their suffering member to a highly reputed indigenous specialist. Ultimately, they do so because of a profound faith in the healer's therapeutic efficacy.

The Western psychiatric specialist is usually unavailable and resorted to only when the family is ready to abandon its troublesome member. He functions in a system that bears

little resemblance to the cultural territory familiar to the folk healer. The indigenous specialist operates from a position of cultural continuity. In Jocano's words, he is best able to employ ritual symbols and paraphernalia that "crystalize the local view of the supernatural world and how this world can be reached, controlled, and manipulated (Jocano, 1973, p. 141)."

VI. MENTAL HEALTH SYSTEM OF THAILAND

INTRODUCTION

Geography and Population

The Kingdom of Thailand occupies 209,000 square miles in the heartland of continental Southeast Asia. Its neighbors are Burma to the west, Laos and Cambodia to the east, and Peninsular Malaysia to the south. This location insures prominence in the affairs of the region, given its strategic crossroads position--between China, Japan, and India, and between these countries and Indonesia to the south (Henderson, 1971).

Shaped like the profiled head of an elephant, Thailand is comprised of four distinct geographical regions. Each region varies significantly in population density, economic activity, accessibility, and topographical characteristics. Central Thailand is the dominant region because of its expansive fertile plain crisscrossed with natural waterways and irrigation canals. It also contains the capital city of Bangkok. Center of the economic, political, and social life of the nation, Bangkok houses 70 per cent of all urbanized Thai (Woolley, 1974).

The sparsely populated Northern region is made up of forested mountains and valleys. These valleys are narrow but fertile enough for rice production. Least accessible is the Northeastern plateau covering one-third of Thailand.

About one-third of the country's population reside here. Most eke out a living as subsistence farmers. Irrigation and flood control projects on the Mekong River are expected to improve farming conditions in the future. Finally, the Southern region is a long, narrow peninsula extending from Central Thailand south to Malaysia. Covered with mountains and rain forests, this area is dotted with farms and sea-ports on its east coast and supports rubber production and tin mining. Thailand has 600 miles of coastline facing the Gulf of Siam and about 300 miles facing the Andaman Sea.

Thailand is a tropical land (6 to 20 degrees north latitude) noted for high temperatures and humidity. The Thai specify three seasons--hot, rainy, and cold--governed by the monsoon winds. Frequent flooding during the rainy season, notably in the Central plain, renews the soil and insures a surplus of the nation's principal crop--rice. Thailand's high fertility, enabling the production of grains, rubber, lumber, and other raw materials, has given shape to Thai's society, economy, and political institutions.

Estimates in 1977 placed Thai population at 44.16 million and density at 81.4 persons per square kilometer (Asian Development Bank, 1978). The average annual population growth rate for 1970-1975 was a jolting 2.9 per cent, although it has slackened slightly since (World Bank, 1978). The vast majority of Thai are rural residents. Yet, the 1970's witnessed an unprecedented migration to the cities,

especially Bangkok. Over 17 per cent reside in urban areas unprepared for the influx. The Bangkok-Thonburi area is the focus of urban flight, boasting well over 4.5 million people, approximately 75 per cent of all city dwellers. Chiangmai in the North is the second largest city but has only 100,000; Udon in the Northeast (80,000) and Hat Yai (30,000) are other large cities. The total area of sparsely populated upland is small. In general, the population is more evenly distributed than other countries in Southeast Asia.

Ethnic diversity abounds in Thailand although the proportion of indigenous minority peoples is quite low. Approximately 800,000 Malay-speaking Muslims live in the Southern peninsula, various hill tribes occupy the North (approximately 286,000 Hmong, Lahu, Yao, Lisu, Lawa, Lolo, and Karen), and smaller numbers of Cambodians and Vietnamese (including refugees) are in the Northeast. The remaining indigenous population belongs almost entirely to the Thai ethnic group (Fisher, 1977). This group includes Lao, ethnically and historically more closely related to the Lao of Laos than the Thai of Central Thailand. Standard Thai, however, is the official language of the country.

The only sizable minority are the country's five million Chinese (14 per cent of the total) living in the larger urban settings. Unlike other parts of the region, Chinese-Thai have achieved a marked degree of social

integration; many assume Thai surnames. Major Chinese dialects include Teochiu, Hakka, Hainanese, Hokkien, and Cantonese (Henderson, 1971). As is the case elsewhere, urban Chinese dominate the commercial sector of the economy. Besides being business leaders, Chinese are well represented in medical, legal, and journalistic professions and among the faculty of Thailand's major universities (Henderson, 1971).

History

Contemporary Thailand is a reflection of several key forces of history. As early as the Sixth and Seventh Centuries A. D., Thai people from Yunnan District in China began to settle southward. They brought with them a culture of rice cultivation. Belief in the Theravada school of Buddhism came from early Indian influence via Sri Lanka. Settlers moving into present-day Thailand found it under the rule of the Khmer Empire of Angkor. But by the mid-Thirteenth Century, a powerful Thai kingdom had arisen in Ayudhya which conquered Angkor and extended its rule northward into Laos, westward into Burma, and far down the Malay peninsula (Wyatt, 1977). In the following century, a formal constitution set the form and character of Central Thailand's socio-political institutions. Former Chinese cultural connections were overshadowed by assimilations of Hindu practices: an absolute monarchy with the authority of a god-king and guided by the moral rule of Theravada

Buddhism, and elaborate hierarchy of social status, classical literature, writing, and even architecture (Henderson, 1971; Wyatt, 1977).

Subsequently, Thailand engaged in periodic power struggles with its neighbors aimed at capturing populations to work its lands. Burma, however, proved formidable on several occasions and destroyed Ayudhya, the Siamese capital, in 1767. The Thai Kingdom, reconstructed politically and economically under the first Rama King, was soon faced with the prospect of dealing with two Western imperial powers-- England and France. Timely concessions by Rama III in 1826 opening Bangkok to a limited British trade gave way in 1855 to a dramatic opening of Thai ports to free commercial intercourse with the West under an Anglo-Siamese Treaty.

Modern Thai history was initiated by the hand of King Rama IV, Mongkut. He saw the opportunity for rapid economic development and modernization in Western contact. To meet the threat of colonization, Mongkut and his son Chulalongkorn (Rama V) embarked on an ambitious course to lay the financial, judicial, educational, and administrative structure for a modern nation state, the first in Southeast Asia. Rama IV and V proved brilliant diplomatic strategists in playing England and France against each other. They retained Thai independence from colonial rule while Burma and Malaya fell to the British and Indo-China came under French control. Thai suzerainty over Cambodia, Laos, and Northern Malaya

was shifted piecemeal to the imperial powers as the price for Thai freedom. Yet, because of their unique situation, Thai have been able to accept, reject, or modify Western ideas and institutional practices.

Contemporary political events have further influenced the character of Thailand. In 1932, a coalition of young military officers, professionals trained abroad, and conservative civil servants staged a coup ending the absolute monarchy and initiating a constitutional government. A coup the following year to install an army-backed prime minister set the precedent for military participation in politics. Phraya Phahon (1933-1938) steered the government along a moderate course earmarked by advances in social welfare--especially education and public health--and economic stagnation (Steinberg, 1971). Extreme Thai nationalism (notably anti-Chinese and anti-Western) erupted in the early war years and included the desire to retrieve lands ceded to the French. This led to a reluctant alliance with the Japanese who occupied Thai soil as "allies" in 1941.

Using American support and goodwill, the first postwar prime minister restored Thai relations with the West. The ensuing years saw leadership change hands repeatedly as the country tried to adopt a new constitution and avoided a reversion to military authoritarianism. In 1948, however, nationalistic wartime leader Field Marshall Phibun returned to power and led a shaky, coup-ridden government into

signing a SEATO pact with the United States. Association with Western powers brought benefits of military and economic aid as countermeasures to security threats from the communists in Laos, Vietnam, and Cambodia.

A bloodless coup in 1957 ended Phibun's lengthy career and ushered in a stable 15-year military government under Field Marshall Sarit and his appointed successor, Thanon Kittikachorn. Achievements included an ambitiously planned economy raising the Gross National Product (GNP) eight per cent annually during the 1960's and major programs for the improvement of communications and social services. Initial Thai reliance on American military might to insure its security in the Indochinese conflict gave way in the post-Vietnam era to a new foreign policy of "correct" relations with China and her neighbors. American bases in the country were disbanded. Yet, the strongest pressure to the Thai government came not from insurgents or age-old enemies but from the country's growing educated urban classes. In 1973, massive student demonstrations managed to force Thanon to flee and a university rector became head of the new civilian government.

Democracy struggled to survive for three years as numerous political parties and coalitions vied for dominance in the House of Representatives. Conservative backlash to student reformists and political parties exploded in 1976 to bring violence to Thai daily life. It culminated October

5 in a bloody assault on defenseless university students at Thammasart University. On that same day, military intervention ended the experiment with constitutional rule. Former Supreme Court Justice Thanin Kraivichien was appointed Prime Minister.

Exactly one year later, at the time of this research, another bloodless coup by the military ousted Thanin. Supreme Commander of the Armed Forces, General Kriangsak Chomanan, was named Prime Minister. An interim constitution was promulgated by the King. In November, 1977, he appointed a 360-member National Assembly. The Assembly formed a committee to draft a new Thai constitution; its members included major party figures from the period of "democratic experiment"--1973 through 1976 (State Department, 1978).

Amid these political machinations in Bangkok, the government continues to face security threats from communist insurgent movements in the Northeast, North, and South. These movements benefited from the flight of several hundred intellectuals and leftist leaders after the October, 1976 Bangkok violence. To his credit, Kriangsak has tried to reach a rapprochement with these exiles through offers of amnesty. He continues to leave the door open for better relations with Thailand's turbulent Indochinese neighbors and the United States.

Economy

Despite seasonal political changes marking Bangkok

affairs, Thailand has been spared the massive disturbances that give Southeast Asia the reputation as one of the globe's most unstable areas. This stability is attributed to several factors: a firm sense of national identity, reverence for the monarchy, minimal minority group alienation (although Muslims and Hill Tribes are not socially integrated), a proud history of independence, and a relatively viable economy (State Department, 1978). In fact, the nation's stable economic progress over the last 15 years has placed it in a position of becoming a fully sustained semi-industrial state (Sithi-Amnuai, 1977).

Reviewing Thailand's economic picture helps to understand the socioeconomic conditions affecting mental health programs. Currently, the Thai economy is healthy. Between 1965 and 1974 it had a 7 per cent per annum real growth rate which jumped to 8.2 per cent in 1976 and 6.2 per cent in 1977. Consumer prices experienced a moderately low rise: 5 per cent in 1976 and 8 per cent in 1977. Three factors support this stability. First, Thailand is the granary of Southeast Asia, ranking as one of the world's largest grain exporters. Diversified agriculture enables the country to not only export rice and maize, but also rubber, kenaf, tapioca, forestry products, and sugar. Tin accounts for 85 per cent of all mining production and is a major export. Furthermore, agriculture employs about 80 per cent of the work force. Since this occupation is

self-sufficient, most Thai have not suffered a decline in their living standard due to mounting inflation. In fact, their standard of living is much higher than the per capita GNP of \$390 indicates.

A second factor explaining the economy's health is an enlightened government policy toward free enterprise. Very few industries are state monopolies with the result that 86 per cent of the GNP is contributed by the private sector. Because of good investment climate (except during the collapse of Vietnam), the country can depend increasingly on international lending institutions, capital for economic development projects (State Department, 1978). For example, the Asian Development Bank (ADB) has loaned \$360 million in the last 10 years. The current five year development plan (1977-1981) calls for expenditures of over \$4 billion in foreign loans. The World Bank, United States, West Germany, and Japan are the main sources of these loans.

Finally, the government's conservative, non-inflationary financial policy has insured the maintenance of economic stability. Its policy has enabled a steady rise in the living standard to take place through assorted infrastructure projects overseen by the Ministry of Development. The Third Development Plan expended \$5 billion on manpower development, agriculture, national security (over \$800 million), industry, and the reduction of income disparities. The Fourth Plan will spend \$31 billion to increase rural

income through diversification and promote export-oriented and labor-intensive agricultural industries (Sithi-Amnuai, 1977). Economic expansion may continue with the discovery of natural gas and petroleum offshore (currently 23 per cent of import dollars are for oil) and the steady rise in manufacturing to 23 per cent GNP.

Other indices more directly reflect the quality of life in Thailand. Public health statistics are especially cogent. Woolley (1974) found that 80 per cent of all babies are born without professional assistance, explaining a moderately high infant mortality rate of 27/1,000 (World Bank, 1978). Also, 50 per cent of those dying are not under professional care at or near the time of death. In fact, the life expectancy at birth was 58 years in 1975--lower than that of the Philippines. Population per doctor is 1:8,530 (WHO, 1977a), approximately half that of India. The nurse ratio, 1:3,341, compares favorably with other countries in the region. General public hygiene is also problematic. Only 25 per cent of the population has access to safe, potable water (World Bank, 1978). However, the average caloric intake--over 2,560 calories per day or 115 per cent of requirement)--is quite satisfactory (Rafferty, 1977).

The education system, in contrast, is relatively well developed and comprehensive. The government spent \$700 million in this area in FY 1976, almost equaling defense

expenditures. School attendance is free and compulsory for seven years. Today, 95 per cent of school age children attend approximately 400 kindergartens, 29,000 elementary and upper elementary schools, and 1,850 secondary schools (Woolley, 1974). Seven technical, 34 teacher training, and several special schools also exist (Woolley, 1974). In 1976, 12 universities offered both undergraduate and graduate courses in all major fields to over 70,000 college students. The Ministry of Education recently set up a Regional Education Development Project to stem the flow of students into the cities. As a result of efforts in the public education, the adult literacy rate is 82 per cent, a fairly impressive figure for a less-developed nation.

Sociocultural Context in Which
Health Services are Delivered

The aforementioned historical and economic information describes the sociocultural grounding upon which health and mental health programs must operate. In review, social unity is prompted by significant communalities: a majority of population share a common ethnic origin, language, Buddhist religion, and respect for the Monarchy. Furthermore, since the mid-Nineteenth Century, enlightened political leadership has been committed to modernization. Independence from colonial domination has enabled the Thai to pick and choose which Western institutions are best suited for promoting national development. Religious devotion in the form of

Theravada Buddhism and reverence for the King have not abated, enabling historical continuity to temper the more destructive impact of establishing new social institutions.

Contemporary Thai society can be described more concretely--in terms relevant to human service delivery--by examining both rural and urban life styles and conditions. This dichotomy is characteristic of all of Southeast Asia. Thai settlement patterns are predominantly agricultural. The rural village (almost 50,000 in number) is the most common form of settlement (Henderson, 1971). In 1970, 89 per cent of the population lived in the country. However, with the recent upsurge in urban migration, the proportion of rural to urban will more than double by 1980.

The basic unit of rural society is the family household. It consists of a husband, his wife, and their offspring. Often other kin reside in the same compound, although the idealized form of Thai family life is the nuclear cluster. Larger groups of kinsmen do cooperate periodically for ceremonial and agricultural functions, but these arrangements are by nature short-term. Aside from his deep sense of responsibility to his immediate family, the rural Thai has few organizational or community bonds (Henderson, 1971).

Two other principal social foci for rural people are the Buddhist temple (wat) and the village school. However, it is the wat and the Buddhist thought it promulgates which

are the keys to understanding the society's core cultural values. Ninety-five per cent of the country are Buddhist; most males become monks or novices for at least a short time. The order of monks, therefore, is a highly influential institution in local settings. Buddhist teachings stress that the highest social values are personal spiritual development and the attainment of merit through a righteous life style (such as generously supporting the local wat).

Complementing these ideals is the fundamental belief in individualism: within wide limits, each person should be responsible only to himself. An individual's actions are no one else's concern since each must take it upon himself to follow the path toward enlightenment. A final social value involves respect for status ranking and authority. In fact, social relationships are generally patterned after the patron and client model: those in authority (like the King) work to insure the well-being of those who serve them.

Urban Thai inhabit a world greatly different from their village-dwelling countrymen. For one, urban residents are ethnically different. More than half of the resident Indians, Pakistanis, Ceylonese, Europeans, and Americans live in Bangkok. Moreover, the capital city has a very large proportion of Chinese-Thai who dominate the commercial sector of the economy. Secondly, socioeconomic status divides urban from rural. Henderson (1971) reports three

social strata in the nation's capital. Foremost is the ruling group who control the political authority and resources. This elite 1 per cent of the population is able to secure advanced degrees from foreign universities--a practice initiated a century ago. It includes aristocrats, top-ranking government officials (many of whom have military backgrounds), and a small number of professionals. A foreign university degree is the single most important asset for entrance to Thailand's new ruling group; it has become a prerequisite for senior positions in the Thai Civil Service.

The middle level is made up of Thai professionals, Chinese merchants, student activists, and middle-ranking government bureaucrats and military officers. The third level consists of low-income groups and rural immigrants. These are the young and poor street vendors and unskilled laborers who come to the city to earn money to take back to their villages. These Thai tend to retain their rural values. They see the city solely as a place to earn money and don't establish formal ties with urban social institutions. For them, the city is lonely and callous--albeit glamorous and entertaining--and the village remains the secure, comfortable home.

Thirdly, urban centers, especially Bangkok, are well-springs of Western innovation and social change. Bangkok is influential because the rest of the nation looks to the

King for guidance. Bangkok standards of dress, behavior, viewpoint, and living conditions are regarded as modern and imitated by provincial inhabitants.

More than anything else, a uniform national education curriculum has spread the capital's influence and made its employment opportunities attractive. Rural-educated people have recently shown an unprecedented interest in acquiring both government jobs and positions within the growing private business sector. Such interest, fostered by new educational opportunities, accounts for the swelling influx of people into the already congested capital.

In review, aspects of Thai human ecology are expected to impact the status of mental health care. Rural Thailand, where the vast majority live in some 50,000 traditional villages and communes, is staunchly family-centered. Villagers are inexperienced in dealing with social organizations outside of the local village wat and school. Thai cities, especially Bangkok, are enclaves of the educated elite: political authorities, bureaucrats, and those managing commercial interests. These elite are receptive to Western health technology. Social innovation in Bangkok has a rippling effect on the rest of the country, be it by design or accident. Western influence has wrought cultural change and the side effects of rapid development: the breakdown of traditional institutions and values that govern social affairs and resolve human needs. More often,

government agencies are established to manage social welfare concerns beyond the capacity of families and traditional community organizations. The vortex of human services (health and mental health) remains in Bangkok, tied to the educational, governmental, and planning structures of the nation.

FACTORS INFLUENCING THE NATIONAL ORGANIZATION OF PSYCHIATRIC SERVICES

Forces operating at the national level to impact Thai psychiatry are now identified along with other general influences. First, the historical evolution of psychiatry in Thailand is presented. An overview of the public health program administered by the Ministry of Public Health follows to clarify the position of mental health services. Thirdly, the Mental Health Division and its resources are shown. The fourth section discusses the role of international consultation (e.g., the World Health Organization) in program development. Aspects of manpower development are taken up next and followed by a list of critical issues confronting mental health programming in Thailand as identified by the surveys of expert consultants and local researchers.

History of Thai Psychiatry

Psychiatry has long and rich history in Thailand. It is fortunate that Dr. Phon Sansingkeo, one of its principal

developers and a leading figure in international psychiatry, has chosen to chronicle this history (Sangsingkeo, 1965, 1975). Sangsingkeo traces three threads in the discipline's evolution: facility development, manpower training and education, and involvement of international consultants.

Facility development occurred in three phases. First was the initial setting-up period. In 1889, during King Chulalongkorn's reign, a small (30 patient) mental hospital opened at Klong Sarn, Dhonburi, across the river from Bangkok. The original purpose was to confine patients (via imprisonment and chains) who were unable to live together with regular medical patients. European medical influence began in 1905 when H. Campbell Hyed, and English doctor-administrator, took charge of Klong Sarn Mental Hospital among his other duties as head of the Bangkok Health Ministry. Unfortunately, Hyde had very little time to supervise activities in this unit which grew to 296 admissions in 1910. As a result, conditions deteriorated to such a critical point that Hyde was forced to report, ". . . due to shortage of room, some of them (violent patients) have to be kept together and often fight each other. Some are chained to the floor like fierce animals. Some of the rooms need repairs badly and cannot be kept clean. This accounts for the diarrhea and dysentary suffered by the patients. This hospital is shamefully falling apart. It is quite apparent that the government should do something to improve

it. I myself cannot find stronger words to show how humiliated and disgusted I am" (Hyde, quoted in Sangsingkeo, 1975, p. 652).

That plea was answered two years later with the construction of hospital buildings on 17 acres of land close to the original asylum. From its inception, Somdej Chaopraya Mental Hospital (presently Thailand's premiere teaching facility) was administered according to the strictures of modern medicine. Its first supervisor was another British physician, M. Cathew, Hyde's direct subordinate. Cathew's legacy includes the characteristic red-roofed buildings of the English government offices and land for gardens and orchards.

The Department of Public Health took over Somdej Chaopraya in 1918. Seven years later, all European doctors were discharged and their positions filled by Thais. Dr. Luang Vichien, the first Thai director, later became the first Thai physician to receive training in the United States where he undertook psychiatric studies in 1929. The hospital, officially designed to hold 430 patients, had 721 by 1926. Three years later, a small remand ward for convicts was added.

The second phase of facility development, 1930 to 1950, is characterized by construction of new facilities, the expansion and modernization of Somdej Chaopraya, and establishment of a Ministry of Public Health. A second

major mental hospital was built in 1937 in the southern part of Thailand (Surat Province) to relieve crowding at Dhonburi. In 1938, a third facility was opened in Northern Thailand and found a permanent home in Chiangmai. But population pressure at Somdej Chaopraya did not subside-- records show 1,100 patients in 1940. Therefore, the government opened Nondhaburi's Srithunya Hospital in 1941 to serve Central Thailand and another hospital in Ubol Province (Northeastern region) in 1946.

Dr. Phon Sangsingkeo took over as director of the Dhonburi facility in 1942 and quickly began a reorganization to bring the hospital up to international standards and destroy popular misconceptions and stigma surrounding mental patients and psychiatry. He worked hardest to upgrade the training of doctors and nurses, introduced a psychiatric curricula for medical undergraduates and other professionals, and instituted advanced treatment modalities including an open-ward system.

After five years, a modern building for outpatient services was erected in 1948. It helped raise the status of the institution to parity with other good hospitals.¹

To build momentum in dispelling negative attitudes toward these new hospitals, they were carefully named after beautiful locations, respected ancestors, or sacred religious persons. Also during this phase, in 1942, a separate government ministry was established to manage

public health matters. Within its Medical Services Department (overseeing all Thai hospitals), a division was formed responsible for mental hospitals and psychiatric programs. Its impact and functions will be presented later.

The last phase involved adding specialized services to form a more comprehensive mental health system. Under World Health Organization (WHO) guidance provided by psychologist Margaret Stephan, the Medical Services Division acted in 1963 on a WHO suggestion to set up a Child Guidance Mental Hygiene Clinic on the grounds at Somdej Chaopraya. It extended care to patients with neurotic and neurological complaints. Success from this undertaking prompted the construction a few years later of Prasart Hospital and Research Institute in Neurology directed by Prasop Ratanakorn.

In 1958, Arun Bhaksuwan, another American-trained psychiatrist, became director of the Dhonburi Hospital. He expanded the physical plant substantially and changed its status to teaching center for professionals. In 1960, special hospital for mentally handicapped children and adults opened on Samsaen Road, Bangkok, with Roschong Dasnanjali its director. Five years later, an inpatient facility for childhood disorders began operations in Samrong near Bangkok. Specialty units for drug addicts and the "criminally insane" were built in the metropolitan area in 1966 and 1971 respectively. About this same time, a second provincial mental hospital to serve the Northeastern

region opened to focus on education for nursing and medical students.

Another specialty area, community-oriented care, came early to the system. Sangsingkeo reported that by 1946 a general effort was made to organize outside housing for patients so they could live and work in the community. It wasn't until 1958, however, that the first halfway house opened, operated by Srithunya Hospital. Here, recovering patients work in a farming village until returning to their families. A similar program was started later for Chiangmai chronic cases. The first day hospital opened at Somdej Chaopraya in 1960.

The second historical thread traced by Dr. Sangsingkeo involves the development of educational curricula and manpower training for psychiatry. The pioneers of Thai psychiatry who gave birth to psychiatric education were forced to acquire their expertise at foreign universities. Dr. Luang Vichien Bhatayakom initiated the Thai-American connection for acquiring mental health technology in 1927. Upon his return from postgraduate studies in the United States in 1931, Bhatayakom began the first lectures on this subject. Two years later, psychiatry was included in the curriculum of last-year medical students at Siriraj Hospital.

In the late 1930's, three other Thai physicians, including Phon Sangsingkeo, were sent to the United States. Dr. Sangsingkeo made his way to the University of Colorado

and then Johns Hopkins University with the goal of acquiring knowledge that could be taught to other Thai medical personnel. After a short hiatus during the war years, another group of seven doctors went abroad, mainly to the United States (many ended up at the University of Colorado). Returnees from this group became powerful figures in teaching and administration.

For example, Dr. Ratanakorn founded Prasart Neurological Hospital; Dr. Subha Malakul began the first child guidance clinic; services and training for the mentally retarded were started by Dr. Rosjong Dasnanjali; Dr. Arun Bhaksuvan directed Somdej Chaopraya and transformed it into the nation's major teaching center; and Dr. Chantana Sukavajana became the director for mental health services within the Ministry of Public Health.

Training in psychiatry for the different disciplines began at Dhonburi in the late 1930's: first informally and later with well-structured coursework leading to certification. A one-year course for nurses aides started in 1945. Eleven years later a postgraduate, residential program for physicians was initiated. The first institutions to show enthusiasm for the curricula were Chulalongkorn and Siraraj Hospital nursing schools in 1943.

A major conference to revise medical education in Thailand was held in 1956 under the auspices of the United States Agency for International Development and WHO. It

proved to be a major turning point for psychiatry: recommendations were made to elevate its status to a separate area of study, worthy of its own teaching track and department. Yet, it was a struggle to get curricula included in the four-year medical coursework and it wasn't until 1969 that Siriraj Medical School opened a separate department of psychiatry. In subsequent years, the other three medical schools--Chulalongkorn, Mahidol, and Chiangmai--followed suit.

The early 1960's did see the opening of psychiatric wards and outpatient services at university hospitals and other medical centers in the Bangkok area. Chulalongkorn, in 1962, was the first university to have an inpatient unit. Nearby Buddhist Priest's Hospital began a ward the following year. On the plane of promoting mental health education for other professionals and the public at large, the Thai Psychiatric Association was established in 1954 and the Mental Health Association in 1958. The latter organization, less medically oriented, is aimed at getting public cooperation and participation in mental health activities. On its committees are teachers, social workers, students, and members of other professional groups.

The final thread in the history of Thai psychiatry concerns WHO's involvement. Unquestionably, this agency became more directly involved in Thai mental health service development than in any other Asian country except

for India. Since its inception in 1948, Thai physicians have participated in WHO programs. Dr. Sangsingkeo, for instance, served on the Committee of Mental Health Experts in 1952. In that same year, Dr. Charles Gundry, the first in a series of mental health consultants, was sent by WHO to guide service development. Gundry advised the creation of child guidance clinics to treat neurological and behavioral problems and to serve as centers for further education. A year later, psychologist Margaret Stephan was assigned to help actualize this recommendation. The center was built as part of the Dhonburi complex with Dr. Subbha Malakul as its first chief.

Alan Stoller followed up Gundry's visit in 1958, making a series of explicit recommendations for expansion of services and training programs. Stoller emphasized cooperation with the local public health clinics as a viable strategy. After G. M. Carstairs' brief visit, Tsung-yi Lin (the patriarch of Taiwanese psychiatry) arrived in 1964 for his survey of Thai resources. His advice focused on the need for epidemiological studies, applied research, scholarships for overseas education, and a concern for the role of cultural differences. Since Lin's visit, a number of assignment reports have been filed, including those by Harwood, Lin (again), Miller, and most recently, Kiernan. The scope and depth of these expert surveys and their acceptance by Thai officials have enabled WHO advisors to

make significant contributions to the status and direction of Thai mental health care. Specific WHO accomplishments are taken up later.

The Public Health System as the Context
for Mental Health Services

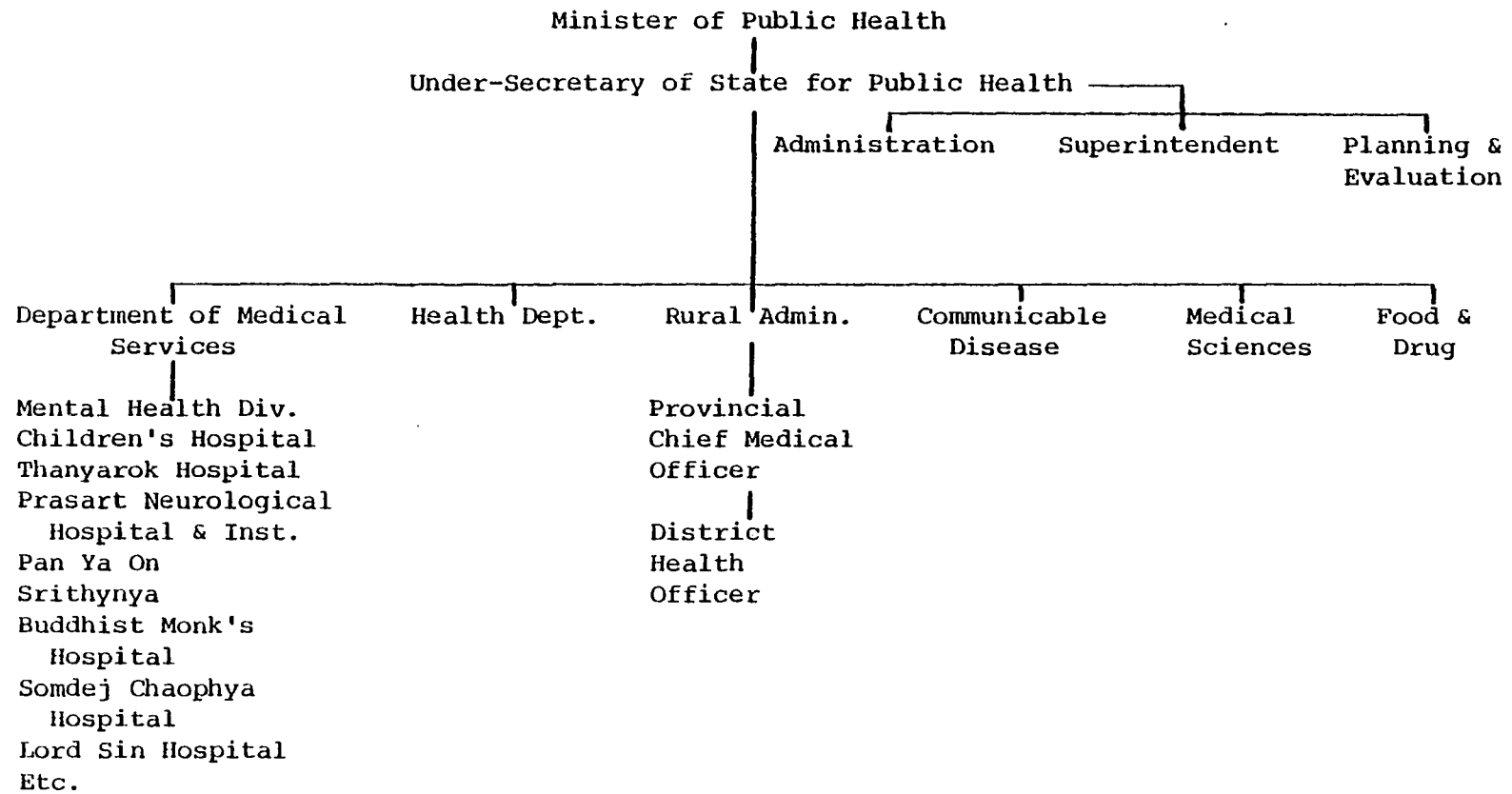
A second factor determining the status of Thailand's mental health program is its position relative to general health delivery. To learn this requires appraisal of the resources commanded by the public health system, its organizational elements, and the constraints under which it labors. Figure 6.1 presents an organizational chart of the Ministry of Public Health (MOPH), the national agency responsible for administering all public and most governmental health services (MOPH, 1977).

The MOPH is divided into six parts. The Office of the Undersecretary of State for Public Health has 18 divisions (e.g., General Administration, Health Training, Health Planning). It coordinates five major departments (Medical Service, Health, Communicable Disease Control, Medical Science, Food and Drugs) and the health program carried out by the 71 Provincial Health Officers.

Significantly, there are separate administrative structures governing health services provided by the Provincial Health Offices and the Bangkok Metropolis Administration. For example, Provincial Health Officers and District Health Officers--operating provincial hospitals,

Figure 6.1

Organization of the Ministry of Public Health



health centers, and midwifery clinics--receive assistance from an office within MOPH. However, they directly answer to the governors of their provinces who are under the authority of the Ministry of the Interior. Thus, administrative control of primary services is actually more diffuse than Figure 6.1 indicates.

Mental health concerns are dealt with exclusively by MOPH's Department of Medical Services. It has responsibility for psychiatric services for the entire country and also handles a part of Metropolitan Bangkok's medical care. Currently, five psychiatric agencies of equal status exist within this department. Four are individual hospitals--Srithunya, Pan Ya On, Prasert, and Somdej Chaopraya--and the fifth is the Division of Mental Health. It supervises 12 facilities including all provincial mental hospitals and various units within the Metropolitan area. This configuration of administration is under pressure for revision to make it more equitable and efficient (Kiernan, 1977).

Public Health Resources

Public Health resources are moderately well developed in Thailand, but not equitably distributed. Clearly, Bangkok Metropolis maintains an unequal proportion. For its estimated 4.3 million population, Bangkok has 34 government hospitals with 13,000 beds, 39 private hospitals of over 25 beds, four of the five university medical centers, and approximately 75 per cent of the health

manpower workforce (MOPH, 1976). The private sector, with an average per capita health expenditure several times greater than the government's, concentrates on curative medicine in Bangkok and other municipal locations. In the remaining 70 provinces of 36 million Thai, the public sector dominates health delivery. The provinces have 97 government hospitals--about 22,000 beds--and only 24 private facilities.

Besides local hospitals, there are three components to rural health delivery. The country's 570 districts (catchment areas of 50,000) have 288 District Health Centers (Class I). Each center is supposed to have at least one doctor, one qualified nurse-midwife, two junior health workers, one auxiliary midwife, and 10 to 25 beds for emergency use. Yet, over 10 per cent of these have M. D. vacancies.

There are 3,720 tambon (commune) or Class II health centers covering about 70 per cent of Thailand's designated tambons (population catchment of 5,000). Tambon health sub-centers employ one junior health worker and one nurse-midwife. Their objectives are limited to maternal and child welfare, environmental sanitation, control of communicable disease, health education, and attention to minor physical ailments.

There are 1,456 midwifery clinics serving 48,847 villages and hamlets throughout the country (approximately 2,000 persons each). These Class III health centers are

staffed by one midwife only. In addition to these units, there are four regional Maternal and Child Health Centers (out of nine regions), each with 200 maternity beds. These provide complete services, training, and public information. Table 6.1 summarizes the resource picture for private as well as public medical facilities based on 1974 statistics.

Other indicators of medical resource strength are found in manpower numbers, budgeting, and the guidelines for the current five-year plan (FY 1977-1981). In terms of distribution statistics for manpower and facilities are very similar. There is a physician to population of 1:1,000 in Bangkok. In smaller municipalities the ratio is 1:30,000 while in the far-flung provinces it is up to 1:150,000 (MOPH, 1976). Of the approximately 5,000 physicians in Thailand (1 per 8,455), 400 are in private practice exclusively, 1,800 are employed by the MOPH, universities and the Ministry of Defense have 2,200, and another 600 work for city and province enterprises. There are also 12,653 qualified nurses (one per 3,342 population), approximately 70 psychologists working in clinical settings (B. A. level), and an overall ratio of one hospital bed per 823 population.

Budgetary allocations for health have been quite modest in the past, but have edged higher in recent years. In 1975, MOPH received \$7.5 million for operating expenses, 3.2 per cent of the total government budget. This sum

Table 6.1
Private and Public Medical Facilities in Thailand

<u>Type of Facility</u>	<u>Number</u>	<u>Number of Beds</u>
General Hospitals	50	10,322
Local/Rural Hospitals	178	27,210
Medical Centers	53	977
Maternity Hospitals	2 (private)	423
Pediatric Hospitals	1 (public)	450
Infectuous Disease Hospital	1 (public)	230
Mental Hospital	14 (public)	7,483
Mental Deficiency Hospital	2 (public)	520
Drug Addicts Hospital	1 (public)	500

Source: World Health Organization. Annual Statistics. Geneva: World Health Organization, 1977.

increased to almost \$18 million in 1977, or 5.1 per cent of the national expenditure. Seventy per cent was earmarked for provincial health needs (free medical care, maternal and child health, etc.). Even so, the government per capita spends a little over two dollars for citizens; private expenditures are three times this amount.

MOPH planners are optimistic that during the 1977-1981 five-year plan, \$1.1 billion can be spent on health. Eight per cent of the national budget will hopefully go to MOPH by 1981. Emphasis in this plan is on the betterment of the health of rural populations, especially those in the villages. Specific foci include birth rate reduction, maternal and child care, elevating nutritional status, communicable disease surveillance, environmental hygiene, national insurance, expansion of health units and manpower, and training village volunteers to assist health workers. Manpower targets call for training an additional 2,500 M. D.'s and 10,000 nurses by 1981: the majority would be deployed in provincial and district health centers. However, these are optimistic plans which may or may not reach fruition. The WHO and other UN and bilateral agencies lent their expertise to the preparation of this five-year plan.

Health development is also progressing with financial and technical assistance from various external agencies-- UNICEF, UFDAC, ILO, IAEA, the Population Council, Ford

Foundation, International Planned Parenthood Federation, United Kingdom, and USAID. Through several projects such as the Population Planning and Health Project and the Lamphang Project, USAID alone is spending close to \$15 million during this period. MOPH publications do not detail future allocations for mental health care. Presently, psychiatric facilities (excluding Pan Ya On) spend only \$7 million annually, half of which is generated by hospital revenues (MOPH, 1977).

Health Needs, Problems, and Government Solutions

Constraints of the public health system are best addressed by enumerating Thailand's health needs and the critical problems encountered in the delivery of effective services. Problems of health delivery are especially pertinent since psychological care providers can expect to face the same issues. Knowing health needs is equally important because they are related to needs requiring psychiatric intervention.

Woolley (1974) found four dominant health concerns: rapid population growth; sanitation and environmental hazards; nutrition; adequacy of resources and their allocation and utilization. With an annual population growth of almost 3 per cent, an average number of births for Thai women at 6.5 offspring, and 44 per cent of the population under 15 years of age, the country is certainly in the throes of a population squeeze. Woolley (1974) warns that the

implications of this problem are lower quality education per capita, lower level of skill and production of labor force, lower per capita income, unemployment, poorer health conditions, and degeneration of urban conditions. (Traffic congestion, housing shortages, air and water pollution are already prevalent in Bangkok.)

The first governmental response to this explosive situation was the establishment of a National Family Planning Program within MOPH in 1970. Regarding the other health concerns, it was previously mentioned that there is an imbalance of allocated resources and that hygiene is hampered by a widespread absence of potable water. Low hygienic standards support the high prevalence of diarrhea, dysentery, and other enteric ailments such as helminthiasis and typhoid fever. These affect as much as 80 per cent of the population in any one year, causing 20,000 deaths (Henderson, 1971).

Woolley's (1974) analysis also yielded a list of fundamental impediments to effective provision of treatment--barriers which mental health workers can expect to face. Basically, three types prevail: those dealing with personnel, administrative planning, and receptiveness of users.

Besides the shortage of personnel--particularly at the middle management and supervisory levels--problems involve inadequate training, "false" professionalism by some doctors and administrators, inefficient specialization, and the

familiar dilemma of brain drain. During a five year period in the 1960's, the number of physicians training abroad was equal to seven years of output from Thai medical schools.

The second problem draws attention to administrative shortsightedness in health planning. The lack of a dynamic national health plan means that MOPH only trains special health workers for projects when needed. Furthermore, there is no coordination between the universities producing the manpower and the government agencies employing them. The conflict arises when curricula aim at one-to-one office practices and specialists work. Yet, the health system actually needs providers capable of addressing curative and preventive services at the community level.

Moreover, organizational functioning per se is hindered by an underlying patron-client relationship typical of Thai social groups. The flow of information is always patron to client. Challenges or suggestions seldom flow in the other direction, thus reducing the possibility for corrective feedback on policies and procedures.

The last issue, user receptiveness, is dramatized by MOPH (1976) statistics. In 1970, only 17 per cent of the people in rural areas were using public services to handle illness in spite of the fact that most of the population average biannual illnesses.

Several factors may explain this finding. First, the only people who actually use health centers are those

living close to the facility. Health center personnel exacerbate this by failing to venture beyond 5.5 kilometers from their base into areas needing help. Besides location inconvenience, dissatisfied users surveyed by MOPH mentioned that center services were slow and wasted much of the client's time, that the staff spoke rudely and seemed uninterested, and that the illness was not cured.

The critical aspect of user resistance, though, lies in a sociocultural phenomena of social distance inhibiting a positive working relationship between physician and rural peasant. On the one side are upper or middle class, urban-educated doctors. On the other side are Thai farming people who by cultural norm (patron-client) are inhibited from expressing their complaints, mistrust, lack of understanding, or disagreement with the treatment. The result is impoverished information to guide medical decisions and unexpressed dissatisfaction.

The subsequent pattern of help-seeking is a progression of contacts: first with persons of low social distance, and then with those of higher social distance if a cure is not obtained. Thus, initially the patient consults with self or friends, gradually moving to monks, traditional healers, drug stores, pharmacists, and finally to the health center. Ultimately, the health center (like the psychiatric institution) deals with the more difficult and chronic problems in late stages of development. Hence it is viewed

as a place for the very sick and dying.

It is likely that Buddhist beliefs of illness as a punishment for individual acts (karma) and animistic notions of disease also contribute to under-utilization by directing the ill toward practitioners of supernatural manipulations. However, as Woolley (1974) sadly concludes, even if health centers were better received, their impact would continue to be insignificant as long as the absence of potable water contributes to the spread of infectious diseases.

National Organization of Psychiatric Resources:

Institutions and Personnel

Reviewing Thailand's health picture gave a realistic context for describing psychiatric services in three important ways. First, it recognized mental health administrative position in the Ministry of Public Health's organizational structure. Namely, as an uncoordinated collection of units within the Department of Medical Services. Secondly, knowing the components and structure of public medical care establishes a standard against which to contrast the availability of psychiatric services. Also reflected is the extent to which psychiatry could be extended if it were incorporated into the existing network. Lastly, difficulties faced by mental health workers are anticipated by assessing general medical care delivery problems. Examples include restricted funding, poor national planning, maldistribution, inappropriate medical curriculum, manpower shortages,

undertrained workers, and poor reception by rural peoples due to staff-user cultural differences.

The MOPH Mental Health Division

A field visit by W. E. S. Kiernan (1976), WHO regional advisor for mental health, offers a current analysis of the Thai mental health picture. According to Kiernan, an MOPH reorganization in 1972 resulted in the two-tiered administrative scheme depicted in Figure 6.2. Prior to this date, the Division of Mental Health (DMH) was responsible for all psychiatric facilities except for the substance abuse center and units in university psychiatry departments.

Presently, as Figure 6.2 shows, the DMH has no direct role in determining the operations of the four major Bangkok institutions on the same administrative level. Rather, the Division is restricted to overseeing the smaller psychiatric centers in the metropolitan area and the mental hospitals in the outer provinces. Moreover, DMH's advisory role within the Directorate is at best perfunctory; a coordinating committee made up of representatives from DMH and the Bangkok institutions exists without a clear mandate (Kiernan, 1976). Under these conditions, Kiernan notes, it is nearly impossible for DMH to discharge its principal functions: "the planning, policy making, resource mobilization, training, evaluation, and supervision of the total mental health service and [its] effective integration with general health services and with health-related activities

in the social welfare field . . . " (Kiernan, 1976, p. 9).

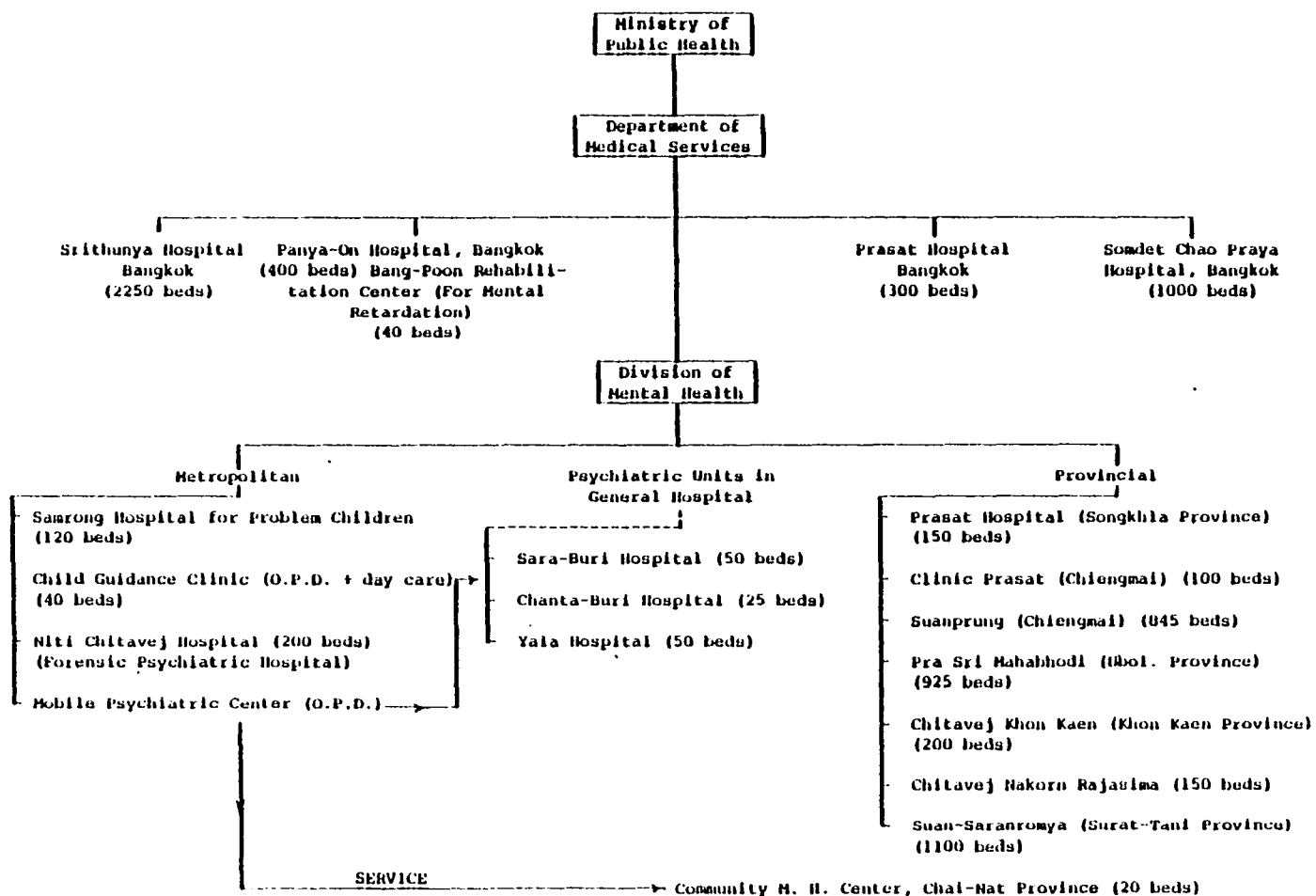
Kiernan's report suggests a number of possible alternative strategies for reorganization to create an effective hierarchy for service coordination, policy making, evaluation, and manpower development. The proposal he argues strongest for is the creation of a Mental Health Services Planning Board. It would have a top operational manager (Deputy Director of Mental Health Services), below which would exist a Mental Health Committee or Planning Board with permanent representation from all existing institutions including universities and the Budget Bureau. Daily operations of the system would be handled by the office of the Deputy Director. The former DMH would become a Mental Health Advisory Office, concentrating on technical issues such as evaluation of services and manpower development. The point of this reorganization is that the major institutions will continue to have direct representation in the higher administration but not independently of each other.

Current Mental Health Facilities

Figure 6.2 lists most of Thailand's psychiatric agencies. Except for a few psychiatrists working full time in Bangkok's private general hospitals (e.g., Paolo Memorial Hospital, Health Unit of the Thai Cement Company, Phayathai Hospital) and those government psychiatrists carrying on part-time private practices, the public sector accounts

Figure 6.2

ORGANIZATIONAL CHART OF MENTAL HEALTH SERVICES IN THAILAND



Taken from W. E. S. Kleinman, Strengthening of mental health services in Thailand. World Health Organization, South-East Asia Region, Mental Health Division, Report No. 34, August 20, 1976.

for all mental health resources.

There are no private mental hospitals in the country. The vast majority of resources are under the Department of Medical Services (DMS). However, five independent units are run by university psychiatry programs, the Army Hospital has 45 psychiatric beds, and the Social Welfare Department operates a half-way house (not shown in Figure 6.2).

In terms of geographical coverage, the problem of rural/urban maldistribution seen with public health centers also holds true for psychiatric agencies. Looking at the availability of beds, for the nine health regions outside of Bangkok there are 3,465 beds or 0.096 per 1,000 population. In marked contrast, Bangkok figures show 1.06 beds per 1,000 population based on 4,400 available beds (most are located at Srithunya and Somdej Chaopraya).

The service gap between rural and urban is further widened when considering that programs for special needs--mental retardation, childhood disorders, forensic, rehabilitation--are extant only in Bangkok (See Figure 6.2). Alternatives to inpatient care such as daycare, after-care, sheltered workshops, walk-in clinics, and so forth exist only to a limited extent in Bangkok itself and not at all in the provinces (Kiernan, 1976). The Mobile Mental Health Center, an active unit giving consultation to outlying general hospital units, was unfortunately forced in 1976 to restrict its operations due to funding cutbacks.

Psychiatric Manpower

The distribution of psychiatric manpower follows the same pattern found for agency location: a dramatic dichotomy between Bangkok and the rest of the nation. The seven provincial area hospitals (Figure 6.2) together have 22 physicians, 165 staff nurses, 213 practical nurses, 17 psychologists and 21 social workers. The doctor to bed ratio is 1:157 and there are 21 beds for each nurse.

Bangkok, on the other hand, has the services of 81 doctors, 276 nurses, 32 psychologists, and 37 social workers within its collection of eight MOPH agencies. With these personnel, the physicians-to-bed ratio is three times lower than that of the provinces (Kiernan, 1976). The five medical school psychiatry programs, two of which have small inpatient wards, employ about 35 faculty to teach psychiatry.

Further aggravating this picture of uneven user access, Kiernan (1976) found that 50 per cent of the psychologists and social workers in Bangkok held positions in 10 per cent of the agencies--those handling children with emotional and developmental disorders. Kiernan also noted that staff were poorly utilized: nurses were employed as technicians, record clerks, and secretaries while practical nurses were left to handle ward operations. What was especially startling, however, was that provincial units, like their health center counterparts, were not overwhelmed with demand. This question of acceptability and what it implies about non-medical healing will be taken up later.

Manpower Training

Psychiatric education for physicians began in the early 1930's with Luang Vichien's return from the United States. Postgraduate residency instruction started 20 years later, in 1954, at the Dhonburi site. Carl Bowman, an American consultant at the 1956 Bangsaen conference on medical curriculum, pushed for a four-year program of instruction and practica in psychiatry for undergraduates. Today, 32 faculty in Thailand's five medical colleges teach under- and postgraduate psychiatry. The postgraduate residency, which was expanded from one to three years in 1972, is well developed in terms of theoretical teaching, but falls short of offering comprehensive clinical training (Kiernan, 1976).

In a WHO progress report on the place of psychiatry in Southeast Asia, it was indicated that Thai undergraduate curricula range from 33 to 94 hours with an average of 57 hours of instruction, excluding clerkship (WHO, 1975). Behavioral sciences are taught in the pre-medicine courses by academic psychologists, although these professors have no formal links with the department of psychiatry. Interestingly, one faculty has integrated teaching between medical and community health departments (Kiernan, 1976).

Education for other mental health professionals and para-professionals is available on a limited basis. Teaching resources are gravely lacking for developing allied professions--clinical psychology, social work, psychiatric

nursing. Universities select the candidates and determine curriculum and teaching methods for these professions, but do not coordinate with the needs of the mental health delivery system. Preparation of front line medical workers like nurses and midwives is also handicapped by a shortage of nursing instructors. In contrast in-service training is more fully established and received by all nursing staff. A six-month standardized course for male practical nurses in psychiatry is conducted by Somdej Chaopraya (Kiernan, 1976). A similar half-year training program prepares psychologists and social workers for service in mental health agencies.

Postgraduate studies in clinical psychology are still unavailable. The Director of the Mental Health Division, Dr. Chantana, also reports coursework opportunities for general medical practitioners who wish to refresh their knowledge and skills in psychiatry (Harper, Shapiro, & Zusman, 1975).

In short, although the last 20 years has seen a gearing-up of educational curricula to train allied workers, there is not yet a critical mass of qualified instructors and students to give the field momentum, identity, and a position of strength from which to deal with the problem it seeks to solve.

World Health Organization Influence

It was mentioned above that Thai psychiatry profitted

from contact with WHO experts and consultants. Such contact has had a significant influence on the direction of mental health development at the national level and continues to guide innovation and the elaboration of existing institutions. Each advisor in the series of consultations made a unique contribution.

Charles Gundry in 1952 recommended the establishment of a Child Guidance Clinic. A year later, Margaret Stephan was sent to help actualize this concept. Alan Stoller followed Stephan in 1958 to push for the regionalization of facilities and the creation of a Division of Mental Health. He also urged a follow-up visit by an expert in epidemiological research. Lin, an international leader in field survey methods and epidemiology, arrived in 1964 to promote Thai psychiatric research and manpower expansion. In 1968, a specialist in psychiatric nursing, L. M. Horwood, was assigned by WHO at the government's request to help initiate post-basic training for psychiatric nurses. Lin returned in 1972; and Milton Miller, an American psychiatrist who arrived in 1975, focused their consultations on boosting educational curricula and upgrading training.

The latest WHO survey was carried out by W. E. S. Kiernan in the summer of 1976. Kiernan gave special attention to strategies for operational research, integration of services, development of community-based prevention and after-care programs, and the reorganization

of national mental health administration. Moreover, Thai educators have actively participated in the WHO South-East Asia Region (SEAR) seminar series on the teaching of psychiatry. The first seminar was held in Agra, India in 1968. Thailand hosted the fifth seminar in 1974 which dealt with "education and training of personnel for mental health work in the community" (Harper, Shapiro, & Zusman, 1975).

In addition, there are four projects in the WHO Medium-Term Mental Health Programme (1975-1982) which involve Thailand: 1) Mental Health In National Health Policy Formulation in SEAR; 2) Review of Mental Retardation Services in SEAR; 3) Mental Health Training for General Health Personnel in SEAR; and 4) Prevention and Treatment of Drug Dependence in Thailand. This last area of concern, drug abuse, as well as opium growing and refining, has brought Thailand international attention. There are several UN-developed programs dealing with this issue and the United States alone in FY 1977 provided over \$2 million to the Thais for narcotics traffic control (State Department, 1978).

In the course of their site visits, the WHO consultants have pinpointed a number of critical issues facing mental health programs. It would be interesting to summarize these problems for comparison with data from this survey gathered in October, 1977. The following problem themes were sifted from the field reports by Kiernan (1976), Lin

(1964), and Stoller (1959). First and most prominent are the acute shortages of trained personnel, mental health educators in all allied disciplines, and the non-independence of psychiatry departments. Integral to this concern is the failure to coordinate between programs providing basic training and the government-administered delivery system. Universal standards for professional qualifications and licensing were only recently considered. Professions such as clinical psychology have only in the last decade come to have any representation whatsoever.

The second problem theme involves availability and comprehensiveness of the programs. The availability issue is one of unequal distribution, as previously cited. The personnel-to-population ratios and the provision of specialized services overwhelmingly favor the Bangkok metropolitan district. Even so, Kiernan's appraisal calls for a four-fold increase in psychiatric beds to meet the needs of special groups and rural citizens. Stoller's call of 20 years ago for additional outpatient care is just as valid today. Kiernan continues this argument by stating that even the large service institutions of Bangkok lack effective after-care and programs aimed at preventive mental health. Also, lower socioeconomic segments of the urban cityscape are completely out of touch with these services even though they are close at hand.

A third issue--raised by all three consultants--is the

need for a strong Mental Health Division with administrative sanction to create and guide responsive national programming. Because at present there is no effective executive body for policy planning and execution, the latest National Health Program omitted mental health from its list of projects. The Mental Health Division was unable to produce indices of the prevalence of psychopathology and clear problem-reduction targets. Therefore, mental health was not included as one of the 15 health programs for project formulation. A body such as this could uniformly tackle the problems existing in care for the mentally deficient. Presently, according to Dasnanjali (1971), three separate Ministries target programs and personnel for this population in a completely uncoordinated and sometimes conflicting manner.

Indifference and negative attitudes toward psychiatry is a fourth problem spotlighted. Affecting both community acceptability and cooperation with service providers, these attitudes hinder the recruitment of competent personnel to operate the system. Adverse public sentiment was implicated by Lin as responsible for the refusal by families to accept returning patients, an act which would cut hospital case-loads by one-third. Community stigma, coupled with the general opinion among doctors that mental illness is only a product of Western societies--and current therapy is impotent if not actually harmful--combine to make it extremely hard for students to opt for mental health work.

Kiernan fears that recruitment in quantity and quality of personnel will continue to lag until these misconceptions are tackled by public education.

The visiting experts listed three additional problems. Lack of prevalence surveys and the failure to cultivate research as part of psychiatric training are unresolved concerns. Another is low patient turnover rate and resultant buildup of chronic inpatients. Stoller was the first to report an over-admission of adult male "schizophrenics" who were profoundly disturbed and aggressive. He recommended a more selective admission screening away from such poor prognostic types. Lastly is the issue of legislative provisions for admission and treatment. In their international survey, Curran and Harding (1977) noted that Thailand had no mental health legislation. It functioned instead on an informal system of admissions.

Kiernan's report called for setting up legislative machinery to provide for rapid and effective compulsory care of acute cases devoid of insight; effective review and appeal procedures; legal accountability of treatment institutions; and screening of criminal detainees to appropriately help those psychologically impaired. To this, Dasnanjali (1971) adds that some laws, such as the educational policy that all children except mentally deficient are required to attend schools, inhibit intervention efforts.

Input From Mental Health Research

This section shifts attention to indigenous research and writings. The reason for considering Thai research is to determine its contribution to service delivery in terms of both planning and evaluation and to learn what topics and issues preoccupy indigenous professionals. Examined first are studies of mental health needs and operational research followed by research on symptom expression, sociocultural causes of disorder, and culture and personality.

Operational Research

Thai operational research involves two types: one concerned with measuring the incidence and prevalence of psychiatric problems (the need for services) and the other dealing with the functioning of existing programs. Stoller's 1959 visit initiated concern for estimating prevalence rates of untreated cases. Since no epidemiological data were available on psychosis, a village survey was undertaken that found 3/500 rate for schizophrenia. This figure closely matches the only other prevalence study of psychosis done by Sangsingkeo, Sitasuwan, Firestone, and Russ a few years later (Visuthikosol & Suwanlert, 1977). In the survey by Sangsingkeo and colleagues, eight cases of mental disorder in a Hill Tribe village were found--six schizophrenic, one mental deficient, and one senile psychosis. Stoller went on to estimate that based on Western figures, mental retardation would be at least one per

cent of the population, and epilepsy would be more than 0.5 per cent because of the poor standard of midwifery.

In 1959, Stoller found 40,000 registered opium smokers in Bangkok alone and 1,041 opium dens throughout the country. He estimated 100,000 addicts in Thailand or 1/50 of that year's male work force. Opium use has since been banned by the government.

Subsequent to Stoller's report, research intensified in the area of substance abuse. Ratanakorn emerged as a leader in alcoholism studies. He has noted the steady increase of admissions for this problem and was instrumental in founding a research unit for its treatment (Ratanakorn, 1975). Drug addiction has been reported at epidemic proportions--30,000 addicts in 1973 with half of the 43,000 prison inmates addicted (Sangsingkeo, Punahitanont & Schneider, 1974).

These figures prompted two surveys of Thai student drug use. Sangsingkeo, Punahitanont, and Schneider (1974) questioned 1,613 students in Chiangmai and Bangkok. They found that 23 per cent had tried illicit drugs, although less than 10 per cent (approximately 25,000) were regular users throughout Thailand. Of these, the vast majority were males involved in marijuana use. Otrakul, Suwanlert, Vatanasoporn, and Starasingha (1975) carried out a similar survey of 5,000 Bangkok adolescents. Their results showed that only 10 per cent had experimented with illegal drugs; most gave up after one or two tries. Like the other study, the most frequently

used substance was marijuana and a mildly narcotic plant called kratom leaf.

Suwanlert (1975) gathered case studies on kratom eaters in Thailand and found them to be almost exclusively middle-aged, ethnic Thai males from the lower and middle classes. Kratom addiction is primarily a rural phenomena; it is taken as a means of stimulating a strong desire to do manual labor in the user's field or garden plot. Kratom is relatively cheap and accessible, but Suwanlert noted its affects on producing psychotic symptoms among chronic users.

Underscoring the interest in drug abuse research is the collaborative investigation undertaken in Thailand, Indonesia, and Malaysia to test an epidemiological case reporting method with addicts being treated. WHO is the principal supporter of this investigation (WHO, 1978).

The second type of operational research focuses on the description and evaluation of current institutions. The most frequent report describes the make-up of inpatient populations. Ratanakorn published the first booklet on the practice of Thai psychiatry in 1957: "Studies of mental health in Thailand." He claimed in the booklet that almost all hospitalized patients were schizophrenics and that the only therapy valued by people was drug injection (Ionescu-Tongyonk, 1977).

Diagnostically, the picture hasn't altered since Ratanakorn's publication. Visuthikosol and Suwanlert (1977)

report that Srithunya had 84 per cent schizophrenics in 1974; most were long-term residents. Ionescu-Tongyongk (1978) is disturbed by the overuse of this one category. He posits that a great number of endogenous depressives, masked by somatic symptoms, go unnoticed or are diagnosed inappropriately. In his Bangkok private practice, Ionescu-Tongyongk noticed a rise from 2 per cent in 1971 to 9 per cent in 1975 of depressed Oriental patients. He attributes the change to the reduction of superstitious folk beliefs regarding these symptoms and bringing such patients more readily into contact with medical personnel.

Clients referred to child guidance clinics have also been investigated. Malakul in 1964 noted that one-third of the 296 children seen were brought in for academic difficulties. The ratio of aggressive and antisocial children to passive, withdrawn, and asocial ones was 2 to 1 (Sangsingkeo, 1969). In a comparison with American statistics, Malakul found in the Thai sample a much higher proportion of aggressive, hyperactive children than those with asocial behaviors. This implies a cultural sensitivity to the acting-out type of behavior problem. The quiet, polite, inhibited child is not regarded as deviant since such behavior is much more expected in Thailand than in the United States.

Somsong Suwanlert and Veena Inseepong (1978) examined separation reactions in pre-school children at the Bangkok

Day Care Center. They related their findings to the child's family structure, mother's emotional lability, the amount of time parents are able to spend with their children, and the extent to which the family fosters self-help skills and contact with persons outside the home.

Descriptions of institutional practices and problems are also available, but to a lesser degree. Visuthikosol and Suwanlert (1976; 1977) have written about the therapeutic community groups operating at Srithunya and commented on the lack of individual therapy and overreliance on long-acting phenothiazine and ECT. They have also rank-ordered referral sources at Srithunya: relatives and siblings were the highest, followed by police and social agencies. Dasnanjali (1971) summarized the barriers to mental retardation care: lack of coordination among government ministries, public apathy or shame associated with such disorders, Thai family reluctance to ask for help in educating retarded children, insufficient staffing, and unsupportive laws on compulsory education.

Surprisingly, no systematic studies evaluating program effectiveness or treatment outcome were encountered. The only data related to evaluation were the observations by visiting experts on programmatic flaws in service organization and the yearly discharge figures gathered by the Division of Mental Health (MOPH, 1977). Nor were links discerned between surveys of psychopathology and proposals

for new programs, a responsibility of the Division of Mental Health. Quite often, the impetus for program development came from the outside consultants and the interests of returning professionals trained overseas.

Symptom Expression

Thai psychiatrists have shown interest in topics beyond the appraisal of institutions and prevalence rates. One popular area is the description of symptom expression. In 1971, John Ionescu-Tongyonk began a series of publications on depression in childhood, adolescence, and adulthood, and relating depression to marriage and sexuality (c.f., Ionescu-Tongyonk, 1977). His major findings are that an extremely high percentage (80 per cent) of his depressed Oriental patients have their depression masked by somatic symptoms and that this condition is an atypical form of endogenous depression. Moreover, the noticeable rise in the frequency of this condition reinforces the view that the extended family--on its way to extinction--provided an effective protection against depression.

In contrast to Ionescu-Tongyonk's attempt to penetrate Thai symptoms to locate a Western syndrome, Sangun Suwanlert has sought to document the culturally unique aspects of Thai psychopathology. In doing so, he has gathered clinical as well as anthropological data on psychotic states attributed to "phii pob" or spirit possession (Suwanlert, 1972, 1976), "latah" and "koro," both culture-bound syndromes (Suwanlert,

1972; Suwanlert & Coates, 1977), and treatment approaches for spirit possession cases (Suwanlert, 1977). Suwanlert's findings on indigenous beliefs and cures of psychopathology will be examined in greater detail in the discussion of indigenous alternatives to psychiatric care.

Sociocultural Change

The pathogenic effects of cultural change, especially in the urban centers, is another topic receiving intense attention. Several authors argue that the cultural basis of Thai society has weakened of late and cannot be compensated for by imported Western institutions. According to Meesook (1975), industrialization and urbanization are incompatible with the perpetuation of traditional Thai values. These are built around Buddhism, the extended family, and the socioeconomic structure of the agricultural village. Bureaucracy now regulates citizen relationships and handles conflicts which before were directly dealt with by those involved. It thus usurps the authority of senior members of extended families.

As children come to have more education than their parents, they desire independence from restrictive customs and choose their own occupation and marriage partners. Perhaps they even feel ashamed of their parents, and disregard parental authority. Besides generational conflict and stress on kinship ties, the omnipotence of Buddhism itself may be on the wane among youth. Kamratana (1972)

surveyed 500 secondary school students 14 to 18 years old and found that most of them were not practicing religion and consider it to be outmoded.

With the enormous value placed on academic education, frustrations arise among students competing for limited university spots. Those graduating find it difficult to obtain suitable employment because industrial development is still in its infancy (Ionescu-Tongyonk, 1977). Fears arise that disillusioned youth will turn to crime, corruption, alcohol, and drugs (Ionescu-Tongyonk, 1977).

Women's roles, too, are dramatically shifting. Instead of being limited to home activities, women are allowed more education and employment to enhance the economic status of the family (Suwana, 1969). Along with rising expectations, Suwana (1969) found increased anxiety among women: the result of unchanging legal discrimination and traditional male attitudes.

Kiernan (1976) noted two sequelae of these shifting cultural patterns which summarize the concerns of many Thai psychiatrists: 1) declining family care of psychologically impaired members due to the pressures of economic survival in urban areas; 2) rising prevalence of disorder due to continued incidence of traditional forms of illness and the appearance of newer patterns of dysfunction related to stress, overindulgence, growing numbers of old people, and iatrogenesis.

Culture and Personality

The final topic addressed by mental health researchers involves delineation of modal personality characteristics found in Thai culture. Before enumerating these however, it should be recognized that while "trait" descriptors of a cultural group are intuitively appealing, "national personality" research is open to strong criticism on both conceptual and methodological grounds (c.f., Draguns, 1979b). Writings on this topic range from the global observations of clinicians, visiting professionals, and anthropologists (e.g., Phillips, 1965; Sangsingkeo, 1966; Stoller, 1959) to reports based on Rorschach protocols and personality inventories (Somsong Suwanlert, 1966; 1974).

Despite diversity in the methods of studying personality, there is apparent uniformity in conclusions about how the "typical" Thai behaves and what is expected of him culturally. An apt description, according to Somsong Suwanlert (1974), is Eysenck's (1959) construct of "introversion": quiet, retiring sort of person, reserved and distant except with intimate friends, likes a well-ordered mode of life, represses emotional spontaneity, and seldom behaves in an aggressive manner. Suwanlert (1974) arrived at this conclusion after administering the Rorschach and Maudsley Personality Inventory (measuring introversion-extroversion) to 500 college level students.

Somsong Suwanlert's findings are consistent with other

observers. Sharp (1956) purported that Thai are quiet, reserved, not "socially minded," nor are they "joiners." For example, Thais who pay for membership in an association may never attend its meetings. Phillips (1965) paints a similar picture for rural Thais. Although villagers' relationships are friendly, genial, and correct, there was little personal commitment or involvement outside the family. Social disapproval befalls those who openly show their feelings and emotions. If angry, a Thai will walk away and say nothing or explode with a violent outburst.

The presumed Thai proclivity toward introversion and social restraint is attributed to authoritarian child rearing practices (Suwanlert, 1974; Stoller, 1959). Stoller (1959) felt that Thai children were more inhibited and obedient than Western children--unable to freely enter into new experiences due to stern treatment to make them dependent and conforming. Parents simply act on the accepted cultural norm that quietness, politeness, and inhibition are preferred traits (Sangsingkeo, 1966).

Ultimately, Buddhist teachings may be the source of personal independence and inhibition toward anyone other than close family and friends. In Buddhism, the emphasis is on self-restraint, personal responsibility for being one's own savior, avoiding hostility, and the dependence of happiness or evil in one's deeds by body, speech, and thought (Pinyayogavipula, 1957).

In conclusion, mental health research has the potential for playing a vital role in guiding the actions of clinicians and planners alike. A good start has been made in the studies concerned with operational research, symptom expression, and culture change cited above. Modal personality research has relevance for assessing behavioral norms and drawing implications from child rearing customs. To date, however, this potential has not been fully exploited due to the lack of applied researchers and the absence of pressure for program evaluation from the Division of Mental Health.

PSYCHIATRIC RESOURCES AVAILABLE: SELECTED EXAMPLES

Historical and current forces governing the national organization of psychiatric care were just reviewed. In its 90-year history, beginning with the 30-patient "hospital" at Klong Sarn, psychiatry has grown into a complex network of services and training institutions. Now there are more than 25 agencies offering 8,000 beds and a budget close to \$7 million. The growth and evolution of this network was nurtured by a sequence of contacts with Western advisors--first by British physicians and later through the offices of the World Health Organization--and through the overseas education of Thai doctors who became progenitors of modern psychiatry. Educational and direct service programs are concentrated in Bangkok and coordinated by the Ministry of Public Health, Department of Medical Services.

Effective service delivery was found to be mitigated by several problem elements, most of which plague public health delivery in general. The most prominent problems were uneven distribution of resources; absence of programs for special patients, misuse and shortage of personnel, lack of coordination between government employers and university trainers of professionals, the impotent position of the national policy making body, and adverse community attitudes causing an underuse of rural agencies.

In this section, attention is shifted from these global determinants of service delivery to specific characteristics of selected Thai psychiatric institutions. These agencies are analyzed according to the seven-variable framework for determining the resource potential of Thailand's mental health network.

Overview of Thai Mental Health System

Residential and non-residential treatment centers are summarized in Table 6.2. All are government sponsored since the private sector has no more than a handful of private practitioners. Unless otherwise indicated, the agencies listed are administered or coordinated by the Department of Medical Services (DMS). Institute size and location are given and whether it is a teaching facility. An asterisk (*) preceding the names on Table 6.2 specifies those eight centers where staff were interviewed for this survey.

Table 6.2

Residential and Out-Patient Treatment Centers in Thailand

	<u>Number of Beds</u>
<u>Bangkok Inpatient Facilities</u>	
*Srithunya Hospital	2,250
*Somdet Chao Praya Hospital (teaching)	1,000
*Panya-On Hospital	400
*Prasart Neurologic Hospital (including Neuroscience Research Center; teaching)	360
Niti Chitavej Forensic Hospital	200
Samrong Hospital for Problem Children	120
Bang-Poon Rehabilitation Center for Mental Retardation	40
Srithunya Hospital Quarterway House and Rehabilitation Village	150
Social Welfare Department Welfare Home	(1,200)
Army Hospital	45
Chulalongkorn University Hospital Department of Psychiatry (teaching)	<u>20</u>
Total	4,583
<u>Provincial Inpatient Facilities</u>	
Suan-Saranomya, Surat-Tani Province	1,100
Pra Sri Mahabhodi, Ubol Province	925
*Suang Prung, Chiangmai (including Clinic Prasart)	1,000
Chitavej Khon Kaen, Khon Kaen Province	200
Chitavej Nakorn Rajasima, Nakorn Rajasima Province	150
Prathumthani Provincial Halfway House	250
Prasart Hospital, Songkhla Province	150
Sara-Buri Hospital Psychiatric Unit	50
Chanta-Buri Hospital Psychiatric Unit	25
Yala Hospital Psychiatric Unit	50
*Chiangmai University Department of Psychiatry (teaching)	<u>25</u>
Total	3,925
<u>Bangkok Outpatient Clinics</u>	
Chulalongkorn University Department of Psychiatry (teaching)	
*Ramathibodi Hospital Department of Psychiatry (teaching)	
Siriraj University Department of Psychiatry (teaching)	
*Child Guidance Clinic (day care 40 beds)	
<u>Provincial Outpatient Clinics</u>	
Chai-Nat Province Community Mental Health Center	

(* = interview site)

Resource Potential of Selected Sites

Sample

Interviews using Questionnaire #1, #2, and #3 were conducted at eight sites. These were Srithunya Hospital (SH), Somdej Chaopraya Hospital (SCP), Pan Ya On Mental Retardation Hospital (PYO), Prasart Neurological Hospital (PN), Bangkok Child Guidance Clinic (CGC), Suang Prung Hospital in Chiangmai (SP), Chiangmai University Department of Psychiatry (CU), and Ramathibodi Hospital (RH). Unstructured interviews were held with Dr. Prasop Ratanakorn, Director of the Drug Research and Prevention Center and Special Health Service, Dr. Phon Sangsingkeo, a founder of modern Thai psychiatry, Mr. Kittikorn, psychologist within the Division of Mental Health, Dr. Sausurree, a leading Thai academic psychologist and administrator at the United Nations Asian Development Institute, and Dr. Narongsak Chunnuel, social psychologist at the University of Chiangmai. A visit to the shrine of a Thai shaman was arranged by Dr. Sangun Suwanlert to view the healing ceremony of a popular Nondhaburi medium (Khon Chung). Table 6.3 lists individuals responding to Questionnaires #1 through #3 and those who completed unstructured interviews.

According to Table 6.3, data for the Thai case study were derived from 20 psychiatrists, seven psychologists, and one social worker responding to Questionnaires #1 and #2. Questionnaire #3 was completed by ten psychiatrists,

Table 6.3

Personnel Administered Questionnaires #1, #2, #3

<u>Facility & Staff</u>	<u>Questionnaire:</u>	<u>Number of Staff Completing</u>			<u>Open-ended Interviews</u>
		<u>#1</u>	<u>#2</u>	<u>#3</u>	
<u>Srithunya</u>					
Psychiatrist (Hospital Director)					1
Psychiatrist (Medical Director)		1	1	1	
Psychiatrist (Consultants)			1	1	
Chief Psychologist			1	1	
Chief Social Worker				1	
<hr/>					
<u>Somdej Chao Phrya</u>					
Psychiatrist (Hospital Director)		1	1		1
Psychiatrist (Consultants)			2	3	
Psychologist			1	2	
Social Worker			1	2	
<hr/>					
<u>Pan Ya On</u>					
Psychiatrist Director		1	1	0	1
<hr/>					
<u>Child Guidance Center</u>					
Chief Psychologist		1	1	1	1
Staff Psychologist			1	1	
<hr/>					
<u>Ramathibodi Hospital</u>					
Chief Psychologist		1			1
<hr/>					
<u>Prasart Neurological Hospital</u>					
Psychiatrist (Director)		1	1	1	1
<hr/>					

Table 6.3 (continued) Personnel Administered Questionnaires #1, #2, #3

<u>Facility & Staff</u>	Questionnaire:	<u>Number of Staff Completing</u>			<u>Open-ended Interviews</u>
		<u>#1</u>	<u>#2</u>	<u>#3</u>	
University of Chiangmai, Department of Psychiatry					
Psychiatrist (Director)		1	1	1	1
Chief Psychologist			1	1	
Chief Nurse				1	
Suang Prung Hospital					
Psychiatrist (Director)		1	1	1	1
Psychiatrist			2	1	
Psychologist				3	
Dr. Phon Sangsingkeo (Psychiatrist)					
				1	1
Division of Mental Health					
					1
University of Chiangmai, Department of Psychiatry					
					1
Drug Research and Prevention Center					
					1
U. N. Asian Development Institute					
					1
TOTALS		8	17	23	13

nine psychologists, one nurse, and three social workers. Interviews were recorded in 12 settings--nine in Metropolitan Bangkok, three in Chiangmai--and 13 informants were sampled through open-ended discussions.

In summary, information about Thai psychiatric resources was derived from contact with about 35 professionals, almost entirely psychiatrists and psychologists, three-fourths of whom work in Bangkok agencies. Limitations to the case study's validity are that it may be biased toward the perceptions of two categories of professionals (although in actuality allied professions are scarce) and does not present a picture of the conditions beyond Thailand's capital and its second largest city, Chiangmai.

Framework for Mental Health Resources

Comprehensive services. The Thai mental health system's capacity to make available comprehensive services (responsive to the full range of clinical needs) is the first variable. The potential for comprehensive care is summarized in Tables 6.4 and 6.5. The first table lists service function criteria for special groups while the second displays the types of treatment modalities offered at each site.

It is clear from Tables 6.4 and 6.5 that basic treatment functions and modalities are available among the sites sampled. At almost every agency, an adult psychiatric case would receive the core elements of "modern" services--inpatient, outpatient and follow-up care, diagnostic, and

Table 6.4

Availability of Comprehensive Services

Service Function	SCP	SH	PN	PYO	CGC	RH	SP	CU
Inpatient	+	+	+	+	-	2 beds	+	+
Outpatient	+	+	+	+	+	+	+	+
Emergency	+	+	-	-	-	-	+	-
Partial Hospitalization	+	-	-	+	+	-	-	-
Transitional Living	-	+	-	+	-	-	+	-
Follow-up	+	Planned	+	+	+	+	+	+
Children's Services	+	+	-	+	+	+	-	-
Geriatric Care	-	+	+	-	-	-	-	-
Drug Abuse	-	-	+	-	-	-	-	+
Diagnostic	+	+	+	+	+	+	+	+
Neurological	+	+	+	+	-	-	+	+
Suicide Prevention	-	-	Planned	-	-	-	-	-
Educational	+	-	+	+	+	+	+	+
Mental Health Research	-	+	+	+	+	+	+	+
Program Evaluation	-	-	-	-	-	-	-	-
Teaching/Training	+	-	+	-	+	+	-	+

+ indicates available
 - indicates unavailable

Table 6.5

Treatment Modalities Available

Modality	SCP	SH	PN	PYO	CGC	RH	SP	CU
ECT'	+++	+++	+	+	-		+++	++
Physiotherapy	++	-	++	+++	+		+	-
Drug	+++	+++	+++	+++	+++	+++	+++	+++
Psychotherapy	++	+++	+++	+++	+++	+++	++	++
Behavior Modification	Planned	-	-	++	+	+++	-	++
Group Therapy	+++	+++	+++	+++	-		++	+++
Family Therapy	++	+	++	++	++	++	-	++
Occupational Therapy	+++	+++	+++	+++	+++		+++	+++
Work Therapy	-	+++	-	+++	-		-	-
Other	Milieu, Recreation	Thera- peutic Community Groups		Rehab. Schooling	Yoga Exercises		Thera- peutic Community Groups	Recreation

+++ Often
 ++ Sometimes
 + Seldom
 - Never

neurological assessment. If easy access to alternative agencies is possible in Bangkok, more specialized units such as emergency care, partial hospitalization, childhood and geriatric services, and treatment for drug abuse are within grasp.

In essence, the actual therapeutics administered are indistinguishable from those of Taiwan or the Philippines either in substance or emphasis. Chemotherapy, individual, group, family, and occupational therapy are all given "often" or "sometimes." ECT is evident but less frequent than drug regimens. Supportive psychotherapy is the most popular mode of talk therapy; selected patients are exposed to psychoanalytic, eclectic, client-centered, and behavioral orientations. These choices reflect the American and British training of many professionals.

Group work is done to remotivate chronic patients. Therapeutic community groups, an integral part of Srithunya wards since the early 1960's, have spread to several other hospitals. Work therapy is carried out at two vocational rehabilitation units set up by Srithunya and Pan Ya On. Public education activities and consultation to gatekeeper agencies in the community--high schools, police, professional associations--were reported at all but one site.

The attributes of these institutions can be compared for perspective. SCP, SH, and SP, Thailand's three largest mental hospitals, appear to have almost identical sets of

functions but differ in several important respects. SCP is the premier training facility. It has almost three times as many physicians as the other two hospitals combined and has more specialized departments, including a Department of Public Relations and Education. Srithunya, with twice as many patients as any other hospital, has pioneered in creating partial-hospitalization and half-way house programs and has several prolific researchers. SP, Chiangmai's non-teaching regional mental hospital, has almost a skeleton crew of professionals. But it still manages to operate one of the country's three half-way houses and undertake research.

PYO is the other large residential program visited. It houses and educates some 450 mentally deficient children and young adults. As a treatment facility for one special population, it makes no pretext of being comprehensive except in reference to its mandated group. In this regard, it offers a spectrum of clinical modalities: individual and group therapy to remotivate children and deal with their emotional problems; special educational curricula; family therapy; and twice-weekly well-baby clinics to screen for mental retardation and PKU (phenylketonuria).

The remaining four sites concentrate on outpatients but maintain some bedspace for acute patients. Within the Prasart Neurological Hospital is the 40-bed psychiatric unit (PN). While less comprehensive than the larger

hospitals, it does house the country's Research Institute for Drug Addiction and an alcoholism treatment ward. PN is also an important teaching center for neurology. Starting as the first child guidance clinic, CGC has now expanded its client capacity to include adult outpatients and operates as a community mental health center. Its foci remain with day-care services for children (providing a 40-bed partial hospitalization unit), training in child psychology, and community/professional education projects. RH and CU, the least comprehensive of the hospital-based programs, were recently established at Mahidol University's Ramathibodi Hospital and Chiangmai University Hospital respectively. When surveyed, RH had two and CU 12 beds for short-term admissions. Teaching and research were the primary roles within these settings, although both carried demanding outpatient loads based on their staffing capacities.

Gaps in the system's ability to provide comprehensive services are also apparent from Tables 6.4 and 6.5. Most obvious is the absence of a suicide or crisis center in Bangkok. Without figures on self-injury, it is hard to determine whether this dysfunction is prevalent or simply not a concern. PN operates the only alcoholism treatment ward in the system. Drug dependence is a major government concern, as shown by the amount of research on this topic and the founding of the Drug Dependence Research and Prevention Center under Dr. Ratanakorn's supervision. Drug

cases amount to 50 per cent of the prison population (Sangsingkeo, et al., 1974) and are most probably handled at the Niti Chitavej Hospital (forensic). But how many are treated and by what means are unknown. Programs for geriatric cases were just introduced at SH and PN. Provisions for childhood disorders outside of PYO and CGC tend to be makeshift. As an example, childhood schizophrenics were admitted to the convalescent ward at SH. Child inpatients are best served by referral to the Samrong Hospital for Problem Children.

Only the largest facilities offered special operations such as emergency and partial hospitalization. The availability of non-service functions was uneven: program evaluation was never mentioned; education and research was evident but with differing intensities. CGC, SH, PN, and PYO were most dedicated to undertaking scientific studies; SCP, CGC, and RH were most involved in teaching functions.

Briefly, except for gaps in application of behavior modification and work therapy, the Thai sites afforded the full complement of therapeutic modalities. The lone psychologist at RH was an expert in behavior therapy, having been exposed to this approach at an English university. Similarly, the chief psychologist at SCP had just returned from Manchester University in England and was preparing to introduce behavioral methods.

To review, Kiernan's (1976) earlier comments on the

dearth of programs for special populations and alternatives to inpatient care--and the imbalance of existing services in favor of Bangkok--are reconfirmed by the findings of this survey. Units for inpatient child care, substance abuse research and intervention, mental retardation, geriatric care, and neurology are all in the capital. Suicide prevention and program evaluation components remain unfounded. Basic service functions like emergency psychiatry, partial hospitalization, transitional living, and child treatment are encountered too infrequently.

Preventive orientaiton. The second resource variable surveys programs aimed at preventing or mediating conditions fostering behavioral dysfunction. Four types of preventive psychiatry are listed in Table 6.6 with estimates of the degree to which each type is present in the eight institutions.

Surprisingly, Public Consultation is by far the most active prevention service. It involves extending technical assistance and advice to other social agencies handling various client populations. Each site except CU has ongoing consultative relationships with professional groups and/or other institutions. Looking at the three large mental hospitals: SP actively sends psychologists to surrounding vocational and high schools to handle behavioral and learning problems; SH renders assistance to staff operating nearby institutions for welfare cases and

Table 6.6
Availability of Preventive Programs

<u>Prevention Type</u>	<u>SCP</u>	<u>SH</u>	<u>PN</u>	<u>PYO</u>	<u>CGC</u>	<u>RH</u>	<u>SP</u>	<u>CU</u>
Public Information	+++	-	+	++	+++		-	-
Public Education	+	-	+	+++	+++		-	-
Public Consultation	++	++	+	+++	+++	++	++	-
Ecological Change	-	-	-	-	+		-	-

+++ Often
 ++ Sometimes
 + Seldom
 - Never

prostitutes; and SCP has a formal program of consultation to the police academy, Bangkok schools, and lawyer groups.

However, PYO and CGC are the most deliberate in their efforts to extend support services to allied agencies. CGC cooperates with the Ministry of Education to accomplish early detection of children with emotional problems and has three mobile mental health teams (psychologist, psychiatrist, social worker) visiting more than a dozen Bangkok universities and demonstration schools. The team's task is to evaluate and treat students and to train counselors. Moreover, CGC offers week-long seminars several times yearly to teachers, public health nurses, and counselors to enhance their assessment and intervention skills. Physicians from PYO sometimes attend normal schools, teacher training centers, prenatal care centers, health clinics, and a facility for profoundly retarded children to assist and advise on matters dealing with mental deficiency.

Efforts to generate heightened public awareness of mental health issues of common concern are evident in only three institutions. Public Information at SCP is the purview of the Department of Public Relations and Public Education started in 1972. This department promotes public tours of the hospital to acquaint citizens with the facility and coordinates information dissemination through the mass media including TV appearances by SCP psychiatrists. Public lectures (often in conjunction with the Thai Mental Health

Association), newspaper articles, and a pamphlet on mental health issues are avenues CGC uses to affect public attitudes. In 1976, CGC distributed 24,600 pamphlets and gave 77 film showings and 51 public lectures on mental health.

The Public Education type of prevention takes the additional step of aiming instructional opportunities at identified high risk groups to bolster their coping resources in the face of impending stress. Only PYO and CGC followed clear mandates to assist high risk groups.

PYO undertakes two prevention projects: first, it organized and holds monthly meetings for the Association of the Parents of Mentally Retarded Children. The meetings educate parents about disorders and problem solving. Secondly, a well-baby clinic is conducted to screen for undetected metabolic disorders requiring early care. The day care unit at CGC is a resource for working parents who cannot care for their pre-school children. CGC holds lectures and discussion groups for these parents every two months to educate them regarding normal child development and appropriate child rearing techniques. These services seek to insure normal adjustment of those children caught in the newly-emerging urban pattern: both parents must work and the children are left alone for long periods of time.

The final prevention type is Ecological Change: action directed at broader social, economic, and political levels

to reduce adverse conditions impacting psychological functioning. As in the Philippines, there was little evidence that these agencies saw their roles as change-agents for socio-political institutions. Programs were not devised for reaching out to people living in the slum areas of Bangkok, nor for tackling the psychosocial stress resulting from high-density urban living, poverty, and rapid social change. CGC's efforts to make educational institutions more responsive to the needs of students--through the creation of counseling services--came closest to the concept of Ecological Change.

In review, other than Public Consultation, only two or three of the eight institutions follow a clear mandate to organize prevention programs. Yet, looking beyond the sites sampled, it is clear that MOPH sees prevention in the area of drug abuse as a major mental health thrust for the 1977-1981 five-year plan. The plan is to step up the assault on addiction through coordination, increased coverage of services including methadone maintenance clinics and health education, as well as the collection of relevant information to serve as the basis for planning strategy (MOPH, 1976). Even though previous research cited showed insignificant "hard drug" use among youth, the presumed population at risk is students: MOPH has planned 111 guidance units manned by school teachers and serving 4,225 schools to prevent the rise in the present addiction rate.

Continuity of care within the facility: Manpower.

The facilities' capacity to assign multi-disciplinary teams to undertake assessment, treatment, and rehabilitation is the third resource variable. Manpower strength, meaning a full range of personnel categories and adequate ratios of staff to patients, helps to assure fluidity of referral among team members--intra-institutional continuity of care.

The manpower situation among the eight institutions is shown in Table 6.7.² The categories of professionals are distributed in a pattern almost identical to that of the Philippines. Specifically, there are nine times as many psychiatric nurses as physicians; psychologists, occupational therapists, and social workers are least available (although found in roughly identical numbers). The parity in representation among these last three types of workers and the fact that in most instances they are not numerically inferior to psychiatrists is significant. It suggests that the Thai psychiatric system permits a more active involvement of non-medical disciplines than observed in the other two countries.

The optimism stimulated by apparent equality in professional ranks quickly gives way to dismay upon inspection of the patient/staff ratios. The overall ratios are adequate, ranging from 1.08 and 1.2 inpatients per therapeutic staff at PN and CU, to 9, 11, and 14.24 inpatients per professional at SP, PM, and SH respectively.

Table 6.7

Multi-Disciplinary Teams and Manpower Availability: Staffing Numbers and Staff Ratios to Patients

Profession	SCP	SH	PN	PYO	CGC	PM	SP	CU	Total
Psychiatrist (including residents)	32	11	4	6	3	3	2	1	62
Psychologist	8	4	4	3	8	3	4	1	35
Nurse (including assistant)	137	125	24	65	15	73	85	8	524
Social Worker	10	8	3	5	6	2	5	-	39
Occupational Therapist	12	10	2	5 15 teachers	2 teachers	-	4	-	35
Beds	1,000	2,250	40	450	40	925	900	12	
1976 Average Monthly Outpatient Visits	4,958*	2,611*	3,750*		1,450	2,307*	862*	108*	
1976 Total New Outpatients	10,189	4,116			1,657	5,345	2,252	500*	
1976 Total Outpatient Visits	59,449	31,333	50,564*	150 day students	17,397 total clients	27,608	10,342	1,300*	
1976 Total Inpatient Admissions	2,255	4,609		60	72	1,087	1,682	250	
Inpatients Per Therapeutic Staff	5.025	14.25	1.08	4.54	511.67 (outpatients)	11.41	9.0	1.2	

* = estimate

These figures are lowered by the high numbers of psychiatric nurses and their trained assistants.

However, in the large residential institutions, the scarce numbers of professional categories become distinct. At SP and PM, each with almost 1,000 residents, there are only two or three psychiatrists. SH in Bangkok has a ratio of 204 patients per psychiatrist, while nearby SCP enjoys a ratio of 32 residents per physician. Psychologists, social workers, and occupational therapists fare little better. In fact, SH's four psychologists are theoretically responsible for 562 patients each. Similarly, PM's two social workers confront 462 needy persons.

The pressures on professional time are felt even more profoundly when outpatient figures are brought into account. SCP had a total of 59,449 contacts in 1976 while PN had 50,564 visits (75 per cent of PN's outpatients are diagnosed psychiatric as opposed to neurological cases). Likewise, SH, PM, SP, and CU gave consultations on 31,333, 27,688, 10,342, and 1,300 occasions respectively. In the same year, CGC's 34 staff saw 5,858 new and old clients. Their total program, including outreach work, brought them into contact with 17,397 cases--approximately 511 clients per staff member.

In contrast, smaller inpatient settings, PN and CU, have excellent ratios for all types of workers. At PN, though, the outpatient demands look formidable, even

considering that these patients are shared with some 15 other physicians working in the neurological units of the hospital.

Accepting the fact that the sheer weight of patient numbers mitigates meaningful staff contact for many patients, it is still possible to observe the extent to which a multi-disciplinary orientation is sought. The team concept, with close collaboration among medical and allied workers, is evident, but not uniformly practiced. Physicians covet their position as primary decision-makers at PN and SCP. Recently, SCP administrators sought to foster a teamwork orientation among the separate disciplines but were without success due to the hesitancy of some status quo-minded staff.

Integrated team approaches and flexible use of staffing appear strongest at sites following contemporary philosophies of treatment. At SH, where group therapy and the therapeutic community were introduced in 1963, psychiatric teams are assigned to each section. Moreover, each team member serves as leader for his own therapeutic group (Visuthikosol & Suwanlert, 1976). In one male section at SCP following this orientation, nurses act as primary therapists with physicians acting as advisors. CGC, emphasizing principles of prevention and outreach, has several mobile teams of mixed professions carrying on training and evaluation functions at Bangkok schools. CU also endorses the therapeutic community philosophy for organizing group discussions.

Nurses there handle recreational, occupational, and individual group therapy sessions, and all disciplines contribute to discharge planning. PYO's program is built around close cooperation among teachers, physicians, occupational therapists, and social workers. Retarded children are provided with three training phases--daily living, social adaptation, and vocational.

Duties are assigned to different personnel vary from traditional assignments to those offering new responsibilities. Psychological testing is the principal task of SCP psychologists who administered 3,000 tests in 1974. Their colleagues at PYO, SP, and CGC were also active with test batteries, giving Thai versions of standardized intelligence tests (WAIS, WISC), personality inventories, and projectives. Where group therapy was conducted, psychologists usually led or helped lead groups. The few psychologists allowed to do psychotherapy choose either supportive talk therapy or psychoanalytic techniques. Behavior therapy may grow in popularity, though, now that the chief psychologists at RH and SCP have begun to teach and practice it. RH's behavior therapist is frequently referred patients with phobic complaints and sexual dysfunctions. As an agency dominated by non-medical practitioners, CGC psychologists occupy their time in community consultation, research, and individual work. The four psychologists at SP have introduced dance and music therapy on several wards and hold

last-minute sessions with all patients prior to discharge.

Social workers, on the other hand, are given the task of working with the families of some patients. At certain sites they have been able to define their role more broadly. SCP social workers, whose chief was trained overseas, handle group therapy sessions, intake interviews, and home visits and coordinate referrals with other agencies. PYO social workers do therapy with the families of retarded children and help the institute's graduates find jobs suitable to their vocational training. Social workers at CGC and their psychologist colleagues are the backbone of the center. They handle the bulk of outpatient and outreach consultations. Occupational therapists are meaningfully pressed into service at PYO where they guide the vocational skill development of children. Their colleagues at SH's quarter-way house rehabilitation unit enhance chronic schizophrenics' chances of making the transition back into the community.

In conclusion, intra-institutional continuity of care is made possible by having sufficient numbers of staff from the major disciplines available for coordinating case management. Such continuity is probable within the Bangkok programs having adequate complement of specialists and tend to organize them into integrated psychiatric teams. PM and SP, typical of provincial mental hospitals, have frightfully small numbers of therapeutic staff. Each professional in principle is responsible for literally hundreds of inpatients

(except for nurses). Other facilities' capacity to provide sufficient intra-institutional referral and follow-up is brought into question when the figures for outpatients are considered.

All institutions except CU have 1,000 to 4,000 out-patient contacts per month. It is hard to imagine a given help-seeker experiencing a fluid transfer from one team member to another based on his diagnosed or changing needs. On the other hand, the mental health system as a whole does appear flexible in some instances: the different disciplines are permitted to broadly conceptualize their involvement with the patient allowing manpower to be used in an effective manner. That is, psychologists, social workers, and occasionally nurses are permitted to accept individual and group therapy assignments. Psychiatrists were willing to provide leadership for group therapy and therapeutic community experiences. Some have even carried their expertise into the community to consult with various groups and secure contact with larger numbers of clients.

Continuity of care: Inter-institutional. Well-established referral pathways and consultation relationships among mental health resources enable the system to function as an integrated unit for diverse needs. To the extent that strong working relationships exist among community agencies, inter-institutional continuity of care is achieved. It enables each patient to move smoothly between agencies

to get required specialty attention. The referral process and communication pathways among Bangkok and Chiangmai institutions are described in Table 6.8 and Figure 6.3

Table 6.8 lists the route by which patients enter the system and the relative importance of each route. Presented at the top of Figure 6.3 are the most significant referral sources: family/friends, schools, and physicians; traditional healers, priests, and employers play lesser roles as "gatekeepers." The strong endorsement of schools, social welfare agencies, and physicians as referral agents implies good links among professionals in allied fields. The especially high listing of other government mental health agencies suggests viable referral pathways among these programs.

Figure 6.3 gives evidence of the connections among psychiatric institutions hinted at in Table 6.8. Rank ordered at the top are seven principal sources guiding patients into the network. In Bangkok, the least threatening agencies (lowest stigma)--those with the easiest patient access--are CGC and PN.

Operating like a switchboard, CGC screens clients from schools, welfare agencies, and police and passes them along (when appropriate) to SCP, PN, PYO, and the child psychiatric hospital. CGC sends some outpatients to RH and has mobile teams offering consultation to several programs from which it receives referrals. PN's drug abuse center is active in

Table 6.8

Frequency of Various Referral Sources

<u>Sources</u>	<u>Frequency</u>			
	<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>Never</u>
Physicians	CGC, CU	SH, PN	SCP, PHO, RH, SP	
Mental Health Professionals	CGC		SH, PN, PYO, SP, CU	RH
Government Mental Health Agencies	SCP, SH, CGC	PYO	RH, SP, CU	PN
Social Welfare Agencies	PN, PYO	CGC, RH	SCP, SH, CU	SP
Schools	PN, PYO, CGC	RH	SCP, SH, SP, CU	
Police	SH, PN	SCP, SP	PYO, CGC, CU	RH
Priests		SCP, PN	SH, PYO, CGC, SP, CU	RH
Traditional Healers		SH	PYO, CGC, RH, CU	SCP, PN, SP
Family/Friends	CGC, SP, SCP, SH, PN	PYO, RH, CU		
Employer		PN, RH, CU	SCP, SH, PYO, CGC, SP	

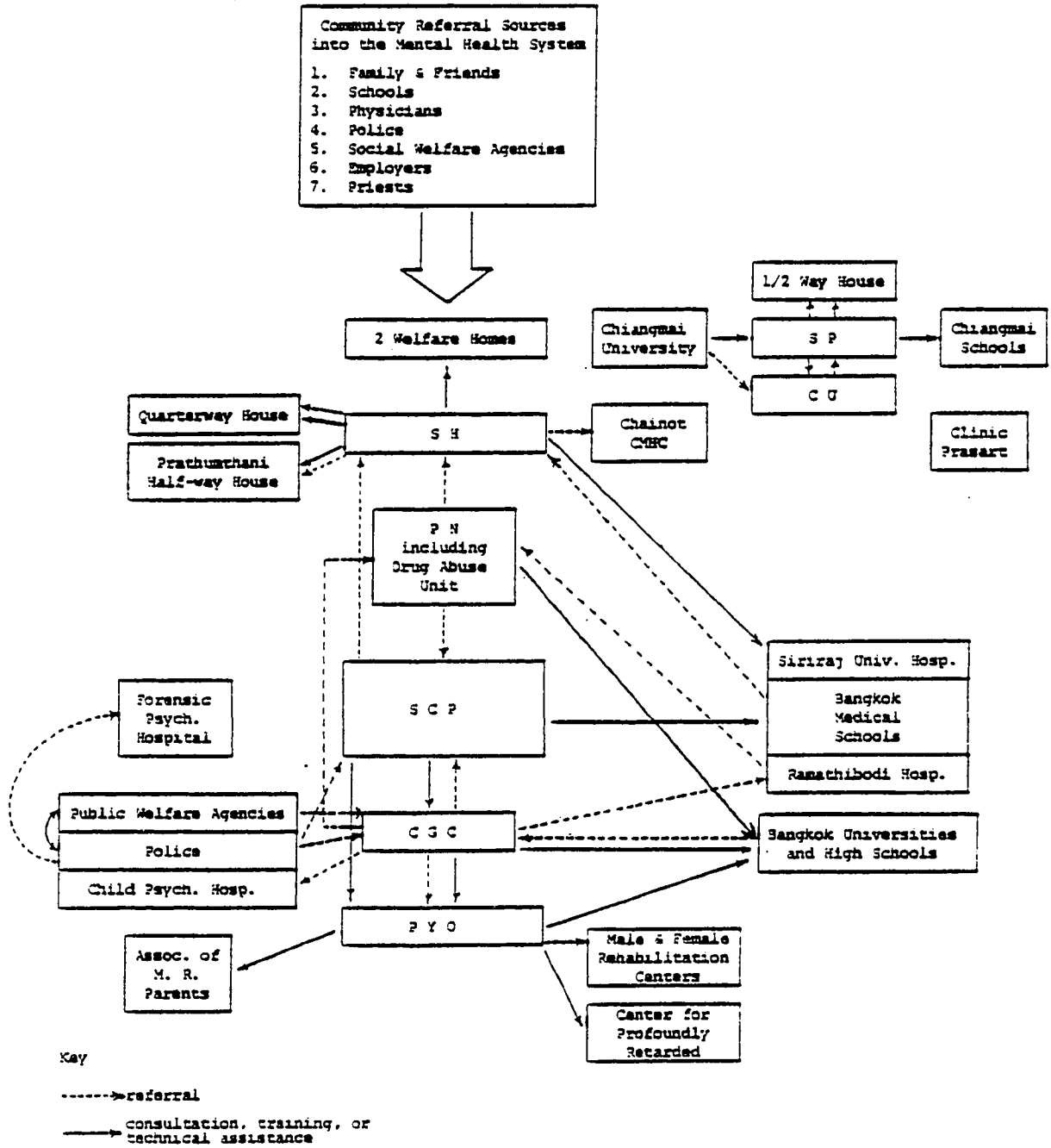
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Figure 6.3
 Referral and Consultation Relationships Among Bangkok
 and Chiangmai Psychiatric Centers



anti-narcotic education in schools through Thailand. SCP pulls in referrals from several sources--CGC, the police, PN--and sends along chronic cases to SH with its larger bedspace. SCP generates more consultation relationships than any other facility, acting as a training ground for the Bangkok medical schools and most psychology and social work students undertaking practica.

SH, in contrast, is the final stop for chronic patients arriving from SCP, PN, and the Bangkok medical school clinics. For those making a marginal adjustment, SH provides a quarter-way house living arrangement or sends them to a community half-way house. Siriraj Medical School is affiliated with SH for purposes of training residents. SH also gives regular consultation to two nearby welfare homes.

PYO is the remaining institution strongly interwoven in the referral network. It receives patients and consultation from CGC and has a consultation relationship with SCP. Like SH, PYO is tied with several specialty programs it alone works with. These include the Association of Parents of Mentally Retarded Children, two rehabilitation units under its auspices, and another center for profoundly retarded children. The only other clear referral relationship noted is between the police and the Forensic Psychiatric Hospital. The extent to which the major institutions consult with or refer criminal patients to the Forensic Hospital is uncertain.

In Chiangmai, the relationships are less complex since there are only three official programs serving psychiatric populations. Chiangmai University Hospital, SP, and CU have mutual ties. The form and extent of their relationships are still developing due to the recent inauguration of Chiangmai University's Department of Psychiatry. As Table 6.8 reveals, SP relies primarily upon family/friends and police for its admissions. CU does occasionally refer long-term patients to SP, given its own limited dormitory space. SP's consultative activities include its contacts with Chiangmai schools, the province's half-way house, and the supervision of CU's medical students in practica work. Chiangmai University Education Department sends instructors to SP to provide counselors in-service training.

In contrast, CU gets most of its admissions from the University Hospital medical departments. At the time of the survey, CU did not have enough manpower to provide consultation outside of the clinic. Clinic Prasart with its 100 beds for neurological cases handles a fair number of psychiatric intakes based on the pattern found at PN. Although this clinic is adjacent to CU, no indication was made by CU staff of an intense working relationship with it.

Conclusions are drawn from the pattern in Figure 6.3 regarding institutional ability to operate as an integrated unit: communicating effectively with one another and transferring patients into appropriate milieus. Well-defined links appear among several of the Bangkok programs.

Yet, the sense of unity and coordination among these elements is less than would be expected, given that they all fall under the Department of Medical Services. This opportunity for centralized leadership in mental health service, a luxury not found in Taiwan or the Philippines, is not fully exploited as Kiernan's (1976) report has suggested. Nevertheless, positive examples may be cited.

CGC is clearly well-integrated both with other community groups (schools, police, public welfare agencies), and with its fellow service providers. CGS clients needing more intensive care than what is offered--including hospitalization, or diagnosed mentally deficient--are readily passed along to either PYO, PN, RH, SCP, or the Children's Hospital. University psychiatry departments in Bangkok have similar relationships with SCP, PN, and SH. PYO, with its residential rehabilitation centers, and SH and SP with their own half-way houses, are able to transfer patients smoothly along to less restrictive environments. SCP is the prime focus of communication/consultation in the network based on its historical significance, large multi-disciplinary staff, and its role as the training center for all categories of workers sent by other institutions. Further underscoring its prominence in the information flow, SCP organizes scientific meetings and case conferences and houses the best psychiatry library in Thailand. The strongest evidence for coordination among these sites are

the findings of mutual consultation between SCP and PYO and between CGC and PYO and the fact that all facilities either gave to or received from another agency some sort of technical assistance. That each hospital may in actuality operate as a separate entity is suggested by the fact that there is only one meeting per year of mental institutions.

In summary, a client whose condition could not be handled by the intake agency may enter the mental health network in Bangkok to be referred to one of the community's full-service or specialty institutions. Those leaving the hospitals are at a disadvantage as community-based follow-up programs and half-way house arrangements remain underdeveloped. This issue is addressed in detail next.

Continuity of care into the community. The final resource variable based on the concept of "continuity" involves agency provisions for easing patient re-entry into their home environments. Continuity of care into the community is more precisely defined by the six alternatives in Table 6.9. These concern either community access to institutional treatment or agency workers extending their contact beyond the clinic walls.

The general findings in Table 6.9 are twofold: first, in line with Kiernan's observation of the failure to provide "alternatives to inpatient care" (Kiernan, 1976, p. 3), there does not appear to be an easy flow of patients from highly restrictive into minimal supervision settings

Table 6.9

Six Alternatives for Providing Continuity of Care into the Community

<u>Alternatives</u>	<u>SCP</u>	<u>SH</u>	<u>PN</u>	<u>PYO</u>	<u>CGC</u>	<u>RH</u>	<u>SP</u>	<u>CU</u>
1. Active patient follow-up especially by social worker	++	+	+	++	++	+	+	+
2. Educate or utilize family members as part of treatment plan (especially at discharge)	+	+	++	+++	+++	++	++	++
3. Relative stays in hospital with patient	-	-	+	++			-	-
4. Treatment within home or village setting	-	-	-		++	+	+	-
5. Community agents assist in treatment (teacher, village leader, M.D., police)	+	+	+		++	?	++	-
6. Participation in community activities during hospitalization encouraged	+	+	-	++			++	++

+++ Always
 ++ Sometimes
 + Seldom
 - Never

or into the hands of responsible community agents. Secondly, the residential programs seldom encourage or make use of family member participation in hospital treatment. Rather, as seen in item 2, it is at the moment of discharge that relatives are brought into the picture and given instructions for home care.

Looking closely at the first finding, we see from item 4 that home or village level intervention is extremely rare. And when follow-up care is done (which is either "seldom" or "sometimes"), it is typically handled by having the patient revisit the hospital's outpatient clinic. After-care staff--public health nurses and social workers--are spread too thinly to make more than token home visits to check the progress of discharged persons. Those who are visited are likely to be living in the immediate vicinity, given transportation handicaps. Follow-up rural trips are unthinkable with present staff.

On the other hand, some efforts to assist discharged patients are made. SCP keeps in contact with certain patients through correspondence--mailing them continued supplies of psychotropic medication--and runs a busy walk-in after-care clinic. SH enjoys access to two transitional living units and occasionally makes use of the Community Mental Health Center in Chai-Nat Province for after-care. PYO keeps in contact with its "graduates" through the Parent's Association and its social workers' efforts to

find steady jobs for the trainees. CGC is more systematic, assigning a public health nurse to administer a questionnaire to former clients at year's end. Moreover, CGC, more than any other, sends its workers out for home visitation. It tries to intervene in the client's natural environment, especially school settings.

The second finding from Table 6.9 indicates the lack of family or community agent involvement during hospitalization. In no instance were relatives asked to stay with their hospitalized family member. Severely disturbed or suicidal patients at PN sometimes had hired watchers observe them for safety reasons, but relatives wishing to stay overnight were required to pay for the bed used. PYO was in the process of building a hostel for the parents of retarded children who traveled from the provinces for the week-long assessment procedure.

Formal family involvement in terms of training or educating parents and siblings, or family therapy, was infrequent. SH had a relatives' weekly group meeting, but it ended when the social worker leading it departed. CU's psychiatrist reported that when he found client problems related to family environment, he would call a family meeting. PYO and CGC were notable exceptions. The former program had monthly meetings of parents to inform them about mental retardation and assist with home problems. CGC brought parents of problem children into individual and

family therapy sessions. It also conducted periodic sessions on child rearing with its day-care clients. The other agencies sought family contact at the point of discharge. SCP, PN, and SP staff told the family that their after-care responsibilities were to closely observe the released patient, making sure that he continued taking his medication, and to report new symptoms during hospital follow-up visits.

Except for CGC and SP psychologists who attempted to coordinate their intervention with school counselors and teachers, liaison with community agents (priests, police, employers, etc.) for case management was undetected. SP staff in Chiangmai did express their desire for future involvement with outlying rural health centers. They hoped to get the public health personnel to take a more active role in mental health care so that patients need not travel so far to get drug therapy. Interestingly, Milton Miller's WHO mission to Thailand in 1976 gave attention to the integration of mental health programs into the public health system and training strategies for personnel to be employed in the integration scheme. Thus, the wish for this approach by provincial workers may eventually be fulfilled.

Lastly, the distance between the community and hospital is examined by noting the extent to which staff report encouraging or structuring patient involvement in outside activities. As shown by item 6, this is done on a "seldom"

or "sometimes" basis in most cases. CU was the only site to mention a specific activity: twice monthly, patients are taken out for excursions to nearby movie houses.

Accessibility. Accessibility of mental health resources is discussed in terms of their availability to the general population and the ease with which users may enter the system. Earlier, Table 6.2 listed the full extent of programs and institutions available. Metropolitan Bangkok accounts for a tremendous proportion of the existent training, research, and therapeutic resources. It has five walk-in clinics and ten residential settings with a combined bedspace of 4,500. These resources serve adults, children, developmentally disabled, criminal offenders, substance abuse cases, and others. The remaining 40 million Thai living in 71 provinces and 126 municipalities have access to six provincial mental hospitals (varying in size from 150 to 1,100 beds), three smaller residential clinics, three psychiatric units in general hospitals, and one half-way house. Provincial bedspace is 3,925.

Given the above figures, it is obvious that individuals who may benefit by admission to the system can only do so by traveling some distance. In fact, at least half of the residents at SCP, SH, PN, and PYO have journeyed to Bangkok from the provinces. Constricting the availability of sites even more is the finding that of the nine provincial hospitals and clinics, three are located in Chiangmai.

Staff perceptions of agency convenience (ease of access due to location) were based on the extent to which they served rural people. SP, SH, and PN personnel handling clients from several parts of the country felt that their agencies were "seldom" conveniently situated. On the other hand, CGC and CU staff working with those who are drawn from the immediate area believed their locations were "often" or "always" conveniently placed.

Additional factors govern the potential use of these sites. These include: cost, hours of operation, availability of empty beds, and policies regulating admissions. On the positive side, there was almost unanimous agreement that persons with little or no money may use the treatment program. Public funds support the basic operations of each agency, although donations are solicited and some charges are made for drug prescriptions. In addition, a \$4 nightly fee is assessed for private patients given special rooms at SCP. Money is collected at PN from those who can afford to pay. CU has a flat \$15 charge for admission and collects another \$10 for drugs and \$5 for recreation therapy materials. At PYO parents are expected to contribute clothing and pay for educational materials while RH charges only for psychological testing.

Given these minimal requirements to receive services from public institutions, it is clear that cost is not a restriction to access for most middle class and lower income

peoples living near these resources. However, for poor people living in far flung provinces to come to Bangkok or Chiangmai for help, the economic hardship and cost in terms of time away from farming or village work--and the expense of travel--may be well beyond their means.

No significant data were collected regarding limitations imposed by inconvenient hours of operations or restrictive policies regulating patient admissions. Ease of access may be hindered by these two factors from the clients' perspective, but little was uncovered from questioning staff. In one instance, psychologists at CGC stated that it was a serious problem for counseling school children because the agency was only open during hours when the students remained in class.

Legally there were not strictures governing admission criteria. While this does make it easy for relatives, police officers, or local judges to place a person in the hospital, it also takes away safeguards regarding such commitment. As Curran and Harding (1977) noted in their international study of mental health legislation, Thailand operates on an "informal" system. The hospital medical officer makes the decision to admit except for those occasions when the patient is sent on a court order. Only one physician is required to do the certification and length of stay is indefinite. Appeals, periodic review, and discharge procedures are neither specified nor required under this

informal system. In many cases, however, patients are voluntary or brought in by family members who can be as adamant about release as they were about admission.

Overcrowded facilities is the final aspect determining ease of access. Based on staff opinion, every agency except CU experiences user overload as a "very serious" problem. PYO has a waiting list of over 100 retarded children hoping to gain access to its classrooms. SH administrators view their hospital as "extremely crowded"--with the mandate to accept all persons that no one else will treat, there is no letup in sight. SCP and SP also operate at full inpatient capacity.

The fact that each of these hospitals has between 10,000 and 60,000 outpatient contacts per year takes its toll on the quality of consultation available. Importantly, it forces the patients and their families to endure a great deal of waiting and frustration just to see the physician. An administrator at PN described how families from the provinces began lining up at 4:00 a.m. to talk with the doctor. This condition, therefore, is a major hindrance to accessibility, although long waiting lists for beds are not serious at all of the sites sampled.

In conclusion, the Thai system has maximum resource access in Bangkok. A full range of specialty and general psychiatric institutions are situated there and obtainable at little cost through public funding. Rural peoples for

the most part are disenfranchised from the privilege of public services because of the small scattering of provincial mental hospitals and clinics. Travel costs to the closest facility or to Bangkok is an insurmountable barrier for rural-dwelling farmers and laborers. The final factor found to inhibit ready access to existing programs is their dramatically overburdened condition. Long waits at walk-in clinics and, in several instances, extreme shortage of bedspace, serve to discourage those seeking to take advantage of these resources.

Staff evaluation of resource strength. The last resource variable is based on staff judgments of the seriousness of 21 potential problems hindering agency operations. These 21 resource deficits are listed in Table 6.10 along with the percentages of professionals endorsing the different categories of problem seriousness. The table presents the perceptions of 16 interviewees from seven sites responding to Questionnaire #2 (see Table 6.3). To pull out the significance in these figures, items are dichotomized as either problematic or non-problematic and an analysis was done to locate trends in the response patterns of individual institutions.

Several interesting discoveries emerge from Table 6.10. First, there is a moderate amount of dispersion across the four seriousness categories. Yet, when they are dichotomized, only about one-third of the items show no significant trend

Table 6.10

Staff Perceptions of Resource Deficits (N = 16)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Lack of help from Government	19%	33%	14%	33%
2. Not enough money for present treatment program	12.5%	31%	12.5%	44%
3. Not enough money for future treatment programs	25%	37%	12.5%	25%
4. Not enough trained administrators	31%	37.5%	31%	
5. Not enough diagnostic staff	19%	31%	31%	19%
6. Not enough treatment staff	56%	12%	31%	
7. Not enough follow-up staff	50%	50%		
8. Lack of relationship with other institutions	0%	31%	19%	50%
9. Other professionals don't support the program	6%	50%	19%	25%
10. Long waiting list	12.5%	12.5%	12.5%	62.5%
11. Not enough rooms to separate different kinds of patients	12.5%	56%	12.5%	19%

Table 6.10 (continued). Staff Perceptions of Resource Deficits (N = 16)

Potential Problem	Problem Seriousness			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
12. Lack of building space	12.5%	44%	12.5%	31%
13. Too many patients	6.9%	19%	0%	12.5%
14. Lack of money for equipment and research	50%	25%	6%	19%
15. Library is not good enough	12.5%	6.3%	19%	63%
16. Little information about new treatments and new research findings	19%	44%	19%	19%
17. Lack of epidemiological data regarding mental health	44%	25%	19%	12.5%
18. Staff relations are not good		12.5%	37.5%	50%
19. Not enough treatment supplies	6%	37.5%	19%	37.5%
20. Lack of transportation services	12.5%	38%	12.5%	38%
21. Low success rate of treatment	6%	50%	19%	25%

in one direction or the other. Second, almost half of the items were endorsed as problematic (60 per cent or more rating an item as "very" or "moderately serious"), while only four items were clearly not viewed as major issues. Third, looking at how staff within individual agencies responded (not shown in Table 6.10), workers at SP and CU in Chiangmai had unique answers. Except for five items, they denied experiencing difficulties with these potential deficits. PYO, CGC, and SH were at the opposite extreme. Staff there saw two-thirds or more of the problems as critical. Interestingly, there was general disagreement among SCP professionals on which problems were serious, reflecting differences among the disciplines. It was unfortunate that more personnel in the other agencies could not be sampled to replicate this finding of intra-institutional disagreement based on role.

The problem groupings in Table 6.10 expose the specific deficits felt by respondents. The first group of items, concerned with budgetary support and the sense of priority, shows clear agreement that funding for future programs is highly uncertain. The seriousness of these three items was clearly recognized by SH personnel. The status of agency manpower is tapped by items 4 through 7. Unquestionably, there is consensus across all sites that administrators, treatment staff, and follow-up personnel are in critically short supply. This correlates with previous data on the

manpower situation and the assertions of WHO consultants.

In contrast, the items dealing with psychiatric workers' sense of alienation from other professionals and social institutions were more positive. Only CGC and PYO reported lack of relationships as a moderate concern. This is peculiar because Figure 6.3 describes CGC as especially well-connected in the Bangkok network. It may be that CGC staff, who base their effectiveness on being able to make smooth referrals, are sensitive to this process and expect it to work better. A very slight majority felt unsupported by fellow professionals. Those who didn't were at SCP (the hub of Thai psychiatry) and at CU.

Crowdedness, formerly described in relation to access to facilities, is appraised in the fourth grouping (items 10-13). Patient overload is a unanimous complaint, except at the 12-bed Chiangmai unit. Moreover, all residential sites except CU find it problematic to separate different kinds of patients. At issue is the need to separate violent patients from the rest of the population at critical times and to provide special rooms for children, the elderly, recent intakes, and so forth. The lack of building space to carry on special functions such as occupational therapy, recreation, and staff development is recognized at SH, PYO, and CGC. It is sharply noticed at PN with its abundant outpatient load and minimal housing provisions for those seeking admission. Only two sites--PYO and PN--are burdened by lengthy wait lists slowing client access to services. In

sum the perception of crowdedness is acute and widespread. It is fostered by sheer patient numbers and inadequate architectural spaces.

The last major grouping pulls together items focusing on two aspects of research: the materials required to carry it out and its availability to guide program operations. It is clear that grants supporting research are one of the lowest priorities within the mental health system. Except for interviewees at CU, almost all staff were disturbed by the lack of opportunity to conduct research. Yet, only CGC and PYO personnel were concerned about not having an adequate library, a central part of the research process. Other workers may have felt that having a good library was too much to hope for--there is little time or funding for research. SCP does have a modern, well-supplied library which is open to investigators in the Bangkok area.

Items 16 and 17 deal with availability of current knowledge in regard to new therapies and assessment of disorder in the community. All but one or two Bangkok professionals expressed distress at the absence of this information. None of the Chiangmai workers experienced a deficit in this regard. It is possible that they felt confident in keeping up to date with advances in the field since those interviewed had all returned recently from studies abroad and are involved in university teaching. However, there was no indication of epidemiological data

on populations within the catchment area (Northern Thailand)-- usually a concern of administrators such as those interviewed.

Of the remaining four items listed, only one distinct finding is noted. Interviewees overwhelmingly disregard the notion that staff relations were not good. Opinions on availability of treatment supplies and transportation were equivocal. Respondents at SH, PYO, and SCP regard these two problems as important; the others do not. Item 21 is included as a general frustration index to determine if the pattern of perceived deficits result in a sense of inability to carry out successful interventions. Although only one practitioner (at SCP) reported that low treatment success was a "very serious" problem, 50 per cent saw their success rate as a "moderately serious" concern.

Interestingly, only four of the 16 interviewed felt success rate was no problem at all. These were the professionals at the recently opened Chiangami University Clinic (where patients tend to be selected for treatability), and one administrator and one psychologist at SCP. The remainder saw the issue of treatment outcome as somewhat problematic, suggesting a pervasive dissatisfaction with the programs' ability to have a positive impact. While widely felt, this sense of treatment failure is not expressed as a significant crisis, but rather like a core component of everyday experience for those who choose to work as mental health providers in a system that just barely meets their minimum support requirements.

In review, a number of clear trends were found in staff perceptions of resource deficits supporting earlier conclusions. The strongest consensus was found on the topics of manpower shortages, especially follow-up personnel, and lack of opportunity for conducting and making use of research. Crowdedness was a third critical domain. It is evoked in response to the sheer numbers of patients handled, particularly at walk-in clients, and the inadequacy of proper building spaces to house them and accommodate support services. On the positive side, relationships with other institutions were not viewed as discouraging, good staff relations were reported, and most hospitals did not have long waiting lists. Yet, these deficits are reflected in the opinion that low success rate was a "moderately serious" problem, thus bringing to light a system-wide sense of frustration.

Community Integration and Acceptance of
Mental Health System

Having completed the analysis of Thai psychiatric resources, it is time to appraise the mental health system's integration into the surrounding community and the extent to which it enjoys public and user acceptance. Integration is measured through instances of community involvement in patient care and community participation in the review of agency objectives and procedures. Practitioner perceptions are the basis for determining the extent to which agency

programs are accepted by the clients served.

Community Integration Through Involvement in Treatment

Institutions can reduce their community isolation through active liaison with responsible persons in the patient's natural environment. Patient's family, teachers, and other community agents could assist with problem definitions, treatment selection and delivery, and preparation for return to a suitable place in the community. Community integration processes correspond closely with alternatives for providing continuity of care into the community listed in Table 6.9. Assistance from persons in the patient's social network boosts the chances of continuity of care and breaks down the agency-community barriers detrimental to program acceptance.

Previous discussion of Table 6.9 centered on the recognition that persons from the patient's social environment were seldom partners in case management until discharge. The residential program in particular were not prepared to cooperate with relatives in formulating treatment plans, undertaking family therapy, or having staff train them as collaborators during hospitalization. There is no watcher or "amah" system as in the Philippines and Taiwan. The treatment plan is the physician's exclusive domain, an international attribute of medical institutions. Of course, visitation is encouraged and relatives are allowed to bring in food and money in some places. But only at discharge is

there a widespread effort to communicate expectations regarding the family's role. Namely, to watch the person for new symptoms, make sure that his medication is taken regularly, and return him for appointments.

In sharp contrast, when practitioners carry out consultation work at schools and counseling and health centers, they do not hesitate to use non-professional allies. The community mental health oriented CGC and the facility for retarded children have the deepest outside penetration in regard to treatment. Both seek to arm parents with new skills for managing their children's behavior problems including helping the parents cope with the stress of having impaired children. In short, except for the two cases mentioned, the role given concerned outsiders is restricted to after-care activities. Given the extreme shortage of staff assigned to after-care services and the resulting access barriers, it is hard to visualize how the role could be fulfilled in a meaningful way. Thus, for the most part, it appears that Thailand is without more than superficial community integration through treatment involvement.

Community Integration Via Agency Review

A second avenue for fostering intimacy between mental health programs and recipients involves solicitation of community input into institutional policies and objectives. Input formats include community advisory boards and needs assessment surveys to uncover which users are underserved

and which service strategies are deemed most appropriate. Among the Thai sites sampled, no formal community involvement was present either through steering committees or surveys of user-perceived needs. There were, however, studies dealing with drug use among high school and college youth which reported prevalence rates and suggested education and drug counseling. The absence of advisory boards replicates the Taiwanese and Philippine findings. The director of PN did mention the existence of an advisory group made up of interested physicians and lay persons, but it has since disbanded.

Undoubtedly, the desire to allow community input is a policy decision that must be made within the bureaucracy of the Ministry of Public Health and not by the individual institutions. If a single coordinating committee were to be established for guiding all services, community integration would be served by having community representation on the central planning board. Provisions should also be made for community input at the local level for individual institutions. However, there appears to be little precedence for this approach and no future discernible plan for it.

Staff Evaluation of Acceptability

The final measure of community integration was derived from securing practitioner judgments of their clinic's acceptance. Six items taken from Questionnaire #2 describing various aspects of acceptability are listed in Table 6.11.

Table 6.11

Staff Perceptions of Their Agency's Acceptability (N = 16)

Questionnaire Item	<u>Seriousness of Problem</u>			
	Very Serious	Moderately Serious	Slightly Serious	Not A Problem
1. Community people don't know about or understand the treatment program.	25%	37.5%	25%	12.5%
2. Community people have a bad opinion of the treatment program and use it as a last chance.		37.5%	44%	19%
3. Patients and their families don't believe the treatment will help.		19%	37.5%	44%
4. Patients returning home have problems because people know they were in a mental hospital.	6.3%	62.5%	19%	12%
5. People with traditional beliefs about mental problems won't use the treatment program.	12.5%	31%	50%	6%
6. People go to "Folk Doctors" instead of using the treatment program.		31%	69%	

Item #1 sets a clear tone of alienation: one-fourth of the respondents were maximally disturbed that their clinics were unknown or misunderstood by community people. Only 12 per cent found this not to be a problem. The stigmatizing aspect of psychiatry are tapped by items 2 and 4. There is "moderate" concern that the public is reluctant to become involved in the psychiatric system until the last possible moment (item 2). Yet, a strong consensus is held that once involved, patients cannot return to their homes without the burden of social stigma (item 4). This social taint association with psychiatric contact appears uniform throughout Southeast Asia.

The Hill Tribe people around Chiangmai have an additional fear associated with mental hospitals: the risk of being arrested for growing opium when they come from their mountain villages into the grasp of authorities. Once involvement has been established, however, rejection of the treatment offered and disbelief in its efficacy are not seen as major issues (item 3). What may be operating is either a mobilization of hope that comes from making the choice to come in for help or a cultural norm of not expressing negative attitudes toward someone in the position of authority (like a physician).

The issue of program rejection by tradition-minded persons is taken up in the last two items of Table 6.11. Here again it appears that respondents were mindful of an

incongruity between their service system and beliefs and practices of a segment of the population. Only one practitioner did not feel some level of concern associated with the problem of persons with traditional conceptions of disorder not using agency services. Forty-four per cent saw this condition as "moderately serious" or worse.

The use of folk healers in lieu of modern psychiatry was uniformly recognized as problematic. Interviewees did not denote the use of folk doctors as threatening. Yet, their esteemed position in Thai society, especially among the rural and less educated, has an influence upon the acceptance and use patterns of modern medicine. To the extent that indigenous healers (including Buddhist monks) are easily accessible, attend to patient symptoms in expected ways, and are viewed as effective, such healers perpetuate reluctance to use public services except as a final alternative.

The three sources of evidence regarding community integration of Thailand's mental health programs point unmistakably toward their isolation. Formal intercourse is minimal between institutional handling of patients and important figures in the patient's home environment who could be helpful. CGC was the only consistent exception to this rule. Community liaison with programs to help plan procedures and objectives was conspicuously absent, as were needs assessment approaches to find gaps in the resource

system. Finally staff expressed the opinion that their services were little understood, moderately stigmatizing, and somewhat alien to those who cling to traditional theories of health care. In short, there is good reason to suspect that the Thai mental health system is not well integrated and has little acceptability in the community as a whole.

Cultural Continuity And Accommodation
of Mental Health Services

Selected Examples

The final facet of Thai psychiatry explored is its accommodation to prevailing Thai culture. Available ethnographic accounts and interviews with therapists themselves suggest the presence of several prominent cultural forces guiding client and community commerce with mental health institutions. To the extent that individual facilities are responsive to these forces, it is assumed that their acceptability is enhanced along with their level of community integration and continuity. Examples of cultural accommodation in Thai agencies are reported along five dimensions: family involvement, popular and traditional theories of disorder, accommodation on the ward, staff qualities and mannerisms, and expected modes of therapy.

Thai family role in regulating commerce with institutions.

The Thai family organization plays a primary role in the lives of its individual members. Hence, the family must be understood by practitioners for its regulation of patient

involvement with outside helpers. Regarding matters of mental health, the family inculcates notions of individual identity, decides to tolerate or act on evidence of pathology, serves as the principal referral source, and follows its own set of expectations on what is proper involvement in interaction with health services.

Unquestionably, the immediate family grouping is by far the most powerful affiliation held by any Thai. Its primacy as a social unit cannot be overstated: while loyalty to the nuclear family is enduring, individual identity and cooperation with other social groupings tend to be transitory and ruled by pragmatics (Foster, 1965; Henderson, 1971). Resembling a modified Confucian system, the father is household head; children are raised by mothers or female members and taught to give high respect and obedience to parents (Sangskingkeo, 1969).

Some would characterize socialization as promoting an extreme dependence on the family which may lead to social withdrawal outside the comfortable kinship enclave (Stoller, 1959). However, balanced against this press for conformity is the fundamental Buddhist value of individualism. Each person must remain responsible first to him/herself because individual's actions are the basis of his/her accumulation of merit or demerit. Thus, we may expect that: 1) deviance is primarily the kinship group's concern; and 2) the wider community has little obligation in cases of individual

deviance, rather it permits the individual to follow his own path or create his own "karma."

Support for these two premises come from several sources. First, findings presented earlier (see Figure 3) indicated that family members were the dominant referral source into psychiatric agencies. Visuthikosol and Suwanlert (1977) observed that close to 80 per cent of Srithunya's admissions were brought by mothers, fathers, siblings, and children of patients. Readiness to refer and hospitalize appears to be based, as it was in the Philippines, more on the inability to handle violent and abrasive behavior than on distress at the presence of psychological impairment per se.

As previously noted, it was the aggressive and anti-social children who were over-represented at the Child Guidance Clinic. Extremely withdrawn, inhibited, and passive children (prominent in American clinics) are seldom brought in. In fact, therapists reported a high percentage of presenting complaints from family members centered on themes of violence and uncontrollability. Assaultiveness against others, burning down the house, and expression of paranoid ideas were mentioned as behaviors especially upsetting of the household and neighbors.

Sangsingkeo (1958) suspects that family over-protectiveness prevents some needy persons from receiving psychiatric care. Impaired women from well-to-do families sometimes pass their entire lives in the care of servants without the outside

world being aware of their status. This exact situation was described by Dasnanjali (1971) regarding the responses of families with retarded children. Seen as the results of reincarnation, the retarded child is simply fed, clothed, and cared for as the family's quiet burden.

Traditional theories of illness greatly influence family reaction to patients. When the cause is seen as temporary possession by a spirit or imbalance of body elements, relatives remain genuinely accepting of the person (Ionescu-Tongyok, 1977). Among villagers, spirit possession is a natural part of life and does not by itself become a sign of mental illness. Patients are only brought to a mental hospital when their exhibition of possession becomes uncontrollable and unmanageable in the home environment (Suwanlert, 1976). If self-treatment and home care prove ineffective and the condition is refractory to exorcist ministrations, the family is forced to choose hospitalization. (See discussion of traditional healing below).

Wider community reaction to the deviant is also as predicted. Sangsingkeo (1958) summarizes the attitude held with an old saying: "Don't mind the mad; add no blame to the drunk." The disease is given credit for the person's actions rather than the individual himself. The society allows great latitude for idiosyncrasy of expression. While deviancy is not condoned, it is considered the concern of the individual unless it becomes extreme. Ionescu-Tongyok

(1977) feels that it is the overriding rule of politeness, of avoiding embarrassing topics or things that effect the person deeply, which leads to an outward indifference and non-involvement toward deviant behavior.

Besides deciding which behaviors give cause for referral and where to take the patient, the family also decides the role it will enact vis á vis the agency and what to expect from the institution in return. According to treatment personnel, the dominant family expectation is that hospitalization will achieve a complete, almost immediate cure, returning the person to normalcy. They expect that it will take only one or two sessions so they don't have to keep returning to miss work or classes. Moreover, the family has its own timetable on hospitalization. In some cases, when improvement is not immediately forthcoming, the patient is brought home. This also occurs when the family detects the slightest sign of improvement.

At other times, the family abandons patients to a lifetime of hospital care. Abandonment happens more often with chronic cases and when relatives cannot afford the burden of patients at home. For the most part, staff perceive families as not preferring to take an active role during hospital care. Some families, in fact, refuse to visit until they are assured the patient is normal. As a general rule, the sites visited reported only rare cooperation with relatives for treatment plans. Most came for

visits only occasionally, bringing food or money. Relatives formally spoke with staff only at intake and discharge conferences.

Examples of facility efforts to accommodate to the Thai family system include earlier descriptions of attempts to involve family members in hospital and post-discharge care. (See sections on continuity of care into the community and community integration through involvement in treatment). Specific accommodation practices noted were: PYO's building a hostel for the parents of children brought there for assessment; family education groups held regularly at PYO, CGC, and SH; occasional family therapy sessions to change the home environment at CU and CGC; and utilization of families in after-care responsibilities.

Other examples of accommodation to the family system were also discovered. As a neurological treatment center, PN admitted acute psychiatric patients whose families feared that their reputations would be damaged by admission to an acknowledged mental hospital. Before administering ECT, PN asked for consent from the family to insure their cooperation with the most extreme measures of treatment. SP and SH approve family requests for permission to visit native healers where ceremonies are arranged and holy water acquired for purification. Finally, recent community psychiatry experimental wards at SH include group sessions with relatives of patients. Family members of patients on those

wards meet to talk with one another on how home care should proceed after discharge, especially how to get the patient to take medication.

In short, agency liaison with patients' families is tenuous up until the point of discharge when efforts are usually made to encourage family participation in an after-care scheme to protect the patient. The lack of involvement prior to that time seems to reflect a mutual agreement. The institution would prefer no interference from the family in its regimen and the family turns over responsibility to the physicians for a cure. If a cure is not forthcoming or it takes too long, families decide either to take their members elsewhere or abandon them to lifetime custodial care. However, there may be a far larger population of potential cases whose families never brought to the attention of these institutions. They take disturbed members to local specialists or simply tolerate them within the home or village. Failure to use institutions may be due to accessibility barriers or family preference for local resources.

Accommodation response to popular traditional conceptions of disorder. Service users carry into treatment a rich array of popular conceptions and folk theories regarding the nature and causes of their illnesses. Anthropologists have observed that this collection of explanatory notions and nosologies do not form a single, self-contained or integrated system. Rather, they represent

a synthesis of often competing sub-systems based on animist traditions, Buddhism, contact with Hinduism and Chinese folk beliefs, plus a dash of Western medicine (Hinderling, 1973; Kunstader, 1975). Major lay explanations are at variance with mental health workers' understanding of psychopathology. Such conceptual discrepancies offer opportunities for cultural sensitivity and accommodation on the part of hospital personnel.

Anthropologists have identified four major indigenous theories of disorder based on ethnographic studies in Central and Northwestern Thailand (Hanks, 1968; Hinderling, 1973; Kunstadter, 1975; Suwanlert, 1976; Textor, 1960). The two most prominent of these explain illness by the Ayurvedic doctrine of thaad (Muecke, 1978) and the intrusion of foreign elements, both physical and supernatural. Thaad refers to the belief that the human body is composed of various elementary substances in balance with one another. When there is a disturbance in the earth, fire, water, and wind body elements, the person becomes ill. Therapy restores equilibrium, returning the person to health.

The penetration of foreign elements also brings illness. Two sorts of substances may enter an individual--spirits or particles sent by spirits or persons practicing black magic (khun khon). Illnesses caused by witchcraft or the incantation of a magic formula (khatha) are thought rare in Thailand. They are difficult to diagnose and only

recognizable by social circumstances such as arguments over land rights (Kunstadter, 1975; Hinderling, 1973). There are many classifications of spirits, though, including the souls and angels of the Hindu Pantheon (thewada). Possession by these spirits is generally desirable as it blesses the individual with "higher powers."

However, the intrusion of phii spirits is associated with sickness and mental illness. Kunstadter (1975) found that among the Hill Tribes of Northern Thailand, phii spirits were said to cause illness in order to call human attention to their desire to be fed an animal sacrifice (Kunstadter, 1975, p. 357). Phii spirits emanate from the dead (especially those who die violently or away from home) and from other living persons, sacred things, or from the village itself. There is risk of possession when persons violate incest or exogamy taboos, are absent from the village without proper spirit propitiation, and when other native customs are disrespected. Possession may also follow family quarrels or wandering near the place where a violent death occurred (Kunstadter, 1975; Suwanlert, 1976). Cases of spirit possession were familiar to Thai psychiatrists working with rural populations. Dr. Suwanlert at SH has undertaken an extensive investigation of possessed patients.

Soul loss and "sin" or "Karma" are two remaining notions of illness etiology. Khwan is the Thai concept of body-spirit or life-soul which can reside either inside or outside

of the body. Khwan bestows life, health, and prosperity when it remains inside. If Khwan slips away and becomes lost or injured, the person may become ill, chronically weak, or even die (Henderson, 1971; Kunstadter, 1975). To bind in the Khwan sick persons have their wrists tied with a piece of unspun thread after a ceremony designed to recall all 32 parts of their Khwan (Henderson, 1971).

Buddhist teachings stress that people, through actions, accumulate merit (bun) and demerit (bap). The balance of merits and sins determines one's fate or future life form through reincarnation. Kunstadter (1975) notes that "be good, get good" is a Thai prescription for prevention of illness as disease is sometimes regarded as the results of past sin. However, Hinderling (1973) points out that this does not necessarily lead to a fatalistic attitude toward sickness. Except for certain handicaps and deformities, karma is not thought of as a direct cause of the problem. Yet, in the instance of congenital birth defects and mental deficiency in children, there is a tendency for parents to view these as reincarnation and not to seek out special services or education for the child (Dasnanjali, 1971).

A final folk diagnosis, lom (meaning air or wind) is worth mentioning because of its focus on mental status. According to Kunstadter (1975), a person with this condition experiences faintness and loss of consciousness, occasionally has seizures, and may talk in a meaningless and incoherent

manner. Extreme lom is interpreted as direct contact with the spirit world.

Juxtaposed with these historically colored folk theories are another set of perceived causal agents used by patients and their families when they enter mental institutions. Sifting through staff descriptions of typical problems (Section 1 of Questionnaire #2), there appear to be three dominant popular conceptions of psychopathology. The most common understanding relates the problem to a physical anomaly. As in Taiwan and the Philippines, the vast majority of patients complain chiefly of physical discomfort. Frequently mentioned are chest pains, "heart attack," headache, insomnia, weakness, loss of appetite, weight loss, stomach ache, etc. At other times, the problem is said to be caused by "bad nerves" (prasart) or a neurological disease. It is expected that the physician will check out the brain and nervous system. Loss of physical strength through masturbation and excessive coitus is a reason sometimes cited by parents.

A second lay interpretation attributes disorder to overwhelming life burdens. Children develop problem behavior before difficult exams or when they haven't studied enough and are failing school. Adults become disturbed when they lose a spouse or parent, when they have to work long hours for little pay, when they feel inferior about their jobs or educational status, and when there is conflict among family members.

Thirdly, moral violations are thought to foster disturbed behavior. Young Chinese men were reported to have strong feelings of guilt regarding masturbation or homosexuality--taboo activities in the eyes of their elders. Guilt associated with sex was even more intensely experienced by Muslim patients from the South. Islamic precepts condemn persons for acts of premarital or extramarital intercourse. One patient at SH was found to have hysterically-induced seizures triggered by guilt after sexual activity. Conflicts related to sexual behavior were voiced by women in ward therapy sessions at SH. These women voiced distress at their spouses' infidelity and the practice of taking a concubine once the wife began raising the children. This was also a source of anxiety among Suwana's (1969) female patients seen in private practice in Bangkok. It is not surprising that the same women at SH revealed problems with orgasmic dysfunction and impotency on their husbands' part.

Along similar lines, RH's psychologist had a substantial caseload of men complaining about premature ejaculation. He felt that this problem was endemic in the population due to the fact that Thai men are socialized into an egocentric view of receiving pleasure from their sexual partners. This view hinders their ability to reciprocate in sexual activities and attend to their partners' needs.

Although informally conceived and carried out, institutional accommodation to indigenous theories was noted at

several locations. First, doctors seeing patients from Northern Thailand had direct experience with spirit possession cases. Most other practitioners had a general awareness that folk theories existed although only a handful were deeply interested in the content of these beliefs. At the time of this study, Chiangmai psychiatrists had one case of a young girl who had visions of an angel asking her to die and join it in a mountain near the old Thai capital. Another case was a young man who had thought his mother was a phii spirit because she would go at night to the water closet, so he attacked her to drive away the phii.

Bangkok therapists also reported instances where patients interpreted physical symptoms as spirit-induced. RH staff were treating clients with phobic reactions to the "spirit houses" kept in the gardens of many Thai homes. Along similar lines, one Bangkok patient explained his disorder as the consequence of urinating too close to a spirit house.

Dr. Sagun Suwanlert at Srithunya Hospital is the recognized expert in diagnosis and treatment of spirit possession. After observing several dozen cases, he concluded the following: 1) Doctors themselves must bring up the question of possession since clients fear being scolded for prior contact with native healers; 2) "Neurotic possession" lasting 48 hours or less occurs among individuals with "hysterical" personalities facing seemingly insoluble problems; 3) "possession psychosis" is the diagnosis of those

brought into the hospital after lengthy exorcism has failed to drive out the spirit; 4) Possession itself is manifested in several stages--the most intense period characterized by numbness of limbs, convulsions, rigid body, muscle spasms, and speaking the name of the possessing spirit followed by a period of exhausted sleep and amnesia; 5) Possession may be viewed as a socially sanctioned mechanism for handling internal and social conflicts: in trance states, persons can command superior family members to kneel before them or carry out tasks; and 6) Therapy with extreme cases may take up to a week; it includes injections of major tranquilizers or anti-depressants and supportive talk therapy focused on the problems leading to the possession episode (Suwanlert, 1977).

Suwanlert's culture accommodation tactic is to initiate his medical and psychological intervention only after a thorough understanding of how different spirits affect patients who perceived themselves as possessed. A second tactic is to simply maintain a permissive attitude toward patients who pay homage to folk beliefs as long as it doesn't directly conflict with the clinic regimen. At CGC, staff faced with persons insisting that they are possessed simply accept the idea but continue treating what they see as the problem in their own way. Therapists don't attack the belief directly but may offer their own conceptualization during the course of counseling. Neither CGC nor SP staff object to patients visiting folk specialists. In fact,

families at SP are allowed to take the patient out to visit priests or herbalists to get holy water treatment if they ask. Other instances of accommodation to both Thai family patterns and conceptions of disorder are found within ward activities, staff personal manner, and expected therapeutics described below.

Accommodation in ward activities. Ward-level practices reflecting sensitivity to client background variables and life styles were noticed in most institutions. Perhaps the clearest example of this type of accommodation is undertaken at the Buddhist Priest's Hospital in Bangkok. This hospital was set up to serve only priests and novices: it is considered improper for them to mix with laymen in general hospitals. The medical attendants there are all males in line with the taboo against women touching priests. According to the hospital's former chief psychiatrist, Dr. Dusit, psychiatric conditions and pulmonary tuberculosis account for the majority of intakes (Dusit, 1972). Psychosomatic and neurotic complaints predominate, and many priests are addicted to bromide drugs taken to relieve psychophysiological symptoms. Since priests are not supposed to have problems and are presumably masters of self-healing, they are reluctant to admit psychological concerns. Physicians must be extremely cautious in their questioning to accord these holy men proper respect. Drug therapy for "diseases of learned men" is deemed most appropriate (Dusit, 1972).

Culture accommodation to language was also noted. Most agencies had staff proficient in the various Thai dialects so linguistic matching was common. Hmong and Karen Hill Tribe persons were sometimes brought to SP by missionaries for drug dependence, intoxication, toxic psychosis, and post-partum psychosis. On these occasions, the language barriers were handled by translators from the nearby Chiangmai Hill Tribe Center.

Moreover, SP made special provisions to ease the admission shock of tribal people. Because it is difficult for them to mix easily with the Thai patients, they are taken off the admission ward as quickly as possible, housed together, and rapidly placed on medication to reduce agitation. These procedures are done so that relatives can take them home as soon as possible. Staff feel that psychotherapy with this population is quite unrealistic because of language and educational differences.

Accommodation was evidenced in other psychiatric wards. Permission is granted at CGC, SH, and SP to attend outside healing rituals although ingestion of medicines from folk doctors is frowned upon. Recreation and occupation therapy at SP and CU focus on familiar, enjoyable, and satisfying activities such as sewing, knitting, flower-making, gardening, group singing sessions, and folk dancing.

SH and SCP have pioneered in the design of ward groups as therapeutic communities. Their patients come together to support one another; some assume leadership roles to

represent patient viewpoints to the staff. Initially, it was thought contrary to Thai social norms for people to speak in groups. In fact, patients would not speak when their group leaders (therapists) acted in an authoritarian manner. After ten years of observation of ward groups, it was found that patients have free communication when discussing ward administration, treatment programs, and even their own problems, when the therapist creates a permissive and relaxed atmosphere (Visuthikosol & Suwanlert, 1976). However, group psychotherapy at SP was discontinued on the male wards when it was found that their participation was minimal.

Other accommodation practices aimed at "normalizing" the hospital atmosphere. Certain SP staff reside on the hospital grounds and invite patients to visit them in their living quarters. SCP administrators are trying to make the hospital more "homey" through new dorms without bars and the planned addition of recreation, reading, and group activity rooms. SCP prides itself with its lovely and well-tended gardens. The trees and flowers are being preserved against the press for more space because historically they have been grown as therapeutic instruments to "calm the mind and lift the spirits." Nevertheless, hospitals in general have negative emotional loadings for rural Thai; these may prove difficult to overcome. First, they evoke anxiety linked to dying away from home. Thus, the hospital is a dwelling place for malevolent spirits. Secondly, unfamiliar

people of higher status and power are encountered there; customary forms of social interaction seem no longer valid. This uncertainty, too, gives rise to user discomfort.

Accommodation through staff qualities and mannerisms.

When asked their understanding of what the therapist's personal manner should be to fulfill the expectations of Thai clients, most respondents expressed similar opinions. Expected professional manner had two prominent qualities: 1) Present oneself as a respectable authority figure with expertise and advice which should be followed; and 2) Temper the authoritarian quality with warmth, friendliness, calmness, and above all, a helpful and cheerful attitude. Since social norms dictate passivity and deference to those of higher status, therapists wishing open communication with their clients recognized the importance of downplaying their position as authority figures. They did so through a warm and easygoing style of interaction.

Moreover, to establish a good working relationship in counseling, embarrassing topics were not brought up in initial sessions. One psychologist, using deep muscle relaxation, remarked that he avoided having female clients tense and relax their buttocks muscle group because he believed it would offend them. Apparently, problems related to sexuality are most embarrassing and require an extremely gingerly approach to bring out. The profound "shyness" of some psychotic patients in the presence of authorities is such that it may take 80 to 100 sessions before the patient

freely expresses himself in therapy interactions (Suwanlert, 1970).

Boesch (1972) and Hinderling (1973), analyzing communication between patients and doctors (including folk doctors), bring to light other important attributes of physicians influencing their relationships with clients. First, patients and doctors occupy different strata of the Thai social hierarchy and hence have no basis for a customary relationship founded upon mutual dependency and loyalty. Unless ill, a patient would strongly hesitate to approach a person of the doctor's status (Boesch, 1972, p. 72). He would be more comfortable if introduced by a relative or friend of the doctor, bringing the medical relationship into one of more traditional loyalty.

In other words, status imposes barriers and evokes suspicion in the patient because he has no power in the relationship except to reciprocate through money. Differences in education, thinking styles, and basic social values heighten the inability of the two parties to communicate. The physician has another strike against him as a government officer. Historically, rural people associate government agencies with control and taking rather than providing; they lie outside of the bonds of mutual loyalty which bind people in the village (Boesch, 1972, p. 27).

On the other hand, these investigators stress that patients visiting health centers did have expectations that

the physicians were competent in diagnosis and therapy, especially when treating serious diseases (Hinderling, 1973). Suffering patients were more inclined to travel to a modern physician than to continue treatment with a local, albeit familiar, native specialist. These same patients were critical of the businesslike, arrogant, often scolding, and inattentive manner of some doctors. Their preference was for someone who consoled them, who explained the illness in a manner which would allow them to have confidence in the healer's knowledge, and who took enough time in the consultation to give the patient a feeling of contact and being looked after. Amazingly, Boesh (1972) found that most office interviews lasted only two minutes. The patients had 10 to 40 seconds of speaking time to explain their problem. Only a handful of the physicians observed did show sensitivity to these expectations and took the time to console and explain the diagnosis in a friendly, understanding manner.

Providing expected therapeutics. Logically, patients anticipate modes of intervention which follow from the perceived roots of their distress. Since lay beliefs attribute disorders to physical anomalies expressed somatically, psychiatrists are expected to immediately administer medication, or pause long enough to do a brain x-ray or EEG pinpointing what is wrong. Families are particularly keen on the physician using "strong, expensive

medicine," perhaps even "medical shock" to modify the mind. They want the same "strong medicine" that is supposedly reserved for private patients because it is deemed most curative.

Drugs administered through intra-muscular injection have higher credence than oral medication. Hope is expressed that one or two injections of the right chemicals will bring an immediate reverse and cure. In some cases, there is no expressed expectation about type of approach other than a generalized hope of expert help from the staff. Some families simply insist on locking the patient up and the longer the better.

It is safe to conclude that just as in Taiwan and the Philippines, clients in Thailand are looking for strictly physical as opposed to psychological therapies. Help through a cognitive process leading to resolution of psychological conflict is unfathomable except to those urban elite whose educational experiences provide them with a Western view of man. Recognizing this, CGC staff start counseling with an orientation session to describe their approach.

Older adults hope to see a physician rather than a psychologist or social worker and are less accepting of psychological orientation than younger persons. In any event, therapists seek to be directive and supportive. They give explicit advice on how people should change rather than following a reflective, non-directive model. At one time, CGC tried to initiate group therapy sessions but found

a strong opposition which they attributed to a dislike for sharing personal secrets in front of others, especially strangers.

The psychiatrist at CU follows a pills and injections regimen initially to meet patient expectations and build rapport and compliance. Then he shifts to a cognitive-behavior modification strategy based on applying Buddhist meditation. Meditative states are derived through Jacobsonian deep muscle relaxation and breathing exercises. Dr. Chomlong reported employing this integrated behavior therapy/religious meditation technique principally with anxiety-prone patients and those suffering from tension headaches and hypertension.

Possession cases at Srithunya are handled using an accommodation formula worked out by Dr. Suwanlert. First, the patient's beliefs are studied, particularly his schema of the nature of spirits and ghosts. Questioning is then done to learn which symptoms are attributed to possession. It is thought that physician familiarity with the patient's spirit concepts will help explain to the patient the relationship between disturbing states and the personal conflicts causing them. Finally, low dosages of major tranquilizers and supportive psychotherapy taking into account the possession fears are provided.

Suwanlert (1977) adds that the effective psychotherapist, while accepting the patient's schema, must reinterpret it for himself in "modern" concepts of mental illness.

Gradually he should educate the patient to a more rational understanding of his particular problem. Other Thai psychiatrists and counselors endorse this "re-educative" approach for those holding folk conceptions.

In essence, the medically-based regimens of hospital settings appear to fit nicely with popular conceptions of disorder as a physical/neurological illness. For those who are psychologically minded--or can be induced into an alternative framework for viewing their problems--talk therapy is readily available. Dr. Suwanlert has led the way in designing ways to sensitively handle those maintaining traditional ideologies of illness and suffering from spirit possession.

Staff Perceptions of Culture Accommodation

In conjunction with gathering examples of culture accommodation, staff were asked to rate the availability of certain procedures and to express their personal attitudes on the utility of employing them with traditionally-minded patients (Questionnaire #3). Table 6.12 suggests that most respondents perceive their agencies as accommodating in terms of: 1) Staff adjust their personal manner to fit patient expectations, and 2) Inpatient activities are similar to their activities outside the hospital.

Specific examples of these were detailed on pages 480 through 487.

A slight majority of interviewees indicated that their

Table 6.12

Perceptions of Institutional Accommodation Practices (N = 12)

Accommodation Practice	Percentage of Staff Endorsing Accommodation Item	
	Always/Sometimes	Seldom/Never
1. Native healer involvement in patient care		100%
2. Staff seek to re-educate those with traditional beliefs about mental problems	92%	8%
3. Staff adjust their personal manner to fit patient expectations	83%	17%
4. A policy exists to find staff whose backgrounds are similar to those of the patients	33%	67%
5. Inpatient activities are similar to their activities outside the hospital	91%	9%
6. Patients make choices about their daily activities	65%	35%
7. Patients are encouraged to participate in community activities outside the hospital--work and recreation	65%	35%
8. Patients' family helps with hospital care	35%	65%
9. Problems occur because patients and staff have different social backgrounds	39%	61%

programs permitted patients to make choices about their daily activities and encouraged them to remain involved in work and recreation outside the facility. These two accommodation approaches were in evidence at hospitals with therapeutic community wards, at those offering occupational rehabilitation units, and where families were permitted to take the patient to outside healing rituals.

In marked contrast, staff report shutting out two aspects of patient cultural experience by eschewing native healer involvement and trying to re-educate those with traditional beliefs about mental problems. It was brought out earlier that even clinicians sensitive to the influence of folk theories on patient experience of psychopathology still work toward the goal of introducing more "modern" concepts into the patients' understanding of their problems. Finally, agencies have yet to introduce policies to involve family members in treatment or hire staff whose backgrounds are congruent with those served even though 40 per cent exclaimed that problems do occur because patients and staff have different social backgrounds. This finding fits well with Boesh's (1972) discovery that social distance between physician and patient disrupts efficient delivery of health services in general.

Table 6.13 presents the results of Questionnaire #3; staff evaluation of the utility of 16 accommodation procedures. Respondents sampled included ten psychiatrists, nine psychologists, three social workers, and one psychiatric nurse.

Table 6.13

Staff Endorsement of Culture Accommodation Dimensions (N = 23)

Accommodation Statement	% of Staff Endorsing Statement
1. Staff should know the traditional names for mental disorder	100%
2. Staff should know the traditional healing practices for mental disorder	96%
3. It is useless for staff to know the traditional beliefs about the causes of mental disorder	96% disagree
4. Community leaders should help in planning and directing facility activities	96%
5. The doctor alone should decide what the appropriate treatment outcome will be	96% disagree
6. Staff should adjust their professional manner to fit the expectations of patients from different social backgrounds	91%
7. While in the hospital, patients should remain isolated from community activities	87% disagree
8. The patient's activities in the hospital should be similar as possible to their activities in the community	87%
9. Patients should go to large central hospitals for their treatment	87% disagree
10. What is considered the appropriate outcome of treatment should be different for different cultures	83%
11. It is best to hire staff whose social backgrounds are similar to those of the patients	70%
12. The patient and his family should help choose the type of treatment given	66%
13. What is considered "normality" or "good personal adjustment" is the same for all cultures	65% disagree

Table 6.13 (continued). Staff Endorsement of Culture
Accommodation Dimensions (N = 23)

Accommodation Statement	% of Staff Endorsing Statement
14. Only those trained in scientific treatment techniques are qualified to help people with mental problems	65% disagree
15. It is useless to consult with native healers since most of them cannot really help patients with mental problems	57% disagree
16. Staff should try to correct or re-educate patients who maintain their traditional beliefs and customs about mental disorder	13% disagree

The overall endorsement pattern of these professionals mirrors that found for Taiwanese and Filipino respondents: nearly three-fourths of the procedures are overwhelmingly endorsed as useful. Moreover, several items receiving minimal support were the same for all three countries: especially, "Staff should try to correct or re-educate patients who maintain their traditional beliefs and customs about mental disorder."

In essence, those sampled strongly indicated that staff should know the traditional names, beliefs, and healing practices related to mental disorder; community leaders should have a planning role in agency development; doctors do not have a monopoly on treatment goals and such goals differ between cultures; staff should adjust their professional manner to fit expectations; and patients should not go to large central hospitals nor be isolated from the community, but should be exposed to activities which are as similar as possible to outside lifestyles.

Other conclusions may be drawn from Table 6.13. There was less unanimity of support for statements regarding hiring staff based on social background, family and patient choosing treatments, cultural relativity of "good personal adjustment," and the appropriateness of therapists without "scientific" education. Interestingly, although Table 6.12 revealed that there was absolutely no folk healer involvement within these sites, almost three-fifths were of the opinion that folk healer consultation did have some merit.

This may contribute to the willingness of agencies to permit forays to healing temples during hospitalization. Lastly, in line with item #2 in Table 6.12, 87 per cent believed that staff should indeed try to correct clients whose thinking includes folk explanations of their sufferings.

In conclusion, culture accommodation at Thai mental health facilities is most intense at the ward level. This is exemplified by the uniquely designed hospital solely for Buddhist priests, widespread linguistic matching, efforts to release minority patients such as Hill Tribe people as rapidly as possible, the popularity of therapeutic community wards, an emphasis on recreation and occupation therapy, and the lovely gardens included as important parts of hospital milieu. These efforts fall under the rubric "Making in-patient activities as similar as possible to activities in the community."

Secondly, Suwanlert's transcultural approach to psychiatry is an outstanding model of accommodation. His efforts are guided by the recognition that if local psychiatrists treating possession cases "have no insight into practices relevant to transcultural psychiatry, they may never find real answers to patient problems" (Suwanlert, 1977, p. 8). This recognition has led him to study regional theories of mental disorder thoroughly and incorporate these cultural insights into assessment of possession cases and clinical responses to them.

Although vitally important, the weakest domain of accommodation is to the cultural peculiarities of the Thai family system. The family is central to the person's life, is active in choosing treatment location and time, and expresses ingrained suspicion of government institutions. Only at the point of discharge is there motion towards the family to cooperate in decreasing the likelihood of a readmission. The Child Guidance Center, a program closest to the concept of a community mental health center, does the most to guide complete family involvement in all steps of intervention and often assigns home visit duties to certain workers. This model is unique, however, due both to traditional hospital regimen and scarcity of outreach manpower.

INDIGENOUS ALTERNATIVES TO MENTAL HEALTH CARE

Beyond the isolated and Bangkok-centered enclaves of psychiatric medicine are a rich array of healing alternatives to which rural (and some urban) Thai turn in times of trouble. This section concludes the case study of Thai mental health resources with a brief sketch of folk specialists, their availability, the basis of their selection by clients, and the social consequences of folk therapy. This overview of the non-medical system was derived from anthropological references, discussions with Thai ethno-psychiatrists, and the author's own observations of a shamanic healer at work in his temple in Dhonburi (c.f., Boesh, 1972; Hinderling,

1973; Ionescu-Tongyonk, 1977; Suwanlert, 1976a, 1976b, 1977; Suwanlert & Coates, 1977; Kunstadter, 1975).

Deciding When to Seek Specialist Attention

Although they do not comprise a unified system of medical theory, the collection of indigenous beliefs of psychopathology maintain a strong hold on Thai perceptions of illness and what must be done to alleviate abnormal conditions. Prominent explanatory systems previously cited were the thaad system, penetration by foreign elements, loss of soul, religious merit, and the diverse popular explanations like neurological damage, stress, and moral violations. The implications for intervention are naturally quite divergent, depending on which explanations are evoked.

Recognition of serious interference with normal psychological functions--or expectations of function given a person's age--initiates the process of classifying the illness into one of several categories. Each is distinguishable from another in terms of symptoms, causes, treatment indicated, and probable outcome (Kunstadter, 1975, p. 355). Home remedies are the first line of defense for certain perceived dysfunctions (Goldschmidt, 1972). In the case of soul loss, for example, most household heads among hill people can and do perform the correct ceremony to summon and feed the souls at times when persons are thought to be in a high risk condition (Kunstadter, 1975).

Sometimes, recognition of ill health prompts a

consultation with a fortune teller for advice on which of the many folk specialists available is most proper (Suwanlert, 1976a). On these occasions, Kunstadter reports that it is not unusual for patients among Northern Thai and Hill Tribes people to draw upon the medical system of another nearby ethnic group. Unconstrained by cognitive dissonance, individuals appear willing to participate in the medical practices of another culture based on such practical considerations as convenience, low cost, high perceived effectiveness, and even social prestige (Kunstadter, 1975). It is this exact situation which gives rise to the referral of a patient to a psychiatric hospital, in itself a cross-cultural expedition. When the exorcism ritual fails after 48 to 72 hours to dislodge the possessing spirit, the family may resort to a mental institution (Suwanlert, 1976b).

Availability and Use of Folk Practitioners

Just as in the Philippines, folk healing thrives in contemporary Thailand. Traditional doctors are still more numerous than modern ones and engage in a full array of specialties (Boesh, 1972). Some types are required by the government to register. While 15,000 of these eligible traditional practitioners did register in 1970, most monks, herbalists, spirit doctors, self-taught dentists, etc., went unrecorded (Henderson, 1971).

The country's greatest supply of indigenous mental health manpower are its 250,000 Buddhist monks and novices

(Sangsingkeo, 1969). Working from some 22,000 wats, the priests act as front-line therapists giving advice and guidance: instructing troubled individuals to meditate to remove anger and frustration. In a survey of villagers' attitudes toward mental illness, Kamratana (1973) discovered that 25 per cent preferred to have impaired persons treated by Buddhist priests through incantation and spraying of lustral water.

A substantial percentage of both rural and urban Thai make use of the indigenous health system. Many follow the pattern noted in Taiwan of moving from one practitioner to another to get the most satisfactory results. Woolley (1974) asserts that when people become physically ill in urban areas, 50 per cent use traditional healers, drug stores, monks, or self treatment while 66 per cent in rural areas use these same methods. For those cases of possession admitted to Srithunya, Suwanlert (1977) found that 90 per cent of the females had first gone to native healers for pre-hospital treatment.

In a unique opportunity to study reliance on folk therapists for a specific psychological condition, Suwanlert and Coates (1977) interviewed 350 patients in Northeastern Thailand during the 1976 koro epidemic. Koro is a culture-bound syndrome characterized by extreme panic resulting from the impression that the penis is shrinking and retracting into the abdomen and followed by death. Fostered by ethnic

animosity and unstable political conditions, the epidemic affected approximately 2,000 men and women. Among those interviewed--a typical cross-section of young village men--70 per cent sought help from native healers, 20 per cent made their way to local hospitals, and 5 per cent went untreated. Thus, for koro, folk treatment was deemed most appropriate. It consisted of ingesting concoctions of watermelon, peppermint, field crabs, and raw eggs or application of a moist local tuber used on other occasions to prevent drunkenness (Suwanlert & Coates, 1977).

In summary, the rate of reliance on folk healers is determined by type of problem, how it is conceptualized, ease of access to different specialists, and the educational attainment of the patient (Woolley, 1974)

Therapist Qualities and Behaviors

Besides availability at the village level and perceived expertise for culture-specific syndromes, Thai folk practitioners maintain an interpersonal style and approach to healing which draws patients to them. Their clientele expect the therapist to be an acquaintance and give personal attention. Clients also wish to be consoled through a quiet and solemn ceremony, to receive a full explanation of the disease so the therapist's knowledge can be judged, and above all, to be given advice on how to cope with the illness to reduce the sense of helplessness (Boesh, 1972).

Another important attribute of the native healer is his

low fee. Even if government medical attention were free, the cost of travel, room and board for an accompanying family member, and medicine itself are grave burdens for most farming families (Hinderling, 1973). Hinderling suggests that traditional doctors who charge very little or even provide financial assistance to patients do so out of a commitment to the well-being of fellow villagers. Acting like social workers, they have deep sympathy with the problems others face and are compensated through the confidence people have in them and the making of religious merit (Hinderling, 1973, p. 74).

Many of the folk specialists observed by Hinderling practiced as a sideline. They were often retired rice farmers living in houses like those of other villagers. Treating their clients as equals, their payment was usually some small present. Clients were often neighbors who visited before or after work in the fields. However, once a reputation for curing develops, it attracts far-reaching patients (Hinderling, 1973, p. 67).

Types of Folk Specialists

Choosing a native specialist is a complex, ongoing process. It is potentially influenced by problem classification, astrologers' predictions, income, resource proximity, therapist manner and reputation, and satisfaction with treatment. The practitioners available for consultation and the methods they employ are diverse and often unique

to each region. For a deeper insight into the indigenous healing system undergirding Thai society, the major classes of specialists are described along with their associated interventions.

Buddhist monks are a principal source of mental health care. They always seem willing to offer food and shelter to vagrants, the disabled, and those with psychiatric needs but without families' assistance (Henderson, 1971). Priests have always encouraged tolerant and understanding attitudes toward social unfortunates, using their wats as excellent refuges and rehabilitation centers for pre-psychotic and pre-delinquent individuals (Stoller, 1959). Monks who have a knowledge of folk medicine frequently gain a reputation as successful healers (Dusit, 1972). Possession cases choose these monks hoping that the spirits will be expelled by the sacredness of the pagoda and religious ceremonies using powerful holy water (Suwanlert, 1976). In this regard, Visuthikosol and Suwanlert (1977) report that Buddhism has special teachings for the care of sick and medication techniques which help to discipline the mind.

Conversations with priests are akin to psychotherapy. One priest has received international recognition for his healing powers. Priest Phra Charon at Wat Tambrabok has reportedly "cured" 1,000 drug addicts in recent years and was given the Ramon Magsaysay Award for humanitarianism by the Philippines. Based on such effectiveness, some officials hope to involve priests in a program of early diagnosis and

referral for such cases. Others seek to close Phracharon's Clinic claiming that his methods are not "modern" or "scientific." Mystical cults following similar regimens of worship, prayer, and meditation to deal with various human shortcomings are scattered throughout Thailand. Some are rather well-organized with local native healers and monks acting as gurus.

Hinderling (1973, pp. 64-65) has conveniently summarized the remaining categories of healers who function outside the Buddhist wat. These seven therapist types are reproduced in Table 6.14. Included are details of the theories, educational status, and healing methods associated with each type.

The herbalist occupies a central position since frequently he is recognized by the government as the official village "doctor." A few even receive a subsistence salary for their duties. Recently, though, this assignment is being given to those with more training--such as the "modern type"--who may in fact be certified male nurses.

The exorcists and minor exorcists are observed most often by mental health researchers as their role most closely parallels that of the psychiatrist. Many patients have had dealings with exorcists prior to hospitalization. A unique feature of exorcists is their direct communication with spirits by means of a trance. This permits identification of the intruding spirit and knowledge of where and how deeply embedded it is. Expulsion depends on the psychological

Table 6.14

Categories of Folk Specialists

Type	Explanatory systems, education, knowledge	Methods of healing
herbalist	Emphasis lies on traditional system of "thaad". Diseases are mainly attributed to disturbances of the balance in this system, with seasons, age, etc. Often important knowledge of herbs and drugs.	Mainly by herbs and drugs whose preparation and taste play a part. Prayers and holy water are only used additionally. A few medicaments of Chinese origin.
midwife	as herbalist	Basically as herbalist with interest in modern methods. Totally rejects spirits and magic.
mixed type	Systematic-traditional in relation to anatomy, i.e., like herbalist relatively modern in relation to germs. Often important additional modern medical knowledge.	Combination of traditional with modern methods according to experience. Even own experiments; sometimes Chinese medicaments; mainly practice-oriented.
modern type	Training as male nurse. Explanations based on modern system, occasionally mixed with traditional explanations, "thaad" system not well known.	Modern medicines. Injections. Often cooperation with hospitals. Very occasionally herbs or Chinese medicine.
quack	Ad hoc explanations without systematic background, because of lack of education and little knowledge. Can be either modern or traditional.	Injections, if learnt modern and Chinese

Table 6.14 (continued). Categories of Folk Specialists

Type	Explanatory systems, education, knowledge	Methods of healing
exorcist or spirit doctor	Traditional "thaad" system, known but emphasis on "foreign elements". Certain knowledge of herbal medicines but little practice.	Exorcism by holy water, beating, blowing, flour, etc. Also aided by "Buddhist" instruments. Herbs only occasionally used.
"minor exorcist"	Explanation, of given, is usually magical. Only little medical knowledge.	Magic-exorcistic with holy water, blowing, prayers, flour, etc. Only individual, special patients are treated. If knowledge sufficient, herbs, Chinese and modern medicament will be used.

and physical strength of the exorcist and his experience in handling resistant spirits. Many Northern Thai communities have women mediums (chao nai or moh lum) who specialize in diagnosis of illness through trance or spirit possession (Kunstadter, 1975; Suwanlert, 1971).

Table 6.14 suggests that therapeutic procedures are specific to therapist type. Sangsingeko (1965) reports that treatment methods were rather punitive historically. One approach required drawing blood, starving the person, and forcing him to take laxatives. It was reasoned that as these methods reduce energy, "insanity" will then diminish with it (Sangsingeko, 1965, p. 4). Hysterical patients had blood drawn three times at three-day intervals. If there was no recovery, they were then chained and beaten unconscious if the hysteria continued. Today, some exorcists continue to use punitive measures such as burning chili peppers in front of the patient and beating him with a rattan whip to drive out malevolent spirits.

Other methods relied upon by the different specialists are less punitive. One of the most important instruments is prayer or magic formula. Exalted words and incantations (katha) presumably originating in pre-Buddhist writings permit those who use them to be masters of magic (Hinderling, 1973, p. 38). Serious training under a master accompanied by a book of katha is required to learn incantations for casting curses, preventing curses, or curing. Exorcists who

practice such incantations are both respected and feared because of their power (Kunstadter, 1975). In general, though, prayers are an indispensable part of herbalist and exorcist ritual enabling them to sanctify water, blow out diseases, enhance curing power of plants, and produce various medicine.

Meditation is a second instrument of curing. It is taught to clients as a means of purification and is a necessary component of all religiously-inspired healing rites such as sanctification of medicine and the production of holy water. Holy water itself is a third vital treatment technique. In the Buddhist purification ceremony, holy water is a vehicle for transporting the strength of holy words. It forces spirits to expose themselves to the full force of the magic incantation. Taken internally or sprinkled upon the person, holy water is thought to guard against black magic, force the phii spirit to talk, and heal the whip scars of the exorcist ritual (Hinderling, 1973, p. 38).

Several other treatment rituals were noted by Hinderling. Incense sticks and candles are burned to communicate human devotion to the dieties and to seek their protection. Some specialists pay homage to their teachers to invoke their power prior to the performance of diagnosis or cure. The practice of jan involves writing holy words on orange, red, or white material to be used as protective amulets or writing these words over the person's body. Intruding

spirits or particles are sometimes exorcised by "blowing out." In conjunction with katha, wind is blown three times in the direction in which the disease is to be expelled. Like holy water, the wind brings the spirit in contact with the religious incantations.

In place of holy water, a katha concoction made of flour or chalk-like substances can be applied to pull out disease-causing particles. A final method involves constructing an ugly doll of clay and rags to absorb the spirit. It is taken to a fork in the river and allowed to float away. Undoubtedly there are numerous other healing rites and countless variations on these mentioned which are used by folk practitioners to return wellness to their clients or cast black magic on some unfortunate offender.

Consequences of Folk Therapy

What is the aftermath of the client's contact with the native healer? Suwanlert purports that once a person's spirit has been expelled, he is considered cured and can continue to live in the village without prejudice (Suwanlert, 1976a, p. 80). This follows the attribution that sick persons are victims of outside forces and share no responsibility for their deviant behavior. Hence, as Kamratana's (1973) survey found, many relatives are genuinely accepting of psychiatric patients.

In sharp contrast, villagers look with disfavor upon a phii pob, the person from whom an illness-causing spirit

originates. The possessed victim during treatment is supposed to speak out the name of the originating host (phii pob) who is then asked to end the possession. If the accused person denies responsibility, an argument or conflict may ensue. The only means of reconciliation for the accused is to admit being a phii pob and promise to undergo exorcism himself. The other alternative is exile from the village; this may be done violently through stone throwing or knife attacks.

The situation may be abused by vindictive persons falsely accusing their enemies of being a phii pob. Unfortunately, once labeled a phii pob, the person and his family are forced to migrate to where others are unaware of their stigma. Interestingly, Tolo Village in Roi-Et Province is renowned for accepting phii pob exiles. Suwanlert has visited this village and observed that no one there appeared possessed. Undoubtedly, however, the social ostracization befalling these persons takes its toll on their sense of personal well-being.

In conclusion, multi-ethnic Thailand has a wealth of indigenous theories of psychopathology and a diverse array of healers versed in folk medicine to treat these dysfunctions. A common element in both explanation and therapy is Buddhist doctrine and practice. The quarter of a million monks in the country represent an impressive front-line army of therapists. Their wats frequently serve as community mental health centers and half-way houses. Joining the

priests are folk specialists ranging from government-recognized "traditional" doctors to quacks and exorcists. Each has a little different understanding of dysfunctions and draws upon his own set of rituals and methods for achieving a cure.

Thailand still has more native healers than licensed physicians. Persons in need make their choices based on the exigencies of proximity, cost, need to find immediate relief, and the sense of fulfillment anticipated due to personal familiarity, lack of social distance, and expectations of personal attention. Given these pre-conditions, it is not surprising that folk healers remain a popular source of health and mental health care throughout Thailand.

FOOTNOTES

¹Sangsingkeo (1975) mentions an historical anecdote about Somdej Chaopraya and one successful effort to remove psychiatry's stigma. "A well-do-do merchant whose son was sent to a mental hospital provides an example of how public opinion changes. This merchant could not bring himself to visit his son, fearing that he would have to see his son being hurt. But one day he could not resist the longing for his son, and he asked for permission to visit him. When he got to the hospital, things were not as he expected: he saw no torture, no imprisonment. What he did see was kindness. Patients were allowed to walk around, and his son was improving amazingly. The merchant was so impressed by what he saw that he asked for permission to build a memorial in front of the male section of the hospital. It was named "Monument of Sympathy" and represents a nurse, standing with a male and female patient on each side, showing love and pleasure. The monument stands today." Sangsingkeo, 1975, p. 657.

²Prasri Mahphod (PM), located in the Northeast province of Ubol, replaces RU in this table. This was done because figures on RU were lacking and PM has staffing features characteristic of a large, outlying mental hospital.

VII. MODERN PSYCHIATRY IN TAIWAN, THE PHILIPPINES,
AND THAILAND: IS IT FEASIBLE AND CULTURALLY VALID?

INTRODUCTION

The preceding chapters set forth comprehensive case studies of psychological service delivery in Taiwan, the Philippines, and Thailand. These accounts detail the status of psychiatric resources within the sociocultural context of developing Asian nations; they form the basis for answering the survey's two central questions.

First, is it feasible for these countries to embrace the standards of modern psychiatry in the design of mental health systems? Secondly, does an essentially Western model of service delivery manifest cultural sensitivity to these societies as measured by community acceptability and agency accommodations to "fit" unique cultural patterns? The objective of this chapter is to reiterate the case study findings in light of these two questions. In order to draw clear answers from these results, conclusions will be stated summarizing the preponderance of evidence for and against the cultural sensitivity and the feasibility of modern psychiatric systems.

Before presenting these conclusions, it is wise to bear in mind the caveats raised in Chapter III: namely, certain constraints potentially limit the generalizations drawn from these data. First, the case studies are restricted to the perspective of mental health professionals employed in

government and private institutions visited--persons who, for the most part, spoke English and were interested in expressing their perceptions. Second, the tendency to give "official" and socially desirable answers is a threat to valid, reliable data.

On the other hand, by taking into account these biases and securing diverse sources of information, the limitations are attenuated. The completed picture accurately portrays the structure of psychiatric resources: its highest potential for attaining comprehensive standards of service delivery. The conclusions are based on this optimistic estimate of resource status. The negative findings, therefore, carry even more weight given this consideration.

FEASIBILITY OF DESIGNING MENTAL HEALTH CARE ACCORDING TO CRITERIA OF MODERN PSYCHIATRY

Prevailing criteria of "modern psychiatry" were delineated in Chapter I. The essential components of a complete system were specified as comprehensive, preventive, continuous, and accessible care. These criteria were operationalized into a seven-variable framework which became the principal vehicle for analyzing the status of mental health services in each case study. In this section, the chief concern is to decide whether or not these countries have been able to attain the standards of care prescribed.

Having adopted the model of modern psychiatry, are they able to allocate resources to successfully achieve

comprehensive services, prevention programs, continuity of care within and between institutions and into the community, and accessibility of services? To answer this, a set of general conclusions is drawn from the findings of the three case studies. The conclusions present both the factors mitigating the attainment of modern standards and those instances where successes have been demonstrated.

Conditions Inhibiting the Attainment of a Modern Standard of Mental Health Delivery

Reviewing the case analyses for Taiwan, the Philippines, and Thailand, it is evident that powerful forces are extant which severely limit the development of viable mental health programs. These forces operate at the national level, involving governmental priorities and economics, and at the level of agency functioning. The following generalizations attend to both global and institution-specific factors serving as barriers to a modern system of psychiatry.

Barriers at the National Level

a. Governmental attention in developing nations is on agricultural growth and industrial capabilities, and the elaboration of infrastructure supporting them. Social welfare and public health matters are assigned priorities well below these main concerns. Recent figures show Taiwan, the Philippines, and Thailand expending 1.29 per cent, 3.05 per cent, and 5.1 per cent of their respective national budget on public health.

b. Mental health services are given low priority within public health administrations. Resource allocations go first toward health infrastructure (building health centers, hospitals, manpower training), and programs for nutrition, environmental sanitation, maternal and child care, infectious disease control, and health education. International agencies extensively fund family planning and population control projects. Only an occasional advisor is made available for program review and consultation on mental health topics.

c. National executive bodies for planning, policy making, coordinating, and evaluating mental health programs are either weak and ineffective or non-existent. Without an effective executive committee, proposals for psychiatric service development, implementation, and integration within existing health structures will not be incorporated into national health development plans.

d. Weak national health leadership and administrative clout also hinder: 1) creation of legislation strengthening and regulating psychiatric services; 2) coordination of university teaching curricula with community needs and governmental demands; 3) recruitment and effective use of qualified mental health manpower; and 4) planning for nationwide coverage, and integration of local, regional, and national service units.

e. Government health insurance covering payments for psychiatric intervention is non-existent. Without

third-party payment, all private and some public psychological services are beyond the economic reach of most citizens. Professionals with an eye to personal income are also discouraged from entering this specialty without insurance schemes.

f. Independent university psychiatry departments offering comprehensive clinical coursework and practica are quite rare. Standard coursework, internships, and certification for allied professionals--social workers, occupational therapists, clinical psychologists--are almost completely absent. Throughout these countries and the entire region no more than a tiny handful of master's and doctorate-level clinical psychologists are found.

g. Qualified professionals exit in disturbing numbers to Western industrial countries. The "brain drain" is prompted by a teaching system which focuses on specialization and disease patterns appropriate to affluent societies, absence of attractive employment positions, and economic conditions in the home country which cannot support specialized practitioners in the private sector.

h. Except for Taiwan, there remains an inadequate mapping of the incidence and prevalence of psychological impairment and its link with adverse psychosocial conditions. Empirical documentation of community needs, characteristics of potential service users, and the sociocultural origins of dysfunction is required to focus government attention to

these concerns and guide new program creation. Program evaluation to test treatment effectiveness in meeting these needs is the second step which has yet to be taken.

i. Of singular significance is the extreme maldistribution of mental health resources following the dichotomy between urban and rural living conditions. Hospitals, clinics, after-care units, training institutions, specialty programs of all descriptions, and manpower are concentrated almost exclusively in one or two urban centers in each country. Psychiatry is a Western institution approachable by city-dwelling Westernized elite. It is a cultural island, disconnected from a surrounding sea of rural life styles and traditions. Rural people are cut off from psychiatry in the same manner they are cut off from each other and their nation's capital: by barriers of geography, transportation, communication, and social distance.

Barriers at the Agency Level

a. As a rule, individual agencies do not provide a comprehensive array of functions and treatments. If the capital cities operate as an integrated referral network, then most specialized services are obtainable to those who can afford them. Psychiatry's core elements--inpatient, outpatient, diagnostics, neurological assessment--are prevalent. But services for special groups and alternatives to inpatient care are rare. Exceedingly scarce are programs for suicide crisis, geriatric patients, substance abuse,

transitional living, mental retardation, autism and other childhood disorders, and follow-up and outreach to discharged patients. Only one or two semi-comprehensive community-level centers are available. Most agencies over-rely on drug and ECT management excluding alternative therapeutics. Behavior therapy has just been introduced. It has yet to make an impression.

b. Preventive mental health functions and indirect services are given low priority. Prevention is difficult to undertake because it demands additional manpower in a system overloaded with existing cases. It is assigned to allied professionals of which there are few and requires a sophisticated understanding of psychosocial stressors in order to conceptualize appropriate interventions. At best, one or two centers in each country exclusively orient their efforts toward public information, education, and consultation. Taiwan has the only suicide prevention and hot-line service. Prevention through ecological change, striving to re-direct sociopolitical institutions and ameliorate stress from poverty groups, was not deemed within the purview of any agency visited.

c. The large residential programs did not maintain sufficient multi-disciplinary staffing to allow either meaningful professional/patient contact or fluid transfer from one psychiatric team member to another based on diagnosis or changing needs. There are especially grave shortages of non-medical professionals throughout these

systems. Those present perform stereotyped functions. They are denied leadership roles and case responsibility except in a few community-based clinics. Hospital settings are almost totally dominated by nursing and physician personnel. Without the abundance of nurses, the inpatients-to-staff ratios would be astronomically poor. As it is, the small university and private inpatient units are the most adequately staffed, offering the best opportunities for therapeutic contact. Manpower deficiencies are most acute at provincial institutions; treatment is custodial at best. The sheer weight of outpatient contacts--sometimes numbering several thousand per month--dictates that professional contact be restricted to prescribing and monitoring drug interventions.

d. Inter-institutional continuity of care, the ability of diverse agencies to function as a unified service system, has two weak points: 1) the inadequate linkage between the mental health and public health systems; and 2) the proliferation of "dumping ground" institutions: those with multiple referral sources into them, but few, if any, referral pathways leading back out into the community.

e. Institutional action aimed at permitting smooth patient transition back into the social environment is another low priority function. Manpower is deemed too precious for delivering after-care services at the home or village level. Outreach beyond the immediate agency vicinity

is unthinkable. Agencies are reluctant to deploy personnel to liaison with relatives and significant others in cooperative case management during and after hospitalization. Compounding the problem, there are insufficient alternatives to inpatient care. This hinders the flow of patients from highly restrictive environments to those with minimal supervision. It also forces an over-reliance on institutionalization.

f. Access to psychological care is severely impeded by several conditions: 1) general and specialist services are concentrated almost exclusively in one or two metropolitan districts; 2) those without financial resources can neither afford to travel to these centralized clinics nor pay for private practitioners and the minimal fees for public-funded institutions; and 3) waiting lists and chronic overcrowding of the few respected inpatient units frustrate potential users and are nightmares to outpatients waiting long hours for brief physician consultations. In essence, rural and low-income citizens are disenfranchised from the privilege of public mental health care.

Conditions Favorable to the Attainment of a Modern
Standard of Mental Health Provision

Juxtaposed with the previous set of limitations, there are conditions which appear favorable to the provision of modern psychiatry. Situations enhancing the feasibility of psychiatry's development are now reviewed.

National Conditions Enhancing Service Availability

a. Historically, indigenous psychiatrists have created and maintained connections with overseas centers of psychiatric education, training, and research. By necessity, the first group of sojourners received their post-graduate instruction in these centers. As initial couriers of Western mental health technology, they founded the new discipline upon their return. Subsequent generations of students were dispatched along the international pathways forged by their instructors. They brought back updated theories and practices for designing mental health systems. The two-way avenues of interchange between indigenous professionals and overseas colleges have become a fruitful source for alternative conceptions of disorders, treatment strategies, and models of practitioner education.

b. Consultants and expert advisors from the World Health Organization (WHO) constitute an invaluable support group for innovation and elaboration of national mental health programs. Except for Taiwan, no longer a member state, these countries may draw upon WHO assistance for several functions: evaluation of existing systems; recommendations for designing new services; guidelines on the creation of executive structures to coordinate and administer national programs; input into educational curricula, training and certification; and research priorities. WHO also provides a framework for regional

collaboration in research, curricula development, and tackling common problems such as drug addiction. More importantly, it seeks to bolster the position of mental health programming within governmental bureaucracies.

c. Capital cities contain misallocations of hospitals, clinics, specialty units, university training centers, and an abundance of multi-disciplinary manpower. These resources, concentrated in a relatively small area, offer an essentially modern psychiatric system. This full set of services is completely appropriate to the educated upper strata of urban populations whose incomes, life styles, and medical beliefs render such services accessible to them. In short, a Western standard of psychiatry is feasible within the unique confines of metropolitan capitals. There, economic conditions, "modern" values, and cosmopolitan life styles of the nation's elite support and appreciate them.

Conditions Enhancing Service Availability at the Agency Level

a. Institutions within capital cities have created elaborate pathways for mutual consultation and patient referral. This network permits ease of access into the mental health system for referrals from allied agencies (police, schools, medical clinics) and enhances inter-institutional continuity of care when transfer to another facility is appropriate. Taipei has the most formal structure for integration and coordination of city-wide

institutions. Its five prominent psychiatric hospitals have divided the city into catchment zones and supervise community-based personnel in scattered health stations. Each capital, however, has key agencies whose breadth of ties throughout the network and into the community make them highly influential. This central position is used for transmitting information, assisting the development of other institutions, introducing innovation, and fluidly channeling staff and patients among facilities.

To recapitulate this section, the feasibility of achieving a Western standard of service delivery is rendered improbable by an overwhelming set of impediments. National barriers include preoccupation with economic development to the exclusion of social welfare matters, psychiatry's low priority in the context of pressing public health crisis (population, sanitation, infectious diseases), absence of a dynamic executive committee for mental health administration, and inadequately developed educational programs. Brain drain, lack of epidemiological data, and profound inequality in the distribution of manpower and facilities also hinder feasibility. At the level of agency operations, comprehensive service clinics are almost non-existent. Preventive mental health is too taxing of current resources. Multi-disciplinary team approaches within clinics are constrained by acute shortages of non-medical professionals and stereotyped role assignments. Moreover, agencies downplay family

and community involvement in treatment due to time pressures. Ease of access is impeded by agency location (urban settings only), waiting lists at respected clinics, and costs unaffordable for low-income citizens.

Despite these overpowering restrictions, a critical mass of service units and professionals has emerged in the capital cities. Psychiatry is accessible to select urban dwellers and achieves a measure of comprehensiveness when diverse agencies function in a cooperative, integrated manner. Furthermore, historical interchange with foreign training centers and expertise from international consultants have undergirded the creation and expansion of national mental health programs. Despite the continual infusion and updating of mental health technology by international sources, the overall impact is imperceptible. These nations simply cannot allocate sufficient political, economic, educational, and manpower resources to generate a fully functioning delivery system beyond one or two metropolitan enclaves. In brief, the Western model of psychiatry cannot be lauded as even remotely feasible as a standard for nationwide mental health service delivery.

CULTURAL SENSITIVITY OF EXISTING PSYCHIATRIC SYSTEMS

The second issue addressed by the case studies concerns the interface between sociocultural context and agency operations. Succinctly stated, to what extent do programs reflect prevailing community ethos? Culturally sensitive

services strive to represent distinct cultural patterns in their policies, plans, and procedures. This process is termed "cultural accommodation." Cultural sensitivity is also measured by willingness of potential users to draw upon clinic services in times of need and clinic acceptability as a resource option among community members. This section summarizes the case study findings regarding agency acceptability and accommodation--two indices of cultural sensitivity.

Community Acceptance of Existing Psychiatric Services

Evidence of Non-Acceptance

a. The community/agency gap is bridged through active institutional liaison with responsible persons from the patient's natural environment. Yet, there are few formal ways in which community members close to the patient are brought into the procedures for goal setting and therapy administration. Unquestionably, treatment planning and case management are the purview of the medical staff, especially the physician, who remains the final authority.

b. Acceptability is also strengthened by formal avenues of agency accountability to the opinions of social leaders and service recipients. However, the concept of a community advisory board empowered to assist program specification was alien to every agency except the Philippine Mental Health Association (PMHA). Needs assessment surveys, a second means of establishing accountability by identifying under-

served users, were also absent from program priorities.

c. In the eyes of service providers, mental institutions are disturbingly alienated and isolated from the ongoing stream of community life. They see their clinics as unknown or mostly misunderstood. Even worse, institutional care stigmatizes those who receive it. Psychiatry is thus reserved as a last resort when all other methods of help--such as self-remedies and folk healers--have failed. In short, programs are rejected by traditional-minded citizens whose beliefs and health customs are incongruent with what is offered. There are grave doubts about meaningful integration and acceptance of mental health institutions in these communities by the staff who work in them.

Instances of Community Acceptance

a. Agency penetration by the community was noted at a few key points of contact involving family members. Examples were recorded of family therapy, family education seminars, and spouse counseling. Relatives were sometimes assigned the responsibility of watching for new symptoms, giving medicine, and making sure the patient returned for follow-up visits. Furthermore, institutions encouraged visitation and permitted families to bring in food and money. The most significant correspondence between clinic and patient's social group occurred in Taiwanese and Philippine institutions which allowed relatives to "live in" and take part in the day-to-day management routine.

In several cases these "watchers" were given training by professionals to enhance their usefulness.

b. The PMHA and Taipei's Life Line Center were the only two programs with administrative accountability to local review boards. Private agencies whose governing boards are not dominated by medical personnel are in a position to be more responsive to community expressed needs. Private agencies in general seem to have a better chance of operating under the auspices of review boards whose membership includes wider community interests than just the medical fields.

c. Agency acceptance was not a problem, according to respondents, after the family made the commitment to bring their impaired member for help. Once this threshold was surpassed, rejection of treatment approaches and disbelief in therapeutic efficacy are no longer issues. It may be that agency contact mobilizes hope and faith in a positive outcome. This may be true especially in light of the trials and tribulations endured by the family and patient prior to their seeking clinic assistance.

In conclusion, community integration into agency practices chiefly involved family participation in some aspect of in-hospital and discharge care. Still, these admirable gestures cannot begin to offset the profound stigma and alienation experienced by agencies, especially in regards to provincial client populations not exposed to modern education. Stated tersely, psychiatric institutions

are unacceptable to most, except when all other avenues have failed and desperation reaches its climax. Small, private outpatient clinics or those educationally oriented and with leadership tied to local interests may be the exception to this rather negative conclusion.

Culture Accommodation in Agency Operations

The second index of cultural sensitivity is measurable through efforts to incorporate key customs of community health behavior into institutional environments. Critical dimensions for culture accommodation deserving agency attention include family role, popular and traditional conceptions of disorder, expected therapist manner, and expected therapeutics.

Kinship Role

The pre-eminent position of Asian kinship groups in controlling the lives of individual family members is generally recognized among mental health workers. The initial point of clinic contact with the family is crucial for engendering their cooperation and respect, and halting the widening patient/family chasm which may result in abandonment to institutional care. Preliminary accommodation to gain kinship confidence was undertaken in a variety of ways: entire families were invited in for the intake interview; physicians sought to relieve unspoken fears by fully explaining treatment approaches and asking permission prior to shock therapy; quick, demonstrable improvements

via drugs were sought before asking family participation in rehabilitation efforts; and family attendants are allowed to live-in on certain wards and offered formal staff contact in some cases. Other examples where the strong emotional attachments between relatives are taken into account include child rearing seminars for parents, family attendance at ward groups to plan home care, assignment of specific after-care responsibilities to parents and spouses, encouragement of regular visitation, and permission to bring in food, money, and holy water from native healers.

Folk Theories

Sensitivity to popular and folk theories of psychological impairment is another requirement of a culturally responsive organization. The most dominant form of accommodation to traditional concepts of disorder is non-judgmental acceptance of them. When confronted with such beliefs, it was recognized that attacking them directly would only serve to alienate the patient. One strategy was to simply ignore folk notions or gently point out the difference between traditional and "scientific" concepts. Seasoned therapists recognized that knowledge of folk nosologies and culture-bound syndromes was useful in working effectively with traditional clients. Professionals like Sangun Suwanlert have become experts in ethno-psychiatry. They guide their medical and psychological interventions by a thorough understanding of how belief in spirit

possession, for example, influences symptom expression and response to treatment. Most workers manifest a permissive attitude toward adherence to folk healing customs as long as it does not interfere with their approach to therapy. A few even permit visitation to priests or herbalists during hospitalization. At minimum, there is a general awareness that patients take a circuitous route to the hospital, arriving only after a variety of local healers and self-cures are exhausted.

Ward Activities

Ward-level activities provide a rich arena for accommodation to family/patient relationship, folk beliefs, and other important aspects of the patient's background. Linguistic matching--the assignment of patients to staff who speak the same dialect--was prevalent throughout these programs. Often, relatives of ill, elderly, suicidal, or unmanageable inpatients were asked to reside on the ward as "watchers" or "amahs." The Buddhist Priest's Hospital was set up in harmony with the culture of its residents; all attendants there are male and physicians are careful to accord full respect to the holy men they treat. Recreational, occupational, and vocational therapies were aimed at familiar pastimes. They also teach skills enabling the person to return to his family capable of making an economic contribution. PMHA had rehabilitation programs aimed at patients with either rural or industrial orientations. Ethnic and

religious minorities were sometimes permitted to stay together in the hospital and observe their own customs of worship and diet. Practitioners deemed it urgent to stabilize minority patients with drugs and return them quickly to their families, because hospitals were more alien to them than to other groups. At several sites, acreage was devoted to attractive landscaping and flora. Besides giving the residents an opportunity to do their own gardening, these natural scenes were intended to stimulate an aesthetic sense among residents and perhaps induce a relaxed state of mind.

Therapist's Manner

Persons seeking clinic aid appear to hold well-defined expectations of what the therapist's manner should be in order to make them feel secure and confident. The most commonly described attribute was that of an authority figure--"fatherly," in command of the situation, and almost godlike. Yet, equally important, the authoritarian stance should be tempered with a warm, human side. He/she should allow emotional dependency, be cheerful, friendly, and helpful. It was also best for the therapist to give direct, concrete advice and exude confidence that the intervention will assuredly work. In Taiwan, sensitivity to non-verbal communication was considered a pre-requisite as Chinese are reserved in verbal self-expression. In all cases, one should avoid shaming the patient and mentioning embarrassing

topics until the relationship is well-established.

Communication among Thais in group therapy was stimulated by leaders who downplayed their authority positions and fostered a permissive, "anything goes" group atmosphere.

Expected Therapeutics

To an overwhelming extent, patients admitted to psychiatric clinics construe their presenting problems in somatic terms. They expect curing measures to be physical rather than psychological. The medically-oriented institutions are well-suited to accommodate to these expectations. The uniform components of hospital care are psychotropic medication, electro-convulsive shock, bed rest, and vitamin supplements. Very few receive talk therapy. When it is given, therapists concentrate on being supportive, offering explicit advice on how to handle specific problems. Insight-oriented psychotherapy and behavioral therapies are seldom practiced. Non-medically oriented centers must sometimes provide orientation sessions to teach clients what to expect. Therapists interested in applying psychological interventions first meet their patients' medical expectations in order to build rapport and compliance before shifting to alternative strategies.

Instances of Non-Accommodation

Over 80 per cent of those completing Questionnaire #3 endorsed 12 of the 16 accommodation items in each country.

Such statements as: "Staff should adjust their personal manner to fit the expectations of patients from different social backgrounds," "Staff should know the traditional names for mental disorder," and "Community leaders should help in planning and directing facility activities," were nearly unanimously agreed to by respondents. With such strong, consistent endorsement of these 16 accommodation statements, it could be concluded that most professionals are favorably disposed to culture accommodation when providing services to traditional client populations. Yet, there are clear discrepancies between these apparent positive attitudes and actual practices found in or missing from clinic procedures. For example, there was a conspicuous lack of community leaders involved in planning facility activities. While in the hospital, patients are in fact isolated from community activities, although most staff agree that they should not be. Below are other examples of non-accommodation to community customs detracting from agency cultural validity.

Patient Re-education

Many staff consider it proper, even mandatory, to re-educate those patients maintaining traditional conceptions of psychopathology. Personnel strive to teach traditional-minded individuals to view their problems in psychiatric terms. Becoming acquainted with psychiatric methods will presumably make them more psychologically-

minded. Even those ethno-psychiatrists who have documented the influence of indigenous theories on symptom expression maintain that the effective psychotherapist, while accepting the patient's scheme, must reinterpret it for himself in modern concepts. In brief, the "superstitious" patient must be educated to a more "rational" understanding of his problem.

Native Healer Rejection

Although there was solid agreement that staff should know the folk healing practices for mental disorder, in no instance was native healer participation sought in case management. Most, in fact, eschew folk doctor involvement. They view it as a waste of finances, a delay from proper care, or even harmful. Staff will ask that families stop taking their ailing member to indigenous practitioners while under psychiatric care. When staff feel that such visits interfere with their own therapeutics, they insist on discontinuation of healer contact.

Social Status Differences

Even though it was clearly recognized that social differences between staff and clients was a moderate problem, there was seldom any policy or recommendation that personnel be hired whose backgrounds closely matched those of service users. This problem was most acute in Thailand. Rural Thai are extremely reluctant to approach persons of the

physician's status. Communication barriers arise from differences in social status and differences in education, thinking styles, and basic values between the two groups. Patients are put off by the businesslike, arrogant, scolding, and inattentive manner of clinic doctors. They much prefer local healers who spend a lot of time with them, explaining what has caused their illness and expressing genuine concern.

Limited Family Participation

As a rule, institutions prefer minimal interference by family members in the treatment regimen. The exception, of course, is the Philippine "watcher" system. With pressing shortages of personnel, it is simply too great a luxury in most cases to take the time to permit community members meaningful involvement in the therapeutic routine. Families are invited to visit and staff do encourage their continued contact with the patient to avoid abandonment, but any treatment role relatives do play is generally circumscribed and under the supervision of hospital workers.

Negative Stereotypes

Lastly, mental institutions not only carry the negative connotations of custodial care--confinement places for the "mad" and hospitals from which no one returns--but are also associated with poor souls dying away from home. In Thailand, such places are filled with the wandering spirits of persons who did not have a peaceful death in their homes.

These spirits themselves are looking to possess the living and cause illness.

In review, sociocultural context elements such as strong kinship ties, indigenous conceptions of illness, expectations of therapist manner and medical applications, are represented in the day-to-day procedures of certain clinics. Such efforts bring a closer correspondence between these Western-derived institutions and the prevailing cultures in which they are embedded. Yet, a careful scrutiny of existing culture accommodation practices shows that many are undertaken at the initial phase of agency--family contact as a method to win confidence, respect, and rapport. Once the initial expectations are met and compliance is established, these same agencies switch into their preferred treatment modalities. With newly-won patient cooperation, they coax the uninitiated into accepting established psychiatric procedures.

Certain of these preferred approaches include physical methods such as shock treatment; others involve getting the family to take an active role in rehabilitation and patient after-care. In the latter case, the staff are trying to prevent the tendency of some families to turn over complete responsibility to the institution and simply return later expecting to find a completely recovered person.

CONCLUSION

The survey of mental health resources in Taiwan, the Philippines, and Thailand was intended to learn whether or not the standard of Western psychiatry is feasible as a model for service delivery among developing Southeast Asian nations. A second phase of the survey assessed the degree to which Western-derived institutions are integrated into the sociocultural milieu of their intended recipients. A guiding premise is that continuity with client culture builds agency acceptability and establishes the cultural validity of mental health programs.

On the issue of feasibility, the case study findings are unequivocal. At national or even regional levels, these countries are unable (unwilling) to allocate economic, educational, administrative, research, and manpower resources to secure the standards of care prescribed by contemporary criteria of comprehensive service delivery. Extant psychiatric systems, functioning in an integrated fashion, are capable of providing sufficient intervention resources to meet the needs of a circumscribed number of middle and upper class residents of these nation's capital cities.

The question of cultural sensitivity of mental hospitals and clinics is less straightforward because community attitudes were not directly assessed. Nevertheless, staff perceive their clinics as alien entities in the ongoing stream of community life. Psychiatric treatment is

stigmatizing; it is unacceptable except at the last possible moment as a desperate gesture to relieve suffering. Yet, a tiny scattering of community based units--staffed mainly by non-medical personnel--do appear well-connected with diverse community groups. They appear non-threatening and acceptable, serving as smooth conduits into the mental health network.

Agency-specific practices of culture accommodation diminish community alienation by strengthening cultural validity. A full range of accommodation tactics were noted, but most tended to be informal and makeshift. Accommodation per se was not elevated to the level of policy or program objective. For example, linguistic matching was carried out whenever possible, yet policies of hiring staff based on background similarity with client populations were not considered. Moreover, accommodation undertaken at the initial point of agency contact was intended to win over family confidence and cooperation. Once staff secured the family's commitment to treatment, then clinic-preferred therapy modes were introduced. Traditional-minded patients were re-educated to acquire a more psychological view of their problems and appreciate the advantages of psychiatric methods.

In summary, the sites visited were culturally insensitive and isolated in relation to the healing customs and beliefs of the general population. Their range of appropriateness

and accessibility was narrowly restricted to the urban elite. The following chapter considers in detail the implications of culturally unresponsive services and describes an approach for designing new services continuous with cultural values and behavior.

VIII. TOWARD AN INTEGRATION OF CULTURAL CONTEXT
WITH THE DESIGN OF MENTAL HEALTH SERVICES:
THE CULTURE ASSESSMENT AND ACCOMMODATION MODEL

INTRODUCTION

The case study analyses and prior review of the literature in Chapter II point toward the unmistakable conclusion that Western psychiatry is burdened by manifold limitations in Southeast Asia. Constrained by the socio-economic shortcomings inherent in developing nations, psychiatry fails to fulfill its promise as a feasible model for service design and delivery. These Asian nations are hard pressed to meet the standards of modern mental health care because their attainment requires an intensive allocation of human and financial resources. To do so would entail diversion of resources from high priority enterprises--agricultural and industrial development--which is economically and politically unthinkable.

In essence, the Western model is inappropriate because it makes extensive demands on a socioeconomic system preoccupied with basic survival. Furthermore, no future changes in the minimal resource allocation to existing facilities are anticipated for many years. Yet, the pressure on present services will continue to mount in response to rapid urbanization (people moving closer to clinic locations), soaring population increases, lower mortality of mentally retarded and brain damaged, and

greater willingness among health professionals to refer patients into the system.

Of equal significance is the conclusion that psychiatric institutions are culturally insensitive (unacceptable, non-accommodating) to large segments of the population, especially those from traditional and rural backgrounds. The implications of discontinuity between psychiatric services and sociocultural context were delineated in Chapter II. The key revelation was that host culture incongruity with Western mental health technology brings impetus for sociocultural adaptation or even disintegration. Yet, as shown by the case studies, there is no community-level review of agency goals to help choose the direction of such change. Using psychiatry as a force of innovation raises serious ethical questions when community consent is absent.

Specifically, mismatched service technology threatens five cultural systems. First, indigenous conceptions of dysfunction and disease are replaced by psychiatric nosologies and standards of normality. Second, certain social values, life styles, and child rearing customs are judged pathological. From the psychiatric perspective, changes are demanded at the social systems level. Third, medical institutions represent unique sub-cultures, hierarchically structuring roles and relationships of their members. These sub-cultures undermine an intricate pattern

of interpersonal relationships between the patient and significant others who seek to care for his needs. Fourth, medical technology, under the control of the urban power elite, strengthens their positions vis á vis the rural peasant majority. It bolsters government efforts to impose new administrative frameworks on heretofore autonomous village units. Fifth, governmental sanctions against traditional medicine, in favor of formal psychological services, may actually decrease assistance for those in need. Native specialists are curative, useful in mediating social change stress, and massively relied upon by rural and urban citizens alike. Official disapproval and suppression of folk institutions would create a psychological care vacuum since modern mental health systems maintain only token resources and still suffer the stigma of community rejection.

In summary, without cultural sensitivity, institutions created according to Western strictures of organization and purpose are discontinuous with Asian patterns of psychological healing. Unless services are integrated with basic sociocultural elements--community politics, education, family structure, economics, theories of disorder, extant healing systems--they impose social change. Change without the participation of those affected is unethical. Unfortunately, imposition of influential yet incongruent institutions hastens sociocultural disintegration. This

is counter to cultural adaptation which is a necessary, ongoing process in the face of modernization pressure and national development.

REQUIREMENTS OF A NEW MODEL

Given the problematic status of mental health delivery in Southeast Asia and the brave but fragmented attempts to adapt Western therapeutics, there remains a pressing need for a unified, culture-specific approach to guide the design of helping services. This new approach must be capable of coping with current dilemmas: unfavorable national priorities, resource inaccessibility, manpower deficits, community acceptability, ethics, and continuity of delivery system with culture.

In the following section, a proposal is set forth offering solutions to these issues through a culture assessment and culture accommodation framework. This framework emerged from an attempt to integrate concepts from the culture and psychopathology literature with the practices of professionals working in non-Western settings (Higginbotham, 1976). The purpose is to give practitioners explicit guidelines for planning and evaluating services from the perspective of the client's cultural context. To prepare guidelines, questions must first be directed toward the recipient community. These questions focus on the cultural assessment of needs, concepts of normality, the ways and means of handling mental problems, and expectations

of agency performance.

FOUNDATIONS OF THE CULTURE ASSESSMENT MODEL

The field of culture and psychopathology provides a point of departure for determining attributes of a cultural group which must be understood prior to the design of a mental health system (See Draguns, 1979; Draguns & Phillips, 1972; Marsella, 1979; Kiev, 1972; Opler, 1967 for reviews). In this regard, the literature offers three contributions: 1) culture-specific (emic) definitions of abnormality; 2) socio-cultural causes of disorder including formal causative models relating socio-cultural stress, disintegration, immigration, rapid social change, and so forth, to rates for psychological problems; and 3) socio-cultural responses to disorder including prescribed procedures for healing and psychotherapy.

These three domains can be transformed into a set of assessment questions and administered through a survey of community recipients. Information from the survey serves as the foundation for determining the scope and operations of a mental health system in that culture. Briefly, the design of a culture-specific treatment program must follow an assessment of: cultural perceptions of problem behavior; norms of individual adjustment; the folk healing practices and network; and expected community relationship with the agency.

Analysis of Culturally Defined Problem

A typology of problem behavior as conceptualized by culture members is the first assessment component. Several interrelated elements comprise the problem typology. The first of these is the classification scheme used to identify and label disturbing behaviors. Category systems of mental disorder, such as those found for Taiwanese, Filipinos, and Thai, have been reported for many diverse peoples (Burton-Bradley & Julius, 1965; Chen, 1970; Colson, 1971; Leighton, et al., 1963; Murphy, 1972).

An important consideration is the process of person/group interaction and the covert rules governing the assignment of a label (Ullmann & Krasner, 1975). No behavior per se is deviant, but is evaluated as abnormal by an observer based on its violations of social expectations (Draguns, 1979; Frank, 1973). Behavior is labeled deviant following several considerations: role and status of the person, attributes of the action (frequency, intensity, duration), the time and setting in which it takes place, the consequences, and the rationale for the behavior as perceived by observers (Fabrega, 1971; Marsella, 1979). Compilation of these data permit the development of a behavioral profile of disorder which differs across cultural groups. Base rates for each problem and their distribution within a population can also be gathered for evaluating program effectiveness.

Another element of the problem typology involves mapping the perceived etiology of each disorder type. Some conditions are thought to be caused by one source only, such as "spoilt brain" (Orley, 1970) or "wind" entering the body (Chen, 1970). Other problems may be attributable to several sources--sorcery, violation of tribal laws, family disharmony, ancestral ghosts, malevolent forest spirits, etc. (Cawte, 1973; Jocano, 1973; Kiev, 1964; Lambo, 1978; Lebra, 1976; Lieban, 1967; Sethi & Lucknow, 1965). Following determination of the problem's origins, each culture prescribes an appropriate location for treatment intervention. Depending on the problem, the therapist directs his ministrations toward the person, social group, supernatural world, physical environment, or relationships among these levels.

The final problem typology element is the social reaction or attitude toward each "type" of deviant. Does the community respond differentially to the deviants in their midst? In fact, the attitude of the immediate social group may be the most crucial determinant of treatment outcome (Lambo, 1962; Sangsingkeo, 1958; Waxler, 1974). In some cases, the individual himself is not held responsible and maintains family support (Maguigad, 1964). When outside forces such as sorcerers or possessing spirits are blamed, the sick role may be shed rather quickly (Dean & Thong, 1972; Kleinman, 1977; Suwanlert, 1976; Waxler, 1974). In other cases, particularly when the patient has

been violent, embarrassing, and repeatedly brings suffering onto others, this process is reversed (Jackson, 1964). Disorders associated with acts or threats of violence are judged to be more permanent. The sick role stays with the person along with an attitude of rejection. He is often banished from the village. If institutionalized, he is likely to be abandoned there by relatives (Colson, 1971; Suwanlert, 1976).

Norms of Personal Adjustment

The second component of culture assessment attends to the specific values and expectations of adjustment in the community. Treatment objectives should be determined by knowledge of socially accepted roles and standards of interpersonal relations; this was ignored in the past. Planners adopted implicit therapeutic goals and assumptions from American and European personality theories.

In contrast, the culture-specific approach focuses on idealized standards, norms, and boundaries of behavior for individuals in specific situations. The behavioral qualities a person should ideally possess according to community consensus are termed "areté" (Goldschmidt, 1971). It is toward the cultural areté which therapy attempts to resocialize the nonconformist (Draguns, 1975). In designing a mental health program, the areté or profile of ideal behavior in situ is valuable as a general guideline. However, using it as the outcome criterion of resocialization

and skills training should be balanced against ethical considerations of individual rights, client consent and choice, and the long-range benefits for the person in a changing environment (Harshbarger & Maley, 1974).

Aiding the program designer in this phase of culture assessment are anthropology's ethnographic accounts, the Human Relations Area Files (Murdock, 1969). Also, ethno-psychologists have recently developed standardized questionnaires providing profiles of "normality" for different ethnic groups (Ching & Sanborn, 1971; Katz & Sanborn, 1973). For example, the Relatives Rating Inventory Scale by Katz (Hogarty & Katz, 1971) has items indicating the level of performance of socially expected activities. Although these scales tap culture members' perceptions of each other juxtaposed with their perceptions of the ideal, the items themselves are Western in origin. Their transcultural sensitivity remains to be demonstrated.

Expected Ways and Means of Curing

In the case study presentations it was recognized that each culture has its own network of healers and helping persons along with well-defined procedures for curing. For example, Taiwanese tang-ki, possessed by the diety of their shrine, performed ceremonial cures for ailing clients and followers. Using unseen power from God, the Filipino arbularyos pray and rely on available pharmacopoeia to ameliorate illness from natural and supernatural origins.

Thai exorcists enter trance states to directly communicate with phii spirits, identifying and coaxing them from their host victims.

Analyses of the helping network, healers, and their curing is the third culture assessment component. In this way, we attempt to understand how the means of social influence employed by an agent of social change (healer) brings about resocialization to community goals and restores the deviant to social grace.

Culture members have set expectations about the processes and techniques of healing (Quah, 1977). Different scenarios of treatment outcome are predicted based on "met" versus "unmet" expectations (Higginbotham, 1977). When expectancies are tapped and included in program operations, the client recognizes that he is receiving the necessary and correct help he sought; it is coming from a recognizable expert possessing the required skill to ameliorate suffering and cure the condition. With this recognition is born positive emotion. The client has hope, confidence, and faith in improvement; demoralization and hopelessness are counter-acted. He is motivated to stay in treatment.

Contrasting this scenario is an alternative one arising from unmet expectations. A negative patient reaction is likely when it is found that what is supposed to happen in order to receive help doesn't occur. Unless the client can be "taught" to appreciate agency methods, a "therapeutic"

relationship will not develop and the patient/family will go elsewhere. This is supported by the case study findings that professionals are quite concerned about re-educating patients maintaining traditional beliefs of disorder and therapy.

Unfulfilled expectations are sparked by a treatment rationale with low credibility from the patient/family perspective, inadequate explanation of the problem, and a therapist style, attitude, and manner which are unfavorably evaluated. Since these are associated with incompetent help, positive emotions, trust, and expectations of cure are not aroused.

Some writers postulate a universality in the behavior influence tactics used by therapists (Draguns, 1975; Frank, 1973; Torrey, 1972). Elements common to all therapeutic experiences include therapist and patient sharing a world view; therapist possessing special personal qualities; expectancy of cure believed appropriate; facilitation of emotions and a success experience in therapy; and the "specialness" of the therapist/client relationship--intense trusting and confiding. The techniques are continuous with the style of social control relied upon in everyday life, whether they be authoritarian or self-generated (Draguns, 1975). A typology of tactics includes providing expert testimony, placebo manipulations, use of modeling, and principles of reward and punishment. The means for influencing change could also involve physical exercise,

herbal medicines, concoctions for driving away or propitiating spirits, or altered states of consciousness--sleep, meditation, and trance (Higginbotham, 1976).

The tactics of behavior change are put into operation formally through certain community sanctioned roles. The roles discussed most extensively in the case studies were the folk doctors, priests, and shamans. However, other individuals in relationship with the identified patient may also come to apply means of social influence before or after the traditional doctor has been consulted. These sources of influence are recognized as legitimate change agents due to their expertise, authority within the village, or kinship with the person. In Western settings, typical sources of influence are medical doctors, teachers, ministers, parents, or psychotherapists. In traditional societies, parallel roles are enacted by spiritualists, herbalists, midwives, kinsmen, and village elders. It is imperative to assess the referral network and determine when the family will take the disturbing person to which source of influence based on what definition of the problem.

Expected Community Relationship with Agency

One stop in the referral network--sometimes the end point, according to the survey findings--may be the mental health center. Appraising the community's expected relationship with the treatment agency is the final culture assessment component. Community members hold expectations

about the preferred type of agency and the nature of their interaction with it. Acceptability of the program is dependent upon the extent to which these expectations are met. For example, there is the issue of community control. Have local leaders been called upon to sanction the service? Is there an advisory group to suggest and review program activities and objectives? In most instances, as we have seen, this is not the case. Before administering treatment, is there an effort to get informed consent? Who is sanctioned to give informed consent--the client, relatives, or village authorities?

A second set of questions concerns expectations of organizational structure and activities within the facility. Recipients may have definite preferences regarding location, cost, treatment within the home, types of service units, therapies, vocational rehabilitation choices, residence within the hospital, and the facility's community-like atmosphere. The most important consideration in this area is the family's expected involvement with the patient during agency contact. In some instances, the family insists on having one of its members remain with the patient in the hospital (e.g., Tung, 1972). They may also wish to play an active role in treatment choice, therapy administration, and discharge decision, or refuse to have any contact whatsoever (Kiev, 1972).

Community members also have definite ideas about agency

personnel. The question arises if indigenous healers should be allowed to care for certain patients or be employed as consultants? Some psychiatrists suggest there are times when this is useful (Roan, 1973; Ruiz & Langrod, 1976; Torrey, 1972; Wittkower & Warnes, 1974; WHO, 1975a). More generally, what knowledge are staff expected to have of folk theories, culture-bound syndromes, and traditional healing practices? How accepting should they be of patients who maintain folk beliefs regarding their problems? Finally, the importance of personnel characteristics and manners can be stressed. Age, sex, social status, language capabilities, and ethnicity all play a role in evaluating the appropriateness of the healer. However, as anthropologists have found, these may be overshadowed by personal mannerisms like social distance, faith in one's therapy, professional aloofness, taking time to explain the disorder, attitude toward the family, and so forth (Clark, 1959; Lieban, 1973; Marriot, 1955).

A FRAMEWORK FOR CULTURE ASSESSMENT: THE ETHNO-THERAPY AND CULTURE ACCOMMODATION SCALE

The previous section laid the foundations and rationale for gathering culture-specific mental health data. A framework for organizing the diverse kinds of information sought would be helpful to the planner. For this purpose, the author proposes the development of an Ethno-Therapy and Culture Accommodation Scale (ETCAS).

Procedurally, four phases of research are required to construct and validate the instrument. In Phase One, "domain definition" or "open-ended" interviews of community leaders and knowledgeable sources are done to generate items for ETCAS (c.f., Marsella, Chase, Sine, & Perron, 1977). The topics addressed by the interviews include: perceptions of problem behavior and causes; norms of adjustment; expected treatment techniques and healers; and expected relationship with agency.

Phase Two consists of an analysis of survey data to construct weighted items. The practices and expectations gathered from informants are transformed into statements of items. For example, an item for a Malay population might be: "The successful healer knows that gila (madness) is caused by loss of semangat (soul) plus possession by hantu (ghosts)" (Chen, 1975). Similarly, a Taiwanese item might read, "Going into a trance and becoming possessed by the god of the healing shrine is the best cure," or, for Northern India, "The healer should always make his own medicines and have complete faith in their powers" (Mariott, 1955). These items are then compiled into a questionnaire and re-administered to the community leaders and informants. Weightings are assigned to each item by asking the respondents to endorse the statements in terms of their significance in providing helpful, successful, and appropriate care.

Phase Three is the application phase. The weighted items are grouped according to priority. Summary statements are drafted indicating which mental health considerations are deemed most important from the community's standpoint. At this point, an existing psychiatric program can be assessed in terms of its degree of congruity with the ETCAS. An examination of agency objectives and practices yields an evaluation of the extent to which the service provides a treatment orientation overlapping with the one shared by community members.

Finally, Phase Four attempts to appraise criterion and predictive validity of the instrument. One means of establishing scale validity is to correlate ETCAS scores obtained from evaluating a psychiatric clinic with independent measures of treatment accommodation and indices of community satisfaction. The ETCAS could be correlated: with measures of acceptance, support, and utilization of the facility; with expectations of success during the client's initial agency contact; and with other indices of treatment satisfaction, like drop-out rates, Relative Rating Inventory Scale (Hogarty & Katz, 1971), and patient's perceptions of improvement, etc.

Presumably, high scores found on the ETCAS are associated with high scores found on these independent criterion measures. Low scores would reflect lack of integration or discontinuity of the program with cultural patterns of helping. Low ETCAS scores would predict underuse of the

facility or use as a last resort, negative attitudes toward the program, patient stigmatization, and low expectations of cure.

APPLICATION OF THE ETHNO-THERAPY AND CULTURE ACCOMMODATION SCALE

Potential uses of the ETCAS are threefold. As detailed above, it is useful in agency evaluation to determine the degree of congruity between the community's expressed needs and services actually provided. In this way, existing programs are modified to increase their attractiveness, utilization, and client satisfaction--often stated goals (Collomb, 1973; Draguns, 1975; Wittkower & Warnes, 1974).

A second use is to design new facilities and programs based on community criteria. A new treatment system aimed at culture accommodation is one which does not usurp or compete with present indigenous care. Instead, it fills in the gaps where the community recognizes treatment is needed but is unavailable (Kiev, 1972). The village system of care developed by Lambo (1966, 1968) and replicated in other African settings (Collomb, 1975; Osborne, 1969; Swift, 1972) goes the furthest towards culture accommodation in program planning. A second example is the Gombok Hospital for Malaysian aborigines located a few miles from Kuala Lumpur. Hospitalized Negritos, Senoi, and Proto-Malays are airlifted with their families to a jungle setting compound. Tribal health workers manage patient needs. Their families

encourage them to carry out daily customs such as craft-making, fishing, hunting, and farming in the nearby jungle (Kinzie & Bolton, 1973).

Thirdly, the ETCAS is helpful in identifying existing resources in need of strengthening. This use follows closely the formulation for community psychology offered by Rappaport (1977). The aim of professional helpers is to aid in developing existing community values and strengths. This is done by making available society's resources based on cultural relativity and diversity. ETCAS results provide criteria of relativity and diversity, thus helping to avoid discrimination against minority groups that occurs when a single standard is used to judge "normalcy."

Similarly, the instrument permits a social group to enhance its inherent competency and retain its cultural continuity. In this context, Rappaport, Davidson, Wilson, and Mitchell (1975) apply the concept of "cultural amplifiers". It is defined as those aspects of technology which enable a community to transfer skills from areas of existing competency to new ones. A tactic of community psychology is to employ cultural amplifiers to increase the level of community competency (Iscoe, 1974). The ETCAS is a framework for identifying cultural amplifiers, cultural resources, values, and strengths.

CONCLUSION

This survey of three Southeast Asian nations uncovered

innumerable problems in setting up comprehensive, accessible, preventive, and continuous care within the socioeconomic context of developing countries. The crux of our findings is that Western style services are inappropriate. Such services are unaffordable, far beyond the horizon in terms of manpower, and are unaccepted and potentially destructive of integrated elements in the host culture. What is required is a treatment system continuous with cultural beliefs, values, and existing patterns of helping. Through a culture assessment, looking at the community definitions of problems, normality, ways and means of curing, and expectations of program performance, a clear understanding of appropriate intervention can be established. A procedure for systematically gathering and analyzing this information is proposed. The Ethno-Therapy and Culture Accommodation scale is a device for judging the congruity of an existing program with the expectations and preferences of the recipient community. It is intended to serve as a guideline for introducing programs with a high level of cultural sensitivity and to identify healing networks that may be strengthened by the allocation of additional resources. The end product in harmony with the aims of community psychology is to create competent communities capable of actualizing the values and goals they select for themselves.

Questionnaire #1

ADMINISTRATORS OVERVIEW AND DESCRIPTION OF PROGRAM

BACKGROUND DATA

1.0. Facility Title

1.1. Country

1.2. City

1.3. Address

2.0. Physical Environment of Facility

2.1. Cottage _____ Hospital _____ Other _____

2.2. Number of rooms

2.3. Types of living/working spaces

2.4. Layout of facility and spatial configuration

2.5. Condition of buildings: excellent good average poor

2.6. Density and crowding: Extremely moderately slightly uncrow-
crowded crowded crowded ded

3.0. Location

3.1. Relation to city layout

3.2. Distance to urban center

3.3. Ease of access

INTERVIEW QUESTIONS

4.0. Types of services available

4.1. What are the objectives of this facility and the types of
services offered?

4.2. Are the following services available?

Yes	No	Formerly Planned
-----	----	---------------------

- 4.2.1. Emergency services
- 4.2.2. Inpatient services
- 4.2.3. Partial hospitalization
- 4.2.4. Transitional living
- 4.2.5. Follow-up services after
discharge
- 4.2.6. Outpatient services
- 4.2.7. Specialized services for
children
- 4.2.8. Specialized services for the
elderly
- 4.2.9. Programs for alcohol and drug
abusers
- 4.2.10. Diagnostic and mental assessment
- 4.2.11. Neurological assessment
- 4.2.12. Suicide prevention program
- 4.2.13. Consultation and education ser-
vice, including the promotion of
preventive mental health program

5.0. Funding

5.1. What is the main source of funding for this facility?

- 5.1.1. Public___ Private grants___ Private donations___
Fee for service___ Hospital generated funds___ Other

6.0. Dimensions of the Program

6.1. How many full time staff are there?

- 6.1.1. Psychiatrists _____
- 6.1.2. Psychologists _____
- 6.1.3. Nurses _____

- 6.1.4. Social workers
 - 6.1.5. M.D.s _____
 - 6.1.6. PMAS _____
 - 6.1.7. Nurse's aides _____
 - 6.1.8. O.T. Workers _____
 - 6.1.9. Recreation therapy
 - 6.1.10. Neurology _____
 - 6.1.11. Surgery _____
- 6.2. How many part-time staff are there?
- 6.2.1. Psychiatrists _____
 - 6.2.2. Psychologists _____
 - 6.2.3. Nurses _____
 - 6.2.4. Social Workers _____
 - 6.2.5. M.D.s _____
 - 6.2.6. PMAs _____
 - 6.2.7. Nurse's aides _____
 - 6.2.8. O.T. Workers _____
 - 6.2.9. Recreation therapy _____
 - 6.2.10. Neurology _____
 - 6.2.11. Surgery _____
- 6.3. What is the facility's capacity with regards to:
- 6.3.1. Number of inpatient beds
 - 6.3.2. Number of outpatients
 - 6.3.3. Other clients
- 6.4. What is the facility's present occupancy/use regarding:

6.4.1. Number of inpatient beds

6.4.2. Number of outpatients served

7.0. Characteristics of Personnel

7.1. How would you characterize the background of the professional staff with regard to:

7.1.1. Type of training and therapy orientation of psychiatrists?

7.1.2. Place of training of psychiatrists?
M.D. _____ Residency _____

7.1.3. Ethnicity, language group and place of origin of psychiatrist?

7.1.4. Type of orientation and training of psychologists?

7.1.5. Place of training of psychologists?

7.1.6. Ethnicity, language group and place of psychologists?

7.2. How would you characterize the backgrounds of other staff with regards to their ethnicity, language groups and place of origin?

8.0. Client Population

8.1. What geographical areas are the clients drawn from?

8.2. What language and cultural groups are served by the program within each area?

8.3. What is the age range of clients?

8.4. What are the major diagnostic types treated?

8.5. How many patients are there within each diagnostic type?

8.6. How many new patients are admitted each year?

8.6.1. Total

8.6.2. For each diagnostic type

9.0. Referral System and Pathways to the Facility

- 9.1. How are the patients referred to the program?
- 9.2. How frequently are each of the following used as referral sources?

Some-
Often times Seldom Never

- 9.2.1. M.D.'s in private office
- 9.2.2. Mental health professionals in private practice
- 9.2.3. Other mental health institutions
- 9.2.4. Social welfare agencies
- 9.2.5. Schools
- 9.2.6. Police and courts
- 9.2.7. Priests and clergy
- 9.2.8. Traditional healers
- 9.2.9. Family and friends
- 9.2.10 Employer
- 9.3. What other institutions or agencies is there a close working relationship with?
- 9.4. What proportion of patients are voluntary vs. involuntary?
- 9.5. Where are the patients referred after contact with the facility?
- 9.5.1. Successfully treated
- 9.5.2. Those needing additional treatment

10.0. Outcome Measures

- 10.1. What is the turnover rate?
- 10.2. What are the discharge criteria?
- 10.3. How are patient-improvement data gathered?

- 11.0. Do you have the following programs in primary prevention?

- 11.1. Community education/workshop?
- 11.2. Training of non-professionals in the community?
- 11.3. Crisis intervention?
- 11.4. Consultation with other institutions?
- 11.5. Social action, community organization, political action?
- 11.6. Research (listing of all research)?

12.0. How often are the following therapy techniques used?

Some-
Often times Seldom Never

- 12.1. Chemotherapy
- 12.2. Physical therapy
- 12.3. Psychotherapy (types)
- 12.4. Behavior therapy
- 12.5. Group therapy
- 12.6. ECT
- 12.7. Family therapy
- 12.8. Orthomolecular
- 12.9. O.T.
- 12.10 Work therapy
- 12.11 Other

13.0. Patient's Family Involvement

- 13.1. In what ways are the patient's family involved in the treatment?
- 13.2. Is there a program to train, educate or work with the patient's family as part of the treatment plan?
- 13.3. Are any other individuals in the patient's immediate social group involved in helping with treatment?

14.0. COMMUNITY PARTICIPATION

14.1. In what ways do community members served by the program participate in planning or directing the activities of the program?

. 14.1.1. Does the program have consultants from the community?
Yes _____ No _____

14.1.1.a. Who are they?

14.1.1.b. What are their responsibilities?

14.1.2. Is there a community advisory board? Yes _____ No _____

14.1.2.a. How many on the advisory board?

14.1.2.b. Who are they?

14.1.2.c. How are they selected?

14.1.2.d. What are their responsibilities?

15.0. What are the future plans for the facility?

APPENDIX B

Questionnaire #2

STAFF PERCEPTION OF AGENCY

DATA SOURCES

1. Respondent
 - 1.1. Name
 - 1.2. Position
 - 1.3. Professional training
 - 1.4. Age
 - 1.5. Sex
 - 1.6. Where received training
 - 1.7. How long at this facility
 - 1.8. Other current affiliations
 - 1.9. Language and culture group

2. Conditions of interview
 - 2.1. Location
 - 2.2. Others present
 - 2.3. Quality of communication
3. Confidence and reliability: excellent good average poor
4. Time started _____ Time ended _____
5. Written Materials Utilized
 - 5.1. Types of materials
 - 5.2. Titles of materials

Patient and Family Conceptions of Disorder

6. Complaints

In general, what are types of complaints and symptoms that bring the patient to the treatment program? Have you found "culture-bound" or a typical symptoms among patients?
7. Classification

What names or labels do patients and their families use to describe mental problems? Do they ever use "folk" names?
8. Causality

How do patients and their families explain the causes of mental problems?
9. Expectations

Do patients and their families have definite expectations about the treatment program? What are their expectations? If their expectations are different from the treatment they actually receive, how is this problem handled?
10. Treatment Goals

What do patients and their families believe the goals or outcome of treatment should be?
11. Professional Manner

What should the doctor's personal manner be like when meeting with patients?

12. What would you say are the major problems faced by the treatment program?

13. How serious would you say each of the problems are for this program?

- | | very serious
problem | moderately se-
rious problem | slightly seri-
ous problem | not a problem
at all | not
applicable |
|--|-------------------------|---------------------------------|-------------------------------|-------------------------|-------------------|
| 13.1. Lack of help from the government | | | | | |
| 13.2. Not enough money for present treat-
ment programs | | | | | |
| 13.3. Not enough money to develop new
treatment programs | | | | | |
| 13.4. Lack of relationships with other
institutions (e.g., hospitals,
clinics, welfare agencies) | | | | | |
| 13.5. People in the community don't re-
quest this kind of treatment pro-
gram | | | | | |
| 13.6. Other professionals don't support
the treatment program | | | | | |
| 13.7. Not enough trained administrators | | | | | |
| 13.8. Staff relations are not good | | | | | |
| 13.9. Not enough building space | | | | | |
| 13.10. Too many patients | | | | | |
| 13.11. Not enough treatment supplies | | | | | |
| 13.12. Not enough information about men-
tal problems in the community | | | | | |
| 13.13. Not enough trained staff for dia-
gnosis | | | | | |
| 13.14. Not enough trained staff for
treatment | | | | | |
| 13.15. Not enough trained staff for
follow-up care | | | | | |
| 13.16. Staff receive little information
about new treatments and new re-
search findings | | | | | |

- 13.17. Low success rate of treatment
- 13.18. Patients leave treatment program before treatment is finished
- 13.19. Community people don't know about or understand the treatment program
- 13.20. Community people have a bad opinion of the treatment program and use it only as a last chance
- 13.21. The staff and patients are different from each other in their social backgrounds
- 13.22. People with traditional beliefs about mental problems won't use the treatment program
- 13.23. People go to "Folk doctors" instead of using the treatment program
- 13.24. Community people have problems using the treatment program because of its location, costs, or hours of working
- 13.25. Long waiting list
- 13.26. Patients and their families don't believe the treatment will help
- 13.27. Patients returning home have problems because people know they were in a mental hospital
- 13.28. Library is not good enough
- 13.29. Lack of money for equipment and research
- 13.30. Not enough rooms to separate different types of patients
- 13.31. Lack of transportation services

very serious
problems

moderately
serious prob.

slightly seri-
ous problem

Not a problem

Not applicable 568

GOAL SETTING

14.0. How often do each of the following help decide the therapy to be used and the goals of therapy?

- | | always | Some-
times | seldom | never |
|---|--------|----------------|--------|-------|
| 14.1. Psychiatrist or Doctor-in-charge | | | | |
| 14.2. Other professional staff (psychologist, social worker, nurse) | | | | |
| 14.3. Patient | | | | |
| 14.4. Family of patient | | | | |
| 14.5. Folk healer (e.g. shaman) | | | | |
| 14.6. Police/courts | | | | |
| 14.7. Clergy/priests | | | | |
| 14.8. Friends/neighbors | | | | |

STAFF ACCOMODATION TO PATIENT'S CONCEPTIONS OF DISORDER

- 15.0. Do staff seek to correct or reeducate those patients who maintain traditional beliefs about mental problems?
- 15.1. Do staff adjust their personal maner to fit the expectations of different patients?
- 15.2. Are efforts made to find staff whose social and cultural backgrounds (place of birth, language, income level, etc.) are similar to those of the patients?

ADJUSTING INPATIENT SERVICES TO CULTURAL PATTERNS

- 16.0. Are the patients' daily activities in the hospital similar to their activities outside of the hospital?
- 16.1. Do patients make choices about their daily activities?

- | | Always | Often | Some-
times | Never |
|--|--------|-------|----------------|-------|
| 16.2. Are patients encouraged to participate in community activities outside of the hospital; both work and recreation | | | | |
| 16.3. Does the patient's family help with patient care within the hospital? | | | | |

ACCESSIBILITY OF SERVICES

- 17.0. Is the program located in a place which is easy to visit and convenient for clients?
- 17.1. Is it possible for people with little money to use the treatment program?
- 17.2. Is treatment provided within the patient's own home or village setting?

INVOLVING COMMUNITY RESOURCES

- 18.0. Are efforts made to use community people who often handle mental problems? For example, religious leaders family group, "Folk" doctors, Public health nurses?

APPENDIX C

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Questionnaire #3

STAFF ATTITUDES TOWARD ACCOMMODATION

IN OPERATING A SUCCESSFUL MENTAL HEALTH FACILITY FOR A COMMUNITY WHERE PEOPLE MAINTAIN THEIR TRADITIONAL BELIEFS AND CUSTOMS ABOUT MENTAL DISORDER:

- | | Strongly
agree | Agree | Disagree | Strongly
Disagree |
|---|-------------------|-------|----------|----------------------|
| 1. Staff should know the traditional names for mental disorder | | | | |
| 2. It is useless to consult with native healers since most of them cannot really help patients with mental problems | | | | |
| 3. Staff should know the traditional healing practices for mental disorders | | | | |
| 4. It is useless for staff to know the traditional beliefs about the causes of mental disorders | | | | |
| 5. Community leaders should help in planning and directing facility activities | | | | |
| 6. The doctor alone should decide what the appropriate treatment goals will be | | | | |
| 7. The patient and his family should help choose the type of treatment given | | | | |
| 8. What is considered as "normality" or "good personal adjustment" is the same for all cultures | | | | |
| 9. Staff should adjust their professional manner to fit the expectations of patients from different social backgrounds | | | | |
| 10. Staff should try to correct or re-educate patients who maintain their traditional beliefs and customs about mental health | | | | |

- | | Strongly
agree | Agree | Disagree | Strongly
Disagree |
|---|-------------------|-------|----------|----------------------|
| 11. It is best to hire staff whose so-
social backgrounds are similar to
those of the patients | | | | |
| 12. While in the hospital, patients
should remain isolated from acti-
vities in the community | | | | |
| 13. The patient's activities in the
hospital should be as similar as
possible to their activities in
the community | | | | |
| 14. Patients should go to large cen-
tral hospitals for their treatment | | | | |
| 15. What is considered as the appropriate
goals of treatment should be different
for different cultures | | | | |
| 16. Only those trained in scientific
treatment techniques are quali-
fied to help people with mental
problems | | | | |

APPENDIX D

April 4, 1977

Dr. Koichi Ogino
Psychiatric Research Institute
of Tokyo
Division of Social Psychiatry
2-1-8 Kamikitazawa
Setagazaki, Tokyo, Japan 156

Dear Dr. Ogino:

I am writing on behalf of Mr. Nick Higginbotham, who is currently working toward his PhD in Psychology at the University of Hawaii under the auspices of the East-West Culture Learning Institute. Under the cosponsorship of the Culture Learning Institute and the University of Hawaii Department of Clinical Psychology, Mr. Higginbotham will be visiting several Asian and Pacific countries later this year to gather information on psychiatric services available. Mr. Higginbotham hopes to visit a number of psychiatric treatment centers and programs located in diverse socio-cultural settings to learn about differences in the design, development and delivery of psychiatric services. Specifically, he hopes to discuss/observe the following: (1) recent trends in service delivery, (2) characteristic problems encountered in the delivery of treatment programs, and (3) approaches used to accommodate or adapt mental health services to the distinct socio-cultural qualities of the patient population in each community.

The information gathered from this project will be subsequently used by Mr. Higginbotham in generating a useful "model" for the design of mental health delivery systems that offers guidelines for mental health specialists seeking to establish new treatment programs in non-Western communities. In addition, we hope that this project will eventually stimulate international discussion and exchange of information on this topic and contribute to the development of mental health research programs for Asian and Pacific immigrant populations in the United States.

At the suggestion of Dr. Anthony Marsella and Mrs. Junko Tanaka-Matsumi, I am writing to you in the hope of making arrangements for Mr. Higginbotham to visit your psychiatric research facility while he is in Japan, sometime between June 15 and July 15, 1977. As you well know, international

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travel requires a great deal of preparation time, so we would greatly appreciate hearing from you at your earliest convenience.

In closing, may I express our appreciation both for your consideration shown to Mrs. Tanaka-Matsumi during her visit four years ago and for any assistance you may be able to extend to Mr. Higginbotham during the coming summer.

Sincerely,

(Ms.) Lyn F. Anzai
Program Officer

LFA/emj

APPENDIX E

OVERVIEW AND RATIONALE OF FIELD EDUCATION PROPOSAL

Howard N. Higginbotham
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Beginning in June, 1977, I will be visiting a number of countries in Asia and the Pacific to study the psychiatric services provided for each country's citizens. The study will be conducted under the sponsorship of the East-West Center Culture Learning Institute and the University of Hawaii Department of Clinical Psychology. I intend to visit a number of psychiatric treatment centers located in diverse cultural settings to learn about the role of the socio-cultural context in the development and delivery of psychiatric services. This topic has become increasingly important as modern psychiatry strives to achieve greater acceptance and effectiveness in non-Western communities. Moreover, it is a crucial consideration when mental health professionals seek to establish viable systems of patient care in settings characterized by cultural diversity, traditionalism, and/or well established patterns of indigenous healing and health practices.

The mental health programs, professionals and researchers I hope to visit were selected based on a review of the published literature in transcultural psychiatry and recommendations offered by psychologists, psychiatrists and anthropologists at the University of Hawaii and East-West Center. During my visit to each site, I shall seek to:

- (1) Acquire a detailed description of the program with regards to the types of services rendered and how they are provided;
- (2) Acquire an understanding of the characteristic difficulties encountered by each program in providing services to the community;
- (3) Acquire knowledge of particular practices which each program uses to accommodate or adapt to the distinct cultural characteristics of the patient population, and; the methods which may be employed to gather and assess culture-specific information related to the patient population.

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Among the methods that will be useful for securing the kinds of information sought by these visits, are the gathering of printed materials available at each site, informal discussion with staff and administrators, observation of procedures and program routines, and the administration of structured interview instruments to staff and administrators. Naturally, any effort to inquire about the nature of a program must be tailored to the particular circumstances found at the facility. More importantly, I am sensitive to the requirements of ethical responsibility and the inherent need for discretion when seeking specific information about an agency delivering health care to a community.

The focus of the study is not to be construed as an evaluation or assessment of effectiveness. Rather, it is an initial attempt to understand how different psychiatric programs, serving different cultural populations, respond to a common problem--how to make modern psychiatry a viable treatment option for a particular socio-cultural group. The information sought will be gathered and handled in a manner consistent with the requirements, responsibilities, and integrity of the host institution.

The ultimate objective of the proposed study is an applied one: it is intended to benefit mental health professionals designing and administering programs for non-Western peoples. The information gained from these visits will be used in several ways: (1) To generate a general methodology concerned with translating the unique cultural characteristics of a community into a mental health delivery system that successfully accommodates to the distinct beliefs, practices, expectations and problem conditions shared by those community members; (2) To guide the development of mental health research programs for Asian and Pacific immigrant populations in the United States; (3) To stimulate communication between professionals engaged in ethno-psychiatry research and practice. The final report based on the site visits will be sent to participating agencies, to other agencies and researchers carrying out similar work, and will be submitted to international mental health journals (e.g., International Journal of Social Psychiatry; Transcultural Psychiatric Research Review).

APPENDIX F

GLOBAL VARIABLES EFFECTING MENTAL HEALTH SERVICES

1. What are the major institutions or programs providing manpower training for mental health?
2. Are there manpower shortages?
3. Is there an insurance or financial assistance program available for mental patients?
4. What mental health legislation affects the development and delivery of mental health services?
5. How are mental health services organized at the national, regional, city, and local levels?
6. What national, regional, city, or local planning and policy making committees exist for mental health?
7. In what ways does the government support or fail to support the development of M. H. services?
8. Historically speaking, what have been the critical factors affecting the development of mental health services?
9. Is there adequate cooperation and communication between different agencies, institutions, and individual leaders of mental health care? Where are there communication breakdowns?
10. Are there culture specific or unique ways on which mental health services are designed to fit the expectations or life style of the communities served?
11. How does the indigenous or folk system of mental health care influence the activities of mental health workers?

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