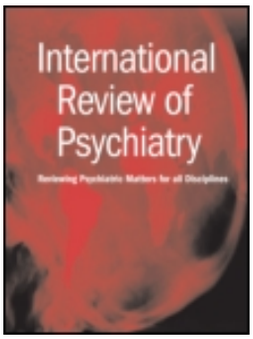

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Families and family therapy in Hong Kong

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Abstract
Family therapy views humans not as separate entities, but as embedded in a network of relationships, highlighting the reciprocal influences of one's behaviours on one another. This article gives an overview of family demographics and the implementation of family therapy in Hong Kong. We start with a review of the family demographics in Hong Kong and brief notes on families in mainland China. Demographics show that the landscape has changed markedly in the past decade, with more cross-border marriages, an increased divorce rate, and an ageing overall population – all of which could mean that there is increasing demand for professional family therapy interventions. However, only a limited number of professionals are practising the systems-based approach in Hong Kong. Some possible reasons as to why family therapy is not well disseminated and practised are discussed. These reasons include a lack of mental health policy to support family therapy, a lack of systematic family therapy training, and a shortage of skilled professionals. Furthermore, challenges in applying the western model in Chinese culture are also outlined. We conclude that more future research is warranted to investigate how family therapy can be adapted for Chinese families.

Background information on families in Hong Kong

Demographic profile

According to the latest Census, the total population of Hong Kong reached 7.07 million in mid 2011 (CSD, 2012). A full 93.6% of the population consists of individuals of Chinese nationality, and the other 6.4% are termed ethnic minorities (CSD, 2007). The birth rate of the total population rose from 7.2% in 2001 to 9.6% in 2006 (CSD, 2006). Notably, about 40% of these babies (65,194 recorded births) were not born by women permanently residing in Hong Kong, but by women visiting from mainland China (CSD, 2011a).

In 2011, in the total population, the proportion of men to women is skewed towards women (876 men per 1,000 women). Of the total population, 11.6% are below 15 years old, followed by those in the 15–24 age group (12.4%); 25–44 age group (31.4%), 45–64 age group (31.3%), and those above 65 years (13.3%). There was an increase in the proportion of the population in the 65 + age group from 11.6% and to 13.3% in 2011 in 2001 to 12.4% in 2006 (CSD, 2012). The median age of the total population has also risen from 36 years in 2001 to 39 years in 2006, and to 41.7 in 2011 indicating that the Hong Kong population is getting older, which is consistent with the international trend. Household sizes in Hong Kong are also declining. The average number of people per family dropped from 3.4 in 1991 to 3.0 in 2006 and further decreased to 2.9 in 2011. In the past few years, the proportion of households with six members or more also dropped from 5.8% in 2001 to 3.3% in 2011.

Ethnic minorities in Hong Kong

Among the 6.4% non-Chinese population or the ethnic minorities, the largest sub-groups are Filipinos, followed by Indonesians and South Asians (including people from India, Pakistan, Nepal, Bangladesh, and Sri Lanka, see Table I). While a large proportion of the Filipinos and Indonesians are domestic migrant workers, many of the South Asians are permanent residents who have migrated to Hong Kong for settlement.

According to the 2006 Census, the majority of the ethnic minorities are in the 25–44 year age group, with a median age of 32. Of the ethnic minorities, 9.4% were below 15 years old, while those in the 65 + age group constituted 1.9%. Within the ethnic minority

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Table I. Ethnic minorities in Hong Kong, (2006).

Ethnicity	Number	Population %
Filipino	112,453	1.6
Indonesian	87,840	1.3
White	36,384	0.5
Indian	20,444	0.3
Nepalese	15,950	0.2
Japanese	13,189	0.2
Thai	11,900	0.2
Pakistani	11,111	0.2
Other Asian	12,663	0.2
Others	20,264	0.3
Total	342,198	5.0

Source: 2006 population Census (Census and Statistics Department, 2007).

population in Hong Kong, there are 911 females for every 1,000 males (excluding foreign domestic workers). Among the ethnic minorities, 63.9% live in nuclear families, and the average number of people per family is 2.6. Regarding marital status, 68.5% of men and 52.2% of women aged 15 years and above are married. A total of 5.6% of the ethnic population were widowed, divorced or separated.

Marriage and family structures

Returning to the total population in 2011, 61.2% of men and 54.8% of women are married. There is a higher proportion of women who have been widowed, divorced, or separated (15.5%) than males (5.2%). Crude marriage rates increased from 9.5 per 1,000 men and 9.9 per 1,000 women in 2001 to 14.0 for men and 15.4 for women in 2006 (CSD, 2007). However, more people are getting married at a later age, with a median age at first marriage of 31 years for men and 29 years for women in 2010 (CSD, 2011b). This has also led to a slowdown of household formation among people of marriageable age.

There has also been an increased rate of divorces in the past few years. In 2001 there was a total of 13,425 divorces, which increased to 17,242 in 2006 (CSD, 2007). The number of single parents as recorded in the 2006 population census was 72,326. Among these, there were more female single parents (57,613) than male single parents (14,713). The majority of these single parents are in the age group of 40–49 years. Compared to male single parents (70%), only about half of the female single parents (54%) are employed. The median monthly income in 2006 for female single parents was HK$8,500 (approximately US$1,093) and HK$10,500 (approximately US$1,350) for male single parents (CSD, 2008).

With rising social and economic activities between Hong Kong and mainland China, there has also been an increase in cross-border marriage. Registered cross-border marriages between Hong Kong men and women from the mainland increased sharply in Hong Kong, from 5,169 in 2001 to 18,182 in 2006 (CSD, 2007). There was also a substantial number of Hong Kong female residents marrying male residents from the mainland, with recorded marriages registered in Hong Kong from 723 in 2001 to 3,406 in 2006 (CSD, 2007).

Brief overview of families in mainland China

Although it is well beyond the scope of the present paper to provide a comprehensive review of the changing landscape of families in China, it is necessary to provide a snapshot, given the rapidly growing ties between Hong Kong and mainland China. Since the implementation of the one child policy in 1978, the total birth rate and average family size have decreased in mainland China, and a gross imbalance in the sex ratio has emerged. In 2006, the average fertility rate was 1.94 in women over 35 (2.1 in rural areas and 1.4 in urban areas) and 1.73 for women under 35 (Ding & Hesketh, 2006). The average number of family members was 4.41 in 1982 and 3.10 in 2010. Of all mainland families in the 2000 Census, 68.2% were nuclear families, and 8.6% were single families. Future generations may expect less support from their children as the number of children declines. For instance, in 1998 there were more than six working-age adults (15 to 59 years) for every one elderly person (aged 60 and over); by 2040, there will be only two working-age adults for every one elderly person (UN, 1999). The male to female ratio rose from 1.11 in 1980–1989 to 1.23 in 1996–2001 (Ding & Hesketh, 2006). The female deficit at birth has continued to grow, with the overall sex ratio at birth reaching 118 boys born for every 100 girls in 2005 (*China Daily*, 2007).

The divorce rate has been steadily climbing, with divorce rates of 4 per 100 individuals in 1985 to 18.5 in 2009 (Ministry of Chinese Civil Affairs, 2009). In other words, approximately one in five mainland marriages ended in divorce (Ministry of Chinese Civil Affairs, 2009). China also faces a rapidly growing aged population due to improved life expectancy and large population cohorts born between the 1950s and 1970s, which has resulted in an increasing population of widows. The elderly (aged 65 and over) made up 7.0% of the population in 2000, 8.4% in 2010, and is projected to make up 11.8% in 2020. With rapid urbanization and industrialization, rural migrants are flooding to the city to look for opportunities, which provides a major source of the low-cost labour demanded by the urban-centred economic boom. According to the 2000 census, 144.39 million rural residents in China – or 11.6% of the total

population – had migrated into cities and towns (He et al., 2008). Meanwhile the reform of state-owned enterprises has resulted in tens of millions of workers being laid off in Chinese cities (Liu et al., 2008).

Family therapy and Chinese culture

Background

Family therapy brings forth a new way of understanding human behaviour and treating human problems. Instead of focusing on individual psychopathology and the cause-and-effect perspective of individual psychotherapy, family therapy views humans not as separate entities, but as embedded in a network of relationships. Family therapy adopts a circular perspective of human behaviour that highlights the reciprocal influences of our behaviours on each other (Nichols, 2009). Family therapy is focused on changing the whole family system – the relationship or interactional patterns, the family members' roles to each other, and the family system's structure and rules. Family therapy does not deal with intrapsychic dynamics as in individually based psychotherapy. A system is defined as a set of inter-related elements that function as a unity within a particular environment and where the whole is larger than the sum of its parts.

In the west, trans-generational orientated family analysts started working with two or more generations using object relations concepts in the 1950s (Ackerman, 1958). In that perspective, the treatment focus is more on understanding how unresolved losses and trauma in parental and grandparental generations may lead to ego boundary problems. Although psychodynamic family therapies have been previously criticized for having limited evidence, there has been a recent surge in evidence for their value in various types 1971of psychological disorders (Diamond et al., 2010). When Bowen (1978) introduced the principles of 'systems theory' into family therapy, there was a shift in focus from subjective unconscious experience to an objective evaluation of the family as an organizational structure. Based on his work with family members affected by schizophrenia, Bowen described the family as a multigenerational emotional system marked by intense emotional interdependency (Bowen, 1978). Bowen posited that anxiety plays a crucial role in the functioning of family members and that treatment is about decreasing anxiety and increasing differentiation of self (or emotional functioning). Minuchin and his associates (1978) have elaborated on this systems theory by arguing that children with psychosomatic problems (e.g. anorexia nervosa, poorly controlled asthma, or diabetes mellitus) are symptomatic manifestations of marital discord between parents, enmeshment of family members to avoid confrontation and tension, or even coalitions between children and one parent/grandparent against other family members. However, such a shift in conceptual thinking has invited criticism that systems approaches neglect subjective experiences and are inattentive to social and domestic injustice (e.g. domestic violence and racial discrimination; see Bloch & Haran, 2009). Indeed, if one considers political, social, and cultural structures as systems of a higher order, it is obvious that the interaction of these systems with the family system needs to be considered in some families affected by real-life difficulties (e.g. financial hardships, relationship difficulties). Such real-life crises and practical difficulties are especially prevalent among individuals affected by major psychiatric disorders. Behaviourally based family interventions for mental illness have been found to be an effective psychosocial intervention in terms of reducing relapse rates and the duration and frequency of hospitalizations, as well as increasing adherence to medication in multiple trials (for a review, see MacFarlane et al., 2003; Pharoah et al., 2010). While behaviourally based family interventions emphasize problem-solving for real-life difficulties, cognitive behavioural therapists have addressed family analysts' exclusive focus on intra-psychic unconscious fantasies by focusing on more accessible and immediate maladaptive automatic thoughts, dysfunctional assumptions, and problematic core beliefs of individual family members in maintaining marital and family problems (Dattilio & Beck, 2009). Other strategies that cognitive behavioural family therapists use include role play and role reversal to encourage adaptive family interactions and behaviours.

Family therapy in Chinese communities

Chinese culture is a collectivist culture with a strong emphasis on harmony, respect for elders and superiors, and altruism for the good of the community (Bond, 1991). It is therefore logical to believe that family-orientated intervention is a highly acceptable form of therapy and care to Chinese communities. However, psychoanalysis, with its emphasis on unconscious sexual and aggressive drives, has never gained a strong foothold in Chinese societies in the past 50 years. Furthermore, the intensive nature of therapy also precludes wide dissemination of individual or family analytic therapy in Hong Kong, where there is a persistent shortage of skilled mental health professionals. Across the border, psychotherapy was banned during the Cultural Revolution as counter-revolutionary and is only becoming more available through contact with overseas experts in psychotherapy after the adoption of the Open Door policy (Wong & Ng, in press).

Systems-based approaches are more widely disseminated in Hong Kong and Taiwan because systems-based family therapists have been more proactive in disseminating this modality to mental health professionals. Yet this approach is mainly practised by social workers in private practice or voluntary service sectors, possibly due to the fact that its theory of the social causation of mental illness may be particularly appealing to social workers. A fair number of social workers and counsellors in Hong Kong practise Satir's (1991) growth model and the structural approach because these two approaches have a longer history in the city. Bowen's theory (Nichols & Schwartz, 2001) has had roots in Hong Kong for over ten years, and many practitioners have found its systemic and multigenerational perspective – as well as its concept of differentiation of self (as reflected in the ability to maintain individual autonomy and yet also maintain good and meaningful relationships with others) – enlightening and relevant to Chinese culture. Solution-focused therapy and its pragmatic nature is a handy tool for those practising in settings that require brief treatment (e.g. adjustment disorder and addiction problems). With the increasing complexities and challenges facing marriages in Hong Kong, social workers and counsellors are also showing interest in emotionally focused therapy as a tool to work with couples and families. Furthermore, there has been research evidence documenting the positive clinical outcomes of family-based care programmes for families with loved ones affected by schizophrenia in Hong Kong (Chan et al., 2009; Chien & Lee, 2010; Chien & Wong, 2007) and in mainland China (Li & Arthur, 2005; Ran et al., 2003a). However, evidence-based family interventions – as with all psychological interventions – have never been well disseminated in Hong Kong and other parts of the world. Major barriers include lack of training and protected time for mental health professionals and conflicting needs between service users and the organizations (Berry & Haddock, 2009).

Apart from common barriers encountered in the dissemination of psychological interventions in general, there are obstacles that are specific to Hong Kong. In public mental health settings in Hong Kong, psychological interventions are usually individually based supportive psychotherapy or cognitive behavioural therapy. There is no explicit requirement for psychiatrists, clinical psychologists, or social workers to have core competencies in family therapy throughout their training. For example, trainee psychiatrists are required to submit only two supervised psychotherapy cases of any modality (e.g. psychodynamic, cognitive behavioural, or family therapy) during the six-year period of psychiatric training (HK College of Psychiatrists, 2010). There is as yet no requirement to undergo a minimum number of hours of supervised training in any particular modality of psychotherapy. Apart from the lack of an explicit training requirement, failure to provide comprehensive family therapy in public settings could be related to two reasons: (1) psychiatrists, clinical psychologists, and mental health social workers have such a high patient load that they have very limited time for each consultation, and (2) there is a lack of high quality systematic family therapy training in Hong Kong. The family therapy literature has listed a number of major disorders that might be amenable to family therapy, yet family therapy is not readily available in the public mental health sector. This implies that there are unmet needs among individuals recovering from major psychiatric disorders (and their family) who receive care from the public system in Hong Kong. The Mental Health Service Plan (2010–2015) has clearly spelled out the importance of service user involvement in the design and evaluation of future services, which is indeed a welcome move in improving service delivery (HK Hospital Authority, 2010). With service users' increasing access to the Internet, the present authors envisage that they will soon vocalize more demand for family therapy as an integral component of intervention for psychiatric disorders. There have been some preliminary efforts to critically reflect on nursing practice and promote family systems nursing in Hong Kong (Simpson et al., 2006). What needs to be put in place is a coherent, top-down policy of skills training and promotion of the use of family-based psychological interventions by a designated workforce in Hong Kong.

Moving forward

Even if family therapy is becoming more widely available in Hong Kong and China, it cannot be assumed that the western style of family therapy can be readily applied to Chinese families without adaptation. Previous studies in Hong Kong and mainland China (Ng et al., 2001; Ran et al., 2003b; Yang et al., 2004) have found that high expressed emotion in the form of over-criticism and hostility among family members was predictive of relapse among individuals with schizophrenia. However, moderate levels of overprotectiveness were found not to be predictive (Ng et al., 2001). This can be explained by the relatives' causal attributions about the negative behaviours manifested by people in recovery from schizophrenia. Only those critical relatives who viewed challenging behaviours as personal and controllable were predictive of relapse among individuals with schizophrenia (Yang et al., 2004). If relatives had a more benign or social explanation of challenging behaviour they were more likely to show support and concern. A recent study conducted in China has partially supported

this hypothesis (Yang et al., 2011). Yang and associates found that urban people who had prior contact with people affected by psychosis and who labelled the illness as 'non-psychiatric and indigenous' in nature considered themselves less socially distant from these patients. Similar to the application of cognitive therapy for Chinese people, family therapy also needs to have certain adaptations in collaborative style, feedback elicitation, and culturally relevant metaphors and stories (Ng, 2008). Due to Hong Kong's strong cognitive behavioural tradition, existing professionals will more easily learn cognitive behavioural family therapy and behaviourally based family intervention, and these will more easily become the common modalities of family therapy available in public health service in the future. Because Chinese culture has a strong emphasis on filial piety, obedience, respect for elders, and maintaining harmony, family therapists need to be mindful of such culturally relevant family interactions. For example, when family therapists want to elicit the negative cognitions or expectations of parents and children that maintain children's eating disorders, troubled Chinese children have extreme difficulty expressing thoughts of disrespect or rebellion against their parents. Similarly, parents would be extremely reluctant to disclose their own private thoughts and feelings in front of the child for fear of losing 'face' and respect from the child. It is also more difficult for a family to trust a family therapist and to disclose family secrets in front of a 'stranger' because Chinese people tend to view the world more dichotomously as 'insiders' and 'outsiders' (Gudykunst et al., 1992). Unless people are considered 'insiders' of the family, they will not have the privilege of access to the internal world and secrets of the family. To become an insider in a family, family therapists need to take extra effort to understand different aspects of the family (e.g. environment, economic status, and employment situation). Therapists need to use a 'befriending' strategy and not focus exclusively on intra-psychic material or system issues in a family right away. Not only does family assessment need to take a different approach for Chinese people, intervention strategies might also need to be modified. In the west, family therapists might encourage depressed children to gain independence from their over-controlling parents. This strategy might not be beneficial for a child from a Chinese family, since there are studies suggesting that filial piety may be a protective factor against depression among service users in an outpatient setting (Ng & Bhugra, 2008) and among survivors of childhood abuse (Ng et al., 2011). Instead of encouraging depressed children to 'rebel' against their parents to gain independence, family therapists may provide the child with a more benign explanation of parental over-involvement (e.g. parental involvement is out of love and concern) if clinically appropriate. According to the second author's clinical experience (Ng), this sort of explanation might paradoxically reduce parents' need for excessive control and encourage them to use more protective and nurturing behaviours with their children. A recent study in an Asian community found that the level of parent–child conflicts increased with widening discrepancies over a variety of issues (e.g. family norms, career choice, and respect for elders) between parents and children (perceived by either part) (Tsai-Chae & Nagata, 2008). However, it must be emphasized that existing studies on family therapy have not systematically compared the outcomes of family therapy using a traditional western approach versus a more culturally responsive approach. Other considerations in adapting family therapy to Chinese families include resource restraints in the settings where the therapy takes place and the stigma and pervasive myths associated with psychiatric disorder (e.g. onset of the illness is viewed as a form of punishment passing from generations) (Yang & Pearson, 2002). More research is urgently needed on the cultural adaptation of family therapy and its value in improving the efficacy of family therapy for Chinese families.

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