

تدارک یک فرایند به منظور برگردان مفهومی برنامه‌های روانی - تربیتی

The Development of a Process for the Conceptual Translation of Psychoeducation Programs : Initial Trials

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Abstract

This project attempted to develop a process for the conceptual translation of psycho-educational materials for families from diverse backgrounds. Participants were selected from the Arabic and Cantonese speaking immigrants with a serious mental illness, and their families. A previously established psycho-educational program and its manual, developed for English speaking families, were adapted to the objectives of this program and were applied. Bi-lingual Arabic and Chinese mental health professionals translated the concepts into Arabic and Chinese and taught them during multiple-family group programs and routine clinical practice. After completing the program, families attending the multiple-family programs reported a reduction in the burden and stress of taking care of their mentally ill relative. The approval of findings requires replicating the study, using a larger sample size.

Key words : conceptual translation, psychoeducation material, multiple-family program, serious mental illness.

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چکیده

هدف این پژوهش، فراهم کردن یک فرایند برگردان مفهومی مواد روانی - تربیتی برای خانواده‌های واجد پیشینه‌های مختلف فرهنگی بود. افراد مبتلا به بیماری‌های وخیم روانی و خانواده آنها از جامعه مهاجران عرب و چینی زبان، به عنوان گروه‌های نمونه انتخاب شدند. سپس یک برنامه روانی - تربیتی متداول همراه با دفترچه راهنمای آن - که برای خانواده‌های انگلیسی زبان تدارک شده بود با هدف‌های این پژوهش منطبق شد. ترجمه مفهومی اطلاعات به زبان‌های عربی و چینی توسط متخصصان بهداشت روانی دو زبانه در خلال اجرای برنامه‌های «چند خانواری» و فعالیتهای متداول بالینی به شرکت‌کنندگان آموزش داده شد. پس از اتمام برنامه، خانواده‌هایی که در آموزش‌های «چند خانواری» شرکت کرده بودند کاهش فشار ناشی از مراقبت از خویشاوند بیمار خود را گزارش دادند. تأیید این یافته‌ها مستلزم تکرار پژوهش با نمونه‌های گسترده‌تری است.

واژه‌های کلیدی : برگردان مفهومی، مواد روانی تربیتی، برنامه چند خانواری، بیماری روانی وخیم.

Introduction

The effective treatment of serious mental illnesses such as schizophrenia is a challenge faced by mental health systems across the world. Schizophrenia occurs in .63% to 1.5% of the population, with an incidence rate that appears stable across countries and cultures and over time, for at least the last 50 years (Hafner & van der Heiden, 1997). These figures reflect the incidence of schizophrenia in individuals; these individuals have friends and family who also experience their own distress in connection with their loved one's illness (Jones, 1997).

The successful treatment of serious mental illnesses such as schizophrenia calls for a multifaceted and multidisciplinary approach (American Psychiatric Association, 1997; Canadian Psychiatric Association, 1998); unfortunately, not all effective treatments are universally available to those who need them. A number of psychosocial treatments have been developed in response to this need for a multifaceted approach (Penn & Mueser, 1996), including cognitive-behavioral interventions in the US and the UK for families of consumers with schizophrenia. Controlled studies in English-speaking countries have demonstrated that these interventions can reduce relapse rates in the primary consumer (Falloon, Boyd, McGill, Razani, Moss & Gilderman, 1982; Falloon & Pederson, 1985; Goldstein, Rodnick, Evans, May & Steinberg, 1978; Hogarty et al., 1986; Hogarty et al., 1991; Leff, Kuipers, Berkowitz, Eberlein-Vries & Sturgeon,

1982; Leff, Kuipers, Berkowitz & Sturgeon, 1985; McFarlane et al., 1995; Randolph et al., 1994; Tarrrier et al., 1989). Similar findings have been made in China (Mingyuan, et al., 1993; Xiong, et al., 1994; Zhang, Wang, Li & Phillips, 1994). In some studies, the interventions have also been found to moderate the stress on the family (Falloon et al., 1982; Falloon & Pederson, 1985; Mingyuan et al., 1993; Xiong et al., 1994). Similar interventions have also been developed for bipolar disorder (Bland & Harrison, 2000, Glick, et al., 1985; Miklowitz & Goldstein, 1990) and depression (Sherrill, Frank, Geary, Stack & Reynoldd, 1997). An important component of cognitive-behavioral family interventions is the provision of psychoeducation in the early phase of treatment (Pekkala & Merider, 2000). There is evidence that this alone can have a positive impact both on relatives' knowledge about mental illness (Barrowclough, Tarrrier, Watts, Vaughn, Bamrah & Freeman, 1987; Berkowitz, Eberlein-Friess, Kuipers & Leff, 1984; Smith & Birchwood, 1987), and their level of distress (Abramowitz & Coursey, 1989; Laube & Higson, 2000; Prema & Kodandaram, 1998; Smith & Birchwood, 1987).

Congitive-behavioral family interventions have mainly been used in Western countries with English-speaking populations, exceptions being in China (Mingyuan et al., 1993; Xiang, Ran & Li, 1994; Xiong et al., 1994; Zhang, Wang, Li & Phillips, 1994), India (Prema & Kodandaram, 1998; Shankar &

Menon, 1993), Singapore (Bentelspacher, DeSilva, Leng Chuang Goh & LaRowe, 1996) and with a Spanish-speaking population in the US (Telles et al., 1995). There has been little discussion about whether these family interventions suit migrant families from different cultures (Lam, Chan & Leff, 1995), although one study examined the comparative effectiveness of a brief family intervention with families from English-speaking background (ESB) and non English-speaking background (NESB) in Australia (Higson & Laube, 2001). This study found evidence of equal benefits for the two groups.

Mental health systems need to be able to provide effective treatments for their migrant, as well as their native-born populations. In the state of New South Wales, Australia, 26.7% of the population were born overseas, the majority of these people coming from the United Kingdom, New Zealand, Italy, China, Vietnam, Lebanon and the Philippines (Epidemiology and Surveillance Branch, Public Health Division, NSW Health Department, 1997). Studies examining the prevalence of schizophrenia among migrants to Australia (Bruxner, Burvill, Fazio & Febbo, 1997; Wijesinghe & Clancy, 1991) suggest that it is at least as high, and sometimes higher, among migrant groups as among the native-born population.

Similar findings have been made in the United Kingdom (Cochrane & Bal, 1989; Dean, Walsh, Downing & Shelley, 1981; Harrison et al., 1997; Littlewood & Lipsedge,

1981). In the state of New South Wales, Australia, it appears that migrants do not voluntarily use mental health services for schizophrenia and related disorders to the same extent as the Australian-born population. McDonald & Steel (1997) found that hospital patients with mental disorders from NESB are more likely to be involuntary than those from ESB; they suggest that any strategies that lead to more timely access to appropriate specialist care of NESB people with mental disorders will lead to a decrease in the proportion of NESB patients who are admitted (or readmitted) involuntarily. One of these strategies could be to provide psychoeducation for these patients and their families.

One dilemma in the provision of psychoeducation for people from NESB is to ensure that it is in an appropriate and accessible form. To have maximum value, the information must be accurate, in a language accessible to members of the target group (Gleeson & Davenport, 1999) and sensitive to the person's beliefs. If the person speaks limited English, the information may need to be in his or her own language. Literal, word-for-word translations of educational materials may be offensive, incomprehensible, or culturally irrelevant (Sabogal, Otero-Sabogal, Pasick, Jenkins, & Perez-Stable, 1996). For this reason, the concepts, and not just the words, need to be translated in a meaningful way. The information then needs to be presented in a culturally appropriate manner (Johnson, 1994), Sensitive to pre-existing

beliefs and community traditions of health care and information exchange. The aim of the current project was to develop a process of *Conceptual Translation* to create psycho-education material that is accessible and culturally meaningful for consumers and families from diverse backgrounds.

Method

Participants

Just over 21% of the NSW population speak a language other than English at home. Chinese, Arabic, Italian, Greek, Vietnamese, Spanish and Filipino are the non-English languages most commonly spoken (Epidemiology and Surveillance Branch, Public Health Division, NSW Health Department, 1997). Two of the fastest growing language groups (other than English) in the state are Arabic and Cantonese (Ethnic Affairs Commission of NSW, 1998). Members of the Arabic and Cantonese-speaking communities with serious mental illness, and their families, were selected to be the pilot groups for this project.

Procedure

Recruitment of Consumer and Carer Consultants. There is increasing recognition in Australia and other countries of the importance of participation by consumers and carers in the development, evaluation and management of mental health services (Barry & Schaecken, 1996; Sozemenou, Mitchell, Fitzgerald, Malak & Silove, 2000). For this reason, the Consumer Project Coordinator,

the Carer Project Coordinator, an NESB Consumer representative, and an NESB Carer representative were recruited from the New South Wales Transcultural Mental Health Centre (TMHC) to provide ongoing consultation throughout the project.

Recruitment of bi-cultural health professionals. Experienced bi-cultural / bi-lingual health professionals were sought through the Arabic and Chinese language subcommittees of the TMHC and the clinicians associated with the TMHC in a sessional capacity. All health professionals were offered payment at prevailing sessional rates. A total of 17 Arabic-speaking and 19 Cantonese-speaking health professionals were approached and invited to field trial the translated mental health information booklets as part of their routine work. This resulted in five health professionals from the Arabic-speaking community and four from the Cantonese-speaking community being recruited. Of the Arabic speakers, three were of Lebanese background, one Assyrian, and one Egyptian. Of the Cantonese speakers, three were of Hong Kong, and one of ethnic Chinese / Vietnamese background.

Preparation of the manual and the information booklets for families. A manual for conducting a four-session psycho-education program with multiple-family groups was prepared. This manual was based on a program developed by Laube & Smith (1994), a version of which was found to be associated with reduction in family burden for participating families (Laube & Higson, 2000).

As mentioned above, the latter edition of the program had also been found to be associated with equal benefits for ESB and NESB families who had at least a fair command of spoken English (Higson & Laube, 2001). In consultation with the consumer and carer representatives, the appropriateness of the manual for the Arabic and Cantonese-speaking communities was considered and discussed. Modifications were made, based on the discussion.

An information booklet for families was also prepared, using information and ideas from American Psychiatric Association (1994), Laube & Smith (1994), Ng (1997), Piatkowska & Visotina (1989), Sane Australia (1998) and Schizophrenia Fellowship of NSW (1999). It was then perused by the consumer and carer representatives and the language subcommittees, who provided the authors with feedback regarding the appropriateness of the information and concepts for the Arabic and Cantonese-speaking communities. Modifications were also made to this material, based on the feedback.

Translation of information for families.
The information booklet was sent to an independent commercial agency to be translated into Arabic and Chinese, with the requirement to employ translators with previous experience in translating health information and National Accreditation Authority for Translators & Interpreters level 3 credentials, the highest credential level used for translation of health information.

Field trials of psychoeducation materials.

The manual and the booklet were field trialed through four-week psychoeducation programs with multiple-family groups from each of the two language communities. The third and fourth authors, who are both bilingual Cantonese speaking mental health professionals, conducted the Cantonese speaking programs. The fifth and sixth authors, who are both bilingual Arabic speaking health professionals (one is a mental health professional), conducted the Arabic speaking programs. The program facilitators recruited the families through a public mental health service in metropolitan Sydney.

Evaluation of clinical service delivery requires modification of traditional models of investigation (Norquist, Lebowitz, & Hyman, 1999). This project employed the Public Health model where consumers are offered service on a needs identification basis and formal control groups are not practical. The families of five consumers attended the Arabic-speaking program. The families of three consumers attended the first Cantonese speaking program and the families of four consumers attended the second Cantonese-speaking program.

During the delivery of the programs, the facilitators aimed to highlight the value of each participant's knowledge and experience prior to attending the multiple family groups, and to emphasise respect for any beliefs held by participants. A cognitive change approach was employed in which beliefs were elicited from participants and evidence [or paucity of evidence] was examined without prejudice.

An important element in this approach is to recognize that some concepts have not been empirically investigated, perhaps due to logistic impracticality, such as spiritual or metaphysical beliefs. This openness promotes engagement of families by displaying respect for all suggestions. The professionals conducting the program aimed to facilitate choices rather than dispense wisdom.

The five Arabic and four Cantonese-speaking health professionals not involved in conducting the multiple-family groups assisted with further field trials by using the information with individual mentally ill consumers and their families and providing the authors with feedback. The feedback concerned the comprehensibility and cultural appropriateness of the concepts and information for the consumers and families.

Coordination of feedback from field trials. A range of opinions regarding the comprehensibility and appropriateness of the booklets for the consumers and their families was obtained from the field trials. For this reason, a discussion session was conducted to finalise the content of the booklets for members of each language group. Unsuccessful attempts were made to recruit the Arabic and Cantonese-speaking consumers and carers who had been involved in the project to attend these discussion sessions.

Evaluation of impact on families. The Family Burden Interview Schedule (FBIS) (Pai & Kapur, 1981) was administered immediately before the families' participation

in the multiple family programs, and again six months later to evaluate the impact of those programs on the families involved. The FBIS is a semistructured interview conducted with the family by a health professional to assess the level of burden the family might be experiencing in relation to caring for a mentally ill member. The interviews were conducted in the families' first language (Arabic or Cantonese) by the multiple family program facilitators.

Results

Feedback from consultation and field trials

Before any translation of psychoeducation material took place, the consumer and carer representative and the language sub-committees were asked to provide feedback regarding the appropriateness of the manual and information booklet for the language communities. At that stage, it was decided that the psychoeducation material should include both some practical suggestions regarding caring for a mentally ill family member on a day-to-day basis, and a section on dealing with the stigma of mental illness. It was also pointed out that due to poor literacy, some Arabic-speaking families might have difficulty reading the information booklets. This observation lent weight to the importance of the information about mental illness also being delivered interactively by mental health professionals, as in the manual for conducting the multiple-family groups.

After initial literal translation, the Can-

tonese-speaking health professionals considered several of the words and phrases in the Chinese information booklet needed to be changed. This included spelling, reflecting the variety of styles and forms that written Chinese can take; some of the words and phrases were thought to have military connotations. However, no major changes were suggested to the overall content, structure or organization of the material. After the field trial of the manual and information booklet with the first multiple-family group, a linguistic dilemma became apparent: written Chinese is not a phonetic representation of words, and spoken Cantonese evolves more quickly than written Chinese does. This meant that when the health professionals conducting the group identified the most accurate oral phrases and expressions to successfully convey the intended information to participants, [usually by using colloquial language], this could not be codified in writing for the manual or the information booklets.

For both the Arabic and Cantonese-speaking families, a section on dealing with the stigma of mental illness was included in the manual and in the booklet. Feedback suggested that although it was important for this section to be included, the way in which it was presented needed to be approached delicately. In Arabic, one observation was that it could be offensive to families to suggest that they might experience shame regarding a relative's mental illness. In Chinese, it was found that there is no direct

translation of the word *stigma*, and attempts to find an approximate translation resulted in expressions that were unacceptably confronting for families. The feedback from the field trials confirmed that the issue was important, but the language used posed a difficulty. The field trial and consultation process revealed that in both the Arabic and Chinese booklets, this section should be referred to by translations of the phrase *Talking About Mental Illness*, rather than a phrase containing translations or approximations of the word *stigma*.

For groups conducted in both communities, the bi-cultural health professionals found the interactive model of information delivery/cognitive change to be effective. In particular, the approach of *respectful interest* for pre-existing beliefs, and the *exchange* of ideas with participants, created a non-judgemental ethos in which families could safely consider alternate beliefs about mental illness, its origins and its treatment. In general, the group facilitators found that the manual was best used as a guide to conducting the multiple-family groups, rather than as a rigid prescription. The collaborative approach with families progressing through the four-session program allows different parts of the program to be emphasized with different groups of families.

Impact of program on participants in multiple family groups. Baseline and follow-up FBIS measures were collected for the five families involved in the Arabic-speaking multiple-family group program. The mean

score on the FBIS was less after the program than before, as shown in Table 1.

Table 1 : Pre-and Post-program FBIS scores of Arabic speaking families (n=5)

| FBIS score | Mean | Standard Deviation |
|------------|-------|--------------------|
| Pre | 11.00 | 1.10 |
| Post | 7.20 | 1.60 |

These results suggest that for the families involved in this program, the burden associated with caring for a mentally ill member was reduced after participation in the program. In the first Cantonese-speaking multiple-family group program, the families found the presentation on living with stigma to be unacceptably confronting. This part of the program was modified in accordance with the intended field-trial-and-revision process before the second Cantonese-speaking program was conducted. The program appeared to be better accepted by the second group than the first group.

Baseline and follow-up FBIS measures were collected for the four families involved in the second Cantonese-speaking program. The mean score on the FBIS was less after the program than before, as shown in Table 2.

Table 2 : Pre-and Post-program FBIS scores for Cantonese speaking families (n=4)

| FBIS score | Mean | Standard Deviation |
|------------|-------|--------------------|
| FBIS-Pre | 11.00 | 2.00 |
| FBIS-Post | 7.75 | 2.76 |

As with the Arabic speaking group, these results suggest that for the families involved in this program, the burden associated with caring for a mentally ill member was reduced after participation in the program. The samples for both programs were too small to warrant meaningful statistical analysis of change in FBIS scores.

Discussion

This paper outlines a process which psychoeducation material can be conceptually translated to make it accessible and culturally meaningful for consumers and families from diverse backgrounds. The initial trials identified important challenges, some of which were sufficiently overcome to allow a satisfactory and encouraging outcome.

Two consumer representatives and two carer representatives contributed suggestions during the project. However, attempts to include Arabic and Cantonese-speaking consumers and carers directly in the revisions of the information booklets (ie. at the discussion sessions with mental health professionals) were unsuccessful. This may reflect suggestions by Sozemenou et al (2000) that some consumers and carers find it difficult to be involved in projects at a formal level. Another possibility raised by several bi-cultural health professionals is that many migrants come from a culture in which ‘professionals’ are perceived to have the ‘correct’ information and make all relevant decisions, (Erickson & Al-Timimi, 2001). The very concept of community consultation

may be alien to some consumers. However, consumers and carers were indirectly involved in the revisions of the manual and information booklets by participating in the family psychoeducation programs and field trials of the materials.

The multiple-family psychoeducation groups were associated with a positive impact upon the participating families: the follow-up data for groups from both communities indicate that family burden decreased after involvement in this program. The *conceptual Translation* process may have successfully produced a program and related materials that can deliver the same benefits to both Arabic-speaking and Cantonese-speaking consumers as found for English-speaking groups using the same base program (Higson & Laube, 2001; Laube & Higson, 2000). However, one limitation of the current project is that control groups were not included. Other variables, such as a social support element from the multiple family programs, may have influenced the reduction in family burden. Other limitations of the current project include very small samples for the multiple family groups, and possible demand effects associated with some of the authors administering the pre and post FBIS evaluation measures.

It is recommended that this model be replicated with larger samples of Arabic and Cantonese speaking families before being considered for other language/culture groups. It is also recommended that the impact of the programs on the families be more rigoro-

usly evaluated through the inclusion of wait-list control groups, and through pre and post program interviews being conducted by bilingual mental health professionals who are blind to the research design.

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