Cultural Adaptation of the Basic Conversational Skills Module for a Chinese Population

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Introduction by the column editors: **Persons with schizophrenia experience numerous deficits in their daily lives, particularly in the area of social competence. Social skills training is an evidence-based element of a comprehensive approach to the rehabilitation of persons with serious mental illness (1). The basic conversational skills module, or curriculum, is one in a series of social and independent living skills modules developed to overcome the social deficits of individuals with schizophrenia (2). It has been translated into a dozen languages and used in numerous countries with demonstrated efficacy for improving knowledge and performance of conversation skills and enhancing social functioning of persons with schizophrenia (3).**

Chinese individuals with schizophrenia have limited access to empirically validated methods for improving their social skills (4). Although the process of developing interpersonal relationships in Western and Asian societies is probably more similar than different, the adaptation of programs developed in the United States to the needs of Chinese persons requires careful consideration of cultural and linguistic issues. The authors of this month's column describe the process of translating and culturally adapting the basic conversational skills module for use in a Chinese population and provide preliminary evidence of the module's beneficial effects on the social competence, self-esteem, and personal well-being of persons with schizophrenia in Hong Kong.

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The basic conversational skills module was designed to teach persons with serious and persistent mental illness how to start and maintain informal conversations with friends, colleagues, and strangers and thus to reduce their social isolation. The goals of this training are to improve the skills of persons who have had little success in developing social relationships as well as to help those who need retraining and upgrading of their social skills to function more autonomously. Skills trainers teach social perception, social problem solving, and verbal and nonverbal communication skills. Educational techniques used in the module comprise instructions, modeling, rehearsal, social reinforcement, shaping, and corrective feedback. The module is divided into five skills areas: verbal and nonverbal communication behaviors; starting a friendly conversation; keeping a conversation going; ending a friendly conversation; and putting it all together.

Cultural adaptation and translation

Several steps were taken to adapt the basic conversational skills module for use in Hong Kong. First, the three components of the module—a trainer's manual, a client's workbook, and the script of a demonstration video—were translated into Chinese by three bilingual occupational therapists. An independent translator then back-translated the Chinese version into English. Next, the original English version and the back-translated English version were compared. Semantic discrepancies were identified in 56 sentences and 32 phrases. These discrepancies were resolved through a discussion process involving an expert panel of six bilingual occupational therapists. For example, one homework assignment in the English version asks participants to "Find a place where you're likely to meet a friend or an acquaintance who will give you Go signals." In English, the term "Go signals" refers to verbal and nonverbal behaviors indicating that a person is willing to engage in a conversation. However, the literal Chinese translation does not convey the same meaning. To preserve the meaning with a Chinese phrase, the panel chose a term that means "signals of communication."

The expert panel also identified 12 role-playing scenarios that required accommodation to Chinese norms. For example, one scenario in the English version of the module is, "You're attending a party at a friend's house. You're new in town and you don't know anyone at the party but your friend. You see an attractive per-

son of the opposite sex sitting alone, tapping a foot in time with the music . . . you approach that person and strike up a conversation." In Western societies, the term "party" is used for a social gathering in which people get together and new people can be met. However, Chinese people seldom gather in this way. Instead, such social gatherings usually take place in a restaurant where the focus is on eating dim sum and drinking Chinese tea. The scenario was changed accordingly in the Chinese version of the module.

Another example of the need for cultural modification was the American use of the term "opening lines" as a means of starting a conversation. In the West, discussing the weather is a common way of engaging in dialogue with a stranger. In Hong Kong, a more typical discussion would begin with a reference to the quality of life, food, or worsening road traffic conditions. Other topics that required cultural adaptation included appropriate levels of self-disclosure, acceptable degrees of assertiveness, and appropriate forms of eye contact.

Evaluation of the Chinese module

Six participants—two men and four women—who had diagnoses of schizophrenia were recruited from the inpatient psychiatric ward of Kowloon Hospital in Hong Kong. The participants' mean±SD age was 43±6.87 years, and they had been ill for an average of 11 years. Each of the participants had at least some high school education. All were free from other associated major chronic physical illnesses, organic brain disease, mental retardation, and substance abuse.

The Expanded UCLA Brief Psychiatric Rating Scale (5) was used to monitor symptoms. The Social Skill Assessment Scale (6) was used to assess the participants' self-reported social competence and behavioral competence in role-playing situations. The Adult Self-Esteem Inventory (7) was used to measure the participants' level of self-esteem, and the Personal Well-Being Index (8) was used to assess their general satisfaction with life.

After providing informed consent, all participants completed the above-mentioned outcome measures. The first author then conducted the skills training by using the Chinese version of the basic conversation skills module with the same seven learning activities that were included in the English version. The skills training sessions were conducted in a group setting in the hospital for 90 minutes each weekday for five weeks.

Participants attended an average of 24 out of 26 sessions (92 percent). Changes in scores on the various instruments were evaluated for statistical significance by using the Wilcoxon signed-rank test, a nonparametric analogue for the t test for paired observations (9). A nonparametric test was used because of uncertainties about whether the assumptions for the t test were met. No significant changes in psychiatric symptoms were observed over the course of the study. Significant improvements were noted in overall social skills ($z=-2.264$, $p=.024$), voice quality ($z=-2.226$, $p=.026$), nonverbal expressiveness ($z=-2.060$, $p=.039$), and verbal content ($z=-2.207$ $p=.027$). Generalization of improvement in social skills to other aspects of psychological functioning was noted for perceived well-being ($z=-2.201$, $p<.05$) and self-esteem ($z=-1.992$, $p<.05$).

Five of the six participants reported improvements in their own conversation performance and interpersonal relationships. All participants endorsed the belief that the content of the module was culturally relevant, and five stated that the learning activities were easy to follow. Evaluations by the hospital staff mirrored those of the participants. All staff members reported improvements in the conversation skills of the participants, and half noticed enhanced socialization with peers and staff.

Case vignette

Ms. T, a 33-year-old woman, had her first psychotic episode while working as a laborer in a factory at the age of 22. For several months, she had had frequent conflicts with her coworkers as well as with her brother. She believed that her coworkers were verbally attacking her. Her increasingly bizarre behavior led to a diagnosis of schizophrenia and admission to a psychiatric hospital. She was hospitalized six times over a ten-year period because of relapses related to poor compliance with her medication regimen.

During her most recent hospitalization in 2003, Ms. T's symptoms quickly stabilized with antipsychotic medication, but she continued to manifest serious deficits in social skills, including verbal and nonverbal skills, politeness, voice quality, facial expression, and reciprocity, or meshing of turn-taking when speaking. She felt incapable of communicating with people, with resulting feelings of inadequacy.

At first, Ms. T was passive, and her participation in the conversational skills group was limited. She found it difficult to understand the meaning of verbal and nonverbal communication behaviors. However, in the second skill area—starting a friendly conversation—the level and quality of her participation improved, particularly in role playing and in vivo exercises. Her social behaviors became more appropriate through the use of corrective and positive feedback, modeling, and repetition. Improvements were noted in her conversations with fellow patients and staff on the ward. Ms. T herself stated that the training had taught her how to tell whether people wanted to speak with her by watching their facial expressions, eye contact, and posture.

Formal assessment of Ms. T echoed the staff's observations. Her score on the Social Skill Assessment Scale jumped from 49 to 84 (out of a possible 92). Areas of improvement included voice quality, politeness, and gesturing during conversation. Her score on the Adult Self-Esteem Inventory increased from 95 to 164 (out of a possible 200), with gains also noted in overall quality of life.

Afterword by the column editors:

The results of this pilot study suggest that the Chinese version of the basic conversation skills module is culturally relevant. The success in adapting this American program for use in Chinese populations may be credited to the systematic manner in which cultural competence was used for the translation. Another module, on medication management, also was culturally adapted to Chinese

norms, expectancies, and practices, with subsequent efficacy documented in a controlled clinical trial at a psychiatric hospital in Beijing (10). Similar experiences have been noted in translations and cultural adaptations of skills training modules in Bulgaria, Poland, Germany, France, and Finland (3).

The lack of improvement in psychopathology may be explained by the lengthy hospitalizations still extant in Hong Kong, with resulting stabilization of symptoms over time with antipsychotic medication. The benefits of the Chinese version of this module compared with other treatments remains to be determined through a randomized controlled clinical trial. This type of study has begun in Hong Kong, and results should be available for reporting in two years. ♦

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