琉球大学学術リポジトリ

# [原著] Attitudes toward mental illness : A cross-cultural comparative study of nurses and high school teachers in Canada and Japan



| メタデータ | 言語: English<br>出版者: 琉球医学会<br>公開日: 2010-07-02<br>キーワード (Ja):<br>キーワード (En): attitudes, mental illness, cultural variables<br>作成者: Naka, Koichi, Oda, Melanie, Randall, Maxine, Inoue, Shimpei, Ishizu, Hiroshi<br>メールアドレス:<br>所属: |
|---|---|
| URL | http://hdl.handle.net/20.500.12000/0002015974 |

# Attitudes toward mental illness: A cross-cultural comparative study of nurses and high school teachers in Canada and Japan

Koichi Naka*, Melanie Oda***, Maxine Randall**,
Shimpei Inoue**** and Hiroshi Ishizu*

**Department of Mental Health and Research Center of Comprehensive Medicine,*
***Department of Neuropsychiatry, Faculty of Medicine, University of the Ryukyus, Okinawa 903-01, Japan;*
****Queen Street Mental Health Centre, Toronto, Canada,*
*****Kochi Medical School, Kochi, Japan*

(Received on July 26, 1995, accepted on October 24, 1995)

## ABSTRACT

A cross-cultural comparative study examining attitudes of nurses and high school teachers in Canada and Japan toward mental illness was undertaken. The population sampled included 76 Canadian nurses and 77 high school teachers, 187 Okinawan nurses and 179 high school teachers, and 98 Kochi nurses and 107 high school teachers. A self-administered questionnaire, which included the semantic differential, attitudes toward mental illness, and social distance scales as well as case vignettes, was utilized to ascertain the knowledge and attitudes regarding mental illness and the acceptance or rejection of the mentally ill. The main findings of this investigation were: 1) the Japanese subjects seemed comparatively less able to discriminate differences in causality, diagnosis, and prognosis of the various psychiatric disorders described. 2) the Japanese, whether from Okinawa or Kochi, desired a greater distance than the Canadians from the mentally ill. 3) the Canadians tended to have a more positive realistic attitude toward the mentally ill. A careful assessment of these differences in attitudes from the social and cultural context in which they originate provides some insight into how a more realistic and supportive attitude toward the mentally ill might be instituted or improved in all three cultural groups investigated. Our findings point not only to the importance of recognizing the influence of culture on attitudes toward mental illness, but also to the importance of the effect of cultural variables on the interrelationship between attitudes, education and service delivery. *Ryukyu Med. J., 15(4)165~172, 1995*

Key words: attitudes, mental illness, cultural variables

## INTRODUCTION

In order to implement positive changes in a mental health system it is important to identify and understand the context of that system. Not only do sociocultural factors affect the development and effectiveness of the system, but also influences the attitudes held by the recipients of mental health services as well as those who deliver those services. The purpose of this study was to examine the attitudes toward mental illness held by nurses and high school teachers from Canada (Ontario) and Japan (Okinawa, Kochi) by identifying those attitudes and attempting to understand them from a sociocultural perspective. After review of the literature and in recognition of the differences that exist in the social and cultural values of the different societies, it was hypothesized that Canadian subjects, regardless of group, would have a more positive attitude toward mental illness than Japanese subjects.

## SUBJECTS AND METHODS

The populations sampled totaled 724 subjects: 76 Canadian nurses and 77 high school teachers; 187 Okinawan nurses and 179 high school teachers; 98 Kochi nurses and 107 high school teachers. A self-administered questionnaire which included a semantic differential scale, measures of attitudes toward mental illness, case vignettes and a social distance scale was utilized to ascertain the knowledge and attitudes regarding mental illness and the acceptance or rejection of the mentally ill. Portions of the questionnaires differed based on the profession of the subjects. The nurses were asked in the vignette portion about their opinion as to whether the individual described required hospitalization or should consult a psychiatrist. The high school teachers were asked whether they had had contact with a mentally ill individual and if so, where. They were also asked to indicate whether they had ever met a person like

the ones described in the case vignettes. In the personal background column, a question was included inquiring whether the subjects had received prior information regarding mental illness and from where they received such information. The Canadian survey for both groups included a question pertaining to ethnic identity since the population is comprised of people from various ethnic and cultural backgrounds. There was such great diversity within the Canadian population by 1971 that a national policy regarding multiculturalism was established[1]. The data was collected from August, 1991 to June, 1992.

Descriptive statistics were employed to analyze and compare the responses of the subjects. Given the history and unique culture of Okinawa, and the possibility of biasing the results, Kochi was also selected and regarded as a separate location in the analysis.

## RESULTS

Through the use of the Semantic Differenctial Scale (Fig.1) it was found that the Canadian nurses generally had a more positive image of the mentally ill than the nurses from Okinawa and Kochi. Within the nursing group the items of significant difference are as follows: soft/hard (p=0.0001); good/bad (p=0.0004); strong/weak (p=0.0001); clean/dirty (p=0.0002); positive/negative (p=0.0001); sharp/dull (p=0.0099); gay/plain (p=0.0006); familiar/weird (p=0.0041); bright/dark (p=0.0001); safe/dangerous (p=0.0001); complex/simple (p=0.0179); and lively/apathetic (p=0.0001).

The results of the high school teacher groups were similar to those of the nurses. The Okinawan and Kochi teachers' images of the mentally ill were more similar to each other than either was to the Canadian counterpart. Significant differences were apparent in the following items: soft/hard (p=0.0001); good/bad (p=0.0001); strong/weak (p=0.0001); clean/dirty (p=0.0009); positive/negative (p=0.0002); familiar/weird (p=0.0058); bright/dark (p=0.0001); safe/dangerous (p=0.0143); clever/foolish (p=0.0002); and lively/apathetic (p=0.0001). For the two items, sharp/dull (p=0.0076) and calm/tense (p=0.023) the Canadian teachers had a significantly more negative image of the mentally ill than the teachers from either Okinawa or Kochi.

Overall, the Canadian nurses and high school teachers had a more positive image of the mentally ill than the subjects from either Okinawa or Kochi.

The Attitudes Toward Mental Illness scale (Fig.2) indicated that nurses from both Okinawa and Kochi felt, to a greater degree than their Canadian counterparts, that psychiatric patients were: more violent and fearful; should be sterilized; could not make correct judgments; lacked interest to improve; and should be segregated by gender on a psychiatric ward. A genetic cause for psychiatric illness and being fearful with a psychiatric patient were also more strongly held beliefs among Okinawan and Kochi nurses than those in Canada. The Kochi nurses, relative to the Okinawan and Canadian nurses, respectively, would choose a psychiatric hospital in a remote area for someone in their family and felt that a psychiatric patient in a family would

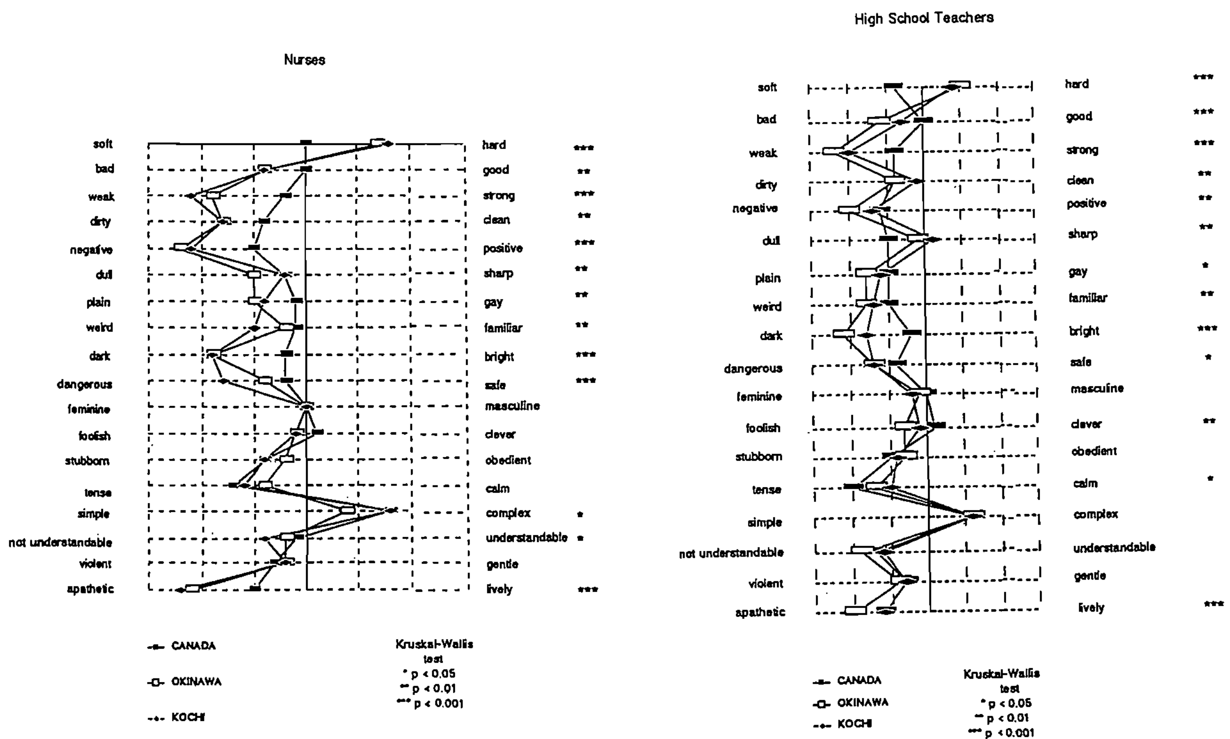


Fig.1 Comparative semantic differential scale for nurses and high school teachers.

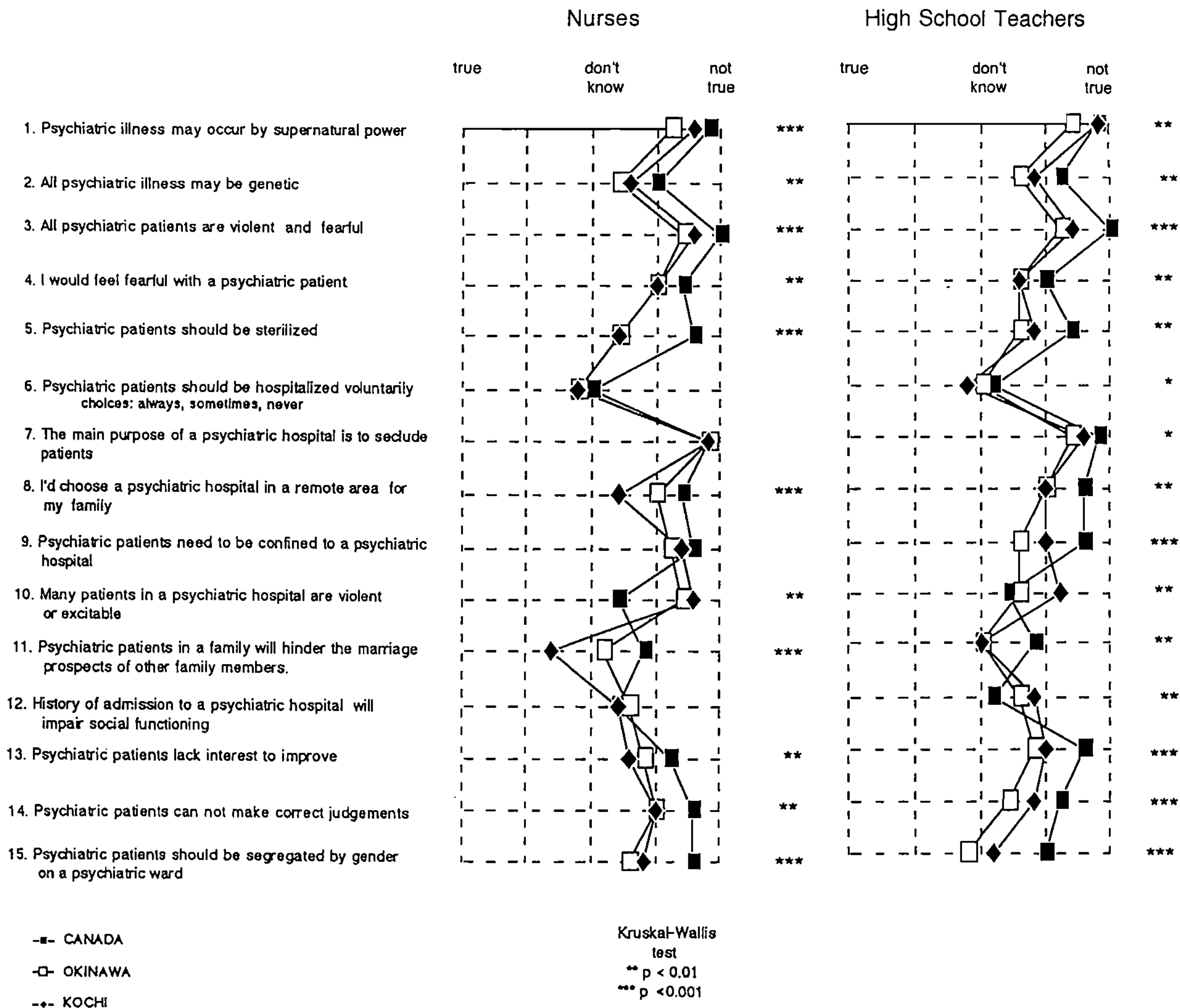


Fig.2 Attitudes toward mental illness.

hinder the marriage prospects of a family member. The Canadian nurses believed that patients in a psychiatric hospital were more violent or excitable than the Japanese nurses did. The Okinawan nurses held the strongest belief that psychiatric illness may occur by supernatural power compared to the nurses from Kochi or Canada.

The high school teachers had significant differences in every item of this scale. The strongest degrees of differences appeared in the Canadians disagreeing with the statements that: patients are violent or fearful; psychiatric patients need to be confined to a psychiatric hospital; psychiatric patients lack interest to improve; psychiatric patients are not able to make correct judgments; and psychiatric patients should be segregated by gender on a psychiatric ward. Although differences were significant in only the high school teacher group, both Okinawan teachers and nurses had a stronger tendency to attribute the cause of psychiatric illness to supernatural power.

On the Concept of Mental Illness scale (Fig.3) the Canadian nurses and high school teachers believed that a mental illness was serious, yet indicated a more positive outlook on life in the community and the ability of a mentally ill individual to go to work or school.

Although no figure is shown, concerning appropriate facility for consultation, the Canadian subjects identified more service options than the Japanese subjects did. The Okinawan nurses chose psychiatric hospitals more frequently than any other facility appropriate for consultation. The high school teachers in all three locations identified a variety of facilities as being appropriate for consultation. Once again, the Okinawan high school teachers believed that the most appropriate facility for consultation was a psychiatric hospital.

Regarding previous contact with a mentally ill individual, 84% of the high school teachers from Canada had had previous contact with a mentally ill person, Kochi high school teachers had the least contact at 68.9%, whereas 75.3% of the Okinawans had met a mentally ill person. The Canadians had considerably more contact with a mentally ill individual in most areas but not "in my

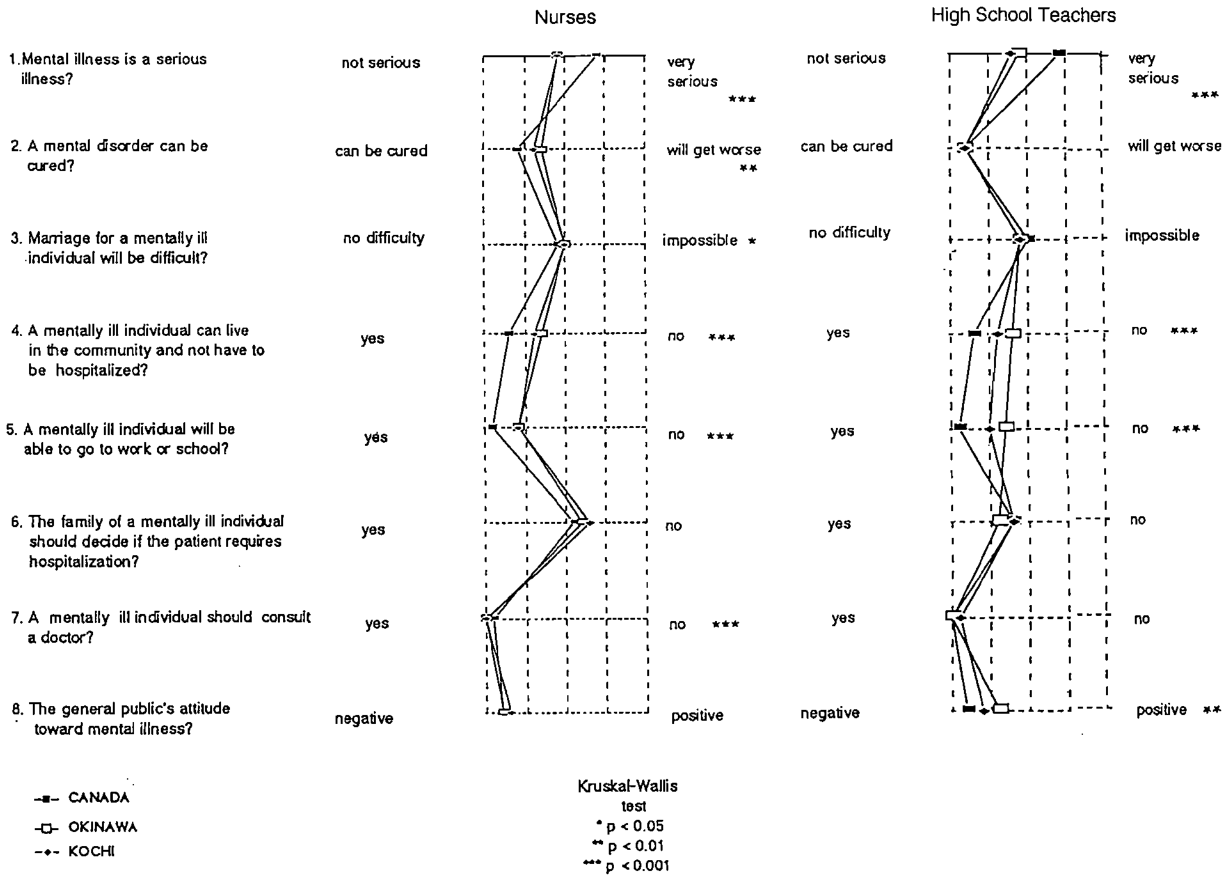


Fig.3 Concepts of mental illness.

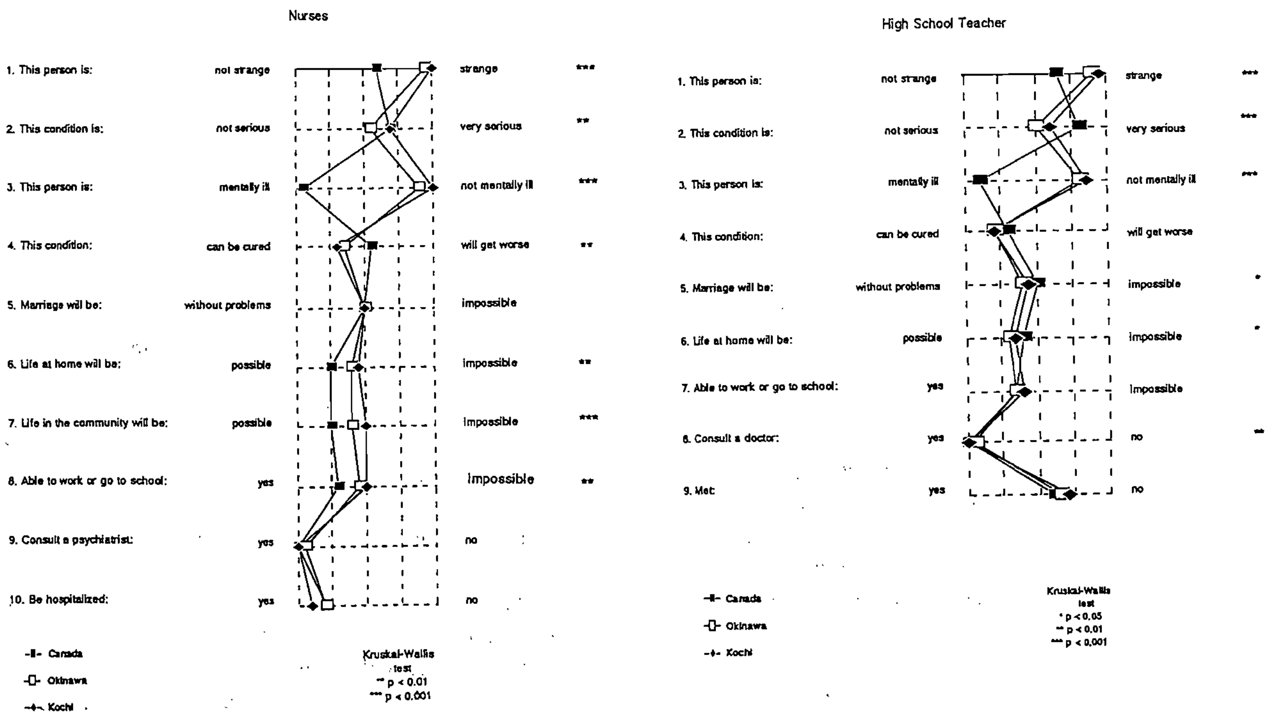


Fig.4 Case vignette : Acute psychosis.
An assesment of subjects' level of understanding of the problem and degree of acceptance of persons with such a problem

neighbourhood, workplace, or among my friends or acquaintance".

Case vignettes for mental retardation, epilepsy, mania, acute psychosis, depression, process schizophrenia and depressive neurosis were used to assess the subjects' level of understanding of the problem as well as their attitude toward persons with such problems. Fig.4, showing the results of the vignette for acute psychosis, is given as a representative example of the findings.

In all the case vignettes the Canadian nurses and high school teachers tended to view the cases in a more realistic fashion. They were more apt to label a case as a mental illness, except for the mentally retarded and the epileptic. The trends were generally similar between Okinawa and Kochi regardless of the occupational background. Interestingly, when the Japanese identified an individual as strange, as in the case of mania, acute psychosis and process schizophrenia, they were more reluctant to label it as a mental illness, and viewed the curability in a more optimistic light. However, in the case of mental retardation, epilepsy and depressive neurosis, the nurses as well as high school teachers in both Okinawa and Kochi viewed the individuals as strange, and labeled them as mentally ill; they were not regarded as such by the Canadian subjects.

The Social Distance scale (Fig.5) indicated that within the nursing group, the Canadians were more accepting of a mentally ill patient; a significant difference existed in the item regarding trusting one's children with a former mental hospital patient. In this item the Canadian nurses were more rejecting. There was a significant difference noted in all items within the high school teacher group. The Canadian high school teachers did indicate more willingness overall to accept a mentally ill individual. In this group the significant difference was between Canadians and both the Kochi and Okinawa groups.

The Fear of Illness scale (Fig.6) showed that for all three groups, nurses feared cancer and psychiatric illness the most. The Canadian nurses feared cancer the most and equally feared psychiatric illness and stroke. Both Japanese groups feared psychiatric illness more than any other illness.

Regarding the degree of exposure to mental illness

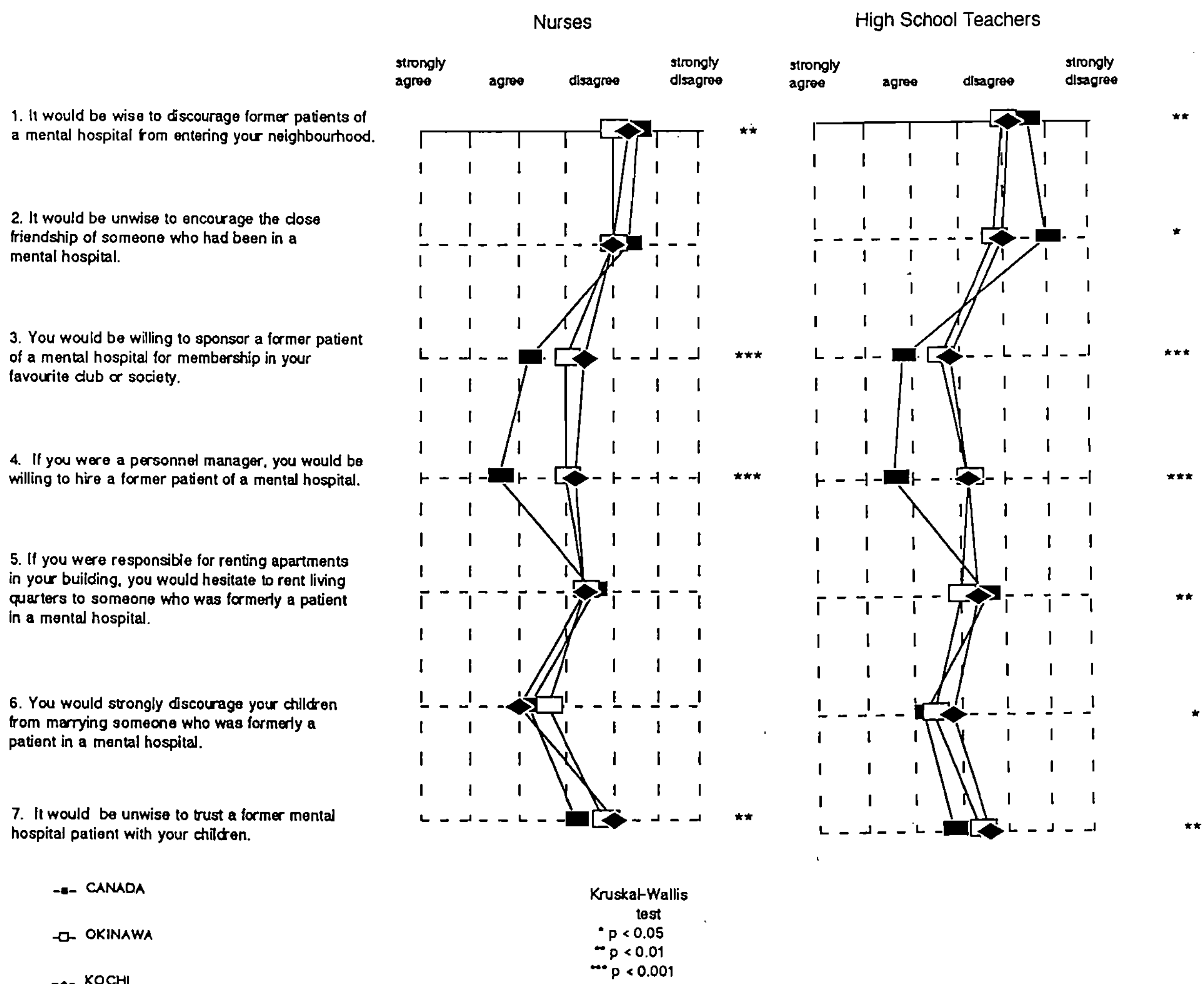


Fig.5 Social distance scale.
An assessment of the level of social accestability of persons with mental desorder

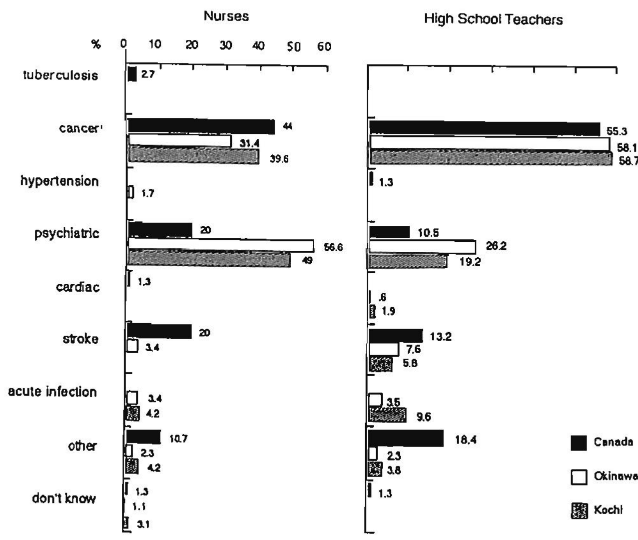


Fig.6 Fear of illness scale.

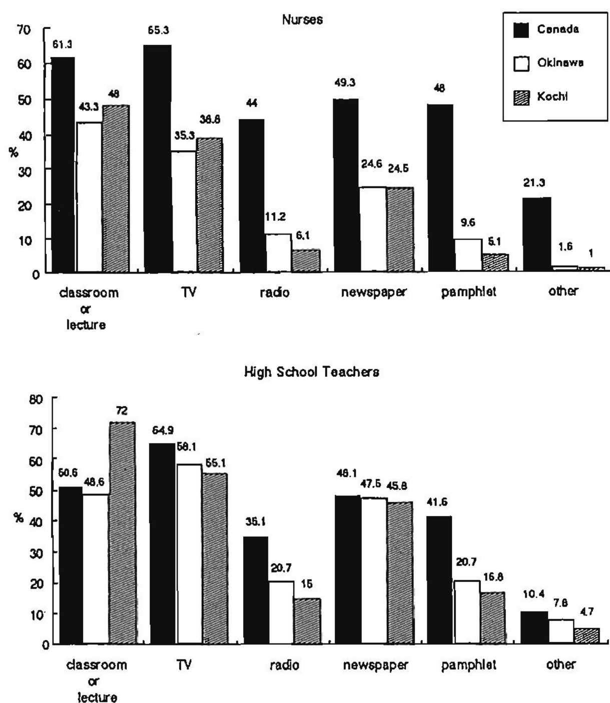


Fig.7 More information pertaining to mental health.

information that high school teachers have received, the results indicated that in all areas, the Canadians reported having received more previous information pertaining to mental illness than either the teachers from Okinawa or Kochi. Information pertaining to mental illness was most frequently received from the newspaper and television.

The request for more information pertaining to mental illness results (Fig.7) emphasized that overall, the Canadian subjects, regardless of profession indicated a desire to receive more education about mental illness as well as have educational materials available.

## DISCUSSION

The Canadian subjects generally had a more positive, realistic attitude about the mentally ill, and did indicate to a greater extent than their Japanese counterparts that hospitalized patients could be violent. Both nurses and high school teachers seemed to more clearly discriminate differences in causality, diagnosis, and prognosis of the various psychiatric disorders described. These findings could be related to the fact that because mental health services are community as well as hospital based, mentally ill individuals are more visible within the general public. This in turn would probably increase the likelihood of contact with such individuals, which was apparent in the results. The fact that the high school teachers from Canada also indicated having had more information pertaining to mental illness may have influenced the more positive attitudes.

The Japanese, on the other hand, whether from Okinawa or Kochi tended to express a less positive image of the mentally ill and more rejecting attitudes. The desire to maintain distance from the mentally ill suggests that negative attitudes toward the mentally ill held in the past persist today. Both nurses and high school teachers were reluctant to label an individual as mentally ill. However, when the Japanese did label an individual as mentally ill, i.e. epileptic, mentally retarded, the Canadians did not. This is an example of cultural differences in classification of disorders. The results also indicated that the Japanese teachers had less contact with the mentally ill and had received less information regarding mental illness, than the Canadians. This was not only evident in the semantic differential, where a positive image was apparent but also in the case vignettes. This may be attributed to the fact that the number of years of education for the Canadians was higher than that of the Japanese. It appears that the Canadians are more specialized in their education and training. This could be due to the fact that the Canadians undergo more severe competition in entering the work force, whereas the Japanese have much stricter and competitive requirements for entering University. Regardless of the national differences the results are in agreement with findings of Malla and Shaw's[2], Chinnayya's[3] and Eker and Arkar's[4] that education and training will have a positive effect on attitudes toward mental illness.

The more positive attitude of high school teachers could have been influenced by the increased contact with a mentally ill individual, as well as their higher level of education and receipt of more information about mental illness than the Kochi and Okinawan teachers. Regarding education, the Canadian high school teachers possessed either a Bachelors degree or Masters in a larger proportion than the Japanese subjects. These findings are similar to those of Pratt[5] and Crocetti, Spiro and Siassi[6].

The fact that there is a greater variety of services available for psychiatric patients may influence the more positive attitude evident in Canada. Mental health services

have expanded from the once large institutional settings to more community-based, out-patient programs. With the expansion of services, the result has been higher visibility of mentally ill individuals in the community. In Japan the greatest source for psychiatric treatment remains the institution, predominantly psychiatric hospitals[7~9].

Although there is evidence to support the supposition that more contact and education will positively affect attitudes toward mental illness, a closer examination of the reasons for increased exposure and more education needs to be addressed. The sociocultural environment of any given area will influence practical aspects of a given society such as health care, education and government policy[10]. Of course it also has an impact on the attitudes and thinking of the people. We can not examine the efficacy of a system, i.e. health care, education or government, without also taking into consideration the cultural and social values that are intricately woven into the fabric of a society. From this perspective, we presume that an understanding and appreciation of the sociocultural factors which affect a given society should be examined in order to comprehend the differences. The types of services available and various occupations present in the mental health field, especially evident in Canada, not only reflect government policy regarding health care and funding for mental health services and education but also reflect and affect the attitudes toward mental illness.

When considering both Japanese and Canadian cultures, the concept of humans and their environment are fundamentally different. In a Western culture, the individual is valued and seen as a separate unit distinct from the environment and independent of surrounding persons and things. The expectation is that persons think, feel and act on their own accord and responsibility. That is not to say that the interrelationship between other persons and objects is not important, but the individual entity is the starting point[11].

By contrast, Japanese culture sees individuals in relation to the other people and things around them. A person is considered a member of a group, the family, the organization, the society. It is always the larger whole, rather than the individual parts that are of importance[11~15]. The Japanese sense of the necessity of harmony, not only with nature but also within one's group, may be one reason why an individual who is different or appears to disrupt group harmony is often excluded or set apart. When an individual requires hospitalization, there seems to be a transfer of the dependence on the family group to dependence on the institution which by nature is tolerant of disruptive behavior. This could be one of the reasons why Japanese have lengthier hospitalizations (average length of hospitalization in Canada is 90 days and in Japan is 536 days). Although, the health insurance system seems to condone lengthy hospitalizations, other factors such as identifying the need for service or lack of alternative services could also be contributing factors. The fact that patients requiring psychiatric attention will wait from 2 days to 20 years before seeking out treatment is an area previously examined by various researchers[12,16,17]. All of these studies have dealt with the important role the family plays in relation to a mentally ill individual and also suggest the strong stigma concerning mental illness as the rationale for why Japanese choose their particular pathway of seeking psychiatric help. In Okinawa, the belief in ancestral spirits and the ongoing practice of consulting a Yuta (shaman) for all types of problems, including mental disturbances, explains in part the delay in seeking psychiatric help and explains why the Okinawans indicated their belief in supernatural causation more than either the Kochi or Canadian subjects[18,19].

The Canadians may have seen the mentally ill individual as more violent than subjects from Okinawa and Kochi due to the fact that only individuals who are severely ill or no longer manageable in the community will be hospitalized and therefore they may be more out of control. Once admitted to the hospital, a patient can exercise his personal right to refuse treatment, such as medication or therapy, whether he/she is an involuntary patient or not. Medication or treatment can be administered without a patient's consent if and when a psychiatrist assesses him/her to be a danger to him/herself or others. The other factor that may influence a difference in responses is related to the fact that once individuals are admitted to the hospital in Japan, they tend to be much more compliant. The Japanese patient and family often defer to the psychiatrist for advice and develop a dependent relationship on the psychiatrist[15].

The results of the case vignettes implied that the Japanese subjects were apt to identify the disordered person as being strange, yet were less inclined to label the individual described as being mentally ill, except in the case of mental retardation, epilepsy, and depressive neurosis. These findings are consistent with Terashima's finding in 1969[20], and imply that the Japanese, 26 years later, remain reluctant to label someone as mentally ill. Generally, the Japanese subjects were more optimistic about curability, whereas the Canadians recognized that problems or difficulties may be encountered. Concerning the Japanese response to causality of the various case vignettes, the majority of their responses reflected the impression that, depending on the case, a psychological factor was a cause of mental illness.

## CONCLUSION

In conclusion, although the results obtained are only reflective of a small sampling of the Japanese and Canadian populations, the findings suggest that a difference does exist between the two populations with respect to attitudes toward mental illness. It is important when examining attitudes that the background context of subjects be recognized, not only in terms of location and size, but more importantly in

terms of the larger picture, i.e. the total sociocultural perspective. These findings suggest that both Canadian and Japanese attitudes toward the mentally ill could be greatly improved. If, for example, Japan intends to expand its services as has been recommended and stated in the new Mental Health Law[7,8], then the reasons for the existing attitudes regarding mental illness need to be understood. This understanding is necessary at both a government policy (funding) level as well as at the care giver and consumer levels. The results of this study support the concept that cross-cultural studies can provide a clearer insight into origins of negative attitudes toward mental illness and the mentally ill. Such insight can in turn contribute to the development of an educational approach which would bring about positive changes in the attitudes not only of the general public and policy makers but of mental health professionals as well. It is important to recognize not only the influence of culture on attitudes toward mental illness, but also the interrelationship that exists between culture, attitudes, education and service delivery.

## REFERENCES


1) Lin, T.Y.: Multiculturalism and Canadian psychiatry: Opportunities and challenges. presented 35th Annual Meeting, Canadian Psychiatric Association, Quebec, 1985.
2) Malla, A., and Shaw, T.: Attitudes towards mental illness: The influence of education and experience. Int. J. Soc. Psychiatry 33: 33-41, 1987.
3) Chinnayya, H.P.: Training primary care health workers in mental health care: Evaluation of attitudes towards mental illness before and after training. Int. J. Soc. Psychiatry 36: 300-307, 1990.
4) Eker, D., and Arkar, H.: Experienced Turkish nurses' attitudes towards mental illness and the predictor variables of their attitudes. Int. J. Soc. Psychiatry 37: 214-222, 1991.
5) Pratt, S.: Attitudes toward the mental hospital and selected population characteristics. J. Clinical Psychology 16: 214-218, 1960.
6) Crocetti, G., Spiro, H.R., and Siassi, I.: Are the ranks closed attitudinal social distance and mental illness. Amer. J. Psychiatry 127: 1121-1127, 1971.
7) Kawasaki, S.: Japan's welfare policy: What more is needed ?. J. Japanese Association of Psychiatric Hospitals (English summary) 2: 42-44, 1991.
8) Salzberg, S.: Japan's new mental health law: More light shed on dark places ?. Int. J. Law and Psychiatry 14: 137-168, 1991.
9) Kuwabara, J.H., and True, R.: National policy toward the mentally ill in Japan and its consequences. Int. J. Mental Health 5: 95-108, 1976.
10) Ojanen, M.: Attitudes towards mental patients. Int. J. Soc. Psychiatry 38: 120-130, 1992.
11) Lin, T.Y.: Culture and psychiatry: A Chinese perspective. Australian and New Zealand J. Psychiatry 16: 235-245, 1982.
12) Asai, K.: Responses of Japanese families to mental disorder. Int. J. Soc. Psychiatry 257-263, Winter, 1983.
13) Caudill, W., and Doi, L.T.: Psychiatry and culture in Japan: Man's Image in Medicine and Anthropology (Iago Galdston, ed), pp374-421, Inter. Universities Press, Inc., New York, 1963.
14) Munakata, T.: Japanese attitudes toward mental illness and mental health care: Japanese Culture and Behaviour (Lebra, T.S. and Lebra, W.P., eds), pp369-378, The University of Hawaii Press, East-West Center, Honolulu, 1974.
15) Doi, L.T.: Japanese psychology: Dependency need and mental health: Mental Health Research in Asia and the Pacific (Caudill, W. and Lin, T. Y.,eds), pp335-341, East-West Center Press, Honolulu, 1969.
16) Naka, K., Oda, M., Randall, M., Ikei, A., Ishizu, H., and Takaishi, T.: Pathways of help-seeking of mental patients in Okinawa, Japan. Unpublished presentation at the World Federation for Mental Health, World Congress, Mexico City, Mexico, 1991.
17) Lin, T.Y., Dometz, G., and Goresky, W.: Ethnicity and patterns of help-seeking. Culture, Medicine and Psychiatry 2: 3-14, 1978.
18) Naka, K, Toguchi, S., Takaishi, T., Ishizu, H. and Sasaki, Y.: Yuta (Shaman) and community mental health on Okinawa. Int. J. Soc. Psychiatry 31: 267-274, 1985.
19) Randall, M.: A medical anthropological study of the interconnections in Okinawan society between the cultural phenomenon of high spirit rank birth (Saadaka Unmari) and mental health. Unpublished Masters Thesis, University of the Ryukyus, Okinawa, Japan, 1989.
20) Terashima, S.: The structure of rejecting attitudes toward the mentally ill in Japan: Mental Health Research in Asia and the Pacific (Caudill, W. and Lin, T.Y., eds), pp195-215, East-West Center Press, Honolulu, 1969.