ATTITUDES TOWARD THE MENTALLY ILL:
A CROSS CULTURAL STUDY ON JAPANESE AND CHINESE NURSES

by

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A Thesis

Presented to

the Oregon Health Sciences University

School of Nursing

in partial fulfillment

of the Requirements for the Degree of

Master of Science

May 21, 1990

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ACKNOWLEDGMENT

We would like to thank a number of people who supported us in carrying out this research. They kindly contributed their time, money, knowledge and expertise to this project. The emotional support we got from some of them also helped us tremendously. Without their help it would be impossible for us to finish this research project.

First of all we would like to thank all the nurses who were willing to participate in this research. You generously devoted your time, and to certain degree, you gave up your privacy by sharing your personal views and opinions. We appreciate your cooperation, and admire your enthusiasm.

We would also like to acknowledge the Japanese and Chinese students and visiting scholars who gave us great assistance in approaching participants, transcribing and translating the data. You also cordially shared your cultural expertise in this process. Special acknowledgment also goes to the Japanese researchers who contributed to our study by sending us literatures.

Margaret Imle and Joe Horsley, thank you for supervising us in the research methods. Than you Carol Holt for helping us editing the thesis. We know it was a lot of work, and you must have sacrificed some of your weekends to help us. Deep appreciation from us!

Thank you Pamela Jacklin and Leonard Girard. You not only helped us financially but also emotionally. You lovingly and understandingly lent us a shoulder to cry on when we needed it, and supported us going through many stressful moments. We would always remember you sincerely.

Finally, we would like to thank the faculty in our committee. You spent a lot of time and energy working with us on this project. You devoted a great deal of patience in helping us with the English, our second language. Your encouragement and emotional support were what made it possible for us to have completed this research project. Best regards to Carol Burckhardt, Barbara Limandri, and Mary K. King. Thank you too, Janet Mathews for chairing our defense. We really put you on the spot at the last moment.

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CHAPTER I

INTRODUCTION

Introduction to the Problem

The mentally ill have always been a stigmatized population. Attitudes towards the mentally ill, especially by health professionals, not only have a great impact on the public's view, but also, to a great extent, influence the care of patients. Malla has pointed out that " psychiatric patients often have low self-esteem and awareness of social stigma, and are particularly vulnerable to the attitudes and behavior of mental health professionals who are directly involved in their care" (Malla, 1987, p.33). While more and more studies on this issue are being done in the United States and some other countries in the western world, few have been done in the eastern cultures, such as China and Japan. (In this report "China" represents mainland China, and "Chinese" would mean people from mainland China, unless otherwise specified, for example: Taiwan or Taiwanese).

Since traditionally, Chinese have held a different philosophy of looking at diseases, it would be interesting and valuable to study how Chinese nurses view the mentally ill, and to explore the cultural

elements behind their attitudes. Two concepts in Chinese philosophy mentioned by Singer (1974) were Tao and Yin Yang balance.

Singer explained that Tao meant the way of harmonizing earthly conduct with the demands of the other world. She described: "Chinese organic philosophy of nature viewed all things including man as parts of a vast organism, the Universe. Man was a microcosm whose structure and functions reflected those of the surrounding Universe. Human behavior was thus linked with physical happenings in the cosmos. Furthermore all things in nature worked together in harmony. Disruption of this harmony led to disorder, of which disease was an example." (p. 50, 1974).

She also explained that the qualities of Yin and Yang were possessed by all things. The balanced mixture of these two meant soundness of health and the good life. Imbalance led to disorder. "The quality of Yang was associated with the sun, light, maleness, for example; Yin was associated with the moon, darkness and so on." (Singer, 1974, p. 50).

Many changes have been occurring in China. Today, people's attitudes toward life are not only influenced by the traditional philosophy but also by the current

political system. As Sidel (1973) wrote after his two trips to the People's Republic of China: "Recent visitors to China have returned to the West describing a country with a 'high pitch of collective spirit,' a 'sense of purpose, self-confidence, and dignity,' and a 'deep sense of mission.'" (p.732).

Even in psychiatry, he stated that as one aspect of treatment in China is that psychiatric patients were encouraged to feel part of a force larger than themselves--the revolution. They were urged to take an optimistic view of their problems, and to understand and overcome their illness, not only for their own benefit but also for the sake of the revolution (Sidel, 1973). How the result of this research would reflect this aspect of Chinese culture is another worthwhile point to be explored.

In Japan the general public, especially those who are elderly and less educated, hold strong stigmatizing attitudes toward the mentally ill (Terashima, 1969). Toguchi(1988) pointed out that nurses' conceptions about their patients and their own work was affected by how the patients were treated in the society. It would be valuable to study how the culture affects nurses' attitudes toward the mentally ill.

This research was a descriptive, ethnographic study on Chinese and Japanese nurses. The primary purpose of this study was to explore the viewpoint of these particular two groups in terms of their attitudes toward the mentally ill.

Statement of the Research Problem

As Germain (1986) pointed out in talking about the research method of ethnography: "The problem is one that can be best addressed through descriptive analysis of the subculture selected. The researcher will be guided by specific research questions addressing the ethnographic focus. These will take the form of questions such as 'What is this?' or 'What's happening here in this subculture?'" (Germain in Munhall & Oiler, 1986, p. 149).

The research questions asked in this study were:

1) What are the attitudes towards the mentally ill among Chinese nurses?

2) What are the attitudes towards the mentally ill among Japanese nurses?

3) What are some of the sociocultural variables related to the attitudes of Chinese nurses?

4) What are some of the sociocultural variables related to the attitudes of Japanese nurses?

CHAPTER II

REVIEW OF THE LITERATURE

Attitudes Toward Mental Illness

History of Attitudes Toward Mental Illness in the Western World

Rabkin (1974) reviewed the Western world history in terms of the attitudes toward the mentally ill, and she identified some models of the view. Until the seventeenth century, the mentally ill, who were labeled "madmen" or "fools," were not regarded as a public threat or confined to special institutions. However, after that time, many institutions that had served as leprosariums until that disease disappeared from the Western world were converted to institutions for the mentally ill. At the end of the 18th century, the introduction of the medical model into psychiatric thinking occurred and led to the rise of the "scientific psychiatry" of the 19th century. It became generally believed that disturbed behavior was the result of a physical disease of unknown etiology, which could be treated only by chemical or physical means. But such means were then unknown, so the patients seldom received more than custodial care. On the other hand, there was another stream of theory in the 18th

century in the U.S., called the moral model. This view was essentially that people became mentally ill because they had weak character or were not "right with God."

In the 20th century, it has become increasingly acknowledged by many professionals in the mental health field that mental illness can be understood as an exaggeration of particular behaviors common to all people, brought about by stressful life conditions and resulting in impairment of the ability to cope with social expectations and standards. Rabkin (1972) also stated in another review that "replacement of the medical model by a psychosocial or public health model in psychiatry represents a fairly recent change in view among the more highly trained professionals in the field . . . and is not yet often found among lower-ranking personnel in psychiatric institutions, much less the general public." (p.155).

Research Methods Used for Attitude Study

Before reviewing literature, it would be helpful to look at some of the tools which have been commonly used to measure attitudes toward the mentally ill.

Nunnally's (1961) questionnaire, Stereotyped Image of the Mental Patient questionnaire (SIMP), constructed in 1954, was designed to learn what the public knew and

thought about mental illness. Over 3,000 opinion statements related to the causes, symptoms, prognosis, incidence, and social significance of mental health problems were collected, and then reconstructed into 240 items with a 7-point Likert format. After factor analysis and with continued experience of survey, a final revised 60-item form was made.

The Star abstracts (1959) also have been used widely by researchers. Each abstract consists of a paragraph, describing behavior meant to illustrate a particular diagnostic entity such as simple schizophrenia or neurotic depression. Participants read these paragraphs and may be asked to rank them in terms of perceived pathology, social distance, or other parameters.

Cohen and Struening (1962) developed a multidimensional scale, Opinions about Mental Illness (OMI). They administered 70 original items and analyzed the responses and made a final 51-item OMI questionnaire with five independent factors. The five dimensions of the scale are: " Authoritarianism," a view of the mentally ill as inferior; "benevolence," a kindly paternalism whose origins lie in religion and humanism rather than science or the sophistication of

professionalism; "mental hygiene ideology," the belief that mental disease is an illness like any other; "social restrictiveness," the idea that the mental patient constitutes a threat to society, particularly to the family unit; "interpersonal etiology," the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. Rabkin (1972) reported that the most widely used instrument for the measurement of attitudes toward mental illness was the OMI. The reason why none of these tools were used in this research will be mentioned in Chapter III.

Research about Public Attitudes

In the 1950's, a great effort was launched through public education campaigns in the popular media, academic instruction in college psychology courses, and political efforts at local, state, and national level, to educate the public to accept the belief that mental illness was like any other illness (Rabkin, 1974). Also many researchers conducted research on public attitudes toward the mentally ill.

Cumming and Cumming (1957) conducted an experimental study in a small, rural agricultural Canadian town. They planned to test residents before

and after a 6-month educational campaign designed to promote more accepting attitudes toward mental illness, and although the townspeople accepted some of the education, people rejected the entire program when the proposition was stated that normal and abnormal behavior fell within a single continuum, and that anyone could become insane under certain circumstances.

Nunnally (1961) conducted a 6-year survey during the 1950's, designing the sample of 400 respondents as nationally representative in terms of sex, age, education, income, and religion. Nunnally reported that the stigma associated with mental illness was found to be very general, both across social groups and across attitude indicators, with little relation to demographic variables such as age and education. "All tend to regard the mentally ill as relatively dangerous, dirty, unpredictable and worthless" (p.51).

Dohrenwend and Chin-Shong's (1967) study was done on community leaders and ethnic cross-sections in an area of New York City, comparing their attitudes toward psychological disorder with each other and with psychiatrists' evaluations. They used case descriptions developed by Star. The results showed that the psychiatrists judged the cases largely by the

seriousness of the intrapsychic pathology, while community respondents appeared to have judged the seriousness of each in terms of whether or not it threatened others rather than on the nature of the intrapsychic pathology. However, it was the more educated who came closest to a psychiatric point of view. They also found that low-status groups seemed to have greater tolerance of deviant behavior, but that once low-status groups defined a pattern of behavior as seriously deviant from their norms, they were less tolerant.

Research on Attitudes of Mental Health Personnel

When reviewing literature about attitudes of mental health personnel and students, it should be noted that the situation before the discovery of psychotropic drugs as different from the one that occurred after these drugs became popular. Middleton (1953) conducted a study on hospital employees of the state hospital which he believed was fairly representative of state hospitals. The description of the hospital showed that the patients' behaviors were more severely impaired and the care given by the hospital was custodial rather than a total treatment program. The result showed that the better educated,

more intelligent, younger employee was less prejudiced. He concluded that setting high standards for employment, and immediate and repeated educational instructions were important to get best attitudes toward mentally ill. It should be considered that although much research has been done, not all the results may be valid for today's practice. However, the efforts which many researchers have made to identify the effective factors for attitude change cannot be ignored.

Gelfand and Ullmann (1961) measured attitudes of diploma program nursing students about mental illness. They used Cohen and Struening's (1962) OMI scale. The experimental group was composed of 36 students who participated in the psychiatric affiliate program, which was of 13 weeks duration and consisted of didactic instruction as well as contact with patients. The control group was composed of 23 students who had not attended the program. On the first day and last day of the program, both groups completed the questionnaire. The result showed significant differences on Authoritarianism, and Social Restrictiveness. It indicated that education and contact with patients in the program decreased the

students' tendency to see mental patients as dangerous people, and to believe that mental patients should be restricted both during and after hospitalization.

Wright and Klein (1966) compared 100 people in the community with 179 hospital employees regarding attitudes toward mental illness. They used the Wright Mental Illness Questionnaire Form I. Hospital employees were divided into 3 groups: Professional treatment personnel, which included social workers, registered nurses, physical therapists, and physicians; non-professional treatment personnel, which included physical therapy assistants and nursing assistants; and non-professional, non-treatment personnel, which included registrar, housekeeping, dietetics, engineering, and laundry staff. The results showed that the mean acceptance score for the hospital personnel was more favorable than the community. It was also found that the professional personnel had more accepting attitudes than the non-professionals, and the non-professional treatment group had more accepting attitudes than the non-professional, non-treatment group. They concluded that formal education and training and also experience with mental illness can have a powerful favorable effect on attitudes.

Anderson (1978) conducted a study by presenting a case history and a set of questions to three separate groups of health professionals and students in the psychiatric field. Group 1 was given the diagnosis of simple schizophrenia with the case history; Group 2 was given the suggestion that there was a diagnosis, but it was concealed; Group 3 was not given the diagnosis. The result showed that the professionals were more positive in order of omitted diagnosis, labeled, and concealed, while the students were more positive in order of concealed, labeled, and omitted. The students were more negative than the professionals in their predictions about the patient's future performance. Anderson concluded that diagnostic labeling influenced professionals negatively, and that the inexperienced students seemed more influenced by the stereotype of the psychiatric patient.

Napoletano (1981) compared two groups of nursing students' attitudes toward mental illness; one group had completed the two psychology courses, and the other had not. Students were group-tested on the first and last days of their psychiatric practicum. To evaluate the effectiveness of selected cognitive and experiential components of the practicum, students'

self-reports were obtained by using a 13-item Likert scale. The result showed that for both groups, experiential rather than cognitive components of the practicum were effective in developing favorable attitudes toward mental illness, and that students who had completed psychology courses tended to complete the practicum and were more influenced by each of the components of the practicum including classroom instruction. She suggested that academic instruction seemed to be more effective in combination with personal experience.

Malla and Shaw (1987) compared two groups of nursing students. One group was composed of 37 students who had completed their course work on psychiatry as well as a six weeks supervised clinical exposure to psychiatric patients, while the other group was composed of 34 students who had not received either of them. There were no differences between the two groups on age, sex, educational background, previous experience with the mentally ill, and work experience prior to joining the nursing program. They used a variation of the vignettes made by Star (1959), which were answered through a seven point scale. The result showed that instructional education and direct exposure

to psychiatric patients only influenced their ability to perceive the presence and severity of mental illness, but made no difference in their attitudes toward the mentally ill.

In short, these studies indicate that professional education and training may be critical factors for changing attitudes in a favorable direction, but the findings are not consistent enough to draw a specific factor.

Cultural Effects on Attitudes Toward the Mentally Ill

There are several studies which have reported that cultural influence is more powerful in deciding health professionals' or students' attitude than knowledge or training .

Townsend (1975) conducted research both in the U.S. and Germany, using matched samples of German and American high school students and mental hospital staffs. Nunnally's (1961) questionnaire was utilized to assess conceptions of mental illness. He reported that the conceptions of these groups showed greater differences between countries than between popular and professional views within each country. German participants showed their biological orientation, while Americans stressed the importance of will power and

self-control.

Koutrelakos, Gedeon, and Struening (1978) compared the attitudes of professionals and lay people in the U.S. and in Greece, choosing 220 subjects from each country who were matched on occupation, age, and sex. Cohen and Struening's (1962) OMI scale was used to measure the opinions. The Greek group showed much stronger emphasis on authority and family life compared to the Americans. They concluded that even among mental health professionals, attitudes were more strongly influenced by their culture than by their professional training, and the influence of professional training appeared selective and limited by local social norms.

Koutrelakos and Zarniari (1983) examined the influence of cultural change on attitudes toward mental patients by comparing two American and two Greek groups, one drawn from each country in 1969 and the second in 1979. Social work students responded to the Cohen and Struening's (1962) OMI scale. In Greece a decrease in negative attitudes was observed while in the U.S. a reduction in positive attitudes was noted. The result appeared to reflect socioeconomic developments in each country during the decade;

improved economic conditions and modernization in Greece, and economic recession and conservativism in the United States. They concluded that mental health professionals appeared to follow rather than shape social policy.

Two studies done in Israel were found. Jaffe, Maoz, and Avram (1979) conducted a study on nursing students. Cohen and Struening's (1962) OMI scale and Nunnally's (1961) SIMP were administered to 69 nursing students; 23 students, before and after a 2 month psychopathology course, 46 students, before and after a 2 month psychiatric affiliation. Half of the 46 students had their clinical experience in a hospital where patients were given more rights and freedom. The other half in a state hospital where the treatment was more custodial. The results showed that classroom instruction was ineffective, and that practical experience in a progressive psychiatric hospital resulted in a more favorable change than the experience under hospital conditions which supported the stereotyped conception. They concluded these findings were consistent with previous reports from the U.S. and did not mention cultural characteristics specifically.

Weller and Grunes (1988) examined the effects of

contact on nurses' attitudes toward psychiatric patients, using their own 24-item Attitude towards Mental Illness (AMI) questionnaire. They compared three groups; nurses who worked in a psychiatric hospital, nurses who worked in a general hospital where psychiatric patients received medical treatment, and nurses who worked in a general hospital which did not accept psychiatric patients. ANOVA tests were run on the factors including country of origin and religiosity, which were specifically related to Israeli society. The result showed that contact did not influence attitudes toward the mentally ill. But they found that the practical nurses who initially had more direct contact with patients were more positive than the RNs who were administrators, and that the more religious nurses held more positive attitudes than the secular nurses.

Chinese Attitudes About Mental Health and Illness

There are three topics identified from the articles based on the observation in China, Hong Kong and Chinese Americans. They are: beliefs about health and illness, sociocultural differences, and the public's attitudes toward the mentally ill.

Sidel (1973), Livingston & Lowinger (1983),

Flaskerud (1984), and Singer (1974) all came to the conclusion that Chinese beliefs about health and illness are based upon the concept of Tao and the philosophy of Yin-Yang balance. The Chinese organic philosophy of nature viewed all things as parts of a vast organism, the Universe. It is a belief that illness results from humans' failure to adjust to their environment. The qualities of Yin-Yang are possessed by all things. The balanced mixture of these two equates to soundness of health and the good life. Imbalance leads to disorder, including mental diseases. Supernatural methods of healing were popular in the distant past. Yet, today, reliance has been heavily placed on naturalistic techniques, such as relaxation, breathing exercises, medication, massage, herbs and acupuncture.

Some of the cultural differences identified by Louie (1985) through working with Chinese clients included: A strong, cohesive bond in the Chinese family; guilt used to further control the child's behavior; and social behaviors based on cultural values that have been passed from one generation to another. Many of the values concerning achievement, responsibility, and ambition are similar to those in

Western culture, but these values bring reward and status to the family and community instead of the individual. From the value of self-discipline, children learn to control their emotions, relying on their own capabilities and resources to solve problems. Strong negative feelings, such as anger and pain, may be suppressed.

Through observation, Sidel (1973) found that as one aspect of their treatment, psychiatric patients were encouraged to feel part of a force larger than themselves, which was the revolution of the country. They were urged to take an optimistic view of their problems, and to understand and overcome their illness, not only for their own benefit but also for the sake of the revolution. However, one important point needs to be made here. Rapid changes have been occurring in the past few years. Some of the treatment methods mentioned by Sidel (1973) are no longer in practice in China. No research was found on Chinese professional/nurses' attitudes toward the mentally ill.

Japanese History and Research on Attitudes Toward the Mentally Ill

In Japan, for many centuries, the prevailing ideas about the etiology of mental illness were derived

largely from animistic and supernatural thinking. Behavior disturbances were considered beyond the reach of a physician and were left to be treated by monks and shamans, mainly by incantations, exorcisms, and bathing under waterfalls (Kuwabara and True, 1976). In society, any deviant behavior was severely penalized and many mental patients were locked away in a cell at home. During the middle part of the 19th century, many medical students studied under Dutch physicians, and were exposed to revolutionary ideas in Western medicine and facilitated the humane treatment of the mentally ill. But the tight social and political climate was preserved, and the law administered in 1900, which placed the major responsibility for the care of the mentally ill in the hands of family, was in effect for 50 years. In 1950, a new law which abrogated the family responsibility was promulgated. At that time, the shortage of the mental hospitals was the main barrier to improving the treatment of the mentally ill. But because of the protection of the government, the number of private hospitals increased rapidly for beneficial reason, without the improvement in terms of the treatment; most of the patients stayed in custodial care, and were treated with overuse of psychotropic

drugs. In 1965, a lot of change was made in the law, and the treatment of the mentally ill in the community was focused. In 1988, the newest law was promulgated which focused more on a public health model and a welfare model. Now increasing the facilities in the community base which can accept the patients from hospitals and improving the mentally ill's quality of life is emphasized (Sato, 1988).

There are several surveys about attitudes toward the mentally ill in Japan. Wada and Hiraoka (1984) conducted a survey about attitudes toward the mentally ill in 759 lay people in Tokyo whose age ranged from 20 to 70 years old. The result showed that the participants who were younger, more educated, and having more contact with the mentally ill had more positive attitudes about the mentally ill's social rights and independence.

Ohshima, Yamazaki, Nakamura, and Ozawa (1989) conducted a survey about social distance on 397 lay people who were living in the area in which there was a mental hospital. The hospital was famous in terms of the efforts to open to the community; it had hospital festivals to invite people in the community, and the facilities such as a pool or conference rooms were open

to the community use. They reported that people living nearer to the hospital had more daily contacts with the patients of the hospital. Also the people who had more contacts with the mentally ill and who had more knowledge about the hospital showed smaller social distance with the mentally ill.

Sakuraba, Ohta, Sakata, and Yokota (1984) conducted a survey on 380 nurses in Chiba prefecture in Japan. Their instrument was a combination of the Attitude toward Mental Illness Scale made by Kato and Nakagawa (1962), and part of Star abstracts (1959). They compared the result with a study by Ohshima (1963), which was done using the same method. The result showed a great decrease in the attitude that mental illness was genetic. Participants also agreed much less that the main role of mental hospitals was segregation. They concluded that the result reflected that the change in the conception of mental illness held by nurses paralleled the social change.

Yamada and Ichimaru (1984 a) reported a survey which was conducted for 11 years on nursing students from 1972 to 1982. They used questionnaires with second year nursing students before and after their psychiatric nursing class every year. They reported

there was no significant relationship between attitude and the experience of contact with mental patients. It appeared that there was a small favorable change in attitude after classroom instruction, but on the questions about marriage and having children, there was a tendency to reject that for the mentally ill. There was no significant relationship between knowledge and attitude.

Yamada and Ichimaru (1984 b) conducted another survey in which they compared attitudes among medical students, nursing students, and social work students. There were no significant differences between gender, but there seemed to be differences among majors. Nursing students were most rejective of the mentally ill and more than half of them rejected living next to the mentally ill and marrying a man whose family had a history of mental illness. Social work students were the most accepting.

Inaoka and Munakata (1986) compared attitudes between nurses, nursing assistants, public health nurses, psychiatrists, and occupational therapists and social workers. They hypothesized that the factors which affect attitudes were sex, age, profession, experience, the atmosphere of the place where they

work, and personality characteristics. The results showed that the younger and the more educated the participants were, the more they believed in the mentally ill's independence in the society and human rights. Also there seemed to be differences between occupations. Social workers emphasized the mentally ill's right to live in the society, while physicians and nurses tended to protect the mentally ill from the harsh reality of the society. They concluded that the background in which the professionals had grown up, such as the social situation and the educational situation, were among the most important factors. They also reported that the role in which each professional trained affected their attitudes.

Summary

Understanding of mental illness has been changing into a more psychosocial or a public health model in the 20th century. Since the early 20th century, many studies have been done on the attitudes toward the mentally ill. Several factors indicated changing attitudes in a favorable direction, but the findings were not consistent enough to draw a specific factor. Among them, several studies suggested that cultural influence was more powerful in deciding health

professionals' or students' attitudes than knowledge or training. China and Japan each have their own cultural background attitudes toward mental illness as presented earlier in this section. It will be interesting to explore how each culture characterizes the nurses' attitudes toward the mentally ill.

Conceptual Framework

Attitudes

Until the early twentieth century, social scientists assumed that attitudes could be used to explain human action since they viewed attitudes as behavioral dispositions. In 1931, Thurstone made it clear that although a person's attitude toward an object should be related to the pattern of behavior with respect to the object, there was no necessary relation between attitude and any given behavior. He defined attitude as "the affect for or against a psychological object" (p.261). By the late 1950s, attitudes were viewed as complex systems comprising the person's belief about the object, feeling toward the object, and action tendencies with respect to the object. Figure 1 shows Rosenberg and Hovland's (1960, cited by Ajzen and Fishbein, 1980) schematic representation of the three-component view of attitude.

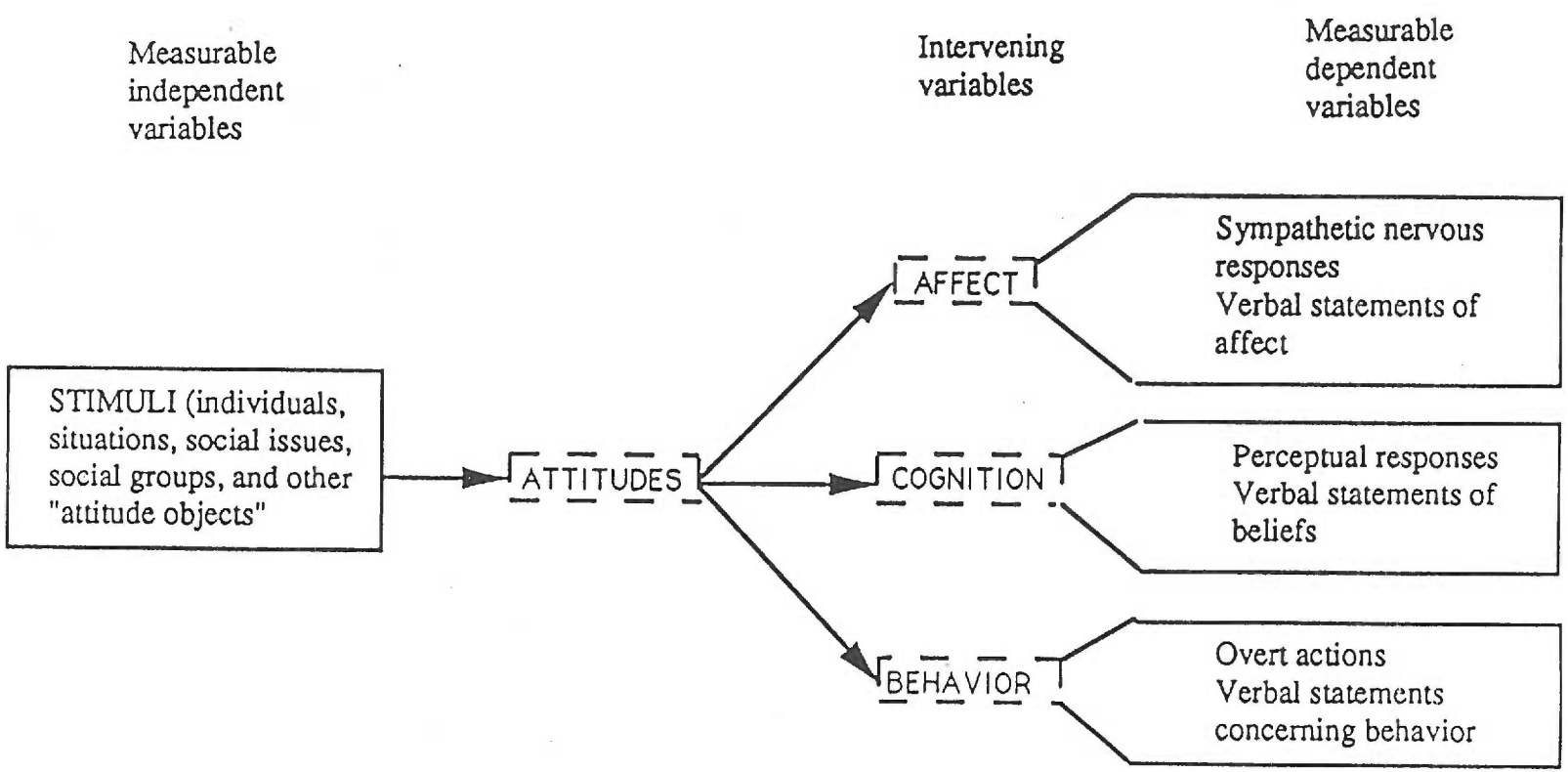
As seen in the figure, cultural elements, issues, and social groups are included in "stimuli" to attitudes.

Insert Figure 1 about here

Ajzen and Fishbein (1980) defined attitude as "a person's evaluation of any psychological object" (p.84), and clearly defined beliefs, attitudes, intentions, and behavior as different concepts. They stated that attitudes toward any object were determined by beliefs about that object, and that a person's experiences lead to the formation of many different beliefs about various objects, actions, and events (Ajzen and Fishbein, 1980). Figure 2 shows Ajzen and Fishbein's (1980) model of indirect effects of external variables on behavior. Within their theory, a behavior is explained once its determinants have been traced to the underlying beliefs. As external variables, all three groups of variables include cultural elements.

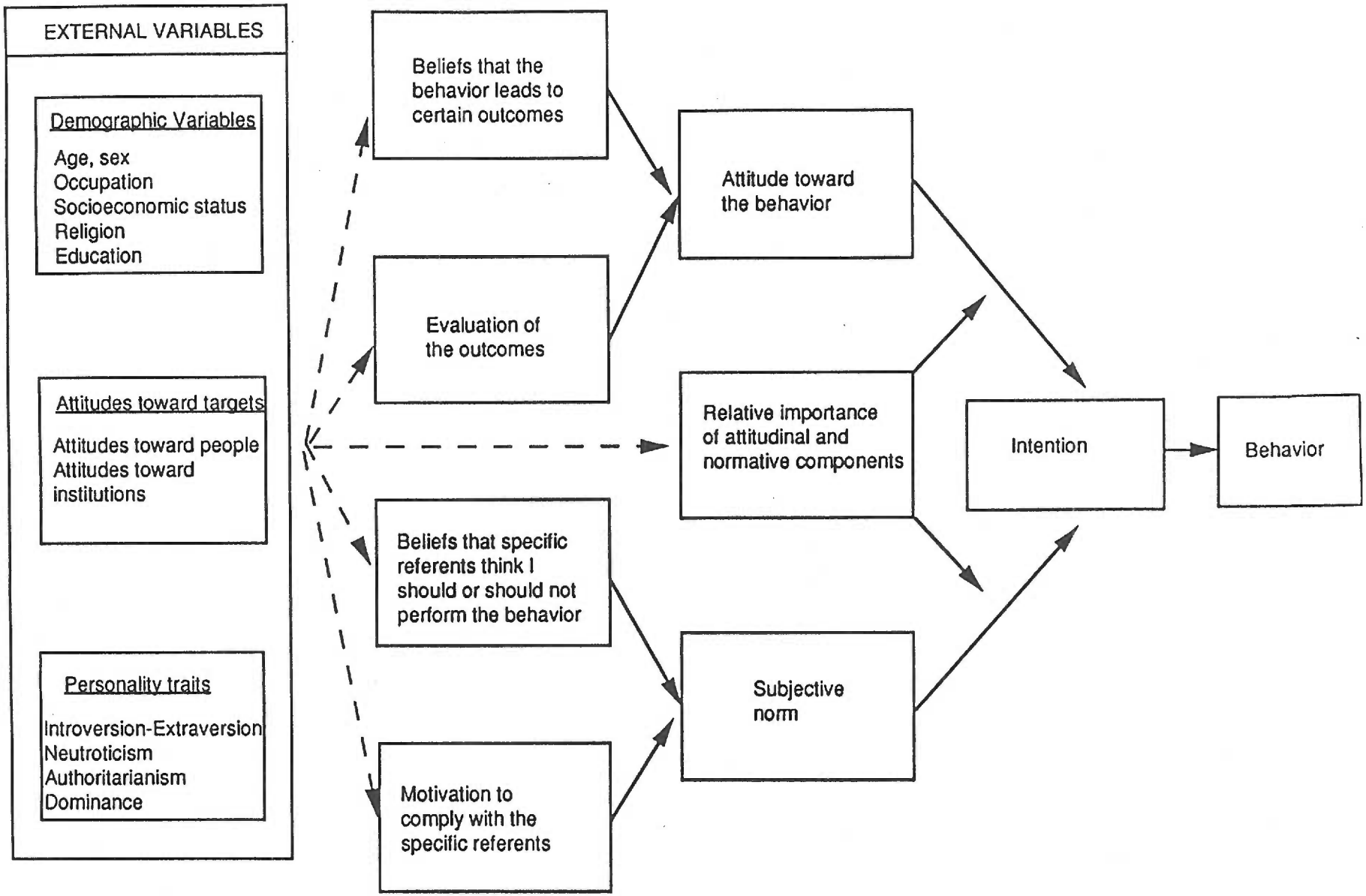
Insert Figure 2 about here

FIGURE 1 Three-component view of attitude



From Rosenberg & others (1960), Attitude Organization and Change. New Haven: Yale University Press.

FIGURE 2 Indirect effects of external variables on behavior



From Ajen & Fishbein (1980), Understanding Attitudes and Predicting Social Behavior. New Jersey: Prentice-Hall.

Culture

Several authors have defined culture. Among them, Harris (1968) proposed a definition of culture as a concept that "behavior patterns associated with particular groups of people, that is to 'customs,' or to a people's 'way of life'" (p.16). Spradley (1979) criticized this definition saying that it obscured the crucial distinction between the outsider's and insider's points of view. Taking this into consideration, Spradley (1979) defined culture as "the acquired knowledge that people use to interpret experience and generate social behavior" (p.5).

Flaskerud (1984) explained three components of culture which interact and are integrated with each other: technology, social structures, and ideology or belief system. She stated that technology arose in response to environment, social structures arose in response to technology, and ideology or belief systems arose in response to social structures. Such systems of values, attitudes, and beliefs labeled the social structures and technology.

Nanda (1984) defined culture as learned and shared kinds of behaviors that were typical of a particular human group. She also stated that culture was the

major way in which human beings adapted to their environment. This view of cultural ecology suggests that attitudes, values, beliefs, and behaviors are viewed as normative within a specific culture.

The view stated above by Spradley (1979) and Nanda (1984) are referred to as "emic" approaches. It is a relatively new approach in anthropology and often used in "the New Ethnography," "ethnoscience," or "ethnosemantics." Pelto and Pelto (1978) citing Pike (1954) contrast this approach with the etic:

> An etic analytical standpoint . . . might be called "external" or "alien," since for etic purpose the analyst stands "far enough away" from or "outside" of a particular culture to see its separate events, primarily in relation to their similarities and their differences, as compared to events in other cultures . . . In contrast to the Etic approach, . . . It(the emic) is an attempt to <u>discover</u> and describe the pattern of that particular language or culture in reference to the way in which the various elements of that culture are related to each other in the functioning of the particular pattern, rather than an attempt to describe them in reference to a generalized classification derived in advance of the study of that culture. (Pike, 1954, p.8-10, cited by Pelto and Pelto, 1970, p.54)

"Emic" and "etic" are often treated as dichotomies, but a balanced approach probably is best for understanding culture.

Nursing and Mental Health

Many researchers recommend including anthropological aspects in nursing and mental health area. Pedersen (1981) stated that groups define for themselves the behaviors they consider mentally ill, unacceptable, or abnormal. Pedersen (1984) emphasized the importance of balancing "emic" and "etic" for the mediation of a mental health service. Also Leininger (1985) introduced ethnonursing as a method to study emic and etic data together. Leininger (1984) also stated in another study that care behaviors, values, and expressions existed in all human cultures, but its characteristics and values tended to be different and largely convert. Leininger (1985) also pointed out that the cross-cultural approach used in anthropology provides a broad comparative picture of human nature and human behavior. She asserted that it was not only sound for nursing to use a cross-cultural approach, it was mandatory. Clients had a right to have their sociocultural backgrounds understood in the same way that they expected their physical and psychological needs to be recognized and understood.

Attitudinal Study and Qualitative Method

In this study, we take a relativistic position based on an emic perspective to explain Chinese and Japanese nurses' attitudes toward the mentally ill. As stated above, cultural effects are reflected on people's belief, attitudes, and behaviors. And although there are some criticisms, we still support Ajzen and Fishbein's (1980) theory that people's actions are systematically related to their attitudes when the nature of the attitudinal predictors and behavioral criteria are taken into consideration. We believe that studying nurses' attitudes toward the mentally ill from an emic perspective will clarify the interaction of complex society and human behavior which directly affect the mentally ill. At the same time, we try to include etic perspective in terms of finding similarities and differences in the Chinese and Japanese cultures.

CHAPTER III

METHODS

Introduction

Because of the nature of cultural differences it was hypothesized that Japanese nurses and Chinese nurses were different in their attitudes toward the mentally ill. They could not only be different from each other but also from nurses in other cultures, for example, in the United States. As Nanda (1984) stated: "All over the world, people are ethnocentric. They tend to see things from their own culturally patterned point of view, to value what they have been taught to value, and to see the meaning of life in their own culturally defined purposes." (p.17). This research was done in the attempt to gain understanding in some of the Japanese and Chinese nurses' values and beliefs in terms of the mentally ill. To a certain extent, if and how their cultures have shaped these values and beliefs were also examined.

Design

The researchers chose the ethnographic approach for this research. The rationale for this approach can be provided by Germain's (1986) definition of ethnography as: "portrait of a people," and "As a

product, ethnography is a factual description and analysis of aspects of the way of life of a particular culture of subcultural group." (p.147). One of the essential ways of approaching ethnography--interviewing was used in this research. Again as Germain pointed out: "Through the essential methods of participant-observation and intensive interviewing of the members of the subculture, the researcher learns from informants the rituals, and other aspects of their lifestyle." (p.174).

Due to the multidimensional nature of attitudes the researchers decided to report the data in a qualitative descriptive way. The literatures found in this area were either correlational or quantitative using Likert scales as instruments. They were inadequate to capture the rich context of culture and particular details in the culture. A descriptive design in this research is also more appropriate in looking at sophisticated sociocultural variables related to the attitudes, rather than inferring causal or correlational relationship between the two.

Instrument

Data were collected using interviews done by the two researchers of this study. The content of the

interview is based on a set of questions to guarantee consistency. Several instruments were examined in the literature review before developing the questions for this study, although, the researchers decided not to use them. Nunnally's SIMP (1961) and Cohen & Struening's OMI (1962) were both outdated. Because they were developed in the United States a large portion of the questions would not fit the cultures of this study. The Star abstracts (1959) used vignettes based on Western culture which would not be able to measure the cultural elements of this study appropriately.

The questions for this study were developed by the two researchers from a study done by Weller and Grunes (1988) in Israel. This study examined the effects of contact on nurses' attitudes toward psychiatric patients. Three groups of nurses with differing degrees of contact answered the Attitude towards Mental Illness (AMI) questionnaire. The questionnaire, a five-point Likert scale, was originally composed of 30 items. Weller and Grunes eliminated 6 items, and the Cronbach alpha of the rest of 24 items yielded a reliability correlation coefficient of 0.79.

The researchers of this study changed the 24-item

questionnaire (Appendix A) into 11 items of open-ended questions (Appendix B). For example, the question No.5, "to what extent do you trust the mentally ill person's judgement?" is the integration of three original questions. The original questions were: No.3, "the mentally ill, with a number of exceptions, cannot tell the difference between good and bad," No.12, "it is not necessary to consider the opinion of a person who has been released from a mental hospital," and No.23, "the mentally ill should not be allowed to make decisions, even those concerning routine events." The reason for the change was that the researchers of this study were interested in exploring what the attitudes were rather than labeling these attitudes as positive or negative.

To achieve some content validity, the first 11 items were examined by a faculty member who was an expert in ethnographic interviewing. She suggested that questions that asked the definition of the term "mentally ill" and the "mentally healthy" would be helpful to understand the participants' attitudes. After adding these two questions, the 13 items were examined by another faculty member who was also an expert in qualitative research. She mentioned

excluding the question that asked the "meaning of life for the mentally ill," because it was too vague. She also recommended using probes to get additional details. These suggestions were incorporated into a final 12-item open-ended interview guide with probes.

Translations of the questions into Chinese and Japanese were done originally by the researchers of this study who are Chinese and Japanese (Appendix C & D). Editing of the translation and back-translation were done by graduate students who are fluent both in Chinese/Japanese and English.

Participant Access

Introduction

It was the researchers' beliefs that obtaining oral consent would be more appropriate than written consent in this study. Since the researchers are from the cultures that they were studying (one from Japan, the other from mainland China) they knew that Chinese and Japanese were not accustomed to signing papers. Due to prevailing political stress, the process of gaining permission to do the research with the Chinese sample was quite different from the process with the Japanese sample.

Japanese

Japanese participants were collected through convenience sampling at Asahikawa, Japan. Asahikawa is a middle-size city which has a population of about 360,000 and is located in Hokkaido, a northern island of Japan. The number of the mentally disabled population covered by Asahikawa health center was 4,351 (1987). Asahikawa Medical College Hospital is a general hospital which has 600 beds. The psychiatry and Neurology unit is one of the units which has 43 beds. Psychiatric patients are approximately 1/6 of the inpatients. The outpatient clinic deals with about 770-990 patients per month, including neurologic patients (1988).

The researcher met the director of the nursing department and got the permission for the research from Asahikawa Medical College Hospital in August, 1989. The letters to the participants (Appendix G), describing the purpose of the research and guaranteeing confidentiality, were administered to the nurses through the nursing department in November, 1989. Volunteers called back or returned self-addressed post cards to the researcher. The interviews were done at the conference room of the hospital, which was isolated

and quiet.

Before the interview, the purpose of the study was explained to each interviewee. They were assured that their answers would be confidential and that they had the freedom to withdraw from the study at any time. Those who agreed to be interviewed were audiotaped. Of the fourteen nurses who agreed to be interviewed seven nurses were in general practice, and seven were in psychiatric nursing. One interview appointment with a general nurse could not be kept because of the failure of the recording machine.

Chinese

The original plan for sample selection of Chinese nurses was the same as for Japanese nurses. Because of the political upheavals which occurred in mainland China at the time the interviews were scheduled, the researcher was unable to go back to China. Therefore, nurses who had recently come to America became the possible population from which to select the sample. The researcher encountered a lot of difficulties in finding people who could meet the criteria for this study. Because nursing was not considered an area that needed immediate advancement, not many nurses were sent to America to study, even after China began to open its

door in the late 70's and early 80's. After the political crisis in June 1989, even fewer Chinese people could get permission to go abroad.

The process of soliciting participants and gaining their consent for the study took approximately three months. For the sake of confidentiality the specific geographic areas and schools that the sample came from will not be addressed here. The researcher basically used convenience sampling. She first talked about the study with the Chinese nurses that she knew. Both Taiwanese and Chinese nurses were approached at that point because of the difficulty of finding sufficient nurses from mainland China. The letter to participants (Appendix F) describing the purpose of the research and guaranteed confidentiality was shown to them and explained. Among the seven people approached, six agreed to participate.

The researcher then asked these nurses if they had acquaintances in America that would qualify for this study. Five names and their phone numbers were given to the researcher. The researcher failed to make contact with two of these people. She called the other three, read the "letter to participants" to them on the phone, and all three agreed to participate and were

interviewed on the phone.

Some of the disadvantages of using Chinese nurses studying in America in this study will be discussed in the section of "threats to validity and reliability." The justifications of this decision were:

1. It would be hard to get permission from the leaders in any hospitals in China. They would be pressured by the government to question the political motives of the research.

2. The researcher would risk not being able to come back to America to finish her study if she had gone back.

3. Because of the political system, people would be suspicious about a research attempt to be done in a western country. Even if they had agreed to participate in the study, they might not be able to speak their true feelings due to fear of the governmental punishment.

4. The researcher did not want to jeopardize the safety of people who might be willing to honestly participate.

Sample

Participants were composed of two groups. There was group of Chinese nurses (total number was 9, from

both Taiwan and mainland China) studying in America, and a group of Japanese nurses (total number: 13) working at Asahikawa Medical College Hospital, Japan.

Criteria for Chinese Sample

Due to inability to collect data in China the criteria for the Chinese sample had to be modified:

1. Nurses who worked in either Taiwan or mainland China for at least one year.

2. They arrived in America within the last five years.

3. Half of them worked in psychiatric nursing, and the other half worked in other areas of nursing but not psychiatric nursing.

The third criteria was not met because only one psychiatric nurse was available in the planned geographic area. Nurses interviewed explained that psychiatric nursing was not emphasized in either Taiwan or mainland China. Most Chinese nurses come to America to study medical surgical nursing, an area considered having more potential for growth and development. The demographic information of the samples is presented in Table 2 & 3 in this report.

Criteria for Japanese Sample

1. Nurses who are working in Japan.

2. Half of them are working in a psychiatric unit, and the other half are working in other areas and have no experience in a psychiatric unit.

Among six participants, only one general nurse had one year experience in a psychiatric unit during her nursing career of over 20 years. However, she was included in the sample of general nurses because the researcher assumed it would be beneficial to get her opinion considering her career. Some psychiatric nurses had experience of working in general units.

It should be noted that there is not a system of nursing specialists in Japan, so "psychiatric nurses" means "nurses who are working in the psychiatric area," and does not necessarily mean that they are especially educated in psychiatric field.

Insert Table 1 & 2 about here

Procedures

The same instrument was used with both groups. The individual interviews of the Japanese sample were carried out by one of the researchers who was from Japan. The individual interviews of the Chinese sample were done by the other researcher who was from China.

Table 1: Demographic Information of the Chinese Nurses

Total = 9	Mainland China	6	
	Taiwan	3	
Age			
		21 - 30	6
		31 - 40	3
Education in Own Country			
RN 1 1/2 years			1
2 1/2 years			4
3 years			1
Baccalaureate degree			3
Working Experience in Own Country			
General Nurses		1 - 5	1
		6 - 10	4
		11 - 15	1
		16 - 20	2
Psych Nurse		1 - 5	1
Years in the U. S.			
<1 year			5
1< x <2			1
2< x <3			1
3< x <4			1
4< x <5			1

Table 2: Demographic Information of the Japanese Nurses

Total = 13 (7), ( ) = Psych Nurses

Age	21 - 30	6 (3)
	31 - 40	6 (4)
	41 - 50	1
Education		
RN Diploma (3 years)		8 (4)
LPN 2yrs + CE class 2yrs		3 (2)
Associate degree (3 years)		2 (1)
Working Experience		
Psych Nurses	1 - 5	3
	6 -10	1
	11 - 15	1
	15 - 20	2
General Nurses	1 - 5	4
	6 - 10	0
	11 -15	1
	16 - 20	0
	21 - 25	0
	26 - 30	1

Each interview lasted 25-45 minutes, and the participants' own languages were used for the interviews.

Chinese Sample

Six participants were interviewed in person. Interviews were recorded using audiotapes, in order to retain the content as accurate as possible. Three participants were interviewed on the phone, and the conversations were also audiotaped. The impression of the researcher about the interviews in person was that it was comfortable for both the participants and the researcher to be able to have eye contact, and to some extent using body language to communicate. It was a bit uneasy to talk on the phone with strangers, but it was the interviewer's impression that to a certain extent the participants spoke more honestly.

Each open-ended question was asked, and sufficient time was given to the participants to answer it. Probes were then given to the participants if the researcher wanted more detail in a specific area. The participants also gave general comments on each question.

The taped data was then transcribed by the researcher and translated into English. The

translation on the first two interviews was verified with two other Chinese attending Oregon Health Sciences University, one was a visiting scholar and the other a graduate nursing student.

Japanese Sample

All of the 13 Japanese participants were interviewed in person. The process of the interview and the translation was the same as Chinese sample, except the translation was verified by Japanese graduate students.

Analysis

The data from both groups were analyzed separately first using a descriptive, inductive process. The raw data of the two groups were coded separately by both of the researchers. Coding was then verified by Japanese and Chinese visiting scholars and graduate students studying in America. They knew both Japanese/Chinese and English, and Chinese or Japanese cultures.

Themes and concepts were identified, and put into major categories. Interpretations in terms of the cultural elements were made with each group of data. Literature on related cultural issues were referenced in this interpretation process. In the end, similarities and differences in both cultures were

explored and compared. During the process of the analysis verification with the Chinese and Japanese visiting scholars and graduate students comparisons of language differences and interpretations of cultural differences were constantly made. For example, it was the researcher's impression that in China the word "community" usually means the local government, the community organizations or the leaders in these organizations. She verified this with other Chinese, and was told it was a commonly held view.

In Japanese the words "community" and "society" vaguely means both organizations or system, or simply a group of people. In the interview, it seemed clearer for the participants when "community" was translated as "neighborhood," and "society" as "government". The validity of these translations was verified with three Japanese graduate students.

CHAPTER IV

RESULTS

In this chapter the Chinese results and Japanese results will be presented separately. Because there were both similarities and differences in the two sets of data, some codes identified were the same between the two groups, and some were different. These codes will be used as subtitles. The data were organized, grouped, and presented under each subtitle.

Results of Chinese Sample

Definition of "Mentally Ill"

When asked to define "mentally ill," all the participants mentioned that the mentally ill look different. Some of the words they used were: "weird appearance," "disheveled," "staring at others," and "flat affect."

Every participant mentioned either one or two signs and symptoms or characteristics to define "mentally ill". Their descriptions included: "personality problem"; "depression"; "mood swings"; "poor adaptation to environment"; "self-consciousness"; "low self-esteem"; "mental disabilities"; "culturally unacceptable behavior"; "silly laughter"; and "talking differently".

Six out of nine participants related "mentally ill" to "not normal or too different from normal." More specifically they said the thoughts and behaviors of people with mental illness are different from the general population. One participant phrased it as: "the mentally ill react to things in life differently from normal people, and the public cannot accept this kind of reaction." "Violent" was mentioned by them as an example of behavioral difference.

Two participants mentioned that the public might call the "mentally ill" crazy. They also said that a lot of people confused it with "being neurotic."

Detection of the Mentally Ill by Appearance

Most participants (five out of nine) agreed that sometimes they could detect if someone was mentally ill by physical appearance. One participant said that she definitely could tell. One said she could tell the severe ones by appearance, and another said that only professional people could tell. The most frequently mentioned (five out of nine) characteristics were "different or weird behaviors" and "different facial expressions". Others noted different talk/speech patterns, such as inability to carry on normal conversations; nervous and restless behaviors when

talking; silly laughter; and self-talk.

Other noticeable signs (each mentioned one or two times) included: eyes looking different; disheveled appearance; violence; stiff/slow body movement (that might be influenced by medication); flat affect; different manner; outlandish attire; and different posturing from normal people. One participant noted that the mentally ill demonstrated "illogical/delusional thoughts and mood swings". One participant said she could not tell by how people dress themselves, while another said she could tell if she knew the person before he/she got ill.

Responsibilities

Most participants could not say definitely that specific persons were responsible for taking care of the mentally ill. Almost all of them identified that the primary responsibility belongs to the family. The responsibilities of the community and society were also mentioned.

Family. Two participants held a strong belief that one of the family's most important responsibilities was to try to prevent mental illness. Specific methods of prevention included:

1. providing a good family environment to family

members;

2. preventing mentally ill family members from having children;

3. creating family harmony at home; providing "good" communication and healthy life style;

4. watching out for each other;

5. detecting family members who have weaknesses then protecting and helping them; and,

6. decreasing stress in life for family members. They said if a family member was already ill, the family should try to prevent relapse for him/her, and be alert about the potential of other family members' getting ill.

Some other family responsibilities mentioned were financial responsibility, basic daily care, medications and follow-up hospital visits, treatment compliance, cooperating with medical workers in terms of treatment, and protection of the mentally ill from hurting other people or being hurt themselves.

One participant thought that it was not necessarily ideal to have the family take so many responsibilities because of the burden and the feeling of shame. In China, however, patients have nowhere else to go after being discharged from the hospital.

Two participants mentioned the Chinese tradition that the oldest son should take care of the parents, then the second son, then the third. If there were no sons in the family the oldest daughter, and then the second daughter should be responsible. One participant mentioned if they had a mentally ill child, the parents should be responsible for the child's whole life. If they were no longer capable to provide care they should hire other people to take care of the child.
Most participants agreed that if there were no immediate family members, the closest relatives should be responsible for taking care of the mentally ill person.

Community. The neighborhood committee/community's responsibilities mentioned were maintaining the safety of the neighborhood, not letting the mentally ill hurt other people, and preventing the mentally ill from hurting themselves. If possible, the community should help to find ways to occupy the mentally ill.

Society. In terms of society's responsibilities toward the mentally ill the participants suggested providing care centers, support groups, social support and acceptance of the mentally ill, and alternatives for families who are burned out. Also mentioned were

improving care and treatment, educating both public and health-workers about mental illness to increase understanding and acceptance, and decreasing stereotyping and discrimination.

It was also thought to be important to promote community involvement, promote charities and insurance for the mentally ill, to build more nursing homes, to help the mentally ill find jobs, and to provide recreation and socialization opportunities. One participant put her answer this way: " finding ways to meet their biological, sociological, psychological and spiritual needs." Another participant stated: "at least providing shelter to help the mentally ill survive in the society." She also said: "it's the policemen's responsibility to keep the mentally ill off the street so that they would not disturb others."

Two participants stated that no matter whose responsibility it was to take care of the mentally ill, the basic responsibility would be to at least help the mentally ill with daily living and teach them how to survive. "We can't just let them end up on the street, like what is happening now sometimes."

Trust

Most participants (56%) said they could trust the

mentally ill when they were stable, and could demonstrate the ability to care for themselves. One participant stated that in order to decide whether to trust someone she had to meet this person, and evaluate the logic of this person's thoughts and coherence of his/her conversation. She also believed that she could get a good idea whether to trust someone by his/her behaviors. Another participant phrased this as: "you can not trust someone who is yelling and screaming on the street."

One participant stated that during acute stages the mentally ill persons' judgement is definitely impaired. Three participants agreed that the mentally ill could manage their money, and choose their own jobs when stable, but they should not be given jobs that require much responsibility or were too complicated.

Three participants said the mentally ill could marry, but they would not support the idea of their having children. Their reasoning was best described by one who said "they are unable to take care of the children, and children add stress to their lives." One participant said it is better for the mentally ill to be unmarried than married also because she thought it would be a burden for them. Another participant

believed that the mentally ill had no judgment in terms of who would be good for them to marry.

Two participants thought that mentally ill persons should not vote because the choice of voting would complicate the person's life, and be an additional stress to them. Also, the persons with mental illness would feel bad if they did not know for whom to vote. Finally, the mentally ill might be used by others if they were given the privilege to vote because of their poor judgement.

One participant said persons with mental illness should only be allowed to vote when they were stable. Another participant thought it was not anybody's business to talk about the mentally ill's judgment, it was the physician's territory.

Rights

Five out of nine participants believed that it was a human right to choose to marry or not, and that the mentally ill should not be judged differently than any other people. Four out of nine participants thought that the mentally ill should not marry each other because: "it would increase the burden on society"; "it would increase stress to themselves"; and "it would increase the possibility of having mentally ill

children."

Two participants mentioned that if the mentally ill were not allowed to marry or have children it would add stress to their lives. "It might increase stigma toward the mentally ill too." Also two participants stated that the mentally ill can marry if they demonstrate being able to care for themselves first.

Most participants said they would not support the mentally ill having children. Some of the justifications mentioned were: "they might give birth to mentally ill children"; "it would increase the burden on society"; "they are not able to take care of children," and "it might be a burden to themselves."

Three participants thought the mentally ill can have children because "we are not sure if they would definitely give birth to mentally ill children," and "they have normal and stable periods in their lives when they can enjoy the children."

Two participants thought that the mentally ill should not be allowed to vote. However, three participants believed that the persons with mental illness should be allowed to vote because our society is based on majority rule and the mentally ill are only a small portion of our population. One participant

thought they should be able to vote because it was their human right.

Most participants (56%) thought persons with mental illness should be punished by law for the crimes they committed. Some of their justifications for this include "if not punished they could really be harmful to the society," "we could say anyone who killed people were in a mentally disturbed stage," and "if they can't be totally responsible for their crimes, at least they should be held partially responsible."

One participant said "the mentally ill persons should be punished for their crimes, but this decision needs to be made with caution," and "it should be judged by professionals." They stated that if a mentally ill person killed someone when he/she was mentally incompetent the sentence should be reduced. If competent he/she should be punished as others" and " the mentally ill can also learn what is acceptable behavior and what is not."

One participant thought family members should be held responsible in some way for their mentally ill family members' misdeed. Another person believed that it was society's responsibility to prevent mentally disturbed people from committing crimes and maintain

their acceptable behavior. One participant noted the ambivalence in this area saying "I don't know what is fair in this matter, it's not fair to punish family members though."

On the subject of voting and punishment for crimes, instead of giving opinions, two participants stated that they "dare not say," "there must be laws in these matters, and law decides whether one can vote or not, or should be punished or not." One of these two participants stated that "sometimes mental illness is being used as an excuse for less punishment."

Causes of Mental Illness

Every participant agreed that mental illness is caused by both genetic and environmental factors. Four out of nine participants thought environmental factors contribute more to mental illness then genetic factors. Some of the specific reasons mentioned were "family environment to be specific," "there are more mentally ill in cities because there's more competition in cities than in the countryside," and "can be caused by too much stress, pressure, upsetting or traumatic events in life."

"Mental illness is related to weak character, weak willpower, or lack of life experience" were mentioned

by two participants.

More than half of the participants believed genetic factors were the main cause of mental illness. One of them thought one fact about the mentally ill was that they might be too intelligent. "Their weird thoughts or ideas might be proven true in the future. Just because nobody at the moment can comprehend the way they do."

Another participant believed that society was in some way responsible for the occurrence of mental illness. One participant thought both mental illness and mental retardation had something to do with being poor--"peasants." Another participant addressed the question in this way: "Family environment is not important because people in a rich family can also develop mental illness, and people who have had rough childhood do not necessarily become mentally ill."

Some causes related to family environment included: "mistreatment, discrimination by family members"; "dysfunctional upbringing"; "family members' attitudes toward each other"; and "financial situation at home."

One participant mentioned that in China people might attribute mental illness to "retribution for

ancestors' evil deeds" or "bad thoughts." She explained: "it might be considered a curse for the family to have a mentally ill." She explained that it didn't necessarily mean people really believe these sayings. "Most of the time the sayings are used to ventilate personal anger or frustration toward a family."

One participant believed that a superpower might be the cause of mental illness because there was no definite answer to this question. Another participant stated "it's too backwards to think a superpower causes mental illness". Three participants were not sure about the "superpower theory," and another three did not think mental illness had anything to with a superpower.

Treatment

In terms of a suitable place for treatment, most the participants thought that the acutely mentally ill should be treated in the hospital, and when stable or chronic they should stay at home. Two participants did not differentiate between acute and chronic stating "they should be treated in the hospital because they need structure, and it's safe there."

One of them thought treatment in the community was

sufficient as long as it provided structure and safety. One participant phrased her answer to this question as "providing treatment for them according to their needs, and I guess doctors should know what's good for them."

As for segregation interviewees noted that "acutely mentally ill should be segregated," "anything good for them should be done for them even if it's segregation," "segregation is OK because the mentally ill might harm others otherwise," "segregation is not necessarily inappropriate for the acutely mentally ill," and "psychiatric hospital is not so different from segregation anyway."

Most participants agreed medications were important. Two participants mentioned that traditional Chinese medicines help too.

Two participants believed that mental illness is preventable. The way to do it is to pay attention to child development. They suggested that the family should provide children a healthy environment to grow in. Family members should watch out for each other, detect weaknesses of each other, and protect family members who have weaknesses.

Three participants mentioned occupational therapy and electric convulsion therapy. Other treatments

mentioned were psychotherapy, milieu therapy, community follow-up, group therapy, good discharge planning, family support, psychological support, good daily care, and insulin therapy. One participant thought mental and emotional support would not mean anything to the mentally ill because the mentally ill can not understand it. Three participants actually believe some mental illness could go away without treatment. Another person said "some of them can get by without treatment."

Most of the participants thought superstitious methods would not help. They thought some people sometimes went to pray or went to witches for treatment because there was no cure for mental illness, and sometimes it was done because the family felt helpless. "It makes the family members feel better that at least they are doing something to help the ill family members to whom they have obligations," they stated.

Prognosis

When asked what they thought about the saying--"once crazy always crazy" one participant said it was not something she was able to comment on. Half of the rest of the participants thought there was some truth in the saying. Reasons they offered were "the fact of

relapses of mental illness"; "not any one doctor can guarantee his/her mentally ill patient will totally recover"; "mental illness, in some way, is like personality, people who have 'weird' personalities, not necessarily diagnosed with mental illness, will stay that way until they die"; and "the fact many cases of mental illness are not being cured."

The other half said they did not like the saying, because: "there is no clear-cut 'recovered' or 'not recovered'"; "some mentally ill can be maintained as normal as most people with little medication"; and "many mentally ill have stable periods." One of them believed that mental illness can be cured.

Working with the Mentally Ill

When asked how they would feel working with the mentally ill, most participants (five out of nine) either said they wouldn't if they did not have to, or would not choose to work with the mentally ill. One person actually thought she would refuse to work in the psychiatric field.

One participant said if she were assigned to work in psychiatric nursing she might give it a try because of "curiosity." "It would be new for me," she said. Another participant thought she could give it a try too

because she likes to play with patients in OT.

The only psychiatric nurse interviewed gave the following reasons why she chose psychiatric nursing:

1. "like psychology",

2. "like helping others",

3. "have low self-esteem myself, so helping them can help me too",

4. "have a mentally ill member in my family, so I want to learn more about it",

5. "like working with patients not just for them, but with them", and,

6. "like talking with clients, getting to know them, and help them problem solve, which one doesn't get to do in other areas of nursing".

"Fear of violence" was the most frequently mentioned reason why they would not want to work with the mentally ill. "I'm afraid of them probably because I heard too many violent stories about the mentally ill when I was little," one participant said. "Also, when I visited a psych. hospital after becoming a nurse I saw some of them yelling and screaming behind the iron bars. It made me have chills."

Another participant recalled she felt very uncomfortable when she did her psychiatric rotation in

nursing school. "I do not want the same feeling come back," she said. Another person said "it is depressing to see them behind iron bars and not getting well." She thought she probably could work with the mentally ill's family, and help to decrease the burden for the family.

"It is a hard job" and "it needs special training to work in psychiatric field" were reasons mentioned for not wanting to work with the mentally ill. One participant said "it is not an easy job because of the psychological aspect."

"I did not think there would be any future for me to work in the psychiatric area when I graduated from nursing school (about 6 years ago). My classmates thought the same." Four out nine participants mentioned they were aware of secondary stigmatization. Another participant stated: "Nurses need to have a strong personality to work in a psychiatric field, otherwise they themselves could also become mentally ill."

Personal Involvement

Two participants said definitely they would not want to marry a person with mental illness. The rest of the participants were reluctant to comment on their

own marriages. Most of them said they would not want their children to marry people who have mental illness. They said they thought if their children insisted on wanting to marry the mentally ill they could not stop their children, but they would point out to their children the possible consequences of the marriage.

Mentally Healthy

When asked to define "mentally healthy" most participants (five out of nine) felt "having good coping skills" was very important. For example one participant noted mental health as "being able to cope with depressed situations."

Most participants thought "not being too different from the general population" as one of the criteria for being mentally healthy. Similar comments included: "same as others"; "thoughts and behaviors are not too different"; "in the normal range"; and "there's an unwritten standard in a society, one just has to do what the majority of people do, and meet social norms." They also identified "high self-esteem," "self-awareness," "comfortable with self" as being important to mental health.

A few more scattered views included "optimistic," "not suspicious of others," "able to express self

correctly," "no inner-conflicts," "have strong will power," "able to live a balanced life," "have harmonious relationship with society," and "think logically."

One participant stated that mentally healthy could not be separated from physically healthy, while another said "literally, mentally healthy excludes physical health aspect." Another participant said it meant "without mental illness".

Two participants emphasized morality as requirements for mental health. Mentally healthy persons

1. "have good moral standards",
2. "have good thoughts",
3. "are not selfish",
4. "have no bad spiritual thoughts",
5. "have good personality", and "fine personal quality".

Results of Japanese Sample

Definition of the Mentally Ill

The most notable tendency of Japanese nurses' answers to the question asking for a definition of the mentally ill was hesitation of labeling. More than half (8 out of 13) tried not to use any personal

interpretation, and answered the question literally as people who have an "illness of mind," "mental illness," "psychiatric illness," "difficulty in mental aspect," and "abnormality in mental area." Including those participants who gave some definitions, six of them were reluctant to label the "mentally ill." Three of them simply answered "I can't define," two of them said that it was hard to draw a line between the mentally ill and non-mentally ill, and one said, "I don't like the expression because it gives an impression that they are belonging to a different place from general people."

Three participants mentioned interpersonal relationships, as "the people around him/her would be troubled by his/her behavior," "the person is too weak and gets troubled by the people around him/her," "the people who have a little abnormal way of thinking compared to people who have common sense," and "people who have difficulty to live because of mental deficiency."

The hesitation of labeling was also observed in hesitation of giving specific diagnosis. Ten participants said that they did not relate the mentally ill to any specific illness. One answered that she

thought of schizophrenia, and another thought of bipolar disorder. To the questions if alcoholism and suicidal thoughts were mental illness or not, nine of them said "alcoholism is a mental illness," but most of them said "it depends on the condition." Also about suicidal thoughts, seven of them said "it's not a mental illness," and as a reason, they mentioned "it's natural to think about death when you have a rough time."

Detection by Appearance

In terms of whether or not others can tell if someone is mentally ill by physical appearance, most participants (77%, 10) said "I usually can't tell." But two added, "I can tell when excessive symptoms appear" and "I can tell chronic schizophrenic patients because of effect of the medicine." Another two answered " I can't define in public, but sometimes I can tell when they are in the hospital." Only one participant mentioned "I can tell, for example, Downs syndrome patients, but not psychiatric patients." This answer seemed to come from the interviewee's translation of the "mentally ill" into the "mentally disabled." Among the characteristics that were discernible as mental illness were facial expression,

body movement, incoherent behavior, content of speech. Two of them said, "they just look different." One participant said, "it's rude to tell that someone is mentally ill by appearance."

Responsibilities for the Mentally Ill

Lack of the Concept of Responsibility. All the participants showed difficulty using the word "responsibility." It should be noted that the translation of the word "responsibility" (sekinin) often gives the impression of "getting blamed for not doing enough" if it is used in an informal group. Because the concept of "contract" does not exist in Japan except in formal systems such as companies or institutions, it seemed to be uncomfortable for the participants to assert that "this is so and so's responsibility." Three of them clearly stated "no one is responsible," and another phrased it as "it would be ideal if everybody cooperated to help patients in the society, because environment is really important for them to live independently. But you can't blame the family or the community which can't cooperate. It is better if they can help. So the word 'responsibility' doesn't really fit."

Family. Related to family and responsibility,

emphasis was on strong family ties and not on individuals. Most of them answered "in reality," family should be responsible (twelve of 13 participants), first parents, and second, siblings or spouses. As reasons, two mentioned the word "closeness" (mijika) which includes both physical/geographic and emotional closeness. One said "because people who are living with the patient are responsible." One said "family is a unit in which there is a blood tie plus the people who know the patient well." One participant reasoned that the blood tie and closeness and love are all combined in a family. One participant expressed family in the word "sorenari-no-hitotachi," which means "people whom the culture/society assumes as caretakers." Another expressed it as "miuchi" which means "people within a boundary."

Most participants agreed on the strong tie of parent-child relationship. However, when asked about siblings and spouses, some participants had different ideas about boundary. One phrased "I would say parents are responsible, but it's too much to ask siblings for the mentally ill's care especially when they are young, because they have their own future."

One said, "if the spouse got married knowing the illness of the other party, she/he is responsible for the care, but if she/he was not told the truth, she/he is not responsible." Another said, "if the patient got sick after the marriage, it would be too much to ask the spouse to take the responsibility of the care, because the spouse would not know what to do. When she/he expressed the feeling in the form of rejection, you couldn't shuffle the responsibility on him/her." On the contrary, one said, "if the patient got married and got sick after that, the spouse is responsible, not the siblings."

As some of family's responsibilities, the following were mentioned: Financial support, daily living, emotional support, maintaining safety for both the mentally ill and the people around, and treatment (such as taking the patients to the hospitals).

Society (Government). When the question was moved from the family to society, some answers had emphasis on an individual rather than on a collective role in care. One stated, "society should be ready to offer any kind of help so that patients can choose and use it when they need it." Three of the participants said, "ideally, everything should be provided."

From the more realistic point of view, many participants pointed out the lack of resources for helping people with mental illness to remain independent. The most frequent answer was support for patients after discharge from the hospital (10 out of 13). They suggested creating a network where patients can get help immediately, providing public health nurses, making intermediate institutions for vocational and social rehabilitations, and following up treatment after discharge.

One participant said that the responsibility ratio of family to government was 3:7. Five participants said government was responsible when families were overwhelmed by taking care of the patients. Also five emphasized economical support, and four mentioned socialization. One participant mentioned public education and distribution of information about the mentally ill.

Relatives. Expectations of the participants about the role of relatives in terms of care of the mentally ill was low. It seemed that geographic closeness was one of the elements to determine responsibility of relatives. Seven said that relatives had no responsibility, especially when they were living far

away. One participant said that relatives could be responsible in the case where the relatives were close to the patient and they had been around since childhood.

Community (Neighbors). Expectation of the community taking responsibility for care of the mentally ill was also low. Five said that neighbors had no responsibility. One said, "it's not realistic to ask them for help, because they don't have positive attitudes toward the mentally ill. But it would be ideal if everybody thought that it was his/her responsibility to help the mentally ill." One answered that it was not neighbors' responsibility, but there was a need. Two answered that neighbors should accept the patients' right to live in the community, but they do not have any other responsibilities. One said, "in reality, people even protest the construction of a day care center or a group home in their community."

Individualization. Some participants emphasized that each individual was different. One phrased it as "It's case by case who takes the responsibility. The most important thing is thinking about who is the best for the patient and whom the patient wants help from. Sometimes parents are not the best in terms of

parent-child relationship." One said, "talking about emotional support, each person has his/her best person to whom she/he can talk to from the heart, whom she/he can trust. The person whom the patient needs most at the moment is responsible." Another participant said, "I think everybody who has contact with the mentally ill has responsibility. Because any contact affects the patients, for example, the way you talk or the way you behave."

Judgment and competency

As far as trusting the mentally ill's judgment, nine participants answered that it depended on the condition of the illness, the kind of illness, and the situation. One said that it was basically patients who made judgment and medical staff could only give advice. Two participants said that the mentally ill need mental health professionals' screening and help to make judgments. The other two said the mentally ill who were living in the society could make any kind of judgment for themselves. When asked about more specific judgments, some of them responded differently. The participants who denied trusting the mentally ill's judgment about budgeting, marriage, and choosing a job said that voting was all right. The reason for their

opinions was patients should be protected from making decisions that might lead to failure which in turn might hurt patients' sensitive feelings or might give trouble to others. However, voting didn't affect patients or others seriously. One participant expressed the opposite opinion that the mentally ill could do personal things but not voting which was public and required a higher level of thinking process.

To the question if the mentally ill can be responsible for the crimes they committed, six of the participants answered that patients living in the society could make judgment about "what was bad and good," so they should be responsible as human beings. Three of the participants said it would be the medical professional's problem if they misjudged the patients' condition. One phrased it as "once a patient is discharged and comes back into the society, it has to mean that the person is able to live as a member of the society, because she/he won't walk with the placard 'I'm mentally ill. Please take care of me.'" Two participants mentioned that the presence of delusion or hallucination should be considered in making a decision about competency. Two simply said "I have no comment. I respect the judge's sentence."

In terms of the marriage issue of the mentally ill, no participant said that they should not be allowed to get married. Two of them stated that it was a human right, six of them said that it depended on the situation, and four of them said it would be difficult and it would be better if they got advice, help, or supervision. One said: "It's OK if the two who are going to get married consent. However, it would be better if they could find someone who would "watch them closely" (mijika ni mimamoru)." The word "mimamoru" has both meanings of "watch" and "protect". Two mentioned that in the case of marriage of the mentally ill to the non-mentally ill, the non-mentally ill should have full understanding of the condition of the mentally ill person.

Having and raising children raised another issue in terms of the effects on the children. Basically the participants agreed to respect the mentally ill's human rights, such as marriage, but five said "I don't agree personally." The reason was the genetic and medication effects on the mentally ill person's body and reproductive system in terms of having children, and negative environmental effects in terms of raising children. One participant said "patients who have

epilepsy or schizophrenia should not have kids because these are genetic for sure." Another participant said "marriage, having and raising children are stressful events for them, so they need enough preparation. Sometimes they need help, sometimes not."

Cause of the Mental Illness

All the participants agreed that the cause of mental illness was contributed by both genetic and environmental factors. For genetic factors, four of them used the word "disposition," and three of them mentioned "some form of brain damage." As environmental factors, most of them (11 out of 13) mentioned family environment, especially lack of love contributing to mental illness. Two of them suggested "up-bringing" as a factor, and one of them said "in terms of personality disorder, lack of discipline." One of the participants said family environment was not a cause, and the other said it didn't "cause" mental illness, but might "lead" to it.

Eight of the 13 participants mentioned social environment. Two said that the mental illness appeared when genetic and environmental factors combined. Other factors related to environment were stress, interpersonal relationships, psychological shock or

burden when these piled up. Only one participant agreed that lack of willpower was related to the mental illness. When asked about superpower, ten of the participants denied it. One said "personally I tend to believe it, but scientifically it can't be." Another said that she half believed and half not, and the other said she didn't believe in it but did not want to deny others' belief.

Treatment

In terms of the place for the treatment of the mentally ill, most of them agreed that the acutely mentally ill should be treated in the hospital, and depending on the condition, they should go out into the society gradually. Treatment possibilities to facilitate this transition included day care, outpatient clinics, night care, vocational rehabilitation and other intermediate institutions, doctor visitation, and other follow-up treatment at home such as public nurse visitation.

To the question about a colony, ten of them disagreed to it in terms of segregation, emphasizing the importance of contact with the non-mentally ill. One participant phrased it as "I don't want to increase the feeling of estrangement which already exists in the

mentally ill." Some agreed to a colony when it was used as an intermediate institution for a short period. Two participants supported segregation. One reasoned that it would be better for them because the society was too harsh, and the other said that the staff working in the colony would have a better understanding of the illness and support the patients, and the idea would be spread to the society. One participant said she did not like the hospital care which was provided today in Japan, because it was too much stimulus for some patients, and she thought treatment should be done at home where it was more stable and had a familiar environment for a patient.

As for the treatment of mental illness, two of participants said that it depended on each patient's condition, and another two said "anything that works would be OK." Six participants agreed to psychotherapy, and two suggested "listening and talking to them" as treatment. Four participants said milieu would be important, and seven participants agreed to occupational therapy, including one who said "only when it is done according to each patient's need, not systematically."

In terms of medication, nine participants agreed

on the importance of medication, although they added some comments as "sometimes," or "only when it is really needed." Three participants showed negative attitudes toward the way medication was used today in Japan. One nurse noted "by medicines being used too much, the aspect of 'being as a human' tend to be pushed down, and the patients can't show positive aspects." When asked about a superpower, most of them denied it except one who thought it would work for psychogenic reaction and another who did not want to deny others' belief.

Working with the Mentally Ill

When asked how they would feel working with the mentally ill, most non-psychiatric nurses (five out of six) answered they would not refuse. Two of them said that it was just the same as in other units, because patients were patients, and basic nursing characteristics, such as fulfilling each patient's need or respecting each patient's characteristic, was the same in any units. The others commented that it would be hard to work in a psychiatric unit, because "communication with patients would be difficult, and it would be the most important part of nursing," "every single word would affect patients," or "a nurse should

be 'rich' in personality." One nurse said, " I want to understand what patients want to do by having a lot of conversation." Another nurse said, "It would be an interesting area for a nurse, to try to draw a line between 'normal' and 'abnormal'." Only one nurse said that she would not like to be assigned to a psychiatric unit because of the fear of being a minority in terms of "normal" among "abnormal," saying " I would not know which is really abnormal."

When psychiatric nurses were asked why they were working in a psychiatric unit, three of them said they chose it and four of them were assigned. Most of them liked working in a psychiatric unit, except one who was assigned. She said, "a nurse has areas which she is good at and poor at, and I don't think I'm good at psych." She also mentioned she was not satisfied with the treatment being done today. Two of the assigned nurses at first had thought it would be hard, because "you should see a patient as a whole person, and it's basic but the hardest part of nursing." But both of them said they were now thinking it was an interesting and rewarding area. The reason for the positive attitudes toward psychiatric nursing were "the condition of mental illness can be changed through

personal relationship," "nurses' effects are strong," "everybody has capacity hidden inside and finding it and drawing it out is interesting and rewarding," "it's not repetitious or systematic," "there are a lot of unknowns." A nurse mentioned, "it is a good area for a nurse who likes it. It's hard, so if you don't like it, you can't continue."

Personal Involvement

When asked about the possibility of their own marriage with the mentally ill, six of thirteen participants said that they would not decide about marriage only from the fact that the other party had the mental illness. One participant phrased it as " I would stop to think about genetic effects, his personality, and the possibility of relapse. But I might get married if he could think about his own illness without denying and if he had enough ability to live in the society and to have a good interpersonal relationship." Another participant said, "I can hardly tell because I couldn't tell if he was 'now' mentally ill just because of the diagnostic history, or couldn't tell just because he didn't have a diagnostic history; if you don't go to see a doctor, you don't have a diagnosis." Three of the participants said they would

not choose the mentally ill as partners. One of them reasoned "it would be hard to keep a normal husband-wife relationship, because most of the mentally ill relapse and can't get a stable job. Men should work and get money." Another gave a different reason. "Because I'd like to continue my work and I don't want to be a nurse when I'm at home... I'd like to choose a person who can live on his own without my support... In that meaning, I would stop to think about marrying him, not because of 'mental' but because of 'illness.'"

In terms of public repudiation because of having a mentally ill person as a husband or a family member, seven participants expressed beliefs similar to one participant who said "I don't think it's a shame," and one said that she would notice the public stigma but would not care. Two said that they would hesitate to tell people because "it would be easier for us to live in the society if we didn't tell it."

Mentally Healthy

When asked to define "mentally healthy," the answers varied. Two participants said " I can't define," and two mentioned that the concept of health was a continuum and there was no clear cut difference between healthy and not healthy. The most popular

opinion (five out of 13) was "being positive." Other opinions were "energetic," "confident of self," "self-sufficient," "self-content," "being natural self," "flexible," "adaptable," "want to be helpful, being kind to others, or can think of others," "good coping, or problem solving," "can make a good judgment," "emotionally stable," "not being worried for a long time," and "having purpose of life." One participant stated "I can't tell if someone is in good mental health or not. Feeling vivid and energetic might be manic when seen by others, or other people might see you as depressive when you felt very good."

CHAPTER V

DISCUSSION

Summary and Conclusion of Chinese Results

After analyzing the results the researcher discovered several recurring themes and concepts. These themes and concepts represented some attitudes of Chinese nurses toward the mentally ill. They also, to some extent, reflected how Chinese people felt about mental illness. Cultural elements were found to be related to these attitudes and feelings.

Unwritten Standards/Cultural Expectations

In every culture there are probably unwritten standards and expectations of their people. Some behaviors and beliefs are acceptable, and some are not. One tendency in the Chinese data was that people were confident as to what was considered "normal" in their culture. For example the participants used "not normal" and "different from normal" to define mentally ill. Especially, some participants laughed at the question, saying there's no need to ask, because it obviously meant the mentally ill were not normal.

China, as a socialist country, has been known for its collective nature in many aspects of people's life. People are expected to conform in actions, appearance,

and thoughts. differences are frowned upon, and considered "weird." A Chinese saying labels people who are different or try to be different, as "the camel among a group of sheep." Usually, one with the "camel" label would be discriminated against. Another example is appearance. Periodically, chinese people were supposed to dress uniformly. For example during the cultural revolution (1966-1976) grey and blue were the only acceptable colors for clothes. People who attempted to dress more colorfully were labeled as having "capitalist vanity," "not normal," and were subject to criticism.

The mentally ill, in the same sense, are considered too different and abnormal. Louie (1985) noted that mental illness is considered by most Chinese to be a stigma. Usually clients enter the health care system when they have reached the point of exhibiting severe personality disorganization. The family usually tries to maintain the mentally ill client at home for as long as they can cope with the situation. They view the mentally ill person as a shameful reflection on the family, and among the Chinese, seeking help for mental or emotional difficulties is considered a disgrace and taboo.

Family Role

Family ties are very strong in China. Previously, almost everyone researched many generations of his/her family. Until recently, and sometimes even today, several generations sharing the same roof as a family is still not rare. Family members depend on each other, take care of each other, and feel responsible for each other.

As Livingston & Lowinger (1983) explained within a Chinese family there was emphasis on the equal protection and welfare of all members. So a weak person, who might have difficulties in earning a living if she/he had to depend solely on her/his own ability, could take comfort from the fact that her/his brothers and cousins could be counted on for help. Each member of the family would look upon any honors conferred upon the family, or any disgrace that befell it, as something inseparable from herself/himself. In fact, family honor or disgrace was even more important than herself/himself.

As the data showed, most participants admitted that the family's responsibility for their mentally ill members was not an exception. Families were not only supposed to prevent mental illness from happening to

their members, but also take the primary responsibility to take care of mentally ill members. It is not surprising then that families are blamed if they failed or are considered to have failed to fulfill their responsibilities to the mentally ill.

Society/Government versus Individual

After China began to open up in the late 1970's the world started to have some more contact with the Chinese. People have gradually been exposed to Chinese society and its system. Especially after the student movements in China in 1989, and the changes which occurred in Eastern Europe, people are more curious about what will happen to China. The study of the Chinese system is not a goal of this research, but its influence on people's attitudes stood out clearly in the results.

An impression drawn from the data was that the Chinese system is based on a distinct hierarchy. At the top is the political government ruled by the party, then the society, and then the community (or "units" which means people's work place). Families are under community units, and individuals fall at the bottom. The lower should obey the upper. This pattern devalues the individuals' input in any significant matters. It

makes people feel they are unimportant, and they are not accountable.

Some participants did not want to give any opinions on certain matters. They believed those questions were "untouchable," or simply did not concern them. Typical responses were "there must be laws about that"; or "I dare not say, the law decides this." In china laws are made by the non-democratic government. The participants considered a larger picture, society, when discussing care of the mentally ill. For example, one response that appeared quite often in the data was "burden to society."

Some literature also supports this finding. As Coye, Livingston & Highland (1984) stated, that the Communist Party of China is the core of the leadership of the whole Chinese people and that the citizens must support the Party leadership. In other words, the Party is the law. Kong-Ming New & Louie New(1978) also explained "unlike many Western countries, the People's Republic makes an effort to remind its citizens that life in China, including health behavior, cannot be divorced from its more important political structure and ideology. Much of personal life is guided by publicly espoused ideologies..." (p.16). Also,

"through peer pressure influence or influence from above, individuals are constantly reminded that a particular program has high priority." (p.16).

One phenomenon that should be explained here is that several participants gave some recognition to "human right" in the interviews. The researcher thought the reason for this was that these participants, especially people from mainland China, had been influenced by American values and beliefs. In China, the system, as mentioned above, never emphasized individual rights. The real meaning of the concept--"human right" was even unheard of until recently. In public, Chinese people still cannot use "human rights" to justify their thoughts or behaviors.

As Coye, Livingston & Highland (1984) explained "if human rights are conceived as absolutes, based on natural law, there is little support in China's heritage for the values incorporated in the first amendment to the U.S. Constitution." (p. 451). They also stated that the concept of liberalism was still a foreign import which many Chinese regarded with suspicion (Coye et al, 1984).

Stigma and Stereotypes

Overall the Chinese attitudes appeared to be

negative about the mentally ill. They were considered to be violent and harmful. They were viewed as incompetent, weak and "not normal." They had to demonstrate what they could do, and prove themselves to others in terms of their capacity. They were not only considered a burden to the family but also to the society. Secondary stigma about working with the mentally ill clearly showed in the data.

Psychiatric Development

The data supported that the psychiatric field is undeveloped in China. In most cases patients are still kept in hospitals for a long time. There are few community resources for the mentally ill, and the responsibility for their care still falls on families. Very few participants viewed promoting patients' independence as important.

The way most nurses defined "mental illness" showed their lack of education in mental health. Instead of defining it literally, for example, "disorder of the mind," they described how a mentally ill person might look or act. Because of a lack of understanding most general nurses expressed fear and ambivalence about working with the mentally ill. Some of them simply stated that psychiatric nursing was "a

hard job," but could not elaborate why. Some nurses viewed "occupational therapy" in mental health facilities as simply playing with patients.

Summary and Conclusion of Japanese Results

Politeness/Kindness

One of the most outstanding characteristics of the answers of Japanese participants was their politeness or kindness. This was expressed in the form of hesitating to label, trying not to blame others in terms of responsibility, and avoiding stereotyping the mentally ill by saying "it depends on the condition." This tendency of politeness and kindness may be explained by the fact that Japanese culture can be characterized by the word "interdependence." Kikkawa (1988) discussed that the interdependence was supported by protectiveness, dependence, and anticipation of each other's feelings or limitations. In such a society, people anticipate others' feelings and try not to hurt others. Being polite and kind is very important to keep good interpersonal relationships. These behaviors were evident in the interviews in that participants seemed to offer polite responses, and possibly imposes a threat to the internal validity.

More than half of the participants interviewed

answered that having suicidal thoughts was natural when having a difficult time. In terms of alcoholism, one participant said, "a person who is trying to quit drinking in a support group is no longer mentally ill." Accepting others' weaknesses and appreciating others' efforts are commonly seen in Japanese culture.

The emphasis on "human-to-human relationship" and "seeing a patient as a whole person" in nursing is one characteristic in Japanese nursing education. In the interview, many participants referred to holistic nursing care as related to working with the mentally ill. This may seem to be respecting independence, but it should be noted that when saying "anticipating and fulfilling each patient's need," the emphasis is more on "anticipating" and "fulfilling," in other words, more on interpersonal relationship between nurses and patients. Again, the politeness and kindness emphasized in nursing seems to be rooted in the interdependence of Japanese culture.

Boundary

The expressions of the sense of boundary were often found in the interview. For example, participants referred to "miuchi" (people within a boundary, usually meaning family members), or

"sorenari-no-hitotachi" (people whom the culture/society assumes to be responsible, in this case, as caretakers).

Tsukishima (1977) pointed out that Japanese were traditionally kind only to the people with whom they had some relationship, in other words, within their boundary. It seems that the participants were empathetic to the mentally ill because the mentally ill are within their boundary as "patients" when they consider themselves as "nurses."

In relation to social stigma, one participant said "from our point of view, society seems to be very cold to patients, but from their (patients') point of view, I think they are feeling that family members are colder." It seems that the mentally ill also have their own boundary. They expect more from family than from society or other people, and family members' love is more important to them.

When comparing the results of the interview related to responsibilities of family and society, there is another Japanese characteristic of boundary. Participants emphasized strong family ties, using the word "mijika," meaning both physical/geographic and emotional closeness. To the contrary, when asked about

the responsibility of the society, emphasis was on the individual. One participant said, "I don't like depending on the government easily...maybe because people around me are closer (mijika)." Another said, "although I said that society should be responsible for everything, in terms of marriage and having children, you should respect each individual's freedom. There would be the problem of human rights if society or government tried to intervene in these issues." In Japan, society is something out of an individual's reach, and at the same time people are defensive against being deprived of human rights as individuals.

Protectiveness

In discussing the nurse-patient relationship, many participants expressed protectiveness of patients. For example, related to marriage, one said that the mentally ill needed to have someone who "watches them closely" (mijika ni mimamoru). The word "mimamoru" was often heard, which means "watch" and "protect." It may be translated into the word "patronize," but it should be noted that patronizing in Japanese culture is usually taken as a positive meaning and accompanied with affection. It seems to be related to the national characteristic of interdependence found in the Japanese

culture.

The patronizing characteristic is most clearly seen in the mother-child relationship. Miyagi(1979) pointed out the tightness of the mother-child relationship using the word "en bloc" or "in a body" (ittai) (p.154). Such a fused relationship does not have negative meaning and often seen as "closeness." In this interview, one nurse used the word "kureru" related to the care of the mentally ill. The word has the meaning of "benefit-getting" accompanied by the feeling of appreciation to the "benefit-giver" (in this case, the care-giver). But she used the word as if it were to her own benefit in the situation that a patient was actually the one who got the benefit. Such a feeling with a patient is similar to the feeling of mother with a child. Also some participants showed protectiveness in terms of decision marrying or choosing a job. It seems that it was not only because of the mentally ill, but also because such personal decision making often involves other family members. It is not uncommon in Japan that parents take the role of making final decision about the marriage of children. It is a possibility that because the mentally ill often stay in a hospital for a long time,

nurses tend to take on a part of such a role in place of parents.

On the other hand, some participants emphasized each individual's right. It can be explained by the historical change in the Japanese system. After World War II, the democratic way of thinking and individualism were brought in by the United States, and traditional Japanese social and family system have changed tremendously. The concept of authority, for example, government as the top of the country, or a father or an eldest son as the top of a family, has been vanishing because the concept that everybody is equal as a human being has spread. But the traditional Japanese characteristic has been partially retained as described in the interview. It can be said that Japan is still in the process of changing.

Comparison of Chinese and Japanese Sample Results

Mentally Healthy and Mentally Ill

The attitudes toward mental health and illness appeared to be different in China and Japan. When asked to define the mentally ill, Chinese participants emphasized "different" or "abnormal" appearance and behavior of the mentally ill. In contrast, Japanese participants hesitated to put a personal interpretation

to the word, and answered literally as "illness of mind." In terms of appearance, one participant said "it's rude to say someone is mentally ill because of appearance."

When asked to define the mentally healthy, the difference became clearer. Chinese participants emphasized coping skills, being the same as others, and moral qualities. Japanese emphasized the condition of "self," as being positive and self-sufficient.

It appears that in China, mental health and illness can be interpreted as "normal" and "abnormal" within the social norm. In Japan, the concept is more vague and health and illness are on one continuum. It does not necessarily mean that the Japanese do not have a social norm, but it seems that not being rude to others is more important for Japanese rather than labeling "normal" and "abnormal."

Nurses' View of the Mentally Ill

Chinese and Japanese participants had both similarities and differences in terms of how they looked at the mentally ill. Both stated that the mentally ill were less competent and vulnerable population. Chinese participants emphasized that the mentally ill were a burden to families and the society.

In contrast, Japanese participants showed protectiveness of the mentally ill, trying not to hurt them. The difference may come from the different perception of the importance of society and one's own boundaries. As discussed in the previous section, Chinese are more thoughtful of society as a whole and the social norm, while Japanese are more concerned about their own personal boundaries and closer interpersonal relationships.

Family Role

There appeared to be another similarity in the Chinese and Japanese cultures: strong family ties and the family as a primary care-giver. In both countries, parents were considered responsible for the care of the mentally ill. The difference was that the Chinese emphasized more concrete care-giving and prevention of illness, while the Japanese emphasized closeness and love. The Chinese appear to consider family more as part of the society and having certain roles and Japanese appear to have a more emotional view of family.

Working with the Mentally Ill

In nurses' work with the mentally ill, the comment often heard in both Chinese and Japanese interviews was

"it's a hard job." General nurses who had no experience working with the mentally ill population often made this comment. Although it was not the intention of this study to find a cause-effect relationship of the variables, it seemed that working experience with the mentally ill had some positive effect. Japanese psychiatric nurses who participated in this study often referred to their experience leading to a more positive attitude. It should be noted that most Chinese participants were not only general nurses but also did not have any contact with the mentally ill. It was not required, as a nursing student, to do a practicum in psychiatric nursing. Their fear or other negative comments on working with the mentally ill may come from the lack of experience.

Prejudice

Chinese participants showed prejudice towards the mentally ill more clearly, in terms of labeling them as "abnormal" and emphasizing "violence" and "burden." But it does not mean that Japanese do not have prejudice. It can be said that they tried to be polite and less discriminating because of the social desirability. Sometimes the words related to prejudice were heard during the interviews with Japanese

participants. For example, some used the word "nobanashi" (meaning let someone free in the field), which originally is used for animals. One participant referred to "people like the mentally ill" to express people who were hazardous to the society. It seems that both Chinese and Japanese still have prejudice toward the mentally ill, but it is less acceptable in Japan to express negative attitudes.

Society versus Individual

As discussed above, there are some similarities and differences in Chinese and Japanese culture. Most of them can be explained by the models of social systems (Figure 3). As seen in the model, Chinese society can be drawn with definite lines, because the word society is almost equal to the word government, which is a structured formal system. Also community and family are part of the system, which have roles and responsibilities. It may be explained as a "vertical" relationship, because the emphasis of the social norm is on whether it is right or wrong. It is considered part of the requirement or the philosophy of the government, rather than as each individual's personal relationships or emotional concerns.

Insert Figure 3 about here

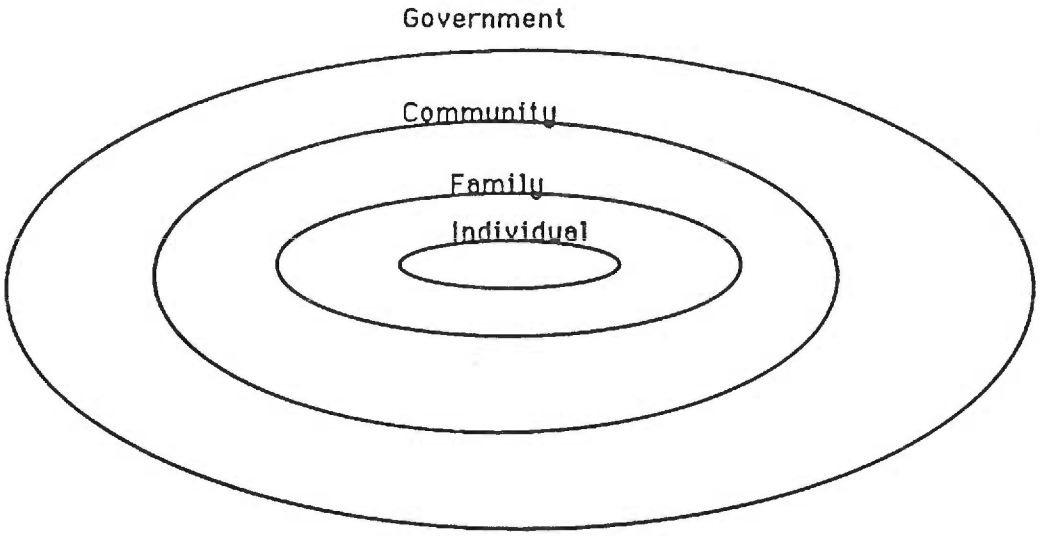
To the contrary, in Japan interpersonal relationship within a small boundary is the core of the society. Such small relationships are related to each other and make up the larger boundary, the community. Because those relationships are not formal systems, the concept of community and society is vague except when used as government. It can be called a "horizontal" relationship, because hierarchy or authority is not the one which leads the social norm, and people are more considerate of each other's feelings and interpersonal relationships.

Conclusion

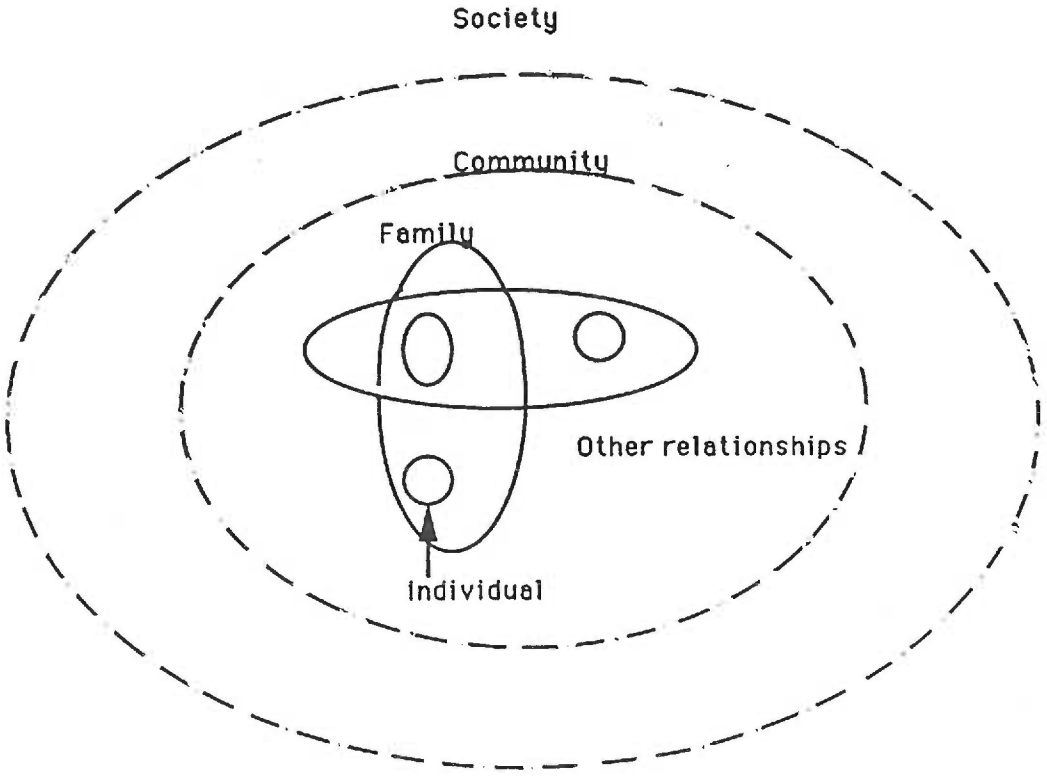
China and Japan are both Asian countries which have family and group oriented tradition. Generally, authority in China is based on top-down and authority in Japan on bottom-up. Because of the different social systems, as this research indicated, the idea of a family or a group as part of the society is very different in these two countries. Changes that have been occurring in both countries have also been influencing their traditions. In China, it has been a

FIGURE 3: SOCIAL SYSTEM

CHINESE



JAPANESE



tradition to obey the authorities, but the recent anti-government movements challenged this idea. In Japan, because the tie of the relationship of the group is informal, the role of the group is changing due to the spread of individualism brought by the United States after World War II. It is important to understand the characteristics of each country, but at the same time, attention should be paid to these changes in the future.

Limitations and Threats

Threats

A number of threats were identified in this study.

1. Social Desirability

In general, both researchers felt a certain degree of desire to please in the tone of some participants. Some participants provided answers explaining what others would think about a certain question, instead of giving their own opinions. Sometimes Chinese participants explained what was being done in certain areas instead of what they thought should be done. Some Japanese nurses measured their answers in order to sound kind and fair.

2. Interaction of History

The political upheavals in the past year in China

not only limited alternatives for sample collection, but also influenced the way people expressed themselves. Due to fear of being reported, labeled as "counter-revolutionary" or "causing trouble" some participants were more guarded during the interviews, particularly in response to legal questions or questions that might be more political or concerning the government. Also because some participants had been in America for several years, they were influenced by American attitudes and beliefs. One example was that some participants mentioned "human rights" which would not be likely to have come up if the research had been done in China.

3. Cultural Bias

It may have been a disadvantage that the researchers were from the same cultures as the participants'. For example, instead of further pursuing an issue the researchers sometimes took some participants' answers for granted.

4. Language

Because the data had to be translated into English from Chinese and Japanese, some content might have been lost or made less clear in the process.

5. Diversity of the Chinese sample

Because the Chinese sample included both Taiwanese and nurses from mainland China the results could have been more scattered. Because, even though Taiwanese are considered Chinese, the two cultures still have many differences.

Limitations

One limitation was caused by using convenience samples. The Japanese sample was from only one hospital in a relatively small area. Thus, the results might have just represented characteristics of that hospital. The Chinese sample was obtained in America, and acquaintances were used, which may limit the generalizability to Chinese nurses. Also because of the threats listed above the results could not fully represent Chinese and Japanese nurses' attitudes.

Implications

This research can contribute to nursing development, in both education and practice in several ways. First, involving nurses from China in this study is an excellent way to introduce research into Chinese nursing. Nursing development in China, an area where research was unheard of until just a couple of years ago, needs new knowledge and new skills.

Following years of isolation, China has just begun

to open its door. Nurses have been looking for opportunities to study in the United States. These nurses are pioneers, and they hope to return to China and use what they have learned to help nursing develop. The results of this research will remind these nurses of cultural relevance. That is, it is true that Chinese nursing needs new blood, but because of the cultural differences they can not simply take the theories developed in the United States or other countries, and use them in China. Some of these theories must be refined or combined with what has been working for Chinese people in nursing. Psychiatric nursing is very underdeveloped in China. This research will provide some information in terms of what needs to be added, what needs to remain the same, and what needs to be eliminated.

Second, it is also true that more Japanese nurses are coming to the United States and other countries to study. According to the results of this research the Japanese culture is unique in many ways. This indicates that the body of Japanese nursing theory and nursing practice need to be built around its own culture.

Little research has been done at the academic

level in Japanese nursing either. Many nurses who do research do not have a graduate level education. This research will set an example in terms of how research can be incorporated into graduate nursing education. Also since more emphasis has been put on quantitative research, this qualitative approach could provide a new point of view about the research process itself.

Third, findings of the study will enrich America's understanding of other cultures. When providing care to Chinese or Japanese patients, it will be important for American nurses to know how the term mentally ill is defined in their patients' cultures, what kind of role family plays, and what the patients expect from the society. Also because of the shortage of nurses, more foreign nurses are being hired to work in the United States. It is helpful to know that the cultures these nurses come from might influence how they view patient care in their practice in the United States.

Recommendation

Recommendable Methods Used in This Study

The researchers found individual interviews were comfortable for both the interviewers and the interviewees. Interviewing in person increased the communication and comprehension through body language.

There were some advantages to interviewing by phone. More geographic areas were covered by interviewing on the phone. Also the participants enjoyed the anonymity of not being identified by face, so they were more at ease to express themselves.

Doing this ethnographic research with a partner from a different culture not only enhanced the emic but also the etic aspects of the study. The partner could see things from a different perspective. By asking questions and challenging the other person's analogy made the other person think twice about an aspect of her own culture. Having a partner made the other person less likely take for granted ideas about a certain cultural issues.

Also we could not emphasize too much the support the partners got from each other in the process of the study. It made the work seem less difficult, and the study more enjoyable. The each researcher's strength and weakness in terms of research also complimented each other, which enhanced the value of the study.

The richness of a qualitative study made the study very enjoyable. Using interviews and open-ended questions provided more materials for description.

Changes and Further Suggestions

1. In order to increase the generalizability of the study a random sample might be considered. If possible, increasing the sample size would be helpful too.

2. Selecting the sample in the researchers' own culture would be beneficial.

3. In order to find out more cultural aspects, lay people should be included in the sample.

4. Revising the questions used in this study to increase the reliability and validity, so that they represent the culture more accurately would be helpful. The quantity of the content might also need to be increased to reflect more cultural elements, such as religion.

5. Because the study was done in America, a group of American nurses could have been included so that three cultures could be compared.

6. Further study could also pursue the relationship between the cultural elements found in this study and professional attitudes.

REFERENCES

Ajzen, I. & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. NJ: Prentice-Hall.

Anderson, J. (1978). The effects of the patient's diagnosis of professionals and students in a psychiatric setting: A labeling perspective. Nursing Papers, 10(1), 4-23.

Cohen, J. & Struening, E.L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. Journal of Abnormal and Social Psychology, 64(5), 349-360.

Coye, M.J., Livingston, J., & Highland, J. (Eds.). (1984). China: Yesterday and today (3rd ed.). New York: Bantam Books.

Cumming, E. & Cumming, J. (1957). Closed ranks: An experiment in mental health. Cambridge, MA: Harvard University Press.

Dohrenwend, B.P. & Chin-shong, E. (1967). Social status and attitudes toward psychological disorder: The problem of tolerance of deviance. American Sociological Review, 32, 417-433.

Flaskerud, J.H. (1984). A comparison of perceptions of problematic behavior by six minority groups and

mental health professionals. Nursing Research, 33,(4), 190-197.

Gelfand, S. & Ullmann, L.P. (1961). Attitude changes associated with psychiatric affiliation. Nursing Research, 10(4), 200-204.

Germain, C. (1986). Ethnography: The method. In P.L. Munhall & C.J. Oiler (Eds.), Nursing research, a qualitative perspective (pp.147-162). Norwalk, CO: Appleton Century Crafts.

Harris, M. (1968). The rise of Anthropological theory. New York: Cowell.

Inaoka, F. & Munakata, T. (1986). Seishin iryo, eisei jyujisha no motsu seishin shougaikan to iryou, fukushikan ni kansuru chousa kenkyu. [Mental health professionals' attitudes toward mental illness, medical care, and welfare.] In Zenkoku seishin shougaisha kazoku rengoukai (Ed.), Seishin shouugaisha no shakai fukki, fukushi shisaku keisei kiban ni kansuru chousa,Chapter 6, (pp.143-230.)

Jaffe, Y., Maoz, B. & Avram, L. (1979). Mental hospital experience, classroom instruction and change in conceptions and attitudes towards mental illness. British Journal of Medical Psychology, 52, 253-258.

Kato, M. & Nakagawa, S. (1962). Seishin eisei narabini seishin shougai ni taisuru ninshiki oyobi chiryoutei taido ni kansuru kenkyu. [A study about understanding and theraputic attitudes toward mental health and illness.] Seishin Eisei Kenkyu, 10, 1-15.

Kikkawa, T. (1988). Nihonjin no kokoro no Yamai. [Japanese illness of mind.] Tokyo: Komichi shobou.

Koutrelakos, J., Gedeon, S., & Struening, E. (1978). Opinions about mental illness: A comparison of American and Greek professionals and laymen. Psychological Reports, 43, 915-923.

Koutrelakos, J. & Zarniari, O. (1983). Opinions about mental illness: A comparison of American and Greek social work students. Psychological Reports, 53, 71-80.

Kuwabara, H. & True, R. (1976). National social policy toward the mentally ill in Japan and its consequence. International Journal of Mental Health, 5(3), 95-108.

Leininger, M.M. (1984). Care: The essence of nursing and health. NJ: Carles B. Slack.

M.M. Leininger (Ed.), Qualitative research methods in nursing, (pp.33-71). Orlando: Grune and Stratton.

Livingston, M. & Lowinger, P. (1983). The minds of the Chinese people. Englewood Cliffs, NJ: Prentice-Hall.

Louie, K.B. (1985). Providing health care to Chinese clients. Topics in Clinical Nursing, 7(3), 18-25.

Malla, A. & Shaw, T. (1987). Attitudes towards mental illness: The influence of education and experience. The International Journal of Social Psychiatry, 33(1), 33-41.

Middleton, J. (1953). The prejudices and opinions of mental hospital employees regarding mental illness. American Journal of Psychiatry, 110, 133-138.

Miyagi, H. (1979). Oyako. [Parents and Children.] In T. Mitsuyoshi, H. Tsuchida, & H. Miyagi, Kazoku shakai gaku nyumon, chapter 5, (pp.137-166). Tokyo: Yuhikaku.

Nanda, S. (1984). Cultural anthropology. CA: Wadsworth.

Napoletano, M.A. (1981). Correlates of change in attitudes toward mental illness among vocational

nursing students. Psychological Reports, 49, 147-150.

New, P.K. & New, M.L. (1978). Reflections on health care in China: Lessons for the West. Comparative Medicine East and West, 6(1), 15-22.

Nunnally, J.C. (1961). Popular conceptions of mental health: Their development and change. New York: Holt, Rinehart & Winston.

Ohshima, S. (1963). Seishin iryo jyugyoin no seishin shougaisha ni taisuru ninshiki oyobi chiryo teki taido ni tsuite. [Research on consciousness and theraputic attitudes of psychiatric professionals toward the mentally ill.] Meiji Gakuin Ronko, 8, 1-14.

Ohshima, I., Yamazaki, K., Nakamura, S., & Ozawa (1989). Nichijouteki na sesshoku taiken o yuhsuru ippan juhmin no seishin shougaishakan. [Attitudes of lay people who have daily contacts with the mentally ill.] Shakai Seishin Igaku, 12(3),286-297.

Pedersen, P.B. (1981). The cultural inclusiveness of counseling. In P.B. Pedersen, J. Draguns, W. Lonner, & J. Trinble (Eds.), Counseling across cultures (pp.22-58). Honolulu: University of

Hawaii Press.

Pedersen, P.B. (1984). Introduction: The cultural complexity of mental health. In P.B. Pdersen, N. Sartorius, & A.J. Marsella (Eds.), Mental health services: The cross-cultural context, (pp.13-27). CA: Sage Publications.

Pelto, P.J. & Pelto, G.H. (1978). Anthropological research: The structure of inquiry. (Second ed.) New York: Cambridge University Press.

Pike, K. (1954). Language in relation to a unified theory of the structure of human behavior, vol.1. CA: Summer Institute of Linguistics.

Rabkin, J. (1972). Opinions about mental illness: A review of the literature. Psychological Bulletin, 77(3), 153-171.

Rabkin, J. (1974). Public attitude toward mental illness: A review of the literature. Schizophrenia Bulletin, 10, 9-33.

Ratnarale, D.N. (1973). Psychiatry in Shanghai, China: Observation in 1973. American Journal of Psychiatry, 130(10), 1082-1087.

Rosenberg, M.J. & Hovland, C.I. (1960). Cognitive, affective, and behavioral components of attitudes. In C.I. Hovland & M.J. Rosenberg (Eds.), Attitude

organization and change. New Haven, CT: Yale University Press.

Sakuraba, S., Ohta, T., Sakata, M., & Yokota, M. (1984). Chiba ken ni okeru seishinka kangosha no ishiki chousa (2). [Research on consciousness of psychiatric nurses working in Chiba Prefecture (2).] Chiba Daigaku Kango Gakubu Kiyou, 6, 1-9.

Sato, H. (1988). Shougaisha taisaku o meguru kaikaku doukou. [Movement of innovation around the policy for the disabled.] In K. Okagami, I. Ohshima, & M. Arai, Nihon no seishin shougaisha --sono seikatsu to kazoku, (pp.33-43). Tokyo: Mineruva shobou.

Shumacker, H.B. (1980). Health and health care in the People's Republic of China. The Journal of the Indiana State Medical Association, 7.

Sidel, R. (1973). The role of revolutionary optimism in the treatment of mental illness in the People's Republic of China. American Journal of Orthopsychiatry, 43(5), 732-736.

Singer, K. (1974). Society and rights of the mentally ill: A historical perspective of the Chinese. Mental Health and Society, 1, 49-55.

Spradley, J.P. (1979). The ethnographic interview. New York: Holt, Rinehart and Winston.

Star, S. (1959). What the public thinks about mental health and mental illness: Paper presented at the annual meeting of the National Association for Mental Health, National Opinion Research Council. (Mimeo).

Terashima, S. (1969). The structure of rejecting attitudes toward the mentally ill in Japan. In W. Caudill and T. Lin (Eds.), Mental health research in Asia and the Pacific. Honolulu: East West Center Press.

Thurstone, L.L. (1931). The measurement of attitudes. Journal of Abnormal and Social Psychology, 26, 249-269.

Toguchi, T. (1988). Seishinka kango kyouiku no genjou to tenbou. [Now and the future of psychiatric nursing education in Japan.] In T. Toguchi, Hito to ba o tsunagu kea, (pp.258-266). Tokyo: Igagu shoin.

Townsend, J.M. (1975). Cultural conceptions, mental disorders and social roles: A comparison of Germany and America. American Sociological Review, 40(6), 739-752.

Tsukishima, K. (1977). Nihonjin o kangaeru -- hikaku shinri no tachiba de. [Thinking about Japanese:

From the view point of comparative psychology.] Tokyo: Dai nihon tosho.

Wada, S. & Hiraoka, K. (1984). Shimin no seishin shougaisha ni taisuru taido to seishin eisei taisaku eno iken. [Lay people's attitudes toward the mentally ill and opinions about mental health policy.] In Zenkoku seishin shougaisha kazoku rengoukai (Ed.), Seishin shougaisha no shakai fukki, fukushi shisaku keisei kiban ni kansuru chousa, Chapter 3,(pp.35-72.)

Weller, L. & Grunes, S. (1988). Does contact with the mentally ill affect nurses' attitudes to mental illness? British Journal of Medical Psychology, 61, 277-284.

Wright, F.H. & Klein, R.A. (1966). Attitudes of hospital personnel and the community regarding mental illness. Journal of Counseling Psychology,13(1), 106-107.

Yamada, H. & Ichimaru, S. (1984 a). Seishin shougai to shakaiteki taido (2): Kango gakusei no ishiki chousa kara. [Mental disorder and social attitudes (2): An inquiry on nursing students.] Sumitomo byouin Igaku zasshi, 11, 21-33.

Yamada, H. & Ichimaru, S. (1984 b). Seishin shougai

to shakaiteki taido (3): Igakusei, kango gakusei, fukushi gakusei no ishiki no hikaku chousa. [Mental disorder and social attitudes (3): A comparison between medical students, nursing students and social work students.] Sumitomo Byouin Igaku Zasshi, 11, 34-42.

Yang, H.Y. (1989). Attitudes towards psychoses and psychotic patients in Beijing. International Journal of Psychiatry, 35(2), 181-187.

Appendix A

Original Questions

The Attitude towards Mental Illness (AMI) Questionnaire

1. One can always tell a mentally ill person by his physical appearance.

2. In order to work with the mentally ill, there is no need for professional knowledge.

3. The mentally ill, with a number of exceptions, cannot tell the difference between good and bad.

4. Mental illness is genetic.

5. The mentally ill should be prevented from having children.

6. Mental illness cannot be cured.

7. One should avoid all contact with the mentally ill.

8. Psychiatric hospitals should not be located in residential areas.

9. Those who work in hospitals for the mentally ill do so because they have no other choice.

10. The mentally ill should not get married.

11. Life has no value for the mentally ill.

12. It is not necessary to consider the opinion of a person who has been released from a mental hospital.

13. The mentally ill should live only among themselves.

14. There are people who were never in a mental hospital and are more disturbed than those who are in a

mental hospital.

15. Once crazy, always crazy.

16. It is not necessarily true that a person who was once in a hospital for the mentally ill will continually have to return there.

17. Usually, there is no way of telling when seeing a person walking in the street if he was ever in a hospital for the mentally ill.

18. Very few, if any, mentally ill are capable of true friendships.

19. Mentally ill people should be prevented from walking freely in public places.

20. One should hide his/her mental illness from his/her family.

21. Mentally ill people who do not get well have no one to blame but themselves.

22. Mentally ill people who are not hospitalized should be prevented from walking freely in public places at night.

23. The mentally ill should not be allowed to make decisions, even those concerning routine events.

24. Every mentally ill person should be in an institution where he/she will be under supervision and control.

From: Weller, L. and Grunes, S. (1988). Does contact with the mentally ill affect nurses' attitudes to mental illness? British Journal of Medical Psychology, 61, 277-284.

1. How do you define the mentally ill?

2. Could you tell if someone is mentally ill by physical appearance?

   If yes, what do you notice?

3. Who do you think is responsible for the care of the mentally ill? Who else?

   Probe: immediate family
   community members
   relatives

What are some of the responsibilities?

   Probe: economical support
   emotional support
   helping chores
   budgeting

4. What kind of responsibility do you think our society has in terms of taking care of the mentally ill?

   Probe: Providing shelter
   food
   money
   treatment
   entertainment

5. To what extent do you trust the mentally ill person's judgment?

   Probe: ability to care for themselves
   budgeting
   choosing job
   getting married
   ability to vote
   criminal activity

What made you feel this way? Could you give me the example?

6. What do you believe are the causes of mental illness?

   Probe: biological
   socioenvironmental
   family
   will power
   superpower

7. Do you believe the chronically mentally ill should be allowed to get married?

   Probe: marrying each other
   marrying non mentally ill
   having children
   keeping children
   how would you feel marrying the mentally ill?
   how would you feel if your children get married?

Why or why not?

8. How do you feel about the saying "once crazy, always crazy"? What made you feel that way?

9. Where do you think the mentally ill should be treated?

Probe: hospitalized
community
segregated

10. How do you think the mentally ill should be treated?

Probe: chemotherapy
OT
heal without treatment
folk medicine

11 a) If you are a psychiatric nurse: What made you choose this speciality in the nursing profession? If you were assigned to work with the mentally ill, how do you feel about this work?

b) If you are not a psychiatric nurse: How would you feel if you were assigned to the psychiatric unit?

12. How do you define the mentally healthy?

Probe: without mental illness
other condition

* After each question, the interviewers will ask to explain more and what made the participants feel that way in order to get the sociocultural variables related to attitudes.

Appendix C

Questions (Chinese Version)

采访问题

1. 请用你自己的语言解释什么叫做"精神病"?

2. 你认为从一个人的外表能看出一个人是否有精神病吗? 如果可以, 他/她的外表有哪些特征?

3. 在你看来照顾精神病患者是谁的责任? 还有谁?

引句: 直系亲属
非直系亲属
居民社区
公社团体

责任有哪些?

引句: 经济方面
感情支持
料理家务及财经

4. 在照顾精神病患者方面你认为我们社会有哪些责任?

引句: 供给吃住
供给钱治疗
供给娱乐场所

5. 在什么程度上你信认精神病患者的判断能力?

引句: 照顾自己的能力
料理生活财经
选择工作职业
选结婚举能力
对自己犯罪行为负责

你为什么这样认为? 能举例说明吗?

6. 你认为"精神病"是什么造成的?

引句: 生理原因
社会环境因素
精神脆弱
超人的东西

7. 你认为慢性精神病患者应被允许结婚么?
为什么?

引句: 互相结婚
非精神病患者结婚
能生孩子吗?保留还是代养
如你的孩子要与精神病患者
结婚你会怎样想?

8. 你对"一个人要是疯了就永远是疯子"的说法
怎样看?为什么?

9. 你认为精神病患者应在哪里得到治疗?

引句: 住院
局民区,社团体
被隔离

10. 你认为我们应该用什么方法治疗精神病?

引句: 西药
中药
职业治疗
不民间疗法

11. 如果你是精神科护士，是什么促使你选择这个职业的？如果你是被安排到这个专业的，你对这个工作有什么感觉？

如果不是精神科护士，假如你被安排到这科工作你会怎么想？为什么？

12. 你认为什么叫做"精神健康"？

Appendix D

Questions (Japanese Version)

質問項目

1.「精神障害者」という言葉を聞いて、どういう意味にとりますか。

例えば：アルコール依存症は精神病ですか。

自殺念慮はどうですか。

パーソナリティディスオーダーはどうですか。

2.貴方は外見からその人が精神障害者かどうか判断出来ますか。もしできるとしたら、どのような点からでしょうか。

3.精神障害者の世話は誰の責任だと思いますか。

ほかには誰の責任でしょうか。

例えば：血族としての家族

地域の人

親戚

どんな責任があるでしょうか。

例えば：経済的な援助

心理的な援助（気持ちの支え）

身のまわりの世話

お金の管理

4.精神障害者の世話に関して、社会にはどのような責任があると思いますか。

例えば：住居の提供

食物の提供

お金の提供

治療の提供

娯楽の提供

5.精神障害者の判断はどの程度信頼できるでしょうか。

例えば：自分の世話が自分でできる。

お金の管理

仕事の選択

結婚

投票

法的な行為

そのようにお考えになる理由をお聞かせください。例をあげて下さいますか。

6.精神病はどのような原因で起こると思いますか。

例えば：生物学的（遺伝など）

社会環境

家族環境

意志の力

人間の力のおよばないもの（たたり、狐つきなど）

7.精神障害者の結婚は許されるべきだと思いますか。

例えば:障害者同士の結婚

健常者との結婚

子供を産むこと

子供を育てること

御自分が精神障害者と結婚すること

あなたのお子さんが精神障害者と結婚すること

8.「気狂いは一生治らない」という言い習わしを聞いてどのように感じますか。それはどうしてでしょうか。理由をお聞かせ下さい。

9.精神障害者はどのような場所で治療を受けるべきだと思いますか。

例えば:病院(入院)

地域

隔離(コロニーなど)

10.精神障害者はどのような治療を受けるべきだと思いますか。

例えば:薬物療法

作業療法

精神療法

治療は受けなくても良い

民間療法(おはらいなど)

11.a)精神科の看護婦(士)さんへ: どうして精神科看護を選びましたか。精神科に配置されたからという場合、この仕事についてどう思いますか。

b)精神科以外の看護婦(士)さんへ: もし精神科に配置されたら、どのように感じるでしょうか。

12.「精神的に健康な」という言葉を聞いて、どういう意味にとりますか。

Appendix E

Letters to the Participants

(English Version)

Dear participant:

This letter briefly describes a research study entitled "Attitudes toward the Mentally Ill". The study is on the cultural aspects of attitudes toward the mentally ill. If you choose to participate, you will be interviewed and asked questions about your opinions, beliefs, or feelings about mental illness or mentally ill patients.

Your participation is confidential and voluntary. Although questions are not supposed to be intrusive or too personal, you may refuse to answer them at any time.

The interview will take about 30 minutes and will be tape-recorded for analysis purposes. Tapes will be erased after the data is transcribed,and your name will not be identified in any way.

This study will help develop a better understanding of the sociocultural elements related to the attitudes toward the mentally ill. We are willing to share with you the result of the study on your request (Yumi Sekizawa: 2-18 Asahikawa Hokkaido, JAPAN).

Please contact us directly if you want to be part of this study.

We cordially invite your participation.

Fan, Li-Ping, RN, BS.

Sekizawa, Yumi, RN, BA.

Appendix F

Letters to the Participants

(Chinese Version)

致被访者

这封信将简单地描述一个科研题目："对精神病患者的态度". 这个科研将从社会文化的角度来观察对精神病及其患者的看法. 如果读者愿意参加请與我们联系.科研的方法是"采访". 你将被问一些有关精神病及其患者的问题.

你参加这科研项目完全是自愿的. 你所表达的任何看法都是保密的. 你也可以拒绝回达某些问题. 采访大约需要45分钟并被录音下来. 录音内容用完后会马上被清洗掉. 你的名字也不会在科研报告中任和地方被识别出来.

这个科研有助于从社会文化方面来理解对精神病患者的看法并促进我们在这方面的认识. 如果读者有这个要求的话我们很愿意与你分享这个科研的结果. 来信请寄：

Yumi Sekizawa,2_18 Ashikawa Hokkaido, Japan.

如果有其它问题请打电话来问或写信与我们联系.

我们欢迎并诚心地邀请读者参加我们这项科研.

范丽萍

(503) 248_0363

Yumi Sekizawa

(503) 274_8845

Appendix G

Letters to the Participants

(Japanese Version)

各科　看護婦（士）さんへ

私は、この度修士論文の一環として「精神障害者に対する態度」というテーマで、調査研究を行うことにいたしました。この研究は、精神障害者に対する態度の分析を通して、その社会文化的な要因の理解をより深めることを目的とするものです。

調査方法は面接で、精神病または精神障害者に対するご意見や日頃、感じていることをお聞きするものです。ご協力いただくかどうかは、ご自由です。もし、ご協力いただいた場合、秘密は厳守いたします。

面接は、約30分を予定しております。質問は、立ち入った個人的なものではありませんが、返答したくないときには、お答えにならなくても結構です。また、分析の都合上、面接はテープに録音させていただきますが、転記後は直ちに消去し、個人名が明らかになるようなことはありません。研究の結果は、ご連絡下さればいつでも喜んでお送りいたします。

私は、昭和63年 3月に道立旭川高等看護学院を卒業し、同年9月よりオレゴン・ヘルス・サイエンス大学の修士課程に留学しております。この研究は、中国人留学生 Fan Li-Pingと共同ですすめております。

ご協力いただける方は、どうぞ下記まで電話、または用意いたしました返信用葉書でご連絡ください。お忙しいところ、恐れいりますがよろしくお願いいたします。

オレゴン・ヘルス・サイエンス大学
看護学部大学院　精神看護学専攻
世木澤　由美

連絡先：〒 078　旭川市 2条18丁目左 5号
☎ (0166) 31- 9747
世木澤 由美（せきざわ　ゆみ）

Abstract

Title: Attitudes toward the Mentally Ill: A Cross Cultural Study on Japanese and Chinese Nurses

Authors: Fan, Li-Ping & Sekizawa, Yumi

Approved: Carol Burckhardt
Carol S. Burckhardt, R.N. Ph.D.,
Associate Professor, Thesis Advisor

The purpose of this descriptive, ethnographic study was to explore the viewpoint of Chinese and Japanese nurses in terms of their attitudes toward the mentally ill. The specific research questions asked in this study were:

1) What are the attitudes toward the mentally ill among Chinese nurses?

2) What are the attitudes toward the mentally ill among Japanese nurses?

3) What are some of the sociocultural variables related to the attitudes of Chinese nurses?

4) What are some of the sociocultural variables related to the attitudes of Japanese nurses?

The participants were collected through convenience sampling. Thirteen Japanese nurses who were working in Asahikawa, Japan were interviewed in person. Because of the political upheavals which

occurred in mainland China, 9 nurses who had recently come to America became the Chinese sample. Six of them were interviewed in person, and 3 of them were interviewed on the phone. Six of them were from mainland China, and 3 of them were from Taiwan.

Twelve-item open-ended interview guide with probes was used for the interview. Data analysis was done using a descriptive, inductive process. Interpretations in terms of the cultural elements were made on each group of data. In the end, similarities and differences in both cultures were explored and compared.

The result showed that Chinese and Japanese participants had both similarity and differences in terms of how they looked at the mentally ill. Both of them mentioned that the mentally ill were vulnerable population. But Chinese participants emphasized the aspect that the mentally ill were a burden for the families and the society. In contrast, Japanese participants showed protectiveness of the mentally ill. The difference may come from the different perception of the importance of society and one's own boundaries. Chinese are more thoughtful of society as a whole and the social norm, while Japanese are more concerned

about their own personal boundaries and closer interpersonal relationships.

Using convenience samples limited the generalizability of this study. Also because of the threats such as social desirability, interaction of history, cultural bias, language, and diversity of the Chinese sample, the results could not fully represent Chinese and Japanese nurses' attitudes.

This research can contribute to nursing development, in both education and practice. The results will remind both Chinese and Japanese nurses that the body of Chinese/Japanese nursing theory and practice need to be built around its own culture. Findings of this study will also enrich America's understanding of other cultures.