JAPANESE AMERICAN ATTITUDES TOWARD MENTAL ILLNESS

by

Katsuko Tanaka, B.S.

Katsuko Tanaka
田中勝子

A Thesis

Presented to
the University of Oregon School of Nursing
and the Graduate Council
of the University of Oregon Health Sciences Center
in partial fulfillment
of the requirements for the degree of
Master of Nursing

June 1980

APPROVED:

[redacted]

Julia S. Brown, Ph.D., Professor, Thesis Advisor

[redacted]

[redacted] Professor,
First Reader

[redacted]

[redacted], Ph.D., Associate Professor, Second Reader

[redacted]

Carol A. Lindeman, Ph.D., Dean, School of Nursing

This study was supported by a United States
Public Health Service Traineeship from
Grant Number 5 A11 NU 00250-03 and
Grant Number 5 A11 NU 00250-04

ACKNOWLEDGMENTS

Deep gratitude is expressed to Dr. Julia Brown for her great dedication and invaluable assistance throughout the study with encouragement and support as thesis advisor. Sincere appreciation is extended to Dr. Florence Hardesty for her encouragement and support, and to Dr. Avis Graham for her interest and understanding. Special thanks go to Professor Yoji Tanabe for his assistance in the translation of the questionnaires, and to Lynn Yoshihara who provided consultation. Lastly, I would like to express my deep appreciation to the participants of the study for their cooperation.

k.t.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Increasingly, nurses are becoming more aware of the importance of understanding the problems of ethnic groups so that they can provide health care that is sensitive to the needs of persons affiliated with those groups. For at least the past decade, it has been increasingly recognized that an understanding of attitudes toward mental illness is one of the most important factors in the management of community based treatment of the mentally ill from various ethnic groups.

Since the 1940's, a number of investigators have explored public attitudes toward mental illness and systematic variations according to age, education and social status. Little is yet known about differences by ethnicity. This research is an attempt to describe attitudes of Japanese Americans toward mental illness, and their acceptance or rejection of the mentally ill.

Review of the Literature

In this review, five areas will be explored: (1) public attitudes toward mental illness will be described, focusing on identification of mental illness and acceptance of the mentally ill; (2) factors influencing such attitudes will be examined; (3) the concept of ethnic identity will be discussed; (4) an overview of attitudes toward mental illness in Japan will be provided; and (5) characteristics of Japanese Americans and their attitudes toward mental illness will be delineated.

Public Attitudes Toward the Mentally Ill

Since the establishment of the National Institute of Mental Health in 1946, a number of investigators have conducted broad assessments of public attitudes about mental illness. Excellent and detailed reviews of these studies have been published by Nunnally (1961), Rabkin (1972, 1975), and Crocetti, Spiro and Siassi (1974). Only a brief summary will be presented here, with an emphasis on public acceptance or rejection of the mentally ill.

One of the most influential studies was conducted by Shirley Star in 1950 at the National Opinion Research Center (Crocetti et al., 1974; Rabkin, 1975). Star interviewed a nationwide sample of 3,500 individuals. One of the key parts of the interview included six case descriptions of mentally ill persons, developed by Star in consultation with psychi-

atrists. The six vignettes describe mentally disturbed behaviors, such as paranoid schizophrenia, chronic alcoholism, and anxiety neurosis. In the survey, subjects were presented with these six fictitious case histories and were asked whether they represented mental illness. Star found that only the paranoid schizophrenic was recognized as mentally ill by a majority of the sample. She concluded that in the general public, there was a tendency to resist identifying people as mentally ill (Rabkin, 1975). Although Star's work was never formally published, her instrument has been used by many other investigators.

In addition to Star's vignettes for assessing public acceptance or rejection of the mentally ill, a Social Distance Scale (SDS) has been widely employed. The scale was first developed and used by Bogardus (1959) for the purpose of measuring the degree of rejection or acceptance of any particular outgroup. The scale consisted of statements concerning the degree of social proximity which respondents say they would permit between themselves and a member of an outgroup. For example, respondents indicate whether or not they would accept outgroup members as kin through marriage, as neighbors on their street, or as visitors to their country. The SDS has been modified to measure the social distance that members of the public place between themselves and the mentally ill (Crocetti et al., 1974). For example, Lemkau and Crocetti (1962) used the measurement and found that about a

half of the subjects responded that they would discourage their children from marrying an ex-mental hospital patient, while a half said they could accept such a person as a roommate or could imagine falling in love with such a person.

Elaine and John Cumming (1957) conducted a field experiment in mental health education in two small towns in Canada. No significant changes in community attitudes resulted despite a six-month educational campaign. The investigators speculated that the educational program had failed largely due to the conflict between the idea presented in the program (i.e., mental health and illness lie on the same continuum) and predominant values and beliefs of the community (i.e., that mental illness is qualitatively distinct from normal behavior). The researchers believed that people of the community rejected the entire program in order to protect themselves from the disturbing thought that anyone could become insane under certain circumstances (Rabkin, 1975). The Cummings (1957) concluded that the public failed to identify mental illnesses "correctly," and rejected the former mentally ill through "isolation."

Starting in 1954, Nunnally (1961) conducted an extensive five-year program of research regarding public beliefs about emotional reactions to mental illness. From his surveys, Nunnally (1961) obtained results similar to those of Star, and of the Cummings. He concluded that the public attached a strong stigma to the mentally ill.

As Rabkin (1975) has indicated, the results of basic studies conducted in the 1950's were in general agreement regarding public attitudes. These studies revealed that the public strongly stigmatized the mentally ill, and was less inclined to identify the subjects in case history descriptions as being mentally ill than were the mental health professionals of that time.

Less consensus characterized the studies conducted in the 1960's. Rabkin (1975) has suggested that the divergent research conclusions were, at least in part due to differences in underlying ideologies and research strategies rather than to actual changes in attitudes. Investigators who subscribed to the traditional psychiatric framework of a medical model found positive attitude changes in the public. They reported that " . . . an increasing proportion of the public believes that mental illness is an illness like any other, that more and more respondents identify case history descriptions as being mentally ill, and that the desire to keep a social distance from ex-patients seems to be declining," (Rabkin, 1975, p. 444). In contrast, investigators who favored more transactional or psychosocial models viewed the findings pessimistic and concluded that "the public still is fearful and ignorant of mental illness and that the stigma remains," (Rabkin, 1975, p. 444).

Undoubtedly, studies conducted in the 1960's reflected the increased public acceptance of the medical model, and of

the ideas that mental disorders are like other illnesses, that they can strike anyone, and that they are treatable. Regardless of the increased acceptance of these ideas, the general public still places a strong stigma on mentally ill persons and regards them with suspicion (Rabkin, 1975).

Influence of Background Factors on Mental Health Attitudes

The relationships of demographic variables to attitudes toward mental illness have been examined in a number of studies. According to Rabkin (1975), the most consistent relationships have been found between rejection of the mentally ill and increasing age and decreasing education. Clark and Binks (1966) concluded that greater education and younger age were associated with a liberal and humanistic ideology of mental illness. However, Nunnally (1961) reported that the stigma associated with mental illness was found to be very general in the public, across age categories and educational levels.

Other attitudinal differences have been found between those of high and low social status. As a rule, lower social status respondents indicated more negative feelings, and more intolerant attitudes toward the mentally ill than higher social status respondents (Hollingshead & Redlich, 1958). According to Dohrenwend and Chin-Shong (1967), respondents of higher status are more likely to recognize deviant behavior as mental disorder than respondents of lower

status. However, when both high and low status individuals agree that given behaviors reflect mental disorder, the lower status individuals are more rejecting. These authors disagreed with the view that lower status individuals are more accepting of disturbed behavior, a view which was quite common among social scientists and mental health professionals at that time. Dohrenwend and Chin-Shong (1967) concluded that it is this narrower definition of disturbed behavior that makes lower status groups appear to be more tolerant of deviant behavior.

An association between acquaintance with a mental patient and more accepting attitudes toward the mentally ill was reported by Phillips (1964). He noticed that attitudinal rejection was reduced if a friend had been mentally ill, and was further lessened in the case of an ill relative. Whatley (1959), however, found no relation between acceptance and acquaintance with the mental patient.

Sex differences on mental health attitudes were reported by Chin-Shong (1968, cited in Crocetti et al., 1974). As he found older women more rejecting than older men and black women more rejecting than black men, Chin-Shong concluded that sex interacts with age and ethnicity to determine attitudes.

The influence of ethnicity on mental health attitudes has elicited more concern recently. Blacks have been re-

ported as more rejecting in their attitudes of the mentally ill than Whites (Ramsey & Seipp, 1948; Whatley, 1959), but because of the overriding social status and educational differences between Blacks and Whites, the influence of ethnicity by itself has remained controversial.

In 1971, Guttmacher and Elinson investigated attitudes of eight ethnoreligious groups. Their instrument consisted of the six Star descriptions in abbreviated form, plus seven new vignettes relating to such behavior as drinking behavior and transvestism. The respondents were asked whether or not each description represented "a serious sign of illness." They found that Puerto Ricans differed substantially from the other ethnic groups in that they less often ascribed illness to deviant behavior. This finding was interpreted in terms of the lower social status and the lower level of acculturation of the Puerto Ricans as a group.

In general, relatively few existing research projects have explored the influence of ethnicity on mental health attitudes. Rabkin (1975) states that it is difficult to assess the influence of ethnicity by itself because of its strong correlation with social status and because of the confounding effects introduced by varying degrees of acculturation.

The Concept of Ethnic Identity

Ethnic identity involves both a subjective and an objec-

tive component. The subjective component refers to the individual's own perception of affiliation with an ethnic group, whereas the objective component refers to the assignment of an individual to an ethnic group by other persons. Usually the two components are intertwined and mutually reinforcing. Occasionally they are not. The focus of this investigation is limited to the subjective element of ethnic identification.

Shibutani and Kwan (1967), and Okano (1976) distinguished two aspects of ethnic identification from the perspective of the self-concept, namely, the cognitive, and the affective. Cognitive identification refers to the definition of self as a member of an ethnic group, and to the adoption of the world view of members of the group (Shibutani & Kwan, 1967). The individual's conception of the world is subjected to confirmation by the group. The extent to which he or she complies with group norms depends upon the degree of identification. The more intense the individual's identification, the more likely he or she will accept the values and beliefs of the ethnic group.

Affective identification is present when the individual feels more comfortable with other members of the ethnic group than with "outgroup" members (Okano, 1976). Emotional identification brings about more relaxed and less defensive feelings in the presence of ethnic members. The person feels more "at home", and a sense of "belonging" to the group. Eth-

nic identity then refers to the individual's emotions and beliefs about his or her ethnic heritage. A strong sense of ethnic identity implies positive feelings about one's heritage, and a strong tendency to conform to the ethnic group's norms, values, and beliefs.

In the United States, acculturation is taking place continuously, and the culture of an ethnic group gradually becomes more similar to that of the dominant group (Glazer & Moynihan, 1975). The ethnic individual becomes less ethnic, and more "American". This is especially true for the younger generations. However despite acculturation, the emotional attachment of persons to their ethnic groups may persist, and at times, as during the 1960's, even appear to increase. Today, there seems to be a conscious effort on the part of many individuals, including Japanese Americans, to renew or recreate their ethnic identity and cultural heritage (Kuo, 1979).

Mental Health Attitudes in Japan

In Japan, psychiatric practice has been developed only recently. Prior to the mid-1950's, the majority of disturbed persons were cared for within their own families or in other noninstitutionalized settings. Only a few were cared for in specialized treatment facilities (Caudill, 1959). Despite the accelerated modernization of Japanese medical practice, its psychiatric treatment programs remain generally

at a custodial level with a lengthy hospitalization (Kuwabara & True, 1976).

Using translations of three Star case descriptions (paranoid schizophrenia, simple schizophrenia, and chronic alcoholic), Terashima (1969) conducted a survey to determine Japanese attitudes toward mental illness and to compare the results with those of North American studies. In his sample, most of the Japanese subjects failed to see chronic alcoholism as a mental illness. This finding was explained in terms of the traditionally tolerant views toward drinking behavior in Japan.

According to Terashima (1969), it is common for Japanese to reject as a suitable marriage partner any person who has had a mental disorder, since it is believed that the origin of mental illness "is in the family". In Japan the general public, especially those who are elderly and less educated, holds strong stigmatizing attitudes toward the mentally ill (Terashima, 1969).

Japanese Americans and Their Attitudes Toward Mental Illness

Japanese Americans may be divided into four major segments by generation. Issei, the first generation, are immigrants from Japan. For the most part they arrived in the United States in the early 20th century, and currently are over 70 years of age. Nisei, the second generation, are the children of Issei immigrants. Sansei, the third generation,

are the children of Nisei parents. Yonsei, the fourth generation are the children of Sansei parents and primarily include younger children.

However, there are substantial numbers of Japanese Americans who do not fall into these generation categories. There are new Issei who arrived after the reopening of Japanese immigration in 1952 (Hosokawa, 1969). Many of these recent Issei consist of businessmen and their families, and many are Japanese war brides (Kitano, 1976). The Ainoko, or children of mixed ancestry are distinguished from the Nisei whose parents are both Japanese. Another atypical group consists of the Kibei who are Nisei sent back as children to Japan by their Issei parents to receive a Japanese upbringing. Consequently, the Kibei tend to see themselves as Japanese more than do Nisei who were brought up in the United States (Kitano, 1976). In summary, the Japanese American population includes diverse groups, but the Issei-Nisei-Sansei divisions are widely recognized within the ethnic community and comprise the majority of Japanese Americans in the United States.

Most pioneering Issei left Japan during the Meiji era (1868-1912) when a transition was taking place from the isolationist Tokugawa era with its ancestral tradition to the beginning of the period of Western modernization (Reischauer, 1974). When Issei arrived in the United States from Japan, they brought many of the attitudes and beliefs which were

shared by their community members in Japan. They included attitudes toward the mental illness such as fear, ostracism, and repression, and the idea of a "hereditary trait" origin (Kitano, 1969).

With limited interactions with American communities, Issei built a self-sufficient, tightly knit Japanese community in the United States. The community is described as a tight cohesive family and community system with high conformity and social control over various deviant behavior, as well as norms of attitudes and beliefs (Kitano, 1976).

The outbreak of World War II with the subsequent relocation and internment caused the Japanese community to disperse from the West Coast to the East and Midwest. This wartime evacuation facilitated the acculturation of Japanese Americans, and led to a wider spectrum of new opportunities for the following generations (Kitano, 1976). While their parents had a limited education and worked primarily in agriculture and ethnic-centered small businesses, the Nisei succeeded in achieving middle class status (Petersen, 1971). Overcoming discrimination against Japanese Americans, many of them went beyond high school and took professional positions (Kitano, 1976). Simultaneously, the Nisei became more acculturated than the Issei and a significant generation gap developed (Mass, 1976).

Sansei, the children of Nisei, were born mostly after World War II and consist of the college-age and young adult

generation (Okano, 1976). Among Japanese Americans, the Sansei, in contrast to the Issei who hold traditional, conservative, "old world" attitudes, are said to be essentially acculturated. However, even though the Sansei embrace the primary goals of American society and its emphasis on socioeconomic success in particular, there is evidence that they still cling to many of the traditional values and beliefs. The "Yellow Power Movement" of the sixties was an example of one conscious effort among younger generation of Japanese Americans to renew or recreate their ethnic identity (Kuo, 1979).

Japanese Americans are believed to have achieved middle class American status through education and socioeconomic success. They are commonly described as hard working, good citizens without problems of deviance, including mental illness. Indeed, the official statistics indicate that mental illness is not a major problem for the Japanese Americans (Kitano, 1976). However, Sue and McKinney (1975) have questioned this view, and suggested that the rate of psychopathology among Japanese Americans has been underestimated due to their low usage of psychiatric facilities.

Kitano (1969) has asserted that despite some changes over generations, the Japanese family in the United States remains a tightly knit, cohesive group with a high degree of social control over its members. These family characteristics may function to protect members who are mentally ill.

Because of "shame" and the blemish on the family's name, there is a high toleration of "crazy behavior" by family members until the deviant behavior causes major disruption in the family. However, once the limits of tolerance are exceeded, the individual may be sent to a mental institution with the feeling that "it's now someone else's problem". Therefore, once a Japanese American is sent to an institution, he is likely to remain there for a long time (Kitano, 1976). In this respect the situation is much the same in this country as in Japan.

Only one systematic piece of research exists on the relation of ethnic identity to the attitudes toward mental illness of Japanese Americans. Okano (1976) conducted an exploratory study using the Star vignettes as abbreviated for the Guttmacher and Elinson's study in 1971. Okano noted that ethnic identity was strong for all his respondents, although it decreased with each successive generation. He also found that Japanese Americans were generally less likely than other Americans to identify the described behaviors as mental health problems. Interestingly, he found that the more elderly respondents, who also identified more strongly with their ethnic group, were more likely than the younger respondents to define the described behaviors as problems. Okano speculated that this unanticipated result was due to the older respondents' sensitivity to problem behaviors rather than to their knowledge of mental health symptoms. However, it is

difficult to draw firm conclusion from only one study. It is necessary to replicate the finding with other samples. In the present investigation, the author will explore the relationship between ethnic identity and attitudes toward mental illness by using the original Star vignettes and the social distance scale so that the results may be meaningfully compared with those of previous studies.

Statement of the Problem

Traditionally, the Japanese have held negative attitudes toward mental illness. Mental illness has been narrowly defined, and those defined as mentally ill have been strongly stigmatized. It may be argued that among Japanese Americans, those with a stronger sense of ethnic identity may adhere more closely to traditional values, and hence manifest more negative views to mental illness. It might also be argued that those who were born in Japan and exposed to traditional values particularly during the sensitive period of early socialization would possess a stronger sense of ethnic identity and more traditional values than those born in America and exposed to Western views and beliefs. Using this reasoning, the following hypotheses have been formulated:

(1) Elderly Issei and young native Japanese express a stronger ethnic identity than young Japanese Americans.

(2) The stronger the respondent's ethnic identity, the less the tendency to identify behavior problems as mental illness.

(3) The stronger the respondent's ethnic identity, the greater the rejection of those who have been labeled as mentally ill persons.

It is the purpose, then, of this study to explore the relation of ethnic identity to attitudes toward mental illness of Japanese Americans, and to test the hypotheses stated above.

CHAPTER II

METHOD

Subjects and Setting

Three samples were drawn, in order to obtain representatives of different generations and cultural backgrounds. Two of these samples consisted of undergraduate college students, the first of foreign Japanese college students (FJCS) studying at Portland State University, or Lewis and Clark College. The second sample was drawn from Japanese American college students (JACS), residents of Portalnd who were the third or fourth generation of Japanese immigrants to the United States, and who were studying at Portland State University or at the University of Oregon. Since no lists existed of FJCS or JACS at the universities, the investigator utilized a snowball method of sampling. The numbers of subjects who participated in this study were 33 FJCS (15 males and 18 females) and 31 JACS (15 males and 16 females). These students ranged in age from 18 to 25 years. The mean ages were 23.2 and 21.3 for FJCS and JACS respectively.

Elderly Issei, first generation Japanese immigrants, comprised the third sample. They were selected from the membership of the Japanese American senior citizens' organiza-

tion, "Ikoi-no-kai", in Southeast Portland. Their mean age was 78.7 and the age range was 67 to 89. Mean educational level for the group was 8.7 years of schooling. Thirty-one Issei participated in this study (15 males and 16 females).

Data Collection Instruments

The basic research instrument was a four-part questionnaire which provided information in the following areas: ethnic identity, recognition and definition of mental illness, acceptance or rejection of the mentally ill, and personal background data.

Ethnic Identity

The first part of the questionnaire was an Ethnic Identity Scale (EIS) developed by Okano (1976). The EIS consists of 16 items which measure the strength of an individual's positive feeling or identification with his or her Japanese ancestry. For example, one item asserts: "I feel more comfortable with other Japanese Americans than with non-Japanese." The 16 items of this instrument are presented in Likert format and require respondents to check extent of agreement along a 4-point scale, ranging from 3 ("strongly agree") to 0 ("strongly disagree"). Individual items are scored from 0 to 3, which are summed to yield the EIS total score which may range from 0 through 48. The higher the score, the greater is the degree of presumed ethnic identity. In regard to

scoring, 14 items have a positive value while two items have a negative value. The latter negative value items were reverse scored. The complete index is presented in Appendix B.

Okano (1976) tested the reliability and validity of the EIS and declared them to be satisfactory. The scale is internally consistent, as is evident from the alpha coefficient of .83 for the English form EIS, and .84 for the Japanese translation. Content validity was established by eliciting evaluations of the EIS from Japanese American consultants.

Recognition and Definition of Mental Illness

In the second part of the questionnaire, the subjects' definition of mental illness was determined by their responses to the Star Vignettes, as administered by Dohrenwend and Chin-Shong (1967). One additional modification was made. The names used in the vignettes were changed to names which are typical of Japanese Americans or native Japanese. For example, the name Frank Jones was changed to Frank Yamada in the English form, and to Masao Yamada in the Japanese translation.

The six vignettes depict behaviors characteristic of six types of psychiatric disorders, namely, paranoid schizophrenia, simple schizophrenia, anxiety neurosis, alcoholism, compulsive-phobic behavior, and juvenile character disorder.

After these cases were presented, subjects were asked to respond to the following questions:

1. Do you think there is anything wrong with a person exhibiting such behavior?
2. If you think something is wrong, do you think it is serious?
3. Do you think it is some kind of mental illness?

The reliability and validity of these vignettes as a test of knowledge about mental illness have not been clearly established. However, the instrument has been used by numerous investigators in various countries: For instance, by Star (1955, cited in Nunnally, 1961), Lemkau and Crocetti (1962), and Dohrenwend and Chin-Shong (1967) in the United States; by Cumming and Cumming (1957) in Canada; and by Terashima (1969) in Japan. In addition, Dohrenwend and Chin-Shong (1967) have claimed validity for the six case descriptions, in that a sample of 34 psychiatrists recognized them as illustrations of the different types of mental disorder. (See Appendix B for a full copy of these vignettes.)

Acceptance or Rejection of the Mentally Ill

A Social Distance Scale comprises the third part of the questionnaire. The original scale was developed by Bogardus (1959) to measure social distance, or the degree of intimacy an individual would allow to members of outgroups (Shaw & Wright, 1967). As modified by Dohrenwend and Chin-Shong (1967),

the scale consists of seven items which refer to the social distance subjects say they would place between themselves and a hypothetical ex-mental-hospital patient. For instance, one of the items states: "It would be wise to discourage former patients of a mental hospital entering your neighborhood." The seven items of this instrument were presented in Likert format, with possible responses ranging from 0 ("strongly disagree") to 3 ("strongly agree"). Thus, total scores might range from 0 through 21, with higher scores signifying greater rejection of an ex-mental hospital patient. In regard to scoring, five items have a positive value while two items have a negative value. The latter negative value items were reverse scored. The scale in its entirety is reproduced in Appendix B.

In regard to its reliability and validity, Shaw and Wright (1967) have indicated that the Social Distance Scale is quite satisfactory in measuring attitudes toward any outgroup. Newcomb (1950, cited in Shaw & Wright, 1967) stated that the split-half reliability of the original Bogardus scale was as high as .90.

Personal Background Information

The final section of the questionnaire included personal background information items, as sex, age, education, and previous exposure to mentally ill persons. The content of both English and Japanese versions of the questionnaire was

identical, except for a few minor and necessary modifications. For example, the English form asked: "Have you been to Japan?" "When?", and "For how long?". The Japanese form asked: "When did you come to the United States?", and "How long have you been living in the U.S.?".

Procedure

To recruit participants for this study, the investigator initially contacted members of the loose social networks of FJCS and JACS which exist on the campuses of Portland State University, Lewis and Clark College, and the University of Oregon in Eugene. As small groups of participants were located, the questionnaires were administered until the desired number of subjects in each sample (roughly 30) was reached. To obtain access to a group of elderly, the investigator visited the Japanese American senior citizen club several times to enlist the support of the authorities and to make arrangements necessary for the conduct of the study.

On all occasions, the same general procedure was used. The investigator first briefly explained the purpose and the confidential nature of the study. After individuals had signed consent forms, the questionnaires were distributed. Verbal instructions were used to reinforce the printed instructions. The English version was administered to the JACS. The Japanese version was distributed to the FJCS and to the Issei, since it was assumed that they have only a limited

knowledge of English (Okano, 1976). A Japanese version of the EIS was already in existence and was used. The rest of the questionnaire was translated into Japanese by the present investigator. This translation was then checked by a Japanese language instructor at Portland State University for clarity, accuracy, and correspondence to the original English version. To further insure its validity, the investigator reviewed and evaluated the translated questionnaire with several Japanese-speaking individuals.

Most subjects completed their questionnaires while the investigator was present. However, a few of them took the questionnaires home and either brought back or mailed the completed forms to the investigator within a few days.

Analysis of Data

Descriptive statistics were employed to analyze and compare the responses of the three samples, and of the sexes, to each of the Star vignettes, and to each of the items of the Social Distance and Ethnic Identity Scales. Two-way analysis of variance determined the significance of the differences among the groups and between the sexes with respect to strength of ethnic identity, ability to identify mental illness, and social distance from the mentally ill. These analyses of variance were followed by Scheffé tests, where appropriate. Finally, Pearson product moment correlations provided estimates of the extent of association between each

combination of the variables of ethnic identity, social distance, and identification of mental illness.

CHAPTER III

RESULTS

Characteristics of the Sample

There were 95 persons from the Portland metropolitan area that participated in this study. Of these, 31 were Issei, 31 were Japanese American college students (JACS), and 33 were foreign Japanese college students (FJCS). Characteristics of these three groups are presented in Table 1. In each sample, the proportions of males and females are approximately the same.

With respect to age, the two college samples were roughly similar. The range in age was from 18 to 25 years, and the mean age was 21.3 for the JACS, and 23.2 for the FJCS. The Issei ranged in age from 67 to 89 years, with a mean age of 78.7 years. The educational levels of the two student groups were virtually identical, slightly over 14 years. The Issei had completed, on the average, 8 or 9 grades of school. JACS had, of course, lived in the United States for an average of 21.3 years, whereas the foreign students had resided here for 1.8 years, and the Issei for 60.6 years. With respect to socioeconomic background, about one half of the JACS came from families headed by blue-collar workers,

Table 1

Characteristics of Samples of Issei, Japanese American College Students (JACS), and Foreign Japanese College Students (FJCS).

Variable	Group		
	Issei (N=31)	JACS (N=31)	FJCS (N=33)
Sex			
Male (N=45)	15	15	15
Female (N=50)	16	16	18
Age (mean)	78.7	21.3	23.2
Length of residence in the U.S. (mean)	60.6	21.3	1.8
Last year school completed (mean)	8.7	14.3	14.5
Marital status			
Married	16	0	5
Not Married	15	31	28
Religion			
Oriental (Buddhism & others)	28	13	12
Western (Protestant & others)	3	11	5
None	0	7	16

and the other half from families of white-collar workers. By contrast, the majority of FJCS were from white-collar families. The Issei were currently retired, and had for the most part been previously employed as small scale farmers. Insofar as martial status is concerned, about 50% of the Issei were married, and the other 50% widowed. Except for five of the foreign students, all students were unmarried. Finally, with respect to religious affiliation, the majority of the Issei, and approximately one-third of the JACS and one-third of the FJCS were Buddhist. More of the FJCS (16) than of the JACS (7) declared they had no religion.

Ethnic Identity

In Table 2, ethnic identity scores by group (sample) and by sex are presented. No difference was found in identity scores of the two sexes ($F=.74$, n.s.), and no interaction was observed between group and sex ($F=.89$, n.s.). However, the differences in ethnic identity among the three groups were highly significant (between groups $F=34.30$, $df=2,89$, $p<.01$). The Issei displayed the strongest ethnic identity (mean=32.78), foreign students next strongest (mean=24.82), and the JACS the weakest (mean=19.78). By the Scheffé test, the Issei differed significantly from the FJCS ($F=13.26$, $p<.01$), the FJCS differed significantly from the JACS ($F=5.32$, $p<.05$), and the Issei differed significantly from the JACS ($F=34.25$, $p<.01$). These data support Hypothesis 1: Elderly

Table 2

Mean Ethnic Identity Scores of Issei, Japanese American College Students (JACS), and Foreign Japanese College Students (FJCS).

Variable	Issei (N=31)		JACS (N=31)		FJCS (N=33)	
	Mean	SD	Mean	SD	Mean	SD
Sex						
Male	33.47	5.28	18.33	8.01	24.00	6.30
Female	32.13	3.36	21.13	7.86	25.50	5.01
Total	32.78	4.37	19.78	7.92	24.82	5.59

Between groups, $F=34.30$, $df=2,89$, $p<.01$
Between sexes, $F=.74$, n.s.
Between group and sex, $F=.89$, n.s.
Between Issei and JACS, $F=34.25$, $df=1,89$, $p<.01$
Between Issei and FJCS, $F=13.26$, $df=1,89$, $p<.01$
Between FJCS and JACS, $F=5.32$, $df=1,89$, $p<.05$

Issei and young native Japanese express a stronger ethnic identity than young Japanese Americans.

Some interesting comparisons among the three samples are possible through analysis of their responses to the individual items on the EIS scores. (See Table 3) All three groups expressed concern over anti-Japanese prejudice. Both groups of students agreed on the need to learn the Japanese heritage and the Japanese language. Surprisingly, the Issei placed less importance on those features. The Issei reported feeling more comfortable with other Japanese Americans, and believed Japanese Americans should marry within the ethnic group. By contrast, both student groups differed in respect to these views; they did not place great importance on being with other Japanese or to choose other Japanese for their marital partners. Finally, both the Issei and the foreign students professed attachment for Japan, but the Japanese American students did not. The Japanese American youth also denied thinking of themselves as Japanese.

The relationship between ethnic identity and religious affiliation is shown in the contingency Table 4. More of the respondents professing belief in an Oriental religion received EIS scores above the median than below. The reverse may be noted for respondents professing a Western religion, as well as for those who claimed to have no religion. These differences were significant statistically ($\chi^2=10.39$, $p<.01$).

Table 3

A Comparison of Mean Scores on Ethnic Identity Items for Three Groups

Ethnic Identity Item	Group Issei (N=31)	JACS (N=31)	FJCS (N=33)
1. Concerns for anti-Japanese prejudice	2.19	2.06	2.06
2. Learning about Japanese heritage	1.81	2.32	2.48
3. Helping other Japanese Americans	2.32	1.84	1.94
4. Japanese customs and observances	2.13	1.71	2.12
5. Preference for Japanese movies	2.16	.74	1.06
6. Vote for Japanese American	1.90	.52	.70
7. More comfortable with other Japanese Americans	2.45	1.00	1.18
8. Marrying other Japanese Americans	2.39	.39	1.06
9. Think of self as Japanese	1.87	.94	2.18
10. Many responsibilities with being of Japanese ancestry	2.26	1.55	1.58
11. Learning Japanese language	1.81	2.20	2.12
12. Preference for Japanese American doctor	1.94	.71	1.42
13. Preference for Japanese American neighborhood	1.61	.97	1.06
14. Preference for Japanese American friends	1.65	.74	.91
15. Preference for Japanese American church	1.94	1.03	.67
16. Feeling of attachment to Japan	2.32	1.06	2.27

Table 4

The Relation of Ethnic Identity and Religious Affiliation, As Determined by the Chi-Square Median Test.

Religion	Ethnic Identity Scores		N
	Below Median (7-26)	Above Median (27-48)	
Oriental	19	34	53
Western	13	6	19
None	16	7	23
Total	48	47	95

$\chi^2=10.39$, df=2, $p<.01$

It may be concluded that subjects who were Buddhist or Shintoist in faith tended to have a stronger ethnic identity than those who were Christians, or atheists.

Recognition and Definition of Mental Illness

Summaries of the responses of the three samples to the six Star vignettes are presented in Tables 5, 6, and 7. Table 5 shows the percentage of respondents stating "something is wrong" about each fictitious case. Overall, the responses of the three samples were quite similar for almost all cases, over 50% of the respondents stated "something is wrong". The only exceptions were (1) the compulsive phobic, whom only 44% of the female Issei and 47% of the male foreign students saw as problematic, (2) the anxiety neurotic, seen as a problem by only 47% of the male foreign students, and (3) the alcoholic, with only 44% of the female Issei seeing that "something is wrong".

Table 6 presents the percentage of respondents considering the "something" to be serious in each hypothetical instance. In all three samples, the paranoid was the most likely to be considered as a "serious" problem. The anxiety neurotic and the compulsive-phobic were the least likely. Some specific differences among the respondents may be noted. None of the Japanese American students judged the case of the compulsive-phobic as serious; the foreign Japanese students were less inclined than the Issei or the JACS to label the

Table 5

Star Vignettes: Percentages of respondents stating "something is wrong"

Group	Case Description					
	Paranoid	*Simple Schizophrenic*	*Anxiety Neurotic*	*Alcoholic*	*Compulsive-Phobic*	*Juvenile Character Disorder*
Issei						
Male (N=15)	87	87	80	80	73	87
Female (N=16)	88	81	56	44	44	94
Total (N=31)	87	84	68	61	58	90
Japanese American College Students (JACS)						
Male (N=15)	100	100	67	93	53	73
Female (N=16)	100	94	88	94	50	100
Total (N=31)	100	98	77	94	52	87
Foreign Japanese College Students (FJCS)						
Male (N=15)	100	80	47	87	47	93
Female (N=18)	100	83	56	56	50	89
Total (N=33)	100	82	52	70	48	91

Table 6

Star Vignettes: Percentages of respondents stating "something is serious"

Group	Case Description					
	Paranoid	*Simple Schizophrenic*	*Anxiety Neurotic*	*Alcoholic*	*Compulsive-Phobic*	*Juvenile Character Disorder*
Issei						
Male (N=15)	73	67	53	80	33	73
Female (N=16)	69	56	25	31	31	63
Total (N=31)	71	61	39	55	32	68
Japanese American College Students (JACS)						
Male (N=15)	93	40	13	87	0	33
Female (N=16)	100	50	38	88	0	75
Total (N=31)	98	45	26	87	0	55
Foreign Japanese College Students (FJCS)						
Male (N=15)	100	47	13	60	13	47
Female (N=18)	89	56	22	56	44	72
Total (N=33)	94	52	18	58	30	61

Table 7

Star Vignettes: Percentages of respondents stating "is mental illness"

Group	Case Description: *Paranoid*	*Simple Schizophrenic*	*Anxiety Neurotic*	*Alcoholic*	*Compulsive-Phobic*	*Juvenile Character Disorder*
Issei						
Male (N=15)	87	67	53	47	40	40
Female (N=16)	81	63	44	19	25	38
Total (N=31)	84	65	48	32	32	39
Japanese American College Students (JACS)						
Male (N=15)	87	47	27	73	33	20
Female (N=16)	100	50	44	69	50	44
Total (N=31)	94	48	35	71	42	32
Foreign Japanese College Students (FJCS)						
Male (N=15)	93	47	20	33	40	27
Female (N=18)	100	56	28	33	39	44
Total (N=33)	97	52	24	33	40	36

anxiety neurotic as serious; and the Issei and the FJCS did not view the alcoholic's problem as serious as did the JACS.

Table 7 indicates the percentagesof respondents stating that the hypothetical person was mentally ill. In all groups, a majority believed the paranoid to be mentally ill. In all groups, the majority did not attribute mental illness to the compulsive-phobic, the anxiety neurotic, or the juvenile with a character disorder. Most of the JACS considered alcoholism an illness, and most of the FJCS and the Issei saw simple schizophrenia an illness. Some other specific differences among the groups may be pointed out: The Issei and the female Japanese American college students to a greater extent than the male Japanese American students or the FJCS viewed the anxiety neurotic as ill; the JACS to a much greater degree than the FJCS or the Issei thought the alcoholic was ill; and the males of the college student groups were less likely to view juvenile character disorder as serious and a mental illness than were female college students or the elderly.

With response to the total number of cases labeled as mental illness, there were no significant differences among the three samples or between the two sexes, ($F=.48$, n.s., and $F=.25$, n.s., respectively).

Finally, the question as to whether religious affiliation affects the tendency to identify the Star vignettes as instances of mental illness may be answered through an in-

spection of Table 8. This table presents the distribution of subjects of each religious affiliation by their greater-than-average or less-than-average recognition of mental illness. Application of the Chi-Square median test demonstrates a lack of any relationship between religious affiliation and recognition of mental illness (χ^2=1.83, n.s.).

Comparison of Present With Previous Samples

The responses of the three samples of this study are compared to the responses of samples of previous studies in Table 9. It may be seen that the responses of the Portland samples differed significantly from the responses of the Japanese samples of Tokyo residents in 1962-63 (Miura et al., cited in Terashima, 1969), of Osaka residents in 1963 and Saga residents in 1964 (Terashima, 1969). The Portland samples identified the paranoid, simple schizophrenic and alcoholic as mentally ill much more frequently than did the Japanese samples. In part, this finding may be attributed to an historical trend to define problematic behaviors as psychiatric disorders. Indeed, this trend has been noted in the American population (Dohrenwend & Chin-Shong, 1967).

Overall, the responses of the present Portland samples are remarkably like these of the cross-section of New Yorkers surveyed in 1960-64. However, both the Issei and the FJCS attributed mental illness to the alcoholic somewhat less than did the U.S. samples studied in the 60's. There may

Table 8

The Relation of Identification of Mental Illness in the Star Vignettes and Religious Affiliation, as Determined by the Chi-Square Median Test.

Religion	Identification of Mental Illness		N
	Below Median (0-2)	Above Median (3-6)	
Oriental	24	29	53
Western	6	13	19
None	12	11	23
Total	42	53	95

χ^2=1.83, n.s.

Table 9

Percentages of Respondents Identifying the Star Vignettes as Mental Illness in Present and Previous Studies.

Study	Case Description					
	Paranoid	*Simple Schizophrenic*	*Alcoholic*	*Anxiety Neurotic*	*Juvenile Character Disorder*	*Compulsive-Phobic*
Portland Study 1980						
Issei (N=31)	84	65	32	48	39	32
JACS (N=31)	94	48	71	35	32	42
FJCS (N=33)	97	52	33	24	36	40
Tokyo Japan (N=1218) Study 1962-63	63	30	9	*	*	*
Osaka Japan (N=549) Study 1963	61	36	9	*	*	*
Saga Japan (N=441) Study 1964	64	42	12	*	*	*
U.S. National Study 1950 (N=3500)	75	34	29	18	16	7
Canadian (N=178) Study 1951	69	36	25	20	4	4
Baltimore (N=1736) Study 1960	91	78	62	*	*	*
New York Study 1960-64						
Community Leaders (N=87)	100	72	63	49	51	40
Cross Section (N=151)	90	67	41	31	41	24

*Not available.

also have been a slightly smaller tendency to consider the simple schizophrenic and juvenile character disorder as mental illness.

Social Distance

The results on the social distance items for the three groups were summarized in Table 10. From the table, a sharp contrast may be seen between the JACS and the other two groups, the Issei and the FJCS. In the groups, the Issei indicated the greatest social distance from the ex-mental patients, followed closely by the FJCS. In contrast, the JACS indicated the least social distance from the ex-mental patients. Analysis of variance among the three groups showed these differences were significant ($F=25.52$, $p<.01$). The Issei and the JACS differed significantly ($F=23.57$, $p<.01$), as did the JACS and the FJCS ($F=15.90$, $p<.01$). On the other hand, the difference between the Issei and the FJCS groups was not significant ($F=1.05$, n.s.). Again, there were no significant differences between the sexes ($F=1.14$, n.s.). However, in their responses to the individual social distance items, some differences did exist between the sexes as well as between the groups.

Ex-mental patients were least rejected by the Issei as potential members of their favorite club but were least accepted as neighbors and friends. It is interesting to note that the Issei females showed greatest tolerance with respect

Table 10

Mean Scores on Social Distance Items for the Three Samples

Sample	Social Distance Item							Total Score	
	Neighbor	Friendship	Club	Hire	Tenant	Child-Marry	Child-Care	Mean	SD
Issei									
Male (N=15)	1.67	1.87	1.27	1.87	1.67	2.07	1.80	12.20	4.46
Female (N=16)	1.94	1.75	1.38	1.44	1.81	1.38	1.69	11.38	2.78
Total (N=31)	1.81	1.81	1.32	1.65	1.74	1.74	1.74	11.77	3.65
Japanese American College Students (JACS)									
Male (N=15)	.80	.80	1.20	1.00	1.00	1.20	1.13	6.47	2.72
Female (N=16)	.75	.44	.69	.69	1.19	1.25	1.13	4.88	2.90
Total (N=31)	.77	.61	.94	.84	1.10	1.23	1.13	5.65	2.88
Foreign Japanese College Students (FJCS)									
Male (N=15)	1.47	1.20	1.40	1.67	1.53	2.07	1.40	10.73	4.70
Female (N=18)	1.22	1.28	1.06	1.56	1.67	2.17	1.44	10.39	3.11
Total (N=33)	1.33	1.24	1.21	1.61	1.61	2.12	1.42	10.55	3.85

Between three groups: $F=25.52$, $df=2,89$, $p<.01$
Between Issei and JACS: $F=23.57$, $df=1,89$, $p<.01$
Between JACS and FJCS: $F=15.90$, $df=1,89$, $p<.01$
Between Issei and FJCS: $F=1.05$, n.s.
Between the sexes: $F=1.14$, n.s.

to their child's marrying a former patient, while the Issei males rejected it the most. The FJCS were most rejecting of ex-mental patients as possible mates for their children, and most accepting of them as members of a favorite club. Unlike the Issei, the FJCS accepted ex-mental patients as friends and neighbors. Similarly, the JACS were most accepting of former patients of mental hospitals as friends and neighbors, while they rejected most often the idea of their children marrying such individuals.

Overall, the Japanese American college students were most accepting of the mentally ill, whereas the Issei and the FJCS were alike in rejecting them moderately.

In Table 11, the relation of social distance scores to religious affiliation is shown. By the Chi-Square median test, the differences among the religious groups were significant ($\chi^2=9.22$, $p<.01$). Individuals preferring an Oriental religion showed the greatest social distance from the ex-patients, whereas those preferring Western religion showed the least. The scores of respondents who asserted they had no religion were equally distributed among the more rejecting and the more accepting.

Comparison of Present With Previous Samples

In Table 12, findings of the present study are compared with those of a previous study conducted in New York during the early 1960's by Dohrenwend and Chin-Shong (1967). The

Table 11

The Relation of Social Distance and Religious Affiliation, As Determined by the Chi-Square Median Test.

Religion	Social Distance Scores		N
	Below Median (0-9)	Above Median (10-21)	
Oriental	18	35	53
Western	14	5	19
None	12	11	23
Total	44	51	95

$\chi^2=9.22$, df=2, $p<.01$

Table 12

Percentages of Respondents Willing to Accept an Ex-Mental Hospital Patient on Seven Social Distance Items: Present and Previous Studies

Social Distance Item	Response	Portland 1980			New York Study (Dohrenwend & Chin-Shong, 1960-64)	
		Issei (N=31)	JACS (N=31)	FJCS (N=33)	Leaders (N=87)	Cross Section (N=150)
It would be wise to discourage former patients of a mental hospital from entering your neighborhood.	Disagree	25.8	93.5	66.7	94.3	82.0
It would be unwise to encourage the close friendship of someone who had been in a mental hospital.	Disagree	29.0	93.5	63.6	89.7	72.1
You would be willing to sponsor a former patient of a mental hospital for membership in your favorite club or society.	Agree	64.5	83.9	57.6	86.2	67.3
If you were a personnel manager, you would be willing to hire a former patient of a mental hospital.	Agree	45.1	96.8	36.4	85.1	62.0
If you were responsible for renting apartments in your building, you would hesitate to rent living quarters to someone who had been in a mental hospital.	Disagree	32.3	80.6	33.3	86.2	54.0
You should strongly discourage your children from marrying someone who was formerly in a mental hospital.	Disagree	35.5	64.5	24.2	39.1	37.3
It would be unwise to trust a former mental hospital patient with your children.	Disagree	41.9	83.9	51.5	55.2	26.7

previous study covered two samples: Community leaders (i.e., state senators, school principals, businessmen, heads of organizations, etc.); and a cross-section of the population which included four ethnic groups (i.e., Jewish, Irish, Puerto Rican, and Negro). As shown in the table, the Issei and the FJCS least tolerated ex-mental hospital patients on all items, whereas the JACS were more tolerant on all items than was a cross-section of the New York population. The rank orders of the responses of the FJCS to the scale were very similar to that of the New York groups. However, the rank order of the responses of the other two Portland groups, especially for the Issei, were dissimilar. Unlike the rest, the Issei strongly rejected the ex-mental hospital patients as residents of their neighborhood and as close friends. And lastly, among of all the five groups, the FJCS indicated the most disapproval of their children marrying former patients of the mental hospital.

Testing of Hypotheses

Hypothesis 1: Elderly Issei and young native Japanese express a stronger ethnic identity than young Japanese Americans.

From Tables 2 and 3, it is evident that both groups, the elderly Issei and young foreign students born in Japan, manifested a stronger sense of ethnic identity than did the Jap-

anese American college students. By the Scheffé test, the Issei were shown to score higher on ethnic identity than the JACS ($F=34.25$, $p<.01$) and than the foreign college students ($F=13.26$, $p<.01$). The FJCS also scored significantly higher on ethnic identity than the JACS ($F=5.32$, $p<.05$). The hypothesis is clearly supported.

The attenuation of ethnic identity in the JACS may be attributed to acculturation into American society. This observation is consistent with that of Okano (1976). The difference in ethnic identification between the Issei and the FJCS may be attributed to the generational gap arising from changes in Japanese culture.

Hypothesis 2: The stronger the respondent's ethnic identity, the less the tendency to identify behavior problems as mental illness.

This hypothesis was weakly supported, as is indicated by the correlation coefficient of -.19 ($p<.05$, one-tailed test) between the respondent's EIS scores and the number of behaviors identified as mental illness by the respondent. These results were somewhat contradictory to the findings of Okano (1976), who observed a weak positive correlation between EIS scores and awareness of mental health problems. In his study, the elderly respondents both identified more strongly with their ethnic group and defined the described behaviors as problems more frequently than did the younger

respondents. In the present study, however, no significant differences were found between the generations, the Issei and the JACS, in defining the described behaviors as mental illness. The discrepancy between the two studies may be at least partially due to the differences in the instruments used, and the differences in the samples studied. Okano (1976) used the modified Star vignettes in the samples taken from members of churches in the Los Angeles metropolitan area.

Hypothesis 3: The stronger the respondent's ethnic identity, the greater the rejection of those who have been labeled as mentally ill persons.

From Table 10, it may be noted that the hypothesis was supported. The Issei who showed the strongest ethnic identity also indicated the greatest social distance from ex-mental hospital patients. The FJCS who had a higher ethnic identity than the JACS, exhibited as great a social distance from patients as did the Issei. In contrast, the JACS indicated the weakest ethnic identity and reported the least social distance from former patients. The correlation coefficient obtained between EIS scores and SDS scores was significant, and supported the hypothesis ($r=.41$, $p<.05$, one-tailed test). However, the correlation was not significant between SDS scores and number of cases identified as mental illness ($r=-.11$).

Summary

Three samples were drawn for this study, one sample of elderly Issei, one of Japanese American college students (JACS), and the third of foreign Japanese college students (FJCS). The Issei had a mean age of 78.7 years, with 8.7 grades of school. They had lived in the United States about 60 years, were mostly small scale farmers, and were currently retired. Most of them claimed Buddhism as their religion. In contrast, the JACS and the FJCS were in their early 20's, and had slightly over 14 years of education. With regard to socioeconomic background, the JACS were from families of blue-collar or white-collar workers, while the FJCS were mostly from white-collar working families. Unlike the Issei, their religious affiliations were diverse, and included Oriental and Western religions, or no religion.

Among the three groups, the Issei indicated the strongest ethnic identity while the JACS showed the least, and the FJCS fell in between. All three groups showed their concern over anti-Japanese prejudice. As was expected, the Issei stated strong preference for being around other Japanese Americans. They also strongly supported endogamy, whereas the JACS did not. However, the JACS and FJCS did support the idea of learning about the Japanese heritage and the Japanese language more often than the Issei. In general, the Issei and the FJCS expressed relatively strong feelings of attachment to

Japan. Religion was related to ethnic identity, with the adherents to Oriental religion scoring higher on the Ethnic Identity Scale.

The three samples did not differ significantly in the number of Star vignettes identified as mental illness. However, in the responses to each described problem behavior, some differences were observed: (1) the Issei and the FJCS did not label alcoholism as mental illness as frequently as did samples in other studies; (2) the FJCS and the males in the JACS labeled anxiety neurosis as mental illness less frequently than others; and (3) the JACS and the FJCS labeled simple schizophrenia as mental illness less frequently than others.

With response to the Social Distance Scale, the JACS contrasted sharply to the other two groups by indicating the least social distance from the ex-mental hospital patients. The Issei indicated the greatest distance while the FJCS followed closely with high scores. The differences between the groups were: (1) the Issei least rejected ex-patients in their favorite clubs and least accepted them as neighbors and friends; (2) the FJCS least rejected ex-patients in clubs and least accepted them as possible mates for their children; and (3) the JACS least rejected ex-patients as neighbors and least accepted them as mates for their children. Differences between the sexes were found within the Issei group; the males rejected ex-patients most as mates for their children but the

females accepted them most in that role. In relation to religious affiliation, respondents with an Oriental religion showed the greatest social distance from former patients of mental hospitals.

The results with response to social distance were compared with results of a previous study conducted on Americans by Dohrenwend and Chin-Shong (1967). It was noted that the Issei and the FJCS of this study rejected the ex-mental hospital patients more in all areas than did the Americans.

With the findings described above, two out of the three hypotheses were supported. The elderly Issei and the FJCS groups demonstrated a higher ethnic identity than the JACS, and also rejected the persons who had been labeled as mentally ill more often than did the JACS. The number of problems behaviors identified as mental illness correlated negatively with the degree of ethnic identity, lending some weak support for that hypothesis.

CHAPTER IV

DISCUSSION

The samples of this study were selected from a very restricted geographical area and social range. All subjects were from the Portland metropolitan area, and were either elderly members of a Japanese American senior citizen club, or young college students. Due to the nonrandom method of selection, and the nonrepresentative nature of these snowball samples, the findings of this survey cannot be generalized to the total population of Japanese Americans in this country or Japanese in Japan. The conclusions may only be taken as suggestions. With this caution, the findings are discussed below, first with respect to ethnic identity, next the identification of mental illness, and then the social distance placed by the respondents between themselves and former mental patients. Finally, the results of testing the three hypotheses will be evaluated.

Ethnic Identity

Both the elderly Issei and the foreign Japanese college students (FJCS) were born and lived in Japan during their formative years. They were, therefore, exposed to Japanese values for an extended period of their lives. As anticipated,

they revealed a stronger ethnic identity than did the Japanese American college students (JACS). However, the EIS scores of the FJCS were significantly less than those of the Issei. The differences may be attributed to the generational gap. Okano (1976) has claimed that generational status exerts a strong effect on EIS scores. In Japan, many changes in life styles and attitudes have occurred over the past few decades due to Western influence. As Berrien (1966) observed, these changes are most noticeable among the youth.

In contrast to the Issei and the FJCS, the attenuation of ethnic identity for the JACS was clearly evident. They did not intend to choose their marital partners on the basis of ethnic background. And indeed the pattern of endogamy has been breaking down. A recent survey has shown that 60% of the Sansei have intermarried into other races (Okubo, 1976).

Despite the evidence of acculturation, the young Japanese Americans still expressed a strong emotional attachment to their own ethnic group. The importance of learning the Japanese language and the Japanese heritage was recognized by the JACS as well as the FJCS, surprisingly even more than by the Issei. As Kuo (1979) has indicated, today the youth is making a conscious efforts to renew or recreate their cultural heritage.

All three groups were concerned over anti-Japanese prejudice. According to Kitano and Sue (1973), to be part of the "American dream" leads to heightened sensitivity to instances

of prejudice and discrimination. Like most ethnic groups, the Issei and the JACS as well as the FJCS are facing additional stresses due to the many forms of racism encountered in the dominant culture.

Ethnic identity was also found to vary with religious affiliation. Subjects who reported an Oriental religion showed a higher ethnic identity than the subjects who claimed a Western religion, or no religion. This finding may be explained in terms of differences in acculturation. Draguns, Leaman, and Rosenfeld (1971) have claimed that Christians reflect a greater level of acculturation to American life than do Buddhists. Okano and Spilka (1971) have also reported that religious affiliation is strongly related to EIS scores.

In passing, it should be noted that only a minority (19) of the respondents professed a Western religion. It may be speculated that where Japanese or Japanese Americans discard their traditional Oriental faith, they often do not replace it by another religion, but may become atheists. The large proportion of atheists may reflect the fact that two samples consisted of college students. It may also reflect the fact that atheism among the Japanese is not regarded as "dangerous" as it is in the United States (Kuroda, Suzuki, & Hayashi, 1978).

Recognition and Definition of Mental Illness

It is the general consensus that the better educated are

more likely to identify mental illnesses correctly (Lemkau & Crocetti, 1962; Dohrenwend & Chin-Shong, 1967). No support for that relationship was found in this study. There were no significant differences among the three groups in the number of cases identified as mental illness. However, in the findings, some cultural differences were observed. It is striking that the majority of the Issei (especially the females) and the FJCS failed to see alcoholism as "serious, mental illness" in contrast to the JACS, and in contrast to the samples of Americans showed in the 1960's. The results, however are in agreement with the view that traditionally, the drinking behavior is tolerated in Japan (Caudill, 1959; Terashima, 1969) and that the alcoholism is not considered a mental illness (Terashima, 1969).

The findings regarding the case of anxiety neurosis are puzzling. The FJCS and the males in the JACS identified the described behavior as "serious, mental illness" significantly less than the Issei or the females in the JACS. The symptoms described in the case of the anxiety neurotic closely resemble "shinkeishitsu", a term used by Morita (Kondo, 1975), for a syndrome characterized by extreme introversion and hypersensitivity to the self and others, attitudes which seem to be exaggerations of general patterns. For the FJCS it may be difficult to separate the syndrome of "shinkeishitsu" from the pathological symptoms of anxiety neurosis. It is unclear however, why the male Japanese Americans responded similarly

to the FJCS, whereas the female Japanese American students and the Issei saw the case more often as "serious, mental illness". In a recent study, Onoda (1977) reported a higher rate of neurotic tendencies for Sansei high school students than for Caucasian students. He speculated that the Sansei students were experiencing a greater degree of hidden stress than the White Americans. This view was supported by Sue and Frank (1972, cited in Kitano & Sue, 1973) who asserted that due to the psychological costs associated with minority group status, Asian American students are experiencing more stress than non-Asian students. If neurotic symptoms serve as a coping function, then Asian Americans may find it difficult to label the neurotic behavior of the fictitious man as mental illness. However, if this is so, why did not the female Japanese American students and the Issei react likewise?

The males of both the college student samples designated the juvenile character disorder as "serious, mental illness" less than the other groups. One possible explanation for this finding may be the tendency of the male students to see the boy's behaviors as situational delinquency rather than pathological. On the other hand, the female college students and the elderly Issei were apparently more sensitive to "acting-out" behaviors since such behaviors were unmasculine, irresponsible, and not Japanese (Kitano, 1969).

The findings of this study are in strong contrast to the findings of studies conducted on the general public of Japan

in the early 1960's. Both the Portland Issei and the FJCS, who lived in Japan during their formative years, recognized the cases as instances of mental illness to a much greater extent than the general Japanese public. The findings are consistent with the view that the public both in Japan and in America is increasingly accepting the medical model, with its assumption that mental disorders are illnesses, that they can strike anyone, and that they are treatable (Rabkin, 1975). This trend is also observed when the responses of the subjects of this study are compared to the responses of studies in the 60's in the United States and Canada.

Despite the fact that more people are embracing the medical model with responses to mental illness, whether or not they label certain behaviors as mental illness largely depends on their cultural norms (Ellenberger, 1960, cited in Askenasy, 1974). Cultural differences may be observed in comparing this study with the studies conducted in Baltimore (Lemkau & Crocetti, 1962) and in New York (Dohrenwend & Chin-Shong, 1967). Like the respondents in the study in Japan by Terashima (1969), the Portland elderly Issei and the FJCS resisted labeling the fictitious case of a chronic alcoholic as a mentally ill person. This finding is consistent with the permissive attitudes of traditional Japanese culture toward drinking behaviors (Caudill, 1959; Terashima, 1969). Another possible cultural difference was manifested in the hesitation of the JACS and the FJCS to declare the young fe-

male "simple schizophrenic" as mentally ill. For respondents of Japanese descent, it may be difficult to differentiate the abnormal features of simple schizophrenia in a young girl from the naiveté, quietness, modesty, and retiring nature considered desirable in a Japanese girl (Terashima, 1969). Finally, in the case of the anxiety neurotic, the FJCS reported less in the case as mental illness. They may have seen the described behaviors as "shinkeishitsu", and not mental illness.

Acceptance or Rejection of the Mentally Ill Persons

By the Social Distance Scale, the JACS showed a greater acceptance of the mentally ill in all seven areas (i.e., neighborhood, friend, club, hireling, tenant, child-marry, child-care) than the other two groups. By contrast, the elderly Issei and the FJCS who have lived in Japan during their formative years evidenced a strong stigma toward the mentally ill. The results are in agreement with the view that Japanese attitudes generally toward the mentally ill have been characterized by fear, ostracism, and repression, and that the Issei brought to the United States these same attitudes (Kitano, 1969). The Issei males and the FJCS strongly rejected the former patients of the mental hospital as mates for their children. This finding is consistent with the previous finding of Terashima (1969) that in Japan, the general public believes in the hereditary nature of mental illness,

and therefore refuses to marry blood relatives of the mentally ill. However, the Issei females were more accepting of the possibility of such a marriage than were the Issei males or the FJCS. This finding probably indicates not so much an attenuation of the belief in "hereditary" trait of mental illness, but rather their respect for their children's decisions. They therefore were hesitant to state that they would strongly discourage their children from marrying someone who had been in a mental hospital. Several Issei females who disagreed with this statement specifically commented that they should not interfere with their children's own decisions. This attitude does not indicate their indifference to the protection of the family bloodline, but reflects the traditional female role in the family hierarchy, namely, to be obedient to her parents as their child, to her husband as his wife, and to her children as an aged parent.

The subjects who reported adherence to Buddhism or other Oriental religions showed less acceptance to the ex-mental hospital patients than did subjects who stated their religions as Western. This difference is harmonious with the interpretation that Christians reflect a greater level of acculturation than Buddhists (Draguns et al., 1971). The persons who defined themselves as Buddhists may be less acculturated than persons affiliated with Western religions, so that they tend to hold to more negative attitudes toward mental illness.

In comparison with the respondents in the New York study (Dohrenwend & Chin-Shong, 1967), the elderly Issei and the FJCS indicated more negative attitudes toward the ex-mental hospital patients than the community leaders or the cross-section of ethnic groups (i.e., Jewish, Irish, Puerto Rican, and Negro). By contrast, the JACS showed a higher level of tolerance even than the community leaders in most of the areas of the SDS. The results of this study did not support the findings of previous investigations. Dohrenwend and Chin-Shong (1967) found that the subjects who more narrowly defined the mental illness in such described cases, also were less tolerant of ex-mental hospital patients. Among the Portland samples, there were no differences in the number of cases which were defined as mental illness but rather differences in the specific behaviors which were so defined. These differences were due to cultural differences as described previously. Moreover, in labeling the fictitious case descriptions as mentally ill, the three Portland samples were quite similar to the cross sectional sample in the New York study; however the JACS accepted the ex-mental hospital patients more, while the Issei and the FJCS accepted them less than did the N.Y. sample.

It is also interesting to note that with the Portland sample, contrary to expectation based on prior research, acceptance of ex-mental hospital patient was not correlated with age and/or education (Rabkin, 1975; Crocetti et al., 1974).

The JACS and the FJCS were about the same in age (means of 21.3 and 23.2, respectively) and in amount of education (slightly over 14 years), yet the two groups differed significantly in their responses to the SDS. The FJCS, young college students, rejected the former patients of mental hospital just as much as did the Issei, elderly persons with little education, while the JACS showed much less rejection. It is apparent that as far as the Issei and the FJCS are concerned, the variables, age and education, have little or no effect on their responses to the SDS. It is possible then, that their differences from the JACS in responding to the SDS may be due to their ethnic orientation.

Testing of Hypotheses

As was hypothesized, the Issei and the FJCS showed stronger ethnic identity than did the JACS, who were mostly Sansei and Yonsei. This finding was consistent with that of a previous study by Okano (1976) who noted the attenuation of ethnic identity with each succeeding generation. Some attenuation of ethnic identity was also seen in the FJCS, probably due to the acculturation process in Japan. Japan has, of course, been exposed much to the Western world, and as a result, changes have occurred, especially among the young (Berrien, 1966) in life styles, attitudes, and cultural values. This trend toward a weakened ethnic identity due to Westernization, is also seen in the practice of religion. It

was apparent that the subjects who professed a Western religion identified less with their ethnic group than did the subjects who professed an Oriental faith. Nonetheless, all three groups still maintained a relatively high degree of ethnic identity, and showed their concerns over anti-Japanese prejudice. Moreover, the JACS as well as the FJCS expressed strong feelings about conserving their heritage.

The second hypothesis which stated that the stronger the respondent's ethnic identity, the less the tendency to identify behavior problems as mental illness, was only weakly supported. As has been shown, the tendency to label certain behavior as mental illness was influenced by the subjects' cultural norms, as for example in the case of alcoholism. However, this influence was not consistent over all cases. The effect of ethnic identity on the labeling of mental illness seemed countered by the effect of the growing acceptance of the medical model which labels disturbed behavior as mental illness.

The third hypothesis stated the stronger the respondent's ethnic identity, the greater the rejection of those who had been labeled as mentally ill persons. This hypothesis was strongly supported by the evidence. Subjects who strongly identified with the Japanese ethnic group attached more negative stigma to persons who had been treated in a mental institution. The present findings were not consistent with the view that more educated and younger persons tend to hold a

more liberal and humanistic ideology of mental illness (Clark & Binks, 1966), and to be more accepting of people who have been mentally ill. Instead, the findings were more consistent with Nunnally's (1961) conclusion that youth and higher education had little or no effect on negative reactions to those who had been labeled as mentally ill.

Despite the increased acceptance of the medical model, and despite general knowledge about mental health, and illness, subjects who strongly identified with the Japanese ethnic group placed a strong stigma on mentally ill persons. It seems that the subjects' emotional reactions have not yet completely caught up with their cognitive information. Needless to say, such attitudes have exercised a negative effect upon the utilization of such services as mental hospitals and community mental health programs.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to determine the effect of ethnic identity on the attitudes of Japanese Americans toward mental illness. Further, it was the purpose of the investigator to explore generational differences in identification of mental illness, and in acceptance or rejection of the mentally ill.

Ninety-five individuals from the Portland metropolitan area comprised the sample. Of these, 31 were elderly Issei (the first generation Japanese immigrants), 31 were Japanese American college students (the third or fourth generation of Japanese immigrants), and 33 were foreign Japanese college students. Since a snowball sampling procedure was used, the groups cannot be considered truly representative of the populations from which they were drawn. Therefore, the conclusions must be reported as merely suggestions.

An exploratory opinion survey was conducted by the use of a questionnaire form which consisted of four parts: Part I contained the Ethnic Identity Scale, constructed by Okano (1976); Part II consisted of the Star vignettes to assess recognition of mental illness, as used by Dohrenwend and Chin-Shong (1967); Part III measured the acceptance of the

mentally ill by means of the Social Distance Scale of Bogardus, as modified by Dohrenwend and Chin-Shong (1967); and Part IV collected demographic data. An English version was administered to the Japanese American college students (JACS), and a Japanese version was used for the elderly Issei and the foreign Japanese college students (FJCS).

Three hypotheses were tested which assessed the effect of ethnic identity upon attitudes toward mental illness in terms of the identification of mental illnesses, and in terms of acceptance or rejection of mentally ill. They were:

1. Elderly Issei and young native Japanese express a stronger ethnic identity than do young Japanese Americans.
2. The stronger the respondent's ethnic identity, the less the tendency to identify behavior problems as mental illness.
3. The stronger the respondent's ethnic identity, the greater the rejection of those who had been labeled as mentally ill persons.

The first hypothesis was supported. The elderly Issei showed the strongest ethnic identity, the JACS the weakest, and the FJCS ranked between the two. Some attenuation of ethnic identity among the FJCS was observed, perhaps due to Western cultural influence in Japan. For all three samples, a realtively strong sense of ethnic identity was noted, es-

pecially in their concern over anti-Japanese prejudice. Furthermore, both college student groups expressed a strong desire to conserve their heritage.

Weak support was found for the second hypothesis. There were no consistent differences among the groups in the number of cases they identified as mental illness in Star vignettes. However, the Issei and the FJCS hesitated to label alcoholism as mental illness while the JACS did not. In general, the subjects accepted the medical model in labeling the described behaviors as mental illness.

The third hypothesis was strongly supported. The elderly Issei who showed the strongest ethnic identity exhibited the least acceptance of ex-mental hospital patients, the JACS who indicated the weakest ethnic identity accepted them the most, and the FJCS again were in the middle. According to their SDS scores, the FJCS showed almost as great a distance from former patients of mental hospitals as did the elderly Issei, and they strongly rejected the possibility that their children should marry such a person. It is clear that the subjects who were exposed to Japanese culture during their formative years and who possessed strong ethnic identity persistently attached a negative stigma to the mentally ill.

In conclusion, although some attenuation was evident over the generations, the Japanese Americans maintained a strong ethnic identity. They were sensitive to anti-Japanese prejudice and were concerned with the preservation of

their heritage. Among Japanese Americans, or between them and the general population, there were no overall significant differences in identifing mental illness. However, the elderly Issei and the FJCS resisted recognizing alcoholism as mental illness. It is clear that subjects who possessed strong ethnic identity attached a negative stigma to the mentally ill. Thus, attitudes toward mental illness may reflect complex cultural beliefs and values. Understanding such attitudes is necessary if nurses are to be effective in providing nursing care along the entire mental health-illness continuum to persons from this ethnic group.

Various nursing implications can be drawn from the results of this study. For example, the nurse should actively involve the family of a Japanese American patient in planning his discharge, since having a member who has been in a mental institution may bring additional stress to the family members. Insensitive discharge planning may cause detrimental effects not only to the patient's successful readjustment to his community, but to the total family's well being. To effectively intervene with the patient of this ethnic group and his family members, the nurse needs to appreciate Japanese American cultural attitudes. It is not an easy task, but this knowledge is vital in providing good quality nursing care. Access to such information is needed through inservice programs or through integration of ethnic content into the nursing curriculum.

On the basis of the present study, the following recommendations are offered. First, replication of the study with another sample of Japanese Americans in a different geographical location is needed, since the sampling method of the present study limits its generalizability to other Japanese Americans. Secondly, comparison with other ethnic groups such as Chinese, Filipinos, or Koreans may increase the understanding of ethnicity and its relationship to attitudes toward mental illness.

Third, since the results of this study indicated that there is a strong correlation between ethnic identity and rejection of the mentally ill, there should be systematic investigation of attitudes toward utilization of the mental health care delivery system by Japanese Americans. Attitudinal differences by generation should be further explored. This may be accomplished through a longitudinal study comparing three generations in the families.

REFERENCES

Askenasy, A. Attitudes toward mental patients: A study across cultures. Netherlands: Mouton & Co., The Hague, 1974.

Berrien, F.K. Japanese values and the democratic process. Journal of Social Psychology, 1966, 68, 129-138.

Bogardus, E.S. Social Distance. Yellow Springs, Ohio: Antioch Press, 1959.

Caudill, W. Observations on the cultural context of Japanese psychiatry. In M.K. Opler (Ed.), Culture and Mental Health. New York: MacMillan, 1959.

Clark, A.W., & Binks, N.N. Relation of age and education to attitudes toward mental illness. Psychological Reports, 1966, 19, 649-650.

Crocetti, G., Spiro, H., & Siassi, I. Contemporary attitudes toward mental illness. Pittsburgh, University of Pittsburgh Press, 1974.

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

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

Draguns, J., Leaman, L., & Rosenfeld, J. Symptom expression in Christian and Buddhist hospitalized psychiatric patients of Japanese descent in Hawaii. Journal of Social Psychology, 1971, 85, 155-161.

Glazer, N., & Moynihan, P.D. Ethnicity: Theory and experience. Cambridge, Mass: Harvard University Press, 1975.

Guttmacher, S. & Elinson, J. Ethno-religious variation in perceptions of illness. Social Science and Medicine, 1971, 5, 117-125.

Hollingshead, A.B., & Redlich, C.F. Social class and mental illness. New York: Wiley, 1958.

Hosokawa, W. Nisei: The quiet Americans. New York: William Morrow & Co., 1969.

Kitano, H.H.L. Japanese American mental illness. In S.C. Plog & R.B. Edgerton (Eds.), Changing perspectives in mental illness. New York: Holt, Rinehart & Winston, 1969.

Kitano, H.H.L. Japanese Americans: The evolution of a subculture. (2nd ed.). Englewood Cliffs, New Jersey: Prentice-Hall, 1976.

Kitano, H.H.L., & Sue, S. The model minorities. Journal of Social Issues, 1973, 29, 1-9.

Kondo, A. Morita therapy: Its sociohistorical context. In S. Arieti & G. Chrzanowski (Eds.), New dimensions in psychiatry: A world view. New York: John Wiley & Sons, 1975.

Kuo, H.W. On the study of Asian-Americans: Its current state and agenda. The Sociological Quarterly, 1979, 20, 279-290.

Kuroda, Y., Suzuki, T., & Hayashi, C. A cross-national analysis of the Japanese character among Japanese Americans in Honolulu. Ethnicity, 1978, 5, 42-59.

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

Lemkau, P., & Crocetti, G. An urban population's opinion and mental illness. American Journal of Psychiatry, 1962, 118, 692-700.

Mass, A.I. Asians as individuals: The Japanese community. Social Casework, 1976, 57, 160-164.

Nunnally, J.C. Popular conception of mental health. New York: Holt, Rinehart & Winston, 1961.

Okano, Y. Japanese Americans and mental health: An exploratory study. Unpublished dissertation, Los Angeles: California School of Professional Psychology, 1976.

Okano, Y., & Spilka, B. Ethnic identity, alienation, and achievement orientation in Japanese American families. Journal of Cross-Cultural Psychology, 1971, 2, 273-282.

Okubo, M. The trend is toward assimilation. Pacific Citizen, December, 24-31, 1976, 4.

Onoda, L. Neurotic-stable tendencies among Japanese American Sanseis and Caucasian students. Journal of Non-White Concerns in Personnel & Guidance, 1977, 5, 180-185.

Petersen, W. Japanese Americans: Oppression and success. New York: Random House, 1971.

Phillips, D.L. Rejection of the mentally ill: The influence of behavior and sex. American Sociological Review, 1964, 29, 679-687.

Rabkin, J.G. Opinions about mental illness. Psychological Bulletin, 1972, 77(3), 153-170.

Rabkin, J.G. The role of attitudes toward mental illness in evaluation of mental health programs. In M. Guttentag & E.L. Struening (Eds.), Handbook of evaluation research. Beverly Hills, California: Sage Publications, 1975.

Ramsey, G.V., & Seipp M. Attitudes and opinions concerning mental illness. Psychiatric Quarterly, 1948, 22, 428-444.

Reischauer, E.O. Japan: The story of a nation. New York: Alfred A. Knopf, 1974.

Shaw, M.E. & Wright, J.M. Scales for the measurements of attitudes. New York: McGraw-Hill, 1967.

Shibutani, T., & Kwan, K. Ethnic stratification. New York: McGraw-Hill, 1967.

Sue, S. & McKinney, H. Asian Americans in the community mental health care system. American Journal of Orthopsychiatry, 1975, 45, 111-118.

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

Whatley, C. Social attitudes toward discharged mental patients. Social Problems, 1958-1959, 6, 313-320.

APPENDICES

APPENDIX A

Consent Form

1. English version administered to the Japanese American college students.

2. Japanese version administered to the elderly Issei and the foreign Japanese college students.

UNIVERSITY OF OREGON HEALTH SCIENCE CENTER

SCHOOL OF NURSING

INFORMED CONSENT

I, _____, herewith
(First Name) (Middle Initial) (Last Name)
agree to serve as a subject in an Opinion Survey Study which explores people's attitudes toward mental health. The study will be conducted by Katsuko Tanaka under the supervision of Julia Brown, Ph.D., University of Oregon School of Nursing. The procedure I will be subjected to is the completion of a written questionnaire of my opinions about mental health and personal background information. The procedure will take approximately 30 minutes.

I may benefit from participation in the study by aiding in the advancement of scientific knowledge for improvement in sensitive, culturally based nursing service. The information will be kept confidential. My name will not appear on the records and anonymity will be insured by the use of code number.

Katsuko Tanaka has offered to answer any questions that I might have about my participation in this study. I understand that I am free to refuse to participate or withdraw from participation in the project at any time.

I have read the foregoing.

_____ _____
Date (Subject's Signature)

_____
(Witness Signature)

アンケート調査に対する同意書

私へ　　（以下に精神衛生に関する）この
アンケート調査に参加することを同意します。この調査は
田中勝子がオレゴン医科大学看護婦学校の教授
レジリアブラウンの指導のもとに行うものですが、その課程
において私は精神衛生に関する質問に対し私の意見
を述べ私の経歴について答えます。その課程はだいたい
三十分くらいかかる予定です。私の参加によって日系人に
対する理解が深まり、日系人に対する看護婦のサービス
が向上することが私の利益ともなりましょう。この調査の
内容は外部の人には決してもらさず、私の名前はどの
答案用紙にも現われず又、任意の番号のみが使われることを
調査者は確約しております。この調査に関する質問に
ついては調査者、田中勝子が一切責任を持って答えます。
又、私はいつでも私が参加を取り止めることが出来ることを
知っています。

右了承いたしました。

一九八十年　月　日

参加者の名前（　　）

証人の名前（　　）

オレゴン医科大学看護婦学校　大学院　殿

APPENDIX B

English version questionnaires administered to the Japanese American college students:

1. Ethnic Identity Scale as constructed by Okano (1976).

2. Star Vignettes as used by Dohrenwend and Chin-Shong (1967).

3. Social Distance Scale as modified by Dohrenwend and Chin-Shong (1967).

4. Background Data Sheet.

ETHNIC IDENTITY SCALE

Listed below are some statements about how you might feel about being of Japanese ancestry. Read each statement carefully and circle the letter to the right which best shows how you feel. The letters represent the following answers:

STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
A	a	d	D

Circle the A if you strongly agree.
Circle the a if you slightly agree.

Circle the d if you slightly disagree.
Circle the D if you strongly disagree.

There are no right or wrong answers. Please answer all the statements, even if you have to guess.

		AGREE		DISAGREE	
1.	Anti-Japanese prejudice is every Japanese person's problem even if he or she does not happen to suffer from it.	A	a	d	D
* 2.	Learning about your Japanese heritage is not important to anyone who plans to spend his or her life in America.	A	a	d	D
3.	Because of their common ethnic background, Japanese Americans should help fellow Japanese Americans who are in need.	A	a	d	D
4.	Japanese customs and observances mean a great deal to me.	A	a	d	D
5.	I prefer Japanese movies over other kinds of movies.	A	a	d	D
6.	I would vote for someone because he or she was Japanese American.	A	a	d	D
7.	I feel more comfortable with other Japanese Americans than with non-Japanese.	A	a	d	D

		AGREE		DISAGREE	
8.	It is better that Japanese Americans marry only other Japanese Americans.	A	a	d	D
9.	I think of myself as more Japanese than American.	A	a	d	D
10.	Being of Japanese ancestry carries with it many responsibilities.	A	a	d	D
* 11.	There is no longer any reason for Japanese Americans to learn the Japanese language.	A	a	d	D
12.	I prefer being treated by a Japanese American doctor.	A	a	d	D
13.	I would like to live in a Japanese American neighborhood.	A	a	d	D
14.	I prefer that my friends be mostly Japanese American.	A	a	d	D
15.	When I go to church, I prefer attending an all Japanese American church.	A	a	d	D
16.	I have a strong feeling of attachment to Japan.	A	a	d	D

* Reverse scored.

STAR VIGNETTES

There are six described particular persons. In response to each described person, please answer each question. There is no right or wrong answer. With each question, pick only one which best describes your opinion. Please answer all the questions.

1. I'm thinking of a man - let's call him Frank Yamada - who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times now he has beaten up men who didn't even know him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her because, he said, she was working against him, too, just like everyone else.

   a) Do you think there is anything wrong with a person exhibiting such behavior?
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

2. Now here's a young woman in her twenties, let's call her Betty Nakada . . . she has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone - even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

   a) Do you think there is anything wrong with a person exhibiting such behavior?
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

3. Here's another kind of man; we can call him George Miyake. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going all right for him, but he can't sleep nights, brooding about the past, and worrying about things that might go wrong.

   a) Do you think there is anything wrong with a person exhibiting such behavior?
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

4. How about Bill Okada? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

   a) Do you think there is anything wrong with a person exhibiting such behavior
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

5. Here's a different sort of girl - let's call her Mary Hashimoto. She seems happy and cheerful; she's pretty, has a good job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her; she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

   a) Do you think there is anything wrong with a person exhibiting such behavior?
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

6. Now, I'd like to describe a twelve year old boy - Bobby Kimura. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores, and taking money from his mother's purse, and he has been playing truant, staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them.

   a) Do you think there is anything wrong with a person exhibiting such behavior?
      ( ) Yes
      ( ) No
   b) If you think something is wrong, do you think it is serious?
      ( ) Serious
      ( ) Not serious
      ( ) Nothing wrong
   c) Do you think it is some kind of mental illness?
      ( ) Yes
      ( ) No

SOCIAL DISTANCE SCALE

Listed below are some statements about how you might feel about a former patient of a mental hospital. Read each statement carefully and circle the letter to the right which best shows how you feel. The letters represent the following answers:

STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
A	a	d	D

Cicrle the A if you strongly agree.
Circle the a if you slightly agree.

Circle the d if you slightly disagree.
Circle the D if you strongly disagree.

There are no right or wrong answers. Please answer all the statements, even if you have to guess.

		AGREE		DISAGREE	
1.	It would be wise to discourage former patients of a mental hospital from entering your neighborhood.	A	a	d	D
2.	It would be unwise to encourage the close friendship of someone who had been in a mental hospital.	A	a	d	D
* 3.	You would be willing to sponsor a former patient of a mental hospital for membership in your favorite club or society.	A	a	d	D
* 4.	If you were a personnel manager, you would be willing to hire a former patient of a mental hospital.	A	a	d	D
5.	If you were responsible for renting apartments in your building, you would hesitate to rent living quarters to someone whowas formerly in a mental hospital.	A	a	d	D
6.	You should strongly discourage your children from marrying someone who was formerly in a mental hospital.	A	a	d	D
7.	It would be unwise to trust a former mental hospital patient with your children.	A	a	d	D

* Reverse scored.

BACKGROUND DATA SHEET

This final section asks a few additional questions for statistical purposes.

1. Sex: Male____ Female____

2. Age at last birthday_____

3. Please circle the number of the last year of school completed.

Elementary								High School			
1	2	3	4	5	6	7	8	9	10	11	12

College				Graduate School			
13	14	15	16	17	18	19	20

If you have a degree(s), please specify:_____

4. Have you ever lived in Japan? Yes____ No____
If yes, during what years? 19____ to 19____

If you lived in Japan, did you attend school there?

Yes____ No____ If Yes, how many years?_____

5. What was (or is) your main occupation?_____
(If you are retired or not working, put your former work).

If you are a student, what is your major?_____

_____

For what occupation are you preparing?_____

_____

6. What was (or is) your father's main occupation?_____

7. What is your generation? (Please check one)

Issei____ Kibei____ Nisei____ Sansei____ Yonsei____

Other (Please specify)_____

Where were you born?_____

Where was your father born?_____

Where was your mother born?_____

8. Marital Status (Check one)

Single____ Married____ Widowed____ Divorced____

Separated____ Living with Companion____

If you are now married or living with companion, is your partner of Japanese ancestry? Yes____ No____

9. What is your religion? (Check one)

Buddhist____ Catholic____ Protestant____ None____

Other (Please specify)_____

_____

10. Have you ever known anyone well who has been labeled mentally ill?

Yes____ No____

11. Have you ever taken any courses which are related to mental illness?

Yes____ No____ If yes, when did you take it? 19_____

What is (or are) the title of the course(s)?_____

_____

Thank you for completing this questionnaire. If you have any comments, please use the space below.

APPENDIX C

Japanese version questionnaires administered to the elderly Issei and the Foreign Japanese college students.

1. Ethnic Identity Scale as constructed by Okano (1976).

2. Star Vignettes as used by Dohrenwend and Chin Shong (1967).

3. Social Distance Scale as modified by Dohrenwend and Chin-Shong (1967).

4. Background Data Sheet.

(一) 次の文は日系人である事についての色々な意見が述べてあります。あなたがどの程度同意なさるかを、適当な度合の言葉を選んで○でかこんで下さい。

大いに同意する（大同）
同意する（同意）
少し不同意（不同）
大いに不同意（大不）

一、日系人に対する偏見は、すべての日系人のプロブレムである。たとえ、その幾人かが たまたま 反日系人偏見に苦しめられなかったとしても。

（大同）（同意）（不同）（大不）

二、アメリカで一生を終わるつもりの人にとって、日本文化を学ぶ事は必要でない。

（大同）（同意）（不同）（大不）

三、同じ民族なのだから、日系人は、他の日系人が困っていれば助けるべきである。

（大同）（同意）（不同）（大不）

四、日本の習慣、行事は、私にとって、とても大切なことです。

（大同）（同意）（不同）（大不）

五、私は他の映画より日本の映画が好きです。

（大同）（同意）（不同）（大不）

六、私は、その人が日系人であるがゆえに投票します。

（大同）（同意）（不同）（大不）

七、私は他の人種の人達より、日系人という方がとても気楽につきあえる

（大同）（同意）（不同）（大不）

八、日系人は 日系人どうし 結婚する事が望ましい。
（大同）（同意） （不同）（大不）

九、私は自分を アメリカ人というより 日本人とみなす。
（大同）（同意） （不同） （大不）

十、日系人であるという事は 多くの責任をともなう。
（大同）（同意） （不同）（大不）

十一、日系人が日本語を 学ばなければ ならない 理由は もはや ひとつもない。
（大同）（同意） （不同）（大不）

十二、私は 日系人のドクターに 見てもらう方がいい。
（大同）（同意） （不同）（大不）

十三、私は 日系人地域に 住みたい。
（大同）（同意） （不同）（大不）

十四、私は、自分の友人のほとんどが 日系人である事を望む。
（大同）（同意） （不同）（大不）

十五、もし私が教会に行くとしたら、日系人ばかりの教会に行きたい。
（大同）（同意） （不同）（大不）

十六、私は日本に対して強い愛着心を いだいていき。
（大同）（同意） （不同）（大不）

どうぞ次の頁に進んで下さい。

(二)

次にいろいろな人物について描写した文が六つ出てきます。各々人物について あなたの意見を述べて下さい。正しい答とか まちがっている答はありません。それぞれの質問に対して あなたの意見に最も近い意見を一つだけ選んで ○印をつけて下さい。どうぞ全部の質問に答えて下さい。

一、

ある男の人を想像して下さい。仮りに山田正夫さんとでも呼びましょう。彼は非常に疑い深い人間で誰も信用しません。そして皆が自分に対してさからっていると思い込んでいます。彼は道端にいる人々が彼の事について ひそひそと話をしたり 又は彼の後をそっとつけたりすると時折 考えています。それで彼は 今々見ず知らずの男の人をなぐってしまった事が二、三度あります。ある夜、彼は突然 妻をのこしり始め なぐり殺すと おどしました。彼は妻が他の人々と同じように 彼にさからっていると いうのです。

(ア) あなたはこういう 態度を示している人は 何か問題があると思いますか。

( ) はい
( ) いいえ

(イ) もし 何か問題があると思うのなら それは深こくなものだと思いますか。

( ) 深こくだと思う
( ) 深こくだとは思わない
( ) 何も問題がない

(ウ) あなたは それを精神病の一種だと思いますか。

( ) はい
( ) いいえ

二、さて、ここに若い二十代の女性がいます。中田花子さんとでも呼びましょう。彼女は一度も仕事を持った事がありません。彼女は外に出て仕事を探したくない様子です。彼女は大変おとなしく誰ともあまり口を聞きません。自分の家族に対しても そうです。そして彼女は人を恐れているような態度を取ります。特に自分と同じ年代の若い男性に対してそうです。彼女は誰とも出掛けようとしません。そしていつも、誰か彼女の家族を訪ねてくると、その人が帰るまで自分の部屋にとじこもっています。彼女は自分の意にとじこもって いつも白日夢にふけっています。そして何事にも 誰にも興味を示しません。

(ア) あなたは こういう態度を示している人は 何か問題があると思いますか。
( ) はい
( ) いいえ

(イ) もし 何か問題があると思うのなら それは深こくなものだと思いますか。
( ) 深こくだと思う
( ) 深こくだとは思わない
( ) 何も問題がない

(ウ) あなたは それを精神病の一種だと思いますか。
( ) はい
( ) いいえ

三、ここに別のタイプの男性がいます。三宅一郎さんとでもしましょう。彼はなかなか良い仕事について その仕事は順調にいっています。たいていという場合、彼は他の人達とうまくいっていますが、非常に繊細で もし自分の思い通りに物事が運ばないとか、もし他の人達が自分の失敗をみつけたりすると いつも すぐ感情的になります。彼は小さな事にでもくよくよと心配します。そして いつも むら気でみじめな様子です。彼にとって何事も うまくいっているのですが 夜、寝れません。くよくよと過去のことを考えたり 先のことを心配したりしています。

(ア) あなたは こういう 態度を 示している人は 何か 問題が あると 思いますか。

( ) はい
( ) いいえ

(イ) もし 何か 問題が あると 思うのなら それは 深く なやんだと 思いますか。

( ) はい
( ) いいえ
( ) 深く なやんだとは 思わない
( ) 何も 問題が ない

(ウ) あなたは それを 精神病の 一種だと 思いますか。

( ) はい
( ) いいえ

四、岡田太郎さんの 場合は どうでしょうか。彼は 決して ひとつの 仕事に 長つづきしません。というのも 彼は 酒を 飲みすぎるからです。ポケットに お金が あるときは いつでも 飲みあるきます。飲み屋が 開いている 間は 外にいて ぜんぜん 妻や 子供の ことを かえりみません。時々 自分の 家族に 対して 大変 すまないと 感じ、妻に ゆるしを こい 酒を やめると ちかいますが いつも 又 同じことの くりかえしです。

(ア) あなたは こういう 態度を 示している人は 何か 問題が あると 思いますか。

( ) はい
( ) いいえ

(イ) もし 何か 問題が あると 思うのなら それは 深く なやんだと 思いますか。

( ) はい
( ) いいえ
( ) 深く なやんだとは 思わない
( ) 何も 問題が ない

(ウ) あなたは それを 精神病の 一種だと 思いますか。

( ) はい
( ) いいえ

五、ここに 又、別のタイプの女性がいます。橋本幸子さんとでも呼びましょう。
彼女は ほがらかで 幸せそうです。彼女は 美人で よい仕事に
ついていて 素敵な若い男性と婚約もしています。ところが 彼女は
ガス ストーブを 消したかどうか 戻って 確かめないと 家から 出掛け
られませんし 又、戸締りを したかどうか 確かめに かならず 一度は
戻ります。それから もう一つ、彼女は エレベーターを こわがります。
彼女は エレベーターに 乗らないと 行けない所へは どこも 行きません。

(ア) あなたは こういう 態度を 示している人は 何か 問題が あると 思いますか。
( ) はい
( ) いいえ

(イ) もし 何か 問題が あると 思うのなら それは 深こくな ものだと 思いますか。
( ) 深こくだと 思う
( ) 深こくだとは 思わない
( ) ( ) 何も 問題が ない

(ウ) あなたは それを 精神病の一種だと 思いますか。
( ) はい
( ) いいえ

六、さて、十二才の少年について お話しましょう。木村みのる君です
彼は 頭もよく 丈夫で 恵まれた 家庭に 育ちました。ところが
彼の両親は 彼が 長い間 自分達に うそを ついていた ことを 知り
ました。彼は 万引をしたり 母親の財布から お金を 盗んだり
なるべく 学校を さぼって ぶらぶらと 遊んだり していたのです。彼の
両親は そんな彼の行動に 気が転倒する 思いをしましたが 彼は
ぜんぜん 気にしていないです。

次の頁へ つづく

(ア) あなたはこういう態度を示している人は何か問題があると思いますか。

( ) はい

( ) いいえ

(イ) もし何か問題があると思うなら、それは深こくなものだと思いますか。

( ) 深こくだと思う

( ) 深こくだとは思わない

( ) 何も問題がない

(ウ) あなたはそれを精神病の一種だと思いますか。

( ) はい

( ) いいえ

どうぞ次の頁に進んで下さい。

(二)

次にかかげる文は以前精神病院の患者だった人に対してどのように感じるかを述べたものです。各々の文を注意深く読んであなたがどの程度同意できるかを次の四つの内から一つだけ選んでください。

大いに同意する（大同）
同意する（同意）
少し不同意（不同）
大いに不同意（大不）

一、以前精神病院の患者だった人が近所に入ってこないようにするのは賛明である。

（大同）（同意）（不同）（大不）

二、以前精神病院の患者だった人との親密な友達づき合いを禁じるのは賛明ではない。

（大同）（同意）（不同）（大不）

三、以前精神病院の患者だった人も進んで自分が所属するクラブや団体の会員になるように援助する。

（大同）（同意）（不同）（大不）

四、もしあなたが雇用者の立場にあるとしたら進んで以前精神病院の患者だった人をやとい入れる。

（大同）（同意）（不同）（大不）

五、もし自分が住んでいるアパートの一部屋を貸す責任があるとすれば以前精神病院の患者だった人に貸すことはちゅうちょする。

（大同）（同意）（不同）（大不）

六、自分の子供が以前精神病院の患者だった人とは極力結婚しないようにする

（大同）（同意）（不同）（大不）

七、自分の子供のことに関して以前精神病院の患者だった人を信用するのは賛明ではない。

（大同）（同意）（不同）（大不）

(四) 次の質問は統計をとるために必要なのです。ようしく ご協力を お願いします。

一、性別。(どちらかを○でかこんで下さい)。

(ア) 男　(イ) 女

二、年令(満で答えて下さい)。

(　　才)

三、最終学歴(どの学年まで教育を学校でうけましたか)。

小学校　中・高等学校　大学　その他

1. 2. 3. 4. 5. 6.　1. 2. 3. 4. 5. 6.　(　　)

もしも何か学位を持っていたら書いて下さい。

(　　)

四、もしあなたが一世なら何年にアメリカへきましたか。

(　　年)

もう何年アメリカに住んでいますか。

(　　年間)

五、あなたの転業を書いて下さい(もし仕事をしていないならまえの仕事を書いて下さい)

(　　)

もしあなたが学生でしたら何を専攻していますか(すきつもりですか)

(　　)

六、あなたの お父さんの 転業は何ですか(でしたか)。

(　　)

七、あなたは次のうちのどの世代に属しますか(ひとつ○でかこんで下さい)

(ア) 一世　(イ) 帰米二世　(ウ) 二世

(エ) その他(くわしく 書いて下さい)。

(　　)

八、結婚の有無（ひとつ○でかこんで下さい）。
(ア) 一度も結婚していない。　(イ) 結婚している。
(ウ) 未亡人またはやもめ。　(エ) 別居中。
(オ) 離婚者。　(カ) 同棲している。
(キ) その他（くわしく書いて下さい。）

（　　）

九、もしあなたが結婚か同棲しているとして、相手の人は日系人ですか。
(ア) はい　(イ) いいえ

（　　）

十、あなたの宗教を示して下さい（ひとつ○でかこんで下さい）。
(ア) 仏教　(イ) カトリック　(ウ) プロテスタント　(エ) なし
(オ) その他（くわしく書いて下さい。）

十一、誰か今までに精神病だといわれたことのある人をよく知っていますか。
(ア) はい。　(イ) いいえ。

十二、今までに精神病に関係した講義を受けたことがありますか。
(ア) はい。　(イ) いいえ。

もし「はい」と答えたのならそれはいつですか。
（　　年）。

何という科目でしたか。

（　　）

大変ありがとうございました。何かご意見がありましたらどうぞ書いて下さい。

AN ABSTRACT OF THE THESIS OF

KATSUKO TANAKA

for the Master of Nursing

Date of receiving this degree: June 8, 1980

Title: JAPANESE AMERICAN ATTITUDES TOWARD MENTAL ILLNESS

Approved: [redacted]

Julia S. Brown, Ph.D., Thesis Advisor

The purpose of this study was to determine the effect of ethnic identity on the attitudes of Japanese Americans toward mental illness. Further, it was the purpose of the investigation to explore generational differences in identification of mental illness, and in acceptance or rejection of the mentally ill.

The sample consisted of 95 individuals from the Portland metropolitan area. Of these, 31 were elderly Issei, 31 were Japanese American college students (JACS), and 33 were foreign Japanese college students (FJCS).

An opinion survey was conducted. Instruments employed were: (1) the Ethnic Identity Scale which was constructed by Okano (1976), (2) the Star vignettes as used by Dohrenwend and Chin-Shong (1967) to assess recognition of mental illness, (3) the Social Distance Scale of Bogardus as modified by Dohrenwend and Chin-Shong (1967) to measure the acceptance of the mentally ill, and (4) a questionnaire constructed by

the investigator to obtain demographic data. An English version was administered to the Japanese American college students, and a Japanese version was used for the elderly Issei and the Japanese college students.

Three hypotheses were tested which assessed the effect of ethnic identity upon attitudes toward mental illness in terms of the identification of mental illnesses, and in terms of acceptance or rejection of mentally ill. They were:

1. Elderly Issei and young native Japanese express a stronger ethnic identity than do young Japanese Americans.
2. The stronger the respondent's ethnic identity, the less the tendency to identify behavior problems as mental illness.
3. The stronger the respondent's ethnic identity, the greater the rejection of those who had been labeled as mentally ill persons.

The first hypothesis was supported. The elderly Issei showed the strongest ethnic identity, the JACS the weakest, and the FJCS ranked between the two. Weak support was found for the second hypothesis. There were no consistent differences among the groups in the number of cases they identified as mental illness in Star vignettes. However, the Issei and the FJCS hesitated to label alcoholism as a mental illness while the JACS did not.

The third hypothesis was strongly supported. The elderly Issei who showed the strongest ethnic identity exhibited the least acceptance of ex-mental-hospital patients, the JACS who indicated the weakest ethnic identity accepted them the most, and the FJCS again were in the middle.

It was concluded on the basis of this study that attitudes toward mental illness reflect complex cultural beliefs and values. Even though there is a trend toward accepting the medical model by labeling the described behavior as mental illness, the emotional responses to the mentally ill still remain strongly influenced by cultural factors.