

In subsequent reports from these surveys we intend to examine differences between the countries in beliefs about causes of mental disorders and in stigmatizing attitudes. These data will allow us to see whether the greater reluctance in Japan to label mental disorders and to expose them outside the family is associated with more negative attitudes or with stigmatizing causal explanations.

Competing interests

The author(s) declare that they have no competing interests.

Authors' contributions

AFJ co-designed the Australian survey, analyzed the Australian data, and co-wrote the manuscript.

YN provided overall supervision of the research and provided comments on the manuscript.

HC co-designed the Australian survey and provided comments on the manuscript.

YK provided specific guidance on the Japanese survey, including participation in survey interviewer training, and co-wrote the manuscript.

KMG co-designed the Australian survey and provided comments on the manuscript.

YW was involved in coordination between the Japanese and Australian surveys and co-wrote the manuscript.

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Public beliefs about causes and risk factors for mental disorders: a comparison of Japan and Australia

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Abstract

Background: Surveys of the public in a range of Western countries have shown a predominant belief in social stressors as causes of mental disorders. However, there has been little direct cross-cultural comparison. Here we report a comparison of public beliefs about the causes of mental disorders in Japan and Australia.

Methods: Surveys of the public were carried out in each country using as similar a methodology as feasible. In both countries, household interviews were carried out concerning beliefs about causes and risk factors in relation to one of four case vignettes, describing either depression, depression with suicidal thoughts, early schizophrenia or chronic schizophrenia. In Japan, the survey involved 2000 adults aged between 20 and 69 from 25 regional sites spread across the country. In Australia, the survey involved a national sample of 3998 adults aged 18 years or over.

Results: In both countries, both social and personal vulnerability causes were commonly endorsed across all vignettes. The major differences in causal beliefs were that Australians were more likely to believe in infection, allergy and genetics, while Japanese were more likely to endorse "nervous person" and "weakness of character". For risk factors, Australians tended to believe that women, the young and the poor were more at risk of depression, but these were not seen as higher risk groups by Japanese.

Conclusion: In both Japan and Australia, the public has a predominant belief in social causes and risk factors, with personal vulnerability factors also seen as important. However, there are also some major differences between the countries. The belief in weakness of character as a cause, which was stronger in Japan, is of particular concern because it may reduce the likelihood of seeking professional help and support from others.

Background

Mental health researchers view mental disorders as having complex causes involving an interplay of biological, psychological and social factors. However, the public's beliefs about causes are generally less sophisticated. Surveys of the public in a range of Western countries have shown a predominant belief in social stressors as causes of mental disorders. Studies from Australia, Ireland, Germany, Switzerland, UK and USA have found that social factors were most often seen as the causes of depression [1-6], whereas genetic factors were much less frequently endorsed [1-4,6]. Social factors are also seen by the public of Western countries as an important cause of schizophrenia [3,6-8]. While genetic factors are more often seen as a cause for schizophrenia than depression, they are still endorsed much less frequently than social factors [3,6]. Social factors covered in these surveys included stressful life events, traumatic experiences, family problems, and social disadvantage.

Of greater concern is the stigmatizing belief that mental disorders are caused by personal weakness or a character flaw. While this is not a predominant belief, it is fairly common. In the USA, around one-third saw "own bad character" as a cause for both schizophrenia and depression [6], implying a moral judgment of mental disorders. In Australia, around half the population believed "weakness of character" is a cause of both depression and schizophrenia [1], while in Turkey over 60% believed that this is a cause of schizophrenia [8].

While there has been considerable research on public beliefs in Western countries, there has been little research in other parts of the world and little cross-cultural comparison. The beliefs that predominate in Western countries cannot be assumed to apply elsewhere. A comparison of teachers' beliefs about schizophrenia in Japan and Taiwan found that "stress from personal relations" was commonly seen as a cause in both countries, which is similar to the belief in social factors in Western countries [9]. However, the Taiwanese were more likely than the Japanese to believe in "weakness of character", "heredity" and "stress from a disaster" as a cause. A comparison of mainly young adults from Hong Kong and England found that the Hong Kong Chinese were more likely to believe in social factors as the cause of schizophrenia, while the English were more likely to endorse genetic factors [10]. This difference was attributed to the more collectivist nature of Chinese culture. There has also been a comparison of public beliefs in Germany, Russia and Mongolia [11]. In all three countries, psychosocial factors such as stressful life events were predominantly seen as the cause of both depression and schizophrenia, whereas biological causes such as heredity and brain disease were less frequently endorsed. Taken together, these cross-cultural compari-

sons indicate that a belief in social causes is common in East Asian countries as well as in Western countries.

Here we report a further cross-cultural comparison involving Japan and Australia. This comparison involved surveys in both countries using the same questions about causes and risk factors for four case vignettes: depression, depression with suicidal thoughts, early schizophrenia, and chronic schizophrenia. On the basis of previous research, it might be expected that a belief in social causes would predominate in both countries. However, there are a number of cultural and health system differences between the two countries that might influence responses. Japan places a greater emphasis on hospital care compared to the emphasis on community care in Australia. The Japanese mental health care system has been described as based on the values of minimizing state financial involvement, retaining family responsibility for family members, and social control of individuals who might contribute to social disorder [12]. By contrast, Western systems are more influenced by the values of individual rights, social reintegration and government responsibility [12]. While these differences exist, it is difficult to predict what effect they might have on causal beliefs, so the study was essentially exploratory.

Methods

Survey interview

Interview questionnaires comprised a common core of questions that would allow comparisons between countries, and a country-specific component to allow investigation of issues particular to each country [13]. Copies of the Japanese questionnaire are available from YN and of the Australian questionnaire from AFJ. The interview was based on a vignette of a person with a mental disorder. On a random basis, respondents were shown one of four vignettes: a person with major depression, one with major depression together with suicidal thoughts, a person with early schizophrenia, and one with chronic schizophrenia. All vignettes were written to satisfy the diagnostic criteria for either major depression or schizophrenia according to DSM-IV and ICD-10. The vignette with depression and the one with early schizophrenia were written to satisfy at a minimal level these diagnostic criteria, so that we could ascertain the public's reaction to cases of developing disorder that had reached the point where intervention was needed. The vignette of the person with depression together with suicidal thoughts was identical to the depression vignette in all respects except the suicidal thoughts and was designed to assess how this symptom affected the public's response. The chronic schizophrenia vignette was designed to assess the response to someone with a severe long-standing disorder, where acceptance seemed less likely. Respondents were also randomly assigned to receive either male ("John") or female

("Mary") versions of the vignette. The vignettes have been given in an earlier publication [13]. After being presented with the vignette, respondents were questioned about what was wrong with the person, how they could be helped, the likely helpfulness of a range of interventions, the likelihood of recovery, knowledge of causes and risk factors, beliefs associated with stigma and discrimination, contact with people like those in the vignette, and the health of the respondent.

The only questions of relevance here are those concerned with causes and risk factors [1]. These questions were: "There are many people in the community who suffer from problems like John's. The next few questions are about possible causes of this sort of problem developing in anybody. How likely do you think each of the following is to be a reason for such problems? Could a virus or other infection, be a reason for these sorts of problems? How likely is an allergy or reaction to be the cause? Day-to-day problems such as stress, family arguments, difficulties at work or financial difficulties? The recent death of a close friend or relative? Some recent traumatic event such as bushfires threatening your home, a severe traffic accident or being mugged? Problems from childhood such as being badly treated or abused, losing one or both parents when young or coming from a broken home? How likely is it that these sorts of problems are inherited or genetic? Is being a nervous person likely to be a reason? Having weakness of character?" Response options to these questions were: very likely, likely, not likely, depends, don't know.

Then followed questions about risk factors: "The next few questions seek your opinion about whether there are some people in the community who are more likely to have these problems and others who are perhaps less likely. Do you think that women would be more likely or less likely than men to suffer these sorts of problems? Would young people, under 25 years of age, be more likely or less likely? Would older people, those aged over 65, be more likely or less likely? Would poor people be more likely or less likely to suffer these sorts of problems? Unemployed people? Divorced or separated people? Would single people, who have never been married or in a long-term relationship be more likely or less likely?". The response options were: More likely, less likely, no difference, depends, don't know.

The Japanese survey

A survey manual supplied from Australia was translated into Japanese and entrusted to Yamate Information Processing Center Ltd. for use with the target population aged 20–69 years, as a rule using the same procedures as Australia. The survey questionnaire, which was developed by the Australian researchers (AFJ, IIC, KMG), was tenta-

tively translated into Japanese. Then a native English translator, who had not seen the original English text, translated the Japanese version back into English. By comparing the two English versions, it was possible to confirm the accuracy of the original translation. There were no significant differences between the original text and the reverse translation. Finally, a Japanese version of the questionnaire was produced, which involved formatting the text into Japanese style and making slight wording adjustments. The names of the characters in the vignettes were translated into the Japanese style, viz. "A-o" (putting an o sound at the end is often used for a man's name) or "B-ko" (putting ko at the end is often used for a woman's name), instead of "John" or "Mary" which were used in the English text.

As well as the questions taken from the Australian survey, the Japanese survey asked questions concerning such issues as psychiatric health and welfare policy, the bodies implementing related services, the existence of action groups, and the change in the Japanese name for schizophrenia by the Japanese Society of Psychiatry and Neurology. These additions were made to clarify the current Japanese situation and issues in related fields. Further, an original Japanese manual was also created and adopted for use concerning points of interest in the implementation of home visits.

The survey method used was home visit interviews. It was not feasible to do a national survey of randomly selected households in Japan because of constraints of human resources, funding and time. It was therefore decided to sample a range of areas that differed in whether they were large or small cities, whether the area had many psychiatric patients or not, and whether the area had a high suicide rate or not. Using this approach, Japan was divided into 5 areas and 5 research sites were selected in each of these areas, giving a total of 25 geographic sites. As the survey was conducted during the winter, and because it was difficult to ensure that there would be enough survey interviewers, implementation in Hokkaido and Shikoku prefectures proved troublesome. Additional reasons for selection of the 25 regional sites were that they were places of comparatively high population within the relevant regions, the survey interviewers could use public transport, and the urban areas involved no particular inconveniences for the researchers to visit within a certain range using public transportation. 80 households were selected from each site, giving a total of 2000. At each site there were 4 interviewers who took responsibility for 20 households each. The survey was conducted over the period from 19 November to 12 December 2003. Each of the four vignettes was received by 250 people. Half received a male version of a vignette and half the female version.

At the start of the survey, an explanatory meeting was held for the survey interviewers in each region. As many members of the research team as possible attended these explanatory meetings. Eighty-five survey interviewers were recruited for this research with an average age of 50 and an average of 17 years' experience of survey interviewing in various types of surveys. The areas for the survey interviewers to canvass were allocated on the basis of where they lived. The question of where the individual survey interviewers should go was determined mutually among the survey interviewers themselves, and by the head survey interviewer (supervisor). As a rule, one survey interviewer conducted 20 interviews, but this was considerably flexible, given the number of years of individual experience and what the individual survey interviewer could handle. The interviews were conducted according to the following procedure: visit the target's home and present the written greetings and request (a draft had been prepared by certain survey bodies, which was put into final form after checks by the research team members), then explain the details of the survey using the documents, ask the target for their participation in the research, start the interview and follow through to completion, check that nothing had been omitted from the survey responses, and hand over the remuneration (1000 yen cash voucher). Data were not collected on the refusal rate for this survey because the emphasis was on achieving the quotas of respondents to fit the required age and gender distribution.

The Australian survey

A household survey was carried out on Australian adults aged 18 years or over by the company AC Nielsen. Households were sampled from 250 census districts covering all states and territories and metropolitan and rural areas. Up to 5 call backs were made to metropolitan selections and 3 to non-metropolitan selections. Interviewers attempted to interview the person in each household with the most recent birthday. To achieve a target sample of 4,000 interviews with adults aged 18 years or over, visits were made to 28,947 households. The outcome of these visits was: no contact after repeated visits 14,630; vacant house or lot 306; refused 7,815; person sampled within household temporarily unavailable 1,132; no suitable respondent in household 287; did not speak English 383; incapable of responding 213; and unavailable for the duration of the survey 181. The achieved sample was 3998 persons, with 1001 receiving the depression vignette, 999 the depression with suicidal thoughts vignette, 997 the early schizophrenia vignette, and 1001 the chronic schizophrenia vignette. The interviews were carried out between November 2003 and February 2004.

In addition to the common core component, the Australian survey interview had questions about awareness of

depression in the media and about Australia's national depression initiative.

Ethics approval was given by the Human Research Ethics Committee of the Australian National University.

Statistical analysis

Data were pooled across male and female versions of each vignette and percent frequencies calculated. For the Japanese survey, percentage frequencies and 95% CIs were calculated using unweighted data with SPSS 12.0. For the Australian survey, percentages were calculated applying survey weights to give better population estimates. Ninety-five percent CIs were estimated using the Complex Samples procedure in SPSS 12.0. This procedure takes account of sampling weights and geographic clustering in the sample.

Because of the very different cultures of Japan and Australia, it is possible that any differences in question endorsement rates might be due to subtleties of language or to the social rules applying to the interview situation, as well as to genuine differences in beliefs about treatment and outcome. For this reason, we have not relied on statistical significance of percentage differences between countries, but rather on the broad patterns of responses, particularly where percent endorsement was ordered very differently across questions.

Results

Characteristics of the samples

Table 1 shows the age and gender distributions of the Japanese and Australian samples. Comparing the Japanese sample to the national population in the same age groups (2003 data), there was an under-representation of 50–59 year olds (20% vs 22.4%) and an over-representation of 60–69 year old males (10% vs 8.9%). Other age-gender groups showed less than 1% discrepancy.

Comparing the Australian sample to the national population, there was an under-representation of males and of younger adults, but the sample was close to the population in marital status, country of birth and education. For the Australian sample, weights were used to correct for these biases.

Beliefs about causes and risk factors

Table 2 shows the results on beliefs about causes. In this table, the percentages pertain to each question asked separately, so that respondents could endorse any number of factors as likely causes. In both countries there was a common belief in social causes, such as day-to-day problems, death of someone close, traumatic event, and problems from childhood. This belief was common across all vignettes. The major differences were that the Australians

Table 1: Age and gender distribution of the Japanese and Australian samples

Age group	Japanese males %	Japanese females %	Japanese total %	Australian males %	Australian females %	Australian total %
18-19	-	-	-	1.5	1.6	3.0
20-29	10.0	10.0	20.0	5.6	8.1	13.8
30-39	10.0	10.0	20.0	7.7	11.8	19.4
40-49	10.0	10.0	20.0	8.6	11.0	19.7
50-59	10.0	10.0	20.0	6.9	9.5	16.3
60-69	10.0	10.0	20.0	4.8	8.0	12.7
70+	-	-	-	6.2	8.9	15.1
Total	50.0	50.0	100.0	41.2	58.8	100.0

Table 2: Percentage (and 95% CI) of Japanese and Australian respondents giving each cause as "very likely" or "likely" for the person described in the vignette

Cause	Depression Vignette	Depression/Suicidal Vignette	Early Schizophrenia Vignette	Chronic Schizophrenia Vignette
Virus or infection				
Japanese	6.2 (4.1-8.3)	6.6 (4.4-8.8)	7.2 (4.9-9.5)	7.2 (4.9-9.5)
Australian	50.5 (47.1-54.0)	41.4 (38.2-44.7)	32.1 (29.0-35.4)	33.6 (30.7-36.6)
Allergy				
Japanese	10.2 (7.5-12.9)	11.4 (8.6-14.2)	12.6 (9.7-15.5)	9.4 (6.8-12.0)
Australian	44.9 (41.4-48.5)	37.6 (34.3-41.0)	31.5 (28.4-34.7)	28.4 (25.5-31.5)
Day-to-day problems				
Japanese	93.6 (91.4-95.8)	91.8 (89.4-94.2)	92.0 (89.6-94.4)	91.2 (88.7-93.7)
Australian	96.8 (95.2-97.9)	95.7 (94.2-96.9)	89.6 (87.6-91.2)	86.6 (84.3-88.7)
Death of someone close				
Japanese	79.8 (76.3-83.3)	81.4 (78.0-84.8)	73.4 (69.5-77.3)	74.0 (70.1-77.9)
Australian	96.3 (94.6-97.5)	94.8 (93.1-96.0)	87.4 (85.2-89.4)	83.3 (80.7-85.6)
Traumatic event				
Japanese	82.6 (79.3-85.9)	79.6 (76.1-83.1)	78.2 (74.6-81.8)	80.8 (77.3-84.3)
Australian	93.9 (91.8-95.4)	92.7 (90.7-94.2)	86.5 (84.1-88.6)	82.8 (80.2-85.1)
Problems from childhood				
Japanese	81.0 (77.5-84.5)	82.0 (78.6-85.4)	88.2 (85.4-91.0)	89.0 (86.2-91.8)
Australian	91.3 (89.2-93.1)	95.0 (93.2-96.3)	90.8 (88.8-92.5)	91.4 (89.4-93.0)
Inherited or genetic				
Japanese	34.6 (30.4-38.8)	34.0 (29.8-38.2)	34.2 (30.0-38.4)	43.8 (39.4-48.2)
Australian	68.0 (64.8-71.0)	68.4 (65.3-71.3)	70.0 (66.8-73.0)	73.7 (70.6-76.6)
Nervous person				
Japanese	81.4 (78.0-84.8)	77.4 (73.7-81.1)	74.0 (70.1-77.9)	81.8 (78.4-85.2)
Australian	67.9 (64.6-70.9)	65.6 (62.3-68.7)	58.1 (54.4-61.7)	56.9 (53.6-60.2)
Weakness of character				
Japanese	73.6 (69.7-77.5)	69.2 (65.1-73.3)	73.4 (69.5-77.3)	82.0 (78.6-85.4)
Australian	43.0 (39.7-46.3)	46.1 (42.8-49.3)	39.7 (36.5-42.9)	35.1 (31.6-38.8)

were more likely to believe in virus or infection, allergy, and inherited or genetic, while the Japanese were more likely to endorse nervous person and weakness of character.

Tables 3 and 4 show the data on beliefs about risk factors. Table 3 gives the percentages believing a group is more at

risk and Table 4 the percentages believing a group is less at risk. As in Table 2, each group was asked about separately, so that respondents could endorse any number as more likely or less likely to be at risk. In both countries, the risk factors most strongly believed in across vignettes were being unemployed and divorced/separated, although these beliefs were more common in Australia.

Table 3: Percentage (and 95% CI) of Japanese and Australian respondents rating each group in the population as "more likely" to experience the problem described in the vignette

Group More Likely at Risk	Depression Vignette	Depression/Suicidal Vignette	Early Schizophrenia Vignette	Chronic Schizophrenia Vignette
Women				
Japanese	29.4 (25.4–33.4)	24.2 (20.4–28.0)	21.4 (17.8–25.0)	23.0 (19.3–26.7)
Australian	26.8 (23.9–30.0)	27.2 (24.4–30.2)	21.1 (18.5–23.9)	14.7 (12.6–17.1)
Young				
Japanese	24.2 (20.4–28.0)	24.4 (20.6–28.2)	40.4 (36.1–44.7)	26.2 (22.3–30.1)
Australian	42.5 (39.1–46.0)	48.2 (45.0–51.4)	55.3 (52.0–58.6)	28.4 (25.6–31.4)
Old				
Japanese	23.4 (19.7–27.1)	21.2 (17.6–24.8)	15.0 (11.9–18.1)	29.2 (25.2–33.2)
Australian	28.6 (25.8–31.5)	29.1 (26.3–32.1)	22.0 (19.4–24.9)	38.3 (35.0–41.7)
Poor				
Japanese	14.8 (11.7–17.9)	13.2 (10.2–16.2)	7.4 (5.1–9.7)	19.6 (16.1–23.1)
Australian	52.6 (49.2–56.0)	52.1 (48.6–55.5)	38.9 (35.7–42.3)	37.8 (34.4–41.2)
Unemployed				
Japanese	58.4 (54.1–62.7)	50.8 (46.4–55.2)	41.0 (36.7–45.3)	50.6 (46.2–55.0)
Australian	76.3 (73.0–79.3)	76.7 (73.6–79.4)	62.7 (59.4–65.9)	54.9 (51.4–58.3)
Divorced/separated				
Japanese	48.6 (44.2–53.0)	43.6 (39.2–48.0)	37.2 (32.9–41.5)	39.6 (35.3–43.9)
Australian	69.6 (66.2–72.8)	64.3 (60.9–67.6)	53.6 (50.3–57.0)	44.3 (40.9–47.8)
Single				
Japanese	18.2 (14.8–21.6)	22.8 (19.1–26.5)	22.8 (19.1–26.5)	24.6 (20.8–28.4)
Australian	23.9 (21.0–27.1)	27.1 (24.2–30.1)	22.0 (19.2–25.0)	25.1 (22.2–28.2)

Table 4: Percentage (and 95% CI) of Japanese and Australian respondents rating each group in the population as "less likely" to experience the problem described in the vignette

Group Less Likely at Risk	Depression Vignette	Depression/Suicidal Vignette	Early Schizophrenia Vignette	Chronic Schizophrenia Vignette
Women				
Japanese	21.6 (18.0–25.2)	22.8 (19.1–26.5)	24.0 (20.2–27.8)	24.8 (21.0–28.6)
Australian	12.0 (9.7–14.7)	13.6 (11.5–16.0)	12.8 (10.8–15.1)	18.7 (16.4–21.3)
Young				
Japanese	24.0 (20.2–27.8)	20.8 (17.2–24.4)	14.6 (11.5–17.7)	27.6 (23.7–31.5)
Australian	19.5 (16.8–22.4)	18.8 (16.4–21.4)	10.9 (8.9–13.2)	30.6 (27.5–33.9)
Old				
Japanese	30.2 (26.2–34.2)	25.0 (21.2–28.8)	38.6 (34.3–42.9)	27.4 (23.5–31.3)
Australian	34.8 (31.5–38.2)	37.2 (34.2–40.3)	43.2 (39.8–46.7)	25.2 (22.5–28.1)
Poor				
Japanese	23.4 (19.7–27.1)	19.6 (16.1–23.1)	26.4 (22.5–30.3)	23.4 (19.7–27.1)
Australian	8.5 (6.6–10.8)	7.4 (6.0–9.2)	9.1 (7.3–11.3)	7.2 (5.7–9.1)
Unemployed				
Japanese	13.0 (10.0–16.0)	11.0 (8.2–13.8)	14.8 (11.7–17.9)	15.6 (12.4–18.8)
Australian	4.4 (3.0–6.2)	4.6 (3.5–6.2)	5.4 (4.1–7.1)	5.5 (4.1–7.5)
Divorced/separated				
Japanese	12.2 (9.3–15.1)	13.6 (10.6–16.6)	14.0 (10.9–17.1)	16.0 (12.8–19.2)
Australian	4.1 (3.0–5.7)	5.5 (4.2–7.3)	5.2 (3.9–6.9)	6.7 (5.1–8.7)
Single				
Japanese	19.2 (15.7–22.7)	13.0 (10.0–16.0)	13.6 (10.6–16.6)	20.4 (16.9–23.9)
Australian	21.4 (18.8–24.4)	19.2 (16.6–22.2)	17.7 (15.2–20.4)	17.1 (14.9–19.6)

There were a number of cross-national differences. The Australians tended to believe that the young and the poor were more at risk of depression, but these were not seen as higher risk groups by the Japanese. In fact, the Japanese public tended to see the poor as having lower risk of depression. For schizophrenia, the Australians saw the young as having higher risk for early schizophrenia, and the poor as having higher risk for both early and chronic schizophrenia. Likewise the Japanese saw the young as having higher risk for early schizophrenia, but they again tended to see the poor as having lower risk.

Discussion

The present findings from Japan and Australia support earlier work from several countries showing a predominant belief in social causes. These causes include day-to-day problems, death of someone close, traumatic events, and problems from childhood. The findings on risk factors are generally consistent with those on causes, with unemployment and divorce/separation widely seen to be risk factors in both countries. While a belief in social causes and risk factors was found in both countries, it was generally more common in Australia than in Japan. As far as depression is concerned, this belief is realistic because there is substantial evidence supporting social factors in the causation of depression [14]. However, for schizophrenia, social factors are of less importance, having an influence only on those who are genetically vulnerable [15].

The findings on poverty as a risk factor were an exception to the general trend of beliefs in social factors. While the Australians tended to see the poor as having higher risk, particularly for depression, for the Japanese the trend was in the opposite direction, with more people believing that the poor would have lower risk. The reason for this difference is unknown. It may reflect inaccurate beliefs in one country or else a true difference in risk factors between countries. In Australia, poverty is known to be associated with both depression and psychotic disorders [16,17], although there is debate about the causal pathways. However, in one Japanese study of depression in the workplace, poor economic status was not associated with increased risk [18]. Furthermore, a Japanese incidence study of schizophrenia found that features of residential areas that are associated with higher incidence in Western countries do not necessarily have the same association in Japan [19].

As well as a frequent public belief about social causes in both countries, there was also a common belief in personal vulnerability factors. However, the endorsement of personal vulnerability factors tended to take a different form in each country. The Japanese were more likely to believe in the role of the trait characteristics of nervous

person and weakness of character, while Australians were more likely to endorse the role of genetics. Being a nervous person could be regarded as a lay description of the personality trait of neuroticism, which is a major risk factor for depression. There is also some evidence that neuroticism is a risk factor for schizophrenia [20]. However, the belief in weakness of character is of more concern, because this is a more stigmatizing explanation which could make people less likely to disclose that they are experiencing a mental disorder and to seek professional help. It has been noted that "Japanese patients are reluctant to openly discuss disturbances of mood, since these are considered to be indicative of personal weakness rather than treatable medical conditions" [21]. For Japanese people, the implication is that the disorder is the person's fault. In Australia, the belief in weakness of character as a cause has declined since the earlier survey in 1995, particularly for schizophrenia [22]. This change may have been affected by efforts to reduce the stigma of mental disorders.

The strong endorsement of genetics by Australians represents a major change from 8 years earlier, from around half the population in 1995 to around two-thirds in 2003–04 [22]. A possible reason for this change is the publicity surrounding the human genome project and the role of genes in health generally. Why this belief is weaker in Japan is unclear. However, in both countries genetics was seen to be more important for the chronic schizophrenia vignette than for the other vignettes, suggesting a greater genetic attribution for severe or chronic mental disorders.

Another difference between the two countries was that Australians were more likely to believe in the role of virus or infection and allergy. It is not clear why these beliefs are more prominent in Australia. However, such beliefs appear to be stable over time, because the percentages endorsing these causes are very similar to an Australian national survey carried out 8 years earlier [22]. These beliefs were most common for the vignette of depression without suicidal thoughts, which is the least severe of the cases presented. It may be that they reflect interpretations of the vignette as being a physical disorder or a secondary reaction to a physical disorder.

Taking all the findings together, there is some broad similarity between public and professional beliefs about causation, in that mental disorders are seen to be influenced by a combination of personal vulnerability and environmental triggers. The major difference would appear to be the greater use of morally judgmental attributions of personal vulnerability by the public compared to the more objective attributions of professionals. In this regard, the

Australian public's views appear closer to those of professionals than do the Japanese public's.

Limitations

We have previously discussed some of the limitations of this work [13]. These relate to the methodology of the surveys, in particular the non-contact and refusal rate in the Australian survey and the lack of truly national coverage of the Japanese one. Furthermore, both surveys lack data on the characteristics of refusers. We also recognise the problems of making cross-national comparisons between two very different cultures. There will inevitably be subtleties of meaning and cultural factors operating within a structured household survey which could affect the results in unknown ways. Finally, the survey used closed rather than open-ended questions, which may have suggested responses that the participants would not have thought of spontaneously.

Conclusion

In both Japan and Australia, the public have a predominant belief in social causes and risk factors for mental disorders. However, there are also some major differences between the countries, with Australians having a stronger belief in infections, allergies and genetics, while Japanese have a stronger belief in being a nervous person and weakness of character. The latter belief is of particular interest because it may be associated with greater stigma and reduce the likelihood of seeking professional help and support from others. Reducing the belief in weakness of character as a cause would be a suitable target for mental health literacy campaigns. This is probably easier to achieve for depression, where there are both contemporary and historical figures who have suffered from depression, yet are perceived as being strong in character.

Competing interests

The author(s) declare that they have no competing interests.

Authors' contributions

YN provided overall supervision of the research and provided comments on the manuscript.

AFJ co-designed the Australian survey, analyzed the Australian data, and co-wrote the manuscript.

YK provided specific guidance on the Japanese survey, including participation in survey interviewer training, and co-wrote the manuscript.

HIC co-designed the Australian survey and provided comments on the manuscript.

HN provided specific guidance on the Japanese survey, including participation in survey interviewer training, and co-wrote the manuscript.

KMG co-designed the Australian survey and provided comments on the manuscript.

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1) 演題名：精神疾患に対する日本人のイメージ

2) 氏名・所属・役職：中根允文・長崎国際大学大学院・教授

3) 抄録本文：

演者は、1998 年に締結された日豪政府間の保健福祉協力 6 項目合意に基づく共同研究の第二ステップとして、2003 年から日本とオーストラリアが共同して行う「精神疾患の知識と理解に関する研究」を継続してきている。同研究では、まず両国の研究者（精神科医が中心）がテーマに関わる共通の調査票を開発した。素案をオーストラリア側が準備し、それを日本側と討論してオリジナルの英語版が開発され、次に日本語版に翻訳・更に逆翻訳して、内容の統一を図った。調査票が完成した時点で、両国は双方の国に居住する住民をそれぞれの方法で抽出し、可能な限り多数の住民に対して、対象者の居宅に訪ねて同調査票を利用して直接面接調査した。

ここでは、日本における結果を詳しく報告し、一般住民が精神疾患および精神疾患にかかった人たちについて、どのように理解し、どのような対応をしてきているかについて紹介する。その中では、精神疾患および同患者に対する偏見や差別の具体的な根拠が見られるはずで、日本人が一般論として精神疾患に対して如何なるイメージを抱いているかに迫りたいと考えた。

面接調査では、統合失調症とうつ病の事例をうかがわせるヴィネットが 2 例ずつ準備され、併せて 4 例のうちの 1 例だけが呈示され、その事例について、いかなる疾患と考えられるか（精神疾患の認識度）、いかなるスタッフが支援者となりうるか、いかなる治療法が妥当と考えるか、有効と考えられる薬剤は何かなどといった処遇のされ方、長期的な経過や転帰および病因についての考え方が問われ、更にそうした事例は差別されるか否か、あるいは日常生活の中でそうした事例と如何に接触していくかなどが問われた。

統合失調症あるいはうつ病のヴィネットを呈示されたとき、それらを統合失調症やうつ病と正しく認識できたのは、調査に協力した一般住民 2,000 名のうちの 25-29%であり、これらの疾患に対する理解は高いものでなかった。こうした事例にとって有用な支援となるスタッフは精神科医よりカウンセラーがあげられ、いわゆる精神科的治療に対する躊躇いも明らかであった。しかし、専門的な処遇を享受できれば、明らかに問題は改善すると考えるが、そうでなければかなり悲観的な転帰が想定されていた。ヴィネットのような事例が社会の中で差別されると考えるかを問うと、うつ病ヴィネットに対しては 30%が、統合失調症ヴィネットに対しては 54%が差別されると考えていた。「彼らは何をしでかすかわからない」との考えはうつ病ヴィネットで 36%、統合失調症ヴィネットでは 63%に上り、約 40%が「彼らの問題は医学的な病気でない」とみなし、約 55-75%の人が「個人的な弱さの表れ」とか「性格の弱点」などと考えていた。とはいえ、「彼らが結婚して家族の一員になってもいい」というのはうつ病ヴィネットが 16%、統合失調症ヴィネット

で9%に止まった。

これらの結果は、日本国内における精神疾患および同疾患にかかっている人たちへの態度が偏見に彩られ差別的であることを実証したと考える。この一般住民に関する調査のあと、いわゆる専門職（精神科医、一般医、精神保健福祉士、作業療法士、一般看護師、精神看護師）における知識と理解を調査しており、それらとのデータの比較を行いつつある。こうした調査研究の結果をもとに、精神保健に関する知識や理解を高め偏見差別の改善を期待して何を普及啓発していくべきであるかを考えていきたい。

データの日豪比較に関する結果の一部は公表されている（BMC Medicine 2005, 3:12 [9 July 2005] ; BMC Psychiatry 2005, 5:33 [21 Sep 2005]）。

「しろうと理論」(Lay theories)

- Adrian F. Furnham (1988) : Lay theories – everyday understanding of problems in the social science. Pergamon Press. (細江達郎 監訳 [1992] : しろうと理論-日常性の社会心理学、北大路書房、京都)
- 「しろうと理論」とは、上記 Furnham (1988) の提唱した概念で、専門家ではない一般の人々(しろうと)が持つ、物事に対する信念の体系
- 「しろうと理論」の発生と発展 :
 - ① 経験とそこから帰納
 - ② 観察からの解釈あるいは推論および演繹
 - ③ 特別な出会いから導かれた類推や推定
 - ④ 権威や他者やメディアの考え方の受容

一般人が精神病を容認する程度に影響を及ぼす要因に係る「しろうと理論」の研究

- 精神病患者の特徴
 1. どの程度予測不能であるか
 2. どの程度説明ができないか
 3. 表出している行動が、その人固有の特徴を有しているか
 4. 病気の特有の症状や診断名、障害された行動が顕在化しているか
 5. 暴力がどの程度問題になっているか
- 一般人の側における特徴
 1. 年齢(加齢と共に精神病への態度に寛容さがなくなり、同情的でなく拒否的となる)
 2. 教育程度
 3. 職業
 4. 人種・民族(明確な関連性は見られていない)
 5. 社会階層(低いほど拒否的で恐怖感や敵意の感情が強く、高いほど羞恥心や罪悪感が大い)
 6. 精神病患者との実際の接触体験(接触仮説 contact hypothesis、接触が強める偏見、あるいは有効な接触の重要性)

Furnham A F: Lay theories – everyday understanding of problems in the social science. Pergamon Press, 1988

調査内容

「精神保健の知識と理解に関する日豪比較研究調査票」

- IDセクション(年齢・性・婚姻状況・住所・学歴)
- ヴィネット呈示例(うつ病2例、統合失調症2例)について
- 考えられる病名、最適な支援とは、薬物・治療法の有用性、最適な専門家の援助を受けたとき・受けなかったときの転帰、治療後の社会生活に付いての予測、考えられる原因、症例に対する被験者自身の対応・一般的な対応、など
- 被験者自身における心身の健康状態
- 精神疾患(例：うつ病)に関するメディアとの係わりについて

以上、約120項からなる質問
- なお、倫理面への配慮に関しては、長崎国際大学人間社会学部倫理委員会における承認を得ている

精神疾患に対する日本人のイメージ —Mental Health Literacyに関する日豪比較調査から—

中根 允文

長崎国際大学 人間社会学部

精神疾患に関する「しろうと理論」

- 人々は以前に精神病患者であった人との距離を置こうとする傾向があり、人々から距離を置かれるということが患者にとってもっとも問題を更に悪化させる社会的孤立という状態を作り出す。(Whalley, 1958)
- 精神病患者は何をするか予測できないという理由からと思われるが、精神病と結びつけられた以前からある嫌悪や恐怖や忌避は、まだ存続している。(Bard, 1971)
- 男性と女性が精神病について同じような信念を持っているが、精神病患者へは全く違った仕方でもって振舞っている。…例えば、女性は男性に比べて精神病に好意的で共感的である。更に現在あるいは以前から精神病患者である女性は、そうである男性よりも親切に好ましく扱われる。…女性患者が男性患者よりも肯定的に扱われる理由は、女性患者が攻撃的・脅威的でないというだけでなく、また彼女らの「遠慮した」行動が伝統的な性別役割規範と矛盾するものではないということによるようである。(Farina, 1981; Rosenfield, 1982)
- 精神病は恐怖感・不信感・嫌悪感をもって見られている。精神病に付着するスティグマは、対象とした全ての集団において一般的見られ、用いられた態度測定などの尺度においても一般的に見つけられることができたが、それについて年齢や教育程度のような人口統計学上の違いによる違いは殆ど見られなかった。おいている人も若い人も、また高度な教育程度がある人々でも精神衛生に関する正式なトレーニングを受けていなければ、精神病を愚鈍で汚らしく何をするか分からず個性のないものと見なす傾向がある。強い否定的なパワー効果で、全ての精神病患者を思ひ込み、そして精神病に関わる全てのことが悪いのだと反動的に考えさせてしまう。(Almed & Viswarathan, 1984)
- 精神病への一般の人々の態度は容認的というより拒否的である。社会的拒絶は行動障害の程度の重大さに応じて増大する。精神病への一般の人々の態度は精神病の種類と現れる実際の行動によってのみならず精神病というラベル付けによって影響を受ける。(Nieradzik & Cochran, 1985)

Furnham A F: Lay theories – everyday understanding of problems in the social science. Pergamon Press, 1988
(細江達郎 監訳: しろうと理論 - 日常性の社会心理学 -, 北大路書房、京都, 1992)

調査の目的と実際

- 調査の目的: 本研究は、1998年に開始された日豪保健福祉協力(Japan-Australia Partnership)の第二段階研究の一部として2003年度からスタートし、日豪両国民更に、国内では医療専門職スタッフの精神保健に関する知識・理解・態度を把握し、それらを改善する啓発活動の指針を得ることを目的として有効な施策に資する情報の確立を目指した。
- 調査の方法: 分担研究者参加の下に、調査員に所定のマニュアルに基づいた面接法の演習を施行。
- 一般住民(一般人)調査については、調査対象者宅を訪問の上、精神保健の知識と理解に関する日豪比較研究調査票をもとに面接を施行(平均面接時間は約20分)
- 医療専門職スタッフ調査には、精神保健の知識と理解に関する日豪比較研究調査票を改変したものをを用い、郵送により調査を行った。

ヴィネット事例呈示(1)

§1/ §2 A雄(B子)さんは30歳。彼(彼女)は、この数週間、これまでに経験したことのないほどの悲しみと不幸を感じています。

彼(彼女)はいつも疲れているのに、殆ど毎晩よく眠れていません。食欲はなく、体重が減ってきています。彼(彼女)は仕事のことを考えられず、あらゆる決断を先延ばしにしています。日々の勤めさえ、もはや自分の手に負えないように見えます。

彼(彼女)の上司もこれに気付いており、彼(彼女)の業績が落ちたことを気遣っています。

§2として下記部分を追加：彼(彼女)は、苦痛から逃れるために、自分のいのちを終わりにする方法をずっと考えています。

§3 A雄(B子)さんは24歳で両親と一緒に暮らしています。彼(彼女)は学校卒業後いくつか臨時の仕事をしましたが、現在は無職です。

ここ半年以上、彼(彼女)は友人に会わず、自分の部屋に鍵を掛けて閉じこもり、家族と一緒に食事したり、風呂に入ったりすることも拒否しています。両親には、彼らが就役している夜間に、自室の中を歩き回っている音が聞こえています。部屋には彼(彼女)が一人だけなのに、まるで誰か他人がそこにいるかのように、彼(彼女)が叫んだり議論したりするのを両親は聞いています。

両親が彼(彼女)にもっと何かをするように促すと、彼(彼女)は「近所の人自分がこっそり見張っているから、家を離れられない」と嘆きます。彼(彼女)が誰にも会わず、どこにも出かけないから、両親は彼が麻薬を使ってはいないと確信しています。

ヴィネット事例呈示(2)

§4 A雄(B子)さんは44歳。彼(彼女)はある工場地帯のアパートに住んでいます。彼(彼女)は何年もの間働いていません。彼(彼女)は、年から年中同じ服を着ていて、髪は伸び放題で、だらしくなっています。

いつもひとりぼっちで、公園で座り込んで独り言を言っているのがよくみかけられています。たまには立ち上がって、あたかも樹のそばにいる誰かと話し合っているかのように手を動かしたりしています。

彼(彼女)は、めったにアルコールを飲むことはありません。彼(彼女)は、異常な、時には自分が作り出した言葉を使って用心深くしゃべります。彼(彼女)は礼儀正しいのですが、他の人たちと話すのを避けています。ときに彼(彼女)は近くの小さい店主に対して、自分に関わる情報を他人に伝えたからといって告発したりもします。彼(彼女)は家主に、自分の部屋のドアにもう一つ鍵を付け、部屋からテレビを運び出して欲しいと求めてきました。「A雄(B子)というのは、テレビ発信機を使って人々をコントロールする国際的なコンピュータシステムの秘密の情報を持っているから、スパイは自分を監視下に置こうと試みている。」と言います。家主は、どんどん汚くなり、ガラス製品でいっぱいになっている部屋を、A雄(B子)さんにきれいにさせることができないうと文句を言っています。A雄(B子)さんは、そういったものを「宇宙からのメッセージを受信するため」に使っているのだと言っています。

§1：うつ病(希死念慮なし)、§2：うつ病(希死念慮あり)、§3：統合失調症(早期)、§4：統合失調症(慢性)

精神保健の知識と理解に関する研究調査票(一部①)

Q1 あなたは、A雄(B子)さんに何か問題があるとすれば、それは何だと思いますか。あなたが思うものを全てをチェックしてください。また、その中で最もそう思うものには、◎を付けてください。

うつ病	<input type="checkbox"/>	ストレス	<input type="checkbox"/>
神経症	<input type="checkbox"/>	なんらかの問題あり	<input type="checkbox"/>
統合失調症(精神分裂病)パラノイア(妄想病)	<input type="checkbox"/>	がん	<input type="checkbox"/>
こころの病氣	<input type="checkbox"/>	その他(具体的に)	<input type="checkbox"/>
心理的・精神的・感情の問題	<input type="checkbox"/>		

Q4 次にあげるそれぞれの人は、A雄(B子)さんにとって助けになるでしょうか、悪影響となるでしょうか、またはどちらでもないでしょうか。

助けになる□1、どちらでもない□2、悪影響□3、場合による□4、分からない□5

普通の一般開業医または家庭医は	<input type="checkbox"/>	心理学者は	<input type="checkbox"/>
普通の薬剤師(薬局)は	<input type="checkbox"/>	彼らに近い家族の援助は	<input type="checkbox"/>
カウンセラーは	<input type="checkbox"/>	親友からの援助は	<input type="checkbox"/>
ソーシャルワーカーは	<input type="checkbox"/>	牧師や司祭など聖職者は	<input type="checkbox"/>
いのちの電話のような電話サービスは	<input type="checkbox"/>	彼らが自分自身で処理しようとする	<input type="checkbox"/>
精神科医は	<input type="checkbox"/>		

Q5 次にあげるいろいろな薬は、A雄(B子)さんにとって助けになるでしょうか、悪影響となるでしょうか、またはどちらでもないでしょうか。

助けになる□1、どちらでもない□2、悪影響□3、場合による□4、分からない□5

ビタミン、ミネラル、強壮剤、漢方薬は	<input type="checkbox"/>	睡眠薬は	<input type="checkbox"/>
アスピリンやコフィンなどの鎮痛剤は	<input type="checkbox"/>	抗精神病薬は	<input type="checkbox"/>
抗うつ薬は	<input type="checkbox"/>	精神安定剤は	<input type="checkbox"/>
抗生剤は	<input type="checkbox"/>		

一般人調査のための調査地点と選択の理由

地域	都府県・地点	選択の理由	対象数
東北・北関東	盛岡市、秋田市、新潟市、水戸市、宇都宮市	自殺が多い地域	400
首都圏	大田区、葛飾区、横浜市、松橋市、川口市	大都市圏、少ない精神科病院	400
東海	浜松市、春日井市、瀬戸市、一宮市、東海市	地方都市、少ない精神科病院	400
近畿	大阪市、堺市、西宮市、神戸市	大都市圏、重大事件の発生や地震	400
北九州・長崎	福岡市、北九州市、長崎市、大村市	地方都市、多い精神科病院	400
全対象地域	25地点		2,000

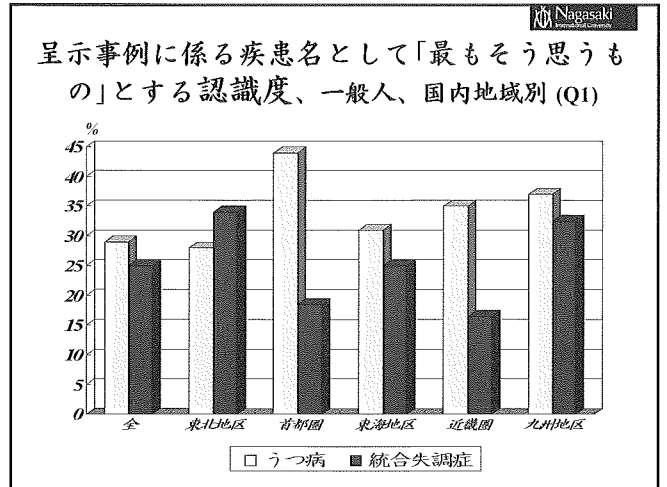
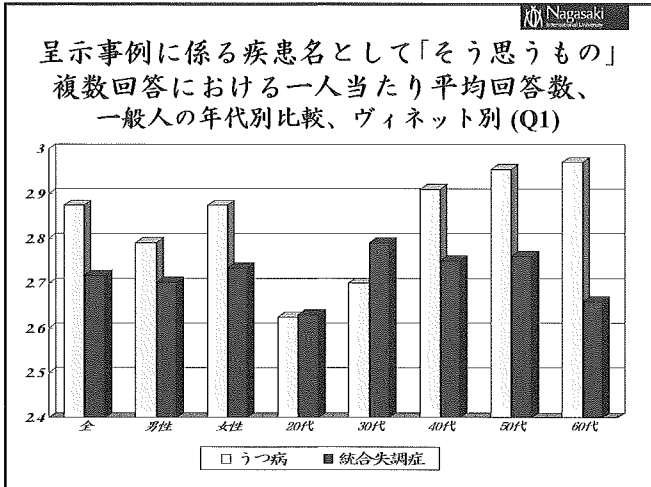
関係諸団体からの協力状況

	調査発送数	回答数
日本精神神経学会	1,000	165
日本プライマリケア学会	375	96
日本精神保健福祉士学会	1,000	365
日本作業療法士協会	1,000	334
日本看護協会	1,000	260
日本精神科看護技術協会、長崎県支部	200	172
日本心理臨床学会	不参加の回答	**
日本精神科看護技術協会	不参加の回答	**
総数	4,575	1,392

調査対象年齢群別一覧：全 (n=3,392)

	20代	30代	40代	50代	60代	合計
一般人	400	400	400	400	400	2,000
精神科医	2 (1.3)	25(15.9)	45(28.7)	40(25.5)	45 (28.7)	157
一般医	0 (0)	8 (9.1)	20 (22.7)	25 (28.4)	35 (39.8)	88
精神保健福祉士	114(31.2)	112(30.7)	76 (20.8)	48 (13.2)	15 (4.1)	365
作業療法士	183(54.8)	108(32.3)	34 (10.2)	5 (1.5)	4 (1.2)	334
精神科看護師	18 (10.5)	39 (22.7)	67 (39.0)	46 (26.7)	2 (1.2)	172
一般看護師	84 (32.7)	68 (26.5)	71 (27.6)	33 (12.8)	1 (0.4)	257
計	801	760	713	597	502	3,373

性年齢不明：19 (精神科医：8、一般医：8、一般看護師：3)
括弧内数字は合計に対する%を表す



一般人および各種専門家群における
うつ病・統合失調症の認識度(%)、単一回答 (Q1)

	うつ病	統合失調症	合計
一般人	28.8 (n=1,000)	25.3 (n=1,000)	27.1 (n=2,000)
精神科医	72.7 (n= 88)	68.8 (n= 77)	70.9 (n=165)
一般医	63.0 (n= 46)	60.0 (n= 50)	61.5 (n= 96)
精神保健福祉士	70.2 (n=188)	76.3 (n=177)	73.2 (n=365)
作業療法士	72.0 (n=157)	73.4 (n=177)	72.8 (n=334)
精神科看護師	29.1 (n= 86)	37.2 (n= 86)	33.1 (n=172)
一般看護師	35.8 (n=134)	32.5 (n=126)	34.2 (n=260)

一般人におけるうつ病・統合失調症の認識度(%)
— 日豪比較 —

	うつ病				統合失調症			
	希死念慮なし		希死念慮あり		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
うつ病	22.6	65.3	35.0	77.3	13.6	34.8	9.6	9.6
統合失調症	2.2	0.0	1.2	0.5	17.2	41.2	33.4	36.1
神経症性的問題	2.0	0.7	2.6	1.6	2.6	1.7	2.4	1.0
心理的な問題	29.4	4.5	24.8	6.0	28.4	12.9	27.2	14.3
こころの病気	9.2	3.0	10.2	5.5	21.6	23.0	12.8	35.8
ストレス	25.0	16.6	19.8	10.9	5.0	3.1	3.8	2.8

呈示事例に考えられる原因 (%)
— 一般人 —

	うつ病			統合失調症		
	全	希死念慮なし	希死念慮あり	全	早期	慢性
ウイルスなど感染症	6.4	6.2	6.6	7.2	7.2	7.2
日々の問題	92.7	93.6	91.8	91.6	92.0	91.2
近親者・親友の死	80.6	79.8	81.4	73.7	73.4	74.0
トラウマ的出来事	81.1	82.6	79.6	79.5	78.2	80.8
幼少時の問題	81.5	81.0	82.0	88.6	88.2	89.0
神経質	79.4	81.4	77.4	77.9	74.0	81.8
性格の弱さ	71.4	73.6	69.2	77.7	73.4	82.0
遺伝	34.3	34.6	34.0	39.0	34.2	43.8

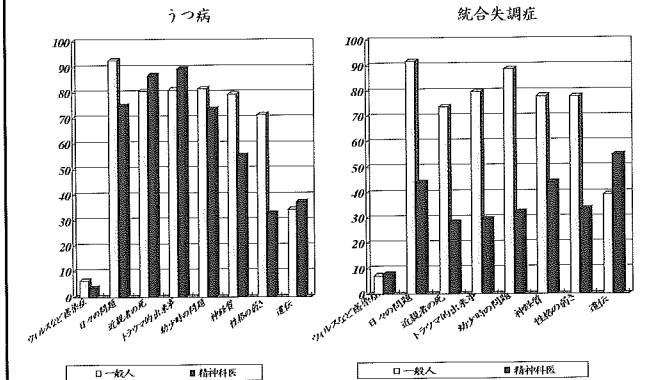
呈示事例に考えられる原因 (%)
— 日豪比較 —

	うつ病				統合失調症			
	希死念慮なし		希死念慮あり		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
ウイルスなど感染症	6.2	50.5	6.6	41.4	7.2	32.1	7.2	33.6
日々の問題	93.6	96.8	91.8	95.7	92.0	89.6	91.2	86.6
近親者・親友の死	79.8	96.3	81.4	94.8	73.4	87.4	74.0	83.3
トラウマ的出来事	82.6	93.9	79.6	92.7	78.2	86.5	80.8	82.8
幼少時の問題	81.0	91.3	82.0	95.0	88.2	90.8	89.0	91.4
神経質	81.4	67.9	77.4	65.6	74.0	58.1	81.8	56.9
性格の弱さ	73.6	43.0	69.2	46.1	73.4	39.7	82.0	35.1
遺伝	34.6	68.0	34.0	68.4	34.2	70.0	43.8	73.7

呈示事例に考えられる原因 (%)
—一般人と精神科医の比較—

	うつ病		統合失調症	
	一般人	精神科医	一般人	精神科医
ウィルスなど感染症	6.4	3.6	7.2	8.0
日々の問題	92.7	74.7	91.6	44.0
近親者・親友の死	80.6	86.7	73.7	28.0
トラウマ的出来事	81.1	89.2	79.5	29.3
幼少時の問題	81.5	73.5	88.6	32.0
神経質	79.4	55.4	77.9	44.0
性格の弱さ	71.4	32.5	77.7	33.3
遺伝	34.3	37.3	39.0	54.7

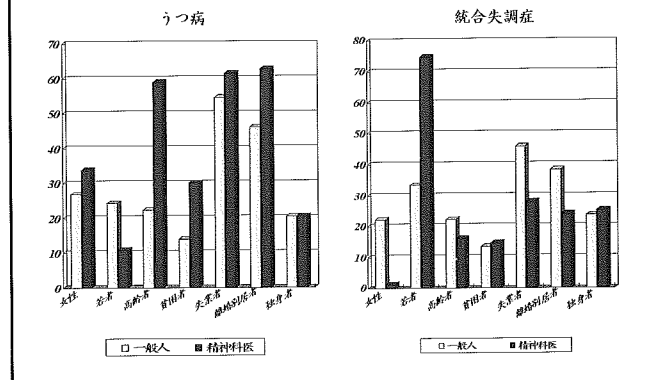
呈示事例に考えられる原因
—一般人と精神科医の比較—



呈示事例に考えられる背景要因 (%)
—一般人と精神科医の比較—

	うつ病		統合失調症	
	一般人	精神科医	一般人	精神科医
女性	26.8	33.7	22.2	1.3
若者(<25歳)	24.3	10.8	33.3	74.7
高齢者(>65歳)	22.3	59.0	22.1	16.0
貧困者	14.0	30.1	13.5	14.7
失業者	54.6	61.4	45.8	28.0
離婚・別居者	46.1	62.7	38.4	24.0
独身者	20.5	20.5	23.7	25.3

呈示事例に考えられる背景要因
—一般人と精神科医の比較—

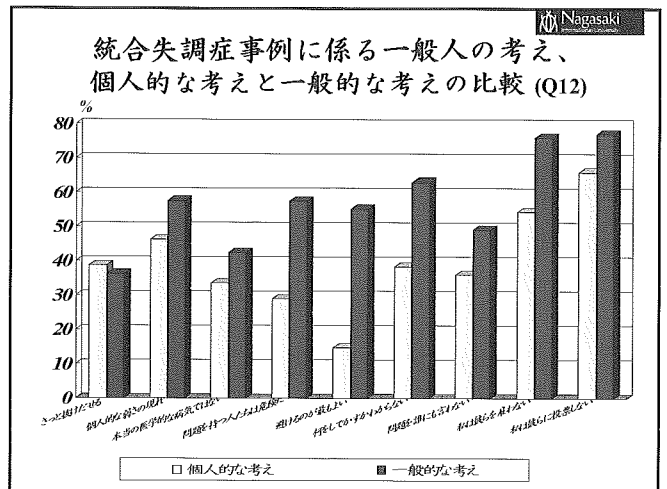
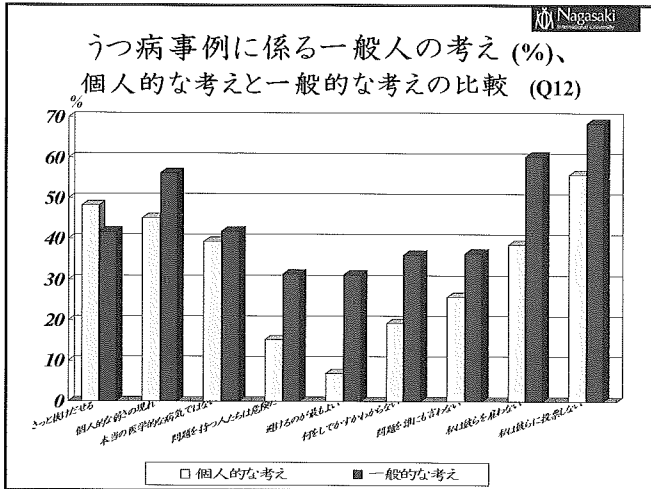


呈示事例についての個人的な考え (%)
—一般人と精神科医の比較—

	うつ病		統合失調症	
	一般人	精神科医	一般人	精神科医
望めばさっと抜け出せる	48.3	25.3	38.8	28.0
個人的な弱さの表れ	45.2	2.4	46.3	4.0
本当の医学的病気ではない	9.3	2.4	33.6	0
問題を持つ人たちは危険だ	15.3	0	29.0	16.0
避けるのが最も良い	6.8	0	14.8	4.0
何をすべきか分からない	19.3	1.2	38.3	14.7
問題を誰にも言わない	25.8	14.5	36.1	18.7

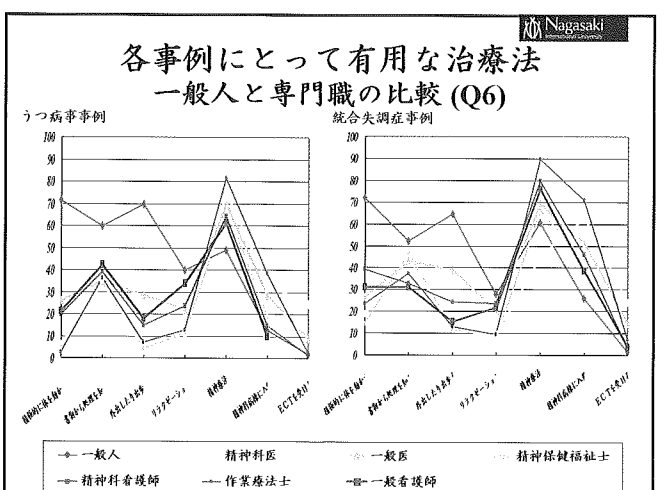
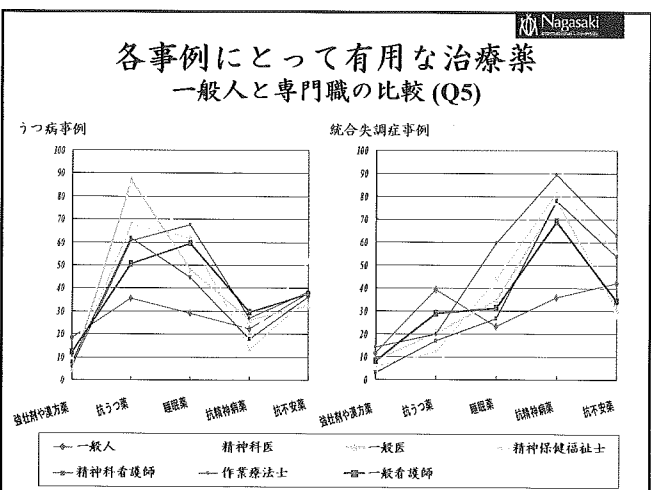
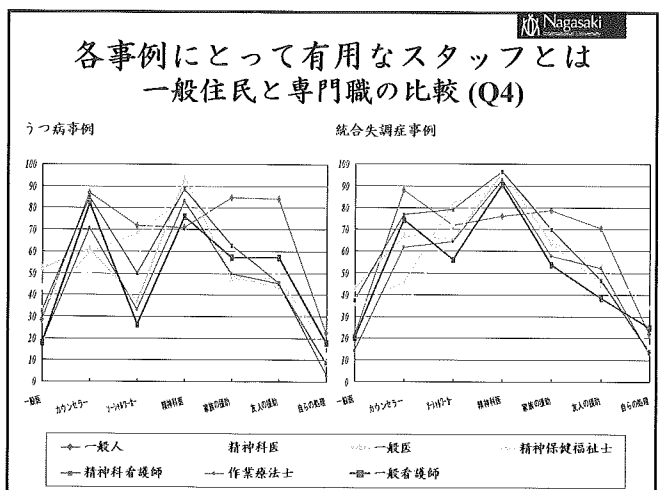
呈示事例についての一般的な考えへの思い (%)
—一般人と精神科医の比較—

	うつ病		統合失調症	
	一般人	精神科医	一般人	精神科医
望めばさっと抜け出せる	41.8	33.7	36.2	21.3
個人的な弱さの表れ	56.2	53.0	57.6	46.7
本当の医学的病気ではない	41.9	37.3	42.5	17.3
問題を持つ人たちは危険だ	31.3	16.9	57.5	68.0
避けるのが最も良い	31.2	22.9	55.2	56.0
何をすべきか分からない	36.1	24.1	63.0	66.7
問題を誰にも言わない	36.5	37.3	49.1	48.0



呈示事例にとって有用な人的資源 (%) — 日豪比較 —

	うつ病				統合失調症			
	希死念慮なし		希死念慮あり		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
精神科医	69.4	65.0	72.4	71.3	73.0	80.5	79.0	80.2
一般医	30.4	87.3	26.0	84.1	19.0	76.7	22.8	76.3
カウンセラー	85.8	82.2	87.6	85.5	87.0	85.0	88.6	83.1
ソーシャルワーカー	73.4	62.8	70.2	67.2	68.4	68.4	75.2	79.1
家族	85.0	67.9	84.2	64.8	76.8	62.7	80.4	61.4
親友	84.8	78.2	83.2	77.1	70.4	73.0	70.2	72.0



呈示事例は長期的に見てどうなるか (%) — 日豪比較 —

	うつ病				統合失調症			
	希死念慮なし		希死念慮あり		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
自殺を企てそう	16.8	18.4	23.8	34.4	18.8	18.4	18.6	34.4
自殺を企てそうにない	46.2	37.1	44.0	24.4	36.0	37.1	43.4	24.4
交友関係が乏しくなりそう	29.0	13.1	28.4	24.9	31.2	13.1	31.4	24.9
交友関係が乏しくなりそうにない	27.0	28.2	34.6	18.5	26.0	28.2	26.8	18.5
暴力的になりそう	4.8	5.2	4.2	12.1	10.0	5.2	11.6	12.1
暴力的になりそうにない	55.4	31.3	66.4	23.6	43.8	31.3	45.0	23.6

呈示事例は長期的に見てどうなるか (%) — 一般人と精神科医の比較 —

	うつ病		統合失調症	
	一般人	精神科医	一般人	精神科医
自殺を企てそう	20.3	25.3	18.7	26.7
自殺を企てそうにない	45.1	25.3	39.7	16.0
交友関係が乏しくなりそう	28.7	19.3	31.3	49.3
交友関係が乏しくなりそうにない	30.8	33.7	26.4	13.3
暴力的になりそう	4.5	0.0	10.8	17.3
暴力的になりそうにない	60.9	61.4	44.4	26.7

社会的距離 (Social distance)

- 人が、他のある集団あるいは人々との間に設定する心理的距離
- 人には自分が安心していられる空間(テリトリー)があり、その空間の境界を越えて近づいてくると緊張や不安が生じてくるために自らの距離を置くことになる。
真の理解のためには近さと適切な判断のための距離が必要となる。専門職の果たす役割によって距離の条件は変わってくる。
例えば、知識や理解度が高かったり、同様の体験を有していたり、受容性が高かったり(内的コントロールが強い)すると、社会的距離は短くなりそうである。
- そこで、その客観的・数量的な測定分析のために社会的距離尺度 (Social distance scale) が開発された。

社会的距離尺度 (Social distance scale)

下記7指標を5段階評価して、アメリカ人の民族的偏見を実証的に分析
1. (強く)同意しない、2. 同意しない、3. どちらでもない、4. 同意する、5. (強く)同意する
Bogardus Emory Stephen; *Measuring social distance*, J Appl Soci Psychol 9, 299-308, 1925.

	Blacks	Jews	Whites	Yuppies
結婚：結婚して親戚となる				
友人：個人的な親友として自分のクラブに入れる				
隣人：隣人づきあいても良い				
就労：自分と同じ職業に就かせる				
市民権：自分の国の市民となっても良い				
一時入国：私の国の訪問者としてだけなら良い				
国外追放：自分の国から締め出したい				

Yuppies：都会派若手エリート

精神保健の知識と理解に関する研究調査票 (一部 ③)

本調査における社会的距離と差別に関する質問項目

Q11 あなたは、地域の他の人々がA様(B子)さんの持つ問題を知ったら、その人たちが彼(彼女)を差別するようになると思いますか。
はい□、いいえ□、分からない□

Q14 次のいくつかの質問は、A様(B子)さんのような誰かど、あなたがどのくらい自らすすんで接触を持とうとする気があるかについてお訊ねします。
確かにそうしたい□1、多分そうしたい□2、多分そうしたくない□3、確かにそうしたくない□4、強く反対□5

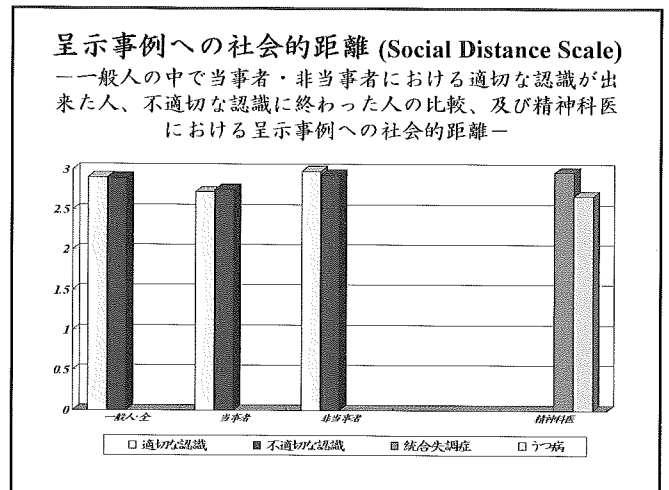
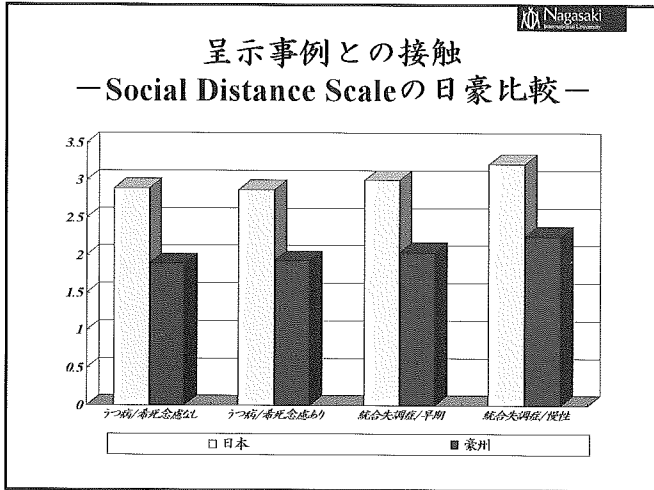
隣りに引越しても良い	<input type="checkbox"/>	職場のあなたの近くで仕事を始めて良い	<input type="checkbox"/>
一晩付き合っても良い	<input type="checkbox"/>	結婚してあなたの家族の一員になっても良い	<input type="checkbox"/>
親しくなっても良い	<input type="checkbox"/>		

社会的距離に関する5項目尺度 (Q14) 評点法：
確かにそうしたい：1点、多分そうしたい：2点、
多分そうしたくない：3点、確かにそうしたくない：4点
と採点し、5項目の平均をとる。評点が高い方が社会的距離が大きいことを示す

Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA: Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *Am J Public Health* 1999; 89:1328-1333.

呈示事例との接触 — 一般人の日豪比較 — 「強く反対」「確かにそうしたくない」頻度 (%)

	うつ病		うつ病		統合失調症		統合失調症	
	希死念慮なし		希死念慮あり		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
隣りに引越しても良い	30.4	11.7	33.2	11.1	38.2	15.1	52.8	25.2
一晩付き合っても良い	24.6	10.9	21.6	12.2	30.6	15.1	47.8	26.1
親しい友人になっても良い	16.4	8.0	17.8	9.3	22.6	12.0	35.4	19.7
近くで仕事を始めても良い	13.8	21.0	15.6	20.0	17.2	23.7	21.6	33.6
結婚して家族になっても良い	43.2	28.8	43.8	33.9	47.2	39.3	61.8	53.0
Social Distance Scale 平均	2.89	1.89	2.87	1.93	3.00	2.04	3.22	2.25



精神保健の知識と理解に関する研究調査票 (一部②)

当事者：下記の質問項目のいずれか1項に「はい」との回答が得られた者 (非当事者:いずれも「いいえ」の者)

Q17 次のいくつかの質問について、「はい」「いいえ」のいずれかをお答え下さい。

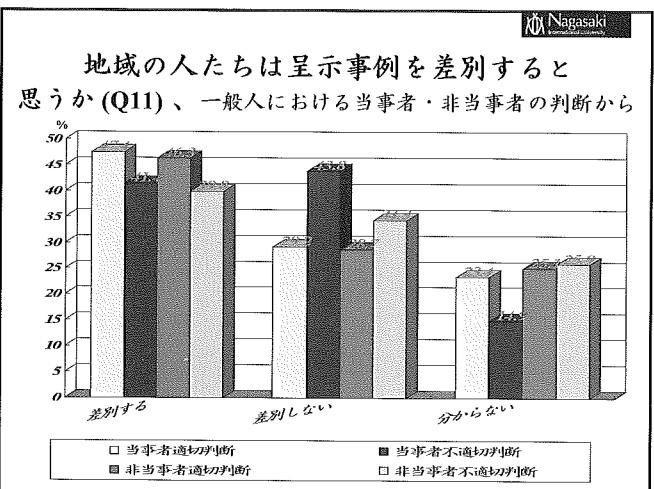
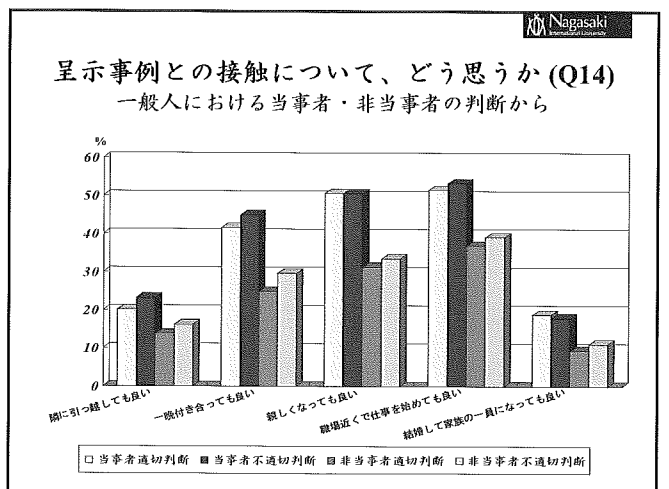
a. あなたの家族や親しい友人達の中にA雄(B子)さんのような問題を持った人がいますか。 はい いいえ

b. あなたはA雄(B子)さんと似た問題を持ったことがありますか。 はい いいえ

Q19 この1ヶ月間に、あなたは次のようなことを患いましたか。

はい1、いいえ2、分からない9

i. 不安状態 (不安神経症)	<input type="checkbox"/>	l. いらいら感	<input type="checkbox"/>
j. うつ病	<input type="checkbox"/>	m. 神経質	<input type="checkbox"/>



呈示事例は差別されると思うか (%) — 一般人の日豪比較 —

	うつ病		うつ病		統合失調症		統合失調症	
	希死念慮なし		希死念慮なし		早期		慢性	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
差別される	27.6	53.5	32.6	62.1	44.8	75.9	62.6	83.0
差別されない	48.6	42.8	41.0	33.8	29.6	20.4	18.4	14.6
分からない	23.8	3.7	26.4	4.1	25.6	3.7	19.0	2.4