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Family Caregivers of People with Schizophrenia in East Asian Countries

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1. Introduction

Public endorsement of mental illness stigma impacts many people. People with mental illness, their families, service providers, and the general public are all groups of special importance when considering stigma. The harm that public stigma causes people who are labeled mentally ill is perhaps of the greatest concern. Their family members and friends are also impacted by public stigma (Phelan et al., 1998). It has been extensively documented that caregivers of persons who have serious and persistent mental disorders must successfully cope with many challenging problems in order to provide good care.

This chapter was written to help European and American people understand the unique aspects of family caregivers' recognition and attitude toward people with schizophrenia in Japan and Korea, East Asian countries. These aspects are based on Confucian ideas and the tradition of providing care for dependents. We discuss the need for support for family caregivers, derived from our family-related studies. We also discuss the current issues of mental health infrastructure and compulsory community treatment, instead of inpatient facilities, for persons with chronic schizophrenia and their family caregivers.

2. A long-term hospitalization system in Japan and Korea

As is known worldwide, Japan formerly had a long-term hospitalization system and a hospital detention policy that involuntarily admitted people with mental diseases to psychiatric hospitals. Many inpatient psychiatric facilities exist today. For example, in 2005, the number of psychiatric beds per 10,000 populations was 28 in Japan, and 14 in South Korea (World Health Organization [WHO], 2005). Compared to South Korea, Japan has higher rate of total psychiatric beds in mental hospitals, general hospitals, and other settings.

South Korea has the higher rate of psychiatric beds in other settings, such as unrecognized "houses of prayer" than Japan. The number of Japanese psychiatric beds continued to be over 25 per 10,000 populations from 1994 to 2005. On the other hand, the number of South Korean psychiatric beds saw a steady increase from 2.8 to 13.8 during the same period. In South Korea, the formulation of the Mental Health Act of 1995 led many private mental asylums to be changed into mental hospitals. Different psychosocial programs have been

developed for rehabilitation, open wards are slowly developing in mental hospitals, and unrecognized “houses of prayer” have been closed.

In Japan and South Korea, both custodial care in mental hospitals and prolonged inappropriate stays of patients persist, primarily due to a lack of adequate staff to care for patients in the community. The length of an inpatient stay is still very long and a great deal of stigma still remains against mental disorders and patients.

2.1 Two kinds of involuntary hospitalization

Interestingly, in Japan and Korea, two forms of “Involuntary Hospitalization” are allowed by the current mental health laws. In Japan, the law is the Law Related to Mental Health and Welfare of the Person with Mental Disorder. One form is “Involuntary Hospitalization”, which is intended for the treatment and care for individuals deemed likely to hurt themselves or others because of mental disorder based upon abnormal behavior and other circumstances. Another form is “Hospitalization for Medical Care and Protection”, which is intended for the treatment and care of individuals who are judged to be mentally disordered based upon examination by a designated physician and who need hospitalization for medical care and protection. “Hospitalization for Medical Care and Protection” requires the family’s consent instead of the patient’s consent, and it has been allowed since 1950 by the Mental Hygiene Law. Furthermore, in these countries, family caregivers are obligated to do the following: (1) protect the person with a mental disorder to ensure treatment and the protection of his or her proprietary interests, (2) cooperate with the physician to ensure that the person with the mental disorder is correctly diagnosed, and (3) comply with the physician’s instructions to ensure medical care for the person with the mental disorder. Therefore, family members of people with mental disorders have experienced guilt related to “involuntary hospitalization” for many years. Additionally, the family member with the mental illness often blames their family members for giving consent. Involuntary psychiatric hospitalization has led to complex family relationships in Japan, especially because patients have little insight into the seriousness of the illness during the acute delusional stage of schizophrenia and later forget these situations.

2.1.1 Compulsory admission and compulsory community treatment

The mental health laws dictate the family’s obligation to ensure treatment and medical care for the patient. The mental health laws explain that the compulsory admission requires the family’s consent, rather than the patient’s consent. However, the laws do not dictate professional compulsory community treatment in Japan and South Korea.

Pervasive negative attitudes and discriminatory treatment towards people with mental illness are well documented in Northeast Asian countries and in Chinese societies. The particular manifestations of the stigma associated with schizophrenia are shaped by cultural meanings based on Confucianism. These cultural meanings are reflected in severe cultural-specific expressions of stigma in Chinese societies (Yang, 2007). In contrast to the political personhood of the West, in which a Westerner considers family as a volitional option, the familial personhood of the East stands on the foundation of a family with each individual understanding that “filial piety is one of the roots of humanity” (Lee, 2009). Both Japan and

South Korea are located in East Asia and have cultures based on Confucian ideas and the tradition of providing care for dependents.

In contrast, in Taiwan of one of East Asian countries, a 2010 Taiwanese pilot program is implementing compulsory community treatment to reduce the “revolving door phenomenon”. This pilot program theoretically serves as a substitute for compulsory admission, discharge planning or condition discharge, and relapse prevention. According to the 2007 Mental Health Act, the process begins when severely mentally ill patients do not comply with medical orders and thus are living in unstable conditions or are feared to jeopardize their daily function. In order to participate in the pilot program, the severely mentally ill patient’s community treatment must have been recommended by a board certified psychiatrist, and the patient must have refused or failed to give consent. If necessary, policemen and firefighters may assist by completing the above measures under appropriate requests. Non-government organizations (NGOs) approved by the government may monitor the compulsory community treatment.

2.1.2 Regional and socio-cultural differences in East Asia

Recently, factors influencing the extent of caregiver burden have attracted attention. Patient variables, caregiver characteristics, and regional differences have been identified as predictors of caregiver burden (Roick et al., 2006). Caregiver burden can also reflect regional differences in patients’ socio-economic situations and family support in European countries (Magliano et al., 2002) and in the provision of rehabilitative interventions for patients (Magliano et al., 2001). Roick and colleagues reported that the burden placed on family members of people with schizophrenia may be influenced not only by patient and caregiver characteristics but also by national differences in the provision of mental health care services (Roick et al., 2007). This assumption was evaluated by comparing caregivers in Germany and Britain, two northern European countries that differ appreciably in their provision of mental health services. Even after controlling for patient and caregiver characteristics, British caregivers reported a significantly higher level of burden than did German caregivers (Roick et al., 2007). In another comparison study, a higher burden was observed in Italy and Britain as compared to the Netherlands, Spain and Denmark. These differences were attributed to differences in the provision of mental health care services (Wijngaarden et al., 2003). Differences in caregiver burden could be caused by cultural characteristics. Cultures may differ in their appraisal of mental illness, with such appraisals ranging in attitude from acceptance and integration into society to stigmatization. Religious beliefs, beliefs regarding the origin of mental illness, and society’s appraisal of the caregiver’s role also play a part (Wijngaarden et al., 2003).

As the vast majority of previous studies have been conducted in Western cultures, it has been difficult to apply their findings to family caregivers in Asian countries. In a sample of caregivers of family members with schizophrenia in Japan and England, Nomura et al. reported that expressed emotion (EE) did not correlate significantly with caregiver burden. Decreased tendencies in caregivers’ positive and negative emotional reactions towards family members, particularly in reactions to critical comments in the Japanese sample, were observed (Nomura et al., 2005).

2.2 Caregiver burden and cultural comparison

East Asian cultures based primarily on Confucian ideas have traditionally emphasized the importance of providing care for dependents. Studies of Chinese families in Malaysia have demonstrated that the stigma of relatives' mental illness has a strong and pervasive impact on family caregivers. To protect their families from "losing face", family caregivers often avoid talking about their relative's mental illness with extended family or friends (Chang & Horrocks, 2006). In a recent study on caregiver burden in China, families who perceived a higher level of caregiver burden were found to have poorer functioning, a lower health status, and lower satisfaction with social support. Social support was identified as the best predictor of caregiver burden (Chien et al., 2007). These results are similar to results obtained from our first survey of Japanese families (Hanzawa et al., 2008).

A cross-cultural and cross-national comparison of caregiver burden between Japan and Taiwan showed that Japanese respondents perceived a significantly stronger stigma for the parents and neighbors of a person with a mental illness presented in a vignette than did Taiwanese respondents (Shinfuku, 1998; Kurumatani et al., 2004). Haraguchi et al. reported that knowledge of mental illness and medication were greater in Japan than in China, but social distance for persons with mental illness was greater in Japan than in China. The reasons for these results include the fact that there are many advanced mental health care inpatient facilities as well as a few regional rehabilitation services in Japan. Also, Japan formerly had a long-term hospitalization system and hospital detention policy. In this policy, people with mental illnesses could be admitted involuntarily to a psychiatric hospital in order to receive treatment, without having exhibited violent behavior or suicide attempts (Haraguchi et al., 2009).

Korea is Japan's closest neighbor. A recent study of Korean relatives of patients with schizophrenia indicated that relatives with less knowledge about schizophrenia exhibited more inappropriate coping strategies and higher burdens (Lim & Ahn, 2003). Differences might exist in family caregivers' beliefs and attitudes among East Asian countries because the countries have varying socio-cultural and political backgrounds of mental health care systems.

2.2.1 Caregiver burden and the institutionalization rate for schizophrenia

In Japan, where the institutionalization rate for schizophrenia patients is the highest in the world, the number of psychiatric beds has not decreased during the last twenty years. Meanwhile, in Korea, a steady increase in the number of psychiatric beds has been observed over the past ten years (WHO, 2005). However, in Northeast Asian countries, little is known about the correlation between caregiver burden and socio-cultural and political factors. These factors may differ from country to country in the appraisal of the caregiver's role and coping strategies. Therefore, it is important to compare Japan and Korea to identify differences in socio-cultural and political backgrounds that could contribute to differences in caregiver burdens in these two countries. First, the tendency for Japanese families to exhibit decreased emotional expression towards family members as compared to Korean families was explored. Second, differences in religious beliefs and beliefs about the origin of mental illness and in the appraisal of the caregiver's role were identified through a cross-cultural

comparison of Japan and Korea, with an emphasis on their histories of hospitalization and cultural differences.

2.2.2 A comparison of caregiver burden in Japan and Korea

In our first comparative study of Japanese and Korean family caregivers (Hanzawa et al., 2010a), members of the Federation of Families of People with Mental Illness in Japan and Korea were recruited and evaluated. Several differences between patients with schizophrenia of the two countries were observed. For example, although there were not significant differences of age and gender between Japanese and Korean sample, the percentage of patients who were frequently hospitalized (at least three times) were 34.3% and 59.8%, respectively. Clearly, Korean patients with schizophrenia were hospitalized more frequently over short periods of time. Differences in social activities over the past years and in the levels of living skills and care needs were also observed. Korean patients, compared to Japanese patients, had more opportunities to go out during the day and exhibited less impairment in the activities of daily living. However, Korean patients were hospitalized more frequently, and their families more strongly encouraged social participation. In a previous study, a multiple regression analysis identified the number of hospitalizations in the previous three years and kinship (mother/father/other) as significant predictors of caregiver burden (Caqueo & Gutierrez, 2006). The results of our second caregiver study did not identify the total number of hospitalizations in the previous year as a significant predictor in either country. However, the patients' social functioning and their care needs were both identified as significant predictors of caregiver burden in both Japan and Korea.

The results of our second caregiver study also suggest that, when compared to Korean families, constraints on the choice of caregiver in Japanese families (e.g., "I want care to be provided only by family members as much as possible") were significantly greater. In both countries, family caregiver burden was significantly correlated with an awareness of the fact that "the individual seems to feel uncomfortable with being cared for by someone outside the family". Thus, patients with schizophrenia in both countries are likely to avoid contact with non-family members and to isolate themselves from society. These factors were correlated with a greater caregiver role and an increased family caregiver burden.

In a study comparing five European countries, regional differences were identified in caregiver burden and support inside and outside the family (Magliano et al., 1998). Our results demonstrate slight differences in independent factors for caregiver burden between Japan and Korea. In Japan, families were more likely to have a greater caregiver burden if they agreed that "The individual seems to feel uncomfortable with being cared for by someone outside the family".

In Korea, family members are more likely to reluctantly allow someone outside the family to care for patients, so their family caregiver burden is lower. In the present study, about 70% of Korean families did not have someone who could provide care, which was a higher proportion than was observed in Japan. The results from Korea suggest that, when other family members also think that a patient with schizophrenia should be cared for by family, family members are more likely to collaborate in order to reduce caregiver burden. It might be difficult for family members to find caregivers who can provide care on behalf of the

family, despite the fact that both Confucian ideas and the tradition of providing care to family members contribute to the reduction of caregiver burden.

Despite high family caregiver burden in both Japan and Korea, the present results demonstrate that patients and family members have a strong desire to restrict care to family members. The issue should be discussed further to reduce family caregiver burden, especially in relation to the quality of community mental health care services. For example, general practitioners, home-visit nurses, home help service providers, mutual support group members, other outreach services, and integrated assertive community services should provide advice for families having difficulties finding treatment and should suggest coping strategies for patients, especially during critical periods of relapse.

2.3 Public endorsement of stigma perception

Public endorsement of stigma affects many people. The following four groups are of special importance: people with mental illness, their families, service providers, and the general public. The harm that public stigma causes people who are labeled as mentally ill, as well as the harm to their family members and friends, is perhaps the greatest concern (Phelan et al., 1998; Link et al., 1999). Published research studies on public stigma (Magliano, 2004a), family stigma (Magliano et al., 2004b; Grausgruber et al., 2007), self-stigma (patient stigma) (Watson et al., 2007), and medical staff stigma (Lauber et al., 2005; Nordt et al., 2006) have elucidated the effects of stigma.

Italy is the country that has the longest experience with community-based psychiatric treatment. In the 20-year period following the promulgation of the 1978 Psychiatric Reform Law, a study revealed fearful attitudes in most of the general population in Italy toward mentally ill people. Twenty years later, a study of the coping strategies of “resignation” and “maintaining social interests” of families with schizophrenia showed a higher burden of care (Magliano et al., 1998). Now, approximately 30 years later, respondents who believe that patients with schizophrenia are unpredictable are more likely to report factors such as the use of alcohol and drugs as being involved in the development of the disorder (Magliano et al., 2004a). The concept of unpredictability is likely connected to the fear of violent behavior of patients with schizophrenia. The family’s attitudes toward patients with schizophrenia may have a significant impact on patients’ social adjustment and achievement of effective goals (Magliano et al., 2004b).

In Japan, the number of psychiatric beds has not decreased in the 20 years since community mental facilities were implemented across the country; thus, it is likely that attitudes regarding schizophrenia and its treatment have not changed. The public fear of assault from mentally ill patients has been expressed through community opposition to the opening of psychiatric institutions and through the general belief that these patients should be admitted to asylums. Japan is one of the few countries with almost no experience with psychiatric outreach treatment in the community for relatives of patients with delusional behavior that may occur during critical periods of schizophrenia. Previous research has demonstrated that Japanese respondents perceived a significantly stronger stigma for the parents and neighbors of a vignette case than did Taiwanese respondents (Shinfuku, 1998). It has been reported that the strong stigma among Japanese respondents may be a consequence of the limited experience of the general public with psychiatric patients in the community. This

limited experience could be attributed to Japan's institutionalization rate for schizophrenia patients, which is the highest in the world (Kurumatani et al., 2004).

Few studies have investigated the relationship between caregiver experience and stigma in families with schizophrenia patients. For example, three out of every four Mexican-American schizophrenia patients live with their families, and a study of patient symptoms and attributes has shown a correlation between family care burden and stigma perception (Magaña et al., 2007). However, the effects of social stigma perception on the experience of families of patients with schizophrenia can vary between countries. Socio-cultural environmental factors regarding mentally ill persons can differ from country to country.

The relationship between burden and stigma in families of patients with schizophrenia remains unclear. No research had compared Japan and Korea with regard to the burden of care, stigma or social distance in families of patients with schizophrenia. In our second comparative study of Japanese and Korean family caregivers, stigma and care burden in families of patients with schizophrenia were compared in both countries (Hanzawa et al., 2009).

2.3.1 Caregiver experiences and stigma perception in Japan

When compared to Korea, the relationship between stigma perception and care burden among Japanese families is slightly more complicated. For example, Japanese families, compared to Korean families, tend to be "embarrassed" by the behaviors of schizophrenia patients, and they report "not feeling comfortable around a relative with schizophrenia". In addition, Japanese families are more likely to resist allowing people other than family members to care for schizophrenia patients. They are more likely to think that schizophrenia patients "feel uncomfortable with others entering his/her house" and "feel uncomfortable with being cared for by someone outside the family". Japanese families appear to be sensitive to schizophrenia patients' tendencies of "rejecting interactions with others and not wanting to be cared for by others besides family members at home, which is their safe space". Japanese families are also resistant to allowing others to take care of schizophrenia patients. Hence, a close family tie between schizophrenia patients and their families is suggested. The ratio of families who have access to people outside the family who could provide care in Japan was greater than half overall. However, even if Japanese families could find someone to provide care, they are more likely to care for schizophrenia patients on their own because they prefer not to have nonfamily members providing care.

In contrast to Korean families, Japanese families tend to believe that other people think chronic schizophrenia patients are "unpredictable and dangerous" and that "it is best to avoid them". Japanese families feel that "if they had a problem with schizophrenia, they would not tell anyone" and that "if a person had a problem with schizophrenia, he or she would not tell anyone", thus suggesting that their attitude is "it is best to hide schizophrenia in family members from others".

To summarize our third caregiver burden and family stigma study, Japanese families of patients with schizophrenia, compared to Korean families, are likely to perceive a stronger stigma from others and are more likely to think that schizophrenia should be hidden from others. Because they are "worried about what relatives and neighbors might think", they are more likely to take care of schizophrenia patients on their own. These findings are in

agreement with the cognitive and behavioral characteristics of decision making by Japanese people (i.e., “make decisions to maintain harmony with others”) (Radford & Nakane, 1991). However, the results of the present study show that the differences between Japan and Korea in terms of family nursing awareness and stigma perception by others do not significantly correlate with care burden. Interestingly, Japanese families that agreed with the statement “Want to provide care from family members only, without using home help services” experienced lower degrees of care burden.

Families of patients with schizophrenia have a more pessimistic view concerning their perception of stigma from the general public compared to their perception of their personal stigma. In particular, they hold pessimistic views concerning the ideas that people with schizophrenia are “dangerous”, “unpredictable”, and best to avoid. The findings of the present study indicate that family stigma of schizophrenia patients differs between Japan and Korea, especially regarding perceived stigma.

2.3.2 Caregiver experiences and stigma perception in Korea

While no significant difference existed in the perception of patients being dangerous to others, a personal stigma parameter, the family care burden exhibited a significant positive correlation in Korea. Furthermore, when compared to Japanese families, Korean families are more likely to believe that schizophrenia patients are “unpredictable”, another personal stigma parameter. Care burden is great for Korean families with great personal stigma (e.g., “People with a problem like John’s are unpredictable and dangerous”). Interestingly, in Korea, the family care burden was great for families who thought that the person in the vignette was discriminated against by families and by others in the community who were not willing to have the person in the vignette as their neighbor. Further, in Korea only, a significant positive correlation was observed between caregiver burden and the survey statement “If I had a problem like John’s, I would not tell anyone”. This correlation corresponds to the respondents’ beliefs about other people’s attitudes towards the person described in the vignette.

These results suggest that it will be necessary to provide support for lessening the care burden for families with personal stigma in Korea. For example, chronic schizophrenia patients are thought to be “dangerous and unpredictable”, and that there are individuals who are unwilling to live near schizophrenia patients. Additionally, it is necessary to introduce family counseling programs and to provide individual family support to families who are likely to perceive social stigma. Such families are likely to agree with the statement “If I had a problem of schizophrenia, I would not tell anyone” and to believe “people in the community would be prejudiced”. At the same time, the results in Korea suggest that strategies for lessening stigma in the local community, such as those exemplified by the statement “It is best to hide and not tell anyone about family members with schizophrenia”, may eventually aid in lessening family care burden.

2.3.3 Coping strategies and stigma perception in East Asian countries

With the current shift to community-centered mental health services, considerable research on the family burden of caring for patients with schizophrenia has been conducted in European countries (Magliano et al., 1998). It has been reported that family burden and

coping strategies can be influenced by cultural factors, and it has been suggested that family interventions should also have a social focus, with the aim of increasing the family social network and reducing stigma (Magliano et al., 1998).

Among Northeast Asian countries, it has been reported that, in Taiwan, caregiver anxiety is the highest of the five dimensions of primary family burden, followed by dependency of the patient and feelings of shame and guilt. In addition, home and family are considered to provide a person with the strongest sense of belonging and with a place to return to throughout life in Taiwanese society. Therefore, psychiatric patients traditionally live with their families (Hou et al., 2008). Similarly, it has been reported that approximately 80% of psychiatric patients in Japan and Korea live with their families (Hanzawa et al., 2009).

Pervasive negative attitudes and discriminatory treatment towards people with mental illness have been well documented in Northeast Asian countries and in Chinese societies. The particular manifestations of the stigma associated with schizophrenia are shaped by cultural meanings based on Confucianism. These cultural meanings are reflected in severe culture-specific expressions of stigma in Chinese societies (Yang, 2007). Yang et al. recently reported that psychiatric stigma in China is particularly pervasive and damaging. Rates of highly expressed emotion ("EE" or family members' emotional attitudes) are generally lower in China than in Western countries (Yang et al., 2010).

In our caregiver burden study, "resignation" and "maintaining social interests" were identified as coping strategies for the burden of care among mothers of patients with schizophrenia who were given the caregiver role by other family members (Hanzawa et al., 2008). In Korea, recent research has indicated that, among relatives of patients with schizophrenia, those relatives with less knowledge have more inappropriate coping strategies and higher burden (Lim & Ahn, 2003). Both Japan and Korea are located in Northeast Asia and have cultures based on Confucian ideas. These ideas include the tradition of providing care for dependents. In addition, Japan formerly had a long-term hospitalization system and a hospital detention policy that involuntarily admitted people with mental diseases to psychiatric hospitals. Thus, many inpatient psychiatric facilities exist today. Few people with serious mental disorders live in the community, given the stronger tendency for institutionalism in Japan than in other Asian countries (Kurihara et al., 2000; Warner, 2005). Consequently, the general public has little chance of coming into contact with patients with schizophrenia in everyday life (Haraguchi et al., 2009). It has been reported that Japanese respondents perceived significantly stronger stigmatization of the parents and neighbors of a vignette case than did Taiwanese respondents (Kurumatani et al., 2004).

Our fourth caregiver burden study compared Japan and Korea in terms of personal stigma and strategies for coping with a family member with schizophrenia, based on socio-cultural factors that could affect the care experience of families in Northeast Asian countries (Hanzawa et al., 2010b). The results clarified the similarities and differences in the characteristics of personal stigma towards a person with schizophrenia described in a vignette and in the coping strategies among families who belong to family support groups in Japan and Korea.

Differences in the attributes of the patients and their families were observed between Japan and Korea in the present study. For example, differences included the total number of

hospitalizations (a higher number of hospitalizations was observed in Korea), patients' social functioning and care needs (Japanese patients had poorer functioning and required more care), optimal social involvement (the highest level of social involvement was observed in Korea), and an alternative caregiver in the family (fewer among families in Korea). Therefore, although Korean patients have a higher level of social functioning and social involvement, they also experience more hospital admissions. The results regarding coping strategies also suggest that patient social involvement with family is better in Korean families and that there are more strategies for coping with "patients' social involvement" in Korea. In contrast, although the overall scores for personal stigma were worse for Korean families, the personal stigma score for "If I had a problem like John's, I would not tell anyone" was worse for Japanese families. Thus, Japanese families of patients with schizophrenia would be more likely to hide their own mental illness from others, compared to Korean families. This likelihood is correlated with their high degree of "resignation" as a family coping strategy. Conversely, Korean families would be more likely to hide their mental illness through "avoidance" of a family member with schizophrenia.

These findings are in agreement with the cognitive and behavioral characteristics observed in cross-cultural qualitative studies that have explored the mental health beliefs and help-seeking attitudes of Korean-American parents of children with schizophrenia (Donnelly, 2005). In the traditional Korean culture, a marriage signifies the union of two families rather than two individuals. Therefore, families of patients with mental illness worry about the marriage prospects for their other children if one child has a mental disorder. Furthermore, it has been reported that Korean families with children with mental disorders even object to visits by researchers. They fear that neighbors might recognize the investigators, thus revealing their child's mental disorder (Donnelly, 2005). Family shame could be explained by the Confucian concept of filial piety, which states that no person should bring dishonor to the family (Sung, 1992). Children with schizophrenia are incapable of following the principles of filial piety, thus risking shame and violating traditional Korean beliefs (Donnelly, 2005).

The results of the present correlation analysis demonstrated many differences between Japan and Korea in terms of factors that affect personal stigma and coping strategies. In particular, it is interesting to note that "coercion" and "avoidance" as family coping strategies were correlated with many aspects of personal stigma in Korea, but these strategies were not correlated with personal stigma in Japan. In contrast, the idea that "it is best to avoid people with a problem like John's" was correlated with almost all factors of coping in Korea.

3. Conclusion

Although the foundation of Confucian ideas and the tradition of providing care to family members are central to both Japanese and Korean cultures, unexpected similarities and differences between the two cultures were observed.

In both countries, patients with schizophrenia are likely to avoid contact with nonfamily members and to isolate themselves from society. These factors are correlated with a greater caregiver role and a worsening of the family caregiver burden.

However, Japanese families of patients with schizophrenia are more likely to perceive a strong stigma from others, compared to Korean families. Thus, they are more likely to think that schizophrenia should be hidden from others. Japanese families tend to cope with the stigma associated with schizophrenia through “resignation”, in contrast to Korean families, who tend to cope through ineffective communication (e.g., “limited communication”, “avoidance”, and “coercion”). Furthermore, Japanese families are resistant to allowing others to care for a schizophrenic family member. A close family tie between schizophrenia patients and their families is suggested.

These findings suggest that Japanese mental health strategies should focus on providing effective support for reducing caregiver burden and for eliminating reliance on inappropriate coping strategies (e.g., “resignation”, unwillingness to accept support from outside the family) for family members with schizophrenia inpatients and outpatients. This support is especially important for outpatients and their caregivers, as continued support from the early clinical stage through the chronic stage should be emphasized.

This issue should be discussed further in the context of community mental health care workers such as general practitioners, home-visit nurses, home help service providers, mutual support group members, and other outreach workers. Integrated assertive community services should be provided. These services are especially necessary during periods of relapse in patients living with chronic psychiatric illnesses. In future research, we will endeavor to summarize therapeutic encounters between family caregivers and health professionals. We will also examine available consultation and outreach treatments, such as using a multi-professional team approach in community settings. The team approach is suggested for optimal support of both patients with schizophrenia and their caregivers in Japan and South Korea.

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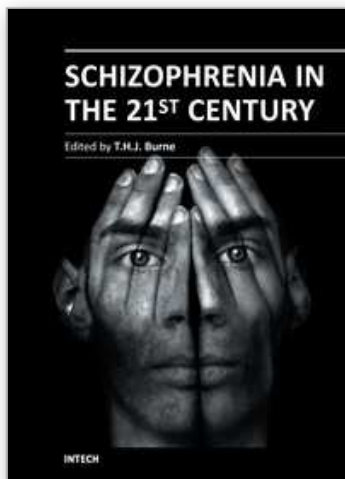
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Schizophrenia is a poorly understood but very disabling group of brain disorders. While hallucinations and delusions (positive symptoms of schizophrenia) feature prominently in diagnostic criteria, impairments of memory and attentional processing (cognitive symptoms of schizophrenia) are attracting increasing interest in modern neuropsychiatry. Schizophrenia in the 21st Century brings together recent findings on this group of devastating disorders. We are still a long way from having effective treatment options, particularly for cognitive symptoms, and lack effective interventions and ways to prevent this disease. This volume covers various current options for therapy, clinical research into cognitive symptoms of schizophrenia and preclinical research in animal models.

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