

Review Article

Review of mental-health-related stigma in Japan

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The aim of this study is to understand the nature and characteristics of mental-health-related stigma among Japanese people. We searched relevant studies in English or Japanese published since 2001 using MEDLINE and PsycINFO, and found 19 studies that examined mental-health-related stigma in Japan. Regarding knowledge about mental illness, reviewed studies showed that in the Japanese general population, few people think that people can recover from mental disorders. Psychosocial factors, including weakness of personality, are often considered the cause of mental illness, rather than biological factors. In addition, the majority of the general public in Japan keep a greater social distance from individuals with mental illness, especially in close personal relationships. Schizophrenia is more stigmatized than depression, and its severity increases the stigmatizing attitude toward mental illness. The literature also showed an association between more direct social

contact between health professionals and individuals with mental illness and less stigmatization by these professionals. Less stigmatization by mental health professionals may be associated with accumulation of clinical experience and daily contact with people who have mental illness. Stigmatizing attitudes in Japan are stronger than in Taiwan or Australia, possibly due to institutionalism, lack of national campaigns to tackle stigma, and/or society's valuing of conformity in Japan. Although educational programs appear to be effective in reducing mental-health-related stigma, future programs in Japan need to address problems regarding institutionalism and offer direct social contact with people with mental illness.

Key words: attitudes, Japan, knowledge, mental-health-related stigma, review.

MENTAL-HEALTH-RELATED STIGMA IS internationally a central issue for people with mental health illness. It results in disadvantages for these individuals, in particular because mental illnesses are generally more stigmatized than other conditions.^{1–3} The term 'stigma' includes the following three com-

ponents: problems related to (i) knowledge (ignorance or misinformation); (ii) attitudes (prejudice); and (iii) behavior (discrimination).³ Indeed, past studies have consistently reported that many people with mental health problems suffer from a lack of mental health literacy, the general public's misunderstanding of mental illness, stigmatizing attitudes and harmful discrimination, and associated problems, including low self-esteem, loss of social opportunities, and economic inequality.^{3–5}

Mental-health-related stigma has played an important role as a barrier to development of and access to mental health services in Japan. For example,

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almost two-thirds of individuals with mental illness never seek help from a health professional because of stigma.⁶ In addition, mental health services in Japan have been internationally criticized due to the excessive number of inpatients, insufficient community resources, and infringement of human rights of individuals with mental illness.⁷ Thus, tackling mental-health-related stigma has been identified as extremely important to improving services for (and hence the lives of) individuals with mental health problems in every country, including Japan.⁸

A variety of efforts to decrease mental-health-related stigma have been made all over the world. At the global level, the World Psychiatric Association (WPA) and the World Health Organization (WHO) conducted a global anti-stigma campaign to develop tools to make it easier to tackle stigma and discrimination.^{9,10} Many types of interventions at the national and local level have also been developed to reduce the mental-health-related stigma of people with mental illness, including large-scale media campaigns, short education programs, social contact, films, and simulations.^{11–13} In terms of Japanese activities aimed at overcoming such stigma, the National Federation of Families with Mentally Ill in Japan requested that the psychiatric society change the name of the illness, which was a translation of the German name *schizophrenie* (literally meaning split mind).⁶ The new name was adopted in 2002 and became commonly used in official documents.¹⁴ In addition, to improve mental health literacy, facilities such as health centers have conducted educational programs about mental health for local communities.¹¹

Despite the development of such approaches to address mental-health-related stigma, it remains a serious problem that adversely affects the lives of people with mental health problems in many countries.^{1,2} Not surprisingly, there is still a harmful mental-health-related stigma in Japan. For example, in a large-scale cross-sectional survey, only 5% of the general public believed that people with mental illness could recover fully from their illness through professional help.¹⁴

Because the level and description of stigma are socially and culturally influenced,¹⁵ understanding characteristics of mental-health-related stigma based on research evidence can contribute to lessening of the stigma and development of future interventions. However, to the best of our knowledge, there has been no review that comprehensively summarizes

the current evidence for mental-health-related stigma in Japan. This study, therefore, aims to conduct a narrative review of articles about mental-health-related stigma in Japan and address the following questions:

- 1 What types of mental illness are stigmatized in Japan?
- 2 How is mental illness stigmatized in Japan?
- 3 Which demographic characteristics are associated with the stigma of mental illness in Japan?
- 4 Why are people with mental illness stigmatized in Japan?
- 5 Is stigmatization in Japan any different from that in other countries (i.e. nature or severity of stigma)?
- 6 What interventions have been introduced to reduce the stigma of mental illness in Japan?

METHODS

Inclusion criteria

In order to collect a wide range of relevant evidence, we included peer-reviewed studies published since 2001 written in English or Japanese. Studies were included if they examined public or personal stigmatization (knowledge, attitudes, and behavior) towards any mental illness in any population in Japan, including students, professionals, informal caregivers, or the general public. All types of studies except reviews were included in this review.

Search strategy

MEDLINE (searched by S.A.) and PsycINFO (searched by S.Y.) were searched from 2001 to October 2011. No restrictions were applied for publication type. The following search terms were used: ((attitud\$ OR social behavio\$ OR social distance\$ OR illusion\$ OR stereotyp\$ OR stigma\$ OR discriminat\$) AND (mental disorder\$) AND (Japan\$)) (\$ = truncation). In addition, MeSH terms, including attitude, social behavior, discrimination, mental disorders, and Japan, were applied.

Study selection and synthesis of evidence

After screening the identified titles for potential relevance, full manuscripts of potentially relevant studies were obtained. Data were extracted, and

narrative synthesis was conducted on the basis of the research questions.

RESULTS

Characteristics of studies included in the review

A total of 365 studies from MEDLINE and 95 studies from PsycINFO were identified by the electronic database search. From these, 19 met inclusion criteria for this review (Table 1).^{16–34} There were many studies which were not included because their focuses were not on public or personal stigma but on self-stigma. Most of those included were cross-sectional studies,^{16–32} including five between Japan and China, Taiwan, or Australia.^{19,25–27,31} Two were intervention studies.^{33,34} Eight studies used community samples as study subjects,^{20,21,24–27,29,32} and six studies used specialists whose fields were associated with mental health.^{16–19,22,28} The other four studies used industrial workers and government employees,³³ employers of industries,²³ elementary school teachers,³¹ medical students,³⁴ or participants in lectures about mental health.³⁰ With regard to types of mental disorders, 11 studies examined schizophrenia,^{16–19,25–31} four studied dementia,^{20–22,24} three studied depression,^{25–27} and four studied general mental illness.^{23,32–34} Many studies used their own questionnaire to assess knowledge and attitudes,^{16–18,20,21,23–27,31,34} although some used established instruments for outcome measurement.^{19,22,28–30,32,33} No studies assessed discrimination (actual behavior).

Question 1. What types of mental illness are stigmatized in Japan?

There was only one study that compared stigmatization of different types of mental illness.²⁵ That study examined public beliefs about depression, depression with suicidal thoughts, early schizophrenia, and chronic schizophrenia.²⁵ In general, schizophrenia was stigmatized to a greater extent than depression. In particular, a greater proportion of participants thought that individuals with schizophrenia were more dangerous and unpredictable than those with depression.²⁵ In terms of chronicity of the disorder, more respondents would refuse to employ an individual with chronic schizophrenia compared to someone with early schizophrenia: 61% versus 48%, respectively.²⁵

Question 2. How is mental illness stigmatized in Japan?

In this section, mental-health-related stigma is categorized into that relating to knowledge of and attitudes towards people with mental illness.

Knowledge of psychiatric symptoms and causes

A significant lack of knowledge about schizophrenia in the general public was observed in several studies.^{16,27,29,31} Approximate proportions of the general population who had correct knowledge about prevalence, onset, and characteristic symptoms of schizophrenia were 27%, 42%, and 12%, respectively.¹⁶ A study involving elementary school teachers showed that only 23% of respondents identified schizophrenia correctly in a case vignette.³¹ Regarding the causes of mental illness, three studies found that the most popular attributed causes of schizophrenia in the general public were psychosocial factors: interpersonal relationships (65%),²⁹ stress from personal relations (79%),³¹ and weakness or nervousness (73%).²⁷

However, mental health workers and students at a health and welfare school had some knowledge about mental illness.¹⁹ More than 70% of the participants gave correct answers to most questions about psychiatric symptoms.¹⁹

Knowledge of treatment and recovery

Several studies examined the general public's knowledge about treatment of depression and schizophrenia. Although most people thought that those mental illnesses could be targets of treatment, they were pessimistic about recovery from the condition. Hori *et al.*¹⁶ found that more than 80% of the general public agreed that schizophrenia could be treated. On the other hand, less than 40% of the general public expected full recovery (with or without relapse) of people with schizophrenia.²⁷

Medication was poorly recognized as a helpful treatment for mental illness, and knowledge about side-effects was especially poor. In addition, a psychiatrist was not typically chosen first by the general public as help for mental illness. In one study, only 30–41% of the general public regarded antipsychotics as helpful for schizophrenia; 54–67% regarded psychotherapy as helpful.²⁷ Similarly, only

Table 1. Characteristics of included studies involving Japan

Reference	Study type	Characteristics of participants (Number of participants)	Intervention	Comparison	Length of follow up	Type of illness	Outcome scale	Brief summary
Hori (2011) ¹⁶	Cross-sectional study (web-based survey)	General population (197) Psychiatric staff (100) Physicians (112) Psychiatrists (36)	NA	NA	NA	Schizophrenia	Own questionnaire	Psychiatrists had the least negative attitudes toward schizophrenia, followed by psychiatric staff
Katakura (2010) ¹⁷	Interview	Home-visit nurses (7)	NA	NA	NA	Schizophrenia	Own questionnaire	'Equal footing with client' was essential in home visits
Mino (2009) ¹⁸	Cross-sectional study	Psychiatrists (549) [†]	NA	NA	NA	Schizophrenia	Own questionnaire	Psychiatrists' discharge judgment affected patient's attitude toward discharge
Haraguchi (2009) ¹⁹	Cross-cultural study	Rehabilitation workers Students at a health and welfare school (352/347 [‡])	NA	Chinese	NA	Schizophrenia	Social Distance Scale-Japanese version Knowledge of Illness and Drugs Inventory	Large social distance from schizophrenia in both China and Japan with different features
Matsubayashi (2009) ²⁰	Cross-sectional study	Community sample (2151/4862 [§])	NA	Community sample	9 years [§]	Dementia	Own questionnaire	Perception of dementia has changed positively
Umegaki (2009) ²¹	Cross-sectional study	Community sample (7000/7000 [¶])	NA	Community sample	4 years [¶]	Dementia	Own questionnaire	Perception of dementia has changed positively
Nakahira (2008) ²²	Cross-sectional study	Staff at facilities caring for elderly people (752)	NA	NA	NA	Dementia	Attitude Toward Aggression Scale	Experience and education reduced aggressive attitudes
Ozawa (2007) ²³	Cross-sectional study	Employers of industries (358)	NA	NA	NA	Psychiatric disability	Own questionnaire	Employers' attitude correlated with age and prior experience
Umegaki (2007) ²⁴	Cross-sectional study	Community sample (7000/3949 ^{††})	NA	NA	NA	Dementia	Own questionnaire	Disclosure of diagnosis of dementia desirable
Griffiths (2006) ²⁵	Cross-cultural study	Community sample aged 20–60 years (2000/3998 ^{‡‡})	NA	Australian adults	NA	Schizophrenia, depression	Own questionnaire based on previous studies	Negative attitudes greater in Japanese than in Australians
Nakane (2005) ²⁶	Cross-cultural study	Community sample aged 20–60 years (2000/3998 ^{‡‡})	NA	Australian adults	NA	Schizophrenia, depression	Own questionnaire	Public attributed social causes for illness
Jorm (2005) ²⁷	Cross-cultural study	Community sample aged 20–60 years (2000/3998 ^{‡‡})	NA	Australian adults	NA	Schizophrenia, depression	Own questionnaire	Recognition of disorder and belief about treatment different between countries
Katsuki (2005) ²⁸	Cross-sectional study	Nurses at two psychiatric hospitals (189)	NA	NA	NA	Schizophrenia	Nurse Attitude Scale	Burnout resulted in critical attitude toward patients
Tanaka (2005) ²⁹	Cross-sectional study	Community sample (2632)	NA	NA	NA	Schizophrenia	Mental Disorder Prejudice Scale	Majority was willing to have patient as a neighbor
Ishige (2005) ³⁰	Cross-sectional study	Participants in lectures and seminars about mental health (786)	NA	NA	NA	Schizophrenia	Social Rejection Scale	Positive contact experiences led to accepting attitude
Kurumatani (2004) ³¹	Cross-cultural study	Elementary school teachers (129/150 ^{§§})	NA	Taiwanese	NA	Schizophrenia	Own questionnaire	Stronger stigma in Japan than in Taiwan
Tanaka (2004) ³²	Cross-sectional study	Community sample (2632)	NA	NA	NA	Mental illness	Mental Disorder Prejudice Scale	Information and interaction with patients important
Tanaka (2003) ³³	Intervention study (before and after study)	Industrial workers Government employees (420)	1.5-h lecture about mental health	Before the lecture	Immediately after the lecture	Mental illness	Mental Illness and Disorder Understanding Scale Negative Attitudes Scale	Mental health lecture reduced stigma of mental illness
Mino (2001) ³⁴	Intervention study (clinical controlled study)	Medical students (95/94 ^{¶¶})	1-h educational program	Students who heard a lecture not related to mental health	Immediately after the program	Mental illness	Own questionnaire based on previous studies	Educational program favorably changed attitudes toward mental illness

[†]Psychiatrists evaluated the feasibility of discharge of 549 patients.[‡]The number of Japanese/Chinese.[§]Different samples were used in the two surveys.[¶]Different samples were used in the two surveys.^{††}Two different studies were included in the paper.^{‡‡}The number of Japanese/Australians.^{§§}The number of Japanese/Taiwanese.^{¶¶}The number of interventions/controls.

NA, not applicable.

about 35% of respondents regarded antidepressants as helpful for depression, while approximately 50% regarded psychotherapy as helpful. In a study of rehabilitation workers and students at a health and welfare school, only 35–60% had correct knowledge about side-effects of psychiatric medication and the importance of maintenance medication, although more than 70% of respondents had correct knowledge regarding the effectiveness of psychiatric medication.¹⁹ The most commonly mentioned suitable help for depression was friends/family (70–72%) followed by counselors (62–75%). Less than 50% of respondents mentioned psychiatrists.²⁷

Attitudes: Prejudice

Significant stigmatizing attitudes towards people with mental illness were observed among the general public. In an Internet-based survey, 56% of participants agreed that schizophrenic patients could harm children.¹⁶ In another general public survey, 48–61% would not employ someone with schizophrenia, 58–74% would not vote for a politician with schizophrenia, and 54–58% would not vote for a politician with depression.²⁵ One survey showed that dementia was regarded as the least desirable disease condition among four conditions (dementia, cancer, stroke, and heart disease) by community-dwelling elderly people in two of the three towns investigated.²⁰ Another study examining dementia revealed that more than 40% of the general public regarded dementia as a shameful condition.^{21,24}

Similar stigmatizing attitudes were observed among some professionals. One study that examined stigmatization in industrial workers and government employees found that only 26% of the participants agreed that individuals who had delusions and hallucinations should live in the community without being hospitalized.³³ Even among medical students, the stigmatizing belief that people with schizophrenia are frightening because of unpredictable behavior was held by many (82% of respondents).³⁴ The same study revealed that approximately 77% of students agreed that it was dangerous for mentally ill patients to live in an apartment by themselves.³⁴ A qualitative study revealed that home-visit nurses underestimated understanding of surroundings and skills for daily life of patients with schizophrenia.¹⁷

Attitudes: Social distance

All studies measuring social distance from people with schizophrenia or depression among the general public found greater distance in closer relationships. In two studies using community samples, for instance, a larger proportion of the general public showed an unwillingness to get married and become family with someone with schizophrenia or depression compared to working closely with those people.^{25,32} In another example from a community-based survey, approximately 78% of the general public showed understanding toward a landlord who rejected renting to an individual with schizophrenia, while approximately 84% of the respondents were accepting of the patient as a neighbor.²⁸ This trend was also similar in medical students. Mino *et al.*³⁴ reported that medical students kept the greatest social distance from individuals with schizophrenia with respect to marriage of their children to former patients (94% of the respondents), followed by renting a room in their home to former patients (86%).

Question 3. Which demographic characteristics are associated with the stigma of mental illness in Japan?

Some of the studies included in this review showed a difference in extent of stigmatizing attitude related to several demographic characteristics and professional backgrounds.

Sociodemographics

Hori *et al.*¹⁶ found no significant effect of sex on stigmatizing attitudes toward schizophrenia. Furthermore, in a study of nurses, there was no significant difference in attitudes towards schizophrenia between men and women.²⁸ No significant effect of age on the stigma of schizophrenia was found in a web-based survey.¹⁶ Two studies, however, reported that older participants tended to be less socially accepting of people with schizophrenia and dementia than younger participants.^{30,32} Similarly, employers in their thirties tended to express lower levels of concern about the activity limitation of people with psychiatric disability than those in their sixties.²³ Furthermore, Umegaki *et al.*²¹ compared perception of dementia between younger adults (40–64 years of age) and an older group (65 years of age or older),

and found that the perception was more negative and inaccurate in the older group. Compared with the younger group, a greater proportion of the older group agreed that dementia was a shameful disease: 53–57% versus 39–42%, respectively.²¹

In a web-based survey, no significant association was found between academic degree and level of stigma of schizophrenia.¹⁶ Tanaka *et al.*³² conversely reported that people in the lowest education group showed greater rejection of people with mental disorders. They also pointed out that widowed (divorced) people tended to demonstrate more negative attitudes towards people with mental disorders.

Professional background

There is a tendency that more objective attribution to mental disorders is held by health professionals than by the general public.²⁶ Hori *et al.*¹⁶ found that psychiatrists and psychiatric staff showed overall less negative attitudes toward schizophrenia than the general public and physicians. Moreover, public health nurses and psychiatric nurses showed a higher acceptance of people with schizophrenia compared with other professionals, although psychiatric nurses demonstrated less socially accepting attitudes than public health nurses.³⁰ A negative correlation was found between years of psychiatric nursing experience and negative attitude (hostility and criticism) towards schizophrenia.²⁸ Similarly, Nakahira *et al.*²² reported that staff who had more clinical experience and/or a higher position in facilities for elderly people tended to have a more positive attitude towards patients' aggression than their less experienced counterparts. Also, Ozawa and Yaeda (2007) reported that motivation to employ workers with psychiatric disabilities was higher in employers with a history of employing people with disabilities.²³

Question 4. Why are people with mental illness stigmatized in Japan?

There was no study with the primary objective being investigation of the mechanism of stigmatization related to mental illness. One study, however, showed that Japanese psychiatrists might be conservative when considering discharge from a psychiatric hospital, with this attitude possibly due to public pressure that promotes admission of individuals with mental illness to such hospitals.¹⁸ It was suggested in another study that the high institutionalization rate

of schizophrenic patients in Japan may be associated with the strong stigma of schizophrenia.³¹

Question 5. Is stigmatization in Japan any different from other countries in nature or severity?

There were five studies that compared mental-health-related stigma in Japan and other countries, including China, Taiwan, and Australia.^{19,25–27,31} Overall, findings suggested that the stigma of mental illness in Japan was less than in China and greater than in Taiwan and Australia.

With regard to knowledge about schizophrenia, there were more correct answers about psychiatric symptoms and medication among rehabilitation workers and health-related students in Japan than in China. The social distance people kept from those with mental illness was less in Japan than in China.¹⁹

Kurumatani *et al.*³¹ examined knowledge, beliefs, and attitudes towards schizophrenia of elementary school teachers in Japan and Taiwan. In response to a case vignette involving schizophrenia, the proportion of those correctly identifying the disorder was lower in Japanese compared to Taiwanese teachers: 23% versus 34%, respectively. A similar proportion of teachers in Japan and Taiwan believed that 'stress from personal relationships' was a cause of schizophrenia (79% vs 78%), although Japanese compared to Taiwanese teachers less often chose 'heredity' (9% vs 37%) and 'stress from a disaster' (5% vs 61%). Although, compared to Taiwanese, the Japanese were more likely to regard pediatricians/physicians (30% vs 11%) and school nurses (75% vs 47%) as effective, they were less likely to regard social workers (38% vs 68%) and physical activity (22% vs 68%) as effective. With respect to prejudice and social distance from people with schizophrenia, significantly more stigmatizing attitudes were observed in Japan than in Taiwan.

A large-scale international cross-sectional survey between Japan and Australia examined mental-health-related stigma.^{25–27} The Japanese individuals were more likely to attribute personality of a person, such as nervousness or weakness, as the causes of schizophrenia and depression compared with Australians.²⁶ In contrast, the Japanese were less likely to view biological factors (virus or infection, allergy, or inheritance) and social/demographic factors (young, poor, unemployed, or divorced/separated) as causes than Australians.²⁶ In terms of treatment and

prognosis of schizophrenia and depression, compared to the Australians, the Japanese were less likely to regard general practitioners as helpful (19–30% vs 70–87%), and were more likely to consider psychiatrists, family, self-cure, and hypnosis as helpful.²⁷ In terms of long-term prognosis, the Japanese were much less optimistic about full recovery even with professional help than Australians (3–7% vs 16–37%).²⁷ In relation to attitudes towards people with schizophrenia and depression, there was a tendency toward more negative attitudes and stronger social rejection in Japanese people compared to Australians.²⁵

Question 6. What interventions have been used to reduce the stigma of mental illness in Japan?

There were two studies that examined effects of intervention aimed at reducing mental-health-related stigma.^{33,34} One study gave 1.5-h lectures to industrial workers and government employees using a 24-page pamphlet.³³ The educational program significantly improved understanding of all examined aspects of mental health (treatability of mental illness, efficacy of medication, and social recognition of illness). About 70% of the participants, for instance, agreed with the statement 'Treatment of mental illness requires medication' after the lecture, compared to 20% at baseline. For another example, the rate of agreement with the statement 'I feel insecure when people with mental illness, singly or as a group, rent and live in an apartment' decreased from 46% to 29% after the lecture.

Another study conducted a 1-h lecture explaining mental health services in Japan and presentation of a case of schizophrenia to medical students.³⁴ The explanation highlighted higher inpatient rate, larger proportion of long-stay (>5 years) inpatients, and a poorer social support system in Japan compared with England. In the case presentation, the importance of development of community services for the mentally ill was stressed. As a result of the lecture, improvement was observed in the stigmatizing attitude towards mental illness. For example, in response to the question 'Would you be willing to work on a job with former patients?', only 41% replied positively before the lecture, but the rate increased to 63% after the lecture. As an example of improvement in attitude towards psychiatric services, although only 37% of students agreed that mental hospitals should be open before the lecture, the rate increased to 67% after the lecture.

DISCUSSION

Main findings

This review addressed six questions in an effort to comprehend the nature and characteristics of mental-health-related stigma in Japan. We will now discuss the Japanese trends and significant characteristics of stigma, considering findings from the current review and past studies.

1. What type of mental illness is stigmatized in Japan?

All types of mental illness examined in the included studies were considerably stigmatized in Japan, including schizophrenia, depression, dementia, and others.^{16–34} Schizophrenia was more stigmatized than depression, and severity increased the stigmatizing attitude toward the mental illness,²⁵ consistent with a previous study showing more stigma of people with schizophrenia than those with depression.³⁵ This result suggests that a wide range of mental illnesses can be the target of programs that tackle the stigma of mental illness.

2. How is mental illness stigmatized in Japan?

Knowledge of mental illness was relatively poor among the general public in Japan. Japanese people are apt to consider psychological factors (e.g. weakness of character) as the cause of mental illness rather than biological factors (e.g. genetic predisposition).^{26,29,31} They also tend to prefer seeking help from counselors and friends/family rather than psychiatrists.²⁷ These findings suggest that Japanese people may be more likely to regard mental health problems as personal problems. Nevertheless, a focus on biological causes of mental illness is not a substantially effective way to reduce stigmatization in the general public, according to evidence from well-structured reviews.^{36,37} What is important may be emphasizing that mental illness is not an individual's fault, rather than focusing on causes of mental illness.

In contrast to common views about mental illness, low expectations for recovery seem to be specific to Japan. Institutionalism in Japan might prevent the general public from seeing people with mental illness in their communities, and make it difficult for them to imagine people recovering from mental illness.^{7,18,37} We should, however, take into account

the possibility that institutionalism is not the cause of the strong mental-health-related stigma, but instead is a result of the strong stigma.²⁵

With respect to attitude towards mental illness, a certain extent of negative attitudes and social rejection were common across the studies included in this review. Particularly, prejudice regarding disabilities, dangerousness, and unpredictability of patients appeared to be strongly linked to negative attitudes toward schizophrenia in the general public.^{16,17,25,34} Similar trends in knowledge and attitudes have been seen even in Western cultures.^{1–3,36,37}

3. Which demographic characteristics are associated with the stigma of mental illness in Japan?

Studies included in this review did not show a sex difference in stigmatization of mental illness. A recent systematic review on stigmatization related to sex among Western countries supported this finding.³⁸ With regard to age, some of the included studies found that older people had more negative attitudes towards schizophrenia, dementia, and general mental illness.^{21,23,30,32} This might be due to the negative social value associated with mental illness in Japan, as well as a lack of appropriate education and opportunities for mentally ill people.³⁰ There was also a tendency for a stigmatizing attitude to be greater in less educated people.³² We speculate that highly educated people in Japan might have opportunities to learn about mental illness, although they might also be sensitive to social desirability, which is a typical bias in stigma research.

Meeting people who have recovered from mental illness may reduce stigmatization. Professionals who had routine contact with people with mental illness, particularly in their communities, showed a less stigmatizing attitude towards them than those who had few such opportunities.^{16,30} This finding may reflect the fact that staff with more experience have more chances to meet people who have recovered from their mental illness.³ Interestingly, both the high quality and the frequency of contact are important in improving stigmatization of people with mental illness, even among professionals.³

4. Why are people with mental illness stigmatized in Japan?

It has been suggested that the high institutionalization rate of schizophrenic patients in Japan may be

correlated with the strong stigma.³¹ The large number of psychiatric beds and long stays in psychiatric hospitals may decrease contact between the general public and patients with schizophrenia. Consequently, misperceptions held by the general public may not be corrected because of few opportunities to meet patients who have recovered from the illness.

In addition, considering the poor knowledge and weaker stigma associated with specific professionals,^{16,26,29–31} lack of appropriate education on mental health literacy may be another reason for the stigma of mental illness.

5. Is stigmatization in Japan any different from other countries in nature or severity?

Different degrees of mental-health-related stigma were seen between Japan and other countries in the included studies. Overall, stigmatization of people with mental illness in Japan appeared to be weaker than in China, but stronger than in Taiwan and Australia. There are several possible reasons for this difference between countries.^{19,25–27,31} For example, different knowledge and preferences regarding treatments between Japan and other countries could be due to social/medical systems, as seen in Australia and Taiwan, where people can easily access general practitioners or social workers.^{25–27,31}

Differences in attitudes and social acceptance of people with mental illness between countries are issues more complicated than can be attributed to knowledge. Haraguchi *et al.*¹⁹ suggested that the reason for keeping a greater social distance from those with mental illness observed in China might be associated with contact with untreated schizophrenic patients. This idea on the impact of contact with untreated people with mental illness aligns with the findings from the recent studies in Western countries.^{39,40}

On the other hand, Kurumatani *et al.*³¹ suggested that stronger stigmatizing attitudes towards schizophrenia in Japan compared to Taiwan come from the higher institutionalization rate of patients with schizophrenia in Japan and consequent limited contact with such patients in the community. The association between frequent contact with people with mental illness and positive attitudes towards people with mental illness were also suggested in a previous study.⁴¹ Institutionalization in Japan may have been sustained by a higher number of psychiatric beds per population compared with Western countries.⁷

In addition, less social rejection in Australia compared to Japan can be explained by implementation of national projects and campaigns to improve mental health services and tackle stigma against mental illness in Australia that began in 2001.⁴² Indeed, recent studies, not only in Australia but also in the UK, consistently reported that the national campaigns had positive effects on changing attitudes and behavior towards people with mental illness in the general public.^{42,43}

Further, the particular history and nature of Japanese culture may explain why Japanese people have often shown stigmatizing attitudes towards mental illness. Furnham and Muraio (2000) suggested that it had been a taboo to discuss mental illness in public, and that family members had been responsible for care of people with mental illness until very recent years.⁴⁴ Such public ignorance of mental illness may be related to strong mental-health-related stigma in Japan. Moreover, in the Japanese culture, it might be more socially acceptable to have a stigmatizing attitude towards mental illness based on *honne/tatemae*.^{45,46} *Honne* refers to real opinions and feelings, and *tatemae* refers to those that are publicly expressed. Japanese people have historically been hesitant to express their true feelings in public, and instead display opinions and behaviors that will be supported by the majority of the general public. They strongly prefer not to stand out as different from others. Therefore, we should take into account that answers from the Japanese respondents might have reflected response bias.

It is difficult to determine the primary reason why people in Japan often have more negative attitudes towards people with mental health problems than people in other countries. However, direct comparisons of attitudes towards people with mental illness between Japan and other countries have emphasized the importance of community care that provides opportunities to have contact with those in the community who have mental illness, as well as the launch of a national campaign to reduce mental-health-related stigma. Further comparative studies between Japan and China are required, considering the limited representativeness of the sample in the previous study.¹⁹ In addition, the statistical validity and reliability of the scales used in four comparative studies were not developed, although they appeared to employ the appropriate back translation method.^{25–27,31}

6. What interventions have been used to reduce the stigma of mental illness in Japan?

Even brief educational programs can improve attitudes towards mental illness, as well as the understanding of mental illness and efficacy of medication, although the long-term effect of education has not been examined.^{33,34} Tanaka *et al.*³³ recommended that educational programs address problems associated with long-term hospitalization, which would help participants understand that people with mental illness can live in their community. Future programs should emphasize that mental illness is not an individual's fault, and include talks by those with mental illness as well as interactions with them through recreation or collaborative activities.³³ An accepting attitude can be facilitated through positive contact experiences, whereas a stigmatizing attitude can be formed through negative contact experiences, such as exposure to socially deviant behavior.^{11,30,33}

Although no studies included in this review conducted an intervention involving social contact with people with mental illness or other effective strategies to lessen mental-health-related stigma, three systematic reviews comparing various types of interventions concluded that social contact with persons with mental illness produced more change in attribution of mental illness than education.^{47–49} On the other hand, there is little clear evidence for the effectiveness of interventions using video-based contact on reduction of mental-health-related stigma.¹¹ In addition, a systematic review that examined the effectiveness of hallucination simulation showed that simulated hallucinations had contradictory effects on stigma, increasing empathy, but also the desire for social distance.¹² We should exercise caution in using such materials to reduce mental-health-related stigma.

Limitations

There are several limitations of this study. First, because this narrative review represents studies from only two electronic databases, there might be relevant studies that were not included. Second, study selection from each database was conducted by only one researcher.

Recommendations for future study and intervention

There was no study that investigated discrimination against people with mental illness in Japan.

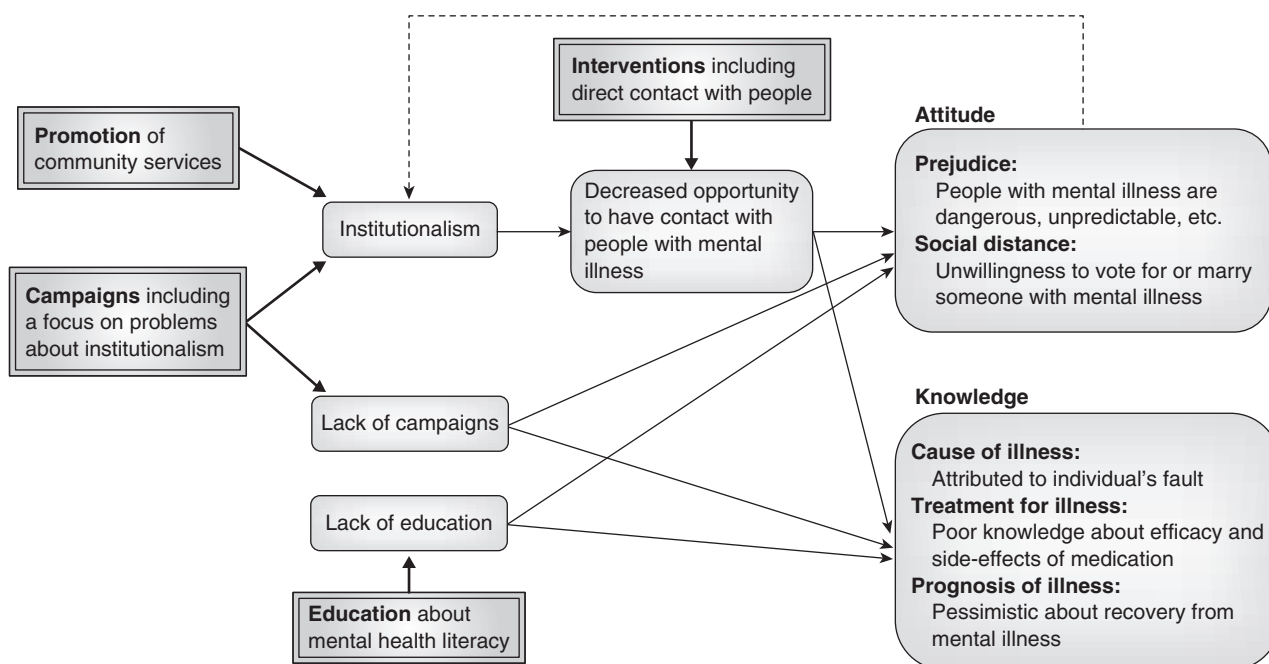


Figure 1. Current problems associated with the stigma of mental illness and expected interventions for these problems in Japan. □ Current problems and consequent stigma toward mental illness; □, expected interventions.

Implementation of such a study should be considered. We found only a few studies that compared mental-health-related stigma between Japan and Western countries. A comparison of Japan with other Western countries, including European countries and the USA, could provide more global findings in terms of cultural differences. We identified no randomized controlled trials on interventions in Japan to decrease the stigma of mental illness. Such trials are required in the future to establish the effectiveness of interventions. In addition, research on interventions involving direct contact with people with mental illness and campaigns to reduce stigma should be promoted (Fig. 1). It is also suggested that future direction for reducing mental-health-related stigma in Japan should focus on further de-institutionalization, as the progress of social inclusion is the primary aim for overcoming stigma in other countries.⁵⁰ Sharing the goal of reducing mental-health-related stigma would contribute not only to maintaining activities tackling against stigma of mental illness but also to developing community care.

CONCLUSION

In Japan, the general public's knowledge of mental illness was found to be relatively poor. Weakness of

personality was most often seen as the cause for mental illness, rather than biological factors, such as heritability. A substantial number of Japanese people do not recognize that people with mental illness can recover. In addition, many people have negative attitudes towards people with mental illness, considering them dangerous and unpredictable. Not surprisingly, the majority of the general public in Japan keeps greater social distance from individuals with mental illness in close relationships. Schizophrenia is more stigmatized than depression, and the severity of the illness increases the stigmatizing attitude toward it.

In terms of professionals' stigmatization, mental health staff who regularly and directly have contact with individuals with mental illness have less negative attitudes. This may be associated with their accumulation of contact with people who have recovered from mental illness. Compared to Taiwan and Australia, the stigma of mental illness was stronger in Japan, which might be due to institutionalism, the lack of implementation of national campaigns, and society's value of conformity. Although some education programs appeared to be effective in reducing mental-health-related stigma, we found key implications for future interventions. For example, both the

general public and professionals need to: (i) eliminate the misunderstanding that mental illness is caused by personal faults; (ii) focus on the adverse effects of institutionalism; (iii) stress the importance of community care; and (iv) offer direct social contact with people with mental illness.

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