Title of paper: Gender and mental health services: barriers to help seeking in Japan

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Introduction

The rapid changes to Japanese society after the Second World War have been unprecedented. Following a long period of economic growth, de-industrialisation is now under way which is leading to the rise of an information-oriented society. At the same time, family life is undergoing significant change as the declining birth rate, ageing population and increasing divorce rate, combined with greater labour force participation for women, is creating more diverse family types.

Women, especially middle-aged ones, are perhaps experiencing the greatest changes. Forced to realign their fundamental life course to the two-income family model, many Japanese middle-aged women made their life plans before these changes became apparent; consequently, they are often carrying out traditional female roles and have strong identities as housewives (Osawa 2002). Changing social roles often place some women under considerable pressure, which is often related to their gender roles and increasing numbers are complaining of depression, visits to psychiatrists are increasing and recently women’s mental health has been the subject of public discussion (Kawano 2005a).

In response to some of these issues the Japanese government was pressed to implement structural changes aimed at creating a gender-equal society. Following international pressure, the Equal Employment Opportunity Law (EEOL) was enacted in 1985 (Iwao 1993). EEOL was amended in 1999 and was also supported by the Basic Law for a Gender-Equal Society which aimed to ensure that women and men share responsibilities for both work and housework (Osawa 2002; Sugimoto 2003).

Simultaneously the Japanese model of social welfare system was under pressure. Based on the notion of the traditional family type of male breadwinner and female housewife, and reinforced by company welfare systems, this family-based system was no longer relevant to many families (Gottfried and O’Reilly 2002; Ida 2004). Under this situation men and women are encouraged to change their ideas about gender roles, but for middle-aged women who have already accepted more traditional roles, any changes in their life courses may potentially lead to problems (Iwakami 2003). Such situations can cause anxiety and depression, especially when family problems occur, but since these psychological conditions arise from the women’s social situations, successful treatment will need to incorporate both clinical and non-clinical approaches. Although much research has been carried out into the biological aspects of women’s vulnerability, less emphasis has been placed on how an effective support system can be introduced for women who are facing difficulties as a consequence of social problems (Kawano 2005a).
This paper argues that many mental health problems are associated with social and economic issues and that effective support needs to take account of women’s concerns. It focuses on the two major barriers against women seeking help from Japanese mental health services. These comprise internalised barriers which relate to Japanese women’s cultural mind-set, external barriers towards accessing both informal and formal support.

The discussion in this paper is mainly based on qualitative interviews which took place in 2002-2003 in Japan with women who experienced mental health difficulties and mental health professionals.

**Gender and mental health services**

**Mental health services for Japanese women**

In Japan, it is only relatively recently that the impact of mental health services on gender has begun to attract attention. Ueno et al. (2000) pointed out that gender issues only began to be discussed in Japan during the late 1980s, but this did not happen in psychiatry until the late 1990s. For instance, the first symposium organised by The Japanese Society of Psychiatry and Neurosis entitled, ‘Today’s issues about psychiatry and women’ only took place in 1998 and attracted few participants (Miyaji 1999). Issues relating to ‘mental health and women’ have therefore only recently been addressed. When The Mental Health Welfare Act was enforced in 1995, with its aim of promoting human rights advocacy and social participation for psychiatric patients, awareness of mental illness was low (Hayama 2004). Mentally ill patients were the subject of psychiatry, and once diagnosed they were thought not to have the ability to judge and consequently their human rights were ignored. In other words, gender issues were not considered because the mentally ill did not have any human rights. Therefore, before gender issues could be considered, it was first necessary to develop human rights for the mentally ill.

In Japan generally speaking, mental health problems are only treated according to their biological factors (WHO 2003). In order to support women’s mental well-being, it is therefore necessary for them to be able to access appropriate mental health services, which in turn must take into account the social model.

**Help seeking in urban areas**
In order to investigate how mental health support work, it is appropriate to consider two types – informal and formal. Informal support is defined as spontaneous behaviour in order to give benefit to others without purpose, money or gift (Matsui and Ura 1998). Informal support includes that given by the immediate family, relatives and friends, but not that provided by outside agencies. By contrast the formal model is generally treatment or counselling given by mental health professionals such as psychiatrists, clinical psychologists, and counsellors, but include both clinical and non-clinical environment (see Table 1).

Table 1: Coping resources and functions

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<th>A</th>
<th>B</th>
<th>Informal</th>
<th>Formal</th>
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<td>Personal</td>
<td>Family/Relatives/ Friends</td>
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<td>Physical</td>
<td>Health, Time, Knowledge</td>
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<td>Financial standing</td>
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<td>Experience</td>
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Note: A are Functional categories, B are Source of resources
Source: Based on Ishihara (2000)

Traditionally much support was received from the family, relatives and the local community in Japan. However, the contemporary Japanese family is now more isolated and this primary support network often no long exists. Therefore, support has begun to be transferred to a more formal secondary network with urban nuclear families being particularly affected by these changes (Mochizuki 1991).

**Barriers to help seeking**

**Internalised barriers to access**

1: Stigma

According to the WHO report (2001) which compared individuals in developed and
developing countries 2, 5, 15, and 25 years after the onset schizophrenia, the prognosis in developed countries was worse than in developing countries. Two years after the onset of schizophrenia, 40 per cent of patients had recovered in developing countries, while only 15 per cent had recovered in developed countries. The report concluded that cultural aspects of the illness were the most likely cause of this difference.

Sakamoto et al. (1998) investigated stigma in developed and developing cultures by comparing Tokyo with Bali, Indonesia. They supported the WHO’s conclusion, since in Tokyo people had a more negative image about the mentally ill than in Bali. In Bali, the mentally ill were understood to be under a spell and mental illness was not caused by the patients themselves, their family or their genes. Consequently, there was relatively less stigma than in Japan and convalescent occurred more easily in Bali. Prescribing drugs for schizophrenia patients was a third less than in Japan and the number of patients who required further treatment after leaving hospital was also lower. Stigma from mental illness therefore has its roots deep in culture and its absence helps patients to recover.

2: Self-criticism – influence of belief

Japanese culture is organised around a view of the self as an interdependent and mutually connected entity. Consequently, it does not highlight the clear separation of each individual; instead it promotes the fundamental connectedness among individuals within significant relationships. In this type of culture individuals may be motivated to adjust and fit themselves into meaningful social relationships. Kitayama et al (1997) point out that while American people are more likely to engage in self-enhancement, by contrast the Japanese are relatively prone to self-criticism. Contemporary Japanese culture reflects both the Buddhist ideal of compassion and the Confucian teaching of role obligation.

The women I interviewed tended to think that their problematic situations were created by themselves. In other words, they did not blame others, instead they have accepted their difficulties and in a sense were patient with their situations. They did not seek to sort their problems out actively, rather they just waited. The Japanese learn socialisation through family and group-centred norms, and women are more likely than men to fail to learn to think independently; instead they rely on their fathers or the elderly. Therefore, they develop a high degree of sensitivity towards what others expect them to be and to do. This attitude is passive and sometimes leads to self-hatred or a loss of self-confidence compared with men when they become adults. Hyde (1996:90) states that people who have a low expectation of success tend to avoid tackling
challenging tasks or they think that their given task is not gender-appropriate for them. In addition, the notion of *omoiyari* (extending caring, warm and sympathetic feelings to others in distress) is much elaborated in everyday customs and the Japanese language (Kitayama *et al* 1997). Furthermore, gender differences in aggressive behaviour have been found in all cultures (Hyde 1996:86). Therefore, it might be difficult for women to blame others and instead they blame themselves. Japanese mature personhood may be understood as occurring through the increasing integration of the individual within the social structure. Japanese women portray themselves as accommodating to duties and to the needs of others, rather than as independent decision-makers (Kondo 1990). This characteristic may affect women’s problem solving processes and when faced with a difficult family problem, they often tried to accept their situations.

3: Sense of control

Weisz *et al* (1984) compared sense of control between Japan and America societies, and they argue that the Japanese use secondary while the Americans use primary control. Secondary control does not use direct approaches, instead an individual makes adjustments to their reality. In this case, they do not change their reality, they change their wishes, purpose, attitude or interpretation. There are several types of secondary control, Japanese women often seem to use an interpretational control strategy in order to cope with their emotional difficulties. Interpretational control means that an individual understands their reality and finds out meanings from their situation. This tendency is called passive impression and describes the behaviour of women who are less autonomous in the context of individualistic culture, although they still wish to ensure a harmonious atmosphere. This is essentially different from Western countries.

Although information about clinical and non-clinical types of organisations is widely disseminated in Japan, the women interviewees tended not to make contact with them. They do not easily trust a non-related person and this cultural mind-set creates a barrier towards seeking outside help. Furthermore, women-sensitive counselling, in general, is kept at a distance because it can not adapt easily to Japanese culture.

*External barriers to formal support in the clinical environment*

1: Psychiatry and prejudice

The Japanese are increasingly turning to doctors with their mental health difficulties. They are stretching the boundaries of medical care, even though psychiatric care is stigmatised. In order to reduce the stigma associated with medical care, mental health professionals who deal with difficulties related to stress are divided into psychiatry and
psychosomatic internal medicine. Moreover, a variety of medical helpers, such as psychiatric social workers, psychiatric nurses, counsellors and clinical psychologists, have been involved in assisting, advising and caring for patients. However, women who have mental difficulties are reluctant to see mental health professionals since by applying a diagnosis to their troubles their unhappiness becomes medicalised.

Although it is necessary to examine the specific needs of female psychiatric patients in Japan, clinical psychology and psychiatry treat women through the male-dominated medical model (Kashiwagi 2000). Feminist therapy, which focuses on a gender perspective within a socio-cultural context, has not been fully accepted in Japanese medical models and therefore it operates outside of clinical psychology. Traditional biomedical models are more concerned with biological factors in the production of women’s illness and disease and with ways of improving diagnosis and treatment once illness and disease have occurred (Kawano 2005). Arata (2000:28) points out that when a patient takes a turn for the worse or problematic behaviour occurs, the medical model focuses more on treatment and less concern is given to the patient’s social background. Consequently, the medical model has limitations in meeting women’s needs. By contrast, the social model examines social background, economic situation, cultural aspects, environment and relationships and these can all be helpful in providing greater understanding of the patients’ problems. In order to support people who are facing mental difficulties it is necessary to consider both the medical and social models; integrating the two has great potential for discovering improvements to mental health services for women (Arata 2000:25).

The majority of interviewees had negative images of psychiatry and many were also prejudiced against it. This poor reputation was caused, in part by inadequate information about and knowledge of mental illness. As a result, barriers to access of mainstream mental health services were created. While such barriers may be evident within the general population, even those interviewees in my sample who had direct experience of the medical health service had similar prejudices against mental health professionals.

2: Drug treatment and its limitations

Although neuroses can be treated using medicine (drugs) or psychology (talking therapy), drug treatments comprise the main treatment in current Japanese psychiatric practice (Oshima and Kanata 1997). Psychotropic treatments, such as hypnotic and anti-anxiety drugs, anti-depressants and major tranquillisers are used extensively. Moreover, drug therapy is more likely to be approved than psychological treatment under the current national health insurance system. Therefore, women who hesitate to
be treated by drugs, as a result, will need to pay at their own expense if they undergo counselling or therapy (Ebana 2002:134). In general the interviewees distrusted and had doubts about psychiatric treatment, especially drug treatment for mental difficulties caused by stress. Many of the images of mental illness that the public have are the consequence of drug treatment rather than symptoms of any ‘mental illness’ (Crepaz-Keay 1996). Moreover, although women can be prescribed pills by their doctors, some did not take their medicine, they thought that pills would not solve their problems, and only give temporary relief. The significant problem with current prescribing practice is the lack of a focus and stated objectives (Crepaz-Keay 1996). Women in this sample, either used drugs as a temporary expedient or did not use them at all. In addition the women feared that they would become a crippled person when the drug was used. Women are not only concerned about psychiatric treatment they are also frightened about subsequently falling into even more serious difficulties

External barriers to formal support in a non-clinical setting

Non-clinical support is organised on the assumption that mental health difficulties are not only caused by individual problems, but that socio-structural factors, which are related to economic vulnerability, inequality in employment, and inaccessibility to primary care services, are important influences on mental health. Since the 1970s, increasing concern has been expressed about the relationship between environment and mental well-being. Increasing urbanisation disrupted human relationships and it is important to examine the psycho-social causes of this phenomenon. Caplan (1974) suggested that mental health support systems need not only be provided by mental health professionals, but also through informal support systems and consequently community support needs to be promoted. Indeed, when women need emotional support, they may turn for help to professionals for formal support, but often they are not their primary or first-line sources, since most people will first seek help from friends, relatives, neighbours, co-workers or even acquaintances (Garbarino 1983).

Non-clinical support for mental health care aims to facilitate easy access to non-stigmatising services and has been sensitive to women’s needs, it offers support in the form of listening and encouragement and helps to resolve their conflicts. On the other hand, it will be difficult for the sector to provide for acutely ill women, but they can connect women to other support organisations. However, the nature of these organisations is diverse and service providers working for them are not required to have specific qualifications; therefore, the quality of support is dependent on the individual
organisations. In order to assist in developing these organisations, it is important to understand their problems.

Two main issues emerged concerning how non-clinical mental health support can be improved. The first relates to training and education. Four out of the five organisations that I visited ran their own training courses. Those working for DV volunteers had to attend courses before being able to work and applicants needed to attend eight classes run by specialists in order to understand issues relating to gender and DV. While this organisation gave successful, comprehensive support, psychologists, social workers, researchers and volunteers provided support in different ways, and their methods have taken a long time to develop fully. The feminist therapy group also ran their own training courses to train therapists, who were not required to hold clinical qualifications, as feminist counsellors. Likewise, the voluntary group for the families of mentally ill patients provided a series of 25 training classes for their volunteers, while ‘Sanctuary’ also ran training courses for suitable volunteers and institutional service providers. Those attending these courses were qualified mental health service providers or students of psychology or social work, but all these groups did not require their workers and volunteers to have specific mental health qualifications. Overall the quality of the services provided was dependent on the organisation or the individuals who worked there, and a good service was not always given. There was however, great potential for high quality, targeted services to be provided.

The second issue concerns finance. In Japan, voluntary groups are different from non-profit organisations in that they are run entirely by volunteers and this creates a limit to their activities. While ‘DV volunteers’ received a local government subsidy, some groups had to rely only on donations to run their small counselling rooms. Sanctuary, a private organisation, gave courses and professional training courses about gender-sensitive support for local government in order to generate income. However, in general voluntary organisations or private counselling rooms experienced financial problems. I went to the Tokyo Voluntary Centre in order to obtain leaflets about support groups for women. There were more than ten non-profit organisations registered, I collected three leaflets and called these groups. I also sent faxes requesting an interview. However, none replied and I was also not able to talk to them by phone. The reason was probably related to their limited working time. They receive telephone calls from women who needed help, but only for a few days a week at specific times, for example between one and four pm. I tried to call at other times, but no one answered. The possibility was that these were small organisations that could not afford to reply to me – they may have not had enough money, time or volunteers. It was therefore impossible to contact them.
and many women must have had similar experiences. These problems are related to finance since most counsellors or therapists work part-time or as volunteers, and consequently, they are likely to have another full- or part-time job. As a result, the number of volunteers working for such organisations is limited.

The non-clinical model has much potential for providing gender-sensitive support, but it is at an early stage of development. It is therefore necessary to provide financial support to those institutions applying the psycho-social model of mental health care and this will allow them to develop their support skills and knowledge base.

References


