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A Comparative Study of Self-Efficacy for Social Participation of People with Mental Illness in Japan and China

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A B S T R A C T

Self-efficacy for social participation (SESP) of people with mental illness was examined in urban areas of Japan and China. The subjects were 266 people (140 Japanese, 126 Chinese) with mental illness who were living in their local community. Our SESP scale (SESP27) and the Rosenberg Self-Esteem Scale, Norbeck Social Support Questionnaire (NSSQ), Sense of Coherence measure (SOC13), General Health Questionnaire (GHQ12), and a self-administered questionnaire related to living conditions were used for data collection. Data were analyzed descriptively, correlations between scales were examined, and multiple regression analysis was performed by country. The results showed that annual income was related to SESP in Japan and China. Therefore, improvement of welfare and employment support for economic independence is likely to improve SESP of people with mental illness in both countries. In addition, SESP in people with mental illness is affected by self-esteem in Japan, and coping skills such as improvement of life functions in China. Thus, SESP is affected differently by the social, cultural and institutional characteristics of each country.

In recent years, the average length of stay of patients with mental disorders admitted to psychiatric hospital in Japan is about 300 days, which is much longer than that in other countries. Settling in the community is difficult following discharge after long-term psychiatric care, and there is a need to promote social participation of people with mental illness. This requires provision of mental health services and promotion of the personal confidence of people with mental illness (McCay & Seeman, 1998; McDermott, 1995; Waghorn, Chant, & King, 2005; Wing & Morris, 1989). Kleim et al. (2008) noted that the negative influence of the lack of understanding of society and self-stigma predicts low self-efficacy for mentally disabled people, and often these people distance themselves from society to avoid prejudice, which also obstructs their recovery. Establishment of community life while stabilizing psychiatric symptoms requires recovery of confidence through both environmental improvement, such as social support, and disease management skills. Social participation of people with mental illness is likely to be improved by strengthening outcome expectations and increasing self-efficacy beliefs. Contextual factors such as sociocultural characteristics surrounding the individual, the medical environment, and human relations are also likely to influence social participation. Knowledge of self-efficacy beliefs for specific tasks could enable a more precise match of support to assistance needs, reducing the risk of task refusal or negative performance experiences.

Bandura (1977) defined self-efficacy as the conviction that one can successfully execute behavior required to produce outcomes, and described four main sources that influence development and maintenance of a person's self-efficacy: (a) performance accomplishments or mastery experiences; (b) vicarious experiences; (c) verbal or social persuasion; and (d) physiological, or somatic and emotional, states. Self-efficacy has been studied in individuals with mental illness (e.g. Carpinello, Knight, Markowitz, & Pease, 2000; McCay & Seeman, 1998; McDermott, 1995; Okawa et al. 2001; Otsuka, Amagai, and Shibata, 2002; Waghorn et al., 2005), and Waghorn et al. developed a new measure of work-related self-efficacy related to task performance and subsequent progress in psychiatric vocational rehabilitation. Knowledge of self-efficacy for specific tasks about work may reduce the risk of task refusal or negative performance experiences.

Recovery needs in community life do not apply only to work for people with mental disabilities. Knowledge of self-efficacy needs for social participation and support of persons with mental disabilities are also important for reduction of the risk of refusal and failure in social participation. Therefore, in a previous study, we developed a scale that can be used to measure the self-efficacy for social participation (SESP) of people with mental illness (Amagai, Suzuki, Shibata, & Tsai, 2012; Hiroshima & Amagai, 2013). This scale permits evaluation of changes in SESP. SESP is likely to be affected by the personal characteristics of people with mental

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illness, the sociocultural characteristics of a country, the mental health medical welfare system and nursing system, and environmental factors such as human relationships. To understand the characteristics of SESP and related factors in Japan objectively, there is a need for comparison with other countries. Therefore, the present study was performed to examine the characteristics of SESP and associated factors in Japan and China, which are close culturally and geographically.

The study was designed to define areas of support needed to foster SESP and to identify cultural and ethnic similarities and differences in factors related to SESP in people with mental illness. The comparison between Japan and China may also reveal different trends that will allow specific approaches to promotion of social participation by the mental health services in each country. Specifically, this study provides perspectives on factor-related success expectation for social participation or reduced risk of failure in society participation for persons with mental disabilities in each country, along with assistance needs and self-evaluation patterns. The results provide the basis for improved strategies for promotion of community life in psychiatric mental nursing practice.

METHODS

Design

This study utilized a descriptive cross-sectional study by a self-report questionnaire.

Setting and Participants

The participants were community-dwelling individuals recruited from hospitals and rehabilitation facilities in metropolitan areas in Japan and China who met the following criteria: (a) mental illness and (b) age over 18 years. An anonymous self-reported questionnaire was distributed to 266 potential participants (140 Japanese, 126 Chinese) and data were ultimately obtained from 139 people in Japan (89 men, 50 women) of average age 38.3 years, and 117 people in China (55 men, 62 women) of average age 36.0 years. The collection rate was 96.2%.

Measurement Instruments

Data were collected on the characteristics of the participants and from five self-reported questionnaires: Self-efficacy for Social Participation scale (SESP; Amagai et al., 2012), Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), NSSQ (Norbeck, Lindsey, & Carrieri, 1981), 13-item Sense of Coherence Scale (SOC; Antonovsky, 1987), and General Mental Health Questionnaire (GHQ12; Goldberg & Hillier, 1979).

The original version of the Self-efficacy for Social Participation Scale (SESP) for people with mental illness (SESP27) was used to measure the level of SESP in the subjects. The reliability and validity of the Japanese version of this scale have been confirmed (Amagai et al., 2012). The scale includes 27 items and 4 subscales: "trust in social self" (8 items), "self-management" (7 items), "social adaptability" (7 items), and "mutual support" (5 items). Subjects evaluate their confidence with regard to each item on a four-point scale from 3 ("I have confidence") to 0 ("no confidence"). Higher scores show greater confidence in social participation. Development of a Chinese version of SESP27 was performed by four researchers in nursing and long-term living by translation from Japanese to Chinese and subsequent back translation. We then held an expert meeting to determine if the Chinese version of SESP27 is appropriate and whether the contents match the circumstances of Chinese people with mental illness to ensure the surface validity and content validity, respectively. The validity of the Chinese version of SESP27 was tested in a preliminary study in several outpatients in China to confirm the appropriateness of the questions. Calculation of Cronbach's alpha was used to show the reliability of the trust in social self, self-management, social adaptability, and mutual support subscales and SESP total scores, and values of 0.86, 0.86, 0.90, 0.86 and 0.96, respectively, were obtained.

The RSES (Inoue, 1992; Rosenberg, 1965) measures the strength of a person's confidence in self-worth and abilities. The scale consists of 10 items rated on a 4-point Likert scale from 0 (strongly disagree) to 3 (strongly agree), with a higher total score indicating higher self-esteem (range = 0–40). Japanese and Chinese versions of the RSES were used in the study. The Japanese version of the RSES has been shown to have good validity and reliability (Inoue, 1992). The psychometric properties of the Chinese version of the RSES (Yang & Wang, 2007) have also been tested and this scale is widely used. In this study, the Cronbach's alpha for the RSES was 0.79.

The NSSQ (Norbeck et al., 1981) is a valid and reliable measure of total network support that consists of two sections. The first section asks respondents to list the people who are important to them or provide them with support. The second section asks respondents to rate, on a 4-point scale from 0 = satisfied to 4 = dissatisfied, each of the people listed in the first section in terms of five dimensions of social support: affect, affirmation, aid, duration of relationships, and frequency of contacts. In this study, we used the Japanese version of the NSSQ (Maeda, Hata, & Hata, 2003) to identify the number of people providing support to respondents. In the Chinese survey in this study, the Cronbach's alpha for the NSSQ was 0.53.

The SOC Scale (Antonovsky, 1987; Togari & Yamazaki, 2005) measures the ability to cope with stress. In this study, we used the 13-item Japanese short version of the SOC (SOC13), which consists of 13 items graded on a 7-point Likert scale (1–7 points), with higher scores showing increased coping with stress (range = 7–91). The validity and reliability of this questionnaire have also been confirmed (Togari & Yamazaki, 2005). In the Chinese survey in this study, the Cronbach's alpha for the SOC was 0.80.

The GHQ12 (Goldberg & Hillier, 1979) is a self-reported measure of mental health state in the past 2 to 3 weeks. The scale consists of 12 items rated on a 4-point Likert scale from 0 (much less than usual) to 3 (much more than usual). Lower scores indicate better mental health (range = 0–36). We used the Japanese version of the GHQ12 (Niiro & Mori, 2001), which has been shown to have good validity and reliability in a survey of Japanese people. We also used the Chinese version of the GHQ12 (Yang, Huang, & Wu, 2003), which has also been tested and is widely used. In the Chinese survey in this study, the Cronbach's alpha for the GHQ was 0.90.

The approval of the respective scale developers was obtained before use of each scale. We also determined the degree of satisfaction of the subjects with their lives and their goals in life, based on an original scale on which participants were asked to rate their life satisfaction. The scale consists of 5 items (such as "How satisfied are you with your current life overall?") rated on a 4-point Likert scale from 0 = very dissatisfied to 3 = very satisfied. A higher score indicates a higher level of life satisfaction (range = 0–15). In addition, information on gender, age, race, religion, diagnosis, hospitalization history, disease duration, housing conditions, economic conditions, current use of social psychological services, and current employment situation was obtained for all subjects.

Procedures and Data Collection

Since people with mental illness generally have greater vulnerability to stress than healthy people, informed consent was obtained by the facilities that recruited the subjects, after the purpose of the research and ethical issues were explained to the subjects at these facilities. We note that we also had strong interactions with all of these facilities. In describing the study, the staff at each research facility were careful to avoid giving the subject the sense that participation was compulsory. People who agreed to participate in the study were asked to sign a consent form. Each questionnaire was mainly conducted as a self-administered survey, with subjects returning the survey to a specified collection box. Collected questionnaires were then placed in a locked