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The Coping Process of Japanese Parents Who Experience Violence From Adult Children With Schizophrenia

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ABSTRACT

With the acceleration of deinstitutionalization might increase families' chances of suffering violence by patients. This study clarified parents' coping processes with violence experienced from patients with schizophrenia. The grounded theory approach was used, and 26 parents were interviewed. We identified a four-stage coping process: (1) hope for treatment, (2) living with violence, (3) trying to solve violence, and (4) last solution for violence. This coping process had two illness-related characteristics: (1) a process of coping with two main stressful events (the illness and violence), and (2) the need for long-term appraisal of violence because of its unclear causes.

Introduction

Violent crimes committed by patients with serious mental illness (SMI) are relatively rare events (Angermeyer, 2000), although they are higher than among the general population (Walsh, Buchanan, & Fahy, 2002). Furthermore, criminal records underestimate the prevalence of violence (Wehring & Carpenter, 2011) because physical violence by patients with SMI tends to not influence the general public, but rather family members and friends (Arboleda-Florez, Holley, & Crisanti, 1998; Imai, Hayashi, Shiina, Sakikawa, & Igarashi, 2014; Steadman et al., 1998). Indeed, in Japan, the rate of physical violence toward any family member by patients with schizophrenia since onset is approximately 60%, while it is less 10% for non-family-members (Kageyama et al., 2015). This high rate of violence may be due to acceleration of deinstitutionalization, thus causing patients to live with parents or family, and lack of sufficient community treatment services. Parents of patients with SMI who experience violence are often more distressed (Kageyama, Solomon, & Yokoyama, 2016), likely due to lack of coping; this suggests the necessity of identifying appropriate coping methods.

Family caregiving in Japan

Japan has long had the highest psychiatric bed ratio among developed nations (Organisation for Economic Co-operation and Development, 2014). While new government policies have helped reduce unnecessarily long hospitalization periods, community resources remain insufficient for discharged patients (Oshima, Mino, & Inomata, 2007). In Japan, approximately 80% (Ministry of Health Labour and Welfare, 2013) of patients live with family members and require family daily support, including medication monitoring (Zenkaren, 2006). A major difficulty faced by family caregivers is insufficient services during crisis: nearly 90% of family caregivers desire outreach crisis intervention for patients (Minna-Net, 2010). Acceleration of deinstitutionalization thus creates a greater care burden for families.

Family violence by patients with SMI

We focused on physical violence toward family members because of its potential for serious harm. Physical violence, according to literature on intimate partner violence (Breiding, Basile, Smith, Black, & Mahendra, 2015), is defined as the use of physical force with the potential for causing death, disability, injury, or harm. Family violence by patients with SMI is common in Japan and the US, with an estimated lifetime prevalence of 40% (Labrum & Solomon, 2015). Such violence is rarely studied because family violence is taboo and fears of further stigmatizing this population exist (Solomon, Cavanaugh, & Gelles, 2005). Limited studies regarding family violence by persons with SMI have revealed the following high-risk factors: young age, low education

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and low employment, poor medication compliance, high number of hospitalizations, severe threat/control-override (TCO) symptoms, alcohol or drug addiction, low family household income, families' cohabitation with patient, and money management by family members (Chan, 2008; Elbogen, Swanson, Swartz, & Van Dorn, 2005; Swan & Lavitt, 1988). However, these quantitative studies provide limited insight into the topic's complexity.

Coping process by family members of patients with SMI

Qualitative studies can provide greater insight into the coping mechanisms of families who have experienced violence by a patient with SMI (Solomon et al., 2005). Lazarus (1993) defined coping from a process perspective as ongoing cognitive and behavioral efforts to manage psychological stress (such as that produced by violence). There is no singular coping pattern; each stressful event has particular coping patterns that are effective (Lazarus & Folkman, 1984).

Some qualitative research already exists on family violence undertaken by those with SMI, including elder abuse in Israel (Avieli, Smeloy, & Band-Winterstein, 2015; Band-Winterstein, Avieli, & Smeloy, 2015; Band-Winterstein, Smeloy, & Avieli, 2014), choice of parents living with their ill children in the US (Copeland & Heilemann, 2011), and descriptions of parents' experiences about violence undertaken by patients with schizophrenia (Hsu & Tu, 2014). Hsu and Tu (2014) identified that management of violence, such as using medication, is one coping strategy. However, these previous studies did not provide specific information on how parents cope with violence.

Violence by patients with schizophrenia has been described as a part of the crisis stage of the caring process in Japan (Kawazoe, 2007) and other countries (Mohr & Regan-Kubinski, 2001; Ngqoboka, Gmeiner, & Poggenpoel, 1999; Tuck, du Mont, Evans, & Shupe, 1997). However, these studies focused on patients' general experiences, rather than specifically on family violence. As the coping process is specific to each situation (Lazarus & Folkman, 1984), identifying the most helpful coping patterns for violence would require a study focusing only on violence in this population. Thus, we clarified parents' process of coping with violence by their adult child with schizophrenia. This has important implications for the discharge planning process and the prevention of family violence by, for instance, support provided by nurses in clinical and community practice settings.

Methods

The grounded theory approach (Strauss & Corbin, 1998) was used for this study because it helps to develop theories as well as identify a series of events and how these change over time (Bluff, 2005).

Sampling and data collection

Parents of patients with schizophrenia who had experienced violence were interviewed. It was difficult to recruit interviewees because family violence is taboo in Japan. Therefore, we asked five acquaintances (family recruiters) from family self-help groups in three prefectures around Tokyo to help recruit interviewees. The theoretical sampling was conducted for almost two years. In total, 26 parents (including two pairs of fathers and mothers) from 24 households were interviewed.

Each possible interviewee could select individual or group interviews with members from the same support group. Only two parents selected individual interviews; the other 24 parents selected group interviews with acquaintances. Eight group interviews were conducted. Each interview ran for 1.5 (individual interview) to 3 h. The family recruiter joined each group interview as an observer at the interviewees' request. Interviews were conducted by the first and second authors, who had PhDs in nursing and considerable experience in qualitative research.

First, we asked each interviewee the following questions: “When and how did the violence from the patients start?” “How have you coped with the violence?” and (only interviewees who were no longer experiencing violence) “How do you feel after being released from the violence?” When interviewees did not provide details of the violence, we asked about them, including the type and frequencies, in what situations the violence occurred, and what parents felt, thought, and did in response to the violence. Next, to all interviewees, we asked further questions to obtain a greater level of detail regarding their individual experiences. The questions focused on why they changed their behavior to deal with violence or not, the triggers of these changes, and the results of the changes. Additionally, we asked questions to clarify any results from our analysis up until that point.

Data analysis

We used a constant comparative analysis (Strauss & Corbin, 1998). The interview data were recorded and transcribed. We used MAXQDA, which is popular qualitative data analysis software. The first author conducted all the analyses and discussed and confirmed the results with the co-authors. First, we came to understand the parents' experiences as a whole by reading the transcripts repeatedly. Next, we analyzed the data by comparing them. The transcripts were processed line-by-line using open coding and labeling of content related to the following research question: “How did the parents cope with the violence?” The coding was compared for similarities and differences, and similar content was categorized. The properties and dimensions of the categories were developed. Connections were made between categories using their properties and dimensions to perform axial coding. The following properties were particularly important: efficacy of medication, psychiatric symptoms, illness stage, parents' emotion toward violence and patients, help-seeking behavior, and support for parents by practitioners. The stages are often described by examining the sequences or shifts in actions/interactions. When we identified the actions/interactions that served as a bridge to subsequent actions/interactions along with the conditions affecting them, and their shifts to the next actions/interactions, we considered these shifts as a sequence of stages.

We conducted the theoretical sampling and constant comparative data analysis simultaneously. Initially, we developed numerous codes and categories from the wide variety of parents interviewed who had experienced different types of violence or coped in different ways. Later on, we expanded our data on important categories or categories that lacked clarity in order to develop our understanding of the coping process. Using numerous categories developed by axial coding, we conducted selective coding. We constructed the categories repeatedly by examining the sequences or shifts in actions/interactions using diagrams and storylines.

To ensure the study's rigor (Lincoln & Guba, 1985), we requested that all interviewees endorse by mail the results from the perspective of typical parents. A total of 23 parents agreed to the results except for three parents who had withdrawn from the family groups, thus we could not contact them.

Ethical considerations

This study was approved by the research ethics committee, the Faculty of Medicine, the University of Tokyo (February 24th, 2014; No. 10415). The interviewees were informed verbally and in writing of the study's purpose, their right to refuse to participate, and the voluntary nature of their participation. The interviewees consented to participate in writing.