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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.

Keywords: mental health; domestic violence; schizophrenia; coping process

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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 et al., 2002). Furthermore, criminal records underestimates the prevalence of violence (Wehring and Carpenter, 2011) because physical violence by patients with SMI tends to not influence the general public, but rather family members and friends (Arboleda-Florez et al., 1998; Steadman et al., 1998; Imai et al., 2014). 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 et al., 2016b), 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 (Organization 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 et al., 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 et al., 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 and Solomon, 2015). Such violence is rarely studied because family violence is taboo and fears of further stigmatizing this population exist (Solomon et al., 2005). Limited studies regarding family violence by persons with SMI have revealed the following high-risk factors: young age, low education 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 (Swan and Lavitt, 1988; Elbogen et al., 2005; Chan, 2008). 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 and Folkman, 1984).

Some qualitative research already exists on family violence undertaken by those with SMI, including elder abuse in Israel (Band-Winterstein et al., 2014, 2015; Avieli et al., 2015), choice of parents living with their ill children in the US (Copeland and Heilemann, 2011), and descriptions of parents' experiences about violence undertaken by patients with schizophrenia (Hsu and 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 (Tuck et al., 1997;

Ngqoboka et al., 1999; Mohr and Regan-Kubinski, 2001). However, these studies focused on patients' general experiences, rather than specifically on family violence. As the coping process is specific to each situation (Lazarus and 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 and 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 and 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.

Results

Demographic Characteristics of Parents and Their Violence Experiences

Of the 26 interviewees, 18 were mothers and 8 were fathers. Average age was 70.8 years old (range: 50–83). The 24 patients with schizophrenia comprised 16 males and 8

females. Their average age was 39.6 years old (range: 20–50); average number of years since the onset of schizophrenia was 19.7 years old (range: 12–29). Of the interviewees, two experienced only property destruction (#17, #24); the remaining 24 experienced direct physical violence. Of these, two experienced it only once (#16, #21), two experienced it several times over half a year (#23) or two years (#25), and 20 experienced it numerous times over several years. Violence typically included pushing, punching, or kicking, although 12 parents were threatened with kitchen knives. Violence occasionally caused severe injury, with three parents experiencing broken limbs (#5, #6, #13).

Storyline

Parents began experiencing violence at the onset of their child's illness. Most parents considered the violence a result of the illness at first, and began to “hope for treatment” (first stage), believing that the violence would disappear if the patients received treatment. This did not necessarily occur, however. Parents then tried to understand the characteristics and causes of violence while “living with violence” (second stage). The home was a closed environment socially, and they did not disclose the violence due to feelings of shame, fear, guilt, responsibility, and love. Parents participated in family self-help groups or attended family education, which sometimes stopped the violence; however, most parents' situation did not change. Some parents eventually realized that the problem was the violence itself, and sought help from healthcare practitioners in “trying to solve

violence” (third stage). Some parents were released from the violence through effective support, but it was overall difficult for parents to obtain effective solutions. Families experiencing long-term violence typically broke apart—parents realized that the “last solution for violence” (fourth stage) was separation and independent living, which release them from the violence. The entire coping process is shown in Figure 1.

[Insert Figure 1 about here]

Stage 1. Hope for Treatment

Embarrassment about violence and beginning treatment. In many cases, the first violence happened around the illness’ onset. One ill child said, “You talked bad about me” (#12), kicking a door, and creating a hole. One parent thought, “He is strange; not normal” (#4) and took him to a psychiatric hospital. Although all parents sought treatment for their children, only three were released from violence after the first hospitalization (#23, 25) or medication (#17).

Illness is the problem. One mother said, “I experienced numerous stressful events after the onset of illness. The violence is not a special event” (#1). Parents were shocked that their child was not the same as before; therefore, they considered the illness the main problem, with violence being only part of the picture. Of the 26 parents, 24 started at the first stage, three were released from their violence at this stage, and 21 proceeded to the second stage.

Stage 2. Living with Violence

Even after adult children started treatment, the violence often did not cease. One parent said, “This illness is serious” (#8). Parents tried to understand the characteristics and causes of the violence.

Seeking the characteristics of violence. Parents sought these characteristics from their own experiences of violence. The following categories emerged: occurred suddenly, intense, and back to calm after violence. Regarding “occurred suddenly,” one parent said, “(At midnight) he opened our bedroom door suddenly and committed violence” (#6). Regarding “intense,” the violence seemed uncontrollable. One parent said, “I was beaten 20 or 30 times by him, whose face was like a devil, and I was bloodied” (#5). Some parents were actually injured: “two or three ribs were cracked by kicking” (#6). Some patients used knives to threaten lives and “swung (it) in the air” (#14). “Back to calm after violence” occurred after the patients had committed intense violence; indeed, patients often apologized, “I was not me at that time” (#2) and “Sorry about that” (#6). This characteristic made parents feel relieved and not act take further action to stop the violence.

Seeking causes of the violence. Most parents did not ask the patients directly about the reasons for the violence; instead, parents inferred the reasons based on their experiences. It was difficult to find reasons. Parents inferred four causes: worsened condition, communication, high stress, and control. Regarding “worsened condition,” parents said,

“Violence happens concurrently with the wave of the condition every two or three months”

(#1). Violence was sometimes obviously caused by delusion: “I heard from his psychiatrist that the reason for the violence was that I had made his girlfriend pregnant. It was not true, so I was surprised” (#5). Regarding “communication,” regular conversations sometimes caused violence; one patient committed violence against his mother because “I could not accept your ways of talking. It hurt my heart” (#2). Regarding “high stress,” even when the adult children took medication as instructed, those who stayed at home almost always without using rehabilitation services seemed to commit violence; one parent said, “Staying home through the year increases his frustration” (#3). Some patients blamed their parents, “Why did you hospitalize me?” (#18) and repeated the violence. Regarding “control,” some patients seemed to be violent to control their parents. “When I went to rescue my husband from violence by him, he said ‘I tested you,’ and ceased his violence” (#6).

In many cases, causes of violence were viewed as overlapping; a specific cause could not be identified. Such difficulties in identifying causes lead to extended violence over a long period.

Living with violence as little as possible. Violence continued and repeated over many years. Living under extreme tension was a usual state. Parents felt “uncertain about the future” (#14) and did not see when the violence would end. Parents’ coping with the violence was like a “cat-and-mouse game” (#1) because they learned how to behave

through trial and error. Parents tried to avoid any stimulation. Most parents “buried kitchen knives or hammers” (#5). Some parents prepared a place to escape to by “renting another apartment” (#3) and “making a shed in the garden” (#14). When the situation worsened, some parents “slept not wearing nightwear, but outdoor clothes” (#6) to escape quickly from home. When violence occurred, parents escaped by “staying at a hotel or relative’s home” (#14) or merely tolerated it, saying “[I must] forgive, [I must] forgive” (#3). One father said, “If I resisted him, he paid me back a hundred times” (#3). One mother looked back and said, “Twenty years passed in managing the violence” (#2).

Undisclosed violence within the home. Violence created complex feelings in the parents, including shame, fear, guilt, responsibility, and love. These feelings prevented them from disclosing the violence they were experiencing.

Regarding “shame,” one mother visited a physician due to internal bleeding in her face; however, “I did not say the true reason to the physician because of shame. I said that I fell down the stairs” (#2). Violence was a “shame for many families” (#16). Regarding “guilt,” one mother said, “I made her sick so I endured her violence” (#9); in this way, some parents sacrificed themselves because of feelings of guilt. Regarding “responsibility,” some parents stayed home all day every day to monitor their children. One father said, “I have to commit hara-kiri if my son swings knives in a public space” (#5). Regarding “fear,” one father said, “(I) scolded my son due to violence against my wife; then, my son got a kitchen

knife” (#3); as such, most parents felt that they could not resist the violence because they feared escalating the violence. Regarding “love,” parents concealed the violence because “I did not want my son to be a criminal” (#4); therefore, some parents did not visit physicians, even when injured. Some parents hesitated to call police officers for several years because their love for their children. Overall, violence went undisclosed because of these feelings.

Efforts to change themselves. Parents participated in family self-help groups to obtain information and support regarding mental illness, but not violence. Some parents learned about the illness and how to communicate with their children through family education programs run by family groups. As a result, their communication changed; for example, “I got angry over small things before learning” (#24). Two parents who experienced only mild violence (#12, #24) reported that the violence gradually ceased because of these changes in communication.

Stage 3. Trying to Solve Violence

One father remained in the second stage, saying, “The situation has not changed for a long time. I wonder if I should change something” (#22). However, other parents began seeking help from practitioners, motivated by fear (“I felt threatened when my daughter broke a glass cup and entered my room holding it, and so I called the police for the first time” [#9]) or love (“I had not wanted to call the police but changed my mind. It is important for my son that he recognize what he done. So I finally called police” [#4]). In

other words, love and fear forced them to resolve the violence outside of the home as much as it prevented them from disclosing it.

Gaining effective support. A pair of parents (#2, #3) sought help and were able to bring practitioners into their home for support. One mother said, “He had withdrawn within the home and committed violence against me for 20 years since dropping out of middle school. He has been supported by home visiting nurses and social workers. The violence has ceased for me” (#2). One parent consulted public health center staff and said that the staff told them, “Violence might be repetitive. I recommend that your son undergo rehabilitation as preparation for independent living” (#18). Through these recommendations and support, two parents (#13, #18) were released from their violence.

Help seeking and failure. However, even if parents overcame their complex feelings and sought help, it was difficult to obtain effective solutions. Some parents said that they were told by psychiatrists that the “Violence was caused by the parents” (#9) and to “Tolerate mild violence” (#12). One father was told by his son “[I will] kill you,” so he consulted public health center staff; however, the staff told him, “There is no service for taking such patients to the hospital” (#7). Most parents considered the police as a better solution than public health centers, psychiatrists, or other mental health agencies. One father said, “Calling police is the only solution for violence” (#13). After failing to resolve the

violence, parents returned to the second stage and once again did not disclose the violence.

In this way, participants vacillated between the second and third stages.

Problem is violence. Two mothers (#16, #21) recognized that the violence was a serious problem even if it only occurred once. Because their adult children had been undergoing treatment for a long time, two parents recognized that the violence was the problem, not the illness. One mother, who was overwhelmed by strong fear because of the violence that occurred, escaped her ill son and asked for support from practitioners; she said, “I cannot live with him because of my fear” (#21). The other mother said to her son, “Violence is not acceptable” (#16). These two mothers both began from the third stage and were thereafter released from violence.

Thus, of the 21 parents who proceeded to the second stage, 4 were released from violence by the third stage, while 7 parents remained in either the second or third stage; the remaining 10 proceeded to the fourth stage.

Stage 4. Last Solution for Violence

Final decision. Many families, after repeated, long-term violence, were broken up. Parents noted “All family members had damage to their mental health” (#14) and “My weight decreased by 28 pounds” (#26). Siblings also experienced damaged health. In some cases, family members left home because of the violence: “Father stayed away after experiencing violence once or twice” (#4) and “Older sisters left our home” (#15). Some

exhausted parents thought about death: “I hoped for my son’s death. I was exhausted” (#4).

Some parents realized the seriousness of this situation, which led them to finally change their minds, thinking, “If a serious incident happened at home, it would be too late to act” (#14). They recognized that the situation was so serious that a family member could die at any moment.

Separation and independent living. These parents selected separation from their adult children as their final, highly painful decision. One father said, “If the violence was repeated, I would die” (#5), while a mother said, “I want to live with my daughter but cannot because of my fear of violence” (#10). Feelings of love were expressed by one father: “I want my son to live independently in the future because I could die at any moment because of my age” (#13). For male patients, such discussions regarding independent living were often conducted with the fathers. One mother said, “My husband talked enough with my son; after that, he decided to live independently in the future” (#1). In choosing to live independently, the parents were released from their violence. All, however, visited the children’s home regularly.

Discussion

Parents’ process of coping with violence by adult children with schizophrenia

According to the transactional theory of stress and coping (Lazarus and Folkman, 1984), when people experience stress, they appraise the significance of an event in light of that stress (primary appraisal) and, upon recognizing that event as stressful, conceive of coping strategies for dealing with their stress (secondary appraisal). Based on their secondary appraisal, people engage in the use of problem-focused or emotion-focused coping, and reappraise their chosen strategy as additional information arrives. This accords with the coping process in this study—in the first stage (“hope for treatment”), parents recognized the onset of illness as a significant event, and therefore, as a coping method, sought treatment for the illness rather than the violence. This released some parents, but not most, from the violence. Thus, in the second stage (“living with violence ”), parents engaged in long-term appraisal of the violence and responded with emotion-focused coping (i.e., avoidance or minimization) to decrease their psychological distress, rather than attempting to solve the problem (Lazarus and Folkman, 1984). In the third stage (“trying to solve violence”), parents reappraised their chosen coping strategies and altered them to a more problem-focused strategy (i.e., changing the situation itself) (Lazarus and Folkman, 1984) focused on the violence rather than the illness. Thus, one of the main characteristics of the coping process for violence by patients with SMI is that there are essentially two stages of coping, which target two different stressful events: the illness and the violence. This accords with previous research on violence and schizophrenia, which has shown that

increased risk of violence is a clinical characteristic of schizophrenia (Fleischman et al., 2014; Harris et al., 2014; Imai et al., 2014) and that medication is a key factor related to violence (Wehring and Carpenter, 2011; Volavka, 2013). This means that coping strategies related to illness treatment and medication are usually selected first. However, treatment compliance is not always related to violence (Monahan et al., 2001; Kageyama et al., 2016a). Therefore, some parents must opt for coping strategies focused on the violence rather than the illness.

The second main characteristic of parents' coping process is the long-term appraisal of violence in the second stage (e.g., "seeking the characteristics of violence" and "seeking causes of the violence"). We found that parents struggled to understand the violence. The exact causes of schizophrenia and violence by patients with schizophrenia are unknown, although possible causes include psychosis, psychopathy, cognitive impairments, antisocial personality, comorbid substance use disorder, and others (Nolan et al., 2003; Volavka, 2013; Harris et al., 2014; Reinharth et al., 2014). The unclear causes of violence make it difficult for parents to understand it and thus they engage in long-term appraisal to select appropriate coping strategies.

Both of these characteristics of the coping process for violence are related to the characteristics of SMI. Therefore, they might be characteristic of the coping process in other countries or SMIs, such as depression and bipolar disorder.

Japanese characteristics of the coping process

The uniquely Japanese characteristics of the coping process might be family destruction in the fourth stage and the feeling of shame that prevented disclosure of the violence in the second stage. The family destruction might be due to an ineffective support system, such as poor outreach services in Japan, in the third stage. Therefore, family destruction could be avoided if the violence is resolved at this stage. It would be particularly helpful to have outreach crisis intervention available 24 hours per day in a community setting, as is present in western countries (Murphy et al., 2012; Wheeler et al., 2015); this could serve as an alternative to contacting police.

Next, in the second stage (“living with violence”), parents’ feelings were what prevented their disclosure of the violence within the home. This is similar to the findings of qualitative studies undertaken in Taiwan (Hsu and Tu, 2014) and the US (Copeland and Heilemann, 2011). These feelings included responsibility, nurturing, and fear (Taiwan), and maternal love and obligation (US). We identified similar feelings, with the addition of shame; this feeling may be specific to Japan. Most Japanese people have no one god, but follow the norm of a “well-behaved” public where nobody can behave in a deviant way (Yamada, 2008). In many countries, religion provides a supportive role for family caregivers of patients with schizophrenia (Grover et al., 2015). However, for most Japanese, religion does not play such a supportive role during a crisis. Therefore, a shame culture due

to higher public stigma of mental illness in Japan (Ando et al., 2013) might force people to not disclose violence within the home.

Practical implications

Aside from the applicability of our findings to Japan, the two characteristics of the coping process identified above suggest some practical implications on a broader scale.

First, the typical coping patterns for preventing or stopping violence should be taught to caregivers by psychiatric nurses. Specifically, while getting treatment for the illness may cause the violence to cease, sometimes it does not, so caregivers should seek help from nurses in order to resolve the violence quickly, considering interventions other than medication such as home visit services or independent living.

Second, to shorten the appraisal needed for selecting coping strategies, family education/psychoeducation on violence would be important. While family education/psychoeducation is often recommended to caregivers (Dixon et al., 2009), such education is often little related to family violence (both its components and its outcomes) (Lucksted et al., 2012; Yesufu-Udechuku et al., 2015; Grácio et al., 2016). Family violence is not a rare event, with almost 40% of family caregivers having experienced violence by the patients in western countries (Labrum and Solomon, 2015). Poor communication with patients has been reported as a risk factor of family violence (Solomon et al., 2005; Hsu and Tu, 2014; Onwumere et al., 2014; Kageyama et al., 2016a), just as regular conversations

were recognized as a cause of violence in the second stage of our study. Thus, in family education programs, topics related to family violence, including its causes, the need for communication, and specific coping strategies, are best included.

Study Limitations

First, some of our findings might be difficult to generalize to other countries. However, we did note two characteristics of the coping process that might be applicable to other countries. Moreover, there are few qualitative studies of family violence relating to SMI. As such, our findings might be important for identifying better solutions and developing further research. Second, we used group interviews as well as individual interviews; therefore, interviewees might have been affected by the statements of other interviewees. We tried to cultivate an affirming and supportive atmosphere by having the family recruiter they knew attend and by encouraging them to talk freely. For most parents, group interviews with acquaintances were more relaxing. Furthermore, we respected each person's choice to talk about this topic. Third, interviewees were recruited through family self-help groups; therefore, parents who do not join such groups might have more serious situations.

Conclusions

We identified parents' coping processes with violence by their adult child. The coping process had two illness-related characteristics: (1) a process of coping with two

different stressful events (the illness and the violence), and (2) long-term appraisal of violence because of its unclear causes.

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