

# **RESPONSES OF JAPANESE FAMILIES TO MENTAL DISORDER**

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## **INTRODUCTION**

The Japanese family plays a very important role in the care of its mentally ill members. It assumes the responsibility for the sick and, indeed, many families discharge their duties faithfully. At the same time, the family has the power to commit its mentally sick member to a psychiatric institution, even without the consent of the concerned individual. Therefore the study of the family concept of mental disorders and their attitude to the mentally ill family member would be of paramount importance for understanding the effectiveness of the Japanese system of delivery of mental health services.

The present study, which represents one of a series of reports of a research project, "Pathways of Help-seeking of Psychiatric Patients in Japan", will be concerned with the response of the family when first confronted with the discovery for a member of the family displaying deviant, disturbing or violent behaviour.

## **METHOD**

Altogether, 100 cases who consulted the Asai Mental Hospital for the first time from March 30, 1980 to June 30, 1981 are included in the study.

Information used for this paper is derived from interviews with the patients and their families, and is mainly concerned with the interpersonal process which took place from the time when a family found the deviant or morbid behaviour of one of its members to the time when it decides to take the sick member to a psychiatrist. Among family members interviewed the following were identified: parents, spouse, siblings, children, grandparents and others.

## RESULTS

The study population is made up of 64 male and 36 female patients. This group may be similarly distributed by demographic characteristics to the psychiatric patients contacting Asai Mental Hospital in previous years. The details were shown in Table 1. It is worthy of note that most lived in a rural area and that only a third had skilled occupation. There were 34 only who had some religious persuasion.

Table 1. Characteristic of subjects (N=100)

1. Age	(%)	2. Marital status	(%)
Less than 39	50	single	36
40 - 50	34	married	46
60+	16	separated or divorced	14
		widowed	4
3. Education		4. Occupation	
Grades 1 - 6	24	None	33
Grades 7 - 12	58	Agriculture	7
University	14	Unskilled	17
Unknown	4	Skilled	36
5. Living arrangements		6. Residence	
alone	10	urban district	9
nuclear family	43	environs	27
other family	43	farm village	49
other persons	4	coastal area	15

Table 2 shows the "family's interpretation of psychoric problems and its relation to the time interval between onset and referral to psychiatrist". Of the 29 psychotic cases, 10 cases (34.5%) were regarded as "psychotic" by the family, 9 cases (31%) as neurotic, psycho-physiological or a result of social maladjustment and 9 cases as having to do with superstitions or as nothing serious. It seems quite evident that the family tends to interpret psychotic problems or severe behaviour change of a member as neurotic with an implication of psychosocial causation or as psychophysiological in nature emphasizing the somatic aspects.

It is also noted that the interval from onset of problem to the time of referral to a

psychiatrist varies with how the family interprets the psychotic problem. Those interpreted as psychotic get referred to a psychiatrist within 189 days and those as non-psychotic in 152 days, while those considered as nothing serious or superstitious in nature take, on an average, 423 days to come to a psychiatrist.

Table 2. Family's interpretation of psychotic problems and its relation to the time interval from onset to referral to psychiatrist

Number of Psychiatric Cases		Time interval from onset to Referral to psychiatrist
Psychotic	10	189 days
Non-psychotic (neurotic, psycho-physiological or social maladjustment)	9	152 days
other (superstitious or nothing)	9	423 days
unknown	1	

Table 3 shows "family's attitude to neighbours reaction". 66% of families were "paying no attention" to how their neighbours might think about the deviant behaviour, 10% of them were "secretive" about it or tried to hide it, and 19% of them are "seeking help" from the neighbours for helping with the sick member. "Paying no attention" is found in many of the following problems; 78% of "psychotic behaviour", 67% of "glue abuse", 71% of "psycho-physiological", 100% of "social maladjustment". "Secretive" accounted for between 4 - 24% of the problems. Compared to the study on family attitudes to schizophrenia by the same authors in 1972, in which 70% of the families feared for social stigma and 15% of the cases said that their work situation or marriage was disturbed by the knowledge ill towards society seems to have changed considerably. This is perhaps attributable to the spread of mental health knowledge resulting in a more enlightened attitude.

Table 3. Family's attitude to neighbour's reaction

		paying no attention	secretive help	seeking	non- applicable
Type of first problems	100	66	10	19	5
psychotic	29	20	2	5	2
alcohol or glue abuse	25	17	1	6	1
non-psychotic	46	29	7	8	2

As shown in Table 4, "change of human relations in the family following the onset of the psychiatric problems", "no change" accounts for 43%, "positive change" for 5% and "negative change" for 47%. "Negative change" is noted both in the families of the psychotic and the alcohol and glue abuse problems in the same amount, between 52 – 60%, while differing from the non-psychotic problems (37%).

Table 4. Change of human relations in the family following the onset of the psychiatric problems

		no change	positive change	negative	no family change
Type of first problems	100	43	5	47	5
psychotic	29	10	2	15	2
alcohol or glue abuse	25	9	0	15	1
non-psychotic	46	24	3	17	2

It is eminently clear from Table 5, "family response to psychiatric attention", that the family of patients with psychiatric problems give a strong affirmative response to receiving psychiatric attention; an average of about 80% give full consent to psychiatric care. This may be also an indication of the family's role in making the decision on the choice of type of intervention for the sick member, for only those so decided go to the Hospital.

Table 5. Family response to psychiatric attention

		full consent of all members	partial consent of family members	indifferent	no family
Type of first problems	100	80	1	14	5
psychotic	29	27	0	0	2
alcohol or glue abuse	25	19	0	5	1
non-psychotic	46	34	1	9	2

“Patient’s attitude to consulting a psychiatrist” is shown in Table 6. 16 cases consulted psychiatrists voluntarily. There is only once case of “Psychotic psychiatric” problems. Most of them were “non-psychotic psychiatric” and “psycho-physiological”. 58 cases consulted psychiatrists “with consent”.

Table 6. Patient’s attitude to consulting a psychiatrist

		voluntarily	with consent	with force	through deception	others
Type of first problems	100	16	58	10	9	7
psychotic	29	1	18	4	5	1
alcohol or glue abuse	25	2	17	3	1	2
non-psychotic	46	13	23	3	3	4

Table 7 shows “family’s understanding of the purpose of hospital visit”. When consulting a psychiatrist for the first time, 69% of the families expect immediate “psychiatric hospitalization”, especially in “psychotic and disturbing to others” and “alcoholic abuse” cases. It seems that the family had already exhausted their resources and tolerance in handling the patient at home by the time they consent to a psychiatrist and, therefore, asks for an immediate hospitalization for their own relief.

There are 9 psychotic patients out of 29 cases who were admitted to the mental hospital by force or through deception. This amounts to about 31% and deserves attention. "By force" usually implies that the family, themselves or through help from relatives, neighbours or sometimes police, physically force the patient to be hospitalized. "Through deception" refers to a fairly common practice in Japan when the family fails to obtain consent from an unwilling sick member for psychiatric treatment. Usually under the guise of seeing a physician, the patient is taken to a mental hospital and admitted. The patient may be given a medication or injection by a physician and the patient will be confined to a mental hospital in an unconscious condition. So long as such a procedure is sanctioned or requested by the family, no legal questions are asked as a rule. It is noteworthy that even for certain non-psychotic patients (6 cases, 13%) such practices of force or deception are being used.

Table 7. Family's understanding of the purpose of hospital visit

		for diagnostic purposes	advice for care	outpatient treatment	hospitalization
Type of first problems	100	13	1	17	69
psychotic	29	3	0	4	22
alcohol or glue abuse	25	0	1	0	24
non-psychotic	46	10	0	13	23

Table 8, "family expectation for the level of recovery from the hospitalization", shows that only 31 cases expect a complete recovery, while 47 cases ask for symptomatic relief or partial behavioural improvement. It can be seen that the family's expectation are not necessarily high. What does this limited expectation signify? It may imply the degree of their exhaustion after a long, frustrating struggle to deal with the sick member. It may also imply their view on the efficacy of psychiatry which is coupled with the stigma on mental illness as being "incurable".

Table 8. Family expectation for the level of recovery from the hospitalization

		becoming as healthy as before	not giving trouble to others	alleviation of symptoms	refrain from alcohol or thinner	no expect tation
Type of first problems	100	31	8	39	21	1
psychotic	29	12	3	12	1	1
alcohol or glue abuse	25	3	1	3	18	0
non-psychotic	46	16	4	24	2	0

### CONCLUDING REMARKS

The Japanese families respond to the onset of mental illness, psychotic manifestations in particular, in certain characteristic ways:

- 1) They tend to minimize it at first, either through denial or rationalization or somatization by attributing them to being neurotic or psycho-physiological in nature.
- 2) The stigma of mental illness, which has been traditionally prevalent in Japanese society, is still pervasive but seems to have diminished in the last decade.
- 3) The presence of mental illness in a family seems to negatively affect the family relations in about half of the sample studied.
- 4) The family assumes major responsibility in the choice of modes of intervention for the illness, quite frequently disregarding the wish of the sick member.
- 5) The families who choose to minimize the mental illness tend to keep the sick individual long at home and consult a psychiatrist with reluctance as a last resort only after the family resources and tolerance come to the point of exhaustion.
- 6) It may be said that the family has a fairly realistic expectation about the recovery of the mentally ill or the outcome of psychiatric treatment.

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