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Original Contributions

Schizophrenic Patients and the Families in Japan

KUNIHIKO ASAI, M.D.

Since 1980, we have been conducting a research project called "Pathways of Help-Seeking of Psychiatric Patients" in Togane City, Japan. Asai Hospital has served as the base for comprehensive mental health services for 150,000 inhabitants of the city and the surrounding rural communities for the last thirty years, which include outpatient and inpatient services, day care, and community consultation, as well as school mental health programs (Asai, 1983a).

This paper will attempt:

1. to identify certain clinical and psychocultural factors that determine the response of the family in seeking psychiatric treatment for a sick individual in Japan, and
2. to clarify the Japanese patterns of help-seeking with reference to stigma attached to mental illness.

Kunihiko Asai is the medical director of Asai Hospital, Togane City, Japan.
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METHOD

Sixty schizophrenic patients of consecutive first admission to Asai Hospital between March 1980 and June 1984 were included in the study. A systematic investigation, with the use of standardized questionnaires, was made on each patient and his/her significant family member(s) to obtain the following information:

1. The time and mode of onset and major clinical characteristics
2. The initial response of the family member(s) to the occurrence of mental illness in the family
3. The subsequent interventions—by whom, when, how, and the result of each intervention
4. The date and reason for referral for treatment and ensuing hospitalization at Asai Hospital

In addition, an assessment was made regarding the quality of "psychiatric experience" of the family. Psychiatric experience connotes not only the presence or absence of psychiatric history of a member or members of the family, but also the nature of the family's past contacts with a psychiatrist or a psychiatric hospital or clinic, the treatment result or outcome of the mentally ill member, and the overall family attitude to the patient in particular and to mental illness in general (Yarrow et al., 1955; Kadushin, 1969; Greenley and Mechanic, 1976; Horwitz, 1977; Lin, Tardiff, Donetz, and Goresky, 1978).

FINDINGS AND DISCUSSION

The 60 schizophrenic patients are classified into three groups according to the length of time—less than one month, up to 24 months, and over 24 months—elapsed between the onset of illness and the contact with the Asai Hospital for psychiatric treatment: 22 patients are in the Early Treatment Group (less than one month), 18 patients in the Intermediate Group (up to 24 months), and 20

patients in the Delayed Treatment Group (over 24 months). The onset of illness is defined as the first manifestation of abnormal behavior or perceptual, cognitive, or emotive dysfunction of an individual as perceived by the individual himself, his family, or his community, which eventually led to the referral for psychiatric treatment.

Based on the mode of onset of illness and characteristics of their psychiatric symptoms, the sample of 60 patients is classified into two major categories—Type A and Type B.

Type A consists of 20 patients who exhibited an acute onset with flagrant psychotic or antisocial behavior constituting disturbance, or potential or actual harm, to others or themselves. Such symptoms as psychomotor excitement; intense hallucination and acting-out behavior due to delusions of reference, persecution, or poisoning; wandering or irrelevant behavior; and suicide attempts are common among the patients in this category.

Type B comprises 40 patients whose onset of illness is subacute or insidious. Their early symptoms or abnormal behavior perceived by the family or significant persons in their lives include gradual decrease of job or social functioning; isolative autistic behavior;

TABLE 1
Onset of Illness and Clinical Characteristics of Patients in Three Treatment Groups

	Early Treatment Group 22		Inter-Mediate Group 18		Delayed Treatment Group 20		Total 60	
Clinical Type	A	B	A	B	A	B	A	B
	14**	8	3***	15	3***	17	20	40
Family Psychiatric History (—)	7*	1	3	11++	2	14++	12*	26++
Family Psychiatric History (+)	7*	7	0	4++	1	3++	8*	14++

***$p<0.001$ ++ or ** $p<0.01$ * $p<0.05$

gradual change in interest and life style; and such psychotic symptoms as monologism, hallucinatory or bizarre behavior, withdrawal, thought disorder, disorder of speech, etc.

Table 1 shows the distribution of patients in the three treatment groups in respect to Type A and Type B and the presence or absence of family psychiatric history. It is noteworthy that the Early Treatment Group has a significantly larger percentage of Type A patients (63.6 percent) than Type B (P 0.01), while the relation is reversed in the Intermediate Group (16.6 percent) and the Delayed Treatment Group (15.0 percent). No difference is found between the latter two groups. These findings clearly suggest that the majority of Japanese families in our sample responded to acute psychotic onset or antisocial behavior of schizophrenic patients with a feeling of urgency and sought psychiatric treatment within one month of the onset of illness. The corollary is that Japanese families tend to delay seeking specialists' help when dealing with non-acute or non-antisocial psychotic behavior: in fact, 32 out of 38 Type B patients (84.2 percent) belong to the Intermediate or Delayed Treatment Groups.

It is noted that the presence or absence of family psychiatric history further influences the distribution of patients in the various treatment groups. For the Type A patients, only 58.3 percent (seven out of twelve) of those without family psychiatric history are classified as Early Treatment Group, as compared to 87.5 percent (seven out of eight) of those with family psychiatric history (P 0.05). As regards Type B patients, 25 out of 26 patients (96.1 percent) of those without family psychiatric history belong to Intermediate Group or Delayed Treatment Group, in contrast to only seven out of fourteen (50.0 percent) of those with family psychiatric history (P 0.01). In short, the great majority of Type B patients with no family psychiatric history tend to delay seeking psychiatric treatment, while a large proportion of those with a family psychiatric history seek an early psychiatric treatment.

The family response of those patients without family psychiatric history can be assumed to largely reflect the prevailing attitude of Japanese society toward mental illness in general and schizo-

phrenia in particular. The greatest majority of Type B patients were probably overlooked for an extended period by their families as requiring psychiatric treatment because their characteristic behavior and mode of onset do not fit Japan's stereotypical concept of madness.

In addition, the pervasive strong prejudice against mental illness in Japanese society may also play a significant role in the delayed treatment of the Type B patient. Although the family might vaguely suspect the bizarre or withdrawn behavior of an individual as psychiatric in nature, they would rather avoid facing the eventuality of a psychiatric diagnostic labelling that would surely, in reality or in fantasy, invite stigma to the family with all conceivable unfavorable social consequences. The family thus procrastinates, while attempting to correct the abnormal behavior with whatever available means, until it is no longer possible to delay seeking psychiatric treatment.

In this connection, it should be noted that the prejudice against mental illness in Japanese society is so powerful as to make the families of even Type A patients procrastinate in seeking psychiatric treatment in spite of being confronted with problems of acute psychotic, antisocial behavior: four out of six Type A patients who belong to the Intermediate and Delayed Group are found to be strongly influenced by the family's prejudice.

The patients with family psychiatric history present a vastly different picture. It is observed that not only the great majority, seven out of eight (87.5 percent), of Type A patients, but a large portion, seven out of fourteen (50.0 percent), of Type B patients also belong to the Early Treatment Group. More significantly, the families of four of these seven Type B patients were found to have "positive psychiatric experiences." Five patients were sent to Asai Hospital by the family for treatment immediately after the onset of illness, largely because the family had a high regard and trust for the hospital, resulting from the excellent treatment another family member received previously at the hospital. Another family's good relationship with the hospital staff, in spite of the rather unfavorable treatment outcome of a family member in the past, resulted in

the early treatment of another patient. In contrast, the seven patients belonging to the Intermediate or Delayed Treatment Groups lack either positive family experiences or a supportive network to expedite an early psychiatric treatment.

Conclusions

The observation that the quality of previous psychiatric experiences of the family significantly influenced the response of the family in seeking help deserves special attention. Favorable treatment results and good rapport and trust between the family and the hospital staff in the past greatly influence the family in taking prompt and appropriate steps in handling a mentally ill member, making early intervention possible. Since early intervention is highly desirable in effective treatment of schizophrenia, the importance of the quality of family's psychiatric experiences cannot be overemphasized. By implication, it is the responsibility of the psychiatric hospital to provide the quality care and favorable treatment results that will, in turn, pave the way for early intervention, if needed by another individual in the family.

In summary, our study strongly suggests that the availability and quality of psychiatric services significantly influence the families of the mentally ill in taking prompt and appropriate steps for seeking help. In addition, it also tells us that there is hope that the deep-rooted traditional prejudicial attitude to mental illness can change, if the providers of mental health services demonstrate their therapeutic skills and establish a trust relationship with the patients, the families, and the community.

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Asai Hospital
38, Katoku, Togane City
Chiba Prefecture, 283 JAPAN
Tel. 04755-8-5000