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Pathways of Help-Seeking of Psychiatric Patients in Japan: A Research Study in Togane City

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Mental health care within primary health care presupposes adequate knowledge of how psychiatric patients are being handled by the family and the community. In this study 121 consecutive cases who consulted the Asai Mental Hospital between March 30 and June 30, 1980, were investigated from the onset of their first contact with an intervenor to the time of psychiatric consultation at the hospital. Tracing the pathways the patient traveled while seeking help revealed some of the attitudes of the family and community toward the sick individual. Seven conclusions helpful in improving the quality and effectiveness of mental health care are drawn from this study.

Mental health care within primary health care presupposes adequate knowledge of how psychiatric patients are being handled by the family and the community. The various modes in which patients are handled prior to psychiatric intervention exert decisive influences on the course and outcome of the patient's illness. A variety of psychosocial, cultural and religious factors operate, individually or jointly, to cause the differences which reflect the beliefs regarding mental illness and the attitudes of the family and community to the sick individual. One of the most effective methods of obtaining factual information as a basis for developing better understanding of the complex interaction of the above factors would be to trace the pathways the patient travels in seeking help, while identifying the intervening agents, their methods and their effectiveness in attempting to modify the deviant behavior or resolving the problems.[1-6]

SAMPLE AND METHODS

In this research study the people who were chosen as a sample live in Togane city and environs. The population in this district is 150,000. Togane city is a garden city located approximately 70 km southeast of Tokyo Metropolis (see Figure 1), and urbanization has not yet fully taken place. Using the consecutive 121 cases who consulted the Asai Mental Hospital from

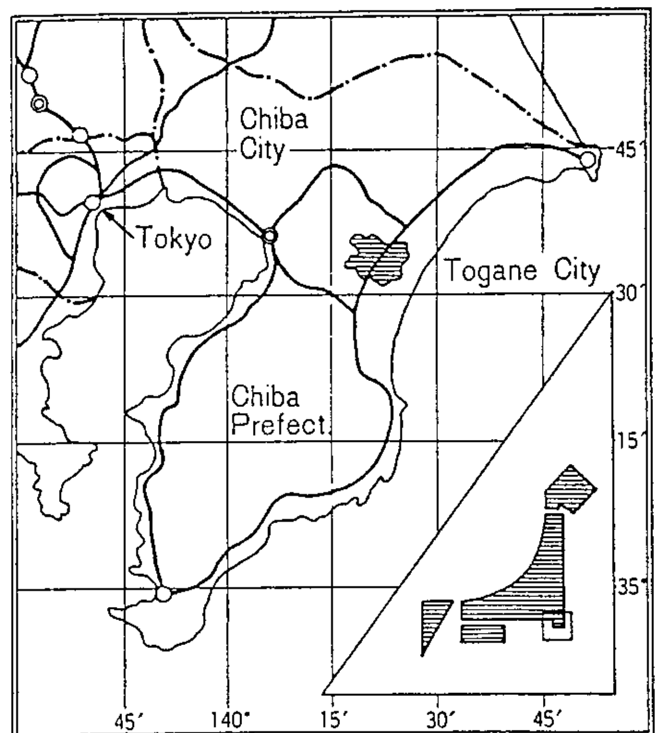

Figure 1. Location of Togane City

This paper was presented at the Regional Symposium of World Psychiatric Association in April 1982, in Kyoto, Japan. Dr. Asai is Medical Director the Asai Mental Hospital in Togane City, Chiba Prefecture, Japan.

TABLE 1

Characteristics of Subjects (n = 121)

Characteristic	%
Age	
19 years & younger	9
20-29 years	18
30-39 years	30
40-49 years	11
50-59 years	17
60-69 years	8
70 years & older	7
Sex	
male	60
female	40
Marital status	
single	37
married	50
separated or divorced	8
widowed	10
Occupation	
none	26
housewife	13
student	6
agriculture	12
unskilled	5
skilled (blue-collar)	13
skilled (white-collar)	25
Living arrangements	
alone	6
nuclear family	41
other family	51
other persons	2
Residence	
urban district	12
environs	26
farm village	50
coastal area	12

March 30 to June 30, 1980, as a sample, each and every intervention on the patient has been investigated—be it psychological, social, medical, legal or religious—from onset to the time of psychiatric consultation at the hospital. An interdisciplinary team, consisting of psychiatrists, clinical psychologists and social workers, interviewed patients and family members in accordance with our checklist.

RESULTS AND DISCUSSION

As can be seen in Table 1, the demograhic characteristics of patients included in the study, in terms of age, sex, marital status, occupation, family size and living arrangements, and residential area, seem to differ very little from those of other patients contacting Asai Hospital in previous years.

TABLE 2

Characterization of First Problem

Type of problem	Total	Males	Females
Psychotic			
Psychotic behavior	30	18	12
Psychotic and disturbing to others	12	5	7
Nonpsychotic violence	4	3	1
Alcohol abuse	7	7	0
Thinner (glue) abuse	9	9	0
Suicide	1	0	1
Nonpsychotic psychiatric	18	16	12
Psychophysiological	25	12	13
Social maladjustment	5	3	2
Total	121	73	48

The first problems noticed are classified into nine types, as listed in Table 2. There were 42 cases of psychotic problems (35%), 4 cases of nonpsychotic violence, 7 of alcohol abuse, 9 of thinner abuse, and 1 suicide attempt. There were 28 nonpsychotic psychiatric cases (23%), 25 psychophysiological cases (21%), and 5 social maladjustment cases.

In the 42 cases who displayed psychotic problems at the onset of their illness, the persons who first noticed the problems were: the family, in 28 cases (67%); the patients themselves, in 7 cases; and the community, in only 4 cases.

TABLE 3

Interpretation of the Nature of the First Problem by the Patient, Family or Community

Group	Interpretation of the Nature of the Problem	TYPE OF FIRST PROBLEM Total Psychotic	Psychotic Behavior	Psychotic and Disturbing to Others
I	Psychotic psychiatric	3	2	1
	Bizarre	9	6	3
II	Nonpsychotic psychiatric	4	3	1
	Psychophysiological	5	2	3
	Social maladjustment	4	3	1
III	Superstitious	1	1	0
	Nothing serious	4	3	1
	Confused	4	3	1
Unknown		8	7	1
Total		42	30	12

TABLE 4

Interpretation of Psychotic Problems and Its Relation to the Time Interval from Onset to Referral to Psychiatrist

	Cases	Time Interval from Onset to First Intervention	Time Interval from First Intervention to Referral to Psychiatrist
I Psychotic psychiatric Bizarre	12	25 days	10 days
II Nonpsychotic psychiatric Psychophysiological Social maladjustment	13	31 days	80 days
III Superstitious Nothing Serious Confused	9	448 days	308 days

Table 3 shows the interpretations given to the first problems by the patient, family or community. Group I, consisting of 12 cases, was considered to have serious psychiatric problems, either frankly psychotic (3 cases) or bizarre (9 cases), showing extremely deviant behavior, which represents only 29%. Group II consists of 13 cases (31%) which were regarded as nonpsychotic, but psychiatric in nature, meaning that something was considered wrong with the brain or the mind of the sick person (4 cases), or psychophysiological (5 cases) or social maladjustment (4 cases). The 9 cases (21%) belonging to Group III were judged as being not serious, only slightly confused, or as superstitious.

As can be seen in Table 4, the duration of time from the discovery of the problem to the first intervention was very different in each group: in Group I it was 25 days; Group II, 31 days; and Group III, 448 days. Similarly, the duration from the first intervention to the referral to psychiatrists showed the same tendency: Group I was 10 days; Group II, 80 days; and Group III, 308 days. It should be noted that Group III takes about 20 times longer than Group I from the time of discovery to the time of referral to psychiatrists.

Table 5 shows the motivator who chooses the first

TABLE 5

Motivator for Intervention

Motivator	TYPE OF FIRST PROBLEM Total Psychotic	Psychotic Behavior	Psychotic and Disturbing to Others
Family	34	26	8
Self	2	2	0
Community	4	2	2
Public agency	1	0	1
Home doctor	0	0	0
Medical specialist	1	0	1
Psychiatrist	0	0	0
Total	42	30	12

TABLE 6

First Intervener

First Intervener	TYPE OF FIRST PROBLEM Total Psychotic	Psychotic Behavior	Psychotic and Disturbing to Others
Family	15	12	3
Self	0	0	0
Community	5	3	2
Public agency	3	2	1
Home doctor	1	0	1
Medical specialist	0	0	0
Psychiatrist	18	13	5
Total	42	30	12

TABLE 7

Type of First Intervention

Type of First Intervention	TYPE OF FIRST PROBLEM Total Psychotic	Psychotic Behavior	Psychotic and Disturbing to Others
Persuasion	16	12	4
Praying or divination	1	1	0
Advice to consult a psychiatrist (rejected)	3	3	0
Consult a home doctor	1	0	1
Consult a psychiatrist—outpatient treatment	5	4	1
Consult a psychiatrist—inpatient treatment	13	9	4
Unknown	3	1	2
Total	42	30	12

TABLE 8

Results of First Intervention

Results of Intervention	TYPE OF FIRST PROBLEM Total Psychotic	Psychotic Behavior	Psychotic and Disturbing to Others
Positive effects	14	10	4
Unchangeable	16	11	5
Negative effects	6	5	1
Unknown	6	4	2
Total	42	30	12

intervener, or who gives advice for consultation with an appropriate person or agency for help. Family members account for 34 cases (81%), especially parents and spouses.

Table 6 indicates the first intervener. Family members account for 15 cases (36%), community agencies for 5 cases, and public agencies for 3 cases. Psychiatrists act as first interveners in 18 cases (43%), especially in Group I, who accept the problems adequately. 15 cases or 83% of motivators who chose psychiatrists as intervener are family members—parent or sibling.

Table 7 compares the type of first intervention with the type of first problem. One is impressed by the large number of cases (16 or 38%) who are given persuasion as a primary form of intervention. There are 18 cases who consulted a psychiatrist, of which 5 cases were given outpatient treatment and 13 cases inpatient treatment. There are 3 cases who rejected the advice to see a psychiatrist.

Table 8 compares the results of the first intervention with the type of first problem. Positive effects were shown in 14 cases (33%), 16 cases were unchanged (37%), and there were negative effects in 6 cases (14%). 72% or 18 cases who consulted a psychiatrist showed positive effects.

Table 9 shows the first interveners for all categories of first problems. The alcohol abuse and thinner abuse cases were composed exclusively of men. Interpretations of the first problem are mostly accurate. Although, in alcohol abuse, of the person who first noticed the problems, the family tops the list with 6 cases (86%), in thinner abuse, family members account for only 1/3 cases, with public agencies (police) 3 cases and community members (neighbor and school teacher) 2 cases, psychiatrists in 2 cases, and the family in 1 case. In alcohol abuse, the family acted as first intervener in 4 cases and home doctor in 2 cases. Both the duration of time from the discovery of the problems to the first intervention and from the first intervention to the referral to psychiatrists were very different in each group: thinner abuse takes 228 days plus 469 days, on an average, but alcohol abuse takes 997 day plus 1,482 days.

Combining nonpsychotic psychiatric (28 cases), psychophysiological (25 cases) and social maladjustment problems (5 cases) together into one category, the interpretation of the first problem is almost always accurate. The person who noticed the problems and the motivator were restricted to family, but 62%

TABLE 9

First Intervener and the Type of First Problem

Type of First Problem	First Intervener Total	Family	Self	Community	Public agency	Home doctor	Medical specialist	Psychiatrist
Psychotic								
Psychotic behavior	30	12	0	3	2	0	0	13
Psychotic and disturbing to others	12	3	0	2	1	1	0	5
Nonpsychotic violence	4	1	0	0	0	0	1	2
Alcohol abuse	7	4	0	1	0	2	0	0
Thinner abuse	9	1	0	2	3	0	1	2
Suicide	1	0	0	0	0	0	0	1
Nonpsychotic psychiatric	28	8	1	2	0	5	4	8
Psychophysiological	25	7	0	1	0	6	5	6
Social maladjustment	5	2	0	1	0	1	0	1
Total	121	38	1	12	6	15	11	38

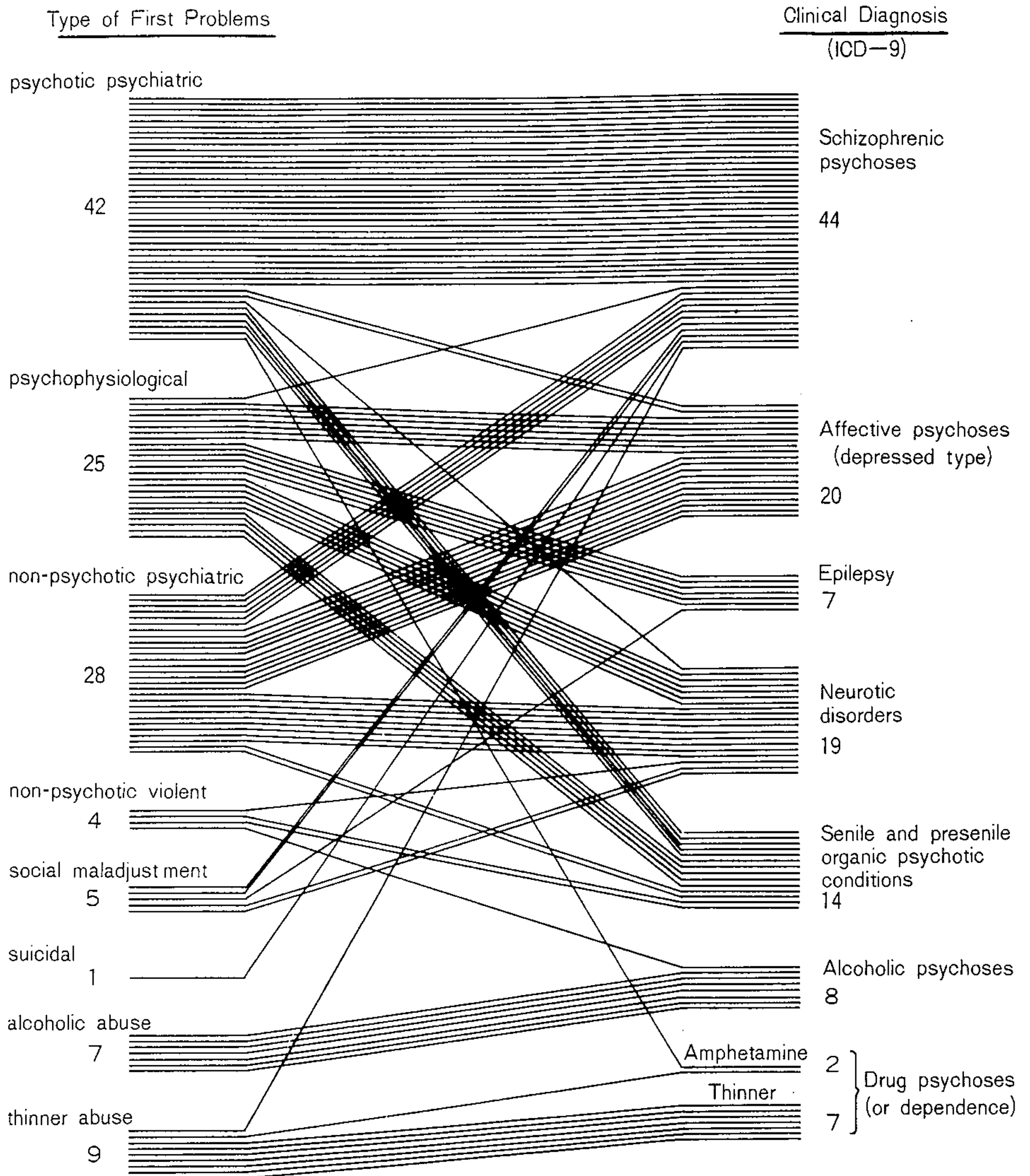

Figure 2. Relationship between Type of First Problem and Clinical Diagnosis

of interveners were home doctor, medical specialist and psychiatrist. Family members accounted for 29%. Although, the social maladjustment problems (school refusal, 5 cases) received intervention within only 4 days, the average duration of time from the first intervention to consulting a psychiatrist is extremely long — 1,300 days. The other two problems also took a long time (800-1,100 days) from discovery to referral to psychiatrist.

Figure 2 shows the relationship between type of first problem and clinical diagnosis (ICD-9). Of 121 cases, schizophrenic psychoses top the list with 44 cases (36%), affective psychoses (depressed type) 20 cases (16.5%), neurotic disorders 19 cases (16%), epilepsy 7 cases (6%), alcoholic psychoses 8 cases (6.5%), and drug psychoses or dependence 9 cases (7.5%) — amphetamine type 2 cases and thinner abuse 7 cases.

Since the public agency, home doctor, medical specialist and community all play an important part in Japanese primary health care in general, we would like to make special reference to their roles relative to the help-seeking pathway of psychiatric patients.

The public agency acted as first intervener in only 6 cases (5%); 4 cases were made by the police, but the problems are restricted to "thinner abuse" and their intervention was limited to persuasion. Although public health nurses intervened in only 2 psychotic behavior cases, their advice to the patients to consult a psychiatrist seemed to be effective — in these 2 cases the duration of time from the first intervention to consulting a psychiatrist was only 16 days.

The home doctor acted as first intervener in 15 cases (12.5%), predominantly in psychophysiological (6) cases and nonpsychotic psychiatric (5) cases. In only one quarter of their patients (4 cases) did their intervention result in a positive effect. The average duration of time from the first intervention to consulting a psychiatrist is extremely long — 1,622 days on the average. The duration of their intervention is also long — 356 days.

Medical specialists acted as first interveners in 11 cases (9%) and only dealt with the problems of psychophysiological (5) cases and nonpsychotic psychiatric (4) cases. The results of medical treatment were positive in only 2 cases (18%), but the duration of intervention was only 14 days. The average duration of time from the first intervention to consulting a psychiatrist was 220 days.

Community members acted as first interveners in 12 cases (10%) and dealt with various problems, as shown in Table 9: superior officer 2, fellow worker 2, class teacher 2, religionist 2, diviner 1, acupuncturist 1, neighbor 1 and friend 1. Of these, 8 cases gave persuasion as the primary form of intervention and only one case each of praying and divination. The results of intervention were positive in only 3 cases (25%), unchanged in 7 cases and negative effects in 1 case.

CONCLUSIONS

1) Significant variation exists between the psychiatric specialist and the people who first noticed the problem in the interpretation of newly noticed psychotic problems of a sick individual. Even in the flagrantly psychotic behavior group, only one quarter of these problems are identified as psychiatric in nature. The interpretation of the initial problems of a psychiatric patient determines the ensuing course of help seeking, for example, what type of intervention to ask for and whom to ask for help. Both the duration of time from the discovery of the problem to the first intervention and from the first intervention to consulting a psychiatrist were markedly short in the accurate interpretation group in comparison with the inaccurate one.
2) Family members play a decisive role as perceivers in noticing the occurrence of a problem, and also as motivators in deciding to seek help appropriate to the interpreted needs of the sick individual. Family members are also the first intervener in one third of the cases.
3) In primary prevention we must make the best use of the support system of such key persons as public health nurses, case workers, district welfare officers, police, superior officers, fellow workers, school teachers, religionists, diviners, neighbors, friends, home doctors and medical specialists. We have to prevent the incidence of psychoses by effective crisis intervention.
4) Contrary to expectation, the role played by the public agencies is relatively insignificant and infrequent. Interventions by the police were restricted to thinner abuse cases and their interventions were not adequate; however, the interventions by public health nurses were quick and effective.
5) The home doctors' role in the community care has been said to be very important in Japan. But their intervention seems to be very limited, both in terms of the types of affliction they handle and their effectiveness in its treatment. Furthermore, they have a tendency to retain psychiatric patients under their care for an unduly extended period.
6) Medical specialists of various disciplines tend to recognize the need for referring psychiatric patients to psychiatrists, while only attending to patients with restricted problems, and most of their interventions were not effective.
7) In the primary care of psychiatric patients, it is a matter of course that both the removal of prejudice attached to psychiatric patients and the dissemination of information on mental health are very important. We must make the most of support systems; especially such key persons as public health nurses, M.S.W. and district welfare officers and the extended mental health network. At the same

time, we specialists have to educate and retrain home doctors and community members who play an important role in primary prevention from a mental health standpoint. Furthermore, we must organize group work in the community.

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