[原著] Help-seeking behavior of schizophrenic patients of a typical mental hospital in Okinawa

Help-seeking behavior of schizophrenic patients of a typical mental hospital in Okinawa

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ABSTRACT

An investigation of the patterns of help-seeking behavior of schizophrenic patients in Okinawa was undertaken. The subjects were 131 schizophrenic patients consisting of 78 males and 53 females, ranging from ages 18 to 64. Of these 131 patients, 53 were inpatients and 78 were outpatients. Information was obtained through structured interviews with the patient's families, discussions with their professional care-givers, and from their medical records. The main findings in the investigation were: (1) the first symptom or problem which was recognized by the family was insomnia for most of the cases in the acute-onset group, and deteriorating behavior or social maladjustment for most of the cases in the gradual-onset group; (2) the average time between the first manifestation of the problem and the first intervention with a mental health professional was 18 months (13 months for males, 25.6 months for females); (3) the person who initially recognized the problem was primarily a family member, mainly the mother; (4) the initial intervening person(s) or motivator(s) was family or the close kin group; they also assumed an important role in emotional support and psychiatric referral. *Ryukyu Med. J., 15(4)173~179, 1995*

Key words: help-seeking behavior, schizophrenic patients, Okinawa

INTRODUCTION

In order to implement an effective community mental health program, it is important to know how patients and their families seek help within their community when a mental health problem arises. Lin and others[1,2] have pointed out that most ethnic groups have unique help-seeking patterns within the context of their particular culture. This implies that when a community health system or program is being developed, the unique pattern of help-seeking of various ethnic sub-groups and accompanying support systems must be taken into consideration. In recognition of this, the present study was done to find out how schizophrenic patients of a typical mental hospital in Okinawa, Japan seek help or treatment.

SUBJECTS AND METHODS

The subjects were selected from a total of 582 schizophrenic patients (209 inpatients, 373 outpatients). The selection procedure was based on receiving consent from the families of the schizophrenic patients to be used as subjects in this particular study, as well as being able to secure enough information from the medical records. Of the total number of patients, 149 representatives from the patients' families were interviewed. From that group, 131 families agreed to participate in this study (53 inpatients, 78 outpatients). These subjects represented 22.5% of the schizophrenic patients. The 131 subjects were comprised of 78 males (59.5%) and 53 females (40.5%). The age range was from 18 to 64 years. The majority of the subjects were under 30 years.

Standard questionnaire forms and structured interviews all carried out by the same interviewer were used in this investigation. The interviews were all conducted at the hospital and lasted about 1 hour. The interviews involved family members (63 mothers, 22 fathers, 28 siblings, 11 spouses, 4 grandparents, 4 relatives and 1 child) and on some occasions included the patient. In addition, information was obtained from the hospital nurses, case workers and psychiatrists, and from the medical records of the patients. The investigation was carried out from April to June in 1989.

RESULTS

Demographic data (Table 1) indicates that the average age of onset for males was 22.6 years and for females, 22.2 years. Most of the subjects were single (80.2%), while 18.3% were married. Concerning the subjects' occupa-

Table 1 Characteristics of the subjects at onset

	Male	Female	Total(%)
	(N=78)	(N=53)	(N=131)
Age			
0-15 years	7	7	14 (10.7)
16-20	28	17	45 (34.4)
21-25	21	17	38 (29.0)
26-30	9	4	13 (9.9)
31-35	6	6	12 (9.2)
36-40	4	2	6 (4.6)
41-45	0	0	0 (0.0)
46-50	1	0	1 (0.8)
unknown	2	0	2 (1.5)
Average Age	22.6	22.2	22.4
Marital Status			
Single	62	43	105 (80.2)
Married	14	10	24 (18.3)
Divorced	1	0	1 (0.8)
Common Law	1	0	1 (0.8)
Occupation			
Professional	6	4	10 (7.6)
Office Worker	2	5	7 (5.3)
Sales and Service	18	10	28 (21.4)
Unskilled Labor	15	4	19 (14.5)
Agriculture	6	1	7 (5.3)
Student	19	15	34 (26.0)
Housewife	0	9	9 (6.9)
No Occupation	10	3	13 (9.9)
Unknown	2	2	4 (3.1)
History of Mental Illness			
History	33	29	62 (47.3)
(a) in family	25	22	47 (35.9)
(b) in relative	8	7	15 (11.5)
No History	45	24	69 (52.7)
Educational History			
1-6 years	6	4	10 (7.6)
7-9	29	17	46 (35.1)
10-12	31	18	49 (37.4)
13-15	7	8	15 (11.5)
university	5	6	11 (8.4)

Table 2 Living arrangements at onset

Arrangement	Total(%)	
With family		99 (75.6)
(a) extended family	10 (7.6)	
(b) nuclear family	89 (67.9)	
Not with family		19 (14.5)
(a) dormitory	9 (6.9)	
(b) with employer	3 (2.3)	
(c) with relative	3 (2.3)	
(d) boarding home	1 (0.8)	
(e) unknown	3 (2.3)	
Alone		13 (9.9)

tions at the time of onset of the illness, the students showed the highest percentage (26.0%), followed by service industry (21.4%) and unskilled laborers (14.5%). There was a history of mental illness in the family of 47.3% of the subjects, while 52.7% had no such history. The subjects had completed 12 years of formal education in 37.4 % of the cases. Most were living with their families (75.6 %) at the time of onset (Table 2), compared to those who were living in residences separate from their families (24.4 %).

The question regarding the initial problem detected (Table 3) allowed for multiple responses (187 responses). The problems detected were classified according to type and also according to whether the onset was gradual (87 cases) or acute (100 cases). A sleep disturbance was recognized

Table 3 Initial problem(s) detected

Symptom/problem	Gradual onset	Acute onset	Total(%)
Bizarre behavior	10	19	29 (15.5)
Problematic/destructive behavior	5	9	14 (7.5)
Behavior change	7	11	18 (9.6)
Social Maladjustment	20*	10	30 (16.0)
Deteriorating behavior	24*	11	35 (18.7)
Sleep disturbance	10	27*	37 (19.8)
Physical complaints	10	12	22 (11.8)
Suicide attempt/self injury	1	1	2 (1.1)
Total**	87	100	187 (100.0)

*$P<0.05$ (χ^2) **subjects sometime indicated multiple problems

in 19.8% of the subjects. In the gradual-onset group the most frequent problem detected was deteriorating behavior (24 subjects), with social maladjustment appearing in 20 of the subjects. The most frequent problem detected in the acute-onset groups was sleep disturbance (27 subjects). In Table 4, the person(s) who first recognized the problem(s) was most frequently a family member (76.3%). The individual him/herself recognized the problem in 8.4% of the subjects.

Table 5 indicates the interpretation of the problem as first detected. In 6.1% of subjects, the interpretation was psychotic symptoms. The most frequent interpretation was a psychological or neurotic disturbance (30.5%). The problem was interpreted as not serious in a total of 27.5% of the subjects (spirit possession, defiant/mischievous behavior, lazy/lethargic) and in 22.9% it was not clear how the problem should be interpreted. In 13.0% of the subjects, a physical disorder was the interpretation.

Table 4 Person who first recognized problem

Person	Total(%)
Family/relative	100 (76.3)
Other (colleague, teacher, acquaintance, police, religious practitioner)	20 (15.3)
Self	11 (8.4)

Table 5 Interpretation of problem as first detected

Interpretation	Total(%)
Psychotic symptom	8 (6.1)
Psychological/neurotic disturbance	40 (30.5)
Physical symptom	17 (13.0)
Kami-daari (spirit possession, etc.)	4 (3.1)
Defiant/mischievous behavior	16 (12.2)
Lazy/lethargic	16 (12.2)
Perplexed/didn't know	30 (22.9)

The time interval from the manifestation of a problem to the first contact with a psychiatrist ranged from 2 days to over 20 years. In the majority of the subjects, intervention occurred within one year, with 72 (54.9%) seeking intervention within 1-6 months and 22 (16.8%) within 7 months to 1 year. Twenty four subjects (18.3%) sought intervention between 1.1 and 3 years, 5 (3.8%) between 3.1-5 years, and 8 (6.1%) after 5 years. The average time span for males was 13 months, and for females 25.6 months (Table 6).

The highest motivating factor for seeking psychiatric intervention was a deteriorating condition (38.9%) and problematic/destructive behavior (22.9%) (Table 7). Table 8 indicates the person(s) who recommended psychiatric

Table 6 Time span from initial problem detection to psychiatric intervention

Time span	Total(%)
Within 1 month	26 (19.8)
2-6 months	46 (35.1)
7 months-1 year	22 (16.8)
1.1-3 years	24 (18.3)
3.1-5 years	5 (3.8)
Over 5 years	8 (6.1)
Averages: Males	13.0 months
Females	25.6 months

Table 7 Incentive for psychiatric intervention

Incentive	Total(%)
Deteriorating condition	51 (38.9)
Condition of long duration	6 (4.6)
Problematic/destructive behavior	30 (22.9)
Suicide attempt/self injury	6 (4.6)
No caretaker in the family	3 (2.3)
Desire for early intervention	12 (9.2)
On advice from other person	23 (17.6)

Table 8 Source of psychiatric referral

Source	Total(%)
Family/relative	110 (84.0)
Other	19 (14.5)
(colleague,civil servant, mental health specialist, religious practitioner, general practitioner, teacher)	
Self	2 (1.5)

Table 9 Attitude of individual at time of intervention

Attitude	Total(%)
Accepting	29 (22.1)
Non-accepting	75 (57.3)
Neither	27 (20.6)

Table 10 Help-seeking behavior pattern

Type			Total(%)
I-Family →		Psychiatrist	25 (19.1)
II-Family →	Non-specialist resource person →	Psychiatrist	40 (30.5)
	a) Trusted person (relative, acquaintance, community health facility)	20 (15.3)	
	b) Religious practitioner/ traditional folk healer	20 (15.3)	
III-Family →	Official social service resource →	Psychiatrist	66 (50.4)
	a) Medical (non-psychiatric)	41 (31.3)	
	b) Social service agency (police, public health center, city office, child guidance)	19 (14.5)	
	c) Medical care institution + other source	6 (4.6)	

intervention. The family/relative (84.0%) was the most frequent source person for recommending a psychiatric intervention. Other sources of referral (14.5%) included friends, religious practitioners, general practitioners, colleagues or teachers, and health care personnel.

Table 9 indicates that 22.1% of the subjects had an accepting attitude toward the initial psychiatric intervention, whereas 57.3% of the subjects had a non-accepting attitude. The remainder of the subjects were unable to respond, because they were either in a severely psychotic state or a confused state (20.6%).

The help-seeking behavior was grouped into three major types of patterns (Table 10). Group I dealt with the problem within the context of the family only, before seeking psychiatric intervention (19.1%). Group II involved a reliable or trusted person(s) outside of the family (30.5%). These persons included relatives, traditional folk healers, and community health facilitators. Group III involved official social and health care services (50.4%). This included medical practitioners, police, public health nurses, city office workers, etc. The results indicate that the pattern of help-seeking behavior of most patients involved modern medical services more than any other single source.

DISCUSSION

The results regarding initial problem detected (Table 3) indicate that the most frequent problem identified was a sleep disturbance. It appears that deteriorating behavior and social maladjustment were apparent at a significantly higher rate in the gradual-onset group than in the acute onset group. This can be understood by the fact that when an individual begins to display behavior which is disruptive and not socially acceptable, that is usually the time when intervention occurs. For the gradual-onset group, the other symptoms or problems would probably be tolerated by the environment, usually the family, either in an attempt to disregard the significance of the existence of a problem or they may attempt to treat the individual within the context of their family. It seems that when the behavior starts to deteriorate and is seen as socially maladaptive, then the family is forced to acknowledge the presence of a problem which they cannot deal with themselves. As is usually the case, it is not a single symptom or problem that causes concern, but usually a series of behaviors. These behaviors, in combination, reach such a state that the family is no longer able to "hold" the patient, warranting their seeking outside assistance. In this respect, the situation in

Okinawa is probably quite similar to that in other parts of East Asia which also embraces Confucianist family ideology. For example, Lin, et. al[1,2] have pointed out that "The handling of the mentally ill in Chinese society cannot... be considered without taking the family context into account." Asai[3], in regard to the Japanese situation, observes that "The Japanese family plays a very important role in the case of its mentally ill members. It assumes the responsibility for the sick and indeed many families discharge their duties faithfully."

Table 6 reflects the average time span between the manifestation of the problem and first intervention with a mental health professional. The fact that the delay for seeking psychiatric intervention was almost two times higher for females than for males (25.6 months; 13.0 months) can be understood when the cultural aspects of the Okinawa people are considered. First of all, in the present day non-agrarian life style of the Okinawan people, males generally experience more social participation than females because of their jobs, while women are still relatively confined to the home. For males, a slight change in behavior such as staying home from work without apparent reason, would call family attention even to a mild problem. Yet, a problem of the same magnitude would either go unnoticed or would be ignored longer for a female, particularly one who is confined to the less socially active role of homemaker.

The traditional practice of evaluating male and female behavior differently might also tend to cause family members to be more sensitive to changes in male behavior than to changes in female behavior and consequently seek quicker remedial action for males. When a disturbance in the social activity of a male occurs, the tendency is to want to quickly restore the individual to a normal pattern of behavior.

The desire of a family to quickly restore a person to normal patterns of behavior is no doubt related to the traditional negative attitudes about persons with a history of mental illness which still persists throughout Japan. Of central significance for a person thus stigmatized is the difficulty in finding a marriage partner. While it is a problem for either sex, it is a more serious problem for a family if a female member develops a mental disorder because the probability that she will marry is even less than for a male.

Okinawan religious beliefs and practices pertaining to aberrant behavior may be the major factor influencing the greater time lapse in seeking psychiatric help for females. In Okinawan society, traditional religious practitioners are usually (though not exclusively) females. One sign that a person is destined to be become a religious practitioner is the onset of aberrant behavior such as seeing and hearing spirits, and other illness-like symptoms. When such symptoms first begin to appear, a female is taken either to a kin group religious practitioner or to a shaman (*yuta*) who then determines the cause or the meaning of the problem[4]. The process requires many sessions with the shaman and involves various rituals and prayer pilgrimages for the afflicted individual. Such activity will continue either until the individual improves and resolves the religious question, or until the symptom becomes severe, and unquestionably requires psychiatric intervention. The aberrant behavior of a female may not be initially viewed as strange at all, but rather as ordinary culturally sanctioned behavior; but when traditional healing rituals do not bring about improvement, a psychotic problem is then suspected and a direct psychiatric referral is made.

The person(s) who first recognized the problem was a family member or relative (Table 4). This is related to the fact that most of the subjects were living with family and it appears that a relationship exists with living arrangement and person(s) who recognized the problem first. The demographic data also show that the majority of the patients were single (Table 1). In Okinawa, it is usual for a single person to live with their family until married. Another characteristic of Okinawan life-style is the close bond which exists between family and relatives, especially with the mother. Therefore, our results on the source of psychiatric referral reflects this cultural trait.

In reviewing histories of illness, it was found that of the 131 subjects, 63 had their first onset prior to the 1972 political reversion to Japan, and 68 had their onset post-reversion. This is a significant feature because of the social and economic climate of Okinawa at the time of reversion. From post World War II until 1972, Okinawa was occupied by the United States of America. This meant that the Okinawans were under the jurisdiction of an American military government and not the Japanese government.

There was also no health insurance in Okinawa to offset the cost of medical services. This meant that the patient and his/her family had to pay 100% of the cost for service. The Mental Health Act in Okinawa, being different from Japan, provided financial support for psychiatric patients if they were involuntarily admitted. Therefore situations would arise in which the family, unable to maintain the individual in the community, would commit the mentally ill individual to one of the limited available beds without the patient's consent. The power of the family to commit an individual to a psychiatric facility without consent occurred not only in Okinawa but in mainland Japan as well. This practice reflects the importance of the family in Japanese society[5].

After reversion to Japan in 1972, medical insurance became available which enabled the Okinawans to receive financial support for cases other than involuntary admission. A change in the Mental Health Act increased the number of psychiatric beds available throughout Japan. As the number of beds increased, this also meant an increase in number of nurses, psychiatrists and other health care professionals. Rather than promote de-institutionalization and develop community resources, as was the trend in the

U.S.A., the continued increase in psychiatric beds appears to have fostered the belief in and attitude toward institutionalization. Although there has been a significant decrease in time span when comparing statistics pre-and post-reversion to Japan, the average length of stay for a patient remains over 530 days.

Table 10 indicates that for 50.4% of the time, the pattern of help-seeking involved the utilization of modern medical services. This would suggest that not only has availability and accessibility increased, but utilization of the resources has increased as well. Yet, despite the increase in modern medical services, the utilization of traditional folk healers has not decreased. The role of the *yuta* holds a very special and important function in the lives of the Okinawans. A *yuta* will be consulted on various issues, for example, good or bad days for marriage, purchasing a home, reason for illness, etc. The yuta addresses the spiritual needs of the people in a way similar to that of religious practitioners in other cultures[6]. Traditional folk healing remains popular and widely used today. In contrast to modern medical technology, which can identify a disease and offer treatment, traditional folk healers provide advice for eliminating the problem as well as offer an explanation as to why the condition existed in the first place. Another factor which may contribute to the continued utilization of traditional folk healers is the issue of "psychological" accessibility. Although the number of beds and service providers has increased which indicates increased accessibility, the fact that traditional folk healers are still consulted needs to be addressed. Often when utilizing modern medical services, the patient waits a long time before seeing a psychiatrist and once seen, the actual contact is relatively brief. On the other hand, when consulting a yuta, the waiting period is shorter and the consultation time is considerably longer[6]. Modern medicine requires the actual presence of the ill person at the time of consultation, but the individual or someone, other than the troubled individual, can consult the yuta on behalf of the troubled individual. Even though the results indicate that the pattern of help-seeking behavior of most patients involved modern medical services more than any other single source, shamans and close kin group members were more frequently sought out for consultation. It is usually a pattern of cumulative help-seeking contacts, made to various non-psychiatric sources prior to an initial psychiatric intervention[7,8].

Historically, illness was seen as a supernatural phenomenon or notification from ancestors concerning various matters[6]. Gradually, with the advent of modern medical technology and thinking, a more scientific understanding has been incorporated. Modern thinking tends to minimize the importance of traditional folk healing practices as being a "superstition"[6]. Therefore the ability to openly admit consulting a traditional folk healer may be inhibited and given this inhibition, the results may not represent the full extent to which patients and their families rely on traditional healers.

CONCLUSION

Our study of the characteristics and patterns of help-seeking behavior of schizophrenic patient in Okinawa has revealed some interesting findings. First, it is clear that the family and relatives continue to play a very vital and important role in the life of a schizophrenic patient. This is supported by the fact that a family member or relative was primarily the source of problem recognition and the source of referral for a psychiatric intervention. Second, the time span between recognition and psychiatric intervention of males and females can be understood in relation to the social and cultural practices still prevalent in Okinawa. Third, the difference between pre-reversion and post-reversion schizophrenics in seeking psychiatric intervention is related to the social and economic conditions of Okinawa during their respective time periods. Although the evidence suggests that modern medical facilities are being utilized with greater frequency and speed than before reversion, our study does not fully illustrate the extent to which traditional healing continues to be utilized. A continuation of the strong reliance of Okinawan people on traditional patterns of help-seeking implies the necessity for a new approach in modern community mental health practices. A strategy for skillful networking is required in which not only modern health professionals are involved, but also the patient's family and kin group. Traditional healers cannot be overlooked and their involvement should be included, if not directly, at least indirectly.

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