5 years after the 2011 Tohoku earthquake and tsunami/Disaster Psychiatry/

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みやぎ心のケアセンター
福地　成

Dr. Fukuchi, first of all, thank you very much for agreeing to do an interview for "World CAP." It is our pleasure to interview you. Before we discuss details of your work in Tohoku region, Japan, could please tell us a little bit about yourself?

I initially started working as a paediatrician in the northern area of Japan. I was mainly engaged in the assessment of developmental problems in infants and young children. A few years following my career as a paediatrician, I changed my major to psychiatry and have since worked in the field of community mental health ever since. I also obtained a Ph.D. in Public Health for suicide prevention in rural areas of Japan. Shortly after the earthquake and tsunami in Japan in 2011, I went to the affected areas and provided mental health care for the victims. Since then I have been deeply engaged in the field of disaster psychiatry.

I am currently working in the Miyagi Disaster Mental Health Care Centre, the main facility that focuses on the care and the recovery of people affected by mental health problems caused by the Great East Japan Earthquake in 2011.

Could you please describe how the earthquake and tsunami in March 2011 impacted the city and the psychiatric hospital you were working at that time? Could you also tell us what your role was for the first couple of weeks and for the first couple of months, respectively?

At the time of the disaster in March 2011, I was working as a child psychiatrist in a hospital where I served as the chief psychiatrist in the child psychiatry unit. Despite the fact that the hospital was built just 4 years prior to the earthquake (and thus it was considered a new building), the damage due to the earthquake was so tremendous that a large part of the ceiling fell down and the water pipes were ruptured, leading to severe water leakage. I was relentlessly providing emotional support, and I continued treatment for 20 hospitalized children on the unit at that time. Because no information was available, children were not aware of this unprecedented disaster immediately following its occurrence, and they did not exhibit any signs of emotional disturbances. Along with serving as a physician, my other roles there were to provide them with accurate information and brief psycho-education and to contact their families.

After I confirmed that the number of inpatients requiring emergent/urgent medical and psychiatric care decreased, I decided to go out of the hospital to provide mental health care for people in the community. I joined the local support team and went around the disaster areas. We went to the evacuation sites and cared for survivors. We wore pink parkas to identify ourselves as mental support team members and approached them to offer mental health support, but they declined our offer despite the fact that many of them obviously seemed upset and confused due to this disaster. We did not realize that there was this degree of stigma against mental health services. We took

off our pink parkas the next day and cleaned the floors of evacuation sites so that people in the community could trust us and reduce their resistances to access to mental health services when required. Most of the evacuation sites were school gyms. There were some children who gathered nearby the power outlets at the evacuation sites and who played portable video games all day.

They were mostly playing fighting games. I tried to talk to them, but most of them did not pay much attention or even look at me. After many visits, they slowly opened up to me and their attitudes changed. They told me that their parents were away to take care of their damaged houses and also that their parents were very busy getting the official documents required for financial support from the government. I thought children could not find anything to make them feel safe while parents were unavailable and they thus
seemed to be trying to escape into the virtual world. They seemed to be fighting with monsters just as they were struggling to survive.

My role for the first couple of weeks was connecting survivors with mental illness to medical institutions and giving survivors appropriate psycho-education. A couple of months later, my role changed. I started to assist supporters who did not have knowledge of mental health. I also began managing the Miyagi Disaster Mental Health Care Centre, the new facility that could provide people in the community with mental health services in the long run.

Please tell us what psychiatric problems, symptoms, and diagnoses you saw during those periods? What were the challenges and obstacles in providing mental health support/care? How did you deal with them?
We found some people who had mental health problems prior to the disaster and who had not been receiving appropriate treatment. For example, they were socially withdrawn due to an autism spectrum disorder or due to negative symptoms of schizophrenia. In some of the communities affected by the earthquake and tsunami, families of these individuals were ashamed of them and tried to hide them in their houses. Many of them, therefore, received no mental health care. However, given that all residents, including these individuals, had to escape from the affected areas to survive, they ended up evacuating to the school gyms and appearing in public. Most of them eventually returned to their destroyed houses or escaped in their cars due to their difficulties engaging with people in the community.

According to our data, the number of residents who started showing signs of mental disorders, including schizophrenia and depression, shortly following the disaster and who received our support, increased considerably right after the disaster. Residents who did not initially show psychiatric symptoms and who tried to endure their painful situation started exhibiting depressive symptoms a few years following the disaster. The number of clients who have had depression after the disaster has been increasing these days.

The rural areas were most heavily affected due to this disaster, where insufficient medical institutions and public awareness of mental health disorders existed. Due to this lack of awareness, residents in these areas had strong stigma against mental illness and tended to refuse conversations with regards to mental health. To overcome this challenge, we attended local events, such as agricultural events and festivals, to understand the culture of the community, and then, through

these events, we could have opportunities to speak on mental health problems related to the disaster. We also arranged several social gatherings for the residents, including tea parties, cooking events, and mah-jongg tournaments, where we attempted to provide them with opportunities to learn about mental health problems.

Would you be able to describe the differences in psychiatric signs, symptoms and problems that you currently see five years after the disaster in comparison with ones you encountered during the acute and sub-acute phases of the disaster?

I met many individuals who talked about their emotional experiences at the evacuation sites. They vividly described their experience in forceful tones. In hindsight, I think they were in a hyperarousal state at that time due to emotional trauma. Traditionally, following their belief that affecting others by showing emotions is rude, Japanese tend to hide their emotions. They often are not willing to speak to others about their experiences and their feelings, even though they have just experienced tragic accidents or disasters.Although huge numbers of residents were affected by the disaster, we were challenged by the fact that most people did not desire to seek help from medical and psychiatric facilities. Younger elementary school children started opening up and speaking about their experiences a few years after the disaster. Their parents and teachers became surprised by this fact, because these children were preschoolers who could not fully express their feelings in the moment of the disaster because of their lack of verbal abilities. At that time they instead showed behavioral problems, including excessive crying and enuresis. I think the process of speaking to mental health professionals is important for these children to deal with their experiences and the associated emotional trauma.

Could you please describe your current work and future projects you would like to accomplish at the Miyagi Disaster Mental Health Care Center?

I would like to put my efforts in support of children, since they bear the future in the disaster affected areas.

Although there are several ways to support their well-being, I think providing psychoeducation with the aim of enhancing their resilience is most important of all. If they could appropriately acquire healthy coping skills and subsequently adapt to any stress caused by the 2011 disaster, they would likely cope well with future potential difficulties and challenges. We have been consistently holding workshops for high school students in some cities located in coastal areas where the earthquake and tsunami hit in 2011. These workshops include discussions about how to rebuild their cities, lectures about how to cope with stress, and relaxation technique practice sessions. We also have been holding outdoor camp activities for elementary school children. For safety reasons, the camping facility is not located in coastal areas. The camping programs include cooking, outside play, group talks, campfire experiences, and psychoeducation on disaster mental health. We use traditional Japanese toys, such as “picture story” and “blowing pipe,” for psychoeducation. The psychological burdens on children following camp participation seem to be reduced, suggesting that these activities might be useful for improving the psychological well-being of children who experienced the 2011 disaster.

写真１　Nawatobi in camping

写真２　Psychoeducation session

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