Current status of recovery and challenges in Miyagi Prefecture

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Miyagi Disaster Mental Health Care Center

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I. Introduction

It has been approximately four years since the Great East Japan Earthquake on March 11th, 2011, and with every passing moment, we can see changes in local lifestyles and support activities in the disaster area. Almost all of the debris generated from the earthquake and tsunami was removed from the heavily damaged region, and construction projects that raise the ground with dirt are present everywhere. The scenery of once lively towns is gradually disappearing, and it is difficult to even imagine what the future appearance will be. Disaster public housing was newly built on safe and solid foundations, and many individuals are being relocated from temporary housing. Meanwhile, many individuals are moving out of container type temporary housing and vacant rooms are emerging everywhere. Various volunteer organizations that have begun activities in the disaster area after the earthquake has begun to withdraw from the region due to insufficient funding and the once-lively nature of activities in the region has begun to die down.

The objectives of this paper are to report on the current status of Miyagi Prefecture today (Fukuchi, 2013), to reflect on the support provided during the emergency period, and to investigate long-term challenges left in the wake of the disaster. Additionally, the paper will discuss observations made while the author was involved in mental health care in the region and provide suggestions from the perspective of a care worker on the rebuilding of future mental health care in the region.

II. Post-disaster mental health characteristics

Characteristics of mental health following a disaster will first be discussed (Figure 1).
Existing mental health structures were significantly damaged due to the disaster and broken into many fragments. The "remaining resources" shown in the figure reflect resources whose magnitude was decreased due to the disaster but can be sufficiently rebuilt with future ingenuity. Additionally, "resources that can be developed" refer to resources that did not play a major role in existing mental health structures but can be developed and grown for future recovery in the region. Specifically, this refers to resident volunteers in the region, such as welfare commissioners or dietitians; and collective functions, such as the junior chamber of commerce and industry and women's associations. Finally, "unrecoverable resources" refer to facilities or human resources that were lost due to the disaster that can no longer be factored into future mental health development in the region. For example, clinics or hospitals that were severely damaged and forced to close due to the tsunami cannot be included in this futuristic design.

Meanwhile, there are many "resources flowing into" the disaster area as a result of the earthquake, and many health care/welfare organizations and volunteer organizations such as NPOs and NGOs from outside of the prefecture have started to conduct activities in the disaster area. Additionally, willing human resources have sought work in specialized institutions within the disaster area and began to work in the region.

A "future vision of mental health" is to be created by gathering these fragments and aligning them with regional conditions. Human movement in disaster areas is fast, so it is important to constantly understand the present overall situation and intervene promptly.

II. Activities of the Miyagi Disaster Mental Health Care Center

Here, the FY 2013 (April 2013 – March 2014) activities of the Miyagi Disaster Mental Health Care Center (henceforth, "Center") are shown and the type of support that each region requires immediately following the disaster is discussed in a simplified manner.

When breaking down the 6391 total support activities conducted by the center, home-visits to residents or temporary housing comprised approximately 60% of all cases, with 3807 (59.6%). This strongly indicated the need for outreach skills from care workers who worked in mental health disciplines after the disaster.

The age group with the highest number of consultation cases was among the senior citizen group, with 60-70 years for men and 70+ years for women, and knowledge on senior citizen-specific problems, such as nursing care or isolation prevention, was thought to be necessary.

The ICD-10 based disease classification with the highest frequency among counselees was F2 (schizophrenia, schizotypal, and delusional disorders) and F3 (Mood- and emotion-based disorders). Many individuals had developed these illnesses before the disaster, and it was thought that many of these were cases where symptoms were exacerbated as a result of the existing protective factors weakening as a result of the earthquake. For this reason, it was thought that there was a need for identifying residents who were already vulnerable beforehand as quickly as possible and connecting them with the appropriate medical institutions. Although few, there were some cases of consultation recommendations or referrals to specialized medical institutions or accompanied visits to a doctor.

From the above, it was thought that, at least for the four years immediately following the earthquake, there was a need for① outreach skills, ② knowledge relating to senior citizen-specific problems, and ③ the identification of individuals with previous mental disorders and connecting them to health care.

However, it is not always the case that the same needs will be in demand in the future and there is a high possibility that support activities will change with time.

IV. Changes in the community

Remarks of the author will be shared here regarding changes in regional conditions following the disaster. The following changes in the overall community can be observed: (1) Strengthened unity, (2) Opening and closing of the community, (3)excessive suspicion, and (4) overdependence.

（1） Strengthened unity

Various meetings were planned in the disaster area to overcome the dangerous conditions at the time, and strengthened unity was observed. There was an increase in the number of various salons for affected residents, meetings for strengthening organizations or networks, and training programs for responding to future changes.

The living situation of regional residents changed with time, and the content demanded at meetings such as salons changed as well. In other words: in the beginning, there was a natural occurrence of gatherings that focused on container type temporary housing with the primary objective of maintaining communities. However, it was later realized that it was the residents in privately-rented temporary housing rather than those in container type temporary housing whose communities were at risk of falling apart, and there were numerous gatherings for residents in privately-rented temporary housing planned throughout the region. Additionally, it was slowly realized that not all evacuated residents could return to their original regions, and there was an increasing need for hosting gatherings regardless of disaster presence that focused on neighborhood associations, to build new communities with evacuated residents.

Most of the participants in these activities related to regional community building were healthy senior-aged women, regardless of the meeting type, and the question of how to increase the number of male participants was raised.

（2） Opening and closing of the community

As time passed since the disaster, there were changes in the regional attitudes of accepting support (Figure 2). Immediately after the disaster, the region was wide open for all support and tended to accept all care workers without limit. The disaster was truly short-staffed, and many care workers were inspired to work in the region. The disaster area required heavy physical work such as individuals to scrape away mud, and there was no significant issue with the fact that support cycled through every few days.

However, as a few months passed, regions began to notice the harmful effects of accepting support without limit, and they began to firmly close their doors to accepting support. It was at this time that the support that was demanded shifted to communication skills, such as conversation partners in salons.

Establishing trust relationships and providing stable relationships became important, and regions needed care workers who could remain for several months at a time. As time further passed, this vigilance gradually wore away, with its doors opening and care workers with longer-term plans starting to become accepted in the region.

In this way, the community variably opened or closed its doors to support over time, and it was thought that care workers needed to provide support in a timed manner.

（3） Excessive suspicion

It is often the case when a crisis that threatens a community emerges that countermeasures are put in place to ensure that the same incident does not occur again, and there is often a temporary period of excessive suspicion. For example, when solitary deaths or suicides began to occur in container type temporary housing, there was a movement to more promptly identify these changes to prevent such incidents from occurring again. Some movements checked both electric meters or mailboxes of individuals and installed security systems in all households to externally communicate emergencies.

Families with disabled individuals experienced how difficult it was to be understood in evacuation shelters, and there were behaviors where they actively disclosed disabilities to regional residents during normal periods so that their needs could be understood (Furusho et al., 2013).

Meanwhile, as can be seen in the construction of extremely large levees, some regions felt discomfort with the excessive suspicion harbored by regional residents and who felt that such levees were unnecessary, resulting in counterdemonstrations.

It is thought that over time, residents will hold these discomforts and their vigilance will gradually return to normal.

（4） Overdependence

Overdependence can easily form between victims and care workers under specialized environments such as those following a disaster (Table).

In some communities, both victims and care workers felt heightened emotions due to their overlapping experiences of trauma and loss due to the large-scale disaster. These feelings can overlap, and dependencies can easily form as a result. Things that objectively would seem strange were considered normal, and a certain implicit understanding began to develop within these groups.

For example, victims who had no particular physical handicaps would request care workers to do a simple grocery run for them, and care workers would help these victims without any question.

These dependencies are often first recognized by the care worker, who then hastily tries to eliminate these relationships to break this status quo, which can easily result in "abandonment anxieties" in the victim. This is identical to the transference and counter-transference phenomena observed in clinical settings within the general public.

V. Phenomena occurring in care workers

Specialists in mental health should be well aware of the concepts of transference and counter-transference. However, these specialists easily began to empathize with victims when conducting support in disaster areas, and they became swept away in these behaviors.

One reason for this is the proximity between victims and care workers. Many care workers previously were employed in clinical practice within hospitals, with support primarily based on counselee-focused mental health consultation activities, and consultations were conducted in a counseling room, where several rules and procedures were in place. However, post-earthquake support involved numerous home-visits to victims, where care workers repeatedly listened to emotional stories. The stories discussed here were qualitatively completely different from those of interviews, where the time and place were strictly defined. Even if the care worker did not develop empathy for the individual victim, they began to empathize with the community or groups they are supporting and this phenomenon of being swept up in this emotional environment was frequently observed.

If this is the case, then how should care workers provide support? It is precisely because it is difficult to control as an individual that it is important to provide support as a team.

① Individual care workers should not take up cases, and instead should be shared amongst a team (i.e., multiple individuals).

② Regularly receive supervision from external care workers and create a mechanism for course-correction based on input.

③ Create a system that allows for regular departure from the disaster area and provide opportunities for viewing what is happening in their region from an outside perspective.

It is thought that these above measures will protect support staff and contribute to the recovery of the affected region.

References

1) Fukuchi, N. （2013）. Current status and challenges of disaster areas. Japanese Journal of Hospital and Community Psychiatry 55:15-17.

2) Furusho, J., et al.（2013）. Advances in the Medicine of Developmental Disabilities 25. Shindan To Chiryosha

Note) Original text