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Rethinking Mental Health Care

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Introduction

At present, the term "mental health care" is entering common use. Its use started in the context of victim support during the 1995 Great Hansin Earthquake,[1)] so we might misunderstand it to mean special consideration given after major disasters. Also, after the Great East Japan Earthquake in 2011, a large number of support groups were active in a number of ways in the name of "mental health care." Precisely that word is also included in the name of my own organization, so I feel I am destined to constantly stand face to face with its essence. Since it is so commonplace, its essence has been warped and the public may feel that it is a bit dubious. In retrospect, did we ever really sit down and discuss the meaning of the word? I use this paper to once again look back on the present and challenges of "mental health care" activities, basing it on my own support experiences after the Great East Japan Earthquake. I want this to be an opportunity to rethink what is needed for disaster victims' psychological recovery and what is effective support.

I. Living culture and "mental health care"

I sometimes refer to sports that I like to watch in order to understand the spirituality unique to Japanese culture. In sumo wrestling, for example, it is considered ill-mannered for the winner to assume a triumphant pose in the ring. The logic is that such an action is insulting toward the defeated and inappropriate from the standpoint of respecting each other's efforts. It is considered a virtue to always be humble, not express one's inner thoughts, and politely perceive the other person's feelings. Another example is high-school baseball. In particular, our hearts are touched during the summer Koshien tournament when we watch the pitcher continuously throwing the ball while riddled with wounds and hear about the reserve players silently supporting the team. The schedule is made so that the middle of the tournament coincides with the anniversary of the end of the war, and we superpose the souls of all the young people who died in the war over the young players having a moment of silence when the siren sounds. The spirit of self-sacrifice that restrains emotional expression to a minimum and cares for the team, I think that is spirituality unique to Japanese culture.

Foreign media praised the Japanese disaster response. Normally, when a major disaster occurs abroad, residents' discontent during ordinary times tends to run to riot and public order deteriorates. That did not happen in Japan. Praise was given of how wonderful that spirit is that favors manners, mutual consideration, and helping each other also in emergencies. I was part of a "mental health care team" that traveled around evacuation shelters immediately after the earthquake. I repeatedly heard people say things like "There are those worse off than me, so go see them. I'm fine." They gritted their teeth despite suffering and struggling, surmising how it would affect those around them if they let out their emotions. I feel that saying "Please talk to me" to residents with such a culture might endanger precisely that local culture that they are desperately trying to protect.

II. Mental health care system in Japan

We need to bear in mind the origins of Japanese mental health care. Japan's mental health care is hospital-centered and still strongly bears the characteristic of specialists "waiting" for people to "come." Thus, the discipline of psychiatry has not developed sufficiently as a form of public health that supports local mental health care. Yet, once a major disaster occurs, many residents experience something that

wreaks havoc with their mental balance and the whole group's level of health is exposed to the risk of deterioration. This caused a switch from the style of "waiting" for people to "come" to having specialists actively spreading information in local areas and finding high-risk local residents. That is, there were rapid movements to raise the standard of existing local capabilities. My role as a pediatric psychiatrist shifted to visiting kindergartens and schools with a lot of children and giving advice to professionals intimately working with children. Suddenly, we were increasingly reaching out to local residents, and the year of the Great East Japan Earthquake in 2011 could be dubbed the "year of outreach."

We were under the illusion that mental health care where specialists head out into local areas is extraordinary and that we were doing something new, and perhaps that is why we applied the word "mental health care." Thinking this through, it was not a special initiative but something that we should perhaps continue in ordinary times as well. Is this not just a backlash from excessive medical specialization? If we verify our current situation and go back to the basics, would it not become a foundation for postwar-style community-building that raises children in an environment where "being a busybody is the norm." The earthquake gave us an opportunity to perceive the need to rethink what we mean by local mental health care and school mental health care.

III. Community transformation

Following exposure to major trauma, such as a major disaster, the dynamics of a community as a whole change with each passing moment.[2)] Groups have defensive reactions the same way organisms do and try to protect themselves instinctively by transforming themselves when exposed to strong stimuli. That is, we must understand not only "individual" pathologies but also the psychology and dynamics of "groups" as well as provide appropriate support when the chance is given. I believe that one of the essential aspects of "mental health care" is assuming an attitude of wanting to accurately understand this transformation and stay with the local residents.

We have observed that in order for a community to overcome a critical situation, a variety of meetings are planned and temporary unity becomes stronger. There was a temporary increase in various salons, meetings within organizations or for networking, trainings to deal with future changes, and other events organized for local victims of the earthquake. We also observed that they would often think of defense measures to prevent something similar happening again as well as tending toward excessively high alertness for a period of time. In the case of someone dying alone or committing suicide in prefab temporary housing, they would sometimes make efforts to keep track of changes in others to prevent such things from happening again. We observed that they might check each other's electricity meters and letter boxes or equip all houses with a warning system to alert the outside of emergencies. Families of persons with disabilities experienced how difficult it can be to gain other people's understanding at the shelters, and we observed that they might actively work also in ordinary times to improve local residents' understanding of disabilities.[3)] The same mechanism underlies the dynamics whereby we perceive the influx of a large number of external supporters as a threat to the existing local system, which is why we observed areas that declined offers of support. There is nothing strange about wariness arising as an instinctive defense reaction in an atmosphere that is out of the ordinary and motivating a strong resistance against too much external support.

IV. Favoring Quantity over Quality

Salons for disaster victims are sometimes too eager as the managers want to have as many users as possible. As I visited local areas, I was often asked "How do you get people who never leave the house to participate?" or "How do we get more men to participate?" I never know what to say. In the first place, is this a problem that requires a solution?

I digress a bit, but in the kind of school dramas that we all like, the typical story concludes with the children uniting and deepening their bonds around a teacher or student with strong leadership skills. Perhaps this is the kind of story we expect and one that we have a fixed concept of. In order to maintain good mental health, is it really optimal to have a strongly united class? As group unity strengthens, you naturally get stronger tacit rules and regulations and an atmosphere is spontaneously generated that considers any movement outside that circle as unjust. Unless you have somewhere else to go, moving outside or being thrown out of that circle means isolation. Perhaps we can say the same thing about the salons after the

earthquake? Instead of just strengthening group unity, it would perhaps benefit users' mental health more to set up many loose networks. Even if one group is unable to cope, the environment lets people think "No worries, I have this group too." Perhaps it is healthier to have a variety of gatherings, where affiliations change, it is free to join and leave, and many people can come and go. I believe that quantity is more important than quality when it comes to team- or network-building.

V. How to create arrangements in groups

I would like to discuss a bit about how to create arrangements in groups. The more experience you have as a specialist, you are likelier to notice things and think, "Perhaps this kind of arrangement can improve mental health," as you provide local support. I can think of two patterns: 1. an external specialist delivers it to the group after it is completed, and 2. internal staff are involved in the design process from the beginning (Figure 1).

In case of 1, the plan goes quickly in the beginning since it relies on the expertise of highly experienced specialists. The planners can avail themselves of previous expertise and so find it enjoyable. However, after delivery to the group, the arrangement often does not take hold. Since it is not something devised by the users themselves, they lack the autonomy to continue running it. Meanwhile, in the case of 2, the planners already include group members from the beginning. Since many are not specialists, it is difficult to reach a consensus and things proceed slowly, even at a crawl, with repetitive clashes, collapses, and rebuilding. Yet, all that trouble is rewarded as the arrangement becomes seen as their own and can often be run stably once it has taken hold. 1 can be used when there is little time before it needs to be completed, while 2 can take a relatively long time. For example, you could use 1 in the case of an arrangement in prefab temporary housing, while 2 might be better in the case of an arrangement in public housing or the local area. It is no exaggeration to say that this kind of group dynamic or sociological perspective is also part of "mental health care."

VI. Increasing local resilience

I think that activities to consistently increase local resilience are another important element of "mental health care." This can be done in a variety of ways, but I would recommend creating a culture of accepting "free people." In Japan, we talk about being everybody's friend and we have a cultural tendency to be suspicious of such "free people."

Having experienced the Great East Japan Earthquake, I think it is of course important to implement concrete measures, but I also felt we need to think about creating people and building communities that can respond to any situation. With disasters of this magnitude, the very organizations that manage communities collapse and there is a need for something to fill in until they recover normal functions. The local area ought not to raise charismatic leaders but "hubs" that can connect different relevant organizations. "Hubs" need to be given a high degree of freedom in ordinary times, go out into the local area, sell themselves to the different organizations, and move in between them. I think raising such human resources from early on and deploying many of them in the local area can help improve local resilience. In the area of children's mental health, more freedom needs to be given to school social workers, and we need to secure human resources with a deep understanding of the characteristics of local children. It is very difficult to achieve anything if you say, "Let's work together," once an emergency occurs but never cooperate normally. I think the ideal is to have multiple networks that at times organically connect and disconnect like living beings.

Conclusion

What I strongly feel through our current activities is that, rather than techniques for diagnosing the mental symptoms of individuals and providing suitable support and treatment, what we need are techniques that view the local area as a unit and consider overall health promotion. That has less to do with psychotherapeutic and pharmacotherapeutic techniques and more to do with ideas relating to public health and abilities for group facilitation. Something more important still is techniques for smoothly working together with local residents and other organizations providing similar support. This is an attitude of understanding the feelings of others, respecting others, and cooperating with others without criticizing them.

I sincerely hope that we can take this opportunity to once more recognize what is needed for community-building and make this terrible disaster a turning point for mental health.

This paper is an edited and expanded version of the Chairman's Address given at the 114th Meeting of Japanese Society of Pediatric Psychiatry and Neurology in October 2015.

References

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3) Naru Fukuchi (2013). *Support for Children with Developmental Disorders during Disasters* (Advances in *Developmental* Disorder Medicine 25, Junichi Furusho ed.). Tokyo: Shindan to chiryo sha, 36–42.

Figure 1. Two ways to create arrangements in groups