

Acute mental care policy to the Great East Japan Earthquake and tsunami, Japan, 2011

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Preface

The earthquake that struck Tohoku, Japan, on March 11th 2011, was the worst massive earthquake in the last two decades in this country, following those happened in Kobe in 1995 and in Niigata in 2006. In response, the Ministry of Health, Labour and Welfare (MHLW) immediately assumed the head-quarter role in scheduling the dispatch of mental health teams, while many different organizations mobilized their staff. On the second day the Japanese Society of Psychiatry and Neurology established the crisis response committee and, on the third, the National Center of Neurology Psychiatry (NCNP) opened the information site for providing more than 20 guidelines, manuals, tools for mental health care provision, to become standard referential. Over the decade preceding this disaster, MHLW, which had accumulated a significant amount of relevant knowledge and data through Health and Labour Sciences Research, continued to train more than ten thousands clinicians and disaster relief workers in the communities. Guidelines for Local Mental Health Care Activities after a Disaster had been prepared by NCNP and were distributed by MHLW throughout the country. As a result, most mental health centers of the prefectures and ordinance-designated cities, including this time's afflicted sites of Iwate, Miyagi, Fukushima and Sendai, had prepared a set of manuals, reporting forms, assessment tools, scheduling lists for post-disaster mental health care.

The comprehensive picture of Japanese mental health care after the Tohoku earthquakes will be reported soon elsewhere, and hereby the following will introduce some of the general principles of post-disaster mental health care. These basic principles are also outlined in the Guidelines for Local Mental Health Care Activities after a Disaster in more detail. Although the guidelines were prepared prior to the Tohoku earthquakes, the following will introduce the basic principles of mental health care activities that can be applicable to the Tohoku relief effort.

Policies for Local Mental Health Care after a Disaster

Upon arrival at the disaster scene, the first requirement in providing mental health care activities is to support mental health centers in the afflicted communities so they can continue to carry out their mental health routines and treatments. In the case of Tohoku earthquakes, provision of medical assistance as well as medication supply took place immediately after the disaster in

response to an interruption of medication delivery. In addition to supporting the local mental health centers, there are two main types of local mental health care activities targeting local residents affected by the disaster. The first type includes activities within the chain of general assistance programs which are designed to improve the mental health of the entire community as a group and to reduce the stress and mental trauma of the group. This type of activities consist mainly of ordinary assistance givers and local mental health treatment staff going to the disaster area in outreach activities, delivery of disaster-related information, and psychology education for the general public. In addition, practical assistance for disaster recovery and life support in itself helps to improve the mental health of the community.

The second type includes prevention, early detection and treatment of particular mental disorders. The second type of activities consist mainly of screening individuals with mental disorders, encouraging people to come for consultations, providing psychology education for individuals, and making referrals to specialists. For the first one to two weeks or longer, the first type of activities will be the main focus. The health level of the community will be enhanced as relief workers enter the scene to meet and talk with survivors and victims and respond to their actual needs. The second type of activities should then follow and be directed toward alleviating states of confusion, excitement and disorientation, rather than making diagnoses.

Types of Psychological Burdens

There are three major types of psychological burdens following a disaster. *Mental trauma* is a condition in which the sympathetic nervous system stays overstimulated in response to a threat-to-life experience and is associated with the increased retrieval of traumatic memory. It can be characterized by heightened anxiety and fear, inability to take in the entire scene in front of one's eyes, focusing of attention on the most fear-inducing stimulus. Acute memory of the disaster scenes and fears are deeply engraved in the mind. The second type includes emotional responses such as *Grief, Loss, Anger and Guilt*, and they may come to the fore after the initial disorientation and excitability have settled down. A person may be beset by a sense of heavy obligation for being the one who survived (survivor's guilt), grief following deaths of loved ones, or a feeling of having been unable to do the right thing. And at the same time, resentment at the fate that has befallen survivors may lead to anger toward relief workers or other people around them. *Social and Lifestyle Stress* is induced by a new living environment and can be characterized by physical or mental malaise, indefinite complaints, insomnia, and irritability. When a large group of displaced people live together, issues arise concerning privacy, the living space (food, toilets, garbage, duty assignments), care for children, the elderly and the handicapped.

Initial Response (During the First Month)

Still the nature of the area or the disaster could make the situation unusual, requiring special measures which match the actual circumstances. With regard to the anguish arising from actual damage, the best response is to take whatever practical measures are obviously required. Issues of survival, bodily health and living arrangements must of course be speedily resolved as the precondition for starting to deal with anxiety or other psychological reactions. But since those steps alone will not be enough to alleviate all of the terror, worry or other reactions, it is important to keep mental health issues in mind while responding to the urgent practical problems.

One of the most important immediate responses is to carry out “first contact.” First contact means meeting and talking with survivors as soon as possible after the event by visiting them at the disaster scene and evacuation centers. If it is delayed, people will be left in anxiety, despair and confusion. As a rule, the early responders making first contact should be people who have served the needs of the local population on previous occasions. While carrying out first contact, when possible the responders should try to identify individuals who are under especially strong stress and provide basic mental health information such as availability of psychological services.

The experience of disaster does not necessarily lead to Posttraumatic Stress Disorder (PTSD). In disaster situations the most commonly observed causes of PTSD are personal experience of fire, flooding or house collapse, the death or injury of a loved one, or seeing corpses. Since there are many other kinds of psychological reactions that may occur after a disaster, mental health treatment is not focused on early detection and treatment of PTSD. Rather, it is important always to maintain the basic approach of readiness to identify a broad range of psychological changes, and to respond as appropriate with diagnosis, evaluation or assistance. Assistance should be provided to minimize the survivor’s responsibilities for care of others, so that the survivor finds security, peace of mind, and restful sleep as soon as possible.

As a rule, in counseling soon after the event, do not ask the survivor to recount the story and emotional impact of the disaster experience. This can be harmful. It was previously thought that using this technique (psychological debriefing) at an early stage could help to prevent the future onset of PTSD. But the technique is now discredited internationally and avoidance is clearly recommended. What is important is to build a network around the survivor of understanding people who can talk together about the actual suffering in the disaster and subsequent difficulties in moving forward.

Natural Recovery from Trauma

For most survivors, even if there is some temporary mental instability, they will naturally return to normal selves. As a policy for mental health care for the community as a whole, it should be assumed that natural recovery will occur in most cases, and support can be provided for that process. In supporting the process of natural recovery, it is necessary to provide conditions that encourage

natural recovery and to diminish factors that impede natural recovery.

Conditions that encourage natural recovery include practical support such as providing bodily safety, providing protection from secondary events, maintaining living conditions and continuity of daily life, offering prospects for recovering economic footing, and providing protection from day to day stress. General support such as providing information on damage and assistance, responding to requests and questions in a prompt manner can be helpful. Informing people about expected psychological changes following a disaster is an important part of psychological care. Suggestions for counseling can be made when needed.

Factors that impede natural recovery are intrusions that cause secondary trauma or threaten the stability of daily life. Some of the most common factors include delayed assistance in rebuilding deteriorated living conditions and loss of family members. Special attentions should be paid for those who belong to any of the especially vulnerable groups (infants, the elderly, the handicapped, the sick or injured, people whose first language is not Japanese, and families of any of these groups). Socially isolated persons (single persons, people with nobody outside the family to talk to) should also be considered as vulnerable. Other common factors include being interviewed by the media against a person's will and having inspections by the police, public officials, insurance companies etc.

Multicultural Issues

Regardless of purposes of stay, most foreigners are considered as especially vulnerable to disaster because of their limited comprehension of the language spoken in the afflicted area. In general they cannot fully grasp public information, and are therefore liable to suffer secondary uncertainty anxiety. In addition, depending on their native culture, foreigners are likely to have different patterns of reaction to a disaster. This may well lead to complications in the course of group activities and refugee shelter living, and mental health care supervisors will need some special understanding to rectify them. It would be helpful to have volunteers who can speak the native languages of the foreigners, but it is often impossible to have the right people on hand in the disaster setting. When there are multicultural needs, it may be possible to have linguists from outside the area prepare special messages for public information releases, or to request the media to prepare multilingual versions of disaster information broadcasts. Even though foreign-language versions may be less complete than the originals, the mere fact that information is provided in their native language will provide valuable reassurance to these survivors.

Mental Health of Relief Workers

Relief workers can be fatigued from ongoing pressure of relief work. They may face limitations in performing a task in the ideal fashion. It is possible that a psychological conflict between the

sense of mission and the limitations of reality will cause feelings of guilt or powerlessness. Amid the extensive damage and suffering, area residents often display emotional reactions such as anger and guilt. It is not unusual for survivors to release their anger toward relief workers who are in the vicinity. If the workers feel like the anger is personally directed toward them, they may come under considerable stress. In addition to the stress of carrying out duties, relief workers are quite likely, even more than most local residents, to be exposed to the sight of terrible damage, corpses and the like, which may result in PTSD or other trauma reactions. It should also be noted that some relief workers may be disaster victims themselves, and they are at risk of extra psychological tensions and exhaustion. Adjusting to a new place and being away from home may also cause considerable stress, especially if the assignment is for an indefinite period.

Relief workers may tend to neglect their own health issues or, even when they recognize them, have too strong a sense of mission to take breaks or seek treatment. The following are some of the countermeasures that can be helpful to relief workers. Though it may not be possible during the emergency phase just after the event, as soon as it is practical the activity periods, relief schedules, responsibilities and job descriptions must be clarified for all mobilized relief workers. It is effective to teach relief workers that stress is nothing to be ashamed of, but instead must be recognized and adequately treated. It is important to give each relief worker a checklist of potential physical and mental irregularities, and when necessary to offer health counseling.

Postface

These principles mentioned above have been widely known to relevant authorities and organizations in Japan over the past decade and regarded as the basic principles of post-disaster mental health care activities. It appears that most of the mental health care teams have been following these basic principles in their relief efforts for the afflicted areas in Tohoku. Nowadays few believe that it is beneficial for the survivors to recount the emotional impact of the disaster experience soon after the event, but there are a few reported cases in which some relief workers of non-clinical backgrounds have used somewhat similar techniques. Further measures have to be taken to disseminate the knowledge to all relief workers regardless of their backgrounds, in order to deliver more effective post-disaster mental health care.