Disaster Support for Children

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1. Introduction

After the unprecedented, unheard of disaster that occurred on that day, numerous organizations rushed to Miyagi Prefecture and began to provide support to affected areas. We were among the individuals who did so, and as child psychiatrists—a special role—we joined a mental health care team in Sendai early on. As former pediatricians, we served as go-betweens between prefectural pediatricians and neurologists. Thus, here, we would like to report on the practices of child mental health care in local areas.

There are fewer than 200 child psychiatrists throughout Japan. It is one of those specialties in which education simply cannot catch up to demand. For this reason, despite being relatively young, we were given rather large roles and asked to handle very important tasks. Day in and day out, we worked with the understanding that we were "rare animals," so to speak. In addition, the aforementioned circumstances had a deep impact on us, and ever since the disaster occurred, we were convinced that "we simply have to do something." Thus, with our sympathetic nervous systems on overdrive, we visited disaster-affected areas day after day, and oversaw the lives and conditions of many children.

2. Disaster Psychology Education

(1) An Environment Protected from Outside Information

After the disaster, the first thing we thought of was how to respond to the needs of the children admitted to the Child and Adolescent Ward of our hospital (the Tohoku Fukushi University Sendan Hospital). For several days after the disaster, power outages prevented these children from watching TV, and thus, they were almost entirely cut off from outside information. As a result, they were far less perturbed than we had expected, and they were even calm in their responses to their parents' calls regarding their wellbeing. After the power eventually came back on, we fibbed and told them that we needed to "save energy," and did not allow them to watch TV. We neither wanted them to see footage of their beloved homes being swept away by the muddied torrents nor witness the tearful, sobbing interviews given by people who had lost their families.

Miyagi Prefecture has psychiatric hospitals located along the coast, and several of these were severely damaged by the tsunami[1]. Patients and staff alike lost their lives, and many struggled valiantly to save those who were left with what limited medical resources they had. Further, it became quite reckless to attempt to stay in these essentially defunct hospitals, and we received many requests for patients to be transferred to our hospital, which was relatively undamaged. If we accepted those requests, we realized that the children in our Child and Adolescent Ward would no longer be protected from outside information; we imagined it would be turned into a mixed ward, filled with adults escaping from tsunami damage. If that were to happen, it was only a matter of time before the children would learn of the damage suffered by nearby areas, and that they would soon be exposed to information from the TV and newspapers.

(2) Implementation of Disaster Psychology Education

As a result, it became difficult to continue to hide the truth of the post-disaster damage from these children, and we decided to begin an impromptu "disaster psychology education" program for them.

At the time, while power outages had been resolved, gas had not yet returned, and the heating system remained unusable. Thus, we brought heated carpets from our homes, laid them out on the floor of the ward, had the children and staff huddle together with each other to keep warm, and used slides to hold an approximately one-hour impromptu disaster psychological education program. The program was divided into three parts: telling the truth, how feelings come about, and relaxation. We also distributed self-check worksheets designed to supplement information on CBT.

We explained the extent of the disaster in full detail, hiding nothing, and also told the children about what might happen next. However, we made sure to comprehensively communicate the message that “no matter what happens, we will protect you.” The children reacted much better than we had expected, and they exchanged opinions with great interest. After the program ended, they all pitched in in the cleanup of their own will, and they ate their food that night without wasting a single morsel.

The slides we used that day have been linked on the “Child Mental Health Treatment Hospital Organization Project” website, from where they can be downloaded for free [2), 3)].

3. Children During School Visitations

(1) Effects of Post-Disaster Hyperarousal

About three months after the disaster, the education board of an elementary school that had suffered severe damage sent out a request for child psychiatrists to be dispatched to their campus. As the school had been used as an evacuation shelter prior to reopening, we were already acquainted with several of the children and teachers there, and we transitioned into our roles relatively smoothly. When we would visit and ask teachers how the children were doing, nearly all of them said “they’re super lively.”

Indeed, if one were to take a look at them, these children did not, in fact, seem to be experiencing any serious worries: they would speak loudly and play energetically. However, when I look back, I think this state may have been greatly influenced by post-disaster “hyperarousal.”

(2) Children Who Stay Back in Areas with Severe Damage

While this has been reported before [4)], even now, one year after the disaster, the number of children who come to medical institutions has by no means increased. Strangely enough, the number of children who come from coastal areas with severe damage is quite low, and the ones who get checked up are almost always those who moved to Sendai, which remained quite “safe” relative to coastal areas.

Behind this unusual phenomenon is likely an issue with these children’s “self-perception.” Almost without exception, children who did not move out of areas with severe damage went through the same experiences. They all saw the tsunami and their neighbors being washed away. Many of them even lost a family member. However, because everyone around them had similar experiences, many of them just assume that this is normal and continue to live with that flawed self-perception.

On the contrary, children who moved or transferred schools to areas with less damage came face-to-face with the gap between their experiences and the experiences of those around them. They compared their experiences with those of others, and were essentially forced into the realization that, “Wow, I really went through something horrible.” They became unable to share their experiences with others, somehow found it difficult to fit in with their peers, and ended up feeling lonely or isolated. As a result, they began to present with a variety of physical symptoms, could even fall into depression, and ended up not going to school. One case I took part in involved a child who had begun going to school in Sendai, but because they found themselves unable to fit in with their peers there, decided to return to their old school on the coast, which was now more than two hours away.

(3) Child Mental Responses

When, then, will the children remaining in coastal areas develop a mental response to what happened to them? I believe that this will happen when the continued existence of their regional community becomes difficult. Many schools whose facilities were damaged beyond usability by the tsunami borrowed space from nearby schools to continue lessons. However, the possibility that these schools would be rebuilt was quite low, and many of the students who formerly attended these schools moved on to others. Thus, we see a trend whereby many of these schools are being consolidated into others.

When that time comes, and when they are forced to confront problems and realize truths about their lives thus far, how will these children react?

When I think of that question, I can’t help but wrack my brain to think of some sort of method to provide preventive interventions to these children in what little time I have.

4. Camp Initiative

(1) Need for a Group Therapy Approach for Children

As I have just described, at the current moment, there are countless children without psychological symptoms who, upon becoming able to form an accurate self-perception, will respond in some unknown way. Even outside of disaster areas, at the national level, the number of specialists capable of providing mental health care for children is horrifically low. Individual work with these children is simply impossible from a practical standpoint, making the group therapy approach the only viable option. I believe that group therapy programs should be incorporated into school curricula.

(2) Implementation of a Camp for Children in Disaster Areas

In Sendai, I have led a research group of individuals involved in clinical practice in child mental health care since 2007; thus, following this most recent earthquake, myself and these members obtained the cooperation of several organizations (volunteer organizations, regional youth sports clubs, etc.) and decided to hold a camp for children in disaster-affected areas. Till date, this camp has been held twice, in July and October 2011, and around 30 children have participated each time (Table 1).

Table 1: Camp Overview

	Session 1	Session 2
Date and Time	July 23–24, 2011 (Sat–Sun),	October 29–30, 2011 (Sat–Sun)
Place	Izumigatake Open-Air School, Sendai	Asahi Open-Air School, Yamagata
Child Participants	29 (16 boys/13 girls)	24 (14 boys/10 girls)
Ages	5–12 years old (average age 8.4)	5–13 years old (average age 9.1)
Parent Participants	12	13
Total Staff	23	37

Further, in preparation for the possibility that these children may later develop mental illness, we recruited participants only from areas in which participating physicians could provide follow-up care. Our staff consisted of a small number of specialists and student volunteers, and we arranged it such that each child would get one-on-one time with a staff member.

The results of this camp initiative have not yet crystallized, but we plan to continue to hold it. As we hold more and more sessions, we predict that some children will participate several times, and we will then be able to watch over them as they grow and develop.

(1) Working with Parents and Guardians

We sent a questionnaire to children's households prior to both sessions, and asked parents to indicate what they were worried about at home and what sorts of things they would like us to focus on or incorporate into our work with their child. As described below, psychological education for parents and children was carried out separately.

On the day of the camp itself, we had parents and children assemble together at an agreed-upon meeting location, where the staff took charge of just the children and took them by bus to the campground. We asked parents to then meet us at a hall near the meeting place, where in addition to simple psychological education from specialists, we had a tea party, where parents could share their experiences and worries about their children in a casual setting.

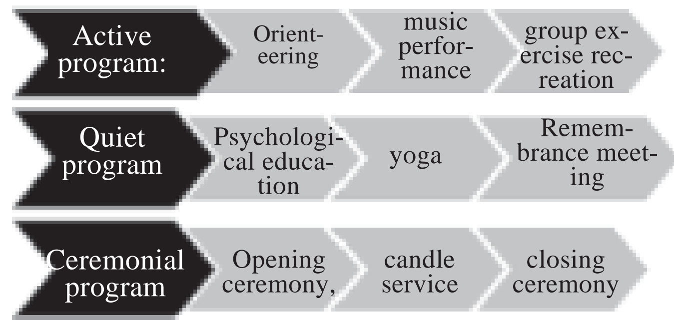
The primary objective of this psychological education was to have parents experience the psychological interventions we had planned for their kids at camp, but it also helped some parents release mental stress. Afterward, we also set up individual booths where parents who wished to receive individual counseling could do so. We carried out a follow-up survey approximately two weeks after the camp, and overall, parents indicated that they were satisfied with the experience.

(2) Working with Children

The camp was quite short (two days and one night); thus, it was infeasible to expect very significant results. However, we alternated events from three separate program types: an active program (orienteering, music performance by a professional, and group exercise re creation), a quiet program (psychological education, yoga, and a remembrance meeting), and a ceremonial program(opening ceremony, candle service, and a closing ceremony). Thus, we maintained a cohesive flow to our activities (Fig. 1).

As children of various ages took part, we needed to design our psychological education program with some skill. For example, we conducted a semi-structured art therapy session. Different children had different levels of concentration; several were able to follow the instructions of the teacher and achieve some level of calm through art, while others were completely unable to concentrate on the art and simply chose to run around.

Figure 1:Child program Flow



Further, in the second session of the camp, we implemented an imagination-based psychological therapy program for upper-class children. We also carried out a follow-up survey, and most indicated that they were satisfied with the camp.

5. Conclusion

In order for children's mental responses to emerge, certain conditions need to be satisfied, and adults must begin to exhibit mental responses. In other words, if their parents and guardians cannot calm down, children will become unable to even cling to their objects of affection. For example, in evacuation shelters, we saw many kids who were unable to safely regress into a more childlike state, and instead spent all their time immersed in videogames. Aid workers' true task still lies ahead of them, as the conditions that are necessary for child responses are expected to be satisfied in two to three years hence. We imagine that this is when the "reconstruction of Tohoku" will be clamored for in earnest.

Most of us know that the journey to reconstruction is a long one, and that our destination is still quite a way off. The strength of us locals is simply not enough to ensure that the mental health of the children of this region will be adequately protected. Through this passage, I humbly ask all of you for your long-lasting support.

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