How should professional associations act during a disaster? - Report from the Japanese Society of Psychosomatic Pediatrics -

*Reference: Japanese Society of Psychosomatic Medicine, Psychosomatic Medicine Vol.56, 257-262, 2016

Miyagi Disaster Mental Health Care Center

Naru Fukuchi

Abstract: We reported the support of the Japanese Society of Psychosomatic Pediatrics for disaster-affected areas after the Great East Japan Earthquake and Tsunami in 2011. At the same time, we received support from professional associations such as academic societies. Whether or not support was effective depended on how supporters evaluated the present needs in the disaster-affected areas. Many professional associations tended to offer their specialties at the beginning of their activities to support the region. However, even if they may have effectively utilized their knowledge and expertise, most people who lived in the affected areas needed general physicians such as public health doctors. We observed many kinds of group dynamics that took place in the disaster affected areas, including the promotion of social gathering and encouraging excessive caution. In some areas, residents made a barrier against outside supports because they sensed threats that may break their system. It is recommended that supporters make efforts to evaluate the present situation and needs of disaster-affected areas to provide appropriate aid, as well as consider that every form of help provided for rapid recovery is influenced by the time spent to respond after a massive disaster. The most important aspect of disaster support is a good structure that can assess the present needs and situation of disaster-affected areas and which can deliver the support that matches these conditions.

Key words： Great East Japan Earthquake, disaster support, professional associations

Introduction

Following the Great East Japan Earthquake on March 11th, 2011, professional associations such as academic societies began to provide support in various forms to the disaster area. The Japanese Society of Psychosomatic Pediatrics (henceforth, "Society") with which the author is affiliated also provided some form of support immediately following the disaster. Some of this support was effective and other aspects of it were less so, and further review and redevelopment of how future emergency support should be enacted are necessary. This was introduced as "Disaster support initiatives of the Japanese Society of Psychosomatic Pediatrics" at the 56th Annual Meeting of the Society, but this paper will discuss the support of all professional associations and not just the support provided by a single society. Additionally, the author has experienced the earthquake as an employed resident of Miyagi Prefecture, who as a group is ultimately in charge of the overall rebuilding of mental health structures in the prefecture and has been engaged in municipal support in coastal regions since the occurrence of the disaster. At the same time, the author was engaged in accepting help from external support organizations. This paper will discuss issues in disaster support from these viewpoints, touch upon community changes from the accepting side, and add a few considerations on this topic.

Activities of the Japanese Society of Psychosomatic Pediatrics[1]

Society initiatives are shown in Table 1. On March 15th, four days after the disaster, the board of directors decided to establish a disaster management committee and initiated support projects primarily through this committee. The first system that this committee set its sights on to utilize its specialist skills was one where physicians from the Society were dispatched to regions who requested them. The registration of this dispatched physician list was started on March 22nd, with applications send through the Society mailing list and 62 individuals were ultimately placed on a waiting list. A training session was hosted on April 16th to ensure that the physicians acquired the preliminary skills for dispatch work, and with 84 participants, it was

evident that there was a high awareness of disaster support by Society members. However, despite the various schemes devised, even now, there have been no physicians dispatched on-site for clinical activities, with physicians only being dispatched for lectures at a few workshops.

There were also two pamphlets created by the Society: "Drug list for children with anxiety, insomnia, or night-time crying due to the earthquake"2), and "Mental health responses for children in disaster situations"3). These were created as distribution materials for the above-mentioned workshop participants but also designed so that they can be used as leaflets for residents or care workers once the physicians have engaged in disaster support. These pamphlets were available for download from the Society home page, and we were able to confirm that a large number of people have downloaded them, resulting in their usage by a wide range of individuals.

Many Society members were directly affected by the Great Hanshin-Awaji Earthquake and the Niigata Chuetsu Earthquake and they have communicated many challenges related to disaster area support from the perspective of their respective disciplines4) 5). It has long been indicated by these members that it is important to re-affirm the necessary common knowledge and concepts for supporting affected children and families during these activities to ensure that effective support is given out. The Society created the "mental health countermeasures guide for post-disaster children"6) to extract and identify finding based on prior experience and issues in the Tohoku region. Society members were asked to contribute, and the Society sought to create a comprehensive document that would be applicable for all scenarios. The text was published in its entirety in the November 2014 Society journal issue, "Children's Body and Mind", and efforts were made to distribute it out to a wide range of Society members.

How were the activities of all professional associations?

Support provided by professional associations, including the Society, will be discussed here. Although the Society was able to rapidly mobilize immediately following the disaster, the development of its activities was not as expected, and the Society encountered numerous difficulties. Generally, there is a limited extent of support that can be provided by a specialized organization, and there are not many other original options beyond what has been done by the Society (specialist dispatch, leaflet creation, guideline creation). The scale of other organizations may have varied, but ultimately, the content of their support was effectively the same, and we have encountered the same roadblocks as our Society. Even after creating the physician dispatch system, there were not as many requests as expected, and the Society had a slightly side-stepped feeling. Several causes can be cited for this, but one of these is perhaps due to the fatigue of on-site coordinating staff members[7]. The reality is that these care workers have provided on-site support while being victims themselves and, despite being thankful for the overwhelming amount of external support, they ultimately could not accommodate them all and were forced to turn them down. Another reason that cannot be ignored is the mismatch between the supporting side and on-site needs. From the supporting perspective, it is natural to want to utilize their specialist skills that they have continued to develop for these regions. However, the skills required on-site are essentially those of general physicians, which anybody in the field of public health can carry out. Ultimately, the regions want individuals who can provide on-the-side support for on-site care workers who reside in disaster areas for relatively long periods and are likely to become overworked. In other words, future challenges for specialist dispatch systems are to accurately determine on-site needs and to create a system that enables long-term dispatched individuals.

Many organizations also provided support by raising public awareness with leaflets and websites[8]. There was a massive influx of information into the disaster area, but this was thought to be advantageous for victims as it became widely disseminated and their choices increased. However, there were times where the distributed information would vary according to the transmitting organization, and victims were confused as to what they should believe. Is it not our duty to re-establish a basic consensus among associated organizations as to what information is necessary for victims in these dangerous conditions? The author believes that the establishment of working groups between associated societies is essential, particularly among disciplines relevant to the situation. Additionally, when creating these public awareness tools, the passions of the creators can become excessive, resulting in verbose communications with an overabundance of information. The mental state of the victims receiving this information is in a hyper-vigilant state to overcome their daily life and it is often the case that they cannot concentrate on or understand public awareness tools which include too many words or too much information. It is necessary to provide information with minimal words and information.

The number of associated publications increased dramatically after the Great East Japan Earthquake, and awareness among specialists on post-disaster psychological support has become very high. Many organizations were engaged in the creation of guidebooks or manuals[9], and these became easily accessible to anybody. However, similar to leaflets, the content of these publications varied slightly between each other, and it became impossible to determine which one to choose since there were so many. Perhaps in the future, associated organizations need to work together, compare and analyze several guidebooks, and select a minimal number of common criteria. Finally, these publications should not be limited to just natural disasters such as earthquakes or tsunamis, but instead provide support for a variety of dangerous conditions, such as accidents or conflict. These types of initiatives are being advanced in various countries, and it is thought that Japan should establish its guiding principles by referencing documents like Psychological First Aid[10], published by the World Health Organization (WHO).

Community changes

Remarks by the author which should be noted as a care worker in disaster areas are discussed here about changes in regional circumstances regarding the acceptance of external support[11]. When care workers continue to provide support close to a disaster area, they recognize defense mechanisms in the attitudes of groups, who instinctually transform to protect themselves against a powerful stimulus. The community was affected by the stimulus of a large-scale disaster and it has constantly transformed to respond to these changes. The following changes in the overall community can be observed: 1) Strengthened unity, 2) Opening and closing of the community, and 3) excessive suspicion.

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. In these ways, the purpose of the meetings must change with time. External care workers often tried to provide support at these types of meetings, but it is difficult to accurately determine the changing needs over time and to shift their roles demanded by that community.

2) Opening and closing of the community

As time passed since the disaster, there were changes in the regional attitudes of accepting support (Figure 1). 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. Disaster areas 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 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 to ensure that the same incident does not occur again and that there is 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 supporters 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[12]. 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. Simultaneously, it is not strange at all for existing regional systems to act as though accepting external care workers en masse is a threat to their dynamic. Under abnormal circumstances, perhaps these regions developed a sense of vigilance and strong resistance to external support as an instinctually developed defense mechanism.

Conclusion

Overcoming massive disasters like the Great East Japan Earthquake is difficult with just on-site care workers and the key to recovery in these regions is their smooth cooperation with external care workers. There are several support methods by professional organizations, but they must accurately determine the needs of the region for these to be effectively utilized. There was little need for specialized skills immediately after the disaster and instead what was needed were care workers who could provide general work that almost anybody could do. It is likely that with time, the demands will change, and specialists will be gradually needed in the region.

One of the experiences felt while engaged in on-site activities is the need for techniques that view the region as a whole, and develop the overall health of the region, rather than techniques that evaluate the mental symptoms of individuals and appropriately support and treat them. These results are likely not in psychological, mental, or drug therapy techniques, but rather in public health perspectives or group-facilitating techniques. And what will be even more important in the future are the techniques that effectively synergize with regional residents or other organizations that provide the same treatment. This is an attitude that understands the other persons' feelings, respects, and values the other, and provides mutual support without criticism. It is my sincerest wish to re-affirm what is necessary for community development and to use this large-scale disaster as a turning point for mental health.

This paper reports no conflict of interest with any other organizations or corporations.

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Figure 1 Initiatives of the Japanese Society of Psychosomatic Pediatrics

Dispatching doctors

- Doctor dispatch activities were determined on March 17th, 2011, registration started on March 22nd (62 registrants)
- Lecturers dispatched to lectures in June of the same year (Iwate Prefecture / Morioka City, Fukushima Prefecture / Soma City)
- Ultimately, only one-time dispatches of lecturers were conducted, and no doctors were dispatched for clinical work

Creation of leaflets

- "Drug list for children with anxiety, insomnia, or night-time crying due to the earthquake"
- "Mental health responses for children in disaster situations"

Workshop and symposium planning

- The 1st mental support workshop for children in disaster areas was hosted on April 16th, 2011.
- The 2nd mental support workshop for children in disaster areas was hosted in the 29th Society Meeting on September 16th of the same year
- A mental health care for children in disaster conditions symposium was hosted in the 31st Society Meeting on September 13th, 2013.

Creation of a guidebook

- The Society Disaster Management Committee created a "mental health countermeasures guide for children in disaster situations".

Figure 2 Opening and closing of the community