FY 2018 Miyagi Mental Health Care Forum Report

Miyagi Disaster Mental Health Care Center
Stem Center, Planning and Research Division
Psychiatric Social Worker – **Hiroyuki Kimura**

Following the Miyagi Prefecture Reconstruction Plan, which set FY 2020 as the target deadline for reconstruction, the Miyagi Disaster Mental Health Care Center formulated a management plan in March 2017. One of the items contained in that plan was the Miyagi Mental Health Care Forum Project, a research program aimed at contributing to future disaster countermeasures. The first iteration of the Forum was held in FY 2017; we plan to continue holding it until 2020.

FY 2018 marks the second year of this event; we have retained the core theme—which was established last year—entitled, "Seven Years of Post-Disaster Mental Health Care Services and Future Goals," along with our subtheme "What We Can Learn from the Issues Confronting Our Communities." We provide an overview of the event below.

1. Setting Up the Forum

(1) Objective

The forum's primary goal was to showcase reports on the progress of the activities and the issues facing various cities and towns, the Miyagi Prefecture, and the Miyagi Disaster Mental Health Care Center, as well. Based on these reports and the ideas and findings of external speakers and attendees, we sought to begin a dialogue exploring the nature of future community psychiatric welfare at the prefectural and township level.

(2) Date: Friday, October 26, 2018, 10:00 AM – 4:00 PM

(3) Location: TKP Garden City Sendai, 21F Halls C & D

(4) Attendees: 130

(5) Program

Title: "7 Years of Post-Disaster Mental Health Care Services and Future Goals"

Subtitle: "What We Can Learn from the Issues Facing Our Communities"

Chair: Kazunori Matsumoto, Associate Professor, Department of Psychiatry and Neurology, Tohoku University Graduate School of Medicine
Vice President, Miyagi Disaster Mental Health Care Center

Part 1 Practical Reports

Presenters:

① Kesennuma Health and Welfare Department, Health Promotion Division
Hiroko Koyama, Public Health Nurse
Ayaka Ogasawara, Psychiatric Social Worker

② Ishinomaki Health Department Deputy Director and Welfare Department Secretary
Hatsuko Kutsuzawa, Public Health Nurse

③ Iwanuma Health and Welfare Department, Health Promotion Division Chief
Ayumi Sugawara, Public Health Nurse

④ Miyagi Prefecture Ministry of Health and Welfare, Disability Welfare Division, Assistant Director of Mental Health
Yukari Oba, Public Health Nurse

⑤ Miyagi Disaster Mental Health Care Center Vice President
Takeshi Yamazaki, Clinical Psychologist

Part 2 Discussion

Keynote Address:
Yoshiharu Kim, President, National Information Center of Stress and Disaster Mental Health

Part 3

Social Exchange

(6) Event Operations

Sponsor: Miyagi Disaster Mental Health Care Center

Co-sponsor: Miyagi Prefecture and the City of Sendai

2. Program

(1) Practical Reports

Hiroko Koyama and Ayaka Ogasawara of the Health Promotion Division of the Kesennuma Health and Welfare Department reported on the fact that support for socially isolated men had become a community-wide problem in their area. They also presented the results of a salon initiative that they had organized to combat this issue.

The Deputy Director of the Ishinomaki Health Department and Welfare Department Secretary Hatsuko Kutsuzawa explained the mental health care initiatives her organization had initiated immediately after the disaster and continued to implement to this day. The issues she raised included a worsening trend in the health of individuals moved into restoration public housing; financial difficulties; childcare issues; and the exhaustion experienced by city officials.

Ayumi Sugawara, Chief of the Health Promotion Division of the Iwanuma Health and Welfare Department, explained the history behind the mental health care initiatives at her agency. She highlighted issues such as the need to shift mental health care activities into the regular work as well as methods to approach high-risk residents.

Yukari Oba, Assistant Director of Mental Health at the Disability Welfare Division of the Miyagi Prefecture Ministry of Health and Welfare explained the status of the reconstruction process and the efforts being made by both the prefecture and other organizations. They also addressed the issue of people's growing mental health welfare needs and the complicated nature of the challenges facing our communities.

Takeshi Yamazaki, Vice-President of the Miyagi Disaster Mental Health Care Center, presented a report detailing the center's activities and what they can teach us about the issues our communities face.

(2) Discussion

There was an exchange of ideas between the presenters, the advisors, and the conference participants on the following themes: support for elderly men living alone; deteriorating family units; the future of support systems; the passing on of our disaster experiences; and human resource development.

Afterward, in his keynote address, Yoshiharu Kim provided an evaluation of the ongoing initiatives in various communities and locales and offered a commentary on the issues of suicide and PTSD. For more details on this, refer to the Symposium Discussion Remarks below.

(3) Social Exchange

After the practical reports had been delivered and the discussion period had ended, speakers and participants engaged in information exchange. Many attendees participated.

3. Attendee Questionnaire Results

To gain useful feedback that would help in the planning of future events, we gave all attendees a questionnaire at the beginning of the event and received 55 responses.

Some of the sample responses are as follows: "I had the opportunity to learn about what's going on in many different areas—something I found very useful," and "This should serve as a good point of reference for future countermeasures." Many individuals expressed similar sentiments, and more than 90% of the attendees expressed their satisfaction with the event overall.

4. Summary

With “7 Years of Post-Disaster Mental Health Care Services and Future Goals” and “What We Can Learn from the Issues Facing Our Communities” as the overarching themes, practical reports were presented, and a discussion was held. Supporters from across many different fields participated.

The speakers reported on their experiences in the field and on what they encountered during their community support work. A common theme was that of elderly men living alone.

Presenters also provided insights into the many problems plaguing disaster-affected regions, such as a prolonged shortage of manpower and supporter exhaustion.

This, the eighth year since the disaster, is a year of development, according to the Miyagi Prefecture Earthquake Reconstruction Plan. As hardware maintenance and disaster public housing move-in programs progress, disaster survivors’ circumstances continue to improve. However, this forum also highlighted some of the many issues that remain.

It is vital for the future mental wellbeing and welfare of our communities that we share, at the prefectural level, and with supporters and specialists from different fields, the problems that have beset each phase of the reconstruction process. As we do so, we must continue to provide them with a space in which they can meet to discuss these problems. It is why we believe that the forum initiative will only grow in importance in the years to come.

Symposium Discussion Remarks

Matsumoto First, we'd like to give the audience a chance to ask the presenters questions and to share their own opinions.

Ichijo (audience member) My name is Ichijo, and I'm with the Child Disaster Support Department at the Tohoku University Graduate School of Education. I'd like to know a little more about the ages and genders of the individuals whose counseling cases were included in the materials presented.

Koyama The individuals we see at the Kesennuma Health Promotion Division are mostly men in their 50s to 70s, I believe.

Kutsuzawa We don't categorize patients by age very strictly. Individuals who move into reconstructed and temporary housing are generally elderly, and I think that they comprise a large percentage of Kesennuma residents. As a result, they tend to be in poor health, have heart problems, trouble sleeping at night, etc. In short, I believe elderly individuals make up the bulk of our counseling cases.

Sugawara It is usually the case that individuals designated by health surveys as "needing support" are elderly. In the context of mother-child health and medical checkups, individuals raising children can also be seen.

Yamazaki Immediately after a health survey, home visits are quite common. As a result, we rarely meet working individuals. Naturally, home-bound elderly individuals are common, especially those in the 50s to 70s age range. People with alcohol problems are often males who are in their 40s and 50s.

Recently, I believe we've had an increase in the number of children and young people in their 20s who are receiving counseling, prompted either by their own needs or by the government.

Matsumoto MDMHCC data shows an increase in the number of young individuals, especially at the Kesennuma Regional Center.

Katayanagi While their percentages haven't been high in the last two to three years, counseling cases with school-affiliated teachers or parents have increased considerably. Complicated issues such as truancy, hikikomori, and difficulty adjusting to school, as well as behind the scenes problems with parents and families, have increased.

Kim We've had several cases with elderly males. Could you maybe tell us a little bit about whether males, who find themselves living alone in the aftermath of a disaster, have the same characteristics as males who are used to living alone? Also, what have you learned about how they came to be living alone, elderly men in particular?

Mitsuura A lot of the residents at Kesennuma were homeowners. We've seen cases where alcohol abuse and other issues surfaced only after these individuals were moved into temporary housing, and that too thanks to their neighbors' solicitousness, as they noticed their troubles.

Another pattern we've seen is that individuals who relied on geographical and familial networks for the support lost that support after the disaster disrupted those networks.

Kutsuzawa Because different kinds of people live together in evacuation shelters, the individuals that you spoke of get the opportunity to see how other married couples live their lives. This helps them realize that the DV or alcohol abuse present in their previous relationships was not normal, and they end up taking some time to decide how they would like to live with a future spouse.

Sugawara Although the disaster-affected areas of Iwanuma were originally neighborhoods with lots of large households, we noticed that elderly couples tended to move into container-type temporary housing, whereas young people chose to move into apartment-type temporary housing, resulting in a kind of separation. I also think that alcohol abuse, which perhaps goes unnoticed in the countryside, tends to surface when individuals move into collective housing.

Yamazaki I suffered as a result of the impact that the disaster had on my home in Higashimatsushima. It's my impression that it has become increasingly common for elderly individuals to be left alone, after households in which three or even four generations lived under one roof were split up by a disaster.

Matsumoto When familial and communal bonds are weakened, men in the middle- to the old-age bracket are often the ones that are hit hardest. I have often felt that we can view this as a phenomenon where men, who were once supported by their families or communities, are now surfacing in the wake of a disaster.

Kim One thing to note is that these men are not indi-viduals who have simply grown older and are accus-tomed to living alone for years on end. These are men that lost their families and began living alone for the first time in their old age. In other words, these el-derly men living alone are not accustomed to that lifestyle at all.

Imano My name is Imano, and I am a member of Ashinaga. I work with children who have lost their parents to a disaster. We have received several requests for counseling from the fathers of children who lost their mothers in the disaster, saying that they are "unable to work." When men like this express the need for support, where can we as administrators refer them so that they can get the information they need?

Koyama In Kesennuma, the Health Promotion Division can accept such cases. I would appreciate it if you would give us a phone call before referring to someone.

Kutsuzawa Ishinomaki's counseling services are always available. Our telephone counseling number is listed in the town bulletin, and we accept walk-in visits as well. We have also set up a support group for men in Karakoro station called "Ojikoro," among other things. Individuals have called this group directly and we have offered advice.

Sugawara One difficulty is figuring out what counseling desk the individual should visit. At Iwanuma, there's one in the city hall, another at the social welfare council, etc. However, some places do not make it clear what sorts of problems they address, and sometimes residents can just get shunted around from agency to agency. I think it would be truly wonderful if more places were able to respond to the needs of individuals in trouble.

Yamazaki At the MDMHCC, we offer counsel to anyone emotionally affected by the disaster. For example, we offer telephone counseling to fathers whose wives have passed away and are struggling with childcare. Because we do not have consultation rooms, it is often difficult for us to meet with clients in person. Normally, we first provide counseling over the phone, after which we make arrangements to meet somewhere, and, if necessary, make a home visit.

Oba At the prefectural level, any health care center can provide such counseling. While the MDMHCC is of course capable of doing so, in Ishinomaki, we also have the Karakoro station program, etc. In terms of referring an individual to spaces and places where men who live alone can meet, these programs differ quite a bit from area to area.
Even in the early stages, we recognized that men were susceptible to this; how we approach them has been an issue we are contending with.

Matsumoto I am sure we are all familiar with the concept of "disaster-vulnerable" individuals. However, having seen how vulnerable men are in the reconstruction period, I have a feeling that the question of how we approach this population will become a central theme of future post-disaster recovery efforts.

Kim Normally, when we refer to disaster-vulnerable in-dividuals, we are referring to the acute period immedi-ately after a disaster, and generally, the term describes women and children. We rarely associate it with men. The concept of vulnerability in the reconstruction pe-riod is a new one, and the work done today has shown that men truly are vulnerable. We must be cognizant of this going forward.

Ogasawara I have often felt that it is difficult to get men to come in (for counseling). Of course, the content of the support provided is important, but building a relationship with the individual through repeated visits is also important. If anyone here is familiar with programs in other municipalities to encourage men to come in, I would love to hear about them.

Kutsuzawa We were only able to set up a men's club in one area. When club members were living in temporary housing, the club was quite active, but not anymore. I had heard from individuals experienced with the Great Hanshin-Awaji earthquake that individuals with alcohol problems, individuals living alone, and individuals in their 50s and 60s were most at risk. As a result, we were aware from the beginning that these groups needed more follow-up and we began thinking of what we could do to meet their needs.
Initially, I just assumed that the club meetings were going to be a social sort of event with drinking and whatnot, but the neighborhood council informed us that the participants would like to learn more about diabetes. So, we all sat down and put together a program to fulfill that request.
Community supporters from the neighborhood watch put together a really beautiful event, including providing non-alcoholic drinks in a "pub-like" setting, creating a shop curtain, and making the surroundings look like a bar. About 15-16 people participated.

Sugawara Back when we had container-type temporary housing in Iwanuma, we held a cooking class for men at the support center. Rather than focusing on the administrators, the supporters made the event all about "learning how to cook with other men," and I heard the event was popular enough to become a fixture in the center's roster of programs.

Matsumoto Do you all have anything else to say or ask?

Kutsuzawa I think child-related issues can pose very big problems. Attitude surveys among residents found that 80% of women in their 30s and 40s were stressed. Thinking about the future is no doubt incredibly stressful; if you all have any clues as to how you think the support process will function in the future, I'd love to hear them.

Yamazaki Generally, we set up desks at the health and welfare departments of the cities and towns that we are in, and based on advice from public health nurses, we've started to move into health care centers and infant health clinics. We have decided that if parents of children receiving counseling have problems of their own that they'd like to discuss, we will provide counseling to them as well.

Sugawara When I look back on what we have done, I get the feeling that we have collectively focused our support far too much on communities that were relocated as a group. Reconstruction happened relatively quickly in Iwanuma, so I think our studies of how our style of concentrating on group relocation committees will change in the future are ending prematurely.

What I am talking about are communities and neighborhoods that originally had rather strong social bonds and were essentially moved en masse first to emergency container-type temporary housing and then into homes. I get the feeling that when these communities begin living in new neighborhoods, the original bonds of community that they'd shared slowly weakened.

We must think about how we can construct and reconstruct these communities. I think that when it comes to transferring the responsibilities of community and environment building from support centers to residents, it is important for us to collectively consider issues like how best to raise morale, and how to help and motivate residents to reach an understanding of the sort of community that they would like to build. Additionally, we have had the Care Center and other organizations dispatch supervisors, assist us with case reviews, etc. However, regardless of whether they've lived through a disaster or not, people need support. I think we should also give some thought to what sorts of organizations and institutions will be able to assist us in providing such support in the coming years. I would like to hear from prefectural people on this matter.

Matsumoto Correct me if I am wrong, but I believe you're asking about how to build a community in a new locale and who should lead this process. Across the world, a lot of value is placed on the idea of self-reliance, accountability, and independence. However, at the end of the day, is it possible for these processes to occur naturally and independently, or do they have to be intentionally created? I think this is truly a difficult question.

Yamazaki I have realized that when trying to hold a gathering for men, planning the right set of activities can be difficult. We must make the event appear both attractive and interesting. I'd appreciate any feedback you all might have on what sorts of things were well-received during the male-oriented activities at Kesennuma, and what sorts of things were not.

Koyama I think our "Communication Mahjong" game was received quite well. A lot of the men at Kesennuma were fishermen, so we thought that they would like doing activities that involved fine handwork. We decided to conduct a papercut art event. But as the event progressed, it became clear that some of the men were unable to participate due to hand tremors, difficulty seeing, etc., and most were simply not interested. We took that as a learning experience moving forward. Finally, we have noticed that a certain number of people will come if food is involved, so this year, we have planned some simple cooking workshops, etc.

Yamazaki In Ishinomaki, the results of a disaster public housing health survey were disheartening. We discovered that the number of people living alone had been increasing. During the Great Hanshin-Awaji Earthquake, the problem of "death by loneliness" got a lot of attention. If I recall correctly, loneliness deaths peaked in the seventh year after the disaster, and after 10 years, approximately 500 people had died of loneliness. I'd love it if anyone could share suggestions with regards to mental health care guidelines and policies, such as how to follow up with individuals after they've moved into disaster public housing, how to build new communities, and what some good countermeasures against death by loneliness are.

Kutsuzawa When I got off the Sanriku Expressway at Konan, I saw that innumerable reconstruction public houses had been built. The neighborhood watch, our supporters, and social welfare council members patrol these homes regularly to check up on cases.

So, rather than providing immediate assistance, we decided to help these people maintain their independence by providing logistical, behind-the-scenes support. We have just started contracting with an organization called CLC in Sendai to provide follow-up support to the whole Shin-Hebita area.

However, we have trouble noticing problems as and when they occur. Early on, when residents had just moved in, we had not yet contracted with that agency. And at the time, we had individuals dying from "loneliness," although the specific definition of what that means can vary. Nowadays, we worry that suicide is starting to become a bit more prevalent. We're in the middle of thinking and re-thinking our plans to combat this, including turning to the neighborhood watch for help with visiting, not just individuals that need follow-up support, but every house in the area at least once every six months.

Matsumoto Although suicide rates have fallen throughout the country by around 10% this year, Ishinomaki's rates have fallen by only half that amount, with a 5% decline. Meanwhile, suicides in Miyagi Prefecture fell drastically in 2011 and 2012, well below the national average, but returned to the same rates more recently. I think that as time passes, the issue of suicide should be cause for grave concern, at least given current trends.

Matsumoto The MDMHCC was built to last for 10 years, in keeping with a plan. In terms of the future, we heard earlier about psychiatric welfare and mental health care activities. Rather than focus on the words used to define these concepts, we have been shown what sorts of functionalities will become necessary in the coming years.

One point to note is the presence of difficult cases: highly complex, intractable situations or individuals in our communities who are either difficult to treat directly or who require many, many visits before they are resolved. Individuals with the skill required to address such cases, that is, with the specialized knowledge required to provide advice in such environments are a functionality we sorely need. Furthermore, as cases get increasingly complex, rather than addressing them in one central location, it will become ever more vital for us to have multiple people in multiple places who can respond to them. Until now, we have provided support by requesting one public health nurse to head out and provide support; as we attempt to get more individuals in different professions involved, how will we implement the functionality we desire?

Finally, we have outreach capabilities. I believe public health nurses have been involved in-home visits in the past. In any case, having just one individual in a small municipality deal with the vast array of potential causes, including difficult situations, individuals in dire straits, young people, children, alcohol abusers, and the elderly, etc., is incredibly unreasonable.

Given that the reports we've just heard have indicated that caseloads have increased twofold or more at present and that support is gradually fading out, we can predict that supporters and other public workers in many municipalities have a hard time dealing with them.

I would love it if people on the front lines, as it were could let us know what sorts of things are indispensable to their practice, what things they would prefer, etc.

Koyama I presented two cases earlier from the perspective of a group initiative, and I would like to reemphasize the importance of groups to supporters; groups ensure that we do not end up feeling isolated or alone. I would be very happy if the MDMHCC could continue to work alongside us in the future.

Matsumoto The Kokoro Café is a collaborative initiative that involves four organizations. This collaboration is what makes it one of our best initiatives, in my opinion. I do not believe that similar resources existed before the disaster, but now that the MDMHCC has entered the fray and functions as a hub, so to speak, this sort of connection has become possible.

While it is sometimes difficult for connections and collaborations to yield quantitative figures or direct results, I would like to highlight the fact that they are nevertheless quite important.

Kutsuzawa After the disaster, we received support from many different professionals. However, I sometimes feel that local public health nurses take things for granted in certain respects.

In reality, there was a significant increase in the number of public health nurses even before the disaster; they hired psychiatric social workers as well. However, in terms of technique, our skillsets were simply not up to par. We had to have others supervise us and conduct outreach activities together. It was also difficult to get this mindset to take root, as people would often just be satisfied with the fact that the new generation of nurses had been "brought up well" or whatnot. Therefore, I think it will continue to be difficult to implement substantial psychiatric welfare measures for some time.

We have heard that caseloads have remained high for several years—for example, the caseloads at the Karakoro station initiative have hovered at around 6,000 for some time now. I think it is important that we make some sort of effort—the specifics are not as important—to ensure that we can continue to provide support in the future.

The reality, however, as I have explained before, is that there are times when the public health nurse will need to take sick leave, or go on vacation, or simply run out of stamina. I was affected by the

disaster, and I find myself hesitant to go to certain locations and unwilling to participate in disaster study sessions. I think it will take some time for us to both addresses these issues and render ourselves capable of maintaining public health in normal times. Thus, I would love it if the Karakoro Station and the MDMHCC, and other supporters could continue to assist us a little longer.

Matsumoto I noticed you mentioned sick leave; there has been an increase in the number of individuals taking sick leave among our staff as well. Attitudes towards work practices are changing, and when it comes to the health of our employees, we can't just ask them to work harder. Given this, I feel that sometimes all the people on the ground can do is just hope. As you mentioned, at the moment, about one in every three public nurses is a young practitioner; it's clear that a sort of generational transition is underway. This is a very uncertain time, I'm sure, and as young newcomers enter the field, full of eagerness and drive, it's important to ensure that they enter a workplace environment that allows them to remain motivated while building know-how.

Sugawara In terms of where to place the functionalities discussed before, I think prefectural health care centers are quite proximal to many municipalities. I think health care centers should be able to work with municipalities to understand what sort of health issues affect their jurisdictions and demographics.

The MDMHCC works to address mental health issues in pregnant mothers, children, and even among the elderly, but I do not think this system of doing anything and everything can last very long. Prefectures have their mental health and welfare centers, but it would be great if the center could maintain its status as an institution with a slightly more specialized apparatus.

Oba Given the current circumstances, we at the prefecture believe that it will be difficult for us to allow the MDMHCC to cease functioning in 2020 and that several long-term initiatives are necessary. However, because they are fulfilling the primary, secondary, and tertiary roles that municipalities, health care centers, and mental health and welfare centers are supposed to handle, when we speak of how we will continue to operate in 2021 and beyond, we need to consider what we will need to continue providing these services.

One topic that was brought up today is the growing prevalence of difficult cases. I think that they will need to be handled by interdisciplinary teams or by involving outside organizations and forming collaborative support teams. While such efforts are necessary, to manage them better, we will need to discuss what our foci will be, where we will concentrate our manpower, and where we will direct our support.

Human resource development is another issue. This disaster has allowed many different people to become involved in many different ways. Once we consider the fact that in 10 to 15 years, people will have changed, human resource development becomes critically important: how can we continue to pass along our knowledge while maintaining the levels of involvement that we have had to date?

The issue of what supervisors should the focusing on has also been raised. I believe that it is important to have this capacity. Key aspects of the prefecture's primary, secondary, and tertiary responsibilities that cannot be returned, right away, to the purview of the agencies that are entitled to oversee them, should receive some sort of special attention. I would love to hear everyone's opinion on what sort of functionalities are truly necessary moving forward.

Yamazaki Two years ago, we surveyed disaster-affected coastal municipalities that brought up the question of exhaustion and other mental health issues among municipal staff. Once the MDMHCC is gone, will it be okay if we just dump all its responsibilities on local authorities? If we do not come up with a clear solution to this rather big problem, the transition will not go smoothly. Simultaneously, we must also think of ways to reduce the exhaustion that municipal staff experience.

Matsumoto Our conversations thus far have made it clear that people "on the ground" are at their limits. At such times, supervision or suggestions are necessary, specifics aside.

Another point I would like to make is that, as I see it, our conversations thus far have hinted at the idea of preventive, early interventions. Rather than only focusing on individuals who are already isolated, I think we have spoken of expanding our efforts to include those that are at risk of becoming isolated. Even in terms of alcoholism, we've discussed similar approaches with regards to temperance programs or γ-GTP-centric interventions. While responding to individuals in dire straits is its challenge, another challenge we must be cognizant of is how to prevent individuals from finding themselves in dire straits. I believe it is important for us to consider what sorts of measures may be necessary for that respect as well.

(Discussion concludes)

< Keynote >

Matsumoto Now, we have a keynote address by Dr. Yoshiharu Kim. Dr. Kim has visited Miyagi Prefecture many times since the disaster and has been a valuable mentor to us here as he provides us with advice and guidance.

Kim First off, after listening to your presentations this morning and based on our discussion just now, I'd like to express my amazement at just how well all of you have been able to grasp the issues facing the residents in your jurisdictions. You are all responding to so many different needs with so many different activities and initiatives. That is not an easy task.

Previously, at this forum, I've discussed many dif-ferent things, including guidelines, disaster PFA, how to interact with disaster survivors, etc. Most of these have been things learned from overseas agencies com-bined with inputs that reflect the situation in Japan. However, because medium- to long-term initiatives were lacking, I think we were weak when it came to creating a place that gave people a sense of belonging during the reconstruction period. But the efforts that Japan is currently involved in, in terms of building this place of belonging, are wonderful. I think if you were to share the things you are currently doing, by translating your work into English, etc., the entire world would be grateful.

It is often said that instead of medical support, what people need is psychological and social support. In other words, we should focus on organizing social get-togethers, tea parties, places that people can visit freely, where people in need can reach out for help. In that sense, I am deeply convinced that what I have seen here today is truly wonderful.

In our day to day lives, we hold tight to a misconception known as the normalcy bias: the mistaken idea that everything about ourselves is good and normal. That is, the idea that both ourselves and our environments will remain the way that they are at the moment. Indeed, without this bias, it would be impossible to go on living at all. But today, we've seen so many slides that list thousands upon thousands of casualties. The bereaved, kin to these casualties, sit around us at this very moment, as do people who were injured alongside them. People whose homes have been damaged, too. All of you continue to work and live surrounded by this. Even though somewhere along the way, such suffering and pain may have become the norm, I would like to remind you that they are not. I believe, from the bottom of my heart, that the fact that you all continue to be devoted to your work amidst such circumstances is exceptionally worthy of praise.

But the truth is, this normalcy bias affects disaster survivors, too.

I run an outpatient clinic in Tokyo, and I see patients from disaster-affected areas there. Some suffer from PTSD; some you cannot quite call PTSD patients but are nevertheless quite troubled. When I ask these patients if they have taken advantage at the home of the sorts of counseling all of you provide, some of them say no, and that they don't intend to.

Of course, there is a stigma associated with seeking psychiatric help, and I initially assumed that was why people didn't want to go. But after talking to these survivors in more detail, I found that when they're at home, many of them don't realize that their symptoms are even symptoms. After all, everyone else they know is in the same boat. After coming to Tokyo for work, and speaking to people there, they're told that "it might be PTSD," or "you should go get some counseling," and then they come to see me. I've seen many people like this.

The fact that the number of cases you all see is so high may also be a result of the fact that the doctors and professionals that provide counseling in your area are just that skilled, and their efforts to spread awareness of mental health are so effective that the residents of your communities are now very self-aware.

Then there is the matter of suicides. Normally, anti-suicide measures are, at the national level, anti-depression measures. We operate with the assumption that treating depression should decrease the number of suicides. But I am not sure if that holds for disaster-affected areas. That is, is it possible for depression to set in and worsen to such a degree, and in such a short period, right after a disaster has occurred? And do people with suicidal ideation appear that depressed?

I've heard today that suicide rates in disaster-affected areas have surpassed pre-disaster levels. What I have not heard is people talking about how, if we had only implemented anti-depression measures or distributed antidepressants more thoroughly, we'd have fixed this problem. After all, in a world in flux, people are kept anchored by constancy. And the best tether of all is a connection to your fellow man.

Those of us who work in these fields also hear a lot about PTSD. PTSD has certain "flashy" symptoms, such as scary, startling flashbacks. Symptoms such as nightmares, or the feeling that one has returned to the scene of the disaster. But recently, a different, more complex sort of PTSD has been recognized internationally. Rather than flashbacks or nightmares, this sort of PTSD is characterized by symptoms including the following: difficulty calming down after being agitated, feeling emotionally paralyzed or shutdown, feeling defeated, feeling worthless, feeling distant from others, and having difficulty maintaining emotional intimacy with others.

What sorts of people do we see this type of PTSD in? Well, one example is someone who has been exposed to rough circumstances since childhood or someone that has lived in adversity for a very long time. While these circumstances may be slightly different from those of disaster survivors that have been exposed to the stress of reconstruction for many years, I hope these examples are at least of some use to you all.

I have found that the people of Tohoku are very persevering, almost to a fault. They will even go as far as killing their own emotions to outlast their problems. Continuing to do this for long periods causes your emotions to be bottled up inside. I think the alcohol problems that were spoken of earlier are part of the same struggle. Normally, one can suppress their emotions or desires and keep things under control, but if something unexpected happens, they get very perturbed, and their emotions either explode outwards or they turn to something like alcohol, etc. Their emotions are shut down, and they stay distant from others. This makes it even more difficult for them to express their emotions. They cannot form intimate emotional relationships with others.

So, then, what can we do to treat someone with these symptoms? That very question has been the subject of a great deal of research, and we've come to implement many of these methods in our work. I would like to introduce all of you to some of them.

Therapy for these sorts of people begins with helping these people discover their own emotions. There are many types of emotions—positive, negative, unwelcome—but emotions themselves are a sort of compass that we can use to direct our lives.

People that have borne significant adversity are sometimes unable to understand their own emotions. For example, in the case of an earthquake victim, we try to speak of how they were before the disaster, and how they have become afterward. How have their emotions changed? Some say that they were more able to laugh at small things before the disaster, but now, they hold back, and rarely expose their emotions. We ask them to monitor their own emotions, to keep track of what they feel. For example, the feeling of boredom at being home alone, or the feeling of embarrassment when they go out into public. Stay in touch with your emotions, we tell them and reflect.

To understand what's truly interesting about this approach, let's take a look at one specific emotion. "Fear," for example. The opposite would be "relief" or "peace of mind." The definitions here don't have to be precise. Just go with what you feel, we say. We then ask patients what sort of emotions resemble fear, to them. People say anger or sadness. Next, we ask what feelings resemble relief. Joy, happiness. We continue talking about this while writing down what the patient says.

The order taken is of little importance. Strict opposites and similarities are also very unimportant. The point is to remind patients just how many words we have, to express emotion. There truly is a lot. You can even write them down while looking at a list.

Going through this process of noticing emotions and remembering the words to identify them with facilitates our next steps.

Once we have amassed a substantial list of emotional words, we ask the patient to practice some simple breathing or relaxation techniques. Afterward, we ask them what emotions they are experiencing. This dialogue proceeds much more smoothly after we've primed them, so to speak, to remember emotional words via the previous exercise. I highly recommend it.

If the individual can produce an abundance of words to describe emotions, the process of helping them find ways to change outbursts of negative emotion into more positive ones will happen more smoothly. For example, exiting the situation that is causing them to feel negative emotions, going outside and taking deep breaths, recalling positive events, etc. The individual then monitors the effect these techniques have on their emotions. I think you'll be surprised at the kind of positive results you can achieve by getting patients used to this exercise.

Recently, we have begun categorizing support for disaster-affected people in one of three levels: 1, 2, and 3. Level 1 is a psychological first aid. At this level, our priority is to make sure that the individual is not hurt any further. We consider that when interacting with them, and we work to support their day-to-day living, to calm their emotional turmoil, and to support their recovery. Level 3 is a therapy for mental illness, such as PTSD or depression. There haven't been many Level 2 cases so far, but these are individuals that do not have overt illnesses per se but may have some lingering symptoms; we treat them by coaching them to alleviate those symptoms over multiple sessions.

Next, I'd like to highlight the fact that it is incredibly important that we determine how we are going to continue care for children in the future. Childhood is a time of much adversity, even without the occurrence of a disaster. For example, one's parents can become sick, or one's father can be an alcoholic who rages at home, or one might have been forced to move far away. People experience these and many other adverse situations throughout their lives.

Research has been done in America to understand what effects these phenomena can have on individuals when they are allowed to pile up over time. After asking adults whether they endured a variety of adverse experiences when they were children, including psychological abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, disorderly or unclean home environments, etc., 11% of respondents said that they had experienced five or more such adverse events. 33% indicated that they had not experienced any such adverse events. Individuals that experienced high levels of adversity as children were found to be more at risk of alcohol addiction and intractable depression as adults.

More shockingly, suicide attempts also increase. Exponentially, in fact. Individuals who were children during the disaster experienced it as an adverse event. Our task moving forward is to try and prevent them from being exposed to further such events. An individual can recover from one or two adverse experiences.

To prevent the number of adverse experiences from increasing to four or five, we must try to prevent children from being exposed to severe stress, bullying, abuse, and other such things in society. In other words, we must implement measures that psychologically safeguard such individuals. For this reason, even if we cannot directly address or treat disaster-linked trauma, promptly addressing and minimizing other sources of trauma will, in reality, allow children to benefit from disaster-related mental health care. There will be a continued need for such an effort for years to come, I think.

This is not to say that adversity in puberty or adulthood will not occur. However, I believe that attempting to protect against them is a very effective way to minimize and mitigate the impact that disasters have on children. In that sense, this practice may become one of the central pillars of post-disaster mental health care for children.

Much of this address has revolved around some rather somber subjects, so I'd like to end on a softer note. We often use breathing techniques as a way to manage anxiety. However, since highly nervous or anxious people are often unable to breathe smoothly, a pulmonary researcher has come up with an exercise that can help such individuals. It is called the Ra-Ta-Ta exercise. You can find it on YouTube. I make use of it in my daily practice, and those of my patients who have anxiety disorder have found that it helps them greatly.

Matsumoto Does anyone have any questions for Dr. Kim?

Sugawara In my district, too, I had an experience where a very cheerful, bright individual committed suicide the day after a disaster.

He was an elderly man who lived alone, and although he wasn't receiving any psychological treatment, he would always have a sort of "not me!" attitude. Our supporters were quite shocked, and they asked, "Why did he die, even though he attended all of our meetings and events?" I just wanted to ask how you would recommend that we deal with such a situation.

This person even filled out our health surveys. Since he was an elderly man living alone, he was of course one of our support targets, and he even visited the comprehensive support center.

Kim Nowhere in the world has any initiative been able to reduce the number of suicides to a flat zero. In the case that you've just described, I'd like to point out the possibility that what happened was not the fault of whoever was assigned to that man's case. Loneliness and isolation are risk factors for suicide, but this per-son was socially active, as you mentioned. This is true quite a difficult business. If I had been in your shoes and had been meeting with and treating this man, I cannot say that I would have been able to predict what happened.

Matsumoto We've thought a lot about whether we should ask individuals that come to our salon activities to fill out questionnaires and the like. Have you ever tried asking such individuals objective questions in person?

Matsumoto Interviews alone do not usually reveal enough, and during screening, we become unsure about whether a person is feeling a certain way or not. I feel that it could be useful to implement a regular mental health checkup for at-risk individuals using something like the K6 scale.

Kin The issue with the K6 scale is that, if overused, people grow accustomed to it. The other issue is that both symptoms and risks need to be analyzed. For example, let us say that someone's relative has recently committed suicide. That isn't the sort of accumulated adverse experience that we spoke about earlier with regards to children, but if someone with that problem had mentioned it while discussing current hardships, then yes, they should be treated like someone at risk of similar behavior.

Matsumoto There's also the fear that if the participant in a counseling session does not, at some point, feel as though they have gained something from the experience, they might consider it a waste of time and unhelpful, resulting in an unwillingness to come in for counseling again.

I've come to believe that knowing how to respond to, address, and keep tabs on an individual's progress in therapy constitutes an important skillset, one that must be shared.

Questions about death, in particular, are difficult to bring up in open, relatively public spaces. It is hard to get someone to talk about such topics if we do not bring them up in a private, safe place with an opener like, "How have you been recently?" In a group, because everyone's having a good time, if we ask anyone "how [they] are doing," they usually just respond with an "I haven't been paying attention," or something of that sort. So, to deal with these problems, we've had to adopt a more discreet approach.

I wanted to ask if you had any experience supervising these kinds of approaches, or if you had a list of some sort you could share with us.

Kim I think one of the problems is that the people that manage these events often try to push them to be bright and cheery affairs. But if a glum person happens to at-tend such an event, they'd find it hard to divulge their gloomy thoughts, especially when surrounded by all that happiness and cheer. That's why I think several different facilitators with different personality types should oversee these events. For example, you can have a bright and energetic person lead the event, but you might want to station a more reserved, moody staff member in the back. someone that views that day's pro-ceedings as pointless might be your best option.

Matsumoto I'm sure we've all heard of the concept of peer pressure. When in a group with others, the peer pressure, so to speak, to be optimistic and upbeat can be quite high. This can be a very good thing for people emotionally capable of reciprocating that energy, but when it is difficult for someone to quickly align with the emotional state of others, such environments can intensify their feelings of solitude.

I guess it is very important to have as many different kinds of people involved; to engage with many differ-ent kinds of people; to hear varied opinions, and to move forward with the teams and groups that sponta-neously arise from these mixed scenarios.

Audience member I'd love it if you could share your thoughts on how to wind down support, how to entrust an endeavor to the next generation, and how to transfer the responsibilities that come with it to other groups.

Kim As an administrative organization, closing a help desk or something can be done fairly quickly, but to put an abrupt end to an activity or program is rather care-less, in my opinion. If you do not make an effort to en-sure that some aspect of these programs lives on—per-haps in a different form and managed by a different group, one that has succeeded the first—the loss of the program itself can often be upsetting enough to cause its participants a new sort of trauma.

Matsumoto The ripple effects of the Great East Ja-pan earthquake will persist for some time, and the pro-cess by which the individuals, communities, cultures, and societies affected by it heal—with therapeutic sup-port or by some other means—will also continue for some time. Wounds that need healing will continue to come to light, and those that treat them must continue to do so, perhaps without end.

Kim I am a doctor, and as a closing remark, I'd like to speak a bit about the Level 3 care I mentioned earlier, for the treatment of PTSD. Although this isn't some-thing people in my field usually tell each other, the bottom line is that if you all continue to fulfill your roles, much of what we've discussed today can be treated. No matter how many years pass, these wounds can and will heal and people will be able to recover. You must be optimistic that there is a path to healing, somewhere out there. If you do, you will find it.

Matsumoto I think we've got to be cognizant of the fact that even though we've been operating for quite some time now, for most people affected by the disaster, the most important phase of the recovery process is just beginning. People are living in post-disaster public housing, people who must build new communities and raise their children in new environments. Grade school truancy in Miyagi Prefecture is among the highest in the entire country. Suicide rates are quite high, too. Our ten-year deadline is artificial and meaningless. We needed to have some sort of deadline, or our sponsors would have gotten mad. That ten-year figure is just a number, and in terms of healing trauma, it has no real basis or reasoning behind it.

I think it is important that we do not become preoccupied with it. In the truest sense, what all of you observe so very closely on the ground is the process itself. Whatever surfaces in those situations are where treatment ought to be directed. And as Dr. Kim says, with your in-tervention and support, there is more than enough room in those places for healing and recovery.

I think what Dr. Kim is trying to say is that even if there isn't a clear end in sight, healing is happening. While things are getting better, we must continue to con-sider what support may be required in the coming years. I am grateful to everyone for teaching me so much today. I would especially like to thank everyone that presented, for taking time off from work in their home regions to come all the way here. We are very grateful for your sup-port. And thank you to Dr. Kim as well, for taking time out of his busy schedule to participate in this event.

(End)

Symposium Summary

The symposium entailed a question-and-answer session that was meant to facilitate a discussion on the topics presented in the first half of the forum. Afterward, a keynote address was delivered. The symposium's key takeaway points have been summarized below.

1. Support for elderly males living alone has become a pressing issue in several places, and various initiatives to combat this problem are underway.

2. While we need to evaluate how best to consolidate and wrap up disaster-related support efforts, we must also be aware of manpower shortages and exhaustion among workers in our communities.

3. Caseloads remain high, and the need for supervisors is also quite high. When wrapping up disaster-related support efforts, the functionalities they provided must be maintained.

4. The number of adverse experiences a child has lived through is related to their future risk of alcohol addiction, depression, and suicide attempts. Keeping these experiences to a minimum is important.