Disaster-Affected Area Support Activities by Alcohol Addiction Treatment Organizations

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Introduction

Most mentally handicapped individuals live in a world in which they are constantly assailed by tsunami-like threats. The source of their anxiety is always a life-threatening fear, the fear of battle itself. Indeed, adopting that perspective on their experience makes the clinical work of a psychiatrist much clearer. In a sense, living for extended periods in such a harsh world gives one a great deal of disaster preparedness. The fear of battle is always terrible, but we find ever more ingenious ways in which to face it each time we do. I suppose these techniques are what psychiatrists refer to as "symptoms."

On the night of the earthquake, even though they were confined to a hospital ward that was pitch-black from all the electrical outages, not a single patient panicked. Several days later, I even heard some of them ask why their ward mates had perished in the tsunami, and why it had not been them. In their state of hyperarousal following the earthquake, many of the patients—struggling with survivor's guilt—had already begun to fall into a depression. One week later, I saw patients who had thrown themselves into their work at the evacuation shelter, completely burned out; and being carted off, sobbing, to the outpatient clinic. In a certain light, one might even call these patients, who simply wished to warn their so-called "healthy" peers about the tragedies that may befall them in the future, disaster support specialists.

In this section, we will focus on what we have learned from these "specialists," and offer an overview of our support activities and a report on our case study support.

1. Support in FY 2018

(1) Overview

The nature, breakdown, and numerical count of each of our support activities in FY 2018 can be seen in Figure 1.

Our total support caseload in FY 2018 numbered 70 cases. Case study work accounted for 22 of them, while cooperative efforts, such as network coordination activities and self-help group support, accounted for 17 cases each. Finally, support for supporters training accounted for 10 cases. (While we were contracted for 61 cases, several of them involved multiple types of support. Thus, the total breakdown by type of support is 70.)

In FY 2016, the total number of case study efforts we were involved in was 4. We more than quintupled that number in FY 2018. The fact that so many examples of difficult regional cases are being cited means that support activities are proceeding apace in our communities.

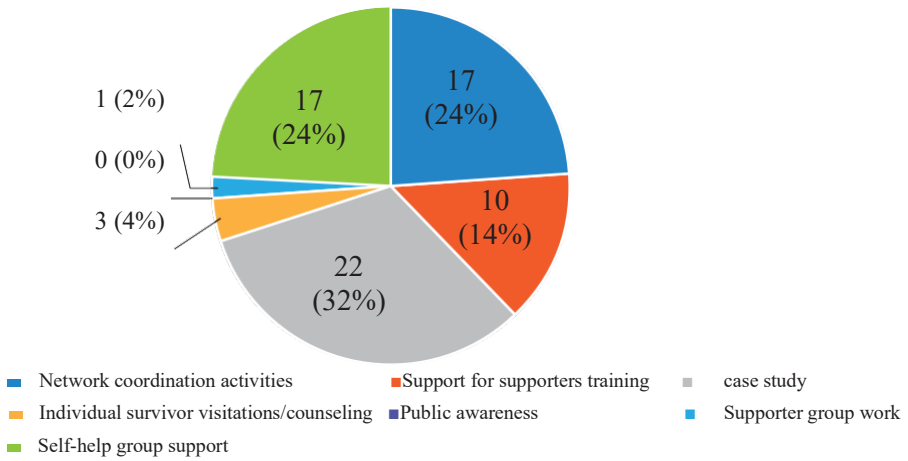

Figure 1. FY 2018 Support Activities and Numerical Breakdown

(2) What we have learned from our cases

The most important part of early-stage addiction support is familial. People with the strength to approach us first for counseling are called first clients (FC), and it is common practice to provide support to these individuals first. Most of the time, they are family members. When the affected person does not have any family and lives alone, the supporter providing aid to them becomes the FC, and it becomes important to construct regional networks involving them while also consulting other affiliated organizations.

① Cases in which supporter biases towards alcohol-related issues became a problem

There are times when a case study has been attempted in a case in which a supporter's anxiety or uncertainty about how to interact with an individual with alcohol-related problems, prevented them from interviewing the affected person or their family appropriately, leading to a lack of basic information. Before beginning to offer support, it is important to determine what sorts of conceptions supporters have of alcohol abusers. Rather than attacking or criticizing a supporter's biases, simply listening to them will give them the chance to become aware of their biases. Supporting them through that process allows them to determine how they can overcome their biases when interacting with support targets.

② Over-reliance on the therapeutic model

The majority of individuals affected by alcohol-related issues do not wish to seek treatment. However, their families and the supporters that interact with them often become desperate for them to go into therapy, and the relationship between the patient and these supporters can take on combative or controlling quality. This merely increases both parties' stress levels, causing the affected person's drinking to worsen, and their family or supporter to become exhausted. First, we try to have supporters and families understand this relationship, and then we propose that they attend family support programs to learn how to change it. Sometimes, we simply continue to provide individual consultation to the family. We recommend that supporters attend training workshops. In any case, the underlying factor in the aforementioned situation is a sense of urgency, that one simply must get the alcohol abuser into therapy. This situation often causes one's relationship with the affected person to devolve into a game of who has more power over the other.

"I want you to get better, but I recognize that it is your choice." This attitude of respecting a patient's autonomy is effective at effecting change, even in unwell people. However, rather than lecture them about this, we have taken the group work approach of "looking for the good" with families and supporters.

They don't honestly admit to their faults. They say yes, but don't change. They even get mad at me and tell me they wouldn't care if I died. Let's try setting aside methods that seek to correct the affected person's flaws, for a minute, and instead talk about the state of their health, the kind of thing that internists talk about. They don't refuse home visits. They listen. They tell me if they feel like dying. These are the sorts of "good" things we ask all participants in our case study workshops to come up with, which we then write on a whiteboard. These traits are a treasure trove of ideas that can be used to change our relationship with the affected individual. We can change a typical supporter response, like, "Don't say that you want to die! Just come with me to the hospital!" to something like "I see. You feel like dying, huh? I appreciate you being honest with me."

③ Cases in which the affected persons' health has deteriorated as a result of binge drinking and support becomes a life-or-death matter

There are times that a patient or affected individual will not want to go to a medical facility even when their life is on the line. The basic point here is that, even then, one continues to emphasize the element of support in the relationship and seeks to improve their communication patterns with the patient. At the same time, however, the supporter or family member must not be afraid to take charge if necessary.

Nevertheless, going straight to, “We’re taking you to the hospital!” doesn’t usually work very well. Conversations with “you” as the subject can easily come off as attacks. The key is to use messages that have “I” as the subject. The supporter must communicate their feelings, as in “I can’t just leave you here when you’re feeling so weak. I’d worry about you. I’m going to call an ambulance now; I’d feel a lot better if you came with me to the hospital.” This phrasing is not commandeering, and it asks the person for their consent. I’d like to mention that a method like this was used by one of our nurses to save a patient’s life, and to emphasize the fact that there’s always an open door; you just have to find it.

④ Cases in which one cannot build a support relationship

Say I can’t get in touch with the patient, and even when I manage to, they don’t keep their word. They threaten me with violence and use abusive language. They only call when they’re drunk, and whatever I say just goes over their head. Many times, the anger that we see in cases like these, hides behind it a fear of other people. It is usually never directly seen, but clues that hint at its existence lie in everyone’s developmental history. Unfortunately, most people’s developmental histories don’t speak very openly.

The underlying reason behind why an individual does not feel safe or secure in interpersonal relationships is the dearth of positive, nurturing experience (also known as abuse). It is often difficult for us to see the unstable nature of their capacity for attachment, and we end up negatively judging an affected person by more noticeable characteristics, such as their cognition, their emotions, or their behavior. This pattern of thinking on the part of the supporter can complicate many cases.

While affected people might harbor a fear of interpersonal relationships, they often also harbor a deep sense of loneliness. Meeting places where different people come to interact with each other, on an individual basis, functions as a sort of treatment for that loneliness. Thus, we recommend that communities hold meetings where affected people and supporters can meet under one roof; and supporters listen to what the affected people assembled there have to say. For such a meeting to function properly, affected people must have a stable and safe support relationship with at least one supporter. Being surrounded by supporters can make the affected attendee feel like they are being attacked. That feeling won’t go away until someone they trust explains what’s going on. I explained earlier what is required of a supporter, for them to build a safe relationship with an affected person.

Listening to an affected person’s rage and loneliness without any judgment functions as a treatment for that person’s pain and is perhaps the most therapeutic thing that can be done for them. The supporter must reliably communicate to the affected person that they have listened to and empathize with what they have said, using “I”-centric language. The original form of this type of network therapy is the self-help group (SHG). The force that drives affected people to seek out self-help groups is a desire for the comfort that comes from being understood and acknowledged by another.

(3) Self-help group founding support

We have been engaged in SHG founding support work since 2015 in Kesennuma, Ishinomaki, and Natori. The work remains the same as described in the detailed explanation provided in issue #6 of this bulletin.

In FY 2018, these meetings continued to function as autonomous regular meetings of the Danshukai, and in Ishinomaki, affected persons and supporters continue to use the SHG meeting format, thanks to assistance from regional support organizations. For more details, please refer to the report by the Miyagi Prefecture Danshukai.

2. Miyagi Prefecture Alcohol Disorder Countermeasure Promotion Plan

In FY 2018, Miyagi Prefecture created the Miyagi Prefecture Alcohol Disorder Countermeasure Promotion Plan and from this FY forward they will begin implementing initiatives outlined therein. The specific key here is how preventive awareness efforts, counseling, therapy, and SHG meetings will work together to function in various areas. This mechanism can be referred to by the English acronym SBIRTS ("ess-birts," Screening, Brief Intervention, Referral to Treatment, Self-help Groups).

The purpose of this mechanism is as follows. Use the AUDIT (Alcohol Use Disorder Identification Test), developed by the WHO (World Health Organization) to screen for alcohol use disorders, send the tested person to intervention, and then treatment, based on their score, and later connect them with an SHG. To build a regional framework, one in which both the affected person and their family members can receive the appropriate counseling and support, disaster support activities developed in disaster-affected regions can prove useful. They can serve as a foundation upon which the columns, walls, and roof of a "house" of countermeasures can be built.

3. Practical Training for Treatment of Alcohol Addiction

From May 2012 to August 2014, our hospital ran the Practical Training for Treatment of Alcohol Addiction program, a workshop for employees of psychiatric hospitals in coastal disaster-affected areas and of the Miyagi Disaster Mental Health Care Center. A total of 97 individuals attended this workshop. This program was implemented in prefectural municipalities in January 2014, up through February 2019 for staff involved in mental health care.

Over the seven years that we have been holding them, a total of 193 staff members from affiliated organizations have taken these courses and workshops. On our attendee training evaluation questionnaires, 98% of respondents have indicated that these workshops have been "very useful," and the remaining 2% indicated that they were "somewhat useful." We have received exactly 0 responses that indicated that these efforts have been "neither useful nor useless" or "useless." We plan to continue them into FY 2019 and beyond.

4. Eight Years of Support

(1) Outline

We have participated in a total of 864 support cases over the last eight years, involving a total of 1,604 employees.

As can be seen in Figure 2, the number of support activities per year has decreased every year, but as has been explained earlier, the number of case study-based cases rose in FY 2018. Figure 3 lists the areas and communities that we traveled to, to conduct support activities and the number of activities conducted in each area.

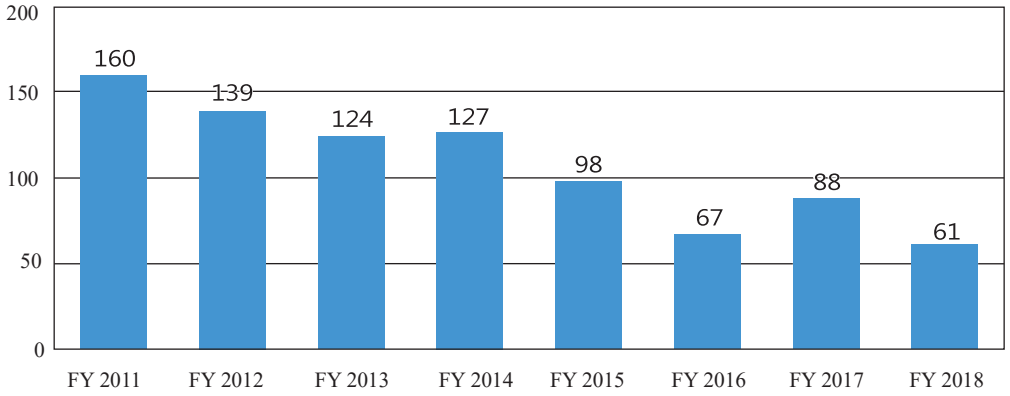

Figure 2: Changes in yearly support caseloads, March 2011 to March 2019 (N =864)

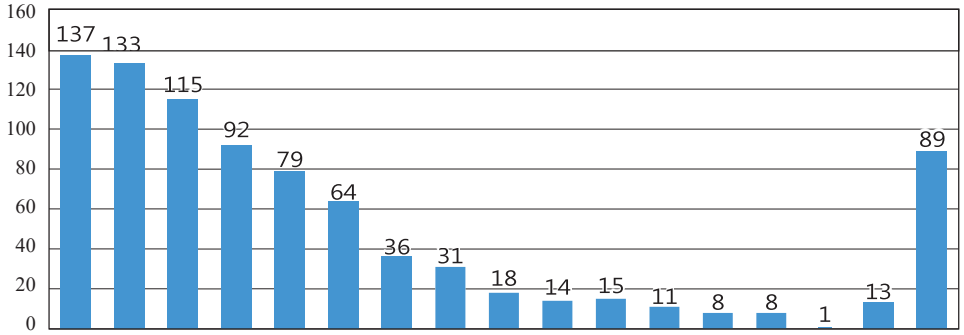

Figure 3. Support Activity Counts by Region, March 2011 to March 2019 (N =864)

* Countermeasure meetings and conferences that broadly concern all disaster-area support initiatives were previously counted under the Sendai total, as that is where they were held. Since March 2015, however, they have been counted separately as widespread activities.

Figure 4 is a breakdown of each of our support activities. “Network coordination activities” are the starting point of all of our other activities, and add up to 225 cases; “case studies” account for 173; and “support for supporters training” for 160. As can be seen in the change-over-time graph in Figure 5, the self-help group support we have been engaged in since 2015 in various locales has shifted into autonomous Danshukai activity, which the decrease in FY 2018 indicates. By contrast, the number of case studies, which peaked in FY 2015, declined slightly afterward, only to begin rising again in FY 2017 and FY 2018.

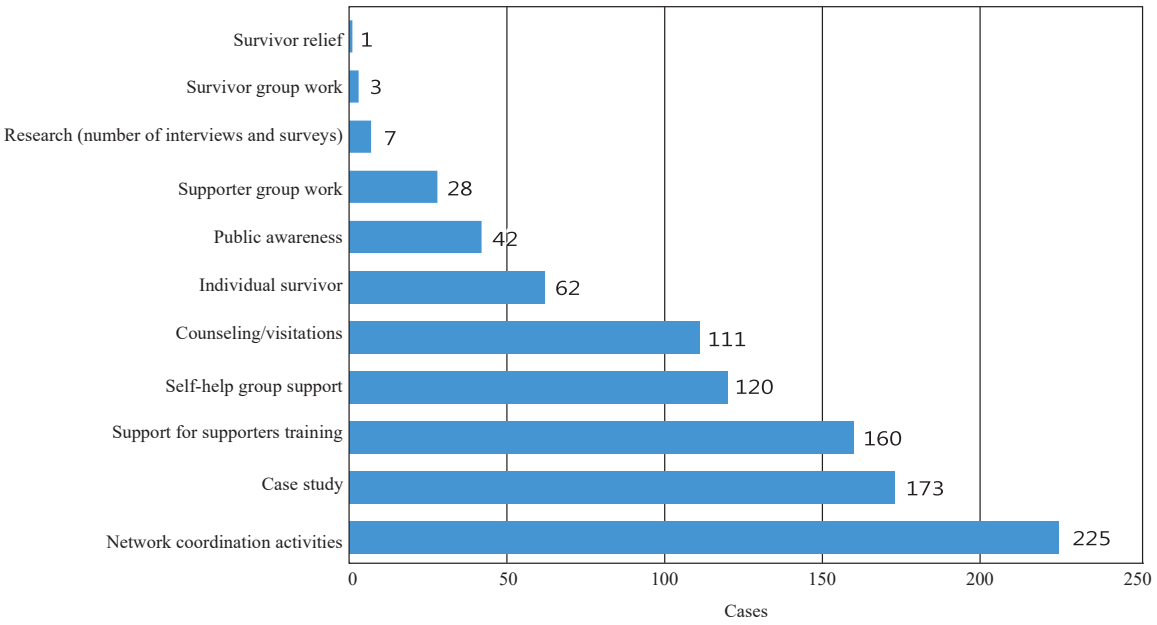

Figure 4. Support Activity Counts by Type, March 2011 to March 2019

*The reason the total number of cases by type is larger than the caseload total given above is that a single requested support case can involve multiple types of support.

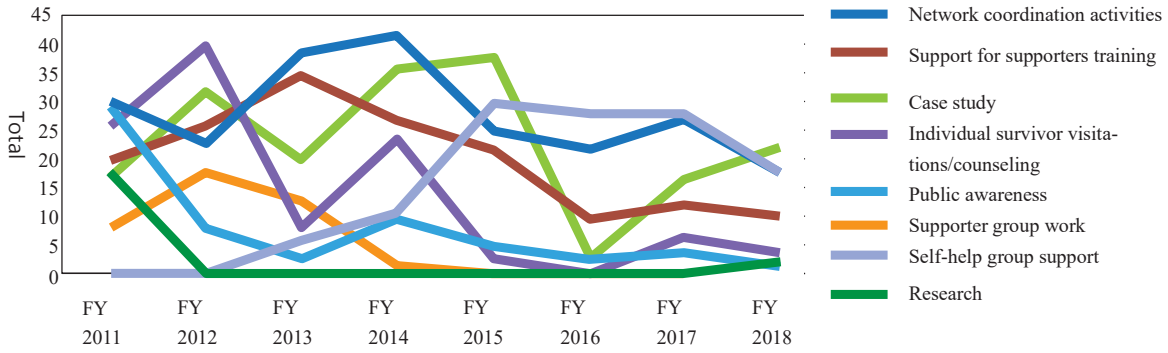

Figure 5. Changes in Support Activities by Type Per Year

Summary

Many case studies gloss over those aspects of the support relationship that the supporter was unable to fulfill. Our job is to fix these aspects and raise the overall quality of support. And rather than focus only on disaster support, our methods have shone a light on the strengths that families and supporters currently possess.

This method has been variously called the “empowerment” or the “strength model,” but it is not one that we simply aped and implemented. We arrived at it quite organically and inevitably, after countless interactions with addicts, their families, and regional supporters.

Something that supporters realize—after trying to control; trying desperately to help; and then abandoning the alcoholics they work with—is that, much like those alcoholics themselves, they are powerless. But realizing this powerlessness is the first step to noticing the greatest power, the very same power that drives a frail, bedridden alcoholic to feebly suck whiskey through a straw: the power of life. The dark abyss of this disease hides a paradox: some people try so very hard to live that they nearly die.