KOKORO NO KAZE: MENTAL HEALTH CRISIS IN FUKUSHIMA

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Abstract. In 1999 a pharmaceutical company, marketing its antidepressants in Japan, rechristened depression as “kokoro no kaze”, or “the soul has a cold.” Japanese happily bought the new concept for an old condition; sales boomed. A little over a decade later a series of horrific disasters has erupted in Japan, and it will take a good deal more than a pill to heal the survivors. 3/11’s quake, tsunami, and nuclear melt-down have caused mass depression, now termed “Japan’s national ailment. The stigma against depression has also reappeared. And there is much debate as to what constitutes depression or post traumatic stress disorder – ptsd-- and how they should be treated. Some favor the Western approach to ptsd, despite its tendency to ignore cultural relativity and produce long term negative effects. Others have pioneered new approaches, such as cognitive behavioral therapy or systemic psychodynamic therapy, saying “The goal is to help the system to recover and raise the level of mindfulness.” Further, the stigma against depression must be removed. And WHO mental health official Shekhar Saxena may be right: the disasters provide an opportunity to change the Japanese mental health system completely.

DEPRESSION: KOKORO, THE SOUL, AND JAPAN’S “NATIONAL AILMENT”

When Americans talk about depression, the word has a very broad and casual application. You can say that you’re depressed about missing a bus, or failing a test; or a TV program that isn’t being renewed, or about your favorite football team’s not making it to the Super Bowl. Equally, you can talk about depression as something deeply painful, serious, often caused by a loss -- a death. About something that impairs the normal activities of your life. That makes you want to go to bed, pull the bedclothes about your head, and never get up again.

In Japan, depression as a condition, or a disease, even before its connection to the crises in Fukushima, has followed a very different path.

It is arguable that “depression” per se did not exist as a disease in the minds of Japanese until 1999, when the pharmacological company GlaxoSmithKline launched a relentless ad campaign that convinced many Japanese that their kokoro was their soul. And that the soul could “catch cold (kaze)”: Kokoro no kaze. Kokoro no kaze was introduced to Japan by the pharmaceutical industry --to explain the concept of depression to a country that didn’t think about it, talk about it, or know they had it.

In Japan, the coining of kokoro no kaze marked a change in people's thinking about depression. The pharmaceutical industry's contribution to Japan in 1999 was to provide the diagnosis and the cure for the newly discovered kokoro no kaze: the modern antidepressant Paxil.

Certainly, as Kathryn Schulz of The New York Times reported on August 22, 2004, Japan was long overdue for an overhaul of its treatment of mental health. Serious mental illness had never been adequately addressed. Japan’s suicide rate was more than twice that of the United States. Depression was regarded as comparable to schizophrenia, and treatment was available almost exclusively in institutions. Talking therapy was rare.


However, in 2003, in a radical turnaround, the Ministry of Health launched a committee to help educate the public about depression. Two revelations which may have favorably influenced the
public in its thinking about depression- a popular movie actress, and the Crown Princess of Japan, both acknowledged that they were under treatment for depression.

At the other end of the depression spectrum, the idea of “mild depression” gained traction. Since 1999, the American pharmaceutical industry and the media have communicated one consistent message: your suffering might be a sickness and it might respond to their drugs.

*The New York Times* commented that this willingness to consider mild depression an illness treatable by drugs must be termed a major change in the history of Japan’s medicine. Attitudes towards mental health in Japan are strongly influenced by cultural norms. And fifteen hundred years of Buddhism in Japan have encouraged the acceptance of a bittersweet aesthetic, known as *aware*. Melancholy as a sign of sensitivity.

So it is a remarkable shift for Japanese to move from a poetic melancholy acceptance of the innate sadness of things, to a crass concrete belief that one’s soul has a cold and will respond positively to the ingestion of a Paxil pill. So positively that sales have passed $1 billion.

One sufferer from depression commented: "The phrase *kokoro no kaze* did some good. It changed people's perception and made depression easier to talk about." But counseling is still rare in Japan; eminent psychiatrist Yutaka Ono has said, psychotherapy has been far slower to catch on than medication.

**Public health; cross section of sufferers; stigmatization?**

Well, it’s debatable. Or let’s say, given the extraordinary circumstances of this last year, it’s possible that no one medication or treatment could address these crises effectively.

On Sunday, Feb. 12, 2012 Roger Pulvers wrote “Depression is a national ailment that demands open recognition in Japan.” for *The Japan Times*. Nearly a year after the great earthquake, tsunami, and nuclear meltdown of March 11, 2011, *The Times* declared emphatically that the greatest public health issue facing the people of Japan today is depression.

Not “mild” depression- depression. In fact, clinical depression.

The elderly are particularly vulnerable. In fact, depressive illness is the most frequent mental disorder among older people.

Furthermore, in Japan, where 1 in 5 people will experience depression in their lifetime, there is a powerful stigma associated with mental health concerns. And also with those exposed to radiation, like the people in Nagasaki and Hiroshima and now in Fukushima. Those who have been exposed may be shunned. Some people exposed to radiation who are seeking resettlement in other prefectures have already been rejected.

Stigmatization is a very useful tactic for those in authority - if you force the person to internalize the stigma of mental illness, to withdraw and hide from society in shame, you can then ignore him. With luck he will never request Medicare.

It is important to note that depression is not confined solely to the elderly- it affects young and old, men and women: schoolchildren, housewives, working men, and men behind bars in prison. A Hokkaido University psychiatrist has reported that 1 in 12 elementary school pupils suffers from depression, while at the middle-school level the figure may be as high as 1 in 4. At least one-third of the prison population is made up of the clinically depressed.

*The Japan Times* said that statistics on depression for the Japanese population in general and for women in particular are very similar to those in the West: 6.6 percent of Japanese are depressed, and women with depression outnumber male sufferers by about 3 to 1.
Discussions of depression in Japan have emphasized the conditions of working men. Japanese women, whose field of operations is in the home, are told to bear their suffering silently and not burden others with their personal problems.

The Japan Times declared that the task ahead for Japan is the total destigmatization of depression. Unfortunately, given the long entrenched nature of the stigma, this is neither an easy goal nor a likely one.

But it is a goal worth striving for. The human cost of suicides stemming from depression is very high. Conservatively, 30 percent of the annual suicide toll — more than 30,000 dead for 13 consecutive years — is due to depression. Some estimates go as high as 80 to 90 percent.

The Japan Times soberly concluded: “As much as two-thirds of psychiatric disorders go untreated; and only one-fourth of sufferers receives some sort of medical help. This would imply that millions of people are still forced to suffer in silence.

“All this makes depression the gravest public health problem in the nation.”

NAGASAKI, HIROSHIMA, FUKUSHIMA – NUCLEAR HEALTH CRIZES:

Since 3/11, health problems which have assumed even greater importance by the Japanese people after the meltdown, particularly mental health problems, have not been treated as priorities.

And yet the negative effects of the meltdown are not limited to just the harm caused by radiation levels present immediately after the Fukushima disaster. Simply living through this catastrophic disaster caused severe and persistent shock and trauma.

The hibakusha: A corollary can be made to the experience of the Fukushima survivors and the experience of the hibakusha, the people of Hiroshima and Nagasaki, termed the “people of the bomb”.

Half a century after the atomic bombings of Hiroshima and Nagasaki, Yoshiharu Kim, M.D., PhD, noted in the British Journal of Psychiatry that the victims who were in the vicinity of the bombs, even if they were not exposed to radiation poisoning, continued to suffer intense psychological stress and poor mental health.

As a result of these findings, the Japanese government has made available financial aid for individual mental healthcare to the hibakusha and has also begun a campaign of public mental health promotion for the affected individuals.

It is Yoshiharu Kim’s and his fellow authors’ hopes that their study will also help those working to understand the conditions of the victims of the Fukushima disaster.

However, despite the attention of Japan’s government towards the victims of the Hiroshima and Nagasaki atomic bombs, people with mental health issues that have resulted from the Fukushima nuclear disasters are not likely to receive similar attention.

Need for treatment; WHO Western Pacific: Even if they receive financial aid for treatment, Mark Willacy of the Australian Broadcasting Corporation, in his June 17 2011 article “Japan's tsunami survivors face mental challenge” has reported that there are fewer than 20 psychotherapists in the country specializing in PTSD to treat them.

(It should be noted that this statement has been very vigorously disputed—see below.)
Japan is not alone here, either, in experiencing disasters or in the mental health disorders resulting from radiation exposure. Throughout the Western Pacific, 2011 was beset with natural and manmade disasters – flooding, earthquakes, tsunamis and radiological disasters. WHO (World Health Organization) officials said in October that they were expecting incidents of mental health problems to rise dramatically in the Western Pacific region.

They noted again that children, the elderly, and people with disabilities, would likely be the worst affected with PTSD (post traumatic stress disorder) and depression resulting from these disasters. http://www.wpro.who.int/media_centre/press_releases/pr_20111013_MNH.htm

Tufts University’s Dr. Wang Xiangdong and regional leader for the WHO in the Western Pacific, makes a strong case for the importance of identifying and treating people with mental health issues. Ibarra C. Mateo of GMA News, October 13, 2011 reports:

Wang argues the “general mental health of the [affected] population is not getting the attention it merits. Mental health measures should be integrated into the total post-disaster response package…[They] are among the most significant and lasting impacts of disasters and calamities.”


“USE JAPAN N[UCLEAR] -DISASTER TO REFORM MENTAL HEALTH”

A very useful article on the post-Fukushima mental health crisis, its symptoms, onset and treatment, and the social ills that confront sufferers, appeared in the online journal Japan Today, on October 25, 2011.

The article was pulled off the web two days after it was posted. But a link or two remains. (http://zeenews.india.com/news/world/use-japan-n-disaster-to-reform-mental-health_738303.html)

Some important facets of the article are:

• Speaking at the World Health Summit in Berlin, Shekhar Saxena, from the mental health division of the World Health Organization, has said that Japan should use a higher rate of mental health problems after the Fukushima nuclear accident to update outdated attitudes toward depression in the country.
• “We recommend for Japan to utilize the opportunity presented by the disaster to actually change the system to make it more community-oriented,” Saxena argues.
• Saxena said the mental aspects of disasters tended to be ignored.
• Officials have previously warned of an increase in depression cases in a country where this illness still carries a stigma.
• It is only recently, that urban areas of Japan have begun to tackle the taboo surrounding depression, a condition euphemistically known as kokoro no kaze- “heart flu”.
• After a disaster such as Fukushima, the prevalence of severe mental disorders, such as psychosis, increased from 2-3 percent of the population to 3-4 percent, said Saxena.
• More mild mental disorders like depression have increase from one in ten to one in five, he added.
• Treating such disorders is best done within the community rather than in medical institutions, he said.
• “In Japan, mental health care is largely undertaken by specialized institutions whereas it is more effective.
Another expert, Shunichi Yamashita, from Fukushima Medical University, said the tragic war-time history of Japan has sparked greater anxiety than might have been the case anywhere elsewhere in the world.

“People in Japan are very much aware of the risks from radiation from the atomic bombs in Hiroshima and Nagasaki, so they worry more,” said Yamashita.

Yamashita, who moved from Nagasaki to Fukushima to assist in the response to the accident, said Japan needed an “unprecedented effort” to monitor the health impact of the disaster.

“There are uncertainties about the risks of chronic low-dose radiation exposures for human health but there is no alternative than to take the responsibility of monitoring the health condition of people around Fukushima,” Shunichi Yamashita said.

THE SURVIVORS

Like much of rural Japan, the economy in Tohoku had been in decline for decades before the tsunami. The area was marked by depopulation, aging, and chronic underinvestment, and by decades of neglect from the central government. It is now desolate, marked by debris and rubble, containers from ocean going vessels cast up on land, and one lone pine tree which has somehow managed to survive.

About one in three survivors are more than 65 years old, and 22 % are impoverished. They are rural people, fishermen and farmers whose livelihood has been taken from them.

Their anxiety and distress is evident. They can’t sleep- they have nightmares. They keep reliving terrifying moments during the disasters. Yet they are also reluctant to discuss their distress- as all their lives, they have been taught to be stoic, to keep it all within.

Survivors are beset by fears of exposure to radiation. They are very angry with TEPCO (Tokyo Electric Power Company) and the Japanese government, which they feel have concealed the truth about radiation and shown little concern about their battered lives. They are distressed over their uncertainty about the future. And finally, they are overwhelmed by sadness at having had to desert their land, jobs and community. (Alexandra Harney of the Atlantic).

The survivors are living packed together by family in makeshift shelters in zendos and high school cafeterias.

In a Minamisanriku evacuation center an 82-year-old survivor said “I saw people being swept away right in front of me. One person was screaming, help me! But I couldn’t help.”

He only just managed to save himself as a huge black mass of water smashed into his home. Now all he has left is the nightmares that haunt his sleep.

[A link to an article by Alexandra Harney about the survivors.]

A cross-section of people affected:

- the residents of Okuma town, situated in the center of the Fukushima reactors;
- local civil servants, first responders in three of the worst affected prefectures: Miyagi, Iwate, and Fukushima;
- a job counseling service turned, by demand, into a mental health crisis counseling
service, in Miyagi Prefecture;
• and the troubled children of nonprofit organization Mercy Corps’ camps.

**Okuma town:** On February 13, 2012 Reuters reported that although nearly a year had passed since the giant earthquake hit Japan, the town of Okuma, at the centre of the Fukushima nuclear crisis, remains off limits for residents, save for short trips to abandoned homes. Okuma is the location of four out of six reactors at the centre of the nuclear crisis.

Evacuees do not know when, if ever, they can return to land that has been in their families for generations.

Many of the 11,000 Okuma evacuees left their homes in such haste that they left their futons (sleeping quilts) spread out on the floors—something no good Japanese housewife would ever do..

Now, families are allowed only a periodic three hour window of time to visit their abandoned homes, take care of their possessions, and take care of the family graves.

The physical and emotional stress on local individuals is severe. Okuma resident 74-year-old Miyoko Takeda said she is suffering insomnia and depression since being evacuated. "I can't sleep, I can't eat, I lost 8 kilograms and when I went to the doctor I threw up everything I took," she said.

Reuters noted that with the family’s grave headstones overturned and weeds encroaching, 59-year-old Minoru Fukuo and his wife tidied up the family grave area even though its only visitors now are passing wild animals. "We just prayed that we want to come back soon, and clean up the grave properly. So we asked them (our ancestors) to wait until then," Fukuo said.

**Miyagi Counseling Service:** A counseling service in Miyagi Prefecture which was originally set up to help people find a job, responding to insistent demand from people in crisis, has now turned into a mental health crisis hotline. In October, the health ministry in Miyagi found that more than 40% of disaster survivors appeared to suffer from sleep disorders. Subsequently, the ministry’s mental health counseling hotline has been flooded with 1,300 calls.

Miyagi’s Hello Work job counselors have been referring to psychiatrists, callers ostensibly seeking work but essentially distraught over their experiences with the tsunami and earthquakes. The Hello Work employment agencies now hold weekly counseling services for job seekers.

Prof. Ichiro Tsuji at Tohoku University, an expert in public health, said: "Survivors are highly likely to suffer from mental problems after such traumatic experiences as losing family members, friends and homes."

Miyagi survivors' mental strain has seriously affected local residents. 16 people committed suicide in June.

http://crisisreliefjapan.wordpress.com/2011/10/15/tsunami-survivors-suffer-from-mental-strain/

**Fukushima civil servants:** The effects of 3/11 have also been felt within Fukushima local government. Civil servants, those most directly responsible for affected areas and people, have had to work 24/7, sometimes sleeping in their cars if their homes are gone, with no respite and little public acknowledgement of their stress. And no health insurance.
From April to October, the number of local officials who took sick leave to seek mental health care soared to 70 percent in the three ravaged prefectures — Iwate, Miyagi and Fukushima. Although eleven months have passed, the psychological stress on local government officials shows no signs of abating.

Nobuyasu Kato, head of the welfare section in Sendai, said weekend shifts are taking a toll.

A large number of officials have to work even on weekends due to an increase in disaster-related work, Kato said. Furthermore, "civil service workers in disaster-hit areas, victims themselves, have yet a third layer of stress in their lives. They tend to blame themselves for failing to prevent damage from the catastrophe," said Masaharu Maeda, associate professor at Kurume University and head of the Japanese Society for Traumatic Stress Studies.

These local government officials, local heroes, deserve full-fledged mental health care, analysts said. (http://www.japantimes.co.jp/text/nn20111229a5.html)

We have mentioned the damage these crises have done to the elderly. The other group of survivors most vulnerable to depression / PTSD is children.

Children, and Mercy Corps: The American NGO Mercy Corps is working with its partner Peace Winds Japan to help Japanese children and adults recover from the emotional effects of a large-scale disaster. Their team is now also exploring ways to build support groups for parents, grandparents and other community members.

At the NGO Mercy Corps’ evacuation centers, the children’s shelter administrators are wise in the ways of the media. When a reporter visits, he is told: no photographs of children's faces. No video. And no interviews with children.

The staff member speaking with the reporter said that this evacuation center has been especially frequented by journalists. Every time someone wants to do an interview with a child survivor, she said, it takes the child back to those terrible days. And the trauma of those feelings can be especially hurtful and harmful for children.

(www.mercycorps.org/japanearthquake)

(http://www.reliefweb.int/node/420789); http://crisisreliefjapan.wordpress.com/tag/survivors/

PTSD: TRAUMA, TREATMENT.

Psychiatrist, and PTSD specialist, Norihiko Kuwayama, has said that he believes

Post traumatic stress disorder will become an even bigger problem. And I think that is related to Japanese culture which subscribes to the view that it’s best to let sleeping dogs lie. So instead of talking about the tsunami people carry it in their hearts. They believe society does not want to know their problems, that it will perceive sufferers as weak.

According to Mark Willacy of the Australian Broadcasting Corporation, Kuwayama believes that it is crucial that Japan changes the way it thinks about mental health and about PTSD. (.http://reliefweb.int/node/420789)

Clearly, depression is endemic among all people regardless of age, sex, social status within the affected areas. But beyond that assertion, there is dissension about many points here, about the
nature and characteristics of “mental problems”, PTSD, or whether the words “clinical depression” more truly characterizes the nature of survivors’ suffering.

There are also disagreements about the ideal locus and nature of treatment for the remaining survivors.

Dispute about ptsd and professional training: In Justin McCurry’s March 26, 2011 *Lancet* article, “Japan, the aftermath,” he stated that Japan’s health system is ill-prepared to address the long-term mental health problems triggered by the disaster. Some Japanese and many Westerners would agree with this statement. www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60413-3

Yoshiharu Kim, director of adult mental health at the National Institute of Mental Health in Tokyo, disagrees. In his article “Post-disaster mental health care in Japan” (*Lancet* 23 July 2011), Kim states:

Valuable lessons about post-disaster mental health have been learned since the disasters, the earthquake at Kobe in 1995 and Niigata in 2006. In 2001, the National Center of Neurology and Psychiatry issued national guidelines for post disaster mental health, and several thousand caregivers have been trained in traumatic stress counseling over the past few years. The directors of most mental health centers have attended lectures in post disaster mental health care. As a result, responses to the present disaster were very rapid, allowing prompt scheduling and dispatch of mental health-care teams to the devastated areas.” (www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61169-0)

Yoshiharu Kim’s statement does alter one’s perception of the availability of mental health care available to the survivors.

It also appears that the numbers of community based models for psychiatric care and the numbers of disaster-trained therapists recommended for Japan by WHO official Shekhar Saxena, are far more robust than one might think.

Another question here is whether Western intervention and treatment in the wake of 3/11 has done any good for the Japanese.

Ethan Watters’ *Crazy Like Us: The Globalization of the American Psyche* (2010) is a critical account of four well intentioned but damaging western psychiatric interventions into non Western cultures, by people who didn’t understand the cultures they had decided to heal. And didn’t want to. And who, as a result, inflicted worse damage on the sufferers than they had experienced in the first place.

Watters argues convincingly that all mental illness is culturally defined. Attempts to use Western modes of treating crisis/trauma in a culture that is non Western, will simply result in greater trauma.

Watters examines four cases– Hong Kong, Sri Lanka, Tanzania, and Japan- each of which calls into question an aspect of Western treatment. The most striking:

• In Sri Lanka, Western –trained “trauma counselors” concluded that the natives’ good nature after a tsunami was actually denial. The counselors decided to reenact the trauma, employing a “trauma debriefing” technique intended to avoid ptsd in the survivors--with long term negative effects on the Sri Lankan survivors.

• In Tanzania, Western psychiatrists attempted to dissuade the natives from their belief in spirit possession which stigmatized the mentally ill. They were unsuccessful. This belief in spirits is helpful to the schizophrenic, keeping him within the social group. By
contrast, Western schizophrenics experience fewer periods of remission and lower levels of functioning than do those who believe in ghosts.

- In Japan, depression became the subject of a marketing war, won by GlaxoSmithKline-so that with its medication Paxil it altered the country’s ways of thinking and feeling about depression – *kokoro no kaze*. Prior to this Eli Lilly, makers of Prozac, had decided that the Japanese concept of melancholy- was too deeply rooted to be susceptible to a Western pill.

The question here is who was the winner- the pharmaceutical company or the people treated? was it a win for Japanese people also?

In accord with Yoshiharu Kim’s comments on immediate “post trauma debriefing”, medical personnel at this year’s many disaster sites were discouraged from immediately counseling survivors in the belief that it would not prevent post traumatic stress disorder and may in fact increase a person's risk. Teams were told to counsel only those with existing mental health problems or those displaying obvious signs of distress.

“After treating the previously mentally ill people, the mental health teams started to take care of the new victims of the disaster,” Yoshiharu Kim said.

Andrew Grimes of Tokyo Counseling Services reported in November 2011 that eight months on, Dr. Kim had said that hospitals and clinics in Japan had so far seen no increase in the number of patients with depression or post traumatic stress disorder..

http://tokyocounselingservices.posterous.com/79945159

**The pioneers of ptsd treatment in Japan:** Yoshiharu Kim, Australian psychologist Justin Kenardy, American psychologist Matthew Yoder, and Naoto Kawabata, an American-trained Japanese psychiatrist, have also reported promising alternative ways of dealing with PTSD.

Last year, Justin Kenardy at the University of Queensland in Brisbane, Australia, found a new approach to the treatment of post-disaster trauma, a version of cognitive-behavioral therapy (CBT).

The technique involves four to twelve psychological sessions, administered at least a month after the trauma. By this time, most survivors will have begun to deal with the stress of the event in their own way, leaving those most at risk of PTSD more readily identifiable.

CBT is currently being given to victims of the tsunami who show symptoms of PTSD. Kim expects the first scientific studies of this strategy to be published within the next few years.


On the other hand, a new twist on the “traditional” or American form of PTSD treatment, could make community mental health therapy more effective within isolated and remote rural areas.

This method was developed by Drs. Peter Tuerk and Matthew Yoder. Both psychologists had returned in May from Japan, where they successfully used their PTSD program to help the victims of the earthquake and tsunami combat anxiety disorders.

One therapy in which Yoder specializes is telemedicine, or providing therapy over video-conferencing equipment.
"With the radiation disaster, there was a big area where no one was going," Yoder said. "So to be able to use telemedicine therapy, for a physician to be outside of the evacuation zone to be treating people inside the evacuation zone, was a unique application of this therapy."


Naoto Kawabata, another psychologist who has become convinced that the model of PTSD is not adequate for the situation in Fukushima, has developed his own.

Kawabata, a Japanese psychologist working with traumatized Fukushima families, is the President of the Kyoto Institute of Psychoanalysis and Psychotherapy (KIPP) and Professor of Psychology at Kyoto Bunkyo University. Kawabata studied advanced psychotherapy and psychoanalysis at the William Alanson White Institute in New York City.

Kawabata, as a result of his experience as a first responder at the 1995 Kobe earthquake, questioned whether and how western theories of trauma treatment could be translatable for Japanese victims. He volunteered to join a support team to work with Fukushima teachers and children.

Kawabata’s comments on his work:

“In Aizu-Wakamatsu, Aizu-Bange and Inawashiro we found that in addition to the stress induced by the disasters, the stress level in the shelters was very high because grandparents, parents and children are living in one small room together. Old people who lost their routine work and chores just lie down the whole day and are very depressed. They have no idea about how long they will have to stay there. We recommended organizing some recreation activity there [and] the next team put that plan into place.

“I have found that the Post Traumatic Stress Disorder (PTSD) model does not fit this situation-- I am developing a different model, which I call the "systemic-psychodynamic" model of disaster aid.

“We need psychologists who will think together with parents, teachers, and children in Fukushima from a systemic and psychodynamic point of view. First we must establish a relationship with the community; then we have to find out what victims need and offer help or come up with some [way] to resolve their most urgent problems.

“[We can] talk to people in depth and ask about their experience of the disaster. After establishing a relationship, we can propose interventions such as screening tests, individual counseling, group counseling or organizational consultation--. But we have to be careful not to be intrusive.

“Very often it works better to provide supervision and consultation for staff who are already working in the community.

“The goal is to help the system to recover and raise the level of mindfulness.”

(http://www.psychologytoday.com/blog/psychoanalysis-30/201106/the-front-lines-japanese-psychologist-the-fukushima-disaster)

It’s clear that survivors in Fukushima, beset by many forms of disaster related stress, need quality institutional mental health care. Unfortunately, mental health care facilities are currently scarce in Fukushima. Virtually all facilities, which fell within the evacuation zone of the Daiichi
Nuclear Power Plant, have been shut down since 3/11.

KOKORO NO CARE- NEW MENTAL HEALTH CARE FOR FUKUSHIMA:

Finally, however, constructive assistance for the survivors of the disasters at Fukushima is coming in the form of a sophisticated mental health system.

In August 8, 2011, five months since 3/11. Japan Society awarded the Japan Medical Society of America (JMSA) a three-year grant to support Kokoro no Care (pun on the phrase kokoro no kaze?) programs in Fukushima. In October 2011, Dr. Shinichi Niwa and his “Kokoro no Care” team at Fukushima Medical University, in cooperation with Japan Society, began building a new mental health care system for the area. Their main goals:

1. Provide ongoing therapy and support for patients with preexisting mental health conditions
2. Provide early intervention for disaster related depression and Post-Traumatic Stress Syndrome (PTSD)
3. Reduce cognitive functional decline in displaced elderly residents
4. Prevent expected rises in the suicide rate and “lonely deaths”
5. Decrease hospital admissions for mental health

Dr. Niwa and his team opened a temporary mental health clinic at Soma Public General Hospital with the support of many volunteer mental health specialists and other medical staff.

In the next phase, Dr. Niwa and his Kokoro no Care team are planning to establish two multidisciplinary satellite mental health care outreach teams as well as a day care center in order to better serve the needs of Soma and Minami Soma. “Kokoro no Care.” The Japanese Medical Society of America (JMSA. August 8, 2011.

The new health system should serve as the nerve center for psychiatry and psychotherapy and a source of new hope, for the region. http://jmsa.org/kokoro-no-care.html

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