

Critical Incident Stress of Rescue Workers after the Great East Japan Earthquake : With Examining Local Firefighters, Special Rescue Team and Rescue Divers of Japan Coast Guard

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ABSTRACT. The purpose of this study was to reveal the general prevalence of PTSD symptoms among rescue workers for two time points: just after the traumatic operation after the Great East Japan Earthquake (Time 1) and seven months or one year after the earthquake (Time 2). We also aimed to examine the effect of the casual conversation about the critical incident on PTSD symptoms and mental condition of rescue workers. The participants were 5 rescue divers and 16 Special Rescue Team (SRT) of Japan Coast Guard (JCG) and 52 local firefighters of disaster area. They answered the questionnaire from November 2011 to March 2012 at voluntary basis. Traumatic stress responses were assessed for two time points (Time 1 and Time 2) with Japanese version of Impact of Event Scale-Revised (IES-R-J, Asukai et al., 2002). The participants answered Time 1 as past reaction, and Time 2 as the current condition. The results revealed that 28.8 % of firefighters, 6.3 % of SRT and 20% of rescue divers were categorized as high risk of PTSD at Time 1, and 13.5 % of firefighters were categorized as high risk at Time 2 and all SRT and rescue divers of JCG were categorized as low risk at Time 2. The results of this study presented that the conversation about the trauma had no effect on PTSD symptoms and mental condition. However, the conversation about the critical incident would work to improve PTSD symptoms and mental condition since it seems to play a key role at the point in the past when people are sharing the experience.

KEY WORDS : critical incident stress IES-R-J PTSD firefighters special rescue team

The Great East Japan Earthquake occurred on March 11, 2011 at 14:46 JST. The Eastern part of Japan, from Tohoku to Kanto region, was severely damaged by the 9.0 magnitude earthquake. The earthquake triggered powerful tsunami waves that reached heights approximately up to eight to nine meters

throughout and travelled up to six kilometers from the coastline of Tohoku and Kanto region. After the issue of tsunami warning, firefighters (both professional and volunteer), police officers, and local government officials guided victims to evacuate from coastal area. Some of them injured or perished while on the duty. Firefighters were one of the main professional rescue workers operating after the disaster. A total of 28,600 firefighters across the country, up to 6,100 at one point, have come to work for rescue service and security operation at disaster area including evacuated area of nuclear plants.

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The Japan Coast Guard (JCG) also conducted the rescue service and port reconstruction as a part of their duty.

It has been widely recognized the importance to work on the critical incident stress (CIS) of rescue workers after the accident of Air Florida in 1982 (e.g., Every & Mitchell, 1997). Following events such as Gulf War, world trade center bombing and September 11 attacks have highlighted the CIS on professional rescue workers. In Japan, the Hanshin Earthquake in 1995 has led people to consider stress measure as an indispensable issue among rescue professionals. The findings on CIS of rescue professionals have piled up in Japan since the earthquake (Hyogo Institute for Traumatic Stress, 2000; Tanouchi, 2005; Japan local government employee safety and health association, 2006; Ohoka et al., 2006; Matsui, Hatanaka & Maruyama, 2011). However, both researchers and practitioners have not come to any conclusions on the issue of the effect of casual conversation about the traumatic experience on PTSD symptoms.

In this study, we conducted a questionnaire research on professional rescue workers who have engaged in rescue operation for the Great East Japan Earthquake. The participating professionals were 66 firefighters in Sendai city, the nearest major city to the earthquake, all rescue divers of Second Regional JCG, and all Special Rescue Team (SRT) of Third Regional JCG. The participants answered on the items of (1) PTSD symptoms with Japanese version of Impact of Event Scale-Revised (IES-R-J, Asukai et al., 2002), (2) the amount of casual

conversation about the critical incident, the operation after the Great East Japan Earthquake, (3) the change of mental condition because of the conversation. Both firefighters in Sendai city and rescue divers of JCG in this research were the victims of the disaster, who resided the area.

Because we did not conduct this study with large-sized population, we applied the analysis adopted from prior studies to compare our results with those of prior studies conducted with large-scale population (Hyogo Institute for Traumatic Stress, 2000; Matsui et al., 2011).

Methods

Procedures

We conducted a questionnaire research on firefighters in Sendai city, rescue divers of second regional JCG, and SRT of third regional JCG, all of whom have had operation for the Great East Japan Earthquake at October of 2011. We distributed the questionnaire of firefighters from company network and collected them later at October of 2011. We sent and collected them via mail for SRT at October of 2011 and rescue divers at March of 2012, respectively.

Research participants

The participants were 66 firefighters in Sendai city, all of 36 SRT of third regional JCG, and all of five rescue divers of second regional JCG. All of them participated at voluntary basis. We limited the data of participants who indicated that they had operation for the Great East Japan Earthquake. After excluding the

invalid data, we applied the data of 73 participants (52 firefighters: $M=40.17$ years, $range: 22-58$ years, $SD=9.80$; 16 SRT: $M=29.00$ years, $range: 24-38$ years, $SD=3.03$; and 5 rescue divers: $M=24.60$ years, $range: 23-27$, $SD=1.52$) for following analyses. All participants were male.

Measures

PTSD symptoms

Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) was applied to assess the reaction of post-traumatic stress during their rescue operation. IES-R is consisted of three subscales: hyper arousal, intrusion, and avoidance. Japanese translated version of this scale (IES-R-J) has confirmed its validity and reliability (Asukai et al., 2002). Higher score means greater traumatic stress at the point of assessing. Asukai et al. (2002) recommended the cutoff values of 24/25 to screen the high risk population of PTSD. In this study, the participants answered IES-R-J for two points (Time 1 and Time 2). They responded Time 1 as their past reaction and Time 2 as that of the current condition.

Casual conversation about the critical incident

We applied five partners to have casual conversation about the critical incident. They were family members, friends, lover, colleagues shared the incident (shared colleagues) and colleagues not shared the incident (non-shared colleagues). Participants were asked to rate how much they have had casual conversation about the critical incident. Responses were on Likert-type scale, ranging from “not at all” = 0

to “very much” = 4. We coded the response from 0 to 1 as “little” and from 2 to 4 as “talk” for casual conversation with each partner. As for family members, friends and lover, we reduced them into one index, intimates. Participants who had at least one code of “talk” among three different intimates were coded as “talk” with intimates whereas those who had no code of “talk” were coded as “little”.

Changes of mental condition because of the casual conversation about the critical incident

We developed the items based on Kawase (1999)’s study of social sharing, which referred as having a conversation about the traumatic experience. Participants were asked to rate how much they have realized the changes of mental condition since having casual conversation about the critical incident. Responses were on Likert-type scale, ranging from “not at all” = 0 to “very much” = 4.

Results

IES-R-J score at Time 1 by occupation of rescue professionals

For the total 52 firefighters, the mean total score of IES-R-J at Time 1 was 20.10 ($SD=17.37$). A total of 15 participants (28.8%) had scores 25 or more points and were classified in the high risk group; the remaining 37 firefighters were categorized into the low risk group with scores less than 24 points. The firefighter’s mean scores of each subscale of IES-R-J at Time 1 were 8.50 ($SD=7.55$) of intrusion, 6.81 ($SD=6.44$) of avoidance, and 4.79 ($SD=5.10$) of hyper arousal. For the total 16 SRT, the mean total score of IES-R-J at

Time 1 was 2.44 ($SD=6.10$). One of 16 participants (6.3%) was classified in the high risk group; the remaining 15 firefighters were categorized into the low risk group. The SRT's mean scores of each subscale of IES-R-J at Time 1 were 1.44 ($SD=3.22$) of intrusion, 0.75 ($SD=2.02$) of avoidance, and 0.25 ($SD=1.00$) of hyper arousal. For the total five rescue divers, the mean total score of IES-R-J at Time 1 was 10.40 ($SD=10.88$). One of five participants (20.0%) was classified in the high risk group; the remaining four rescue divers were categorized into the low risk group. The rescue diver's mean scores of each subscale of IES-R-J at Time 1 were 7.80 ($SD=8.04$) of intrusion, 1.20 ($SD=2.17$) of avoidance, and 1.40 ($SD=2.07$) of hyper arousal.

IES-R-J score at Time 2 by occupation of rescue professionals

For the total 52 firefighters, the mean total score of IES-R-J at Time 2 was 10.73 ($SD=12.73$). A total of 7 participants (13.5%) had scores 25 or more points and were classified in the high risk group; the remaining 45 firefighters were categorized into the low risk group with scores less than 24 points. The firefighter's mean scores of each subscale of IES-R-J at Time 2 were 4.35 ($SD=5.48$) of intrusion, 3.96 ($SD=5.82$) of avoidance, and 2.42 ($SD=2.91$) of hyper arousal. For the total 16 SRT, the mean total score of IES-R-J at Time 2 was 1.19 ($SD=4.23$). All 16 participants were classified in the low risk group. The SRT's mean scores of each subscale of IES-R-J at Time 2 were 0.63 ($SD=2.00$) of intrusion,

0.38 ($SD=1.50$) of avoidance, and 0.19 ($SD=.75$) of hyper arousal. For the total five rescue divers, the mean total score of IES-R-J at Time 2 was 3.80 ($SD=1.92$). All five participants were categorized into the low risk group. The rescue diver's mean scores of each subscale of IES-R-J at Time 2 were 2.60 ($SD=2.30$) of intrusion, 0.60 ($SD=.55$) of avoidance, and 0.60 ($SD=.55$) of hyper arousal.

The PTSD symptom transition from Time 1 to Time 2 by occupation of rescue professionals

Next, we showed the PTSD symptom transition from Time 1 to Time 2. PTSD symptom was categorized into three levels with total score of IES-R-J for both Time 1 and Time 2, respectively. The three groups were less than 9 points, 10-24 points, and 25 or more points of the total score of IES-R-J. We applied the results of Time 1 and Time 2 in combination as the PTSD symptom transition. The category names are shown at Table 1. We applied the name based on Matsui et al. (2011).

For the total of 52 firefighters, a total of 17 participants (33%) had less than 9 points both at Time 1 and Time 2 and were classified in the Non Stress group. The second largest proportion with 14 participants were Resolved group (28%), which showed mild stress with 10-24 points at Time 1 but non stress with less than 9 points at Time 2. Eight participants (16%) who categorized into Recovered group showed severe stress symptoms at Time 1 with 25 or more points but recovered to no problematic level with 20-24 points at Time 2. The two smallest populations were Prolonged

group and Sustained/Worsened group with six participants (12%). Prolonged group population had 25 or more points both at Time 1 and Time 2, which indicated that they suffered severe PTSD symptoms throughout the period. Sustained/Worsened group experienced mild stress symptoms at Time 1 with 10-24 points and sustained or worsen the symptoms at Time 2.

As for 16 SRT, 15 participants (94%) was classified into Non Stress group; the remaining participant (6%) was categorized as Recovered group.

Similarly, the three of the total of six rescue divers (60%) was classified into Non Stress group; the remaining two participants were categorized as Recovered group (20%) and Resolved group (20%), respectively.

Next, we examined whether the PTSD symptoms increased or decreased from Time 1 to Time 2 with all rescue professionals. We excluded the Non Stress group from this analysis because they have never experienced the PTSD symptoms. Before the analysis, we reduced Resolved group and Recovered group

into Decreased group; the remaining Sustained/Worsened group and Prolonged group were reduced into Unchanged/Deteriorated group.

The exact binominal test revealed that the population of Decreased group ($n=26$) was significantly greater than those of Unchanged/Deteriorated group ($n=12$). The result indicates that most of the rescue workers would become better even when they initially suffered from PTSD symptoms.

The occupational difference of rescue professionals on the experience of the casual conversation about the critical incident

We analyzed the occupational difference of the experience of casual conversation about the critical incident with each conversation partners. The results revealed that there were no occupational differences on the experience of the conversation with three different partners, respectively (intimates: $\chi^2_{(2)}=1.32, n.s.$; shared colleagues: $\chi^2_{(2)}=1.66, n.s.$; non-shared colleagues: $\chi^2_{(2)}=2.55, n.s.$).

Table 1
The categorization and the category names of the process of PTSD symptoms

		Total score of IES-R-J Time 2		
		0-9 points	10-24 points	25 points or more
Total score of IES-R-J Time 1	0-9 points	Non Stress	*1	*1
	10-24 points	Resolved	Sustained/Worsened	Sustained/Worsened
	25 points or more	*1	Recovered	Prolonged

Note. *1 indicates no participants were classified into the categories.

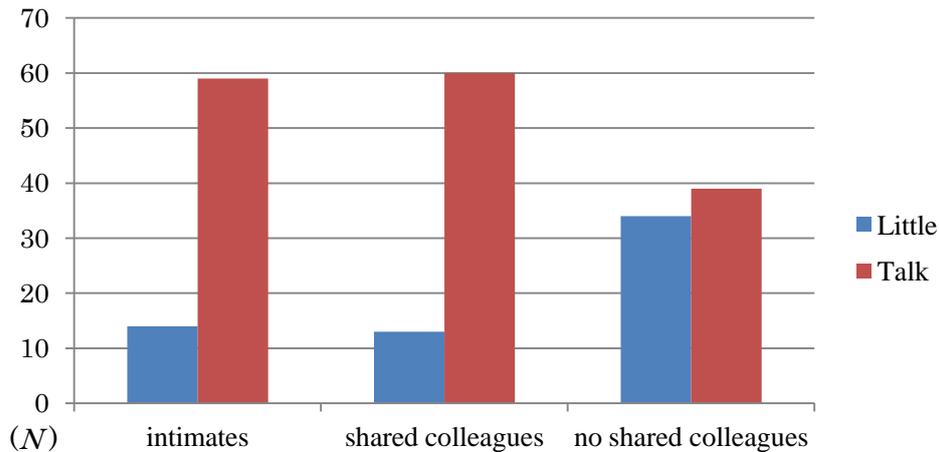


Figure 1. The experience of conversation about the critical incident with three partners among all rescue workers ($N=73$)

The partner difference of casual conversation about the critical incident

Furthermore, we examined the between-partner difference with all rescue professionals. The result showed that the distribution of the experience of casual conversation was different by three partners ($\chi^2_{(2)} = 19.13$, $p < .01$). Following residual analysis revealed that rescue workers have had a conversation about the critical incident more with intimates and shared colleagues while less with non-shared colleagues (Figure 1).

The scale of changes of mental condition (SCMC) because of casual conversation about the critical incident

We conducted factor analysis with promax and principal factor rotations because we assumed the factor correlations for factors underlying the scale. Four factor solution was supported based on the eigen values of just over one (6.79, 1.92, 1.36, and 1.16). The four factor

solution, which explained 74% of the variance, was preferred with both promax and principal factor rotations of the factor loading matrix because of its previous theoretical support, the ‘leveling off’ of eigen values on the scree plot after four factors, and the insufficient number of primary loadings and difficulty of interpreting the fifth factor and subsequent factors.

During several steps, a total of five items were eliminated because they did not contribute to a simple factor structure and failed to meet a minimum criteria of having a primary factor loading of .35 or above, and no cross-loading of .35 or above. The items “exchanging information” and “getting a good idea” did not load above .35 on any factor. The items “understanding own feeling”, “becoming accepted”, “being mentally stable” had cross-loadings on more than two factors.

The factor loading matrix for this final solution is presented in Table 2.

The items highly loading on first factor were “thinking the incident in an organized way”, “thinking the incident in calm way”, “making a sensible judgment”, “confirming own feeling” and “being objective”. We named the first factor as “Sorting out the experience ($M=11.95$, $SD=3.79$, $\alpha=.88$)”. The second factor was “Other’s support ($M=6.89$, $SD=2.51$, $\alpha=.83$)” based on the highly loading items: “receiving a consolation”, “being listened own feeling”,

“being supported”, and “receiving an advice”. The third factor was named “Acceptance ($M=7.23$, $SD=2.34$, $\alpha=.86$)” after the highly loading items: “being agreed”, “developing the idea about the incident”, and “being sympathized”. The last factor was “Feeling better ($M=8.41$, $D=3.37$, $\alpha=.89$)”. The highly loading items were “feeling refreshed”, “being distracted”, and “not being anxious”.

Table 2

Factor loadings and communalities based on a factor analysis with promax and principal factor rotations for 15 items from the Scale of Change of the Mental Condition (SCMC) because of casual conversation about the critical incident ($N = 73$)

	1	2	3	4	Communality
Thinking the incident in an organized way	.87				.77
Think the incident in calm way	.73	.26			.59
Making a sensible judgment	.69				.56
Confirming own feeling	.68		.26		.68
Being objective	.46		.25	.22	.42
Receiving a consolation		.90	-.28		.74
Being listened own feeling		.80	.28		.83
Being supported		.70	.23		.73
Receiving an advice		.59		.22	.63
Being agreed		.21	.84		.83
Developing the idea about the incident	.28	-.31	.77		.61
Being sympathized			.74		.73
Feeling refreshed				.90	.74
Being distracted				.63	.44
Not being anxious			.30	.50	.63
	factor correlations	II	III	IV	
	I	.42	.42	.30	
	II		.56	.47	
	III			.54	

Note. Factor loadings $< .2$ are suppressed.

The regression analyses on IES-R-J Time 1 - IES-R-J Time 2 score difference with all rescue professionals

We conducted a stepwise multi-regression analysis on Time 1 - Time 2 difference of total score of IES-R-J. The predictor variables were three subscales of IES-R-J of both Time 1 and Time 2, the experience of casual conversation with each partner (intimates, shared colleagues and non-shared colleagues), and the four subscales of SCMC ("Sorting out the experience", "Other's support", "Acceptance" and "Feeling better"). The predictor variables explained significant proportion of variance in IES-R-J Time 1 - IES-R-J Time 2 score difference, $R^2 = .93$, $F_{(5)} = 203.49$, $p < .001$. The subscales of IES-R-J both at Time 1 and Time 2 significantly predicted the target variable, whereas, the experience of the conversation and SCMC had no significant effects on the IES-R-J Time 1 - IES-R-J Time 2 score difference. This result indicates that both the experience of the conversation and the

psychological effects of the conversation have no significant influence on the PTSD symptom process (Table 3).

Similarly, we conducted stepwise multi-regression analyses on IES-R-J Time 1 - IES-R-J Time 2 score difference of three subscales of IES-R-J, respectively (IES-R-J Time 1 - IES-R-J Time 2 intrusion, IES-R-J Time 1 - IES-R-J Time 2 avoidance and IES-R-J Time 1 - IES-R-J Time 2 hyper arousal). the predictor variables were the experience of the conversation with each partner(intimates, shared colleagues and non-shared colleagues), and the four subscales of SCMC ("Sorting out the experience", "Other's support", "Acceptance" and "Feeling better").

The predictor variables explained significant proportion of variance in Time 1 - Time 2 score difference for each subscale of IES-R-J (intrusion: $R^2 = .57$, $F_{(1)} = 95.58$, $p < .001$.; avoidance: $R^2 = .27$, $F_{(1)} = 28.21$, $p < .001$.; hyperarousal: $R^2 = .75$, $F_{(1)} = 212.25$,

Table 3

Summary of multiregression analysis for variables predicting the difference of IES-R-J Time 1 - IES-R-J Time 2 (N = 73)

	<i>B</i>	<i>SE B</i>	β
intrusion Time 1	1.15	0.09	.95
intrusion Time 2	-1.25	0.12	-.69
hyper arousal Time 1	1.20	0.14	.64
hyper arousal Time 2	-1.72	0.24	-.51
avoidance Time 1	0.37	0.08	.26
R^2		.93	
F		203.49	

$p < .001$). The results also revealed that Time 1 - IES-R Time 2 score differences of each subscale of IES-R-J were significantly predicted by the subscale of Time 1: Time 1 - Time 2 score differences of intrusion was predicted by intrusion Time 1 ($\beta = .76$), Time 1 - Time 2 score differences of avoidance was predicted by avoidance Time 1 ($\beta = .53$), and Time 1 - IES-R Time 2 score differences of hyperarousal was predicted by hyperarousal Time 1 ($\beta = .87$). These results illustrate that the process of the each symptom also has no significant influence from the experience of the conversation and the mental condition.

The regression analyses on changes of mental condition with all rescue professionals

Aiming to examine the effect of experience of casual conversation about the critical incident on mental condition, we conducted a stepwise multi-regression analysis on total score of SCMC. Predictor variables were the experience of the conversation with each partner (intimates, shared colleagues and non-shared colleagues). The predictor variables explained significant proportion of variance in total score of SCMC ($R^2 = .05$, $F_{(1)} = 4.65$, $p < .05$) although the value of R^2 was quite low. Considering the low value of R^2 , we just report significant predictor variables without further interpretation. The experience of the conversation with non-share colleagues significantly predicted the change of mental condition ($\beta = .25$).

Next, we also conducted stepwise multi-regression analyses on four subscales of

SCMC ("Sorting out the experience", "Other's support", "Acceptance" and "Feeling better"). Predictor variables were the experience of the conversation with partners (intimates, shared colleagues and non-shared colleagues). As with the case of the analysis on the total score of SCMC, The predictor variables explained significant proportion of variance in each subscale of SCMC with low R^2 value, respectively (Sorting out the experience: $R^2 = .05$, $F_{(1)} = 4.71$, $p < .05$; Other's support: $R^2 = .07$, $F_{(1)} = 6.37$, $p < .05$; Acceptance: $R^2 = .08$, $F_{(1)} = 7.50$, $p < .01$; Feeling better: $R^2 = .03$, $F_{(1)} = 0.63$, *n.s.*). Once again, we just report significant predictor variables without further interpretation because of the low value of R . The experience of the conversation with non-shared colleagues was significant predictor of "Sorting out the experience" ($\beta = .25$) and "Other's support" ($\beta = .29$). Moreover, "Acceptance" was significantly predicted by the conversation with shared colleagues ($\beta = .31$).

Given that low R^2 value, we can indicate that the experience of the conversation about the critical incident has no significant effect on mental condition.

Discussions

We revealed the general prevalence of PTSD symptoms among rescue workers at two points: just after the critical incident and seven months or one year after the Great East Japan Earthquake. We also obtained the results that the experience of casual conversation about the incident was not predicted by both PTSD

symptoms and mental condition. We give some considerations on the results at this section.

IES-R-J score by the occupation

We obtained the score of IES-R-J at two points: just after experiencing of the critical incident (Time 1) and seven months to one year after the operation (Time 2). The response of Time 1 was drawn as retrospective answer. Prior studies (Hyogo Institute for Traumatic Stress, 1999; Matsui et al., 2011) have applied the same methodology to assess PTSD symptoms. However, future studies should be examined the reliability of the retrospective data on PTSD symptoms.

Hyogo Institute for Traumatic Stress (1999) reported the percentage of high risk population of PTSD among firefighters at two points: (1) 13 months and (2) four and a half year after the Hanshin Earthquake. The researchers classified the participants as high risk with the 20 points or higher of the total score of IES for 13 months later and 25 points or higher of the total score of IES-R-J for four and a half year later, respectively. At 13 months later, the amount of 15.9% of local firefighters who lived in the affected area was categorized into high risk population of PTSD. As for the firefighters deployed from other areas at the same point in time, high risk PTSD symptoms appeared at the total of 4.9% of them with early stage deployment and 4.2% of them with latter stage deployment. Hyogo Institute for Traumatic Stress (1999) also revealed that high risk population of PTSD varied among the firefighters who had experienced different

operation at four and a half year after the earthquake. High risk PTSD symptoms appeared to 16.3% of firefighters with high level of exposure, who had engaged in field operation and reported severe mental strain after facing the critical incident, 12.4% of those who have had no field operation, 5.8 % of newly employed workers without experiencing the operation on the Hanshin earthquake, and 4.1 % of those who with low level of exposure, who have had engaged in field operation and reported no severe mental strain after facing the critical incident. The mean score of intrusion subscale was higher than that of both avoidance and hyper arousal subscales among the firefighters with different operation experience.

Moreover, Hyogo Institute for Traumatic Stress (1999) presented the process of PTSD symptoms among firefighters with high level of exposure. The approximately 60% of them had the symptom at three month after the earthquake, and 43.2% at half year later, 27.2% at a year later, 15.9% at two years later and 8.7% at the four and a half year later, respectively.

The results of this study showed that the 13.5 % of firefighters was classified as high risk of PTSD at seven months after the Great East Japan Earthquake. No rescue divers and SRT exhibited severe PTSD symptoms at seven months (SRT) or one year (rescue divers) after the earthquake. A prior study revealed that local firefighters who lived in the disaster area had more risk of PTSD after the Hanshin Earthquake (Hyogo Institute for Traumatic Stress, 2000). We can imply that firefighters and

rescue divers of this study have higher risk of PTSD because they lived in the affected area. We can also point out that most Japanese recognized PTSD for the first time at the Hanshin Earthquake. Inadequate knowledge of the symptom resulted in exaggerated news coverage, which led to more people to rate them as high risk of PTSD after the Hanshin Earthquake. On the contrary, the media might handle the PTSD symptom more adequately after the Great East Japan Earthquake, which resulted in less high risk population of PTSD. Meanwhile, we should mention that there was no high risk population of PTSD among rescue divers in this study even though they were also local residents. We can interpret the result based on the fact that the rescue divers of this study were in their twenties. They were younger than local firefighters and might have damaged their private properties and family less than the firefighters have done.

Next, we examined the process of PTSD symptoms by occupation of rescue professionals. A previous study investigated the critical incident of the firefighters within the ten years remembering back from the point of research and the pattern of the process of the PTSD symptoms from the time when they experienced it to the present (Matsui et al., 2011). Matsui et al. (2011) presented the distribution of process of PTSD symptom among firefighters who had experienced critical incident: Non Stress group (65.7%), Resolved group (16.8%), Recovered group (2.1%), Late onset group (6.8%), Worsened group (7.2%), and Prolonged group (1.4%). For the total of 52

firefighters of this study, 33% of them were classified as the Non Stress group, 28% as Resolved group, 16% as Recovered group, and 12% as Prolonged group and 12% as Sustained/Worsened group. As for 16 SRT of this study, 94% of the participants were classified into Non Stress group; the remaining participant was categorized as Recovered group. Similarly, the most (60%) of the rescue divers of this study was categorized into Non Stress group; the remaining two participants were categorized as Recovered group and Resolved group, respectively. We can argue that No Sustained/Worsened or Prolonged group among SRT and rescue divers resulted from the fact that they were still young (SRT: 29.00 years of age, range: 24-37; rescue divers: 24.60 years of age, range: 23-27). This argument might be supported by the result of Matsui et al. (2011) that the young firefighters generally did not suffer severe PTSD symptoms and their prognosis was mostly favorable. While some prior findings indicated that there are some cases of late onset of PTSD (Matsui et al., 2011), it is more psychologically understandable that the PTSD symptom resulted from the critical incident would develop after a short period of time. Our research has already revealed that the current stress symptom mostly results from the current factors rather than the past ones (Wakashima, Kozuka, Itakura, & Usami, 2011). Therefore, cases of late onset of PTSD would be developed by maladaptation to the workplace or worsened human relationship after both personal and environmental changes because of

the critical incident.

This study also showed the result that most of rescue workers experiencing PTSD symptom at Time 1 relieved their symptoms at Time 2. We can maintain that PTSD symptoms generally tend to weaken as time goes.

Casual conversation partners

All rescue workers have experienced casual conversation about their critical incident more with intimates and shared colleagues while less with non-shared colleagues. The results might reflect the difference of frequency of daily interaction.

The association of IES-R-J score with the experience of casual conversation about the critical incident and the mental condition

Prior studies have not reached the conclusion on the effect of the debriefing on PTSD symptoms. Some of them support the advantage (Chemtob, Tomas, Law, & Cremniter, 1997), but others do not (Hytten & Hasle, 1989; Bisson & Deahl, 1994; Deahl, Gillham, Thomas, Searle & Srinivasan, 1994). In Japan, there is a report on the effectiveness of informal debriefing for PTSD symptom (Hyogo Institute for Traumatic Stress, 1999). The report revealed that people rated lower IES score at 13 months after the earthquake than they did at three months after the disaster. However, we can point out that the research is not the evidence of effect of informal debriefing on PTSD symptoms because the decreasing PTSD symptoms could result in less conversation about the incident. Our results showed the no

association between casual conversation about the critical incident and IES-R-J score. Hence, we did not gain the support for effectiveness of informal debriefing on PTSD symptoms.

Although the fact that we obtained the results that there is no association between casual conversation about the critical incident and IES-R-J score, there is a room for casual conversation to be an influential factor for PTSD symptoms. We measured conversation about the trauma experience but we can also measure conversation about the PTSD symptoms resulted from the experience. PTSD symptoms are relatively similar among victims even though each of their traumatic experiences is unique. Therefore, it has large impact on treatment of PTSD to examine the effect of casual conversation about the PTSD symptoms.

The association of the experience of casual conversation about the critical incident with mental condition

Given that low R^2 value, our results also indicate that experience of casual conversation about the critical incident has no significant effect on mental condition. Based on this result as well as the result of the conversation on PTSD symptoms, we may argue that the informal debriefing about critical incident has no effect on PTSD symptoms and mental condition. We need to interpret the result in the light of the fact that research was conducted seven months or one year after the Great East Japan Earthquake and the conversation of the critical incident is a part of daily conversation. Conversation partners in this study (intimates,

shared colleagues and non-shared colleagues) have ongoing relationship with the participants, which means they have a plenty of opportunity to have conversation. Seven months or one year might be enough periods to shift away from talking about the critical incident to more about the other topics on current life. Considering that the current symptom mostly results from the current factors rather than those of the past (Wakashima et al., 2011), the result of this study might reflect that the current conversation on limitless topics rather than the past conversation on critical incident has an effect on PTSD symptoms and the current mental condition of rescue professionals.

However, we cannot underscore the importance of the conversation about the critical incident. This study indicates that most of the rescue professionals have had the experience of the conversation on the topic with others. To have the experience of conversation means that people was experiencing the conversation as a current event at a point in the past. Given that finding that the current symptom mostly results from the current factors rather than the past (Wakashima et al., 2011). Therefore, the conversation about the critical incident could contribute to PTSD symptoms and mental condition at a point in the past when people are sharing the experience.

Conclusions

This study clarified the general tendency and the process of rescue workers' PTSD symptoms just after experiencing a critical incident during

their operation (Time 1) and seven months or one year after the Great East Japan Earthquake. We also examined the association of casual conversation about the critical incident with PTSD symptoms and mental condition of rescue professionals. The results indicated that the conversation has no significant influence on both PTSD symptoms and their mental condition. Given that PTSD symptoms gradually become weakened, the conversation about the critical incident could contribute to PTSD symptoms and mental condition at a point in the past when people are sharing the experience but not in the present where people talk more on the other topics.

References

- Asukai, N., Kato, H., Kawamura, N., Kim, Y., Yamamoto, K., Kishimoto, J., & Nishizono, M. A. (2002). Reliability and validity of the Japanese-language version of the Impact of Event Scale-Revised (IES-R-J). *Journal of Nervous and Mental Disease*, 190, 175-182.
- Bisson, J. I., & Deahl, M. P. (1994). Psychological debriefing and prevention of post-traumatic stress. *British Journal of Psychiatry*, 165, 717-720.
- Chemtob, C. M., Tomas, S., Law, W., & Cremniter, D. (1997). Postdisaster psychosocial intervention: A field study of the impact of debriefing on psychological distress. *American Journal of Psychiatry*, 154, 415-417.
- Deahl, M., Gillham, A. B., Thomas, J., Searle, M. M., & Srinivasan, M. (1994).

- Psychological sequelae following the Gulf War. Factors associated with subsequent morbidity and the effectiveness of psychological debriefing. *British Journal of Psychiatry*, 165, 60-65.
- Everly, G. S. Jr., & Mitchell, J. T. (1997). *Critical incident stress management. A new era and standard of care in crisis intervention* 2nd edition. Ellicott City, MD: Chevron Publishing Corporation.
- Hyogo Institute for Traumatic Stress (1999). *Hijouzitai Stress to Saigaikyuzosya no Kenkozyotai nikansuru Cyosakenkyu Hokokusyo*. (A report of critical incident stress and health condition in rescue professionals). Kobe: Hyogo Institute for Traumatic Stress. [in Japanese] (兵庫県精神保健協会こころのケアセンター (1999), 非常事態ストレスと災害救援者の健康状態に関する調査研究報告書—阪神・淡路大震災が兵庫県下の消防職員に及ぼした影響—).
- Hyogo Institute for Traumatic Stress (2000). *Saigaikyuzosya no Shinriteki Eikyo nikansuru Cyosakenkyu Hokokusyo* (A report of the mental health of rescue professionals). Kobe: Hyogo Institute for Traumatic Stress. [in Japanese] (兵庫県精神保健協会こころのケアセンター (2000). 災害救援者の心理的影響に関する調査研究報告書—阪神・淡路大震災が消防職員に及ぼした長期的影響—).
- Hytten, K., & Hasle, A. (1989). Fire fighters: A study of stress and coping. *Acta Psychiatrica Scandinavica*, 80, Supplementum, 50-55.
- Japan local government employee safety and health association (2006). *Shoubou Syokuin no Genba nikakawaru Stress Taisaku Follow-up Kenkyukai Houkokusyo* (A report of measure of stress on firefighters). Tokyo: Japan local government employee safety and health association. [in Japanese] (財団法人地方公務員安全衛生推進協会 (2006). 消防職員の現場に係わるストレス対策フォローアップ研究会報告書).
- Kawase, T. (1999). Kanjo wo Kataru Riyu (The reason to talk). *Bulletin of Miyazaki Municipal University Faculty of Humanities* 7(1), 135-149. [in Japanese] (川瀬隆千 (1999). 感情を語る理由：人はなぜネガティブな感情を他者に語るのか. 宮崎公立大学人文学部紀要 7(1), 135-149).
- Matsui, Y., Hatanaka, M. & Maruyama, S. (2011). Late-onset critical incident stress in fire fighter in Japan. *Japanese Journal of Interpersonal and Social Psychology*, (11), 43-50. [in Japanese] (松井 豊・畑中美穂・丸山 晋 (2011). 消防職員における遅発性の惨事ストレスの分析. 対人社会心理学研究 (11), 43-50).
- Ohoka, Y., Tsuzimaru, S., Ohnishi, R., Fukuyama, H., Yazima, J., & Maeda, M. (2006). A report on actual conditions of mental health for firefighters. *Bulletin of faculty of literature, Kurume University: Social Welfare*, 6, 85-95. [in Japanese] (大岡由佳・辻丸秀策・大西 良・福山裕夫・矢島潤平・前田正治 (2006). 消防隊員のメンタルヘルスについての実態調査報告. 久留米大学文学部紀要, 社会福祉学科編 6, 85-95).

- Tanouchi, K. (2005). A survey on critical incident stress experienced by disaster response professionals: Fire-fighting personnel. *Journal of Azabu University*, 21-32. [in Japanese] (田之内厚三 (2005). 職業的災害救助者の惨事ストレス調査：消防職員を対象として. *麻布大学雑誌*, 21-32.)
- Wakashima, K., Kozuka, T., Itakura, N., & Usami, T. (2011). Simultaneous and cumulative family relationship: Examining with ICHIGEKI. *International Journal of Brief Therapy and Family Science*, 1(2), 104-110.
- Weiss, D.S., & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In Wilson, J.P., & Keane, T.M. (Eds.), *Assessing psychological trauma and PTSD: A practitioner's handbook* (pp. 399-411). New York: Guilford Press.

Development of the Scale on Symmetry and Complementarity in Conversation

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ABSTRACT. The purpose of this study was to develop the scale to measure the level of symmetry-complementarity (Bateson, 1936) in dyadic conversation and to test the reliability and the validity of the scale. I developed the 25 questionnaire items and selected 13 items based on the result of item-total correlation analysis. The Cronbach's coefficient alpha of the scale was .87, the intra-class correlation coefficients was .58 ($p < .01$) and the correlation between the total scores of the SSCC and actual communication score evaluated by the coding system (FRCCCS ; Heatherington & Friedlander, 1987) was .64 ($p < .01$). The results indicated that the Scale on Symmetry and Complementarity in Conversation (SSCC) possesses high internal consistency, inter-rater reliability and criterion-referenced validity.

KEY WORDS: conversation, symmetry, complementary, Scale on Symmetry and Complementarity in Conversation (SSCC)

Introduction

In psychiatry the frame around the individual has been broken, and questions about why a man does what he does are being answered in terms of the context of relationships he creates and inhabits. The direct manifestation of this change that caused by the continuing emphasis upon interpersonal relations over the years and the development of ideas about systems is in the field of family research and family therapy. Couples and whole families are being brought under systematic observation (Haley, 1977).

Most clinicians have concerned about family structure and family function to assess problematic families. We have obtained the

findings of family structure and family function. However, these concepts are abstract and not easy to observe. These findings may not satisfy the needs of therapeutic practice.

Therefore, it is important to identify the practical method to achieve and understand healthy family with conceptual frameworks that are concrete and easy to observe for clinical practice.

Watzlawick, Beavin, and Jackson (1967) pointed out that communication is observable and reflects interpersonal relationship. Rogers and Escudero (2004) also argued that social relationships lie at the heart of our humanness, and in turn, communication lies at the heart of our relationships. As just described, to understand and help problematic interpersonal relationships (i.e. family), communication is focal because interpersonal behavior are better described by transactions, observable and quantifiable behaviors (Haley, 1963).

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Communications has been classified into symmetry and complementary since Bateson's work (Bateson, 1936). These concepts were originally way of differentiating behavior patterns within and between culture groups. Subsequently, these concepts have applied to smaller groups such as dyadic relationship. Symmetry refers to the communication based on similarity between persons (i.e. relationship in rivals competed for performance.), and complementary refers to the communication based on difference between persons (i.e. relationship between caregiver and their child) (Wakashima & Hasegawa, 2000).

Researchers of communication who use framework of symmetry and complementary have focused on the association between social context and communication pattern. Heatherington and Allen (1984) tested the association between gender and communication patterns in an outpatient therapy setting. Heatherington and Friedlander (1990) tested the association between treatment modality (couples and family) and communication patterns. Friedlander, Heatherington, and Wildman (1991) tested the association between therapeutic approach (structural family therapy and Milan systemic family therapy) and communication patterns. According to a recent study in this area, to classify interpersonal communication into symmetry and complementary is useful to predict the following communication pattern from precede the communication pattern (Kozuka & Wakashima, 2009). As described above, these researches have yield benefits towards

explaining interpersonal communication process.

Most of researchers have examined symmetry and complementary with the coding system such as Relational Communication Control Coding System (RCCCS: Ericson & Rogers, 1973) and Family Communication Control Coding System (FRCCCS : Heatherington & Friedlander, 1987). The disadvantage of these coding systems is to require enormous time and effort for research and clinical assessment of symmetry and complementary. Thus, in this study, I aimed to develop the self-report questionnaire that assess symmetry and complementarity of dyadic conversation and examined reliability and validity of the scale.

Methods

Development of Questionnaire

I developed 25 Japanese written items (see Appendix 1) based on coding systems (RCCCS and FRCCCS) and past discussions about conceptual imprecation of symmetry and complementary (Bateson, 1942; Sluzki & Beavin, 1977). Each item asked about nature of everyday communications between dyad and is rated on 6-point Likert-style scale ranging from "rarely" (=1) to "always" (=6). Higher score indicates symmetrical conversations are more frequently between them. I named this scale as Scale on Symmetry and Complementarity in Conversation (SSCC).

Participants

Data were drawn from 15 intimate dyads of Japanese college students and postgraduate

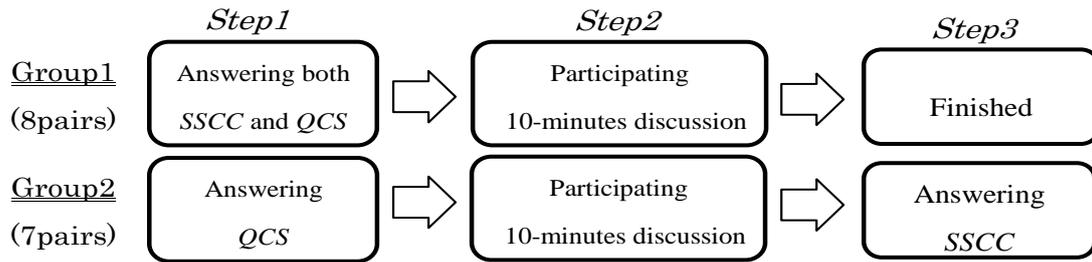


Figure1. Experimental process for each group

students who majored in clinical psychology (mean age of the participants was 25.23, $SD=3.57$). I applied all data for following analyses.

Experimental Process

To control order effect, participants were randomly assigned to two experimental groups (Figure1).

Each dyad participated in a 10 minutes discussion session. Six discussion topics were cited from website (http://www.ic.nanzan-u.ac.jp/~tsumura/kyouza_ikoukai/kyouzaikoukai.html: browsed on September 2011). All topics are about people how get out of critical situation in mountain climbing. These topics are called Questions of Critical Situations (QCS) in this paper. The question that dyads have different opinion was

applied as their discussion theme. I recorded conversation in the discussion session with video and evaluating it with FRCCCS.

Two researchers independently evaluated one of randomly selected VTR data depending on FRCCCS. As for the degree of agreement of evaluated codes between two raters, kappa coefficient (κ) was .84. Subsequently, only one of the two raters conducted the coding of the rest of VTR data. I used FRCCCS as external criterion of symmetry and complementarity observed in conversation.

Results

First, I conducted item-total correlation analysis for the selection of question items of SSCC. The result of analysis was shown at Table1.

Table1. The result of item-total correlation analysis
Adjusted item-total correlation coefficient

<u>Item 1</u>	.72	Item 10	.36	Item 19	.46
<u>Item 2</u>	.67	Item 11	.08	Item 20	.45
<u>Item 3</u>	.58	Item 12	.04	Item 21	.29
<u>Item 4</u>	.54	<u>Item 13</u>	.53	Item 22	.26
<u>Item 5</u>	.52	<u>Item 14</u>	.64	Item 23	.00
<u>Item 6</u>	.62	<u>Item 15</u>	.62	Item 24	.01
<u>Item 7</u>	.52	<u>Item 16</u>	.62	Item 25	.26
Item 8	.18	Item 17	.34		.
<u>Item 9</u>	.61	<u>Item 18</u>	.59		

Note. Underlines indicate that these items were selected as the result of item-total correlation analysis.

I deleted 12 items whose item-total correlation coefficient was lower than .50. 13 items were selected as the items of SSCC based on the result of item-total correlation analysis (see APPIDEX 2).

Second, internal consistency for this scale was examined with Cronbach's coefficient alpha. The alpha was .87. The result indicates that SSCC has high internal consistency. Third, inter-rater reliability for this scale was examined with intra-class correlation coefficient (ICC). ICC was .58 ($p < .01$). The result indicates that SSCC has moderate inter-rater reliability. Therefore, I randomly selected the SSCC data from one-participant of each dyad when I evaluate criterion-referenced validity. Finally, criterion-referenced validity was examined with Pearson Product-moment Correlation Coefficient (r) between scores of SSCC and scores evaluated by coding system (FRCCCS). r was .64 ($p < .01$). The result indicates that SSCC has high criterion-referenced validity as scale of symmetry and complementarity.

As for the descriptive statistics value, I show them at APPIDEX3.

Discussions

The purpose of this study was to develop the scale of symmetry and complementarity of conversation (SSCC). Additionally, I examined the reliability and validity of the scale.

The results indicate that SSCC possesses high internal consistency and high criterion-referenced validity. Moreover, SSCC also possesses inter-rater reliability. It indicates

that symmetry-complementarity of interpersonal relationships could be evaluated data from only one-rater of dyad. These results show that SSCC is useful and low-cost tool to assess interpersonal relationships.

In study area of family therapy, researchers have pointed out that the importance of seeing family as multigenerational when intervening the family system (Kobayashi et al., 2011). Nevertheless, researches about symmetry and complementary have been conducted to limited small groups such as couple and therapist-client. Behind of this issue, the disadvantage of the coding systems is presumed to exist. The coding systems such as RCCCS and FRCCCS are only applicable when researchers can observe actual communication between participants. Therefore, researchers have not used these coding systems to bigger groups such as multigenerational family relationship.

On the other hand, SSCC developed in this study is a self-report questionnaire. Therefore, researchers can collect enormous data more easily with SSCC than those with actual observation and the existing coding systems.

References

- Bateson, G. (1936). *Naven: A Study of the Problems suggested by a Composite Picture of the Culture of a New Guinea Tribe Drawn from Three Points of view*. Stanford: Stanford University Press.
- Bateson, G. (1942). Morale and National Character Watson, G.(ed.), *Civilian Morale*: 71-91, Boston: Houghton Mifflin.
- Ericson, P. M., & Rogers, L. E. (1973).

- New procedures for analyzing relational communication. *Family Process*, 12, 245-267.
- Friedlander, M. L., Heatherington, L., & Wildman, J. (1991). Interpersonal control in structural and Milan systematic family therapy. *Journal of Marital and Family Therapy*, 17, 395-408.
- Haley, J. (1963). *Strategies of psychotherapy*. New York: Grune & Stratton.
- Haley, J. (1977). Toward a Theory of Pathological Systems. Watzlawick, P., & Weakland, J. (eds.). *The Interactional View*, 31 - 49. New York: W. W. Norton & Company.
- Heatherington, L. & Allen, G. J. (1984). Sex and relational communication patterns in counseling. *Journal of Counseling Psychology*, 31, 287-294.
- Heatherington, L. & Friedlander, M. L. (1987). *Family Relational Communication Control Coding Manual*. (Available from Laurie Heatherington, Psychology Department, Bronfman Science Center, Williams College, Williamstown, MA 01267 USA).
- Heatherington, L., & Friedlander, M. L. (1990). Complementary and symmetry in family therapy. *Journal of Counseling Psychology*, 37, 261-286.
- Heatherington, L., & Friedlander, M. L. (2004). From Dyads to Triads, and Beyond: Relational Control in Individual and Family Therapy. Rogers, L. M., & Escudero, V. (eds.). *RELATIONAL COMMUNICATION –An Interactional Perspective to the Study of Process and Form*. 193-129, London: Routledge.
- Kobayashi, T., Itakura, N., Usami, T., Sato, M., Shimizu, A., & Wakashima, K. Predicators for Marital Cohesiveness in three-generation family. *International Journal of Brief Therapy and Family Science*, 1(2), 117-122.
- Kozuka, T., & Wakashima, K. (2009). The typology and change of human relations based on communication patterns: From the viewpoint of Pragmatics of Human Communication. *Japanese Journal of Counseling Science*, 42(1), 1-10. [In Japanese] (狐塚貴博・若島孔文 (2009). コミュニケーション・パターンによる関係性の類型と変化—人間コミュニケーションの語用論の視点から— *カウンセリング研究* 42(1), 1-10).
- Sluzki, C. & Beavin, J. (1977). Symmetry and Complementarity: An Operational Definition and a Typology of Dyads. Watzlawick, P., & Weakland, J. (eds.). *The Interactional View*, 71 - 87. New York: W. W. Norton & Company.
- Tsumura, T. *Tsun Tsun no taiken kara manabou*. <http://www.ic.nanzan-u.ac.jp/~tsumura/kyouzaikoukai/kyouzaikoukai.html> browsed on September 2011. [In Japanese] 津村俊充 つんつんの体験から学ぶ2011年9月閲覧.
- Wakashima, K., & Hasegawa, K. (2000). *Brief Therapy : Theory & Practice*. Tokyo: Kongo Shuppan. [In Japanese] (若島孔文・長谷川啓三 (2000). *短期療法ガイドブック* 東京: 金剛出版).
- Watzlawick, P., Beavin, J., & Jackson, D. D. (1967). *Pragmatics of Human Communication*. New York: W. W. Norton & Company.

APPIDEX1. 25 items of SSCC before item-total correlation analysis

1	あなたは、その相手と意見がなかなか合わなくとも、納得いくまで意見を主張する
2	あなたは、その相手から頼みごとをされたとしても、気乗りしなければ素直に断る
3	あなたは、その相手と違う意見を持っていたとしたら、それをその相手に伝える
<u>4</u>	あなたは、その相手からの頼みであれば、断らずに引き受ける
<u>5</u>	あなたは、その相手が出す意見には賛成する
6	あなたは、もしもその相手の言っていることや態度に納得いかないことがあっても、それを相手になかなか伝えられない
7	あなたは、その相手との会話の中で自分が話したい話題から外れてしまったとしても、その話題へ戻るまで自分から軌道修正をする
<u>8</u>	あなたは、その相手との会話では自分が話したい話題やテーマよりも、その相手が持ち出す話題やテーマを優先する
<u>9</u>	あなたは、その相手と意見がかみ合わない時は、自分から譲歩して相手の意見に合わせる
<u>10</u>	その相手は、あなたの意見について賛成してくれる
<u>11</u>	その相手は、あなたからの頼みごとを、断らずに引き受けてくれる
<u>12</u>	その相手は、最初はあなたと違う意見を持っていたとしても、話しをしているうちにあなたの意見に同調する
13	その相手は、あなたが話している最中であっても、割って入って自分の考えや意見を伝える
14	その相手は、あなたの意見に対して、「でも」や「だけれど」などの言葉を使って返答する
15	その相手は、あなたがその相手とは異なる意見を言ったりその相手に対して反論したりしても、すぐには意見を変えない
16	その相手は、あなたの意見や考えに対して反論する
<u>17</u>	その相手は、あなたとの会話の中で、自分自身よりもあなたの話したい話題やテーマを優先する
<u>18</u>	その相手は、あなたとの会話の中で、自分から新たな話題を提供したり、話題を変えたりはしない
<u>19</u>	あなたは、その相手に対して自分の考えを積極的に言うよりも、その相手の立場や意見に従っている方が気楽だ
<u>20</u>	あなたは、その相手が自分に対して強く出てくると萎縮してしまう
21	あなたは、その相手の成功談を聞くと自分も頑張らなければという気持ちになる
<u>22</u>	あなたは、その相手とのやり取りの中で、お互いの意見や考え方が一致していると感じることがある
23	あなたは、その相手と持ちつ持たれつ関係を築いている
24	あなたは、その相手と話す時、どちらかが一方的に話すよりもお互いに意見を出し合う方だ
25	あなたは、その相手と議論になった際、相手からの反論があった方が熱中する

Note. Items with underline indicate that these items are reversed score items.

APPIDEX2. 13 items of SSCC after item-total correlation analysis

以下の各項目では、あなたとこれから会話を行う相手との普段のやり取りについて、お尋ねします。各項目について、あなたの考えに最も近い番号を1つ選び○をつけて下さい。

1	あなたは、その相手と意見がなかなか合わなくとも、納得いくまで意見を主張する
2	あなたは、その相手から頼みごとをされたとしても、気乗りしなければ素直に断る
3	あなたは、その相手と違う意見を持っていたとしたら、それをその相手に伝える
<u>4</u>	あなたは、その相手からの頼みであれば、断らずに引き受ける
<u>5</u>	あなたは、その相手が出す意見には賛成する
<u>6</u>	あなたは、もしもその相手の言っていることや態度に納得いかないことがあっても、それを相手になかなか伝えられない
7	あなたは、その相手との会話の中で自分が話したい話題から外れてしまったとしても、その話題へ戻るまで自分から軌道修正をする
<u>8</u>	あなたは、その相手と意見がかみ合わない時は、自分から譲歩して相手の意見に合わせる
9	その相手は、あなたが話している最中であっても、割って入って自分の考えや意見を伝える
10	その相手は、あなたの意見に対して、「でも」や「だけれど」などの言葉を使って返答する
11	その相手は、あなたがその相手とは異なる意見を言ったりその相手に対して反論したりしても、すぐには意見を変えない
12	その相手は、あなたの意見や考えに対して反論する
<u>13</u>	その相手は、あなたとの会話の中で、自分から新たな話題を提供したり、話題を変えたりはしない

Note. Items with underline indicate that these items are reversed score items.

SSCC is developed in Japanese. Regarding translation into English, please contact to the author. Complete questionnaire including instruction words is also available from the author.

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APPIDEX3. Descriptive statics values of SSCC

Mean score	44.47
Standard deviation	8.23
Maximum score	61
Minimum score	25

A Case of the Girl Who Reframed the Death of Her Father

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KEY WORDS: wrist-cutting, grief work, reframing

The client was a ninth grade's girl who complained that she could not stop wrist-cutting. In her treatment period, her father died. She could find the meaning of his death and she finally overcame various difficulties. In this report, I present the assessment, the intervention and the consequence of this case.

Interview process

1) Character of the client

When the client was in the sixth grade, her parents got divorced. Her mother often left her and her younger brother at her grandmother's house because she started to work at a nightclub. When she was in the eighth grade, she cut her wrist for the first time, thinking of her one-time boyfriend. A month later, her mother knew that the client sometimes cut her wrist, and after that the mother frequently said to her daughter "*I can't concentrate on my work because you are a worry to me! Get out of this house!*" After a few days, when the client

came to the nurse's office, she told the nurse that she cut her wrist habitually. The teacher let her see to a psychiatrist and she started to receive the treatment. Her overdosing made her grandmother to control her medicine. In January when she was in the ninth grade, she knew that her father remained only a short time to live because he got cancer. After hearing the fact, she cut her wrist in the restroom at the station.

When she was in junior high school, sessions were held once a week. After entering high school, sessions were held once a month, and a total of 12 sessions were carried out.

Sessions before her father's death

(#1: January 22, X ~ #4: February 12, X)

Describe her solution

In the first session, the client said, "*If Mom and I calm down our nerves, I don't need to take medicine and we can be a peaceful family. That's the solution.*" She also told that she cut her wrist when she did not feel needed by the people around her.

Interventions from counselor

The counselor suggested the client 1) not to stop cutting her wrist and 2) to search for small

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happiness (positive change) in her daily life.

Positive changes

The client reported, "*I can be relaxed when I'm with my favorite teacher.*" (#2) In addition, she reported, "*When I go in my mom's bed, she hug me tightly.*" and, "*I can calm down talking with the nurse teacher or the counselor.*" (#3) In her fourth session, she reported that her friends supported her and teachers understood her difficulties. She told that thinking her parted boyfriend had no longer caused her to cry and wrist-cut.

About her father

The client reported that her father was in critical condition. She thought he was a hero for her. She wanted to do something for him but she had no ideas. She grieved, "*Why my dad will die? I wish I had cancer instead of him.*"

Interventions from counselor to "A"

The counselor suggested the client 1) to think about how to make her father a "hero" and 2) bake cookies to respond to her father's request.

Sessions after her father's death

(#6:February 26, X ~#12:August 27, X)

About her father

On February 22 of X, the client's father died of cancer. She was worried about whether it was a burden to her father that she visited him in the hospital. She regretted and said, "I should die instead of him because I often cut my wrist." In this stage, she could not accept her father's death, while she felt his love. She said, "My dad called me 'princess' in E-mail."(#6) She started to think her wrist-cutting in relation to

her father's death. She said, "I wished that my dad live long. Therefore, I should not cut my wrist anymore. It's my dad's happiness to keep myself in good health and be happy." She started to accept his father's death. (#8) Her cousin was born on the day her father was diagnosed as that he could not live long. She believed that there was a precious destiny between her father and her cousin. She came to take care of him eagerly and talk about the hope to live.

Interventions from counselor

The counselor suggested the client 1) to take much time to accept her father's death and 2) to search for whatever she saw positive (positive changes).

Positive changes

Her grandmother suggested the client to talk about the relation with her mother. As a result, the relation with her mother became stable. After that, she told that she was getting well and enjoying her part time job. At the 12th session, she told that she had conflicts with her mother, but she could handle the problem by talking with her grandmother.

Decision of what to do after graduation

The client started to talk about her career path. She talked with her homeroom teacher and school nurse and decided to change her school to be a beautician.

After changed school

In December, X, the client moved to her new school. In May, X+1, she told the counselor

that she stopped wrist-cutting and passed the credits. She came to be on good terms with her mother.

Discussions

1) Vicious circle

The client cut her wrist when her mother blamed her. The mother also blamed her when she saw her daughter wrist-cutting. At first session, the counselor asked her to search for the positive change in her daily life and not to stop wrist-cutting. Then she found that she was supported by the people around her. That made her feel needed by them. I can maintain that the sense of feel needed reduced her wrist-cutting.

2) Her father's death and her change

The client tried to feel her existence with wrist-cutting because she felt nobody needed her. The relationship with her mother, one-time boyfriend, and father made her depressed. As the treatment was progressing, she started to search for her positive change and found that her teachers, friends and family have supported her. She had the chance to realize her resources and a fact that people helped each other to live. Wrist-cutting had been necessary for her to calm down herself before, but after her father died, she thought wrist-cutting made her father sad and must not be done. She was willing to do something for her father. Therefore, she stopped her wrist-cutting. She had a desire to make her father happy. To make him happy, she thought she had to become happy. "For her father" became a good message for her. As the

other way to be happy, she changed her career path and school to become a beautician.

In this case, her father gave her the reason for living. Yokohori (2000) stated that grief is not cured by someone, but the person who has lost someone or something tries to reorganize his/her experiences, finds the meaning of the loss and gets the power from it, with a support from the people around him/her.

As a conclusion, the main point of this case is that she restructured the meaning of her father's death, overcame her problem and found the new career path.

References

Yokobori, M. (2000). Possibility and Needs of the Grief Work Practice in the Japanese welfare Institution. *Journal of Aoyama Gakuin Woman's Junior College*, 54, 151-178. [in Japanese] (横堀 昌子 (2000). 福祉現場におけるグリーフワーク～実践の可能性と必要性. *青山学院女子短期大学紀要*, 54, 151-178.)

Letter Approach to Depressed Patient with Parent-child Conflict

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KEY WORDS: parent-child conflict, letter approach, resistance

Introduction

The report is a case that a therapist applied letter as an intervention. The advantage of this technique is to lower the level of interaction than that of face-to-face communication. Communication with letter does not send non-verbal messages such as facial expression and tone of voice. It gives a benefit of that sender can send conflict-provoking messages to the receiver without conflict. However, while the letter approach may be an easy method to implement, it cannot be familiar for client to do. Therefore, in order to introduce the intervention successfully, it is highly important to effectively deal with client's resistance as therapist do before proposing any interventions. I report the case applied letter approach. The sessions were held with a female in her twenties who was an in-patient with clinical depression and who had conflict with her mother.

The client

The client was a woman in her twenties. Her family: Father was consisted of mother, the client, and her younger brother. She had a partner whom she hoped to marry but her family opposed her to do with him. Her diagnosis was clinical depression. Her main complaint was deteriorated relations with family and to have difficulty in recuperating at home. She also tended to drive herself cornered.

Details Leading to Interview:

The client had been bullied in elementary and junior high school. She went on to graduate from a technical school and started to work. Two years after beginning to work, stress from the job led to loss of sleep, dizziness and emotional instability and a local doctor diagnosed her with clinical depression. She began to recuperate at home but her parents' (specifically her mother's) understanding and cooperation for her symptom was insufficient. Family relations also deteriorated. The doctor determined that these conditions would have a negative effect on the treatment. Hence, the doctor decided to admit her to the psychiatric hospital in which I (therapist) worked. The

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purpose of this hospitalization was to put distance between the client and her family. she had a therapy with therapist once in every two weeks during her hospitalization. The total of eight sessions was conducted at this period (one of which her parents also attended). After being discharged from the hospital, the session was conducted once a month for four months. The treatment was terminated with a total of 12 sessions.

Assessment: attempted solutions and vicious circles

At her intake session, the client talked about her episodes: “My parents (especially my mother) say harsh things like when it is going to get better and call me a good-for-nothing. They have also had a tendency to over-interfere from long ago”, “I feel like I’m causing a lot of trouble for my family because of my sickness and it makes me cry” and “I feel like it would be better if I didn’t exist.” It was obvious that these thoughts strengthened her feelings of self-reproach and her pessimistic thought. Moreover, the fact that her parents showed a strongly negative and oppositional attitude towards the partner to whom she was considering getting married was another large stressor.

She had attempted to solve the problem. She first tried to talk with her parents about their relations and her marriage. However, whenever she tried to talk on these conflict-provoking topics, her parents criticized her saying “You are the reason that our family is in such a bad condition” and attempted to avoid and

disqualify the subject. As a result, there had been no conversation on their conflict-provoking topics. This vicious cycle of communication between parents and child worked to maintain unfavorable condition at this point. On the other hand, when the client was careful not to speak to her parents very much they criticized and blamed her for the fact that her sickness was not improving. Consequently, she thought, “No matter what I say nothing works,” and began to feel a sense of powerlessness that only heightened her feelings of depression.

The suggestion from her doctor of her hospitalize in order to put distance between the client and her parents could also work as a vicious communication circle between them. The visitations of and telephone conversations with her parents during hospitalization frequently became disputes, which made her emotionally instable. Even though those around her gave the client a advice to put distance between herself and her parents, she believed the idea that “If I never talk then things will never change.” That is, it seemed as though she believed that she must absolutely speak with her parents. Therefore, as she strongly opposed any intervention that would stop communicating with her parents and place distance from them, the conflict-provoking situation remained unchanged.

Interventions and Consequences

Based on the assessment, the therapist introduced for the client to communicate with her parents with letter (#2). Five conditions

were set to implement the letter approach for communication: 1) including words of gratitude, 2) not making the letters frequent, 3) to continue sending letters regardless of whether or not a reply is received (because there is a high possibility that the parents may take much time to respond and cannot determine what to write straight away), 4) put important topics (topics of conflict) into the letters, and 5) to keep face-to-face conversation as superficial as possible (For example, talking about vacation or about a pet).

Moreover, upon presenting the intervention, to respect the efforts the client had made so far, the therapist explained, "You've been trying so hard to talk about important things but it seems like your parents are unable to understand what you really want to say." The aim of this remark of therapist was to motivate her to agree on the letter approach.

At the third interview, a positive change in parent-child communication was shown as the client reported that "I received a reply from my mother and it seems our relationship has changed greatly. We've made progress." Hence, in fourth session or later, the therapist aimed to maintain the positive change.

However, before the seventh session, the client handed to her parents her a letter concerning her partner and marriage and the parents read it on the spot. Her mother interacted with the client negatively as she had done before. This made her relapse her depressive symptom. Once again, the therapist coped with this incident by letter approach. That is, the therapist asked the client to discuss

on conflict-provoking topics with written letters, not with face-to-face interaction.

Thereafter, no letters came from her parents for a while. After being discharged from the hospital, the parents began to talk with their daughter about the partner and marriage. This was a large change for the parents-child relation because parents had been unwilling to talk about the topics with their daughter. Through the written letters, her parents had room to face these conflict-provoking issues and it resulted in some developments on their relations.

Afterwards, the client came to live alone and change her job. Furthermore, her parents surprisingly approved her to marriage. Her mother still tended to over-interfere but she came to be able to deal with that and maintain a stable mental condition. After the twelfth session, she said "I believe I can go forward from here" and so the therapy was terminated.

Discussions

We discuss the case with five terms for the letter approach. First term was including words of gratitude: This term is important for the client to obtain a cooperative response from the parents.

The second term was not making the letters frequent. At first the client was prone to try extremely hard to write many letters but this caused her to tire and made the letters hard to continue. Therefore, the therapists told her that she should "continue slowly but surely over a long period of time without getting too worked up over it."

The third term was to continue sending

letters regardless of whether or not a reply is received. This term was effective to give a positive meaning to the lack of responses paradoxically. It also worked that the client did not feel anxiety about the lack of responses and prevented herself from the risk that she fell back into the same vicious circle of communication as before.

The fourth one was to put important topics (topics of conflict) into the letters.” and the fifth was to keep face-to-face conversation as superficial as possible. The points were to use both written letters and face-to-face conversations as methods of communication and to differentiate the role of these communications. In face-to-face communication, the topic was limited to superficial ones (low level of conflict-provoking) and in letters, the topic was the important issues that the client truly wanted to communicate (high level of conflict-provoking). This term could work to form a positive atmosphere between the client and her parents. Through letters, in which the level of mutual interaction decreases, it was assumed that the topics of conflict would become easier for the receiver (the parents) to accept.

Furthermore, as the client believed that she must speak with her parents, it seemed as though any intervention that aimed to stop communicating at face-to-face would only strengthen her resistance. Therefore, in this case, aiming to respect to her believes and values, the therapist introduced the treatment that retain the topics of face-to-face

communication while retaining the opportunity to speak face-to-face.

We can indicate that therapist should introduce letter approach with securing opportunities for face-to-face communication.

References

- Hanada, R., Wakashima, K. & Ikuta, M. (2001). Psychotherapy for client complaining of various problems: diagnosis and intervention by problem-interaction model. *Psychosomatic Medicine*, 5, 287-292. [in Japanese] (花田里欧子, 若島孔文, 生田倫子. (2001). 不安・恐怖症状とさまざまな問題を訴えるクライアントへの心理療法 —問題-相互作用モデルによる見立てと介入—. *心療内科*, 5, 287-292.)
- Ikuta, M. (2004). Basic research and the application to clinical cases in brief therapy. Wakashima, K. (Ed.). *Brief Therapy for Application: The Theory and Practice of Psychotherapy based on Constructivism*. Tokyo: Kaneko Shobo. [in Japanese] (生田倫子. (2004). ブリーフセラピーにおける基礎研究と事例への応用について. 若島孔文 (編), *脱学習のブリーフセラピー 構成主義に基づく心理療法の理論と実践* (158-168). 東京:金子書房.)

The Change of Mother's Involvement Leads to the Development of Junior High School Girl

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KEY WORDS: Black ink letter, Brief therapy, Exception

Problem behaviors

The client was a female freshman. She started spending more time in the school nurse's office during her club activity. Her symptoms got worse, started to hyperventilate regularly and locked herself in the bathroom for four hours. She also started to present the same symptoms at home. Furthermore, she said that she had no recollection of a minor car accident which she had on her way to school.

Since her schoolwork and everyday life have been heavily affected by these problems, we started to work on her problems. First, considering the possibility of dissociative disorder, we consulted her problems with the school nurse. Second, cooperating with advisory teacher of her club, homeroom teacher, and parents, we recommended her to visit the doctor. Third, we aimed to improve her relations with her club members and her

mother. This is the report of her case's assessment and intervention.

Characteristics of the client

The client worked reluctantly, was a little obese and always waited until somebody had to tell her what to do. Her academic performance was also low. Besides, she frequently forgot to bring stuff to school and to do her homework. Therefore, she had frequently received verbal reprimands and advice by her homeroom teacher. The teacher sometimes needed to contact her parents to encourage her to turn them in.

Her family was a double income family. Her father was a company employee who made frequent business trips. Her mother worked at a hospital and she often worked until late at night. She frequently directed, ordered, and encouraged her daughter. Because of her busy schedule, we often could not contact her when the client became ill at school. When the her mother came to school, she behaved as if nothing would had be wrong with the family and said "the daughter and I talk about everything each other at home." However, the

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client told us that she could never withstand her mother because her mother was very smart and did everything.

Case illustration in detail

Because the client became ill at club activity, we decided to watch her carefully after communicating with advisory teacher of her club and homeroom teacher. The advisory teacher was often worried about her and had taken her home frequently. However, her mother usually was away from home. We had a parent-teacher conference and her mother said “Even though my daughter sometimes turns her homework at the last minute, there is no problem since I watch her doing them.”

At this point, the advisory teacher of her club had not understood the relationship between her and his club members yet because he had been just appointed the job at the beginning of this school year. We collected the information about her club and understood that their club rules were very strict; their dress code, language, and practice were checked and advised by club alumni. We also found that the members evaluated and criticized each other very severely. We reported those facts to the advisory teacher and asked those rules to be revised.

We also had a session with the client. At the session, we asked her the question that “imagine you are doing something that you can enjoy, what are you doing?” She answered “I am drawing at my grandmother’s home, who lives at another prefecture.” Therefore, we

recommended that she visited his grandmothers on the weekend, but she said she could not ask for a favor from her mother. She also cried and complained that her mother would not let her quit her club. Eventually, we suggested her to run away from home for a while. The aim of this intervention was to produce exception in her life where she could not withstand her mother. After the conference, she quickly moved to the plan and left a letter to her mother and went to her grandmother’s house by overnight bus. After this incident, her mother and grandmother discussed about the client.

However her mother still did not let the client quit her club and the client’s fear has increased about attending the club activities. She complained about her medical condition on the day of a school event, and got permission for early dismissal. Four hours later, One of the teachers checked the bathroom and found her, leaned on the toilet. We saw the “dissociative symptom” by her saying she could not remember what had happened.

After the incident, we held the conference with her parents in accordance with “Mental Support System”, a support system for maladjusted students. At the conference, we share the incident and her father told us the same thing has happened at home before. As an intervention, we suggested the parents to ask her to visit the doctor.

Few days later, her mother reported us that she visited her primary doctor and there was no problem. Subsequently, she had a minor car accident but she could not remember what happened. Considering the fact that she lost her

memory of the accident, we had another conference. At the conference, her mother insisted that the reason why the client could not remember was an aftereffect by the accident. As interventions, we presented the suggestions that the parents visited the doctor again and asked their daughter to change club activity to the art club which she was interested in. We also ask the mother to turn in the "black ink letter".

Improvement of the client's symptoms and change of parenting style of her mother

After the client's visit of her doctor, even though it was reported "there is no apparent abnormality", her mother started dropping her off and picking her up by car. The mother also started to turn in her "Black Ink Letters". After a while, she reduced her symptoms and no longer stayed at the nurse's office. She became a sophomore and got a group of friends and started studying together and attending the school events

Discussions

The client's mother had made an effort to parent her. The effort was to frequently encourage and order her daughter because the daughter worked slowly. We made a suggestion to visit doctor for the daughter's dissociative symptoms for confirmation with respecting her evaluation that her daughter's symptom was just because of an aftereffect by accident. The mother became to self-monitor her behaviors

and sayings to her daughter by turning in the "Black Ink Letter" every day. The authors maintain that it gave the mother an opportunity to reexamine her parenting methods. Consequently, the client started next the grade and by coming to school with no problems. She changed her club and started learning art and her relationship with her friends was gradually improving.

We can also argue that improvement of client's symptoms results from all the staff member's understanding and trust on her strength and adjustments of the relation with her mother.

Brief Therapy Sessions with Male Client of Depression

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KEY WORDS: Brief Therapy, Depression, Reinstatement, Self-control

Introduction

This case was performed at the NFBT headquarters and is a case report from the trainee institution. To first explain the structure of the interviews within the trainee institution, the actual interview is recorded using a video camera while a team in the next room confirms on a monitor. Then, during the interview, they move into a different room and, during that time, discuss with this team in order to move the case forward.

In this report, we introduce the case focused on the attempted solutions denoted by the client and the goal was to reconsider what points may have led to the conclusion of the case.

Case Summary

The client was a male in his forties who, due

to depressive symptom, repeatedly took leaves from his job. At the time of the first session he was in the middle of a two month break from his job and had been advised by his company's physician to have a couple therapy with his wife. The therapy has been finished with 15 sessions. First through fifth sessions were done once a month. At fifth session, he stated that he would go to show his face at the company. Given that his change, from sixth session onwards, sessions were performed once every two months.

Repeated Pattern of Absence and Reinstatement

From the client's story, the following pattern of absence and reinstatement was revealed. While going to work every day his physical condition gradually deteriorated. When his physical conditions became worsened, he would force himself to continue to work despite his condition. As a consequence of the effort, he was eventually forced into sick leave. At this point, he and those around him agreed that it was best if he were to wait for his condition to fully improve before returning to work. As a

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result, aiming for full-recovery, his sick leave became prolonged but the symptom has not fully recovered at the point of return to work. Therefore, he eventually ended up returning to work with a less than full amount of recovery. After the reinstatement, his physical condition became gradually worsened as he forced himself to work in deteriorated physical condition. Based on this pattern, the following three interventions were introduced.

First Intervention

We told the client to reframe the client's view from "go back to work when my physical condition has fully recovered," to "manage my physical condition while being reinstated at my job." This led to a change of his view of "If my condition is better, then I can work."

Through this change of viewpoint, the client was able to move from the dichotomous view of "working with a perfect physical condition" or "recovering". He was able to work on to goal of "how can I work at my job with checking physical condition?" in the rest of the sessions. Besides, the emphasis on his checking own physical condition encourage him to control himself rather than expect to receive the support from other people, including his counselor and wife.

Second Intervention

Based on the first intervention, therapists asked about the client's pattern after his returning to work. The client revealed that he had settled his pace of his life for approximately one month. However, he caught

a cold, his lower back began to hurt and once more his physical condition deteriorated since then. He tried to cope with this situation by going to bed early at night and just forcing himself to work. His physical condition once again became worsened because of this coping and he ended up having to go to the hospital. To break this vicious cycle, the therapists asked the client to go to the hospital when he could feel himself catching a cold before it worsened. Moreover, as he was concerned about the financial impact of his leave from work, the therapists made a suggestion that the client spend ten percent of his income in advance to stress relief. Based on this suggestion, the client developed his new coping method that he would go to the hospital immediately if he were to catch a cold; he should get a compressor, go to massage or acupuncture therapy for his back pain and generally work to deal with these physical conditions soon after they appear.

Third Intervention

Therapists considered that client's wife had an effect on the client's maintaining his behavior pattern in which he tried to work despite his deteriorating physical condition. His wife often became worried and attempted to talk to him. In turn, the client, in an attempt to not worry his wife further, pretended to be alright and forced himself to work even in bad condition. At this point, his wife understood his intention and therefore stopped talking to him about his condition. She did not want to pressure him further. As a consequence, the couple had little communication. Thus, the

client attempted to handle his problems on his own and even if his wife wanted to support him she was unable to talk about his problems. The situation was vicious cycle of for an interaction between the couple.

Therapists intervened this vicious circle by a suggestion that wife observe her husband who seemed to want a rest with the reframing of the behavior of observing as “watching warmly her husband.” Instead of talk about his condition, therapists made a suggestion to her that she asks her husband to look after the children or to plan vacations. The aim of this intervention was to put off the wife’s pressure from client’s shoulder.

Discussions

From the three interventions, we can assume that a change had occurred in the previous pseudo-solution. We can understand the change by two points. First, the client learned to deal with his problems on his own because of his wife’s new coping behavior of observing. Second, he became able to deal with his physical condition before it deteriorated. Given that these changes, we can consider that he had increased his ability to self-control and had managed to spend his life without therapy sessions even though he still had some difficulty. Furthermore, he could recognize that he successfully cope with his depressive symptoms with support from others.

Effective Brief Therapy for Trauma Treatment

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KEY WORDS : brief therapy, PTSD, EMDR

Introduction

The effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) and Trauma-Focused Cognitive Behavioral Therapy (TFCBT) on Post-Traumatic Stress Disorder (PTSD) have been well understood. Nevertheless, after the onset of PTSD, deteriorated interpersonal relations between Identified Patient (IP) and those around him/her can make there treatments ineffective. As a strategy to cope with the problem that an IP who seems to be falling into a vicious cycle of deteriorating personal relations, a therapist (the author) applied brief therapy with EMDR in order to raise the effectiveness of the treatment.

Case

IP was a 23 year-old, male college student. In June of the year X, while shopping in a building near a station, on the road next to the building an incident occurred in which many

people were murdered or injured. When he exited from the building, a large number of people fell to the ground. He, in possession of the American Heart Association's Basic Life Support certification, helped to treat two victims with light wounds and proceeded to perform Cardiopulmonary Resuscitation (CPR) on a third victim who had entered cardiopulmonary arrest. Upon entrusting the victim on whom he performed CPR over to paramedics he returned to his home but learned from the news on television that this victim had later died.

In July of the same year, during Judo practice, he suddenly had a flashback of the scene of the accident and fell to the ground. Thereafter, he continued to see flashbacks which led to anxiety and loss of sleep and he even quit going to school. This continued until August of the same year in which he came to see a doctor at this institution.

During the medical examination, flashbacks and other re-experience symptoms, avoidance symptoms such as avoiding the station at which the event occurred, over-stimulation symptoms such as loss of sleep as well as impairment to

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social function were noted and he was diagnosed with PTSD.

At first pharmacotherapy was applied but his symptoms persisted and until October of the year when he temporarily withdrew from school. From April of the year+1, while he was reinstated in school, there was no sign that his symptoms were improving and in May of the same year he began EMDR.

After seven sessions of EMDR, his symptoms had been gradually improved. He even went so far as to say that he would like to go down to the station where the incident occurred. However, upon seeing the report on or the dates surrounding the incident, or when he saw large numbers of people and police officers that made him remember the traumatic event, he had flashbacks and showed symptoms as he had done at the onset of his PTSD. When he displayed the symptoms, his friends, university professors, and parents talked to him negative topics such as, "Don't take anymore medicine!", "Can't you consider this news and your experience separately?", and "Can't you do anything yourself without relying on doctors?" IP became confused during these conversations. Therefore, in order to maintain a more favorable environment for his treatment, brief therapy was introduced for his treatment with EMDR. He was treated mainly with complimenting and reframing in order to stop communicating negatively and motivate to receive treatment. The compliments were "It's amazing that you can continue a treatment like EMDR that brings on so much stress," "It's not easy to be told such unpleasant things and not

want to pick a fight." Furthermore, the thought of "No one understands me" was to be reframed with "you yourself didn't understand PTSD very well until you experienced it." Complimenting, reframing and non-verbal messages were used to stop expressing negative emotion from parents and instructors as well. The therapist focused on the involvements without negative messages from his parents and professors and told to them that "because the support of those around you is adequate, even though his symptoms were so severe he can still live a normal college life."

In response to the IP's negative expressions such as, "I'm always fine so why I do suddenly get worse?" , reframing was once again applied with phrases: "There's no such thing as PTSD in which the symptoms are present at every moment," "It's going to take some time before those around you can adjust to your PTSD." When his parents and professors communicated with him too negatively, the therapist visited them. Only complimenting and reframing were used without dealing with the negative communication but there was a certain message from the treatment that physician visited to meet them. The aim of the intervention was to non-verbally encourage them to realize that something very serious had occurred. After the visit, the exchange of strong negative emotions was successfully restrained.

Conclusion

PTSD has the following characteristics: The cause is something far away from everyday life. The Symptom can be prolonged. In general

only the name is known without knowledge of the symptoms and it results in misunderstanding. There is a risk to lead conflict because of the deteriorating interpersonal relations between the people such as victim and family, lovers, friends, school staffs, workplaces, insurance companies, assailants, police officers, firefighters, lawyers, public prosecutors, and judges.

The effectiveness of EMDR and TF-CBT on PTSD has been proven but cases in which deterioration of personal relations with those around the patient can lead to these treatments' ineffective. There is also no evidence to support the idea that brief therapy and/or interpersonal therapy are less effective than these other established treatments.

Brief therapy has a powerful effect on avoiding the risk of personal relations falling into a vicious cycle and improving their communication. The personality and life background of PTSD patients is varied but, there are some similarities between the cases in the patient's interpersonal relationship. Therefore, brief therapy can better the patient's symptoms by treating their interpersonal relationship.

In this case, while EMDR was effective with IP, deteriorated interpersonal relations had negative effect on his symptoms. Therefore, introducing brief therapy with EMDR was effective for improving his treatment environment and symptoms.

An advantage of brief therapy is that therapist can change the patient without direct contact with him/her. The therapist was not necessary

to visit IP's parents and professors. However, this intervention is seen to work as non-verbal message that something very serious had occurred.

In Japan's medical treatment policy, physicians, nurses and psychiatric social worker(PSW)s making up a multi-occupational team has provided outreach service to victims of mental disorders. In the future, there is the possibility that clinical psychologists are to become nationally certified and to join this multi-occupational team of health care professionals. This means that the therapist also would be required to work outside therapy room. Therefore, as with the case presented in this report, I can argue that the outreach therapy service is important.

References

- Bisson J, Andrew M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 3.
- Sharpless, B. A. & Barber, J. P. (2011). A Clinician's Guide to PTSD Treatments for Returning Veterans. *Professional Psychology: Research and Practice*, 42 (1), 8-15.

The Problem Resolution with “Almighty Key” for a Depressive Client

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KEY WORDS: Depression, Brief therapy, Exception

The Characteristics of the client

The client was unmarried 35-year-old man. Although he had worked as a field overseer before the onset of depression, He was technical personnel at the point of the first session. His personality was serious-minded and well-organized and he had been taciturn since he was little. He had very few friends. His family structure consisted of his mother and his younger brother. His mother lived alone and she lived off her pension and the money sent by the client.

He had an onset of depression since five years ago and had sometimes taken leaves of absence from his job. At the point of first session, he had returned to work, however, he could not do his work well and felt alienated in his working place. He had also used to have his suicidal ideation. He still went to hospital and took antidepressants at that point. His main complaints were that he did not want to be like

himself who used to be; He wanted to work in ways that he had worked before he got the disease; He wanted to have more conversations with his colleagues at working places.

The intervention at first session

After the therapist (the author) listened the client's narratives seriously, accepted his emotion, and empathized with him, the therapist let him search the positive sides of his life which is the “almighty key to solve the clients' problems”.

The second session

Therapist (TH): Have you experienced any changes in your life?

Client (CL): I'm surrounded by good people.

TH: Last time you told that you were cold-shouldered, weren't you?

CL: I'm inconsistent, am not I? However, I've noticed that they show consideration for me.

TH: I think it is a good to realize that and you aren't inconsistent.

Besides, the client told that he could sleep without taking sleeping pills despite the fact that he took them at the point of the first session.

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The intervention at second session

The therapist suggested to the client that he takes a leisurely bath on Saturday night and consults with his doctor as to whether or not he may sleep without taking sleeping pills and suggested to him that he continue to search the positive sides of his life.

The third session

TH: Have you experienced something good?

CL: People around me care about myself. They speak to me, and I got praise from the assistant section manager. Now, I have come to be able to think positive. Currently, my main assignment is chores using the computer.

TH: Do you think you can do the field overseer?

CL: I think I can do, though I can't understand some part of the job.

The intervention at third session

After giving the client positive feedback that he can recognize his current situation positively and he behaved to be praised by others, the therapist asked him to do more of searching the positive sides of his life.

The fourth interview

CL: I have experienced so many good things. Until now, I had been depressed because the people around me seem to be busy. However, I no longer experience such feelings.

TH: That's great. Then, can you afford to work

a little bit more?

CL: It is still impossible for me.

TH: However, last time you told that you were in a fair way to return to the field. Do you have any reasons?

CL: Once, when I got depression, I was told by a colleague in front of the other colleagues that I don't want to work with such a guy, which made me depressed. As I had to work with him, I got depression.

TH: Why haven't you gotten depression this time?

CL: It is due to my so-what attitude thinking "I won't lose to such a guy", because the person is less skillful than me at the job.

TH: Great. You have been able to turn defiant, haven't you?

CL: Yes.

The intervention at the fourth session

The therapist conveyed the message that turning defiant is one of the almighty key to overcome the difficulties.

The fifth interview

CL: I have experienced many good things. I have gotten insured, I have lost my weight 1kg, and then, I have come to think that though the content of my job is ordinary this work will give the basis for other's work. Above all, I have come to think I am happy.

Adding to these remarks, the client had come to be able to care about the other colleagues, such as he worried about their depressive mood.

Furthermore, he no longer felt alienated, he had come to speak to others spontaneously, think positive, and work as well as he worked before he got depression. He also has come to talk that his job is interesting. Given those facts, the therapist supposed that the original chief complaint had been solved. Besides, his insomnia symptom has also resolved. Therefore, the treatment had terminated at this session.

Intervention toward Anxiety and Complaint on School Life

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KEY WORDS: Brief Therapy, School teacher, Junior high school

Characteristics of the client

The client was a second-year junior high school girl who was transferred from another school within the same city in April. She started complaining that she did not feel a part of the school and did not want to attend school not long after the transfer. She did not feel comfortable with her classmates because of her reticence and shyness. She found break time particularly difficult as she felt she was alone.

Although she continued to go to school, she started spending time at sickbay or leaving school early.

Her parents were concerned that she might end up not going to school altogether and occasional consultations over the phone or face-to-face occurred. According to the parents, it took her a long time to make close friends at the previous school and it took her until July to get used to the class.

Support and Intervention

On the other hand, that she had a different side at home was observed through her mother's statement. According to the mother's statement, she at home was talkative and somehow droll, interested in singing and dancing and was hoping to become an idol.

Additionally it became apparent that she was suffering from her inability to express her true self in the school. She was also concerned that falling behind academically due to her absenteeism and leaving school early, which in other words showed her willingness to succeed academically.

The client's classroom teacher attempted the following interventions.

Interview with A during break

The lunch break was set as a time for the client to talk with the teacher as she mainly felt anxious during break, although she was given a choice whether she wanted to come or not. She was told she was welcomed to come to the staff room whenever she felt uncomfortable in her class room. The number of visits to the staff room reduced as she started making friends.

Supporting parents

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The teacher provided encouragement to the parents that the client would soon make good friends with her gentle nature and charm and also suggested that they continue to observe the situation until July. Since it took her a long time to familiarize herself with the previous school in the past, her shyness was accepted positively, as part of her personality.

A sense of belonging through extra-curricular activities

The client expressed her wish to join the table tennis club just before the summer holiday. After the trial, she was pleased that senior students gave her the compliment that she was natural with the sport. She made good friends through the activity and the club provided the place where she could feel she belonged and something she could enthuse about.

Self-affirmation and a sense of role

To the question by the teacher what made her happy on the particular day on the one of her visits to the staff room, the client replied by expressing her happiness in her ability to supervise as a team leader at cooking class and in her sense of being dependable. As it coincided with the time of conducting questionnaires to decide group leaders of her homeroom class, the teacher told her that someone in the class recommended her as a Life Group leader as well as mentioning her potential of being a natural leader. She was excited to hear this and showed her keenness to become one. Her parents were informed on this and she was appointed as the Life Group leader.

She started communicating with her team members with eagerness and became lively like a different person.

Consequences

The client's facial expression became brighter as she made a friend who she could let her hair down with. She became anxious when the friend was off school or left early, therefore, she visited the staff room and spent time with the classroom teacher.

One day when she was spending break with the friend's absence, she told that the school without the friend was too lonely to tolerate. The teacher replied that the friend had told the same and acknowledged their bond. Since then she stopped taking absences.

Discussions

The client initially took herself as a failure for her lack of ability to adapt in a new environment. In addition, she seemed to have been suffering from the gap between her true bright and energetic personality and the fact that she could not behave so. The class teacher tried the approach of not rushing to find a solution or giving up easily while understanding that being oneself takes time.

Provision of the place where she could express her feeling (staff room) and the table tennis club as a new environment worked positively and it can be deduced that these helped her regain her true self. Being given the new role of team leader (of which responsibility can be fulfilled within her limit) enhanced her self-affirmation and it played an

important role to solve this issue. As cited in her bond with new friend and the team leader role in this case, to feel needed can strengthen oneself.