The Use of the Three Steps Model after the Great East Japan Earthquake : A Case Study in the Treatment of Flashbacks

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ABSTRACT. After the Great East Japan Earthquake, many citizens experienced severe psychological reactions. This paper describes a three steps model characterized by solution-focused brief therapy sessions. In one particular case, this method was successfully utilized over the course of only two sessions by a therapist who was able to treat and resolve the flashback episodes of an adult female client who saw full recovery and complete normalization of her traumatic symptoms within two years, and all without the use of traditional trauma-oriented treatments. This study examines that particular case, and although there are limitations to this study due to the absence of a control group and its focus on a single case, it remains important and worthwhile to examine the remarkable effectiveness of this three steps model for clients with post-traumatic stress disorder.

KEY WORDS: *Great East Japan Earthquake, Flashback, Solution-focused brief therapy, Three steps model, Post-traumatic stress disorder*

Introduction

At 14:46 on March 11, 2011, a massive undersea earthquake measuring 9.0 on the Richter scale caused a tsunami that devastated the shoreline of eastern Japan from the Kanto region to the Tohoku, and the Iwate, Miyagi, and Fukushima Prefectures in particular. The tsunami damaged Tokyo Electric Power Company's (TEPCO) Fukushima Daiichi Nuclear Power Plant (NPP), creating a catastrophic radiation hazard in Fukushima Prefecture. In total, 15,897 people died, 2,533 people were declared

missing (Japan National Police Agency, 2019), and about 51,778 people are still living as internally-displaced persons as of 2019, eight years after the earthquake (Japan Reconstruction Agency, 2019).

The survivors experienced both physical and mental suffering. Post-traumatic stress disorder (PTSD) is a common psychological problem following natural disasters such as earthquakes and tsunamis (American Psychiatric Association, 2013; Weathers, Keane, & Foa, 2009), and the Great East Japan Earthquake left many survivors with PTSD symptoms. The proportion of the adult population who suffered PTSD symptoms was as high as 21.6% in 2011 and 18.3% in 2012 (Yabe, et al., 2014).

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One of the primary PTSD symptoms is the flashback, or the reexperiencing of a traumatic event, and the Diagnostic and Statistical Manual of Mental Disorders has listed such persistent reliving/reexperiencing phenomena as a diagnostic criterion for PTSD (American Psychiatric Association, 2013). Osuch et al., (2001) noted that flashbacks are unlike normal memories in that patients report that “I feel like I am back there” (i.e., when and where the traumatic event occurred) and experience a loss of control. The flashback is an autonomic response that is physiologically much more similar to a panic attack.

Psychotherapy is a treatment of PTSD, including the flashback, that has been found to be effective. Exposure therapy (ET) and eye movement desensitization and reprocessing (EMDR) have also been found to be effective in the treatment of PTSD symptoms (Watts et al., 2013; De Bont et al., 2016).

In fact, ET and EMDR have been highly recommended for the treatment of PTSD, with much evidence in support of its effectiveness (Department of Veterans Affairs and Department of Defense, 2017). ET includes imaginal exposure to the traumatic memory and in vivo exposure to reminders of the trauma or triggers for trauma-related fear and avoidance are characterized by a series of procedures designed to help individuals confront thoughts using safe or low-risk stimuli

that are feared or avoided (Foa et al., 2008). In studies of earthquake survivors in Turkey, intervention groups that employed self-exposure instructions on PTSD were statistically more effective than control groups after treatment (Başoğlu, Şalcioğlu, Livanou., 2007; Başoğlu et al., 2005). Regardless of the earthquake survivors, many studies found significant pre- to posttreatment changes on standardized measures of PTSD severity (Cahill et al., 2009).

EMDR, developed by Shapiro (2001), is a multistage treatment for PTSD that involves the particularly unique process of desensitization and reprocessing. The core intervention requires the client to recall trauma-related memories while also attending to some form of external oscillatory stimulation typically facilitated by the therapist moving a finger from side to side across the client's field of vision. The client's experience have shown rapid changes in a client's emotions, insights, sensations, and memories and the reduction of subjective distress with each bilateral stimulation (Shapiro, 2001; Shapiro & Laliotis, 2011). Some clients reported feeling as if their brain was cloudy (Broad & Wheeler, 2006). For tsunami survivors in Sri Lanka, case studies illustrated that EMDR is an effective treatment for PTSD in general, with specific utility for disaster-related PTSD (Jayatunge, 2008). Additionally, systematic reviews of

EMDR have shown statistical and clinical significance in reducing PTSD symptoms, anxiety, depression, and other forms of distress experienced by survivors of natural disasters (Natha & Daiches, 2014).

Based on the evidence, ET and EMDR are effective forms of psychotherapy for the treatment of PTSD, though there are drawbacks. ET involves frequent exposure to frightening memories and thus can impose unnecessary burdens on the client. Porges (2017) has even indicated that ET might increase sensitivity to the stimuli associated with a traumatic event. As for EMDR, its implementation requires additional training and cannot be carried out unless a therapist is qualified to employ this rather rarified treatment. This becomes a problem in the event of a large-scale disaster, as the number of qualified therapists available to provide such a treatment is limited and will quickly become strained.

Furthermore, while the effectiveness of ET and EMDR on PTSD has been proven, there are cases in which the deterioration of personal relations with those around the client can lead to these treatments becoming ineffective. On the other hand, though, there is also no evidence to support the idea that solution-focused brief therapy (SFBT) is less effective than these other established treatments. SFBT has a powerful effect on improving

communication and is successful in avoiding the risk of failing personal relations (Otsuka, 2012).

As a form of SFBT, the three steps model is an effective method in the treatment of PTSD (Wakashima et al., 2012). In this model, PTSD symptoms have been shown to undergo spontaneous improvement in many cases. The therapist gives the client advice on how to concretely cope in this method, which is composed of the following three steps:

Step 1: Normalize

Therapists normalize the symptoms and reactions in clients of a disaster. Normalizing comments show empathy for the client and assure them that the symptoms and reactions in clients of a disaster are a natural human reaction.

Step 2: Do More of What's Working & Compliment

Therapists endorse clients that act and cope independently. Therapists make sure to point out differences and improvements from the client's previous psychologically imperiled states. They show clients that PTSD-like reactions reduce gradually over time in many cases.

Step 3: Reframing & Paradox

Therapists give clients some suggestions for intervention. They show that when PTSD-like and grief reactions are avoided,

the more uncontrollable client tend to become. Therapists thus suggest that clients do something different, such as courageously confront the problem.

The three steps model need not necessarily employ Step 3. If clients with disaster stress problems realize their response is a natural reaction and their symptoms are slowly alleviating, they have the option to wait and see if these problems resolve themselves without confronting them directly. When clients experience a slow natural recovery and a disturbed daily life, therapists might be more willing to employ Step 3. This model primarily addresses traumatic memories, including grief or PTSD-like symptoms. People are generally proactive in accessing their memories. However, people with traumatic memories can become confused because traumatic memory can often feel as if they are being invaded. Step 3 thus makes the create meaning for an intervention and pay attention to their problem.

Also, the three steps model is not only used independently, but can also be implemented in combination with other psychotherapy techniques such as EMDR and TFT (Wakashima & Usami, 2013).

The case report in this study examines the application of the three steps model to the clinical case of an adult woman who suffered from flashbacks. In this case, the flashback episodes are resolved before attempting the implementation of

EMDR.

Case description

The client is a 43-year old female living in the Tohoku area with her husband. She is an office worker. On March 11, 2011, she was subject to a natural disaster, the Great East Japan Earthquake. In 2013 she began attending counseling sessions under the therapeutic care of the author. The client's employer gave her a stress test (K-6; Kessler et al., 2002), and her results exceeded the cut-off point by over 13 points. The counseling sessions were confined to a two-week period.

Session 1

The therapist asked the client, "What are your goals from our working together?" The client answered, "Compared with what I was before the earthquake, the efficiency of my work has declined, and I have become less active, so I expect that this situation will only get slightly better." It was revealed that her problem with being less active arose with the earthquake.

She came to think of going out on social occasions as troublesome and avoided drinking with coworkers because of a previous incident where she had said harsh things to a junior coworker. She therefore tries not to drink alcohol. She used to play music in a band before the earthquake, but since the earthquake she

has distanced herself and no longer sees them socially. The problems with her workplace efficiency, though, are relatively recent and began occurring only several months prior to her first counseling session. The trouble she experiences is not remarkable in its severity, but it takes a noticeably longer time to look through unfamiliar documents. Also, she found herself unable to read books unrelated to work. On weekdays she feels occupied because of work, but on her days off she feels a state of emptiness. She finds herself going to the office on Monday mornings and hurriedly finishing a job that she brought home with the intention of finishing it over the weekend only to find herself not able to finish it. She does not miss her deadlines, however, and is thus able to avoid problems at work. In addition to these problems, she lost her parents to the Great East Japan Earthquake. On the other problems, she recounted the episodes of her increased weight, enthusiasm for drinking alcohol, taking out her frustrations on younger coworkers, and so on.

Her post-earthquake flashbacks occurred on a daily basis, and she feels invaded by these past experiences and images (her parents were swept away by the tsunami, she saw the faces of corpses, she recalled the smell when she went to the afflicted area, saw her destroyed home, she was haunted by the fact that

her parents were swept away by the tsunami although she did not actually see it happen, and so on), and she uses a lot of energy to deal with them.

Regarding her medical history, she visited a psychiatrist where she underwent PTSD prevention in the early days after the earthquake, but she has not been there since, deciding that she often cried at home after drinking prescribed medicine with alcohol.

The therapist listened to her story using the three steps model. The therapist normalized that the reactions she had to the trauma were normal reactions, even in their perceived abnormality (Step 1: Normalize). The therapist gave the client compliments about how she was doing her best even in this time of difficulty (Step 2: Do More of What's Working & Compliment). The therapist determined to not use Step 3, but instead opted for EMDR, which has a strong record of addressing flashback memories, because it was the flashbacks that were severely impacting her daily life. The therapist explained the merits and drawbacks of EMDR and recommended doing EMDR at the next session. The client replied that she wanted to try it.

Session 2 (Two weeks after the first session)

Since the last session, the client explained that her condition had gotten better and she was improving her

efficiency at work. She was also able to read three books in two weeks. Her coworkers said she was smiling more. Regarding her flashbacks, they were not occurring as often and had almost become invisible, as if they were a “haze.” She said the following: “When I heard what EMDR is, I realized that I am in a serious situation. Because everyone has had the same disaster experience, I didn’t want to speak much about how much trouble I was having with my situation.”

Therefore, the therapist did not employ EMDR, and instead complemented her current state and told her she would be willing to talk again whenever the client needed.

Follow-up session (Two weeks after the second session)

The therapist noted that the client’s state had been calm since the last session. The therapist therefore determined to terminate the sessions based on the relatively calm state of the client at both the follow-up and second session.

Discussion

The purpose of this study is to examine the effect of applying the three steps model to a client suffering from flashback episodes. As a result of the model’s implementation, the flashback symptoms were reduced. Furthermore, a salutary effect appeared as if EMDR had been utilized. In this case, only Step 1 and

Step 2 of the three steps model had been employed. The model is a method centered on utilizing the knowledge that the nature of PTSD symptoms is that they naturally alleviate with time. (Wakashima et al., 2012).

In addition to the three steps model, it was assumed that informing the client of the EMDR technique, and the possibility of utilizing it on her, exerted a normalization effect. The effectiveness of the ET and EMDR for PTSD has been demonstrated, but for a deterioration of the interpersonal relationship of a client, these therapies have no effect.

On the other hand, SFBT can handle both the PTSD symptoms of an individual and the problems of interpersonal relationships because it avoids the risk of poisoning personal relationships and has a powerful effect on improving communication (Otsuka, 2012). Therefore, some documented cases made use of a combination of EMDR and SFBT (Grandison, 2007).

As client interest in psychotherapy grows, it is expected that the number of clients who feel the need for a specific treatment regimen will also increase. Therapists are needed to ensure the client’s adequate understanding of psychotherapy techniques and to introduce the psychotherapy method desired by the client. Psychotherapy for effective PTSD treatment can have two effects on clients: a psychotherapeutic

effect and a reframing effect. The psychotherapeutic effect refers to the effects of the psychotherapy methods themselves. The reframing effect, on the other hand, is used to convey to the client that they were in a terrible situation when the psychotherapy was conducted. Therefore, for the effective treatment of PTSD symptoms, when therapists use not only the three steps model but also ET or EMDR as a method, it is necessary to be able to deliver a meta-message that conveys the idea that “you [the client] are in a very difficult situation.”

In the case of large-scale disasters such as the Great East Japan Earthquake, these effects are focused only on unhealthy, negative phenomena, such as PTSD. However, in many cases, the symptoms of PTSD or disaster-related stress have been proven to reduce with the passage of time (Yabe, et al., 2014; Wakashima et al., in press). In recent years, rather than the negative aspect, a concept focusing on the positive aspect of individuals such as Posttraumatic growth (Tedeschi, and Calhoun, 1996) and Posttraumatic success (Bannink, 2008) has appeared. If a future large-scale disaster occurs, it is assumed to be necessary that focusing on not only the negative aspects, such as PTSD, but also on the positive aspects, such as Posttraumatic growth or Posttraumatic success, will be crucial in overcoming the crisis.

However, this study was a report based on a single case. Also, the client had flashback symptoms, but she was not diagnosed with PTSD. Furthermore, there is much complexity in the various manifestations of PTSD. Therefore, it is not possible that the results of this research immediately can be adapted to all PTSD symptoms.

Conclusion

Despite these limitations, it was possible in this case to alleviate the symptoms of the flashbacks from which the client had suffered in a relatively short period of two sessions. For the client with symptoms of PTSD, the idea that not only carrying out the therapy but also emphasizing to the client that the “therapy will be carried out” brings reframing and normalizing effects to a difficult situation. It is necessary for the therapist to be aware of these effects to most effectively carry out the more traditional forms of psychotherapeutic treatment.

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