Treating Complex Trauma Using EMDR and Concepts from Individual Psychology

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By

Jessie M. Doughty

Chair: Richard Close

Reader: Shelly Lacher

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Abstract

Complex trauma, though a leading discussion among practitioners and researchers, has not found its place in official diagnosis. This paper integrates literature of neurobiology, EMDR, and Individual Psychology to develop a working understanding of complex trauma. This is followed by a discussion regarding the expectations for treatment, and offers a response to these expectations by outlining EMDR. This eight-phased therapy is considered a preeminent therapeutic approach for complex trauma. Individual Psychology offers a relevant theory and effective techniques that support this trauma-informed approach. This paper explores this integration for the purpose of understanding, diagnosing and treating this disorder.

Keywords: Complex trauma, PTSD, complex PTSD, DES-NOS, EMDR, Individual Psychology
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Dedication

I would like to dedicate this work to my husband, Jeff, and our three sons, Jack, Chaz, and Graham. You have been amazing through this process. Because of your love and support I have been able to see this dream through. I love you.

To my parents, John and Maureen Vogt, thank you for always encouraging me to dream and to look for the possibilities in life. To my other family members and friends who have helped me along the way, thank you.

Most importantly, to the Creator, You saw me through it all.
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Treating Complex Trauma Using EMDR and Concepts from Individual Psychology

Introduction

The purpose of this paper is to provide a comprehensive understanding of complex trauma, to outline one of the most effective treatment approaches that addresses it – Eye Movement Desensitization and Reprocessing (EMDR) – and to show how key concepts of Individual Psychology (IP) can support and enhance this trauma-informed treatment approach. This discussion assumes that readers share a foundational understanding of the key concepts of IP.

Understanding Trauma

Complex trauma is closely connected with the diagnosis referred to as posttraumatic stress disorder (PTSD). PTSD was first introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) by the American Psychiatric Association in 1980 (Friedman, 2016). This offered a major step forward in the understanding of psychiatric disorders (Luxenberg, Spinazzola, & van der Kolk, 2001). The diagnosis recognized that psychiatric disorders can stem from external influences (i.e., a traumatic event) rather than only from an inherent weakness found in the individual (i.e., a traumatic neurosis) (Friedman, 2016). This diagnosis is unique because, in addition to defining symptoms, emphasis is placed on the etiological event that precipitated the symptoms and is included in the diagnosis. The diagnosis is given if the individual’s event and subjective experience meet the criteria as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Friedman, 2016).

Subjective responses to traumatic events vary from person to person. Although there exists a renewed interest in how trauma thresholds vary among individuals, the PTSD diagnosis bases its definition on the premise that certain experiences such as genocide, torture, rape, and
severe war zone stress are responded to similarly among all human beings (Friedman, 2016). The diagnosis evolved in subsequent editions. By the time the fourth edition of the DSM (DSM-IV) was released in 1994 the diagnosis categorized symptom responses into three symptom clusters: intrusive recollections, avoidant and numbing symptoms, and hyper-arousal symptoms (Friedman, 2016). Fourth and fifth criterion addressed the duration of symptoms and the significance of distress or impairment the symptoms cause (Friedman, 2016). Although responses are seen as subjective in nature, in order for the diagnosis to stand the individual’s response had to fit the criteria provided.

While the diagnosis of PTSD was growing more clinically sophisticated it was still unable to differentiate more complex presentations. There was growing evidence of a population of people who not only experienced PTSD symptoms, but also presented with additional symptoms as well. These individuals – most often victims of childhood maltreatment, adult refugees, and adult torture survivors – reported that their most problematic symptoms fell outside the PTSD criteria (Friedman, Resick, Bryant, & Brewin, 2011). Their principal complaints were not flashbacks and nightmares, but were associated with behavioral indicators (such as impulsivity, aggression, addictions, sexual acting out, and self-harming behaviors); emotional difficulties (such as labile affect, depression, and panic symptoms); and cognitive symptoms (such as dissociation, and pathological changes in personality) (Friedman et al., 2011). Since there did not exist a diagnostic home for this population they were assigned a myriad of comorbid diagnosis in addition to PTSD (van der Kolk & Najavits, 2013). They were often misdiagnosed completely because they did not meet any of the criteria for PTSD, but clearly presented with symptoms subsequent to chronic trauma (van der Kolk & Najavits, 2013).
Complex trauma goes beyond the PTSD diagnosis to address psychiatric disorders that result from exposure to chronic and repetitive trauma occurring at developmentally crucial stages and affect the individual’s personality development over time (Courtois & Ford, 2013). *Disorders of Extreme Stress, Not Otherwise Specified* (DES-NOS) was conceptualized to describe the alterations in functions of individuals who had been exposed to chronic trauma (Blaz-Kapusta, 2008). Though not considered an official diagnosis, the descriptors *Complex PTSD* and *DES-NOS* were implemented for the purposes of development and research of the diagnosis.

Although Complex PTSD and DES-NOS were not officially included in the DSM-5, there was much attention given to the etiology of trauma in psychiatric disorders. As a result the diagnosis was moved from the *Anxiety Disorders* chapter and included it in a new chapter titled *Trauma and Stressor Related Disorders* (Turkus, 2013). This new chapter includes *Reactive Attachment Disorder* and *Social Disengagement Disorder* as child diagnoses for trauma when identified early in life. The PTSD criteria is now more developed and can be used to diagnosis individuals who are six years of age or older (Turkus, 2013). Following the PTSD diagnosis, the chapter identifies the diagnoses of *Acute Stress Disorder* and the adjustment disorders. The conclusion of the chapter outlines explanations of “other” and “unspecified” to qualify the diagnoses included in this chapter (Turkus, 2013).

Of importance is the updated criteria included in PTSD that more closely, though not completely, addresses symptoms of complex trauma (Turkus, 2013). As it has become apparent that trauma is not just a fear-based anxiety, the diagnosis has been expanded to include anhedonic/dysphoric presentations which include: negative cognitions, mood states, and disruptive behavioral symptoms (Friedman, 2016).
Although complex trauma is a significant departure from the stand-alone diagnosis of PTSD, having a basic understanding of the origin of this diagnosis is helpful in knowing what complex trauma is, and what it is not.

**History of PTSD**

In her article Eagan Chamberlin (2012) provides a social history of the PTSD diagnosis and discusses the stigma associated with it as it affects masculinity.

Discussion regarding trauma began in the early 1800s when military doctors assigned a diagnosis to soldiers with stress following battle as "exhausted" (Eagan Chamberlin, 2012). This diagnosis was developed further by Dr. Mendez DaCosta, in 1876, when he published a paper introducing the diagnosis of "Soldier's Heart" for veterans of the Civil War. His diagnosis captured symptoms including distress of the cardiovascular system, extreme fatigue, dyspea, heart palpitations, sweating, tremors, and loss of consciousness. Avoiding the ambiguity of the explanation of the symptom from a mind-body framework, the diagnosis continued to be developed from a physicalist medical model that explained the diagnosis as resulting from concussions sustained during constant and repetitive bombardment of artillery (Eagan Chamberlin, 2012).

Though DeCosta's concept of Soldier's Heart fell away, British military psychiatrist, Charles Samuel Meyers, in World War I, proposed the designation *shell shock* (Eagan Chamberlin, 2012). It was attributed to cerebral concussions and the rupture of blood vessels due to being in the proximity of explosions during war. When soldiers began presenting with similar symptoms of shell shock, but were not exposed to explosions his term became inadequate. As a result he delineated the difference by coining the phrase *shell concussion* and associated it to symptoms resulting from direct exposure to explosions, and shell shock became
TREATING COMPLEX TRAUMA

associated to symptoms resulting from exposure to intense conditions of war. These diagnoses
began to serve as a way to identify “men of courage” and “men of timidity.” That is, those who
were identified with shell concussion were considered “real soldiers” whereas men who were
identified with shell shock were considered unfit for warfare (Eagan Chamberlin, 2012).

During the Second World War shell shock was replaced by the term combat fatigue
(Eagan Chamberlin, 2012). The government became preoccupied with the economic costs
resulting from recovery for those with combat fatigue. Intending to create an army of only brave
men, a screening assessment was developed and utilized for enlistment. When this proved to be
futile a shift occurred in the medical and cultural understanding of trauma. What was once
understood etiologically as a biological or psychological weakness, trauma was now reframed as
resulting from the influence of the environment on psychological or physiological behavior.
Herbert Spiegel began his work on developing ways that a man could cope with trauma. Just as
external factors were to blame for psychological problems he believed that external factors, such
as social support, could help prevent and treat psychological weakness. This placed combat
psychiatrists on the front lines of warfare to provide immediate help and relief to soldiers so they
could return to battle quickly (Eagan Chamberlin, 2012).

Social and medical groups began to elevate the importance of understanding and treating
combat trauma during the time of the Vietnam War (Eagan Chamberlin, 2012). Sometime
shortly after the war, with the influence of veterans and practitioners, the DSM-III included a
new diagnostic category: PTSD. A preliminary definition revealed PTSD as a "psychological
condition experienced by a person who had faced a traumatic event, which caused a catastrophic
stressor outside the range of usual human experience" (Eagan Chamberlin, 2012, p. 362).
Van der Kolk and Najavits (2013) contributed to the development of PTSD in their interview, published in the *Journal of Clinical Psychology*. In this “In Session” review van der Kolk posited that the inclusion of the PTSD diagnosis in the DSM was an attempt by Vietnam veterans and two psychoanalysts to create a diagnosis that was non-stigmatizing (van der Kolk & Najavits, 2013). As a result the diagnosis included Criterion B – having “flashbacks and nightmares” about specific events – linking the disorder to a particular set of traumatizing events.

**Diagnosis of PTSD**

The American Psychiatric Association publishes their current definition of PTSD in the DSM-5 (2013):

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) directly experiencing the traumatic event(s), 2) witnessing, in person, the event(s) as it occurred to others, 3) learning that the traumatic event(s) occurred to a close family member or close friend (in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental), or 4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related. (p. 271)

Two key criteria of particular significance to this discussion are 1) level of exposure, which can be broken down into the direct and indirect types and, 2) proximity (May & Wisco, 2016). Level of exposure poses the question regarding whether or not the individual experienced the trauma firsthand (directly) or witnessed the trauma as it occurred to others (indirectly).
Proximity poses the question of how close the individual was to the trauma geographically. While refining the diagnosis with these factors, proximity still presents many questions regarding what constitutes being close enough to a trauma to meet the criteria for PTSD (May & Wisco, 2016).

Whereas criterion A provides an understanding of the etiology of trauma, criteria B, C, D, E, F, G, and H provide an understanding of symptoms exacerbated by the exposure to the traumatic event, as described by criterion A. Criterion B outlines the intrusive recollection of the events often described as flashbacks and distressing dreams (Friedman, 2016). Symptoms look like prolonged intrusive mental and physical experiences such as flashbacks, distressing dreams, and psychological distress and reactions to internal or external cues that resemble the original event. Criterion C describes behavioral problems related to avoidance of stimuli both internally (i.e., thoughts, feelings, memories) and externally (i.e., people, places, activities). Criterion D describes thought and mood alterations such as blocked memories, exaggerated negative beliefs about self, others, and the world, persistent negative emotions that begin or worsen at the time of the trauma. Criterion E describes noticeable alterations in arousal and reactivity associated with the event such as hypervigilance, exaggerated startle response, and sleep disturbances. Criterion F and G are the duration criterion and functional significance criterion, respectively. These stipulate that the symptoms must have been present for at least one month, and that these symptoms have caused the individual significant distress in social, occupational and other areas of functioning. Finally, criterion H rules out that symptoms are due to physiological effects of substance abuse or another medical condition (Friedman, 2016).
Understanding Complex Trauma

Defining Complex Trauma

Complex trauma, also referred to as complex PTSD and DES-NOS, refers to traumatic stressors occurring during a developmentally important time such as early childhood, and adolescence; and are committed by an important person in the individual’s life such as a parent, relative, healthcare provider, or childcare worker (Courtois, n.d.; Courtois & Ford, 2013; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013, van der Kolk & Najavits, 2013). This can also happen later in life if the individual is in a vulnerable condition associated with disability, disempowerment, dependence, age, or infirmity (Courtois, n.d.). Such stressors include, but are not limited to, abuse, neglect, abandonment, rejection, domestic violence, incest, and exploitation (Courtois, n.d.; Courtois & Ford, 2013; van der Kolk & Najavits, 2013). When these violations occur within relationships that are universally expected to provide safety, love, and belonging, it undermines the individual’s natural healthy development (Courtois & Ford, 2013; van der Kolk & Najavits, 2013). The result is pervasive negative beliefs about the self, others, and the world, leading to corresponding behaviors based on the assumption that they need focus solely on surviving (Courtois & Ford, 2013). Complex trauma attempts to confront the symptoms that sometimes incorporate, but also go beyond, the DSM definition of PTSD (Leenarts et al., 2013).

Behaviors turn into patterns that eventually become the means by which the individual organizes his or her life – as if the trauma were still happening (van der Kolk, 2014). In order to survive these stressors these individual learned to disengage from their body and simply get through the horror leaving them unable to attend and listen to their body. The disconnection between mind and body often manifests in addiction to drugs, alcohol, and other compulsive
behaviors (i.e., pornography, masturbation, and gambling); depressive and dissociative symptoms; somatic presentations; and self-injury and eating disorders (van der Kolk, 2014; van der Kolk & Najavits, 2013). These presentations become life-altering as the individual begins to run into problems with the law, with themselves, and with friends and family.

These individuals also struggle with poor psychological adjustment with stress-related problems outside the criteria for a traumatic event. As a result of chronic stress patterns in childhood and adolescence, these individuals are at a higher risk for developing pathological stress responses to events not considered traumatic (Borelli & Sbarra, 2011). An article published by the Journal of Social and Clinical Counseling examined how a self-reported history of trauma is associated with psychological distress and self-blame following divorce, which is considered a negative life event, but not a trauma. According to these authors research on child maltreatment demonstrates that self-blaming, subsequent to abuse, is comorbid with depressive and internalizing symptoms, and this tendency increases when the trauma occurred earlier in life (Borelli & Sbarra, 2011).

Children tend to perceive their experiences as being about them (Courtois & Ford, 2013). They interpret their interactions with the world and others as being causally connected with their involvement in some way. This egocentric approach to interpretation is normal and expectable for children. When chronic trauma is a part of this stage of development, however, children frame their experiences accordingly, and are therefore at risk for developing an identity shaped by self-loathing, shame, and an irrational sense of responsibility for being victimized (Courtois & Ford, 2013). There is research that suggests that those who are victims of trauma develop this type of perception to avoid accepting the notion that bad things can happen to good people. If
they take the blame for everything bad that happens to them, they can continue believe the world is a safe and just place (Borelli & Sbarra, 2011).

This may have something to do with why those who have been exposed to chronic maltreatment are at higher risk for re-victimization. Their perception, perhaps shaped by self-blame, leads them to tolerate excuses for abuse (Leenarts et al., 2013). They find themselves in repetitive patterns that set them up to be traumatized by subsequent experiences (van der Kolk, 2014). Over time these individuals internalize more of their distress which fuels anxiety and depression, leading to prolonged negative responses to stressful life events (Borelli & Sbarra, 2011).

Traumatic experiences and other stressful life events are not the only precipitants that promote this distorted view of the world. For many, behavioral and verbal cues from others trigger this debilitating self-awareness. The scrunching of a stranger’s nose can be interpreted as repulsion, or the shift in tone of a loved one’s voice is heard as threatening. This chronic internalizing becomes difficult to manage over time, and can result in behavioral problems related to self-harm, impulsivity, and addictions (Courtois & Ford, 2013). For those close to these individuals’ relationship becomes increasingly difficult. Friends and loved ones start to distance, set firmer boundaries, and eventually give up because the strain of the relationship becomes untenable. These experiences only reinforce the negative beliefs that the victim holds about him- or herself. It is a self-defeating cycle that makes interpersonal relationships difficult to initiate, develop, and maintain.

**Diagnosis of Complex Trauma**

Post-Traumatic Stress Disorder symptoms may or may not be part of an individual’s presenting complaints. What is clear is that for most, the most distressing symptoms are inter-
and intrapersonal in nature (van der Kolk & Najavits, 2013). Clients come to therapy with a myriad of somatic, emotional, mental, social, and behavioral problems because, at the root of it all, they do not know how to be at peace in their body, enjoy intimate relationships, and stay present in the moment (van der Kolk, 2014; van der Kolk & Najavits, 2013). They are unable to be calm, present, and cannot find any meaningful reasons to be in the world (van der Kolk & Najavits, 2013).

Individuals with complex trauma usually present with histories that illustrate the shock of multiple, repeated, and overlapping experiences that began in childhood within the context of abusive or invalidating relationships (Courtois & Ford, 2013). As children or adolescents their responses to these experiences were either ignored, unacknowledged, or given no explanation. These re-traumatizations strip the individual of his or her sense of safety, hope, and their connection to primary and secondary support systems, along with their personal identity and sense of self. As a result, they create ways of coping, including thoughts and beliefs, which worked well in their childhood environments for survival but interfere with their ability to interact in healthy ways in adulthood. These interferences comprise the presenting complaints when they seek therapy. As clinicians it is important to consider how traumas, large and small, contributed to these presenting complaints. These individuals require complex, multifaceted and individualized treatment approaches in order to fully confront the scope of their problems (Courtois & Ford, 2013).

**Childhood.** Much of the current literature suggests that early childhood attachment plays a significant role in how a child adjusts to stressors throughout life (Courtois & Ford, 2013; van der Kolk, 2013; Williams, 2006). Whether an attachment figure is safe or unsafe, a child’s need to attach is a critical driver in early life. Secure attachment provides the stability for a child to
develop normally. Insecure attachment provides less stability for development and contributes to the child’s preoccupation with the abusers internal states (Williams, 2006). As a result they are constantly monitoring themselves in relation to the mood or emotional state of their caregiver. Because children are egocentric by nature they are constantly considering how they affect their environment. For a child in an insecurely attached primary relationship, their preoccupation with their attachment figure precludes any hope of getting their needs met. For a child, primary needs are met by someone other than themselves (food, shelter, and safety). The alternative to attaching – even to an unsafe caregiver – means accepting a life of isolation and unmet needs (van der Kolk, 2014). On an unconscious level, the child’s survival is vulnerable, so they do what is necessary to get their basic needs met. This is the preoccupation of a child in an abusive or neglectful environment. They learn the cues required to get what they need and develop coping behaviors and personality traits accordingly. Since for most children the alternative is not an option, their energies shift from achieving normal milestones to remaining attuned to their attachment figure to get at least some of their needs meet (van der Kolk, 2014).

As they become preoccupied with surviving, children miss important learning experiences that a loving and protective caregiver would provide. Early, moment to moment, experiences with caregivers provide clues and cues for the child regarding their sense of self, developing self-care habits, adapting to the environment, learning empathy, avoiding danger, regulating emotions, creating a sense of safety, and getting along with others (van der Kolk, 2014). Instead of developing these fundamental skills, they learn to anticipate rejection, hostility, or indifference. As a way of coping with this they learn to block out hostility and neglect by acting as if it does not matter, while the body remains in a state of high alert, ready to respond to any further maltreatment (van der Kolk, 2014).
This simultaneous acts of knowing and denying, are at the root of dissociation. Accepting or tolerating what is known or felt may become overwhelming, so the alternative is denial and dissociation (van der Kolk, 2014). A similar state to dissociation is depersonalization, or not feeling anything at all. When triggered, the individual goes numb and their mind goes blank. This is evidenced in brain scans of individuals during depersonalization that reflects diminished brain activity and unaffected blood pressure. When individuals experience this level of avoidance they are also left with side-effects such as pervasive numbness. In an attempt to feel something, or snap out of a dissociative state, individuals engage in self-harming behaviors such as cutting and burning, engaging in physical altercations with others, or taking extreme risks (van der Kolk, 2014).

**Adulthood.** The literature available points to mounting evidence that complex presentations of trauma are connected to chronic childhood maltreatment (Leenarts et al., 2013). It is important to address how complex trauma can originate later in life. By comparison, chronic childhood trauma derails the personality development of the individual, while chronic adulthood trauma has the potential to damage the already formed personality of the individual (Williams, 2006).

The adolescent or adult has more resources at their disposal to process difficult situations (Courtois & Ford, 2013). This is because their body, personality, identity, and abilities have had an appropriate amount of time to develop (Williams, 2006). This does not render them immune to complex trauma. Generally, in adolescence and adulthood, trauma becomes complex when the events themselves represent an overwhelming threat to the individual’s established sense of safety, identity, relationship, and security. Such traumas include, but are not limited to, combat, chronic homelessness, poverty, inescapable community violence, persecution, human trafficking,
cult involvement, refugee displacement, enslavement, genocide, or torture (Courtois & Ford, 2013). The trauma disempowers the individual, stripping him or her of core assets such as sustaining beliefs, guiding principles, and essential hopes (Courtois & Ford, 2013). Due to the chronic nature of such stressors the individual suffers psychological shock that is disorienting and inhibits their ability to tap into their established inner resources for the purpose of integrating the experience. These individuals can also experience dissociation and depersonalization in an attempt to cope with extreme and prolonged traumas (Courtois & Ford, 2013; van der Kolk, 2014).

The PTSD diagnosis is helpful in understanding what a trauma is, and what traumatic reactions look like, but it does not account for two additional variables of complex trauma. The definitions available in the current literature generally assume that complex trauma has transpired within a specific setting and within a specific timeframe. Contextually, the trauma takes place within relationships that are supposed to be loving and accepting, while time-frames suggest that the trauma, or traumas, happen during a developmentally important or vulnerable phase of an individual’s life. While these adaptations were necessary for the purposes of survival, left unaddressed these coping mechanisms give way to maladaptive patterns and personality problems that block normal functioning. What once worked well in meeting the goal of survival now impedes living in a worthwhile manner. Eventually the individual realizes that he or she no longer lives at the mercy of their oppressors, but still behaves as if they do.

**Neurobiology**

“After trauma the world is experienced with a different nervous system,” Bessel van der Kolk, asserts in his book, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (van der Kolk, 2014, p. 53). A PTSD diagnosis provides a narrative that depicts a person
as pursuing a normal life when suddenly something horrible happens that leaves the individual feeling powerless. After the terrible event is over, the individual lives with recycled memories and a nervous system that is never quite the same again (van der Kolk, 2014). The PTSD diagnosis has paved the way for practitioners to gain a better understanding of what trauma does to the brain and body.

**Brain Science**

The brain’s most fundamental function is to ensure the individual’s survival. This function ranges from telling the body to respond to basic needs such as eating, sleeping, and shelter; and to adjusting actions accordingly to warn the organism of danger by initiating appropriate systems to respond (van der Kolk, 2014, p. 55). Since people are communal creatures, the survival function requires cooperation with others. Psychological problems present themselves when these internal signals are not coordinating or collaborating with one another effectively, and also when the individual is unable to cooperate with others to get their needs met (van der Kolk, 2014).

To better understand the effects of complex trauma on the brain, it can be divided into two domains – the emotional brain, and the rational brain. The emotional brain is the core of the central nervous system and is made up of the reptilian brain and the limbic system (van der Kolk, 2014). The primary task of the central nervous system is to look out for the welfare of the individual by alerting the individual to potential dangers and key prospects. When something is identified as either desirable or undesirable the brain releases appropriate hormones that result in visceral sensations. These sensations interrupt the individual’s current activities in order to get them moving either away from, or toward, something. The repetitive learning that results from this system helps the individual organize and develop what makes them function. The patterns
developed reveal to the individual what they like to eat, the type of people they enjoy being with, their opinions on such things as music and art, and what they like to do with their time (van der Kolk, 2014).

The rational brain, or neocortex (prefrontal lobes), processes input in a more global manner by sorting through a complex set of options (van der Kolk, 2014). Planning and reflecting are the primary tasks of the rational brain. Using language and abstract thought, the neocortex gives the individual the ability to absorb and integrate large amounts of information and attach meaning to it. This function allows the individual to plan future scenarios, and to make guesses as to what will happen based on certain events (i.e., a job interview, a romantic date, or a ride on a rollercoaster). Bessel van der Kolk (2014) points out that this part of the brain, “makes choice possible and underlies our astonishing creativity” (p. 58). The fact that we once used horse-drawn buggies, but now drive automobiles, is the result of the collaboration and cooperation of the frontal lobes (van der Kolk, 2014).

The brain can be described from the bottom to the top, starting with the brainstem and reptilian brain at the bottom, moving up into the limbic brain, and finally to the prefrontal cortex at the top. This structure also reflects the developmental order of the brain. The reptilian brain begins to develop at conception, while the limbic brain develops rapidly after birth, and the frontal cortex is developed later in childhood (van der Kolk, 2014). From a developmental perspective the reptilian brain is responsible for basic needs such as eating, sleeping, and urinating, and can sense pain and discomfort – all behaviors associated with what babies do. This part of the brain also includes the hypothalamus that sits just above the brain stem and is responsible for basic life-sustaining systems (i.e., heart, lungs, endocrine, and immune systems) (van der Kolk, 2014).
The limbic system, which goes through rapid development after birth, is the repository of the emotions. It enables the child to identify and judge what is fear-inducing or pleasurable, and determines what is, and is not, important for survival (van der Kolk, 2014). It is also associated with managing the challenges of living within complex social systems. Between our responses to these experiences and our genetic makeup and temperament, the limbic system creates emotional and perceptual maps that are use-dependent. This means that patterns are set because a circuit in the brain fires repeatedly creating a default setting. A child who experiences secure attachment and love routinely lives from this default setting, whereas a child who is insecurely attached and experiences neglect routinely lives from this default setting. The former default setting provides space for the child to explore, play, and cooperate with others, while the latter leaves the child preoccupied with feelings of fear and abandonment and with little space to explore, play, and cooperate (van der Kolk, 2014).

The prefrontal cortex begins developing at a rapid pace at approximately the age of six and continues into early adolescence. Around first or second grade children begin to organize their life using reason and structure (van der Kolk, 2014). At this stage of development children start to express their emotions in words rather than behavior, are able to understand abstract ideas, think about their plans for tomorrow, and find appropriate ways to participate in a community such as a classroom or family structure (van der Kolk, 2014).

Thus far the brain has been discussed from an emotional and rational standpoint, and developmentally from the bottom up. The brain’s priority is survival of the organism. Once these basic needs are established and maintained, the brain becomes occupied with other functions, related to social interconnectedness, and the executive functions associated with rational thought. How do these parts of the brain react to trauma? And what happens to the roles
they play when complex trauma interrupts the normal development of the brain? The following looks at how a healthy brain reacts to trauma and the effects of chronic stress on the danger response of the brain.

**The Brain and Trauma**

Sensory input enters through the skin, eyes, ears, and nose. Sensations converge in the thalamus (inside the limbic system) (van der Kolk, 2014). The thalamus creates an understandable concept of what is happening to the individual. Once this is completed, the sensations are sent in two separate directions, first, the amygdala (which is the center of the emotional brain), and second, to the prefrontal cortex (or rational brain) (van der Kolk, 2014).

The amygdala determines whether incoming sensations are relevant for survival (van der Kolk, 2014). If it senses a threat, it stimulates the lower brain (the hypothalamus and the brainstem) which recruits the autonomic nervous system (ANS) through the release of powerful hormones, including cortisol and adrenaline, to respond to the threat by fighting, fleeing, or freezing (Sperry, 2016; van der Kolk, 2014). The prefrontal cortex, or rational brain, acts as the executive during trauma. Whereas the amygdala prepares the individual to respond to their experience, the prefrontal cortex observes the situation, predicts outcomes based on specific actions, and makes a conscious choice. The rational brain aides the individual in controlling their stress response by hovering over their thoughts, feelings, and emotions. This ability delays the decision-making process, giving the individual time to develop an appropriate response to the stressor – often resulting in a false alarm (van der Kolk, 2014).

It is important to note that it take milliseconds longer for the sensory input to get to the rational brain compared to the emotional brain (van der Kolk, 2014). This is why reactions to a threat often happen before the individual is consciously aware of the danger. Once the danger
has passed, a healthy response system is able to initiate recovery and efficiently return the individual to his or her normal state (Millar, 2013; van der Kolk, 2014). When this does not happen, the individual continues to feel aggressive, agitated, hypervigilant, and aroused – all symptoms associated with the stand-alone diagnosis of PTSD (Millar, 2013; van der Kolk, 2014).

The Brain and Complex Trauma

For the individual with complex trauma the functions of the brain during stress and trauma operate differently. This first starts in the amygdala where sensory input can become fragmented, disconnected, and normal processing can break down (van der Kolk, 2014). This faulty processing makes it difficult for the individual to truly detect danger. The brain, compromised by the effects of complex trauma, is less able to accurately gauge an experience as threatening or nonthreatening. This is why those in relationship with these individuals reflect back to them how overly-sensitive they are – as they witness them overreact to the slightest shift in facial expression, adjustment in tone of voice, or expression of harmless opinion or comment (van der Kolk, 2014).

The use of the rational part of the brain to oversee the situation from an objective viewpoint is never given a chance because the reaction of the emotional brain takes over (van der Kolk, 2014). Someone with complex trauma lacks the ability to activate their rational brain to evaluate thoughts, feelings, and emotions or to delay their reactions. Instead, these individuals react as they have been conditioned to, from an emotional or reptilian brain response. It automatically sets the individual into either a fight, flight or freeze response, foregoing the prefrontal lobe’s control of the stress response (van der Kolk, 2014).
Dissociation. The avoidant and protective nature of dissociation reflects itself in neurological patterns as well. Recent studies have revealed different neurobiological markers for PTSD with dissociation as compared to PTSD without dissociation. Herkt et al. (2014) pointed out that when PTSD presents with dissociation, limbic and prefrontal activation patterns oppose what is typical in posttraumatic reactions alone (Herkt et al., 2014). Whereas limbic activation increased and prefrontal cortex activation decreased in clients with PTSD, limbic activation decreased and prefrontal cortex activation increased in the clients with PTSD and dissociative symptoms. These results reflect what neurobiological studies show, that chronic trauma changes neurobiological responses in the long-term. Furthermore, this study confirms what van der Kolk (2014) pointed out, that the presence of dissociation suggests the individual, at a very young age, experienced a chronic lack of safety by their caregiver. The differentiating variable here is the timeframe in which the failure of environmental and relational safety occurred. Dissociative symptoms were linked to early childhood trauma, rather than traumas that occurred later in life (van der Kolk, 2014).

For those who experienced a normal upbringing, characterized by attachment to a stable caregiver, free of abandonment or neglect, with their basic needs met, and no overwhelming losses, are able to respond adaptively to a traumatic experience. This may lead to a brief time of readjustment to life as normal, but overall they are able to resolve their experience on a mental, emotional, and psychological level. This is due to how they attached early in life. They experienced the ups and downs of their mother’s experiences and learned to mirror her responses accordingly. They knew what it was like to get all worked up in a wrestling match with dad and then mirrored his ability to calm down and return to normal activity (Eastbrooks, Raskins & McBrian, 2014). The child also learns who they are in relation to others, and where they fit in
the world around them. They come to believe that they are okay in the world despite the ups and downs they will face. These experiences pave the way for them to move through life adapting effectively. When this attachment process is interrupted by patterns of abuse and neglect, the individual becomes occupied with survival rather than developing. Trauma interferes with natural development, and results in long-term neurobiological damage (Sperry, 2016). The trauma of childhood interferes with the individual’s ability to learn to appropriately be in the here and now, connect with others, and accept him- or herself.

Borelli and Sbarra’s (2011) prospective longitudinal study examined whether prior self-reported traumatic experiences are associated with difficulty adjusting to divorce (Borelli & Sbarra, 2011). Over a period of two years they included 99 individuals in their study. Using several standard measures and study-specific questionnaires (Traumatic Life Events Questionnaire, Impact of Events Scale-Revised, and Brief COPE) they gathered data regarding their relationships, trauma history, the impact of the trauma history, coping style, linguistic style, and subjective distress. Specifically, they were observing how individuals with a history of trauma responded to a stressful life event – in this case, divorce - that is not, by definition, traumatic (Borelli & Sbarra, 2011). They found that those with trauma histories were more likely to blame themselves for the divorce and experienced greater psychological distress.

A correlation may exist between this study and the neurological changes of dissociation mentioned by van der Kolk (2014). Dissociation, which correlates with early childhood trauma, reveals itself in alternate brain patterns when a stressful event occurs. Opposite from a typical neurological response to stress, the limbic system, which is associated with protective behavioral reactions, is inactivated while the frontal lobe, associated with reasoning and executive function, is activated. This may suggest that activation of the prefrontal lobe accounts for the results that
Borelli and Sbarra found which revealed that these individuals rationalize in stressful events, using self-blame and shame to explain why the stressful events are happening.

The neurological changes of dissociation may also account for the increased psychological distress reported by individuals in Borelli and Sbarra’s study. The inactivation of the limbic system suggests that there is a lack of protective patterns associated with a normal response to stress. For example, instead of asserting themselves in stressful experiences, these individuals hold their responses internally which results in increased psychological distress over time. Borelli and Sbarra also noted that this psychological distress was compounded if the individual experienced different types of traumas throughout their life. This description implies that complex trauma is a variable in the results of the study, indicating that the accumulation of trauma over time sensitizes stress pathways (Borelli & Sbarra, 2011). Functional and structural changes in the brain may alter how individuals respond to the stress of life events leading to worse psychological adjustment. It is becoming increasingly clear that early experiences of trauma exerts an influence on neurobiological pathways that may block an individual’s ability to regulate their emotions, impacting their ability to respond to all types of negative life events (Borelli & Sbarra, 2011).

The use of self-focus or self-blame in stressful life events may reveal conflicting opinions in the current literature. Borelli and Sbarra (2011) indicated that some researchers suggest self-focus or self-blame can be helpful in adapting to life after divorce while others suggest it has the opposite effect. Borelli and Sbarra’s (2011) offered a possible explanation for this. Those with no history of trauma use self-focus and self-blame as coping resources to help them adjust and learn from the experience for the purpose of moving on (Borelli & Sbarra, 2011; Matheny & Curelette, 2010). This may suggest that those with a healthy perspective on stress go into these
experiences, see them through a self-focused lens, and learn from their mistakes. Those with a history of trauma use self-focus and self-blame as coping responses and as a protective mechanism (Borelli & Sbarra, 2011; Matheny & Curlette, 2010). An individual who has experienced the underpinnings of chronic stress on their neurobiological system, use self-focus and self-blame to avoid facing certain realities.

Referred to as the *just world theory*, some have posited that self-blaming attributions about the cause of trauma helps the individual maintain a sense of safety (Borelli & Sbarra, 2011). The idea here is that if they take the blame for what has occurred, they can continue to believe the world is a safe and just place. The alternative is to accept the notion that bad things happen to good people. Their self-blame helps them regain a sense of control in the short-term (Borelli & Sbarra, 2011). The results in the long-term are reinforced negative beliefs about the self. Rather than learning from the experience, it is another mark against them.

In this section the writer discussed possible correlations between studies that reveal neurological changes of trauma and dissociation on the stress response, and a study that examined the effects of early trauma on the stress response to a non-traumatic life stressor. It was reported that neurological changes in dissociation may account for the use of self-blame to explain negative life events, and results in prolonged psychological distress. It appears those with a history of trauma use self-blame and self-focus to explain these events in order to protect themselves and to avoid facing an existential truth. Instead of facing the truth and learning from the experience, it is stuck in the past and reinforces negative beliefs about the self in the present. This psychological distress floods these individuals when present day experiences trigger the experiences of the past. *Eye Movement Desensitization and Reprocessing* (EMDR) provides the most robust explanation for this maladaptive process in complex trauma.
Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing is a trauma-informed treatment approach that understands pathology as resulting from unprocessed experiences from the past (Shapiro, 2009; Shapiro & Laliotis, 2011). Individuals make sense of experiences within the context of existing memory networks (Shapiro, 2009; Shapiro & Laliotis, 2011). In healthy individuals following a disturbing event whatever is useful is incorporated into existing neural networks, while whatever is useless, is discarded. The event serves as a guide to the person in future experiences (Shapiro, 2009; Shapiro & Laliotis, 2011). These adaptive networks are referred to as *neural networks*. Adaptive learning is stored in adaptive neural networks.

Trauma

For an individual suffering from trauma, experiences are locked in their own neural networks and are not integrated into the adaptive neural network (Shapiro, 2009; Shapiro & Laliotis, 2011). These negative experiences and the associated emotions, thoughts, images, and sensations are stuck in the past, waiting to flood any triggering experience. The following is an example to help explain neural networks, adaptive learning, and stuck experiences.

A two-year-old girl learns to drink from a plastic red cup. This is a good experience for the most part. She learns what happens when the cup tips over or drops, and how to use it to quench her thirst. The child is given a blue plastic cup and is able to recognize and adapt her new stimuli into the learning she experienced from the “red cup” experience. She recognizes that this blue cup functions identically to the red cup. This experience is adapted into her cup experiences. To take this further, sometime later she is given a glass cup, but drops it and it shatters. This is new information to process. Her actions had a loud and destructive result. Lucky for her, she has parents who gently
direct, reassure, and provide her with more instruction about how to use this kind of cup, resulting in adaptive learning. This information is integrated into her cup experiences.

What happens, however, if things go differently when the glass shatters? What if, instead of having parents who gently direct and guide her to try again, she has parents who harshly scold and withdraw from her? The child is left to try to make sense of what happened on her own. And since she was not shown a resolution to the problem or reassured that these things happen, she begins to use her own level of learning (which is not fully developed) to explain it. Instead of learning from the experience and integrating it into her other cup experiences, this event is left stuck in a separate neural network that deceives her into believing that she causes trouble, and that she is bad.

Experiences, big and small, add up over time and lead to maladaptive beliefs, thoughts, feelings, and sensations. Certainly cup experiences alone do not lead to complex trauma. Taken further it becomes clearer how complex trauma develops. Instead of cup experiences, it is repetitive experiences of abuse and neglect in early childhood compounded by the abandonment of a parent due to divorce, an inappropriate sexual experience with a neighbor, or chronic bullying in school. They did not experience a trauma as defined by the PTSD diagnosis, but layered life events, such as these, generate at least as many symptoms (Shapiro, 2009).

For the healthy individual, new experiences are “metabolized” appropriately and learned from accordingly, but for the persistently anxious individual new experiences are frozen in time within a context of fear and pain (Shapiro, 2009; Shapiro & Laliotis, 2011). Experiences that are not adaptively resolved inhibit the individual’s ability to reflect on prior times when things were happy, successful, or enjoyable. These unprocessed memories lay a foundation for dysfunctional responses to erupt during similar events in the future; it is the touchstone event for any associated
experiences (Shapiro, 2009; Shapiro & Laliotis, 2011). Pathology is a result of unprocessed experiences (memories) that are stored in their own neural networks and are unable to link up to adaptive neural networks.

**Complex Trauma**

From the theoretical framework of EMDR these unresolved memories do not need to be exceptional in nature; that is, they do not need to adhere to the PTSD diagnostic criteria in order to color an individual’s perception and create pathology (Shapiro, 2009; Shapiro & Laliotis, 2011). This works well with the definition of complex trauma that originates in experiences that are not necessarily included in the PTSD diagnosis. Current life events provoke unresolved memories, causing stored negative emotions, physical sensations, and perspectives to surface. Occurring without conscious control, the individual associates current experiences with earlier experiences as a way of trying to make sense of the world, but because the original experiences have not been integrated into adaptive processing the individual is flooded by dysfunctionally stored associations (emotions, sensations, and perspectives) that result in reflexive responses that drive the person’s behaviors (Shapiro, 2009; Shapiro & Laliotis, 2011).

Going back to the cup example:

This child is now a grown adult who struggles with feelings of incompetence and defectiveness. She notices that she is able to learn new things, but once things become more complex in her learning she struggles with anxiety and withdrawal. This has become pervasive for her and she is recognizing, as a college student, how much this is affecting her ability to ask for help and complete her assignments. She attends therapy to resolve this problem. Using EMDR, this behavior would be seen as a result of unresolved experiences linked to her current presenting complaint. What would be
uncovered, in addition to her unwanted visceral sensations and avoidant behavior, is a deep-seated belief that she is incompetent and that when things get more difficult she makes them worse. All of these symptoms (beliefs and thoughts included) represent the mechanism to link her presenting complaint to her earlier unresolved childhood experience (the touchstone event), and in her case, the glass cup incident.

This example does not mirror the creation of complex trauma, but it does provide a useful illustration for understanding how complex trauma is constructed. For an individual with complex trauma, repetitive negative experiences throughout childhood shape their perspectives for life. They are usually young children without the consistent guidance and direction provided by a safe and secure caregiver to help them understand their experiences in an adaptive way. An adaptive response to a negative experience initiates a learning process. The individual learns from the experience and moves on. Maladaptive responses interpret negative experiences as resulting from one’s perceived defectiveness or powerlessness. Eye Movement Desensitization and Reprocessing aids the individual in the process of adaptive learning for their unresolved memories. During reprocessing the individual uses their adaptive thinking as a lens through which to view the negative memory. By looking through this lens the individual is able to project adaptive thinking onto the memory, thereby providing more insight regarding the event. As insight increases learning increases and the memory becomes integrated into the adaptive neural network. During this process the dysfunctionally stored material dissipates, and the individual no longer experiences the symptoms that formed the basis of their pathology (Shapiro, 2009; Shapiro & Laliotis, 2011).
**Individual Psychology**

**Trauma**

Alfred Adler, the founder of Individual Psychology (IP), asserted, “We do not suffer from the shock of our experiences – the so-called trauma – but instead make out of them whatever suits our purposes” (Ansbacher & Ansbacher, 1956, p. 24). This quote reinforces his idea that, in addition to neurotic symptoms, traumatic reactions are a “sideshow” of sorts, set in place to avoid dealing with an event that one’s lifestyle fails to address (Hjertaas, 2013; Strauch, 2001). According to IP, pathology is the organization of the self in an attempt to avoid or retreat from life’s demands. The neurotic style of life chooses not to respond to a problem with solutions, and instead exhibits itself in many physical and psychological forms (Strauch, 2001). In the neurosis of trauma, the effort required to integrate the traumatic experience into the lifestyle is too difficult and so the individual focuses on traumatic reactions.

The individual clings to their traumatic reactions for a specific reason (Hjertaas, 2013, Strauch, 2001). This likely has to do with the failure of the lifestyle to adapt a meaning to the traumatic event. Meaning is a term in IP use to describe how an individual sees him or herself by the explanation he or she applies to experiences (Ansbacher & Ansbacher, 1956; Hjertaas, 2013; Sperry, 2016). The challenge of adjusting one’s self-understanding to incorporate the trauma into one’s lifestyle becomes overwhelming so that energy shifts to managing traumatic reactions instead (Strauch, 2001). The management of traumatic reactions surfaces as symptomology. These symptoms, such as those included in PTSD, are seen as purposive in nature. This informs Adler’s concept of the *psychology of use*. The psychology of use, Adler proposed, holds that individuals devise symptoms, either unconsciously or consciously, in
accordance with their lifestyle in order to avoid or retreat from the demand brought about by the traumatic event (Strauch, 2001).

Using an Adlerian perspective Anthea Millar (2013) explores the Crucial Cs in her discussion of traumatic reactions. The Crucial Cs outline four essential needs of the individual; they are: 1) to Connect, 2) to feel Capable, 3) to Count, and 4) to have Courage. Of particular interest in this discussion is courage and the influence it has on the individual’s ability to respond to challenges in a socially constructive manner (Millar, 2013). When the challenge is intense and terrifying it overwhelms the individual’s safeguarding mechanisms and accompanying sense of courage. The result is a complex integration of psycho-somatic reactions that alerts the sympathetic nervous system to mobilize the individual’s flight, fight, or freeze reactions (Millar, 2013). These reactions play an important role in protection and survival. They are meant to protect the individual in the face of danger. Once the danger has passed, the expectation is that the individual returns to normal adaptive functioning (Millar, 2013). In fact, an individual strong in the Crucial C’s is able to use their adaptive responses and return to normal functioning, as expected. When this does not occur, it suggests that the individual does not have adequate adaptive resources at their disposal. When an individual is not strong in these areas, adapting to trauma can prove difficult.

Adaptive resources can often be found in experiences that have enhanced one’s sense of safety, significance, and belonging (Hjertaas, 2013). Here the importance of bringing the discussion of social interest and community feeling is consistent with literature that suggests trauma recovery must be done in the context of community (Matheny & Curlette, 2010). Main and Boughner (2011) discussed how Adler’s writings about encouragement suggested that hope is inspired through action, particularly in community. The clinician’s job is to create a case for
courageous behavior and action in a cognitive and emotional sense, and the client’s responsibility is to participate in his or her community. Together, they integrate both and develop a plan of action. In addition to making a case for courageous behavior, the clinician brings attention to the client’s positive social and familial connections.

**Complex Trauma**

Individual Psychology has continued to build on Adler’s original work regarding trauma. His original view can be applied to trauma that occurs later in life and may more accurately reflect traumatic reactions subsequent to the development of the lifestyle. This can provide an explanation for PTSD symptoms when they stand on their own. This explanation does not address the pathology of chronic trauma occurring simultaneously within the years of lifestyle development.

Complex trauma most often finds its roots in childhood (van der Kolk & Najavits, 2013). Complexities present themselves as a result of a single trauma, or repetitive traumas that occurred in early childhood (van der Kolk & Najavits, 2013). This is important when considering complex trauma from a classical Adlerian perspective. Are all traumatic reactions accounted for by the psychology of use?

**Psychology of Use**

A fundamental assertion of IP is that the teleological explanation for symptomology stems from the individual’s choice (Rasmussen & Watkins, 2012). The individual chooses their symptoms for a specific purpose. The psychology of use is the term Adler used to explain a functional or dynamic psychology, also known as psychological and bodily processes and characteristics. These functions and dynamics are considered to be subordinate to, but a part of, the style of life (Ansbacher & Ansbacher, 1956). This means that the lifestyle is formed, usually
by the age of six, before a behavior or symptom can be identified by the psychology of use. Does the psychology of use explain pathology when chronic trauma occurs during lifestyle development?

Ilan Strauch (2001) highlights the difficulty of the classic Adlerian view of trauma when considering that the source of complex trauma often presents because the individual experienced a trauma in their formative years. Should trauma reactions and personality formation of a client who experienced a terrible loss or violation at the age of 3 years of age, for example, be seen as using the trauma to achieve lifestyle goals? (Strauch, 2001). He posed the question well, “is a traumatic reaction a lifestyle response to an extreme situation, or is it something that leads to a change in the person’s phenomenological field and that effectively could change the lenses through which the individual perceives life?” (Strauch, 2001, p. 248). The writer suggests that when complex trauma is present it is important to see reactions as part of the arrangement of the lifestyle, not just as symptoms of use.

While Strauch does not qualify the difference between trauma and complex trauma he provides a fresh foundation from which to conceptualize complex trauma. Regarding the psychology of use it is assumed that the purpose is psychological in origin (Strauch, 2001). However, developments in neuroscience reveal the biological effects of chronic trauma on the mind and body. We know from this that it is important to consider the neurological, biological, and environmental factors contributing to complex trauma. This aligns well with the Adlerian concept of holism. According to Strauch (2001), “Automatically searching for a psychological purpose may be damaging for two reasons: a) it can lead to overlooking important factors concerning the client’s situation, and b) it is disrespectful to the Adlerian view of holism” (p. 248).
Lifestyle

Holism naturally emerges as relevant in treatment when lifestyle is incorporated. The lifestyle, often referred to in other theories as personality, is a result of the meanings the individual applies to biological, psychological, and sociological influences. Adler asserted that, "The first four to five years are enough for the child to complete his specific and arbitrary training in the face of impressions from his body and the environment. From then on the creative activity of the style of life begins its work. Experiences become assimilated and utilized according to the style of life, by the structure of which the individual is determined" (Ansbacher & Ansbacher, 1956, p. 181). Lifestyle includes the concepts of self and others, worldview, convictions, and movement. It provides the foundation for behavior, thought, emotion, attitudes, morals and values (Strauch, 2001).

Strauch (2001) cites the work of van der Kolk and McFarlane who introduced the concept of the “black hole of trauma” (p. 251). When someone experiences a trauma, the event cannot be included in the person’s lifestyle so the impressions remain raw and unprocessed, held in the body for later reenactment (Strauch, 2001). The trauma serves as a filter and as long as it remains unintegrated with the lifestyle it will play a role in the individual’s psychological movement. Strauch compares trauma to a physical tumor that interferes with normal functioning. He asserts that trauma is both internal and external. It occurs from outside the individual and, once perceived and interpreted, becomes something internal to address (Strauch, 2001).

Depending on its chronological place in the client’s life, trauma has the potential to affect the person’s lifestyle. The magnitude of this affect is associated with many factors including the individual’s level of lifestyle development, perceived severity of the traumatic
event, social embeddedness, and creativity (Strauch, 2001). When trauma occurs early in life it is almost inevitable that it affects lifestyle convictions. Lifestyle provides the plumb line toward which goals and movement are kept congruent with one another. Just as gravity pulls objects towards the earth’s surface, so the lifestyle could be said to have a similar effect on the psychological functions and dynamics toward the unity of the self. Trauma, within the lifestyle, pulls impressions from the environment toward the trauma (Strauch, 2001).

There are complex cases where the initial trauma(s) did not occur during the development of the lifestyle. Keeping with Adler’s (Ansbacher & Ansbacher, 1956) assertion that “everything can also be different” (p. 194), it is important to consider the individuality of each client and that lifestyle development may have required more or less time to form based on the biological, psychological, and sociological soft and hard determinants in the client’s life. Knowing when the trauma occurred, in relation to lifestyle development, will be helpful for the Adlerian therapist. Knowing whether behavior is the result of trauma that influenced convictions within the lifestyle (i.e., trauma that occurred early in life), or whether behavior is a response to established lifestyle convictions (i.e., trauma that occurred later in life) will be helpful in treatment planning, selecting treatment strategies, and in aligning with client.

**Treatment for Complex Trauma**

**Current Research**

A phased approach to treatment is emphasized in the majority of the literature and training for the treatment of complex trauma. The number of phases may vary depending on the theory, but in general they consist of: stabilization, safety, desensitization of traumatic events, and reorienting responses in the present and future (Courtois & Ford, 2013; van der Kolk, 2014).
Stabilization and safety generally occupy the same phase. The client’s safety must be assessed (Courtois & Ford; van der Kolk, 2014). If the client’s current environments are safe, this should be maintained and assessed regularly. If safety is a problem, the clinician and client can work to restore safety. Major changes may need to take place including housing and job changes. Other changes may include learning new coping strategies to help the client maintain their own safety. This may include taking regular breaks, deep-breathing, guided imagery, and containment exercises. Of utmost importance is to establish safety in the therapeutic setting that includes a thorough informed consent process, clarity regarding what to expect in therapy, a discussion regarding boundaries in the therapeutic relationship, and appropriate actions to take in crisis (Courtois & Ford; van der Kolk, 2014).

Desensitizing traumatic memories is the second phase of treatment and involves the client’s informed choice to reexamine the traumatic event (Courtois & Ford, 2013). This is not as simple as discussing the memory, but rather an intentional process of bringing the client’s awareness to the memory via the body-mind connection (Courtois & Ford, 2013; van der Kolk, 2014). By reexamining the memory and its associated affects, desensitization aids the individual in reducing their reactions to specific emotions and sensations (van der Kolk, 2014). This phase requires careful plans made by the clinician to ensure that the client stays within their window of affect tolerance. Since it is expected and necessary that affects become aroused in this phase, it places the client at risk for decompensation. Decompensation is the point at which the client regresses to unhealthy coping methods or shuts down (Courtois & Ford, 2013). The safety and calming strategies introduced and developed in the primary phases provide the precautions to mitigate this risk. Remembering that many of the symptoms associated with complex trauma
(particularly the dissociative ones) are in place to protect the client from distressing affects, clients must be informed and prepared to confront their emotions and sensations.

Generalizing treatment responses follows the desensitization phase (Courtois & Ford, 2013). The goal is to consolidate treatment gains by challenging and guiding the client to apply their new learning to present-day functioning and future scenarios. The client is no longer just a distressed survivor restricted by avoidant behaviors, maladaptive coping mechanisms, and low self-esteem, but rather an individual with increased self-awareness, healthier self-esteem, enhanced mindfulness, who is more capable of learning to respond to challenges and make more effective decisions. This intentional process may require a redefinition of self, social, and familial identities, or radical shifts in behavioral patterns once associated with their traumatic past. Whatever the case may be, this phase focuses on self-knowledge and understanding in context (Courtois & Ford, 2013).

Current literature consistently endorse the use of phase-oriented treatments that include a focus on stabilization, safety, desensitization, and reorientation to the present and future. There appear to be an abundance of treatment approaches to support the stabilization, safety and desensitization phases of treatment (Courtois & Ford, 2013). By contrast, there is a lack of clinical attention to the reorientation phase of treatment with the exception of EMDR which is considered one of the most robust treatment choices for desensitization (Courtois & Ford; 2013; van der Kolk, 2014).

**EMDR: The Treatment of Choice**

Based on the current literature a trauma-informed approach must include phases that address the multiplicity of challenges presented during treatment. Eye Movement Desensitization refers a robust protocol-driven and phase-approached treatment structure.
Three researchers reported on cortisol changes in rape victims following EMDR and prolonged exposure (PE) therapy (Gerardi, Rothbaum, Astin, & Kelley, 2010). When a stress response is initiated similar to behaviors associated with PTSD – certain hormones are activated in response that result in the release of glucocorticoid (cortisol) from the adrenal cortex into the bloodstream. When PTSD is acute or chronic, alterations in cortisol patterns appear (Gerardi et al., 2010). Depressed or chronically traumatized individuals show a suppression in cortisol levels in response to stress. This suppression interrupts the hypothalamic-pituitary-adrenal (HPA) negative feedback loop that alerts the individual to act in the face of danger. This correlates with the study previously discussed which revealed that individuals with chronic or childhood trauma develop different neurological patterns associated with dissociation in response to stress. The results of the study conducted by Gerardi et al. (2010) indicate that both treatments affected the dynamic action of the HPA axis. Following the treatment which involved processing the event on an emotional and cognitive level, participants no longer avoided the traumatic event as evidenced by the reduction of the cortisol suppression response (Gerardi et al., 2010). This suggests that EMDR and PE might influence neuroendocrine patterns in response to stress.

Other studies have shown that EMDR is as effective as trauma-focused Cognitive-Behavioral Therapy (TF-CBT) at reducing PTSD symptoms such as flashbacks, nightmares, and other subjective distress. Unique to EMDR is its ability to decrease distress in fewer sessions, and the stability of effects remain stable up to 35 months after treatment (Roman, 2010). Leenarts’ et al. (2013) systematically evaluated psychotherapeutic treatments for children who are victims of childhood maltreatment. The treatments examined were EMDR, TF-CBT, cognitive-behavioral therapy (CBT), art therapy, child-parent psychotherapy (CPP), and a host of other less well-known therapies. Though the results indicated that TF-CBT was more effective at
treating children with trauma, studies reviewed by the researchers indicated that in addition to a significant reduction in memory-related distress and problematic behaviors, with a trend toward a decrease in post-traumatic stress symptoms, EMDR was able to reach these results in a relatively small number of sessions (Leenarts et al., 2013).

Although EMDR and TF-CBT are considered to be virtually equivalent in their effectiveness at reducing posttraumatic stress symptoms, EMDR shows significant effect-size on subjective distress and other comorbid conditions (Chen et al., 2014). Since clients with complex trauma do not complain primarily about flashbacks and nightmares, but rather with subjective distress associated with anxiety and depressive disorders, the results of this study and others suggests that EMDR is a first-line psychological treatment for this population (Chen et al., 2014; Kar, 2011).

Van der Kolk et al. (2007) examined the effects on three separate client groups treated respectively with 1) EMDR, 2) fluoxetine, and 3) placebo. Each group evidenced improvement at the completion of the eight-week study. At a six-month follow up the EMDR group continued to improve mildly with 57% of them becoming asymptomatic, and the fluoxetine group lost some of its gains with zero percent of them becoming asymptomatic (van der Kolk et al., 2007). The EMDR group’s symptom reduction was not confined to PTSD symptoms alone. Those who initially scored with any significance on the Beck's Depression Inventory (BDI) showed substantial reduction in their scores upon completing treatment. This study revealed that treatment effects were also influenced by the type of trauma (childhood onset trauma verses adult onset trauma). Although EMDR showed positive treatment effect for both groups, it showed a significant reduction in effect for those traumatized in childhood (van der Kolk et al., 2007).
Of particular importance from this study is the effects that EMDR evidently has on the symptoms of depression and other comorbid conditions. This treatment effect was examined in a separate quantitative meta-analysis in which researchers investigated the effects of EMDR on the symptoms associated with PTSD (Chen et al., 2014). The symptoms included those associated with depression, anxiety, and other subjective distress as identified by the individual. When depression, anxiety, or subjective distress accompanied PTSD the results revealed that EMDR showed significant efficacy in reducing the associated symptoms.

The results from all of these studies reveal that EMDR influences neurobiological responses as well as pathological and behavioral responses to traumatic stimuli that are modulated by one’s personality. This is important for complex cases because these individuals do not often present with PTSD symptoms, but rather struggle with other related symptoms. Chen et al. (2014) reinforced the notion that the AIP model, inherent in EMDR, addresses factors related to pathology and personality when they stated that, "EMDR therapy can improve self-awareness in patients, change their beliefs and behaviors, reduce anxiety and depression, and lead to positive outcomes" (p. 15). This is good news for complex trauma survivors and their practitioners.

**EMDR**

Eye Movement Desensitization and Reprocessing, created by Francine Shapiro, Ph.D., is an integrative psychotherapeutic approach, comprised of guided theory, principles, and mechanisms. The theory it is based upon is referred to as *Adaptive Information Processing* (AIP) (Hensley, 2012). The AIP model describes the theoretical framework and principles of EMDR treatment (Hensley, 2012). It asserts that, similar to the body’s self-healing process, there exists a corresponding psychological self-healing process (Hensley, 2012). Using the mechanism of
eye movements, the individual reflects on their presenting problem via a three-pronged approach. The three prongs include: the effects of past traumas, triggers from the present, and concerns for the future. These three: eye movements, AIP, and the three prongs of treatment, are the emphasis of the following sections.

**Eye Movements**

Eye Movement Desensitization and Reprocessing is known for its use of bilateral stimulation (BLS), usually eye-movements (EMs), in reprocessing negative memories. Although there has been some debate and controversy regarding the necessity of EM’s or bilateral stimulation in treatment, recent studies support the notion that these are a necessary component of treatment (Herkt et al., 2014; Lee & Cuijpers, 2013; van den Hout et al., 2010). Three prevailing hypotheses regarding the proposed mechanism of EM’s on effective treatment outcomes have been supported by research (Shapiro, 2014). These hypotheses include that the eye movements: tax working memory (WM), elicit an orienting response, and link into the same processes that occur during rapid eye movement (REM) sleep (Shapiro, 2014).

**Working memory.** Dr. Shapiro (2014) cites 20 randomized controlled trials that revealed in addition to decreased arousal, negative cognitions, and imagery vividness, BLS increased attention flexibility, memory retrieval, and recognition of true information. This speaks to how BLS assists in creating *dual awareness* during reprocessing. Dual awareness is the mechanism that describes a client’s ability to keep their awareness of the present as they simultaneously look back on distressing material from the past. Since dissociation and depersonalization are so prevalent in complex cases, the ability to increase dual awareness, sometimes referred to as *dual attention*, is imperative for maintaining a sense of safety for the client.
The first hypothesis asserts that BLS taxes working memory (WM). When recalling memories, WM resources are limited (van den Hout et al., 2010). This speaks to the arousal present in recalling memory. Though WM limits the capacity to recall memories for those with complex trauma, reflecting back on memories can induce distressing affect (van den Hout et al., 2010). When a secondary task is introduced during recall it disrupts the storage of information resulting in a reduction of episodic quality (Lee & Cuijpers, 2013). This means the client has less capacity to retrieve the information (van den Hout et al., 2010). During EMDR treatment the secondary task of EM’s taxes WM capability thus allowing the client to recall their memories with less vividness and affect arousal.

Clinical findings also point to decreased vividness and arousal when eye movements are present (Herkt et al., 2014). Dual attention tasks may help to decrease the emotional aspects of the memory because it taxes WM. In a study that investigated the neurobiological correlates of bilateral stimulation via EMDR on a group of healthy subjects, researchers demonstrated "that the specific element of the method, i.e. the bilateral alternating stimulation has a distinct neurobiological effect on negative emotion processing" (Herkt et al., 2014, p. 4). They contend that their results dispute previous statements that suggest bilateral stimulation may be an inessential feature of the therapy (Herkt et al., 2014).

**Orienting response.** The second hypothesis asserts that bilateral stimulation (BLS) is the mechanism by which orienting responses (OR’s) are created. Orienting responses help the individual integrate negative experiences with positive emotions and cognitions (Chen et al., 2014). To better understand this it is important to note that an individual also has defensive responses (DR’s) and startle responses (SR’s) (Bergman, 2010). The DR’s and SR’s are considered sympathetic in nature and produce a higher heart rate (HR), increased sensitization,
and the enhancement of readiness for action. Orienting responses are considered parasympathetic in nature and produce lower heart rate, input enhancement of attention and information processing, and promote habituation (Bergmann, 2010). Bilateral mechanisms help the individual stay calm, present, and increases adaptive information processing.

**Rapid eye movement (REM).** Van der Kolk (2014) cited an article published by the journal *Dreaming* suggesting that EMDR is related to REM sleep. During REM the eyes move back and forth rapidly. This is similar to the EM’s in EMDR. Research correlates mood regulation with dream sleep. That is, the more time spent in REM sleep, the more depression is reduced, whereas the less time spent in REM, the less depression is reduced (van der Kolk, 2014). During both deep sleep and REM sleep, the brain reviews the events of the past by increasing emotionally relevant information while allowing irrelevant material to dissipate. The sleeping brain may be able to make more sense out of confusing experiences than the waking brain. Dreams help to forge new relationships between what appears to be unrelated. These new relationships are the brain’s way of integrating new information into the larger memory system. Current studies suggest that the mechanisms in EMDR that include holding the memory in mind while following the clinician’s fingers (back and forth), reproduces what happens in dream sleep (van der Kolk, 2014).

Complex PTSD is also associated with interrupted sleep patterns. Van der Kolk (2014) observed that veterans with PTSD often woke themselves up shortly after REM sleep began. This presents in their sleep patterns since for many REM activates a trauma fragmented by during a dream (van der Kolk, 2014). Since the brain of those with complex trauma is in the habit of avoiding distressing affects, it does the same thing in sleep and pushes them away by
going into a wake cycle. This evidence supports the neurobiological studies that reveal the use and purpose of dissociation in the pathology of complex trauma.

Dissociation presents a challenge for reprocessing memories. A prerequisite for the decreased subjective distress of complex trauma is that there is increased emotional affect in the initial stages of reprocessing (Herkt et al., 2014). In order for bilateral movements to be effective, the client must be able to tap into portions of the emotional aspects of the distressing memory (Hensely, 2012). In EMDR circles it is often said that “in order to heal, one must feel” (Shapiro, 2014; Shapiro, 2001; Hensely, 2012). Coming into contact with distressing emotions is especially challenging for those with complex trauma. Eye movements are the mechanisms that aid in rapid processing of memories as well as mitigating the effects of over-stimulation that leads to decompensation. In addition, EMDR includes practical insights and techniques to help clients with avoidant tendencies to come into contact with their emotions. Working within the client’s “window of tolerance” promotes safety and aides in increasing limbic activation thus producing more effective results (Shapiro, 2016).

**Adaptive Information Processing (AIP)**

In her article, Barbara Hensley (2012) provides an example for understanding the AIP model. When an individual has a splinter stuck in their finger, the body has a built-in response to heal the area of injury. Healing is impeded by the obstruction of the splinter. In order for healing to resume the splinter must be removed (Hensley, 2012). It is similar in the mental process. The AIP model asserts that inherent in the information processing system is the tendency to move toward a state of health. For example, if something mildly disturbing occurs, the individual processes it throughout the day by thinking it over, talking about it, or sleeping on it. What one usually discovers is that due to these processing efforts they are no longer
ruminating on the problem. They have resolved the problem and moved on from it (Hensley, 2012). The distress associated with the event has been alleviated because it has been metabolized by the adaptive information process (Shapiro, 2014; Shapiro, 2001).

Understanding the premise of EMDR from an AIP framework is essential in conceptualizing and considering whether or not this treatment approach is appropriate for the client’s presenting problem (Hensley, 2012). If EMDR proves the appropriate treatment of choice, then the understanding of dysfunction assumed by this model should be used to educate the client about their symptoms and the reason why EMDR has the potential to help them. The clinician’s clear understanding of the AIP and the client’s general understanding of its treatment effects is imperative before proceeding with treatment (Hensley, 2012).

Eye Movement Desensitization and Reprocessing has been described as a complex procedure that, even apart from eye movements, creates a holistic therapeutic benefit (Lee & Cuijpers, 2013). Throughout its eight phases it includes processes such as: mindfulness of the trauma, cognitive restructuring, and an increased sense of personal mastery (Lee & Cuijpers, 2013, p. 237). Should any of the phases be excluded in treatment, leading EMDR practitioners including Shapiro and the *Eye Movement Desensitization and Reprocessing International Association* (EMDRIA) assert that it cannot be considered EMDR (Hensley, 2012). Each phase is considered essential for treatment and should be followed by practitioners.

**Three-Pronged Approach**

In this treatment, clients are directed to discuss and identify the past disturbances, present triggers, and future concerns related to their presenting problem (Hensley, 2012). These are the three prongs of treatment that ensures a balanced focus that leads to success. These building
blocks – the past, the present, and the future – constitute the ingredients of this treatment that build momentum over time contributing to the client’s ultimate healing (Hensley, 2012).

While treatment of single incidents requires the basic EMDR protocol, current literature and training materials suggest that complex presentations of trauma require a comprehensive treatment approach. Non-complex cases generally focus on a single presenting problem, and the memories are targeted and reprocessed in light of the three-pronged protocol. Reprocessing is done for the past trauma, present triggers, and future concerns. In complex cases there are generally multiple presenting problems. For example, an individual may present with panic attacks, flashbacks, interpersonal problems, and an eating disorder. These symptoms must be prioritized by assessing which among them will, by alleviated first, most promote the client’s immediate stability and functioning. As the client’s immediate functioning improves, additional symptoms may become the focus of treatment as the client continues to move toward overall wellness.

**Phases of EMDR Treatment**

**Phase One: History Taking and Treatment Planning**

This phase involves assessing the case systemically as well as individually. From gathering information about the client’s specific problem, to gathering data about his or her family of origin, daily routine, attachment style, the history should be comprehensive and thorough. This involves considering how genetics, environments, and experiences play a role in the presenting problem of the client (Shapiro, 2009).

Assessing whether or not a client is genetically predisposed to conditions that would make them more or less vulnerable to the symptoms they are currently experiencing is important (Shapiro, 2009). This information can be gathered through direct questions or asking the client
to report regarding their family health history and the patterns they have seen among their family members (Shapiro, 2015). This portion of the assessment should also include information regarding the condition their mother was in during her pregnancy with them, and whether the birth was normal or complicated. The answers to these questions may provide clues as to whether or not the client may have been flooded hormonally during prenatal development, endured a trauma, and how these experiences may have affected the client genetically (Shapiro, 2009).

Assessing the client’s environment includes exploring what the emotional and psychological atmosphere was like during their childhood, adolescence, and onward (Shapiro, 2015). The environments assessed should include home, daycare, school, and work settings. Discussing the prenatal environment is important as well and should include whether or not their mother was involved in any traumatic or life-altering experiences when she was pregnant. Gathering data regarding influential experiences is included in this phase of treatment as well. It is important to invite the client to report on family moves, deaths, illnesses, job changes, and any other experiences that stand out to the client. These provide helpful insights regarding what a client can recall, what they might be avoiding, and where trauma may have originated (Shapiro, 2015).

Gathering this information in EMDR treatment aids the clinician in understanding the origin of faulty beliefs and the subsequent environments and experiences that reinforced these beliefs. Based on the AIP model, individuals accumulate experiences throughout life that set the foundation for their sense of self (Shapiro, 2007). When an individual is raised in an adaptive environment they develop flexibility and are able to learn from both positive and negative experiences. When an individual is raised in an insecure or invalidating environment they
develop inflexible concepts that restrict the individual from learning from their experiences (Shapiro, 2007).

For complex cases this phase is important and will likely require more time than a client with other symptom presentations (Shapiro, 2016). Gathering thorough data genetically, environmentally, and developmentally, will help to gain knowledge of the clients’ upbringing and whether or not their case is complex. It is important to watch for emotional flooding as they report on their histories, and careful consideration should be given regarding how this can be an activating experience for the client (Shapiro, 2016). This may be tempered by inviting the client to give “headline” descriptions of the situations that were distressing for them to recall and then encouraging them by pointing out that it is not necessary to go into detail about these experiences for the treatment to be effective.

One additional area that should be discussed in more detail during history-taking with a complex case is the clients’ attachment style (Shapiro, 2016). A clinician, not trained in attachment theory, can gather a fair amount of information about the client by inviting them to describe the dynamics of the relationship they had with each of their parents (or with a specific caregiver). Clients may be inclined to describe their parent’s characteristics, but what is more important is to understand how they saw their connection with their parents. Clinicians are encouraged to include questions in their interview that touch on these, and similar subjects, to gather a broad, yet detailed, idea of what the client’s attachment style is like.

The results of this phase provide clues for the clinician regarding the development of maladaptive neural networks that reinforce these negative perceptions of the self (Shapiro, 2016; Shapiro, 2015; Shapiro, 2001). Once this conceptualization has formed, the clinician begins to develop a treatment plan. This involves identifying the target memories that initiated the
negative neural networks. Based upon the thoughts, feelings, and body sensations associated with the presenting problem, the client is asked to recall through direct reporting the earliest time they felt this way. If they cannot remember anything, the clinician can use an “affect scan” or “affect bridge” technique in which the client is asked to recall the most recent time they experienced their presenting complaint. Once this has been identified the clinician encourages the client to use this experience, and its associated affects, to identify an earlier (earliest is most desirable) time they remember experiencing this. This is the “touchstone” memory and should be targeted first for reprocessing later in treatment. The client is also encouraged to identify the memory in which they experienced their symptoms at their worst. This is considered the “worst” memory and should be targeted following the touchstone memory. It is important to note that in EMDR, the clinician encourages the client to provide brief descriptions of the events and are not required, nor encouraged, to go into detail about them. This is beneficial for clients who are easily aroused or dysregulated when recalling painful memories. The purpose of this phase is to document what memories will be targeted in the reprocessing phases of treatment. Since details are not required, EMDR allows for flexibility for those who cannot discuss their memories, because they can provide a single word or phrase to identify them and from this the clinician documents the word or phrase associated with the memories (Shapiro, 2016; Shapiro, 2015; Shapiro, 2001).

**Individual Psychology in phase one.** The focus of this phase of treatment is history-taking, assessment, and treatment planning. The concepts and techniques of IP provide options to support this phase of EMDR therapy. For this phase of treatment, the Adlerian lifestyle interview and the five life tasks are useful.
Lifestyle interview. Eye Movement Desensitization Reprocessing encourages clinicians to gather information regarding the client’s genetics, environments, and experiences in order to more fully understand their presenting problem and to create an appropriate treatment plan. This focus mirrors the biopsychosocial approach of IP. Adlerian practitioners, Robert Powers and Jane Griffith, in an interview documented and published by The Journal of Individual Psychology asserted that “Adler also thought that not only is the individual not to be divided up, he’s not to be seen as apart from his context either” (Rasmussen & Watkins, 2012, p. 115). It is clear that both psychotherapies emphasize that history-taking must be comprehensive and seen as an influence in the clients’ pathology.

Eye Movement Desensitization and Reprocessing, by virtue of its protocol-driven phases, may unintentionally divert attention away from seeing the individual holistically. The lifestyle interview is an assessment instrument that integrates into Phase 1 of EMDR treatment to facilitate and reinforce a biopsychosocial conceptualization of the individual. This Adlerian assessment instrument, in its original form, is known to be lengthy and may seem overwhelming for a clinician to utilize in EMDR. The interview can be adapted to meet the immediate requirements for conceptualizing a case.

The lifestyle interview provides a useful foundation from which to derive initial interview questions leading to a holistic framework for treatment. The usefulness of the lifestyle interview does not end there but, instead, offers clinicians an opportunity to gather information regarding attachment style that is important data in complex cases. Peluso, Peluso, Buckner, Kern, and Curlette (2009), provide an empirical analysis of the underlying similarities between attachment theory and the IP lifestyle. They assert that whereas attachment theorists believe individuals carry similar attachment patterns from childhood into adulthood, Adlerian theorists believe that
lifestyle consists of self-governing strategies used to move through life that develop in childhood and remain stable throughout adulthood (Peluso et al., 2009).

Their analysis provides additional information concerning how these constructs share similarities supporting the use of the lifestyle to gain an understanding of the client’s attachment history and role. Clinicians are encouraged to develop their understanding of attachment through the use of the lifestyle assessment and to include this in the history-taking and treatment planning phase of EMDR therapy.

Five life tasks. For many with complex trauma the simple task of identifying what they want to work on in therapy can be overwhelming. Their symptoms tend to effect multiple, if not all, areas of their lives. Utilizing the neo-Adlerian formulation of the five tasks of life provides an additional tool to use in the interview to gain a better understanding of the most problematic areas of the client’s life.

Following from the concept of social interest, the life tasks were originally identified by Adler as: love, friendship, and work (Foster, Steen, O’Ryan, & Nelson, 2016). Two additional life tasks, originally proposed by Mosak and Dreikurs based upon consistent themes that Adler wrote about, include one’s relationship with oneself, and one’s relationship with the transcendent (Foster et al., 2016). Though these tasks have been added to, or classified as, major and minor by other practitioners (Hawes & Blanchard, 1993), the original three and additional two make up the five main life tasks that will be discussed.

Most individuals are keenly aware of their responsibilities in life yet struggle with the awareness of their perceived incompetence in specific areas. This often leads to presenting problems such as anxiety and depression or other symptoms. The gap between one’s self-
concept (how one sees oneself) and one’s self-ideal (how one thinks they should be) can provide clinicians and clients alike with a better understanding of why the individual is struggling.

Brokaw (2015) proposed an indirect method for gathering information concerning the client’s self-concept and self-ideal in each of the five life tasks. The client is asked to rate their satisfaction in each of the five life tasks on a scale of one to 10, with one being extremely dissatisfied and ten being extremely satisfied. Based on these client ratings the clinician identifies the areas that are rated strongest in satisfaction and asks the client to identify the strengths that contributed to satisfaction in these areas (Brokaw, 2015). This fosters encouragement which appropriately reflects the strengths-based approach that IP emphasizes in psychotherapy.

Once strengths have been acknowledged, the clinician identifies the two life tasks that were rated by the client as dissatisfying (Brokaw, 2015). The client is asked to explain why they are dissatisfied in these areas, and what the contributing factors leading to the dissatisfaction are. The clinician then asks the client what would need to happen in order for them to, one day, give this life task a rating two digits higher. Should the client have difficulty identifying what would need to happen, the clinician can draw from the strengths identified earlier and ask them how they could apply those strengths to increase satisfaction in that specific life task (Brokaw, 2015).

The use of the life tasks for assessment in this manner raises the client’s awareness of their creative capacities. This is helpful for clinicians and clients alike. For clinicians this provides an opportunity to take into account the creative ingenuity that is unique to the individual (Chandler, 1991). It provides clues to the client’s movement. For the client it provides an opportunity to tap into the personal power that originates in their creative ability.
Formative assessments are meant to provide feedback in an instructional way. Not just limited to initial assessment, the life tasks can also be used as a formative assessment to measure therapeutic effectiveness and promote additional change throughout treatment. Clark (2011) discusses the history and development of formative assessment, their usefulness, and drawbacks in educational settings for children. Feedback is information regarding how to perform the task more effectively. In his discussion he outlines the results of a meta-study that showed higher effect sizes of change when students were provided instruction from formative assessments, and far lower effect sizes of change when students were given praise, reward, or punishment (Clark, 2011). Students improve more when they receive feedback in an instructional way verses feedback using positive or negative reinforcement.

Though the five life tasks are not considered a formal formative assessment, it is possible that clinicians can use this approach in an informal manner in treatment. Doing so provides an ongoing point of accountability for the therapeutic dyad that fosters discussion regarding what is, and is not, working in treatment. Clinicians draw guidance concerning treatment strategies and treatment plans, while clients gain feedback that instructs them concerning ways they can improve in the life-task in question.

**Phase Two: Preparation**

In phase two of EMDR treatment clinicians focus on preparing the client for the reprocessing to come in phases three through five. The emphasis is on creating a therapeutic alliance, establishing client stabilization, psychoeducation regarding EMDR, and addressing any concerns the client has regarding treatment (Shapiro & Laliotis, 2011; Dworkin & Errebo, 2010;
Shapiro, 2001). A thorough informed consent process for EMDR involves the understanding that there may be emotional disturbances that arise during, and following, treatment (Shapiro, 2001). By discussing this with the client it allows them ample opportunity to adjust work and social schedules to accommodate any need for self-care to appropriately cope with any emotional disturbances.

Complex trauma stabilization requires that the client learn, and become proficient at, relaxation and grounding techniques to increase their ability to access positive personal resources (Darongkamas, Kiely & Walker, 2016). Relaxation and grounding can be thought of as emotion regulation. EMDR encourages the use of guided imagery, deep breathing, and other distress-tolerance techniques to help the client return to, or maintain, emotional stabilization.

To access positive personal resources EMDR offers the client the option to install a calm or safe place (Shapiro, 2016; Shapiro, 2015). It should be noted that clients with complex trauma may not respond well to words such as “safe” and “calm”, so “peaceful” is often used in their place. The installation of the “peaceful place” is the first experience that the client has with bilateral stimulation. The client is asked to identify a real or imagined place that fosters sense of peace and tranquility for them. With the use of bilateral stimulation this is installed and enhanced. The client gives their peaceful place a name or verbal cue, and bilateral stimulation is used to enhance the cue-word and associated positive feelings. This technique can be applied to any personal strength that the individual may need to access. The client recalls a time in their life when a specific strength or characteristic stood out to them and, with bilateral stimulation, continues to recall the situation and associated positive feelings. From this they identify a cue-word associated with this memory and enhance it through further bilateral stimulation. The client is directed to practice using their cue-words during times of emotional distress, and to
notice any shifts that occur. While the cue-words are not expected to eliminate distressful feelings altogether, they are meant to moderately reduce symptoms while enhancing the overall effectiveness of other stabilization techniques when used in conjunction with them. Generally this is given as homework for the client to practice every day between sessions (Shapiro, 2016; Shapiro, 2015).

This specific technique can be generalized to installing other types of resources. Each client will be able to identify which approaches work for them, and are encouraged to practice them daily to reinforce learning and enhance overall stability. Clients must be able to eliminate moderate levels of disturbance with these techniques before proceeding to the reprocessing phases of treatment (Shapiro, 2001).

**Individual Psychology in phase two.** This phase provides opportunities to draw from the techniques and concepts of IP. The focus of this section is to present Adler’s thoughts about encouragement in strengthening the therapeutic alliance, the use of early recollections in identifying strengths and resources, and the concepts of the *creative self* and *the hesitating attitude* in understanding and addressing the secondary elaborations that block progress.

**Encouragement.** Eye Movement Desensitization and Reprocessing practitioners and authors assert that a strong therapeutic alliance cannot be overemphasized and is considered a prerequisite for effective treatment, but there is little attention devoted to this topic in the literature and training materials for EMDR (Shapiro & Laliotis, 2011; Dworkin & Errebo, 2010; Shapiro, 2001). The additional time devoted to developing the therapeutic relationship is imperative, especially in complex cases, and for clients with insecure attachment patterns (Dworkin & Errebo, 2010). Although EMDR may be one of the therapies that does not require as much emphasis on the relationship in order to attain effective treatment outcomes, for
complex cases it is clear that attunement and resonance are critical for healing trauma (Dworkin & Errebo, 2010).

Darongkamas, Kiely and Walker (2016) discussed the integration of Cognitive Analytic Therapy (CAT) with EMDR and how each approach can support and complement the other. Of significance is the apparent lack of discussion in EMDR training regarding the importance of the therapeutic relationship. According to the EMDR literature, a good therapeutic relationship is considered a prerequisite to effective treatment outcomes in EMDR, but Darongkmas, Kiely and Walker (2016) suggest that CAT offers an additional complementary intra- and interpersonal structure, implying that EMDR comes up short in this area.

"The potential for a good-enough therapeutic relationship cannot be assumed to be sufficiently present" (Darongkamas, Kiely, & Walker, 2016, p. 7). This cannot be stressed enough for complex cases. The potential for relational ruptures, non-compliance, and dropouts increases considerably due to the interpersonal nature of much of the symptomology of these clients. Eye Movement Desensitization and Reprocessing is considered a comprehensive treatment approach, according to Francine Shapiro, and non-compliance is considered part of the pathology but not reflective of the interpersonal dynamics of the therapeutic relationship (Darogkamas, Kiely & Walker, 2016). The EMDR community has done well to expound on Shapiro's original work by developing the notion that, in EMDR treatment, attention and attunement to the therapeutic relationship is helpful in managing therapeutic relational ruptures, and aids in reducing noncompliance and drop-outs (Darogkamas, Kiely & Walker, 2016; Dworkin & Errebo, 2010). They assert that the therapeutic relationship is a necessary agent through which treatment strategies can effectively facilitate developmental healing (Darogkamas, Kiely & Walker, 2016; Dworkin & Errebo, 2010).
Clients with complex coping strategies, such as dissociation, can benefit from a sound therapeutic relationship in an augmented way. Healthy therapeutic interactions, such as the resolution of disagreements or the effective management of relational ruptures, can be installed as coping skills. It is suggested that this type of resource can decrease the transference of negative aspects of the self still stuck in the past (Darogkamas, Kiely & Walker, 2016).

It is clear that EMDR can benefit from considering other psychotherapies that emphasize the role of the therapeutic relationship. Individual Psychology offers a robust framework for this need. The following emphasizes the Adlerian concepts of the creative self and encouragement within the context of the therapeutic relationship.

In discussing schizophrenia, which Adler saw as the highest form of isolation, the client can be won back “only by patience and the kindliest and friendliest manner” (Ansbacher & Ansbacher, 1956). He went on to say that, for some, courage comes through consistent visits and dialogue. This may be met with some resistance because courage can be difficult to handle for the individual who has had little experience with it. Remaining consistent and non-threatening is important as the client learns to adapt to an environment that promotes their courage (Ansbacher & Ansbacher, 1956). The expectation is that they will eventually begin to understand what to do with courage within the therapeutic setting, and apply this to real life experiences.

In order to increase cooperation and collaboration with a client, the clinician works to develop and maintain an equalitarian therapeutic relationship (Main & Boughner, 2011). The clinician must consider himself or herself a coworker of the client, and minimize any sense of superiority and authority (Ansbacher & Ansbacher, 1956; Main & Boughner, 2011). Instead, the clinician employs a posture of friendliness, attunement, attention, and cool-headedness. The clinician is acutely aware that the person they are interacting with cannot offer this in return and
should anticipate the many up’s and down’s that may persist throughout the course of treatment (Ansbacher & Ansbacher, 1953; Main & Boughner, 2011).

The Adlerian concept of encouragement can take different forms, but for the purposes of treating complex trauma it is demonstrated in the friendly and non-threatening manner of the clinician, and in the atmosphere created in the sessions that allows the client to experience this on a consistent basis. This is especially important for those with complex trauma as many present with personality disorders that, by definition, suggests that they have had little experience with positive interpersonal interaction.

_Early recollections_. In EMDR treatment the processing of negative memories is necessary to dissipate their power in the present. Looking back on traumatic memories can be especially difficult for clients with complex trauma. For many, the purpose of their dissociative symptoms is to avoid becoming flooded by distressing emotions. To ask them to intentionally confront the experiences that instigated their current dysfunction can seem insurmountable. This requires a high level of courage and strength, both of which are not easily in evidence with this client population. Paradoxically, it is not the case that they do not possess either, but they have been lead to believe that they lack them. Bringing this to light in therapy is essential to empowering the client to process negative memories later in treatment.

A strengths-based approach to therapy is essential to promoting the development of these capacities. In recent years there has been a shift in the focus of the research and practice in psychology from a framework of disorder and dysfunction, to one of well-being, strengths, and positive mental health (Coulter, 2014). Stephen Coulter (2014) includes well-being, salutogenesis, coherence, quality of life, and resilience, among strengths-based approaches. He
references their effects on treatment for psychological trauma and provides a critique of the current evidenced-based treatments.

According to Coulter (2014) Solution-Focused Brief Therapy (SFBT) and Narrative Therapy (NT) are identified as the most effective treatments for childhood psychological trauma within the context of systemic family therapy. Solution-Focused Brief Therapy specifically focuses on “solution talk” by exploring “exceptions” that have the potential for revealing the client’s solution(s) to their presenting problems. Narrative Therapy asserts that people are moving through their lives under the assumption that they are failures based upon socially-constructed narratives that reinforce this misconception (Coulter, 2014). Within that narrative, however, are the hidden threads of the individual’s resilience and strength. The purpose of this approach is to facilitate the client in re-authoring his or her life by highlighting these characteristics of hope and change (Coulter, 2014).

Solution-Focused Brief Therapy and Narrative Therapy have a special application for trauma recovery. Solution-Focused Brief Therapy maintains a positive and solution-focused attitude throughout its interview questions and subsequent techniques. This helps to reorient the individual toward a positive future and catalyzes a sense of hope and empowerment (Coulter, 2014). Narrative Therapy approaches trauma by highlighting specific features of the therapy. Trauma is an event that occurs within the current narrative framework of the individual. When re-authoring, clients are encouraged to closely and carefully reexamine their narrative of the event. Actions or responses of resilience and strength, which were not included in the initial narrative due to the intrusive symptomology of the trauma, are identified in this process. This process of self-awareness often surprises clients and reorients them to the strengths they possess in the face of difficulty (Coulter, 2014).
There are drawbacks to these approaches in that they can overlook the deep impact of trauma on the individual, but it is clear that a strengths-based approach to treating trauma can enhance current methods. Reorienting a client’s awareness to their strengths is important for recovery because they struggle with a sense of disempowerment that traps them in a cycle of maladaptive behavior. Strengths-based approaches disavow the belief in “helplessness” in the client and helps to reorient them to their own attempts to reclaim their lives in light of such opposition (Coulter, 2014).

Adler’s discussion of healthy verses unhealthy lifestyles is often conceptualized based on the client’s responses to the challenges faced in fulfilling the demands of the life-tasks (Matheny & Curlette, 2010). Someone with a healthy lifestyle will respond to these challenges with courage and confidence and someone with the neurotic lifestyle will respond to these challenges with indecisiveness and hesitation. The former results in an individual who is contributing to the common social good and experiences a sense of purpose and well-being; the latter results in an individual who withdraws and avoids socially constructive behavior experiencing anxiety instead (Matheny & Curlette, 2010).

The neurotic lifestyle generates coping patterns that keep people preoccupied with avoiding defeat resulting in stressful reactions (Matheny & Curlette, 2010). As Adler would likely suspect, these individuals do not lack these capabilities, but rather their coping mechanisms inhibit their ability to see them. It becomes the role of the clinician to facilitate the client’s recognition of the signs of adaptive functioning. One of the most effective, collaborative, and non-invasive ways to do this is through the use of early recollections (ERs).

Early Recollections are stories or events told by the client that are helpful for understanding how he or she perceives the world, others, and him- or herself (Mosak & Di
Adlerian theory posits that memories prior to the age of 10 are filled with projections of the self on portions of the narrative. This is because most people do not have continuous memory from this stage of their life, so they alter the memories by projecting material onto it. In an attempt to keep it coherent to the storyteller, people tend to unconsciously attach or project details, feelings, and beliefs onto the recollection (Mosak & Di Pietro, 2006).

Adlerian practitioners consider it normal and expectable that people tell their stories in this manner. The gaps they fill in with their projections provide clues and hints as to the individual’s personality. While there are many different ways to gather different types of data from ER’s, for the purposes of integrating this Adlerian technique with EMDR treatment for complex trauma, they can be used as a strengths assessment. That is, in reviewing the narrative with the client the focus is on uncovering the strengths of the client in the narratives they share from their childhood. There is no specific protocol identified for this type of ER, it can be as simple as reviewing an early recollection by breaking it down phrase-by-phrase to examine it for movement that highlights signs of strength and resilience.

Matheny and Curlette (2010) review the use of a measure that is based on Adlerian principles of strengths identification. The *Coping Resource Inventory for Stress-Short Form* (CRIS-SF) was designed to comprehensively measure resources for successful adaptation. Whereas many coping measures assess for *coping responses*, this assessment focuses on identifying *coping resources*. Coping resources are considered factors in place before stressful events occur that can be accessed in order to manage the stressful event (Matheny & Curlette, 2010). Coping responses are the factors in place following a stressful event that are used in reacting to a stressful event. Since the fear of reoccurrence is pervasive in this population, identifying coping resources (strengths) from which they can draw can empower clients to move
forward. This has the potential for moving the client from an avoidant response, as described in the “hesitating attitude”, to an engaging response characterized by “social interest.”

Early recollections can be used in much the same way as this measure. Identifying the characteristic strengths and resiliencies in a client’s narrative may augment the clinical utility of this tool. The process of acquiring ER’s promotes the relationship of the therapeutic dyad through conversation, increases the client’s awareness of their creative capacities, and sets a therapeutic precedent that treatment will focus on drawing from a mental health framework verses a dysfunctional one.

Phases Three through Seven: Reprocessing

Phases three through seven of EMDR occur within one 60 to 90 minute highly interactive session (Shapiro & Laliotis, 2011). Reprocessing of a targeted memory takes place and may require up to three sessions to complete. A target is consider fully reprocessed when the distress associated with the memory is reassessed by the client as being ecologically sound within the body and mind (Shapiro & Laliotis, 2011).

Phase three: assessment. In the assessment phase the clinician refers to the treatment plan and recalls the memories that were targeted from the presenting problem. Each presenting problem can have multiple memories associated with it (Shapiro, 2015). Of primary importance to target are the touchstone memory or earliest memory, and also the worst memory. Additional memories may require reprocessing, but clients discover that the distress of the additional memories often dissipates after the touchstone and worst memories are reprocessed (Shapiro, 2015).

The memory identified as the focus for reprocessing is retrieved from the treatment plan that was established in phase one (Shapiro, 2015). The client is asked to identify key
components concomitant with the memory to establish a baseline from which to measure change. Key components that are identified are related emotions, body sensations, and thoughts. Emotions can range from fear and panic, to shame and sadness. Body sensations can range from tightness in the chest to jittery hands, and physical pain to numbness. There is no limit on what the client reports, it is purely subjective. Identifying these components is important for establishing a baseline, as well as for getting the individual in touch with the memory for the desensitization phase (Shapiro, 2015).

Essential components to identify in assessment are cognitions associated with the memory (Shapiro, 2015). This is referred to as the negative cognition (NC). Identifying the body sensations and emotions first can be the catalyst that brings the client’s awareness to their maladaptive cognitions about what happened. Negative cognitions are generally statements such as “I am worthless/unlovable/dirty/bad” (Shapiro, 2015; Shapiro, 2001). Clients are encouraged to find one that resonates with them, though they may require help from the clinician to identify it. Once the NC is identified the client is asked to choose a positive cognition (PC) that they would like to connect to the memory in place of the NC. This follows a similar pattern to the NC such as “I am worthy/loveable/ok as I am/good.” The client is encouraged to choose one that establishes an internal locus of control in the statement they choose (Shapiro, 2001).

Once the PC has been identified the client is asked to rate how true the PC feels (Shapiro, 2001). This is rated on the seven-point Validity of Cognition Scale (VOC). Next, the client is asked to bring up the NC, along with the image identified earlier, and rate the level of distress associated with the memory. This is rated the 10-point Subjective Units of Disturbance Scale (SUD). Once this is completed the client is asked to identify the location of the disturbance in
the body (Shapiro, 2001). With this is completed the desensitization phase begins (Shapiro, 2015).

**Phase four: desensitization.** Establishing a baseline is necessary for moving to the desensitization phase of treatment in order to watch for a change in the distress connected to the memory. During this phase Bilateral Stimulation (BLS) is employed as the individual focuses on the memory and disturbing affect. The clinician directs the client through a *set*. A set includes BLS anywhere from 30 seconds to several minutes, followed by a brief report by the clinician regarding what they are noticing about the memory (Shapiro, 2015). Sets continue in a cyclical format until the client reports no change in what they are noticing. When no changes are reported that specific neural network is considered desensitized. The clinician then asks the client to bring up the original memory and report what they notice and how they would rate it on the SUD Scale. Whatever the client reports is considered the start of another neural network requiring desensitization. Bilateral stimulation sets resume again until client reports no changes. The client is again asked to go back to the original memory. Until the client reports that they notice nothing when reflecting on the original memory, and give a rating of zero to one, desensitization continues (Shapiro, 2015).

**Phases five, six, and seven: installation, body scan, and closure.** These phases are discussed together since they may all be included when concluding a session. There are two ways of ending a session. One is an “incomplete” and the other is a “complete” session. Incomplete sessions mean that the memory network needs further desensitization so clients are moved directly phase seven, skipping phases five and six. When a session is complete the memory network has reached a SUD of zero or one, meaning there is no need for further desensitization of the memory. These sessions conclude by going to phase five (Shapiro, 2015).
**Installation.** When a memory’s neural networks have been identified and desensitized, the session is considered “complete,” and the client is moved to the fifth phase of treatment (Shapiro, 2015). The *Installation Phase* focuses on the accentuation and enhancement of the strength of the PC. The PC is identified in the Assessment phase of treatment, and often remains the same. However, after desensitization occurs, the PC initially identified by the client may no longer fit (Shapiro, 2015). If this is the case then the client is asked to choose a new PC that more appropriately reflects what they want to believe about themselves as it relates to the target memory. Once the PC is reassessed, the client is asked provide a rating on the VOC scale for the PC. Next, the client is directed to hold the PC and the original memory together. While doing so sets of BLS resume until the VOC reaches seven (Shapiro, 2001), at which point the client is moved to phase six (Shapiro, 2015).

**Body scan.** Phase six focuses on any releasing and residual body sensations. Here the client is asked to bring their attention to their body and notice any discomfort. The clinician can direct the client to sit comfortably, close their eyes, and scan their body from head to toe while making note of any unwanted sensations. The client reports this to the clinician and BLS is resumed as the client notices the feeling and reports when it has dissipated.

**Closure.** Closure is used to conclude a complete or incomplete session. It focuses on returning the client to a state of equilibrium in each case (Shapiro, 2001). This can be achieved by accessing stabilization techniques that were identified and reinforced in phase two of treatment (Shapiro, 2015). These strategies are applied in session until the client reports equilibrium. This phase also includes psychoeducation regarding what might come up as a result of reprocessing memories. Clients are encouraged to take note of any new thoughts, images, cognitions, emotions, and sensations (TICES) that surface (Shapiro, 2015). This can be
documented by the client on a TICES grid and brought to session to be used in the Evaluation Phase of treatment. Providing this type of psychoeducation paints a realistic picture of the potential of positive and negative responses that surface following treatment, and thus decreases the danger of decompensation while increasing the likelihood that equilibrium can be maintained between sessions (Shapiro, 2001).

**Individual Psychology in phases three through seven.** The reprocessing phases of EMDR treatment provides opportunities to integrate Adlerian concepts. A scenario referred to as “blocked processing” provides the most opportune time for this integration. This most often shows up in the desensitization phase of treatment so the following provides support for this phase specifically.

Blocked or “stuck” processing can be identified when the SUD rating does not reach an ecologically sound status, usually zero or one, or when the client is unable to link the memory to adaptive networks (Hensley, 2012; Shapiro, 2001).

Eye Movement Desensitization and Reprocessing literature provides information regarding how to switch mechanics such as type of BLS, and direction of BLS, to help movement in reprocessing (Shapiro, 2015). There are also specific portions of the memory including body sensations or unspoken words that the clinician can direct the client to focus on to get processing moving as well (Shapiro, 2015; Shapiro, 2001). Specific to EMDR is a technique referred to as a cognitive interweave that is effective in addressing problems related to blocked processing. When these attempts do not help, the halted processing may be due to blocking beliefs and fears (Shapiro, 2015).

**Blocking beliefs.** Blocking beliefs are negative beliefs that keep the SUD from reaching zero or the VOC from reaching seven (Shapiro, 2001). When this is the case the clinician asks
the client what is preventing the SUD (or VOC) score from reaching zero (or in the case of the VOC, a seven). Whatever is reported is thought to be the construct that is blocking reprocessing. Using this belief, the client is asked to identify the memory that represents this belief. This memory should be rated and desensitized before returning to the original memory (Shapiro, 2001).

**Fears.** Fears can also block processing and are generally associated with the outcome or process itself (Shapiro, 2001). When fears are connected to clinical outcomes a secondary gain is likely present. When fears are connected to the clinical process the client mentions some element of EMDR treatment that is problematic. Regardless of what the fear is connected to, exploration and remediation of the fear to the point that reprocessing can be restarted is imperative for reaching adaptive resolutions (Shapiro, 2001).

**Secondary gains.** Having a conceptual understanding of negative beliefs and fears, and their purpose in the pathology is important for clinicians. Blocking beliefs and fears can be fueled by secondary gains. Secondary gains suggest that the client finds some form of safety in their dysfunction and that letting go of it may mean they no longer have an excuse to avoid other responsibilities. Adler’s concept of the “hesitating attitude” offers clinicians a useful understanding of secondary gains. Adler asserted that all neuroses and psychoses reflect the hesitating attitude (Ansbacher & Ansbacher, 1956). This emerges when the individual becomes consciously aware of the contrast between the self-concept and the self-ideal. The awareness of the individual’s inability to meet the demands of what they, or society, expects of them becomes overwhelming and the individual retreats by hesitating. Hesitating can be verbalized in the protest “yes, but…” In EMDR, while the individual wants to experience freedom, it may require more of the individual then they are ready to risk. One might say, “Yes, I want to be free from
indecision, but then I will have to make decisions and stick with them.” Here the hesitating attitude reveals the secondary gain associated with blocked reprocessing.

Adler classified the hesitating attitude in four modes of behavior: 1) moving backward, 2) standing still, 3) hesitation and back-and-forth, and 4) construction of obstacles (Ansbacher & Ansbacher, 1956). Moving backward can be seen in such behaviors as suicide, self-harm, and behavioral exhibitions (Ansbacher & Ansbacher, 1956). Examining and challenging behavior exhibitions are of central importance in EMDR reprocessing. These can include such things as forgetfulness, panic feelings, silence, and exaggerated sensations and feelings. These abreacts can persist in blocking the movement of memories in reprocessing and require attention in order to unblock processing (Hensley, 2012; Shapiro, 2001). Standing still generally focuses on occupational, social, and relationship responsibilities that await the client once pathology remits (Ansbacher & Ansbacher, 1956).

The third mode of the hesitating attitude referred to as “hesitation and back-and-forth”, is often present in compulsion. Here the individual sets him- or herself up for failure but keeps him- or herself busy in the process evident in obsessive compulsive behaviors (Ansbacher & Ansbacher, 1956). One result of compulsive behavior is to leave things unfinished. This effect is chameleon-like and can be difficult to recognize if not already in the conscious awareness of the clinician. From the writer’s clinical experience, this presents when the individual over-verbalizes between sets of BLS and gets the clinician talking. Before the clinician knows it, the session is over and the target is unfinished.

The fourth mode of the hesitating attitude is the construction of obstacles. Where an individual once used a behavior to avoid responsibility, they now use it in times of convenience. That is, they have done work around the behavior and appear to have accepted responsibility for
it, but use it as an excuse in the form of a pathological insufficiency over which they have no power. In EMDR this may surface in desensitization and will surprise the clinician because it was previously uncovered and addressed in the preparation phase of treatment (Ansbacher & Ansbacher, 1956).

Whatever the nature of the secondary gain, the clinician must see this as the client’s attempt at safeguarding for fear of failure (Ansbacher & Ansbacher, 1956). The empathic approach emphasized in IP must set the stage for this discussion. As the clinician assumes an empathetic posture this promotes the ability to track the fluctuations in the client’s emotional state, and adapt the discussion accordingly (Reynolds, 2012). This discussion can lead to the origin of a different memory that brings up the affects and beliefs associated with the secondary gain, which would then be targeted and desensitized. If this is not the case, then the clinician and client may require time in talk-therapy to address concerns and make plans that empower the individual to move toward adaptive resolution.

**Phase Eight: Reevaluation**

Reevaluation observes the maintenance of treatment effects over time and any systemic problems that surfaced between sessions (Shapiro & Laliotis, 2010). In the closure phase in the preceding session, processing continues between sessions. Changes are expected to take place between sessions such as new insights, dreams, cognitions, emotions, and body sensations that the client notices. The reevaluation provides the opportunity for the client to share these experiences and for the clinician to observe and document them. (Shapiro & Laliotis, 2010).

Often new problems present themselves as the initially identified problem recedes (Shapiro & Laliotis, 2010). This is to be expected, especially in complex cases. Deep into therapy a client may be reprocessing memories connected to interpersonal problems. Between
sessions the client may recognize increased irritability toward a specific situation or person. This would be reported in the subsequent session and discussed. The presence of a change like this is evidence that reprocessing is doing its work (Shapiro, 2015).

**Phases Three through Eight: Three Prongs**

The preceding section outlined the protocol of phases five through eight that are applied in the treatment of traumatic memories. This is only the first of the three-pronged protocol built into EMDR. Once trauma from the past has been desensitized (first prong), the dyad works on desensitizing triggers in the present (second prong), and preparing for the future (third prong) (Shapiro, 2015).

Phases five through eight for each of the subsequent prongs look similar to the first prong. Present triggers are the situations that currently cue the client’s maladaptive reactions (Shapiro, 2015). It should be noted here that since past traumas have been desensitized, clients may find the present triggers less distressing.

In the third prong the client and clinician discuss reorienting to life with new insight, healing, and awareness (Shapiro, 2015). The client raises concerns about future scenarios in which they may need to develop further resources (Shapiro, 2015). It is expected that clients will encounter situations to which they have rarely responded in an adaptive way. This requires preparation and readiness. The third prong assists the client in seeing him- or herself in a positive future.

**Individual Psychology in the three prongs.** Phases five through eight are well-developed in EMDR. Of importance is the need for support in reprocessing and reevaluating the third prong of treatment. Here the client is reorienting him- or herself to the future. This is a challenging prospect for many clients and is not given enough attention in the current literature.
The lack of emphasis in the reorientation phase of much psychotherapy is evident by the lack of current literature available to support this discussion (Maples & Walker, 2014). The authors investigate this problem by discussing the implications of using specific terminology for this phase with clients. They discuss the potential implications of using the term “termination,” and suggest instead the use of the world “consolidation” in ending the therapeutic process more effectively.

Termination is a problematic term for both client and clinician in that it carries negative connotations similar to meanings associated with abortion and murder (Maples & Walker, 2014). Synonyms for this term such as “breakup,” “extinguish,” and “deactivation” reinforce the term’s negative tone. Maples and Walker (2014) emphasize that the use of this term in the final stage of therapy works against any attempts at ending the therapeutic relationship on a positive note.

The potential problems associated with the word “termination” may justify Maples and Walker’s (2014) suggestion of an alternative term. They propose that the word “consolidation” be used instead as it is more synonymous with what psychotherapists hope to achieve in their work with clients. This word carries with it the idea of integrating one’s learning and encoding it into one’s long-term memory for later use. In this phase practitioners are mindful of the negative emotional experiences that could arise for the client. They also should not overlook the possibility of new positive ones (Maples & Walker, 2014).

This phase of therapy should include focus on the possibility of new experiences as well as those experienced in the past. Both require careful consideration and planning as to how the client will respond (Shapiro, 2015). Specifically, desensitization involves the client playing a movie in their mind of a previously disturbing person, place, or situation. The client reports positive or negative reactions. Positive reactions are processed and reinforced with BLS. If the
client reports disturbing reactions, the clinician assesses and decides if this is due to: 1) a "feeder" memory requiring desensitization, 2) an appropriate response requiring skills training, or 3) a marginal response due to anticipation (Shapiro, 2015). Whichever the case may be the clinician addresses each possibility and helps the client prepare for the future. The focus is on the client’s positive attributes, strengths, mastery, and solutions and how they can use these to create positive experiences to work through challenging experiences.

The third prong included in EMDR treatment may readily be seen as a small detail or after-thought when compared to the hard work of reprocessing past and present experiences. This must not be the case for a comprehensive treatment approach. The current literature suggests a lack of emphasis on this phase of treatment in many treatment approaches. This lack of emphasis is a disservice to all clients, whether they struggle with complex trauma or not. Since therapy is very much about helping people move through their difficulties in order to return to adaptive living patterns, it is imperative that an increased emphasis be placed upon this phase of treatment. This offers the opportunity for the concepts of IP to be integrated in the consolidation phase of treatment.

**Individual Psychology in consolidation.** Many of the concepts and techniques from IP that have been discussed can be employed to support the consolidation or reorientation phase of treatment. The following provides a brief description of how the life tasks and ER’s offer clinicians an opportunity to encourage the client to tap into their skills to address future scenarios.

**Life tasks.** The life tasks assessment can be used to bring attention to strengths that have improved in the client’s life. They can also be used to identify areas of concern for the client.
The clinician can identify with the client any areas of mastery or resilience currently evidenced in any of the life tasks and then explore how those can be recruited to solve a current problem.

The scenarios that come up from this discussion can be run as a movie during reprocessing in EMDR. When the client encounters distress, the clinician may offer cognitive interweaves elicited from the life tasks assessment to help improve the scenario being processed.

*Early recollections.* There are many ways ERs’ can be used in therapy. Wingett and Milliren (2004) outline a technique referred to as the “Stuck? or Lost?” strategy. It offers the clinician and client a look at the client’s movement in problem solving. Within that movement lie strategies used by the client to get out of difficult situations. These strategies are emphasized and developed further in response to the client’s present problem.

Individual Psychology is focused on the psychological movement of an individual. That is, how the individual expresses their unique orientation to self, others, and the world (Wingett & Milliren, 2004). Individuals generally seek therapy when their movement is no longer serving them to solve a specific problem. The role of the clinician is to gather information about the client’s movement. This specific ER strategy aids the clinician and client in uncovering hidden resources within the individual that would be helpful in solving their dilemma (Wingett & Milliren, 2004).

The authors outline this technique in phases. The first phase emphasizes the awareness of the clinician to the client’s verbalization that allude to feelings of being lost or stuck (Wingett & Milliren, 2004). The second phase comprises eliciting an early memory in which the client was lost or stuck. In the third phase the dyad examines the narrative by looking for clues regarding the client’s problem-solving strategies. The final phase requires reorientation of the client’s problem-solving strategies to their present dilemma. This process emphasizes gathering
information for the purposes of uncovering the creative abilities within the individual to solve their own problems (Wingett & Milliren, 2004).

Further Research

Eye Movement Desensitization and Reprocessing offers robust clinical protocols for treating pathology from a trauma-informed approach. The literature reveals a current lack of emphasis in this modality on the clinical utility of the therapeutic relationship itself. It has been revealed that this factor cannot be overemphasized for the treatment of complex trauma. Since EMDR is focused on trauma recovery, developers of this therapy would do well to draw from other theories, such as IP, that recognize this is and thus offer practical tools for its development.

Consolidation of the therapeutic experience is another area that requires further research. This shortcoming is not limited to EMDR, since the literature reveals that there is a lack of emphasis on this phase of the treatment across many different theories and therapies. Individual Psychology refers to this stage of therapy as reorientation and this concept may serve to enrich the development of this phase of treatment.

Conclusion

This literature review revealed that EMDR, though highly effective in its treatment of trauma, requires clinicians to have a fundamental understanding of the therapeutic relationship. Where EMDR provides the clinical and evidence-based components for effective treatment, Individual Psychology can provide the environmental components of safety, encouragement, and positivity needed for client retention. Complex trauma finds its etiology in traumas occurring at developmentally critical stages in the context of important, but unhealthy, relationships. Since this is the case, it is reasonable to assume that healing these memories requires the consistency
and care that a strong therapeutic relationship provides. Clinically sound approaches such as those offered in EMDR are rendered useless if the therapeutic relationship is lacking.

Individual Psychology offers robust and non-invasive approaches for psychotherapy. From history-taking and building the therapeutic alliance, to assessment and techniques, it provides clinicians with a thorough clinical understanding of presenting problems from a biopsychosocial model of mental health. Alfred Adler was known for his way of explaining complex psychological concepts in a manner that was readily understandable by laypeople and professionals outside the field of psychology. This is important for someone with a diagnosis that is rooted in complex trauma. These individuals, by the nature of the effects of their experiences, are defended and insecure about many things in life. To begin the process of healing in a therapeutic environment it is important to create a safe place in which the individual can explore and share their experiences, and gain understanding as to why they are experiencing life as they do. Individual Psychology may offer much to enhance the effectiveness of EMDR due to its emphasis on the safety and stability of the therapeutic relationship itself as a key ingredient in promoting the healing and growth of those affected by complex trauma.
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