Eye Movement Desensitization and Reprocessing
Builds Upon and Enhances Adlerian Early Recollections

A Research Paper
Presented to
The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for
The Degree of Master of Arts in
Adlerian Counseling and Psychotherapy

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August 2015
Abstract

This paper will introduce the reader to Alfred Adler and carry on to explain the core concepts that constitute Adlerian Individual Psychology. Building upon an Adlerian foundation provides therapists with an understanding and appreciation of advancements in the field of psychotherapy (Ansbacher & Ansbacher, 1956). One of the central offerings of Adler was the projective technique of Early Recollections (ER’s) (Brokaw, 2011). This concept will be further described, as well as compared, to the utilization of EMDR. Researchers do not fully understand or agree upon exactly how EMDR therapy is efficacious; however there are theories that have been offered based upon neurologically understanding how the human brain processes and stores information in both adaptive and maladaptive ways. These are concepts that the reader will find to be Adlerian. The next section will describe the utilization of both of ER’s and EMDR as complementary therapies. In conclusion, I will provide my personal thoughts, experiences, and suggestions for future research.
# Table of Contents

**Introduction** 5

**Adlerian Individual Psychology** 5

  - Alfred Adler 5
  - Individual Psychology 5
  - Lifestyle Assessment 6

**The Question** 7

**Family Constellation** 7

**Striving to overcome feelings of inferiority** 8

**Fictional goals** 8

**Social Interest-Gemeinschaftsgefühl versus private logic** 8

**Encouragement** 9

**Mistaken beliefs** 10

**Tasks of life** 11

**Creative self** 11

**Early Recollections** 12

  - Administration of Early Recollections 14

  - Benefits of utilizing Early Recollections 16

  - Transforming Early Recollections 17

**Adler and Neuroscience** 23

**Eye Movement Desensitization and Reprocessing** 25

  - Explanation 25

  - Core Elements 26
Eye Movement Desensitization and Reprocessing (EMDR) is an innovative therapy that began in the late 1980’s. EMDR has been utilized to provide relief through adaptively processing fear-inducing “Big T” traumatic memories that contribute to Post Traumatic Stress Disorder (PTSD), as well as “little t” traumas, adversities, and deficiencies that often occur during early childhood. To demonstrate how EMDR builds upon and enhances Adlerian therapy, this paper will focus on the “little t” traumas and negative beliefs that individuals have internalized since early childhood. Both EMDR, as well as the use of Adlerian Early Recollections (ER’s), may be utilized to encourage clients to challenge these deeply ingrained negative and mistaken beliefs and subsequently move towards more socially interested and adaptive self-acceptance. Although Adler is not specifically credited, there are numerous instances where there are similarities in concepts. These similarities are especially true with the advancement of Adlerian Individual Psychology through the introduction of transforming ER’s. Adler may have hypothesized that counseling could change the neuro-pathways well before Functional Magnetic Resonance Imaging (fMRI) or Single Photon Emission Computed Tomography (SPECT) scans were available to demonstrate actual changes that were occurring within the human brain. With awareness provided by neuroscientists, EMDR appears to transport Adlerian Individual Psychology and the utilization of ER’s into the twenty-first century. “Adler’s words have been prophetic. Many of the insights he articulated have become ‘mainstreamed’ into contemporary thought, particularly in psychology” (Mosak & Maniaci, 1999, Preface X). This is true with regards to the contemporary therapy of EMDR, as well.
Adlerian Individual Psychology

Alfred Adler lived from 1870-1937. Throughout his early years, Adler was fundamentally impacted by issues of belonging, illnesses, deaths, feelings of inferiority, and subsequently the necessity to compensate to overcome these as a child (Mosak & Maniaci, 1999). Adler pursued a medical degree; originally with a specialty in ophthalmology, then later internal medicine, and ultimately neurology. As a physician, Adler noticed that social conditions impacted his patient’s diseases. Because of this conclusion, Adler believed that people needed to be understood holistically. He wanted to understand the totality of the individual within their social context, not simply by examining the client in isolation (Corey, 2009). Adler felt that the individual’s presenting issues were due to “poor adjustment to society” (Mosak & Maniaci, 1999, p 5).

Adlerian theory is known as Individual Psychology. A more accurate German to English translation of what Adler intended would be Indivisible Psychology. Adler was referring to “an indivisible unity, the whole person with his or her uniqueness rather than to a psychology of individual differences” (Shulman & Mosak, 1995, p. 255). One of the fundamental premises of Adlerian Individual Psychology is that people need to be understood holistically, meaning to thoroughly understand the whole person; their body, mind, and environment. To gain holistic knowledge of an individual, Adler would conduct a Lifestyle Assessment. “The life style was seen by him as a unifying principle which organized all drives, strivings, tendencies, and aspirations into a unified pattern that could be apprehended by a trained observer” (Shulman, & Mosak, 1995, p. 2).

Conducting a lifestyle assessment began with a thorough evaluation of the individual’s medical history. Adler was interested in the inferiority of one’s organs, as well as the impacts on
one’s functioning. Organ inferiority could impair the individual’s ability to function, or conversely, it could lead to the ability to compensate (or over-compensate) for the inferiority (Ansbacher & Ansbacher, 1956). Adler believed that many people considered themselves to be inferior in some capacity. Throughout their life, an individual would go to great lengths to hide these feelings of inferiority from being discovered. Sometimes the inferiority feelings would be due to an under-functioning organ, however often it was the individual who determined that somehow they were inferior and did not measure up to their expectations. This would be a psychological, rather than physical impairment.

To help therapists differentiate whether a client’s symptoms were somatic versus psychological ailments, Adler utilized “The Question.” To understand the purpose of the symptoms, Adler would ask how the individual’s life would be different if they were free of their presenting complaint (symptom) (Adler, 1989). Typically, if a client responded in a way indicating that they would physically feel better; their issue was most likely an organic ailment. If their answer indicated that without their ailment, they could perform a certain task, it may be considered a psychological concern. The latter individual might use their symptom to excuse themselves from fully participating in certain tasks. In other words, their symptom is their “creative solution” to avoid certain problems in life (Mosak & Maniacci, 1999).

Adler was also interested in gathering information on an individual’s family of origin. He wanted to fully understand how the family functioned. He would inquire about birth orders, values, atmosphere, attitudes, rules, guiding lines, and myths. From this information, Adler had an understanding of “The Family Constellation” (Shulman & Mosak, 1995). All individuals are shaped by their family, and each person discovered their unique way of finding their sense of significance and belonging within their family of origin. An individual develops their subjective
view of the world through their interactions within their family of origin and society. Their individual worldview becomes their reality (Carlson, Watts, & Maniacci, 2006). In Adlerian terms, this reality is known as the person’s lifestyle; their convictions regarding themselves, others, and the “conclusions” regarding how they must behave in order to feel significant in the world (Shulman & Mosak, 1995).

Adler suggested that people naturally develop feelings of inferiority. As aforementioned, these inferiorities may be organic or psychological. People strive to move from feeling inferior (a perceived minus) to a felt plus to reach their goal of significance and belonging (Mosak & Maniacci, 1999). While moving away from feeling inferior, people also attempt to conceal their deficiencies from others (Brokaw, 2011). The way in which they do this is by compensating in either an adaptive or maladaptive manner.

Adlerians attempt to understand the fictional goals or guiding self-ideals that their clients are striving towards to feel superior (Mosak & Maniacci, 1999). According to Adler, “all of us want to belong, and we establish a final, fictional goal that directs us as to what we should be or accomplish in order to belong” (as cited in Mosak & Maniacci, 1999, p 16). An individual’s fictional goals are how an individual feels they must always behave in order to feel a sense of significance and belonging. Examples of fictional goals are “I must be perfect” or “I must be the best”. These are fictional because they cannot be measured or fully attained.

Adler noticed that his patient’s presenting problems developed within a social context. The problems that people encountered were because the individual lacked the ability to cooperate and contribute in a useful manner with others. Adler referred to this as lacking “Gemeinschaftsgefühl”; a German term that does not directly translate to English. A rough translation, and commonly used Adlerian term would be Social Interest. A more accurate
translation is *Community Feeling*; “shared space, customary values, commonly held assumptions and beliefs, and a shared social structure” (La Voy, Brand, & McFadden, 2013, p. 280).

Adler realized that the individual’s behaviors that worked well for them in their childhood, within their family constellation, were now causing them troubles, typically in relation to others. According to Adler, humans have an innate potential for Social Interest, however this may clash with their lifestyle convictions and ultimately cause problems (Carlson & Maniacci, 2011). These convictions and maladaptive patterns may not make sense to others, because they are not based upon common sense, but rather on the individual’s private logic.

Individuals have a desire to belong and feel significant. When an individual goes about achieving this through adaptive means based on common sense, that individual is considered to have Social Interest. When an individual utilizes maladaptive measures, to protect their interests and conceal their feelings of inferiority, this individual is considered to be operating based on their unique private logic. To best help our clients, Adlerians need to develop empathy as they attempt to discover the individual’s private logic and the purpose of their maladaptive behaviors (Clark & Butler, 2012). Adlerian psychology is based on understanding the individual’s subjective point of view, as well as how they move through the world (Carlson, Watts, and Maniacci, 2006). As Adler stated, “we need to see with his eyes and listen with his ears” (as cited in Ansbacher & Ansbacher, 1956, p. 14). On the surface, the client’s view may not make sense to us; however with deeper understanding of how the larger social context impacted the individual, it will help us to develop the necessary empathy. “When giving consideration to conceptual findings, it is therapeutically useful for a counselor to assume an empathic position of what is like to be a person with maladaptive levels of activity or social interest” (Clark & Butler, 2012, p. 140).
Adlerians perceive maladjusted individuals as discouraged not ill, therefore Individual Psychology emphasizes the use of encouragement toward adaptive changes that increase one’s level of community feeling and Social Interest (Carlson, Watts, and Maniacci, 2006). People need to learn to adapt in useful and prosocial manners. Adlerians encourage their clients to discover their innate ability to connect with others and increase their level of Social Interest. Increasing one’s level of Social Interest involves shifting from what best helps the individual to meet their fictional goals, to considering useful behaviors that are good for others, as well. This is considered to be operating on a horizontal, rather than a vertical, plane. The horizontal plane is cooperative and socially interested. “By vertical, Adlerians mean the construal of people as above or below, superior or inferior, master or slave” (Carlson, Watts, & Maniacci, 2006, p. 87). Therapists may model functioning on the horizontal plane by treating the client respectfully and in a cooperative manner; showing neither the client nor the therapist is superior to the other (Adler, 1989).

Individuals develop their patterns and lifestyle convictions early in their childhood. The child attempts to make sense of their world and discovers how they find their sense of belonging. “Children are expert observers but make many mistakes in interpreting what they observe” (Dreikurs & Soltz, 1964, p. 15). Therefore, children make incorrect assumptions about themselves and the world. Many of these assumptions are pretty well formed within the first five years of life; they become deeply ingrained and ultimately affect future interactions with others (Shulman & Mosak, 1995). “Our way of responding to our first social system, the family constellation, may become the prototype of our world view and attitude toward life, solidified as a psychological ‘style of life’” (Adler & Stein, 2005, p. 340). Since this worldview is based upon childhood misinterpretations, the child develops their lifestyle based upon mistaken beliefs about
themselves and how they need to approach life to overcome feelings of inferiority. These mistaken beliefs are based upon their private logic, not necessarily on common sense and ultimately become their roadmap that determines how the individual must behave. The purpose of these behaviors is to assist the individual in achieving their fictional goal, while at the same time protecting themselves from revealing their perceived inferiorities. All of this occurs unconsciously so that the individual will feel a sense of belonging and significance.

The mistaken conclusions that the individual determined as a child may leave them unprepared to confront the problems of life (Adler, 1989). These problems typically show up through relationship conflicts and the tasks of life. Adlerians want to understand how people function within their tasks of life; work (occupation, student, homemaker, or volunteer), love (intimacy), and social (cooperation and connections with others) were the original tasks (Mosak & Maniacci, 1999). Mosak and Dreikurs added the additional tasks of self-care (survival and care of mind and body) and spiritual (religion, universe, or greater meaning) (Mosak & Maniacci, 1999). When an individual begins counseling, it is typically to help them better manage their relationships, personality conflicts, improve their coping skills, and to be better equipped to handle the stresses of their life (Mosak & DiPietro, 2006). The core of these issues is based upon the individual’s unconscious mistaken beliefs.

The goals of Adlerian therapy are to bring the individual’s mistaken beliefs to their conscious awareness and encourage the client to learn to function in a more socially adaptive manner (Adler & Stein, 2005). Having an awareness of their underlying beliefs allows individuals to begin making improved choices in life. Adler “indicated that if we do not live in a suitable societal situation, we have the obligation to change it” (as cited in Mosak & Maniacci, 1999, p 12). Adlerians refer to this concept of creating a new and socially interested lifestyle as
the Creative Self. People are influenced by heredity and their environment, and at the same time are able to make certain choices. People perceive, react, and are continuously creating their future either through continuing patterns based on the lens of their past or by making new choices. As a patient of Mosak or Maniacci stated, “you mean I’m giving conditioned responses to conditions which no longer exist?” (Mosak & Maniacci, 1999, p. 20). We do not simply need to react to life; we have the ability to creatively change how we move through our lives. We have choices. “Life deals the cards; we only get a chance to play the hand” (Mosak & Maniacci, 1999, p. 18).

Once the individual is aware of their mistaken beliefs, they can be encouraged to make changes in how they think, feel, and behave. Their new thoughts, behaviors, and beliefs can be based upon common sense (rather than private logic), and, therefore increase their levels of adaptive functioning and Social Interest.

**Early Recollections**

To better understand an individual’s lifestyle, Adlerians utilize Early Recollections (ER’s). These are specific memories from a young age that the client carries as metaphors of how he or she presently perceives life (Barker & Hawes, 1999). The utilization of ER’s is considered to be one of Adler’s most important contributions to Individual Psychology (Shulman & Mosak, 1995; Brokaw, 2011). Early Recollections are a means to understand the client’s mistaken beliefs, attitudes, goals, and private logic. After gaining this insight from ER’s, a therapist is better equipped to holistically understand an individual’s lifestyle (Carlson & Maniacci, 2011). The lifestyle is the blueprint that unconsciously guides the individual’s behaviors as they move through life (Adler & Stein, 2005). The purposes of the individual’s behavior are to unconsciously achieve the individual’s goal of significance and belonging, while
simultaneously concealing their inferiorities and fears. Individuals accomplish this by unconsciously setting up interactions that reinforce their unique private logic (Willhite, 1979).

According to Festinger’s 1957 theory of cognitive dissonance, individuals have a difficult time holding two opposing ideas in their mind, therefore people express recollections that are in agreement with how they currently perceive and experience the world (Mosak & DiPietro, 2006). The memory the client selects, as well as the way they recall their early experience, mirrors their current attitude about their presenting issue. Adlerian therapists question “what thoughts, what feelings does this patient keep constantly in his mind, by the selective choice of this particular memory” (Adler, 1989, p. 66).

Early recollections are projective and help therapists to better understand the client’s lifestyle; how they perceive the present. Recollections from their first four to five years of age give hints regarding the individual’s lifestyle and how they overcame difficulties or the deficiencies they experienced in their early developmental years. From this information, Adlerian therapists correlate the client’s perception of the early memory to how it mirrors the present attitude or situation. (Adler & Stein, 2005; Manaster & Mays, 2004). Early Recollections are “metaphoric representations of the recollector’s current life-style” (Kopp, 1998, p. 481)

From ER’s, the way in which the person views themselves becomes apparent. Adlerians refer to this as the self-concept; the individual’s opinion of who they are as a person, and who they are not (Mosak & DiPietro, 2006). ER’s also demonstrate the individual’s self-ideal; this is how the individual believes they “should” be. The family rules and how the individual must always behave to belong within their family system are clarified. The individual’s perception of men, women, and the world can also be gleaned from ER’s. “People act and understand based
on their perceptions. For human beings, perception is reality. Perceptions of others and of the world guide the individual to act in certain ways. How one perceives leads to real consequences” (Mosak & DiPietro, 2006, p. 5). Early recollections demonstrate the client’s priorities, as well as the direction of the individual’s striving (Mosak & DiPietro, 2006).

Individual’s ultimately carried these early childhood “shoulds” and “rules” unconsciously into their future interactions with others. “I am”, “I should”, “men and women are”, “the world is.” are examples of information that can be gathered from ER’s. This information helps the therapist to better understand the individual’s subjective worldview. ER’s give clues about client’s mistaken beliefs that keep causing the client problems, as well as the strategies they use to solve their problems (Kern, Belangee, & Eckstein, 2004). Based on the individual’s mistaken beliefs and private logic, they come to the conclusion that in order to achieve their universal goal of belonging, security, and significance, they must always act in accordance with their fictive goal (Shulman & Mosak, 1995).

Adler did not specifically offer a procedure to follow when gathering ER’s. The following is based upon the administration process recommended by Mosak & DiPietro, 2006. To begin, the therapist asks the client to think back as far as they can remember and recall a specific event (preferably prior to age 10). The recollections need to be specific memories, not reports. Reports are more generalized such as, “when I was a kid, I would go fishing with my dad”. If the client offers a report, the therapist may ask the client to recall a specific time they went fishing with their dad. If somebody cannot remember earlier memories, it is possible that a traumatic event that did not fit into their lifestyle occurred, and therefore, altered their ability to provide recollections (Manaster & Mays, 2004).
There are a few schools of thought regarding the process of gathering ER’s. Some Adlerians ask the client to state their recollection in the present tense, some document ER’s word for word, others merely jot down the overall story. An Adlerian instructor may teach simply to look for movement throughout the memories, paying special attention to what the individual is excited about or moving toward. Alternatively, it is also important to notice what the client avoids in their recollections.

Mosak and DiPietro (2006) advise that the therapist write the recollection verbatim and follow up by asking for the most vivid part of the memory. This would encapsulate the memory as if in a snapshot picture. This helps the therapist understand what the client sees as the central moment of the memory. The most vivid part of the recollection may very well be different than the therapist would assume it to be.

Next, the therapist follows up by asking the client about feelings that go along with the most vivid moment. The feeling the client states helps offer understanding of the ultimate purpose of their behavior (Shulman & Mosak, 1995; Mosak & DiPietro, 2006). When the individual states in the present tense how they feel and why they feel the way they do, this statement can offer an instantaneous glance into the individual’s private logic.

After gathering this recollection, the therapist may ask for clarification if needed and then move on to ask for another ER. It is recommended to gather several recollections, not only one, before attempting to interpret their overall meaning (Mosak & DiPietro, 2006).

Some benefits of turning to ER’s are that they are a fairly effortless means to gather information. They are simple to interpret with the proper training and practice (Mosak & DiPietro, 2006). Early Recollections are considered to have low face validity. Since clients may not fully understand the purpose of recounting their early memories, they are less likely to
purposefully distort their responses or shape their answers (Mosak & DiPietro, 2006). Clients typically consider telling their early memories as trivial, therefore therapists are able to assess their client as they speak freely (Adler, 1989). ER’s help bring awareness to the client about their unconscious patterns that are currently causing problems in their lives, as well as what they need to change, in order to better handle the tasks of life in a socially interested way. “The first step of the therapeutic change process is an experiential awareness of behavior patterns” (Willhite, 1979, p. 129).

ER’s can quickly provide the therapist insight regarding how the client perceives not only themselves and the world, but also the therapist and therapy (Mosak & DiPietro, 2006). Asking a client to recall a memory in which they were helping or being helped will provide information to the therapist on how to best assist the individual. The client’s inner strengths and resources will be revealed through their early recollections. Bringing awareness to their strengths provides the client with tools that they already have within themselves to create the changes they wish to experience. ER’s can be utilized as a baseline, as well as to measure changes that occur throughout therapy (Maniaci et al., 1998). After therapeutic changes have begun, the way the client retells their memories will be altered based on their current way of perceiving life (van der Kolk, 2014). Monitoring the changes in how the client recollects their memories, will demonstrate that the client is progressing with therapy.

Finding himself stumped while interpreting a recollection with a client in 1975, Adlerian therapist Robert Willhite (1979; 2007), developed the concept of creating an altered early recollection in order to help clients discover how they can resolve what they do not like about the original recollection. After the client provides the ER, the most vivid moment, and the overall feeling, Willhite would revisit the memory and ask the client to provide their feeling with each
individual phrase throughout the recollection. Mood and emotion can greatly influence how an individual recalls and experiences memory (Bower, 1981). Willhite offered a list of feelings to his client’s to assist with this. He suggested that if the client cannot offer a feeling for a particular segment, just note that line as a fact and come back to it.

This revisit provides the sequence of feelings that the client experiences to come to their conclusions in life. This will be aligned with the client’s private logic. Throughout this exercise, the client’s perception in life and the purpose of behaviors will be exposed, ultimately demonstrating how the individual moves through life. “Feelings are created to motivate and justify one’s direction of movement” (Slavik & Croake, 2001, p. 354). This is how the client sets up their life to remain consistent with their lifestyle. “This is an emotional set-up which he/she has created-leading to a self-fulfilling prophecy that invariably confirms one’s expectations about life” (Willhite, 1979, p. 113).

While asking for the ER, as well as the associated feelings, Willhite recommends that the therapist stay out of the way. This allows the client to fully provide their own unique recollection and feelings. He refers to this initial recollection and list of feelings as the client’s self-concept (Mosak & DiPietro, 2006).

The therapist next asks the client how they would like to change the recollection; line by line, however they wish. The therapist again asks the client for their feeling with each line. Willhite refers to this new account as the client’s fantasy or self-ideal (Willhite, 1979; Mosak & DiPietro, 2006). Willhite recommends that the therapist pay attention to things that the client does not change. If common sense says the client would change something but they do not, this helps to further highlight their private logic. The therapist can challenge why the client
chose not to change things in their ideal account, but ultimately it is the client’s choice what they change and what they leave the same.

The therapist follows up asking for the overall standout of the transformed memory, as well as the feelings that go along with the standout. Rather than asking how the client ultimately wants to feel or how they want the ER to turn out, Willhite says that it is imperative to go through each step and allow the client to provide the changes and feelings associated with each line. This demonstrates their unique process and at which points they unconsciously become stuck. This process will provide insight for the client regarding what they need to change in order to instigate preferred feelings, attitudes, and outcomes (Maniaci et al., 1998).

Willhite (1979; 2007) suggested that the individual reframe their ER in a way that is more ideal for themselves. This process of reframing encourages clients to imagine how their life could ideally be, as well as what needs to change to move in that direction (Willhite, 1979; Mosak & DiPietro, 2006). Because the client is the one suggesting the changes they would like to see within their altered recollection, it is more feasible that they will acknowledge their own possibilities and take responsibility to implement these changes based upon the data that they provided. This data came from and is within them; they are not foreign suggestions made by the therapist.

After the client has provided this information, the therapist may use hunches to bring more awareness to the client’s unconscious patterns and private logic. Hunches can be especially helpful at points where the client was unable to produce a feeling. If it seems to the therapist that a feeling should be present at a spot where the client could not provide one, this is probably the pivotal point where the client avoids dealing with their feelings (Willhite, 1979). The therapist could ask if the client has a difficult time with certain emotions that would be
typically in line with this. For example, if the client cannot provide a feeling where it seems that sadness would be appropriate, the therapist may ask “Could it be that you have a difficult time expressing sadness?” This could be a feeling that they unconsciously hide from others to protect themselves from showing any inferiority or weakness. This may be their mistaken belief; in order to feel significant and belong, I must not express sadness.

The next step in the Willhite Method is to compare the *self-concept and self-ideal* recollections, to the client’s current presenting complaint. Comparing these will demonstrate how the client is living out their private logic based on repeated patterns and predictable outcomes. Willhite refers to the current situation as the individual’s *private-logic-at-work*. Clients may learn where they get stuck in their initial recollection, as well as what they need to change, based on their self-ideal recollection, to gain a new perspective and reach an improved outcome with their current situation. This can become their new and improved blueprint from which to practice and train themselves to behave differently (Willhite, 1979).

Therapy will consist of encouraging the client to learn and practice new behaviors so they will ultimately develop healthier patterns. The clients will also need to learn that although they have the abilities to create their own changes, they cannot always change the outcomes, especially when it comes to interacting with other people. Ultimately they will need to practice and learn to accept that the client can only change themselves, not others. Whatever the outcome is, the goal of therapy will eventually be for the client to realize that they are and will continue to be okay. Ultimately the goal is loving self-acceptance.

According to Willhite (1979; 2007), the strength of his method and the key to changing behavior is by getting in touch with the feelings involved and discovering alternative behaviors that will lead to the client experiencing their preferred emotions and attitudes (Maniacci, M. et al,
Instigating change is more than simply changing thinking and behaving; it also involves changing the accompanying feelings. Emotions can promote changes in behavior (Brokaw, 2011). The Willhite method focuses on the individual’s mistaken perceptions and redirects them towards ideal ways of feeling, thinking, and behaving that will positively change their lives (Mosak & DiPietro, 2006). When an individual takes responsibility for their emotions and becomes accountable for creating them, they have the ability to use their emotions as cues to positively change their behaviors (Slavik & Croake, 2001). The expectation is that clients will discover how they are able to live up to their own ideal and ultimately change the incorrect conclusions they have made early in their life.

Richard Kopp considered Early Recollections to be metaphors for the client’s presenting issue (Kopp, 1998). Building upon the Willhite Method of transforming ER’s, Kopp incorporated bodily sensations (along with utilizing emotions) to further assist the client in getting in touch with how they could discover ideal changes to their current situation (Kopp, 1998; Brokaw, 2011). The Kopp method begins with asking the client to form as vivid of an image of their current situation as possible. The client is then instructed to notice their accompanying feelings as well as to tune in with their bodily sensations. This internal attunement is followed up by asking for ER’s.

As with the previous methods, the client will provide their most vivid moment, feelings, and the reason for their feelings. After this, the client is asked how they would change the memory in any way so it would be ideal, what stands out most to the client in the changed memory, how would they be feeling in the ideal memory, and why?

At this point, the therapist reads the original memory and asks the client for connections they perceive with their memory and presenting problem (Brokaw, 2011). The therapist may
EMDR AND ER’S

offer hunches about the potential beliefs that were gleaned from the memory. The therapist and client then discuss the ideally changed memory. Similar to Willhite’s, this method also offers suggestions for handling the current situation based on learning from the changed memory. The client is encouraged to implement similar changes with their presenting situation. Again, the therapist stays out of this process and allows the client to create solutions.

Susan Pye Brokaw is an Adlerian trained therapist who built upon the previously mentioned methods for transforming ER’s when a client appears to be stuck and/or becomes triggered with intense emotions. Similar to Kopp, Brokaw incorporates having the clients truly connect with both their emotions and their accompanying bodily sensations before they express their ER’s. The difference with the Brokaw method is that when the client is transforming their memory, the client may only change themselves (Brokaw, 2011; Early Recollection Workshop, February, 28, 2014). They cannot change the overall situation, however they can change whatever they would like about themselves; their size, thoughts, feelings or actions, so that the recollection turns out ideally. The changes they make shall be based upon common sense; for example they should not hurt anybody or do anything that could lead to negative consequences (Brokaw, 2011).

After the client has transformed their part in the recollection, the therapist asks the client to assess how they feel. According to Brokaw (2011), if the client’s answer is “better”, the therapist would follow up by asking what could make the memory even better. The client is to continue to use their creative self to alter their memory until it fits their ideal; at this point they will typically respond that they feel “really good” or “great”.

Changing themselves within their recollection empowers the client and provides them with useful solutions to implement with their current issues. These solutions are based on
common sense, rather than private logic. Through their transformation, the client is discovering the key to adaptively handling their problems without their mistaken belief. Transforming their deeply rooted beliefs will instigate changes that carry over into other tasks of life. “Since it was the foundation for all their current thoughts, feelings, and actions, they will begin to react differently in all the tasks of life because they have changed their core belief” (Brokaw, 2011).

The objective of Adlerian therapy is to bring unconscious patterns to the client’s level of awareness and then encourage the client to learn to challenge their mistaken beliefs that they developed early in life. Early recollections are utilized to gather the necessary information to better understand the individual’s subjective perspective on life, as well as the core beliefs that are currently causing troubles. Willhite enhanced the utilization of ER’s by investigating the feelings associated with the early memories to help clients discover how they could transform their lives to become more ideal. Kopp added the concept of bringing awareness to bodily sensations, and Brokaw further enhanced transforming ER’s with the notion that the client can only change themselves, or in Adlerian terms, utilizing their creative self. The goals of Individual Psychology are to change the client’s mistaken core beliefs towards believing in their inherent significance and belonging without the need for striving toward fictive goals. Through the process of Adlerian therapy, individuals become equipped to adaptively manage their tasks of life and simultaneously rediscover their innate potential for Social Interest.

**Adler and Neuroscience**

Adler was ahead of his time. He understood that humans have an innate potential to connect with others, experience empathy, and live Socially Interested lives. Neuroscience has suggested that humans are “‘prewired’ to feel what the other feels, to act as the other acts, to connect” (LaVoy, Brand, & McFadden, 2013, p. 285). Adler must have had an understanding
that early childhood experiences change the brain’s development. These early experiences actually create an imprint that impact a person’s lifestyle, perception, and future interactions (Carlson & Maniacci, 2011; van der Kolk, 2014). As an early neurologist, it appears that Adler was aware that people could measurably change their brain patterns through counseling, experience, and practice. “Social experience can change gene expression, leading to the restructuring of the brain through neuroplasticity” (Garland & Howard, 2009, p. 197). Prior to neuroimaging techniques such as Single Photon Emission Computed Tomography (SPECT scans) and Functional Magnetic Resonance Imaging (fMRI), it seems as if Adler understood the concept of neuroplasticity well before the first documented use of the term in 1948 by Polish neuroscientist, Jerzy Konorski.

The methods utilized by Adlerians are based upon traditional talk therapy. Gaining awareness and insight, challenging old patterns and habits, and practicing new ones. This process ultimately changes the wiring within the brain. Through practice, the mind can change the ingrained patterns of neural firing; “practice harnesses neural plasticity to alter synaptic connections in a way that transforms a temporary state into a more long-lasting trait of the individual” (Siegel, 2007, p. 259).

Much of traditional talk therapy focuses on insight and understanding. Neuroscience Research has demonstrated that most psychological problems come from deeper regions within the brain creating conflict between an individual’s emotional and rational brain; oftentimes insight, awareness, and practice are not enough to calm the emotional brain from overreacting (van der Kolk, 2014). Research using Positron Emission Tomography (PET scan) observed that when individuals were triggered from past experiences, the right hemisphere of their brain (emotional brain) became activated while the left hemisphere (rational brain) showed a decrease
in activity (Rauch et al., 1996). This research demonstrated that intense emotional experiences are physiologically challenging to process through using reason and logic (Barker & Hawes, 1999). When an individual appears to overreact to a situation, it is often because they are triggered by a past experience that had become frozen and emotionally charged in their limbic system. They react in the same manner developmentally as when the original experience occurred. While this emotional overreaction is occurring, the individual also lacks the ability to connect with their present day rational and logical awareness in order to adaptively process the current situation. They may not even understand, let alone have the ability to control their emotionally driven reaction. “Our awareness may be imprisoned by prior learning, even without our knowing it” (Siegel, 2007 p. 154). Oftentimes something deeper than talk therapy is necessary to physiologically assist the brain to reorganize and learn new ways of responding, rather than primitively reacting, to current day stressors.

According to Dr. Bruce Perry (2009), one hour of standard talk therapy per week is not enough to neurologically reorganize the brain. Developmentally, the higher and more advanced portions of the brain (the cortex) require input from the lower and primitive parts (the brainstem and diencephalon) of the brain. If the lower portions were organized in a chaotic and dysfunctional environment, this leads to higher areas organizing in dysregulated and extreme manners. In order to re-organize and reset the stress response in a healthy manner, the lower portions of the brain require incoming neural activity that is predictable, repetitive, structured, synchronous, patterned, and rhythmic (Perry, 2009; Barfield et al., 2012). In order to target the core source of present day symptoms and adaptively reorganize the brain, therapy is most productive when it targets and activates the neural system it desires to alter, while
simultaneously repetitively creating consistent patterns through connections with present moment sensations such as yoga, breathing, movement, music, or EMDR (Perry, 2009).

**Eye Movement Desensitization and Reprocessing**

While on a walk in 1987, Francine Shapiro noticed that as her eyes were moving between activities occurring on either side of her path, her thoughts were becoming less distressing. She realized that her feelings of disturbance and anxiety had lessened in response to the eye movements. Investigating this phenomenon further, Shapiro noted the effects that she experienced were similar to research begun (but without thorough investigation of the effects) by dream researchers Antrobus, Antrobus, & Singer in 1964 who documented that eye movements, while awake, were associated with altering cognitive content (Shapiro, 2002).

Initially, Shapiro conducted controlled studies based upon the significance of eye movement desensitization that became known as EMD. However, additional research demonstrated that the use of eye movements was also determined to help in terms of reprocessing memories. Eye movements were found to integrate an individual’s disturbing thoughts and feelings with adaptive memories and resources. With the newly found benefits of reprocessing, this therapy subsequently became known as Eye Movement Desensitization and Reprocessing (EMDR).

EMDR may be utilized as psychotherapy for any conditions where environmental influences are a factor such as “learning, conditioning, or stress” (Leeds, 2009, p. 17). Information that is not adaptively processed becomes neurologically “frozen” and essentially hardwired in its original form; therefore making it unable to be adaptively processed (Shapiro, 2001). The utilization of bilateral stimulation appears to allow the “frozen” cognitions and
EMDR AND ER’S

emotions to become desensitized, reprocessed and integrated to an adaptive resolution. (Shapiro, 2001, 2002).

Bilateral Stimulation (BLS) is a core element of EMDR. BLS is the utilization of sensory stimulation which alternates bilaterally from each side (left and right) in a rhythmic manner (Leeds, 2009). Initial research and EMDR therapy focused primarily on the utilization of eye movements. To facilitate eye movements, clinicians may sit in close proximity to their client and instruct the client to simply follow the therapist’s fingers; others use technological instruments such as light bars. Another method of BLS involves tactile stimulation such as physically tapping on the individual’s hands or shoulders, or through the use of handheld electronic tappers. Auditory BLS is also utilized through snapping fingers back and forth, a clicker, or technologically through the use of a headset. Forms of BLS may be combined to include two or all three modes of stimulation; however the alternating rhythms must be in sync. The use of technological aids will facilitate keeping the visual, tactile, and auditory modes in a consistent and rhythmic pattern (Evans & Schaefer, 2013).

In the initial preparatory, as well as the final stages of EMDR, slow BLS is implemented. Slow BLS is utilized for resourcing; which is building and strengthening adaptive neural networks. Faster and more intense BLS is utilized for desensitizing, processing, and reorganizing memory networks.

There are several hypotheses regarding how EMDR is helpful. The rhythmic bilateral stimulation is similar to the processing and reorganization that occurs to memory during REM sleep (Shapiro, 2001; Leeds, 2009). BLS creates communication between the right and left hemispheres of the brain that provides a narrative to help the amygdala to respond in an adaptive manner (Leeds, 2009; Evans & Schaefer, 2013). According to Dr. Andrew Leeds (2012 video),
EMDR could be considered “mindfulness on steroids”. In response to triggers of disturbing memories being activated, the client is instructed to mindfully notice what occurs; silently without judgment, to take deep breaths orienting to the present, and eventually the body and mind are calmed (Leeds, 2009; 2012). The individual remains aware of the disturbing incident, grounded in the present, yet their mind and body quiet; they become desensitized and without stimulation of affect (Corrigan, 2002). Although the understanding behind why EMDR works is not agreed upon, research has shown it to be an effective method for targeting disturbing memories, desensitizing them, and reprocessing these memories in an adaptive fashion.

Dual attention is a necessary component of EMDR. Dual attention is the concept of having the client focus on both the targeted traumatic memory while at the same time remaining aware of the present through bilateral stimulation (Leeds, 2009). The bilateral stimulation is essential for the client to maintain dual awareness. Clients need to be able to easily shift their awareness between the trauma and the sensory experiences of the present moment in order to desensitize and reprocess effectively. The dual awareness reduces the likelihood that the client would become overwhelmed by re-experiencing the trauma (Leeds, 2009).

Another key element of EMDR is ensuring that the client remains within their optimal window of tolerance. The optimal window of tolerance can vary with each client. The client must remain below hyper arousal (highly activated) and above hypo arousal (numb, collapsed, or low activation) (Evans & Schaefer, 2013). The client needs to remain in this window to enable learning to occur as memories are altered to adaptive resolution (Shapiro & Laliotis, 2011; van der Kolk, 2014). It is imperative to remain mindful of the client’s individual window of tolerance throughout all phases of EMDR. While the client is processing, crying is not considered highly activated or outside of their window of tolerance. Typically crying should be
allowed to continue until the client naturally stops; this helps them to fully ride out the emotions and move towards desensitization.

EMDR clinicians classify trauma as either “Big T trauma” or “little t trauma”. Big T traumas are any incidents that are life threatening such as natural disasters, accidents, rape, war, injury, or any other fear-inducing experience. Big T traumas are often single incident traumas. Big T traumas may be thought of as an occurrence that does not fit into the typical day to day happenings of an individual’s life. Because the event is out of the ordinary, the brain does not know how to adaptively process it; therefore it may become maladaptively stored in an individual’s memory network.

Environmental and developmental factors also cause trauma. EMDR refers to these as “little t” or “small t” traumas. Unprocessed childhood dysfunction, neglect, abuse, or any experience which undermines “an individual’s sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one’s sense of control or choices” (Evans & Schaefer, 2013, p. 21). “As a child in a world of adults, everyone had experiences of not being in control, being ignored, or feeling less important than other people” (Shapiro, 2012, p. 16). Oftentimes, these experiences, as Adler demonstrated, were based upon incorrect assumptions and conclusions that the child made early in life, which ultimately created deeply ingrained patterns in the brain. These early developmental stresses and adversities can cause disruptions in how the brain processes and stores information (Shapiro 2001; Leeds, 2009). These are known as implicit memories that become stored in a dysfunctional manner (Shapiro & Laliotis, 2011). Implicit memories are the tapes that unconsciously play in the background and become hardwired into an individual’s mind (Shapiro, 2012). These memories remain stuck along with
all of the interconnected feelings, sensations, and negative beliefs that the individual originally experienced early in their life (Shapiro, 2002, 2012).

Little t traumas may take longer to desensitize and reprocess than Big T traumas because they are sometimes built upon layers of unconscious patterns that have developed over the years. Typically with Big T traumas (rape, war, accidents, or natural disasters) the client understands why the trauma is negatively impacting their lives. With appropriate resources, the process of reorganization can happen quickly with Big T traumas (Leeds, 2009). With little t traumas, the client may not even be aware of their existence, let alone why they are greatly influencing their lives in the here and now. “Implicit memories directly shape our here-and-now experiences without clues to their origins from past events” (Siegel, 2001, p.74).

These little t traumas become how the person views themselves and develops long lasting lifestyle beliefs that impact their current functioning, especially with regards to relating with others (Shapiro, 2002). Little t traumas can be the explanation for current stresses of life and ultimately the reason that brings the client to therapy. Because these traumas and stresses are based on incorrect conclusions made throughout childhood, people can become frustrated and discouraged, assuming that they should be able to use their adult awareness to reason themselves out of negative beliefs and thoughts. Resolving the presenting and long-standing problem is more than an intellectual process; the thoughts, beliefs, feelings, and sensations are maladaptively stored as they were experienced in childhood and need to be adaptively processed through more than reasoning (Shapiro & Laliotis, 2011). Intellectually the client may know the truth about their childhood experiences; however they still deeply feel in a manner that does not match their adult intellect. They cannot simply rationalize themselves out of these deeply ingrained feelings and beliefs. They experience them at their core “gut” level. “Most clients
EMDR AND ER’S

know their affective response is inaccurate and unreasonable, or they would not have sought therapy. It is this affective-cognitive split that is the key to much dysfunction” (Shapiro, 2002, p.30). EMDR develops congruence between an individual’s emotions and cognitions (Corrigan, 2002). An EMDR consultant, Patti Miller, has expressed this as “EMDR helps the client to catch their feelings up with their thinking” (EMDR consultation, March 4, 2015).

Similar to our body, our brain is intrinsically designed to heal itself. When something distressing occurs, our brain is designed to come to an adaptive resolution (Shapiro, 2012, p. 20). According to Leeds (2009), Shapiro’s Adaptive Information Processing (AIP) model is based upon the following three principles. First, humans experience stress responses physiologically, emotionally, and cognitively. After processing these responses in a healthy manner (thinking, journaling, talking, dreaming), our physiological, emotional, and cognitive states return to a stable baseline. From adaptively processing a specific situation, an individual will learn and remember how to adaptively respond to similar situations in the future. Second, trauma or stress during a developmental life stage can disrupt adaptive emotional processing from occurring. The information becomes frozen in a state specific form. This state-dependent memory (Bower, 1981) is locked within maladaptive memory networks and inappropriately guides how the individual handles future experiences (Shapiro & Laliotis, 2011). Third, combining BLS with the standard EMDR protocol helps individuals to self-heal; therefore reaching an adaptive resolution and restoring balance to the AIP (Leeds, 2009, p 19-22). EMDR is based on specifically targeting these physiologically stored traumas, allowing the client’s brain to process them towards an adaptive resolution that then provides a future template from which to appropriately determine future responses to triggers (Shapiro & Laliotis, 2011).
The brain’s inherent information processing allows individuals to reorganize how they respond to life events from a maladaptive to an adaptive state (Shapiro, 2001; Leeds, 2009). Healthy adults usefully process stress by noticing the impacts in their body, thinking about the stressor, talking, dreaming about it, noticing feelings, and journaling. Through these means, the disturbances of stress are reduced, the individual is able to learn from the experience and move forward more productively. The individual’s emotional state, physiological systems and cognitive perspective becomes adaptive. Without proper resources and processing, the results of stress can become increasingly worse, emotionally, physiologically, and psychologically (Leeds, 2009).

However, what about when a child is not taught proper means to process stress, or internalize their confusions in life because they never learned to seek help? This inadvertently happens throughout childhood because of the incorrect conclusions the child determined on their own; their mistaken beliefs. They may not have any awareness of adaptive ways to process distressing and stressful events. Their caregivers and family constellation may be the reason for their distress so cannot help the child to adaptively process information. They may not feel they have a voice at all. These individuals may learn to deal with stress maladaptively, and this will carry through into adulthood without proper awareness and help. EMDR can help resolve the distresses the individual carries through desensitization and reprocessing.

The measure of mental health is fully and adaptively processed memories. Similar to Kopp and Brokaw’s methods for transforming ER’s, EMDR activates all elements of the memory network; thoughts and sounds, bodily sensations, feelings, and beliefs. These are all processed simultaneously (Leeds, 2009). An EMDR instructor, Susan Evans, explained the process as, “EMDR is more than an intellectual process, it actually lights up the brain, accessing
EMDR stimulates the adaptive information process (AIP) of the brain that allows disturbing memories to become “digested”; the brain discards useless and retains helpful information which ultimately changes how the memory is stored (Shapiro, 2012). EMDR is not hypnosis. The individual will still have the memory; it will be remembered as something that happened without the emotional, cognitive, and physiological charge it once had. Because the traumatic memory has become desensitized, reprocessed, and stored appropriately within the memory network, the client will now be able to respond to triggers in more adaptive ways with a new “sense of self” (Shapiro & Laliotis, 2011, p. 193).

The following will explain the process of EMDR, however in order to provide approved EMDR therapy, clinicians need to complete extensive training. The initial Basic Trainings one and two, through EMDR International Association (EMDRIA), take place over four weekends over a four-month time frame. These trainings consist of lectures, training, practice, supervision, and consultation. Homework consists of practicing assessments, resourcing, and conducting EMDR with clients in between trainings. The cases where EMDR was implemented are presented to the group to receive hands-on practical collaboration and consultation. As with other theoretical frameworks, EMDRIA holds its members to high standards, stressing the necessary and ethical requirement of practicing within the clinician’s level of competence. If a clinician ever questions their own ability to help a particular client, it is essential that the therapist consult a supervisor before proceeding. Of course, referring on to a clinician with a higher level of training may be the best course of action.
In order to become certified, the clinician must have two years of EMDR experience, conduct at least fifty clinical EMDR sessions, and attend ongoing EMDRIA approved monthly consultation (according to EMDRIA.org).

Phase one of EMDR consists of history taking, treatment planning, and assessing for readiness. The therapist builds a trusting foundation for the therapeutic alliance. During phase one, the therapist inquires about the client’s psychosocial and medical history, discusses the symptoms and presenting problems that have brought the client to therapy, and creates a treatment plan based on the goals and outcomes the client would like to experience. Through an EMDR lens, the therapist gathers both positive and negative life experiences that were considered significant to the client to determine targets for processing. This also helps to determine connections from the past that are presently affecting (as well as the client’s resources that can help with) the current symptoms (Shapiro & Laliotis, 2011).

The therapist gathers information regarding the client’s attachment patterns with primary caregivers, their family members, and also a history of attachment with romantic partners. The clinician asks questions that help to better understand if the client experienced secure, insecure/preoccupied, insecure/avoidant, disorganized, or disorganized along with physical or sexual abuse patterns of attachment (Leeds, 2009; Evans & Schaefer, 2013).

Another tool utilized during the preparation phase is a twenty-one question assessment that offers an evaluation of the client’s stability and readiness. The therapist asks the client to rate the severity of certain issues both historically, as well as currently. This assessment is based upon clinical judgment rather than actual scores. The issues evaluated are whether or not there are secondary gains or losses the client will experience from treatment, the client’s level of trust, any external crises, financial instability, bipolar depression, high-risk behaviors, denial of
diagnosis, accident-prone self, compulsive sex, compulsive acts, alexithymia (inability to identify feelings), flooding of feelings, depersonalization, and amnesia. There are also questions that require more concern such as if the individual has any health risks, suicide ideation or attempts, self-injury, injury to others, substance abuse, Dissociative Identity Disorder (DID) or Dissociative Disorder Not Otherwise Specified (DDNOS). The clinician must pay strong attention and give special consideration if the client has previously or currently experiences any of the latter. With any of these conditions, EMDR must be conducted with a clinician with a higher level of EMDR training.

Assessing for DID and DDNOS is extremely important. EMDRIA utilizes The Dissociative Experiences Scales (DES-II) to screen for dissociative disorders. The clinician asks the client to rate how often they experience certain instances of dissociation. The questions range from everyday experiences, such as “some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part of or all of what was said”, to more concerning situations such as “some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something, and they actually see themselves as if they were looking at another person”. The clients are asked to provide percentages of how often these situations seem to occur for them. This questionnaire can be scored online to get a taxon score. Clients who score over thirty are likely to have a dissociative disorder, and over forty-five means there is a possibility that the client has a dissociative identity disorder. Again, in these cases, EMDR must be provided by a clinician with a higher level of training. There are several trauma and dissociative symptom assessments available for more in-depth evaluations by qualified clinicians.
During phase two, the clinician educates the client about EMDR to the extent required by each client in order for them to make an informed consent to proceed with treatment. To be able to offer informed consent, the client must understand their diagnosis, symptoms, effects of trauma, phases of their individual treatment plan, and what they may expect during EMDR reprocessing. The client must be aware that through EMDR, they will be re-experiencing portions of past traumas that may trigger intense emotions (Leeds, 2009). The clinician will normalize this experience and assure the client that they will be learning resourcing and self-stability exercises to help manage continued processing than can occur out of the session.

Before beginning reprocessing, it is important to teach anxiety reducing methods, as well as to create or strengthen adaptive networks. This is referred to as resourcing. This empowers the client to be prepared to handle processing that may continue after the session. The client will learn to self-soothe and tap into adaptive memory networks by holding onto positive and calming sensations. The therapist and client will collaboratively discuss skills, strengths, and resources that the client already has within them to help them to manage anxiety and calm themselves in a healthy manner. Information provided from Early Recollections could be helpful to bring awareness to the client’s strengths and resources that they already possess and have within themselves. The client and therapist will also discuss new skills to learn to manage continued processing or to use in response to stressful life experiences. These new skills may include mindfulness techniques, deep breathing, muscle relaxation, or the Safe Place exercise (Leeds, 2009; Shapiro & Laliotis, 2011).

The Safe Place exercise helps the client to learn how to create their own sense of calm. The therapist begins by asking the client to imagine a calm place. The client is instructed to fully activate as many senses as possible (visual, auditory, somatic, emotional, and cognitive) while
envisioning a peaceful situation. If the client is able to hold on to this calm and safe space without it becoming contaminated, the therapist can help to instill the safe place with four to six slow passes of BLS. It is important to use slow BLS during resourcing to build and strengthen the client’s adaptive neural networks. A contaminated place means that a negative sensation entered and changed their calm place into an unsafe place. Whenever this happens, the client should come up with another safe place. If they cannot come up with any calm places without contamination, they may need to begin imagining their own unique calm place that they create and envision within their mind. This will help to create necessary adaptive networks. The client will create a word or phrase to describe their safe place. The therapist will provide additional short and slow sets of BLS to further instill the safe place. The goal of this exercise is for the client to be able to prompt themselves to calm and relax on their own. To test the instillation and the individual’s readiness, the therapist has the client think of a slightly upsetting situation and then the client is instructed to go to their calm place. The client can tap on their legs or cross their arms and tap (the butterfly hug) to instill the calm place. The client should practice this on their own in between sessions.

It is important to teach clients grounding techniques in the event they dissociate or feel like they are becoming “spacey” (Leeds, 2009, p. 117). An exercise that can help reduce dissociation is for the client to consciously become aware of their present senses. In the office or out of session, the client should take the time to notice sounds, colors, count, toss and catch a pillow; anything to bring their awareness to the here-and-now. These grounding techniques can help the client in between sessions and also during processing if they appear to be dissociating, experiencing hypo arousal, or feeling numb. If the client is outside of their window of tolerance, adaptive learning will not occur (Shapiro, 2002).
EMDR therapy is different from the talk therapy to which many clients are accustomed. During EMDR processing, the therapist stays out of the way and does very little talking. EMDR processing allows the brain to do the work of desensitizing disturbing memories. Ultimately the brain learns to link the memories to adaptive memory networks. Processing is also known as active learning in EMDR language.

According to the protocol (Leeds, 2009; Evans & Schaefer, 2013), EMDR processing is described to the client by having them think of it as riding on a train, mindfully noticing what passes by through the train window. The client will have different memories changing and passing through their mind. The client is simply instructed to pay attention to the BLS and notice what happens. The therapist will stop the BLS at certain intervals and ask the client to rest, take a deep breath, and report what they noticed. The client cannot do this procedure incorrectly.

It is important to have the client determine a stop signal. This is a signal that the client will consciously provide in the event they want the therapist to stop. The stop signal could be something as simple as a time-out signal with their hands. The stop signal is important because the client may be crying or saying the word stop, however they may likely be fully processing at this point. The therapist may clinically choose that continuing to fully process is what is best for the client, unless the client specifically provides the stop signal. The stop signal empowers the client and keeps EMDR as a client-centered therapy.

During phase one, the client provided significant life experiences. In phase three, a memory or current situation will be selected for desensitization and reprocessing. Baseline measurements will be provided. Maladaptive memory networks are activated as the client visually senses and thinks about the memory or the current situation to be targeted. If a current
situation (rather than a memory) is being discussed, the client is instructed to focus on the current situation and fully experience it in their mind’s eye. Similarly to gathering ER’s, the client recalls the earliest time they remember feeling the same overall sensations and provides that recollection for targeting. In EMDR, this is referred to as a “float back”.

Once the target memory is established, the EMDR clinician asks the client to provide an image that best signifies the target. This is similar to the snapshot most vivid moment with Early Recollections. Unlike ER’s, where verbatim details are typically recommended, the client does not need to provide specifics of the target memory with EMDR. This is especially beneficial for clients who may feel too much embarrassment or shame to discuss an incident, yet want to lessen their disturbance.

The next step involves asking the client to provide the negative cognition (NC) they believe about themselves when they hold the target in their mind. This is similar to the mistaken belief gathered from Early Recollections. This step continues to activate disturbing feelings associated with the target. The NC must be an “I” statement, such as “I do not belong”. A list of common negative cognitions may be provided to help the client select or create the negative cognition that fits the target best.

Intellectually the client may know their negative cognition is inaccurate, yet it still holds an emotional charge that can be desensitized through EMDR. Thinking does not change how their cognition is stored. Talk therapy focuses on challenging and restructuring the negative ruminating cognitions or irrational beliefs; EMDR digs deeper in reorganizing the memory networks involved (Leeds, 2009; Perry, 2009).

The negative cognition helps to determine the proper and correlating positive cognition (PC) the individual would rather believe about themselves. The NC and PC must be related to
each other. The PC must be an “I” statement and feasible, for example “I must be the best” is not achievable or measurable. In Adlerian terms, this would be considered a private logic statement that is generated from living on a vertical plane. “I am ok as I am” is a common sense and feasible statement for a PC. Asking the client for their positive cognition (PC) accesses their adaptive memory network. The PC helps the therapist to understand the client’s direction of movement as they strive for change.

Clinicians begin by identifying the Target, NC, and PC before accessing the emotions and sensations because the latter can feel even more disturbing than the cognitions that are connected with the disturbing memory. The next steps consist of recording baseline measurements.

The first measurement is called the Validity of Cognition (VoC). The clinician asks the client how true the positive cognition feels to them. This must be a gut level feeling of validity, not intellectually (Corrigan, 2002). The scale used to rate the VoC is from one (the PC feels completely false) to seven (the PC feels completely true).

The next step is to have the client focus on the target, as well as the negative cognition and report their current emotions. The emotions may not necessarily be the ones felt at the time of the incident, but rather are the feelings in the present. These emotions assist the client to open the emotional channels that need to be addressed and desensitized (Evans & Schaefer, 2013).

The clinician next asks the client how disturbing the negative cognition feels to them at this point in time. Again, this is based on how it feels at their core level, not based on their current adult awareness. The rating for this measurement is from zero (the NC is not disturbing to the client) to ten (the NC is the highest disturbance imaginable). This measurement is called the Subjective Units of Disturbance (SUD).
Continuing to activate all of the client’s psychological as well as physiological senses associated with the memory, the clinician then asks the client to focus on all of the previous information; the target, negative cognition, positive cognition, and emotions. Just as Kopp (1998) and Brokaw (2011) recommended, in order to fully activate all elements of the memory, the client is asked where they feel sensations in their body. Bodily sensations are asked last in to confirm that the client is fully feeling the disturbance rather than simply cognitively experiencing the trauma. From this point, the client is now ready for reprocessing.

Phase four is when processing occurs. The goal is to desensitize the disturbing memory that has been stored maladaptively as the brain actively learns to link the memory to adaptive neural networks (Leeds, 2009).

Before beginning the bilateral stimulation, the client should be reminded of the process that is about to occur. The clinician reminds the client to simply notice what comes up as they experience the BLS (eye movements, auditory tones, and tapping). The clinician explains that sometimes new memories will come up and sometimes nothing will change. The client is encouraged to simply notice as if they are riding on a train watching the scenery pass by. It is also important to remind the client to utilize the stop signal if they wish to stop the BLS.

In order to fully activate the state connected to distress, the clinician will instruct the client to focus on all of the aspects previously discussed; the target, negative cognition, feelings, bodily sensations, as well as the bilateral stimulation. Noticing the BLS in addition to their sensory experiences allows the client to experience dual attention and remain within their window of tolerance (Shapiro, 2001; Evans & Schaefer, 2013).
After twenty-four to thirty sets, the clinician will stop the bilateral stimulation. To keep the client in the present moment, the clinician will tell the client “Rest. Take a deep breath” and then ask the client what they noticed (Leeds, 2009).

Some clients may give detailed accounts, others brief snippets, yet others may not have noticed anything. There is no right or wrong way for the client to respond. The clinician simply notes what the client reports and asks the client to focus again on the target, the BLS, and notice what happens.

When returning to target, the clinician does not remind the client of any of the aforementioned specifics of the target, negative cognition, emotions, or bodily sensations, because EMDR will change the way in which the memory is stored (Shapiro, 2002). The clinician instructs the client to focus on the image as it is currently stored and to notice again what happens. The therapist will pay attention to changes in the client’s reports as new associations in memory networks arise. The reports will shift from maladaptive to adaptive as they brain links to adaptive neural networks. “Negative memories give way to new insights, positive thoughts, feelings and sensations that are more adaptive” (Shapiro & Laliotis, 2011, p. 197).

Once the client reports positive or neutral information two times in a row, they are again asked to rate the subjective units of disturbance (SUD). If the SUD is above a zero, the client is instructed to focus again on the target (as it is currently stored), asked what is still disturbing about the target, and to notice where they feel it in their body. Processing continues until the client reports twice that their SUD is zero.

Although there is a protocol and, for the most part, the therapist stays out of the process, there are situations that require clinical consideration. The clinician needs to continuously assess
and confirm that the client is remaining grounded and present. If the client appears to be “spacey” or numb, the clinician helps to orient the client back to the present through different grounding methods engaging the client’s senses; examples are counting objects, smelling, touching, noticing what they hear, or tossing a pillow back and forth (Leeds, 2009; Evans & Schaefer, 2013).

If the client appears to be stuck or looping, the clinician will modify the BLS; the clinician may adjust the volume, intensity, speed, or the length of the sets. If the client appears to have some movement, yet processing appears to be ineffective, the clinician may utilize cognitive interweaves. An interweave is asking the client to use their adult awareness of the incident to view the situation in a more adaptive manner. In Adlerian terms, it would be asking a question that would nudge the client towards a common sense rather than a private logic answer. For example, if the client continues to blame themselves (thinks they were a “bad child”) for neglect that occurred, in order to help shift the responsibility, the therapist may ask “who do you think is responsible for taking care of a child’s needs, the child or the adult?” These are similar to challenging questions that are used during talk therapy; however the clinician must use caution as to use interweaves appropriately. Interweaves are used to help the client properly tap into their own “self-healing paradigm” rather than the clinicians agenda (Leeds, 2009, p. 169). Through the use of cognitive interweaves, the client’s reports may begin to move toward adaptive resolution.

If the client cannot reduce their SUD to zero, the clinician may ask what is getting in the way of it becoming a zero. There may be a blocking belief that will need to be cleared for further movement. Sometimes the client will not be able to reach an SUD of zero simply because
the incident happened. This is considered an etiological zero and is acceptable to move forward with installation.

Once the SUD has been established as a zero (or an etiological zero), the fifth phase of EMDR treatment is to install the client’s positive cognition to replace their previously held negative belief. Because the target has changed in how it is stored, it is possible that the positive cognition previously selected may not fit any longer. The clinician will ask the client if their previously selected PC still seems appropriate or if a different one seems to fit better. The client is then asked to rate again the validity of cognition from one (meaning it feels completely false) to seven (meaning it feels completely true).

To begin installation, the client is instructed to focus on the target (as it is currently stored) and their positive cognition, and then bilateral stimulation is provided once again. After each set, the clinician will ask the client to rate the VoC from one to seven until it reaches a seven. Once the client has reached a VoC of seven, the positive cognition is considered to be fully installed.

If the client cannot get to a seven, the clinician may ask what thought or belief the client has that is stopping it from becoming a seven. This belief could be tied to another maladaptive memory that will be a future target.

In order to assess that the gains made in the prior phases are fully achieved, during phase six the client is instructed to scan their body to notice any unusual physiological sensations or tension. If the client continues to experience residual material within their body, the client is directed to focus on the areas that feel tense, and BLS is again implemented. This is repeated until the client reports that they only experience positive or neutral sensations from head to toe.
During phase seven, the session is completed, and the therapist ensures that the client is stable and “in a state of emotional equilibrium” (Shapiro, 2002, p. 40). The client is briefed on what may occur in between sessions. The client should be told that processing may continue after the session, and they should treat themselves compassionately. They should be reminded of self-control techniques such as deep breathing and the calm place exercise that were previously explained. The client shall maintain a log to record changes, emotions, thoughts, and dreams which occur throughout the time in between sessions.

There are times that the session may not allow enough time for completion. As the end of the session approaches, the client may still have an SUD above one, a VoC below seven, or negative sensations remain in their body. These situations are referred to as incomplete sessions. The clinician does not want the client to feel discouraged, so it is important to encourage the client for their hard work. No matter where the session ends, they have faced a situation that was distressing for them. The clinician shall assess the need to stabilize or ground the client.

A process called containment is helpful for the client to contain anything that has not been fully processed and continues to feel disturbing. To contain these negative thoughts, feelings, or sensations, the client is asked to picture a container. As slow BLS is administered, the client is instructed to picture the container, slowly open it and allow any unresolved issues to be put into it to be opened at a later time. The client is to imagine themselves putting the container away and tells the clinician when this process has been completed. If disturbing thoughts come up in between sessions, the client is able to do this exercise on their own to contain the thoughts until the next session. The brain is equipped to do this exercise.
Whether or not the target was fully desensitized, at the next session the therapist revisits and discusses the target, additional material that has come up, and information that has been contained may all be reassessed for further processing.

Phase eight is an ongoing stage where previous work, as well as the treatment plan, is revisited to assess movement towards the client’s goals.

When the target has been fully cleared (desensitized and reprocessed), a future template may be created. Slow BLS is administered as the client envisions, from beginning to end, a future experience focusing on how they would like to respond. The future template builds a positive and adaptive template for the future that further develops the client’s new sense of self (Shapiro & Laliotis, 2011). This process is similar to ideally transforming an early recollection by instructing the client to focus on adaptive changes they can make in order to ideally manage a future situation, except with EMDR the future template is deeply instilled through the use of BLS.

**Adlerian Therapy and EMDR**

EMDR builds upon and enhances Adlerian therapy. The two theories seem to be complementary and compatible. Adlerian therapy provides a solid foundation for understanding how mistaken core beliefs develop in early childhood, as well as the purpose of the behaviors that one unconsciously performs throughout their lives in order to feel significant and a sense of belonging. Both Adlerian and EMDR trained clinicians understand that the individual’s past leaves imprints on the client’s mind that alter their perception of themselves and their worldview. This deeply ingrained and maladaptive perspective causes troubles in the client’s present life. Both approaches set out to discover the client’s mistaken and negative beliefs that the client had carried, target these beliefs at their core where they began, and help the client to tap into more
adaptive ways of seeing themselves and the world. Ultimately the goal is by clearing these negative core beliefs; the client will have the ability to manage their tasks of life in useful and adaptive ways. Their interactions with others will improve. They will have the ability to see memories as past events without the emotional charge they once held. The goal is to differentiate the past from the here-and-now. To learn from the past without it unconsciously interfering with the present and future; to have awareness that includes both a “sense of the ‘I’ that experiences simultaneously with the ‘me’ that is the historian of lived experience” (Siegel, 2007, p. 261).

The information gathered from the lifestyle assessment and Early Recollections may be utilized to holistically understand clients through an EMDR lens. The information provided from ER’s may be helpful for establishing strengths that the client has for EMDR resourcing. The ER’s themselves may serve as specific memories to target through the use of EMDR. Floating back from the Early Recollection may open up other channels or earlier memories from which core beliefs began.

Utilized as a therapy with individuals who do not dissociate and can remain within their window of tolerance, EMDR may provide treatment results that are more neurologically focused than Adlerian therapy. EMDR therapy, for the most part, keeps the therapist out of the picture which allows the brain to do the work without the therapist’s biases or opinions influencing the natural adaptation of the brain. EMDR does not require interpretations of memories. Insight is not necessary. The brain intrinsically does the work of linking memories to adaptive neural networks.

EMDR may provide more rapid treatment results than Adlerian talk therapy. According to research by Cvetek (2008), individuals with small traumas experienced changes in their
feelings; “from shame to anger to sadness to reconciliation” after only three sessions of EMDR (Cvetek, 2008, p. 11). Scheck, Schaeffer, and Gillette (1998), studied women between the ages of sixteen and twenty-five who experienced dysfunction early in their lives and were currently behaving in maladaptive ways such as running away, sexually promiscuous behaviors, or using drugs. After two therapy sessions that included EMDR, the young women experienced significant decreases in their depression, anxiety, as well as increases in their positive self-concept (Scheck, et al., 1998). EMDR can be quite powerful and provides results quickly, “in many ways the process is like witnessing free association at warp speed” (Morgan, 2006, p. 37).

Neuroimaging techniques have demonstrated that EMDR may be more effective than typical talk therapies such as Adlerian. As previously mentioned, Dr. Perry (2009) has instructed that one hour of talk therapy per week is not enough to re-organize and reset the stress response in a healthy manner. One of the methods he recommended to achieve healthy re-organization is EMDR. Dr. van der Kolk (2014) advised that effective therapy needs to be more than insight and awareness. It needs to target deeper regions within the brain in order to resolve the conflict between the emotional and rational brain (van der Kolk, 2014). EMDR helps the client to catch their feelings up with their thinking. EMDR specifically targets maladaptively stored memories in the limbic system and connects them with necessary information and language of the left hemisphere to result in adaptive connections and processing. Through EMDR, “past hurts that are beneath dysfunctional interactions are desensitized and linked to cognitive reasoning” (Flemke & Protinsky, 2001, p. 7). The individual’s gut level inner feelings become congruent with their present day mature adult awareness.

Recent studies have shown that mindfulness training helps with well-being; “the notion of being mindful, being aware of the present moment without grasping on to judgments, does
indeed improve immune function, enhances a sense of equanimity and clarity and may even increase empathy and relational satisfaction” (Siegel, 2007, p. 259). Dr. Leeds (2012) referred to EMDR as “mindfulness on steroids”; noticing what comes to mind without attaching thoughts or judgments and at the same time remaining focused on the present moment through BLS. EMDR instructions share the same premise as mindfulness training. With mindfulness, “the notion is to create a condition that evokes a non-narrative focus of the mind on the here-and-now mental process” (Siegel, 2007, p. 260).

My own experiences of utilizing EMDR have produced incredibly rapid results often within one or two sessions. The individuals I have worked with mainly targeted little t traumas. As the clinician, it is exciting to observe the client’s brain begin to move from maladaptive to adaptive ways of perceiving often within an hour. The individuals I worked with have mostly been in a church. As their reports have shifted toward neutral and positive perspectives, I have many times heard them mention God or Jesus as part of what they noticed. I would be interested in research studying EMDR with individual’s with a strong spiritual foundation. I am curious to know if this foundation helps people to more quickly tap into their adaptive networks, as well as their innate feelings of significance and belonging.

I would also be interested in learning more about utilizing EMDR with young children. Research regarding EMDR’s efficacy with children has been minimal. Field & Cottrell (2011) found that EMDR can reduce trauma, depression, and anxiety with children, oftentimes in fewer sessions than Cognitive Behavioral Therapy (CBT). However, more research is needed with larger sample sizes and more consistency regarding strictly following EMDR protocol. Because of the limited research, “it seems the evidence for the use of EMDR in children can still only really be described as encouraging” (Field & Cottrell, 2011, p. 386).
It would be interesting to see if combining Adlerian therapy and EMDR could be an effective means to help young children improve their self-concept, as well as believe in their innate feelings of significance and belonging. The goal would be to improve the child’s self-concept and instill the positive cognitions of “I am significant” and “I belong” before incorrect conclusions about themselves becomes too deeply ingrained. An enhanced self-concept “could in turn positively influence their academic achievement, level of depression, ability to make decisions, and aversion to delinquency (Wagner & Elliott, 2014, p. 5). EMDR could be utilized by having the child on focus on negative cognitions of “I am insignificant” or “I do not belong”, then notice all of the sensations that occur within their mind and body. A float back could provide Early Recollections for EMDR targets. Targeting these ER’s at their core through EMDR and instilling the universal positive cognitions of “I am significant” or “I belong” may clear the channels of core mistaken beliefs and help the child to better function in a Socially Interested and adaptive manner. A longitudinal study could be conducted by following up to see how the individual is functioning with the tasks of life as a teenager and adult. EMDR could be implemented again at these points. Of course, a limitation would be that it would be impossible to know how the specific individual would be living without the EMDR intervention; however the results could be compared with others of similar demographics. The subjects could be reassessed as teenagers to learn more about their internal dialog and messages they believe about themselves. Gathering information that measures their level of self-esteem, functioning in school, and troubles with the law would interesting.

Adlerian therapy is based on empathetically and holistically understanding the individual (especially in relation to others), learning and challenging their mistaken core beliefs, and increasing their level of Social Interest. Moving forward, the individual is better equipped to
EMDR AND ER’S

handle the tasks of life and function in a healthier manner within society. EMDR therapy
activates all factors of disturbing early recollections, specifically targets the maladaptively stored
memories, desensitizes their charge, and reorganizes the brain in a manner that creates an
adaptive use of the initial target. The brain learns to process information in an adaptive manner.
Combining the two theories may be an effective means to assist children to tap into their innate
potential for Social Interest and adaptive information processing before too many more years of
external conditioning from their environment occurs. Utilizing empathy, understanding the client
in relation to others, holistically paying attention to psychological and bodily sensations, and
employing bilateral stimulation are means to combing the two therapies; this combination has
demonstrated to be effective treatment. Preschoolers with serious emotional disturbances (SED)
have improved their emotional and social functioning and reduced troublesome behaviors when
therapy focused on relational empathy, somatosensory experience, and soothing, patterned, and
repetitive interventions have been utilized (Barfield et al., 2012).

Targeting maladaptively stored mistaken beliefs of young children and instilling positive
cognitions of “I belong” and “I am significant” could support the child’s brain in forming
adaptive neural networks which would shift their self-concept in a positive manner. This could
increase their level of self-esteem and self-acceptance so the child will internally believe that
they are okay as they are without the need to strive towards fictive goals and dysfunctional
behaviors in order to feel their significance and belonging. This could have positive impacts on
their functioning within all tasks of life and their overall level of Social Interest.
References


Cvetek, R. (2008). EMDR treatment of distressful experiences that fail to meet the criteria for PTSD. *Journal of EMDR Practice and Research, 2*(1), 1-13


van der Kolk, B. (2014). *The body keeps the score.* Kindle version.
