Childhood Sexual Abuse: Treatment Modalities of Eye Movement Desensitization and Early Recollections

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By:

Dynelle Helgeson

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Abstract

This literature review examines current literature about survivors of childhood sexual abuse (CSA) and the treatment modalities employed for the treatment of the trauma symptoms among women who have been sexually abused as children. In addition to describing the EMDR therapeutic process, and exploring the short-and long-term success rates of the Eye Movement Desensitization Reprocessing (EMDR) therapeutic process, this review will also incorporate Alfred Adler’s Early Childhood Recollections (ERs), and examine how these therapeutic techniques parallel and/or complement each other.
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Childhood Sexual Abuse: Treatment Modalities of Eye Movement Desensitization and Early Recollections

Women who experienced childhood sexual abuse (CSA) tend to report a range of psychological issues such as insecure patterns of attachment, unstable interpersonal relationships, post-traumatic stress disorder (PTSD), increased anxiety, low self esteem, self blame, shame, depression, trust issues, and increased risk of victimization (Finkelor, Browne, & Finkelor, 1986; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; Smith, Gambel, Cort, Ward, & Talbot, 2012). The victims of CSA will often cope with both external and internal stress by developing coping strategies of functionally avoidant and self-destructive behaviors (Smith, Gamble, Cort, Ward, & Talbot, 1996). The insult that a CSA victim experiences involves both a physical and psychic assault, leaving the victim to feel confused about both bodily and mental processes. The general consensus among these studies is that most women who were sexually abused as children will need professional help in dealing with the childhood trauma in order to lead healthy functioning lives.

The impact of CSA varies with each individual and can present in therapy with various symptoms and needs. Therefore it is vital for the therapist to be educated and aware of different treatment modalities for sexual abuse victims. Often more than one treatment modality is necessary for successful therapeutic outcomes. This article reviews the eye movement desensitization reprocessing (EMDR) approach as well as other treatment modalities that are often used to treat trauma symptoms affiliated with CSA. This review will incorporate the adaptable approach of EMDR and Alfred Adler’s early recollections (ERs) technique in treating those who have suffered from CSA.
**Childhood Sexual Abuse**

Defining sexual abuse can be a tedious process that is often based on logistics of social, political, and psychological issues. Rosen, Matic and Marsden (2013) define sexual abuse as “the maltreatment of a child (underage minor), disadvantaged individual, or disabled person through any sexual activity involving person of power” (p. 224). Sexual abuse may or may not be physical. Non-physical acts of sexual abuse are more difficult to determine and often occur through coercion, witnessing sexual acts or sexual assault of another by means of internet, texting, phone and child pornography (Rosen, Matic, & Marsden, 2013).

According to the National Child Abuse and Neglect Data System (NCANDS), an estimated 9.1 percent of the reported child abuse and neglect cases in 2010 involved sexual abuse (U.S. Department of Health and Human Services, 2011), with the total number of child sexual abuse (CSA) being reported as 61,472 in 2010 (NCANDS, 2011). This number is based on data reported by Child Protection Services (CPS), following investigation of reported suspicion and determination that sexual abuse did occur in each case. Abuse cases involved children of the ages from infancy up to 17 years old. The highest rate of sexual abuse involved children between the ages of 12 and 15 years old, which accounted for 26.3 percent of the cases reported (U.S. Department of Health and Human Services, 2011). The data collected from NCANDS are broad and did not contain specifics about types of sexual abuse and whether they were repeated cases or one-time incidences. According to the U.S. Department of Justice and Bureau of Juvenile Justice (Snyder, 2000), 67 percent of sexual assaults reported by law enforcement involved victims under the age of 18. One out of seven victims of childhood sexual abuse were under the age of six. Females were more than six times more likely to be victims of sexual abuse (Snyder, 2000). Statistics can vary among studies because CSA is often not
reported; experts agree that the incidence is most likely higher than what is reported by authorities (U.S. Department of Health and Human Services, 2011; NCANDS, 2010; Snyder, 2000).

**Types of Sexual Abuse**

When reviewing the literature of the different types of CSA, there was a wide range of sexual activities that were classified as sexual abuse. The sexual abuse is defined by forced intercourse, threats, coercion, and fondling (Finkelhor, Brown, & Finkelhor, 1986). Finkelhor and collaborators reviewed 26 other studies and concluded that, “What has been more consistently reported is greater trauma from experiences involving fathers or father figures compared with all other types of perpetrators, when these have been separated out” (p. 73). Forced intercourse involving penetration causes more traumas then being coerced. Sexual abuse is more disturbing to the victim when the perpetrator is male versus a female, and an adult rather than a teenager (Finkelhor et al., 1986). CSA that has occurred over an extended length of time and involve more than one perpetrator appears to result in greater emotional difficulties for the victim (Feinauer, 1989). Regardless of the demographics, Rosen and collaborators state that the creative power naturally manifested within individuals is impaired by both the coercion and physical penetration, therefore creating a maladaptive formation of their lifestyle (Rosen, Matic, & Marsden, 2013).

**Effects of Childhood Sexual Abuse on Survivor Functioning**

The experience of CSA and its impact on the victim can range widely depending on the age of onset, frequency, level of violence, family versus non-family member, and chronicity. Understanding the various developmental stage, gender, and socio-cultural aspects of CSA is vital when treating post trauma of children who have been sexually abused (McElheran, et al.,
In 1993, a meta-study conducted by Kendall-Tackett and Williams (1993) reviewed and compared 45 studies of symptomology presented by children who experienced sexual abuse. As one would expect, the study found that children who had been sexually abused had more symptoms than nonabused children. The study concluded the degree of symptomology was affected by force, duration, maternal support, and relationship to the victim. Results of the analysis included symptomology based on developmental stages from preschool up to adolescents. The Kendall-Tackett and Williams (1993) concluded, “For preschoolers, the most common symptoms were anxiety, nightmares, general Post Traumatic Stress Disorder (PTSD), internalizing, externalizing, and inappropriate sexual behaviors. For school age children the most common symptoms included fear, neurotic and general mental illness, aggression, nightmares, school problems, hyperactivity, and repressive behavior. For adolescents the most common behaviors were depression, withdrawal, suicidal or self injurious behaviors, somatic complaints, illegal acts, running away, and substance abuse” (p. 167). Not surprisingly, the study concluded that the impact of childhood sexual abuse is serious and can cause various symptoms with varying degrees of severity. The study also concluded that there is no specific set of symptomology that is related specifically to sexual abuse. Symptomology can vary based on developmental stage of the victim, nature, and the severity of abuse. One of the keys to successful recovery is family support, especially maternal support. Maternal support is defined as a two-fold process that starts with believing the child when sexual abuse has been reported, followed by stepping in to protect the child (Kendall-Tackett & Williams, 1993). The study also concluded that two thirds of the victims showed recovery within 12 to 14 months, indicating that a child can recover from sexual abuse.

According to a study conducted by Feerick and Snow (2005), anxiety is a significant
short and long-term symptom of adult women who have been sexually abused as children. Feerick and Snow (2005) examined the relationship between childhood sexual abuse, social anxiety, and symptoms of posttraumatic stress disorder. This study showed elevated, but nonclinical levels of anxiety in both intrapersonal and interpersonal areas among women with a history of childhood sexual abuse. Feerick & Snow also reported findings that women who were abused at younger ages had issues with avoidance and distress, but fewer symptoms of PTSD than women who were abused later in childhood.

At each developmental stage parental presence to guide and support their child through new developmental tasks is essential. When parents sexually, physically, or emotionally abuse their child, the source of protection and security is threatened and diminished. The child can develop anxiety and avoidant attachment styles, creating difficulties in their intra and interpersonal relationships in childhood as well as in adulthood (Smith, et al., 2012).

According to Shapiro and Laliotis (2011), the current issues abused women are experiencing are primarily related to what happened to them when they were a child. Incomplete processing often occurs when a traumatic event happens and the individual is unable to completely process the situation, therefore creating a foundation set up for pathology and health issues. The traumatic memory is stored in the brain along with the emotions affiliated with the experienced physical sensations and created beliefs that were formulated at the time of the event (Shapiro & Laliotis, 2011). Sexual abuse can create problems such as anxiety, interpersonal relationships and trust issues, as indicated by several studies (Feerick & Snow, 2005; Feinauer, 1989; Finklehor, Brown, & Finkelor, 1986). Sexual abuse committed by the father or father figure appears to have more negative impact on the child and also the more violent the sexual act the more of a negative emotional impact will be on the child (Feerick &
Snow, 2005; Finklehor, Brown, & Finklehor, 1986). The child might form strong negative convictions about men and about their place in the world, causing the victim to avoid relationships with men and/or not trusting men.

There are few studies that have been sophisticated enough to study the effects of various specific forms of sexual abuse, and the psychological impact of each form of sexual abuse. Therefore, as indicated throughout the research process there is a need for more controlled studies concentrating on various forms of sexual abuse as well as the negative psychological impact on survivors. Understanding the psychological impact of sexual abuse can allow for greater insight into how the therapist may create a therapeutic environment based on safety, empathy and, most of all, trust.

**Adlerian View of the Effects of Childhood Sexual Abuse**

Accordingly to Mosak and Maniacci (1999), the act of sexual abuse is a violation of an individual’s boundaries and considered as an act to gain power over the individual. The goal is to gain power and superiority through physical violence and/or emotional cohesion. The perpetrator exerts power and superiority as a reactive response, compensating for their own inferiorities (Mosak & Maniacci, 1999). From an Adlerian theoretical perspective it is not the sexual abuse that is the main concern, but how the victim interprets and develops meaning from the abuse. The sexual abuse can place maladaptive meaning in the understanding of self, others, and the world, and imposes a negative development of lifestyle (Rosen, Matic, & Marsden, 2013). The victim can misinterpret the sexual act as an act of love by the perpetrator’s vindictive manipulation and seductive deception. Through this silent seduction, the victim can misinterpret the sexual act as being treated as special and may expect pampering. The victim can develop their sense of belonging through the sexual act by the perpetrator. Some may feel
worthless, powerless, isolated, shameful, while others feel powerful and special. This can lead to problems with the victim’s life task of love and especially later on when romantic relationships develop. Abused children often do not feel like they belong or have a sense of purpose, both within the family system as well as out in the world (Maniacci & Johnson-Migalski, 2013).

The two most important attachment relationships are the parent/child and the romantic relationship with an adult partner. Sexual abuse can cause a negative perception of romantic relationships, creating negative responses within the relationship and also negative sense of self. The victim can either take little to no enjoyment in sex or feel a sense of obligation to perform regardless of their feelings, therefore continuing to recreate an environment of victimization. Some victims can become hypersexual and join sex groups, prostitution and pornography. The hypersexual behavior is not based on self-gratification, but on mistaken ideas developed from the traumatic event(s). Regardless of which mindset the victim may take within their love relationships, they are left feeling discouraged, hopeless, helpless, confused, and possessing low self-esteem (Harrison, 2001).

A violent physical act of sexual abuse can leave the victim feeling powerless. When the victim’s power is taken away they can often feel helpless, leaving them to believe that they are unable to protect themselves. This can lead to two possible erroneous lifestyle interpretations. The two fictitious lifestyle interpretations described by Rosen, Matic, and Marsden (2013) include: “(a) A survivor may find it necessary to gain superiority so that he or she may never be harmed physically or emotionally again. This can manifest itself as an overly aggressive response to gain power physically or emotionally in interpersonal relationships. (b) The forced accommodation by the survivor to the will of the perpetrator can compromise the physical and
mental integrity of the survivor. This often leads to a breakdown of the self, individual’s autonomy, and the development of healthy relationships” (p.224). A development of healthy life tasks of self and the social task are compromised when CSA has occurred. The child develops a sense of self, through their early experiences and interpretations of their experiences, which formulates his/her lifestyle. The lifestyle created in early childhood is sustained throughout life and is carried into adulthood. The CSA can impose an impairment of the development of a healthy lifestyle, therefore creating maladaptive understanding of self, others and the world.

Incest victims are especially likely to experience problems in their interpersonal functioning. According to Finkelhor, Browne, and Finkelhor (1986), women who have been sexually abused experience problems in relating to men and women, difficulty in their marriages, and difficulty in effectively parenting their own children. The life task of family and parenting is compromised, creating problems with resolving and processing issues related to siblings, parents, grandparents, aunts and uncles, and children. This is different than the social tasks, which involves friends; the family and parenting tasks involves relationships with family members where the bond is much more substantial and intense (Mosak & Maniacci, 1999).

**Impact of Childhood Sexual Abuse on the Therapeutic Alliance**

The CSA survivor will often have trust issues, which create problems throughout the therapeutic process and will need to be addressed by the therapist and client. According to Colangelo (2012), CSA can cause both short term and long-term emotional damage and trauma. Joy (1987) claims that each individual client is unique and needs to be assessed and treated individually. Trust and commitment are two main difficulties that are faced throughout the therapeutic process when dealing with clients that have been sexually abused. Joy (1987) reports that the client who has been sexually abused will have a high risk of dropping out of
therapy, due to trust issues and difficulties within their interpersonal relationships. According to Feinauer (1989), gaining trust is one of the most important therapeutic goals to obtain and maintain throughout the therapeutic process. It is of utmost importance the therapist creates trust within the therapeutic relationship by caring, being dependable, providing an environment of self-acceptance, encouraging individualism, as well as fostering self-awareness (Pearson, 1994).

Anxiety can create problems within the therapeutic relationship and can often be a determining factor in whether a client continues to participate in therapy. Often when the victim comes close to dealing with the sexual abuse and the negative impact it has had on them throughout their lives, the anxiety will begin to increase. The client may have a tendency to temporarily alleviate the anxiety by avoiding or dropping out of therapy. The therapist needs to be aware of the role of anxiety within the therapeutic relationship with clients that have been sexually abused, as well as the importance of directly addressing and educating the client. Anxiety can also increase if the client is not able to trust the therapeutic process. The therapist needs to be aware of the trust issues present and of how this may play a role in increasing anxiety. Developing a therapeutic environment that contains safety, trust and empathy is essential for a successful therapeutic process. Understanding the attachment orientation of each client and the impact it can have on the therapeutic alliance is also vital for a successful therapeutic process.

Smith et al. (2012) focused on how poorer treatment outcomes for abused women were directly related to their inability to formulate and maintain secure relationships. Understanding the attachment style of each client can improve the working alliance between client and therapist, and thereby improve treatment outcomes for women who experienced CSA. Smith
and collaborators studied women between the ages of 19 and 57 years old, with major depression symptoms as well as a history of CSA. This is one of the first studies that examine attachment orientation and the working alliance, associated with treatment outcomes among depressed women with histories of CSA. The study found that “understanding the influence of attachment style and the working alliance on treatment outcomes can inform efforts to improve the treatments for depressed women with a history of childhood sexual abuse” (Smith et al., 2012, p. 123). Poorer treatment outcomes among abused women are due to increased difficulty in forming and maintaining secure relationships. Smith and collaborators found that despite the client’s insecure attachment style, when a strong therapeutic alliance is developed there are positive therapeutic outcomes. This suggests that a structured, collaborative, and relational approach can be a significant benefit throughout the counseling process (Smith et al. 2012).

Further research is needed in utilizing multiple methods of measuring attachment style and alliance with treatment of women who have experienced CSA.

Successful therapeutic alliance relies on trust, safety, and empathy. The abuse victim can often swings from idealization and de-idealization of self and others, following a pattern that stems from the original traumatic event (Talbot, 1996). This process is played over and over again throughout adulthood, especially when the victim feels disappointment within their relationships. This negative cycle can become a challenge throughout the therapeutic process. The therapist needs to promote an empathetic and safe environment, while settings limits and boundaries related to the client’s destructive behaviors.

The counselor can create a healthy therapeutic environment by setting the tone in using appropriate and encouraging language, such as referring to the client as a survivor versus a victim. One of the negative patterns when working with those that have been sexually abused is
that they are more prone to regularly cancel appointments. Encouragement is a technique that assists the survivor to feel a sense of self and self-respect. As discussed by Harrison (2001), an encouraged person is able to meet the life tasks of work, social, love, self and spirituality, as well as taking risks when needed to move forward in the healing process. The abuse victim’s shame and guilt can increase the avoidance of dealing with the abuse (Harrison, 2001). This can become frustrating for the therapist and it is important for the therapist to understand how to create a therapeutic environment by allowing the client to feel like they have control, options, and safety, as well to feeling free to express feelings. Survivors have difficulty in addressing the five life tasks due to feeling of powerlessness, helplessness, anger, PTSD symptoms, difficulty making decisions, following through on tasks, anxiety, shame, and depression (Harrison, 2001).

It is important for the therapist to understand the stages of healing for a CSA victim, in order to have success throughout the therapeutic process. In the book “The Courage to Heal” (Davis & Bass, 1988) the stages are described as follows:

1. The Decision to Heal. Once a victim acknowledges the sexual abuse, the decision to heal takes place.

2. The Emergency Stage. This is when the victim starts to deal with the traumatic memories of the abuse and feelings that often have been suppressed. This stage can be a hard stage because the victim finally starts to deal with the memories along with their feelings, which can create personal turmoil.

3. Remembering. This is the stage where memory and feelings unite.

4. Believing It Happened. The victim comes to terms that the abuse happened and that it hurt them emotionally and physically.

5. Breaking Silence. The victim moves from the assault as a secret to sharing the
experience with someone they trust. Sharing with a safe person can help the victim to deal with the shame that often comes along with the abuse.

6. Understanding That It Was Not Your Fault. The abuse victim will often believe that the abuse was their fault. During this stage the victim places the fault where it belongs.

7. Making Contact With the Child Within. The abuse victim often loses touch with their feelings. This is the stage where they learn how to feel again, while nurturing the child within and placing their anger where it belongs, with the abuser.

8. Trusting Yourself. Trust is something that needs to be restored within the abuse victim. Trust has been violated literally within the victim by the abuser. This stage is crucial and is where the victim can learn to trust their inner voice. They can learn to trust their own feelings and perceptions, allowing for a restoration of their personal sense of meaning.

9. Grieving and Mourning. As a child, the victim often does not have the opportunity to grieve the loss of their innocence as well as the personal violation that was committed against them. This stage allows the victim to feel, work through their losses, and restore their inner self. During stage nine the victim honors their feelings and sense of loss, which helps them to live in the present instead of in the past.

10. Anger. This is the Backbone of Healing. In this stage the victim will address their anger and direct it toward the abuser as well as those that did not step up and protect them. Feeling and expressing anger can be empowering to the victim.

11. Forgiveness. This stage allows forgiveness to free the victim from the abuser. Forgiveness gives the victim the key to freedom from the abuse and abuser.

12. Spirituality. Knowing that there is a greater power and tapping into that power
allows the victim to move through the healing process. Spirituality is unique to each individual and can be found through different avenues such as meditation, religion, yoga, and nature.

13. Resolution and Moving Forward. The victim will move through the former stages many times and then eventually come to terms with the abuse and the abuser. During this final stage of healing the victim lets go, accepts, leans on their higher power and moves forward into freedom (Davis & Bass, 1988, pp. 64-65).

Davis and Bass (1988) state the victim does not have to move through all the stages to have complete healing. According to these authors, emergency stage, confronting the abuser as well as family members, and forgiveness are not required for complete healing.

**Current Approaches for Treatment of Survivors of Childhood Sexual Abuse**

Research indicates that there are a number of therapeutic strategies to address issues related to a history of CSA. The most current strategies found were Cognitive Behavioral Therapy (CBT), Group Therapy (using various trauma therapy programs), and Eye Movement Desensitization and Reprocessing (EMDR). EMDR is widely used for the treatment of PTSD, which can be a consequence of CSA. The writer found several studies, from 1989 (Shapiro, 1989) to 2012 (Smeets, Dijs, Pervan, Engelhard, & Hout, 2012), supporting the use of EMDR techniques with individuals who have experienced trauma. Several studies compared and contrasted each of the therapeutic strategies mentioned above. While researching, this writer found that an important component of the recovery process appears to be forgiveness.

**The Role of Forgiveness in the Recovery From Childhood Sexual Abuse**

Development of the forgiveness can be an effective intervention in the treatment of survivors of CSA and has become increasingly popular in psychotherapy (Freedman & Enright
1996; Shechtman, Wade & Khoury, 2009; Walton, 2005). Walton (2005) defines therapeutic forgiveness, “as a process through which an abused person heals the wounds of hurt and hate, is disconnected from an unhealthy connection (physical or mental) with the offender, and is freed to pursue healthy and growth-promoting activities” (p. 196). Therapists have a tendency to focus on treating the symptoms while dealing with unresolved feelings toward their offenders (Freedom & Enright 1996). Walton (2005) found that integrating cognitive restructuring and behavioral assertiveness was useful in treating clients who were sexually abused but did not lead to deep healing. She concluded deep healing of wounds caused by sexual abuse require more time and depth. Walton proposed a five-step forgiveness process to accomplish deep healing for CSA victims. Results indicated that clients who went through the five stage forgiveness process, viewed themselves as no longer victims, experienced self-enhancement and personal growth, developed healthier relationships, and experienced reconciliation with the offender (Walton, 2005). Reconciliation means the survivor recognizes the offender’s behavior and understands that the behavior is based on weakness, sickness and evil. Therefore the survivor gains empathy and pity, but does not stay pathologically connected with the offender (Walton, 2005).

Freedman & Enrigh (1996) studied the importance of the forgiveness in the healing process of 12 Causation female incest survivors between the ages of 24 to 54 from a Midwestern city. This study used a randomized experimental and control group design. Participants were matched closely with each other based on variables of nature of abuse, abuser, current age of survivor, education level, and socioeconomic status. The participants in the experimental group received forgiveness intervention immediately, while the participants from control waitlist received forgiveness intervention only after the paired participant of the
experimental group completed forgiveness intervention. Data indicated that the experimental group, who went through the forgiveness intervention process immediately, had gained more than the control group in forgiveness, hope, and significant decrease in anxiety and depression. The control group, who had a delay in forgiveness intervention, showed similar changes as they moved through the program, as well as an increase in self-esteem. This study concluded forgiveness intervention is an effective therapeutic tool intervention for female incest survivors. Forgiveness is important regardless of whenever it develops early on or later in the treatment process. Similar results were reported by Shechtman, Wade, and Khoury (2009) who studied a group of 146 Arab adolescents of which half of them received forgiveness counseling, while the others did not. The study concluded those who received the forgiveness counseling intervention reported increased empathy and reduction of aggression, revenge, avoidance, and hostility while the control group did not show improvement (Shechtman et al., 2009). These studies indicate that forgiveness is an important component of the healing process and holds true regardless of the client’s age or culture (Freedman & Enright, 1996; Shechtman et al., 2009; Watson, 2005).

Group Process As a Tool to Promote Recovery From Childhood Sexual Abuse

An early study by Alexander, Neimeyer, Follette, Moore, & Harter, (1989) provided evidence that group therapy is effective in treating some of the long-term negative effects experienced by women who were sexually abused as children. The authors of this study found that group therapy improved social functioning and reduced depression and distress throughout the therapeutic process. Positive therapeutic results were maintained at a six-month follow up. More recently, Lundqvist, Hansson, and Svedin (2009) also found group therapy to be an effective treatment modality for CSA. In this study, 45 females who experienced CSA participated in a two-year-long trauma focused group. The study focused on family climate,
social interaction, and social adjustment. Treatment was based on psycho-dynamical theory with emphasis on object relational theory. The framework of the model used to treat clients was based on Yalom’s model of 11 psychotherapeutic factors which included; instillation of hope, universality, imparting of information, altruism, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Lundqvist et al., 2009, p. 163). Data obtained through pre-and post- treatment questionnaires indicated a significant improvement of social interactions and social adjustment after treatment completion. There was not much of an improvement in family climate, other than a reduction of criticism to the related partner. The overall conclusion of this study is that trauma-focused group therapy can be effective in improving the relationships and social life of the women who were sexually abused as children. Positive therapeutic results were maintained at a six-month follow up.

Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing in the Treatment of Trauma

Cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) are two treatment modalities frequently used with survivors of trauma. Bronner, Beer, Van Zelm Van Eldik, Grootenhuis, and Last (2009) assessed a combination of trauma-focused cognitive behavioral therapy and EMDR treatment of acute stress in an 18 year old female. Bronner and collaborators used Children’s Revised Impact of Event Scale (CRIES-13) to measure efficacy of the treatment combination of trauma focused-CBT (TF-CBT) and EMDR. Results indicated a decrease in acute stress as well as a self-report of no more flashbacks, sleeping difficulty, and reoccurring distressing memories. The overall conclusion was that the combination of TF-CBT and EMDR appears to be effective when treating trauma. Another
study conducted by Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) focused on TF-CBT treatment for 210 children, ages four to 11, who had a history of CSA and PTSD symptoms based on the DSM-IV-TR. Parents of the children were also included in the study and participated in eight sessions of TF-CBT. Results indicted that there was an overall improvement of children’s safety skills, parenting skills, and fear related to abuse as well as decrease in general anxiety. Iverson and collaborators (2011) examined 150 women diagnosed with PTSD related to interpersonal traumatic insults of sexual and physical assault in childhood. Although the primary aim of their study was to investigate the effect of CBT treatment for PTSD and depression symptoms on the occurrence of future partner violence, the data obtained also indicate that CBT is not always an effective treatment for PTSD and depression of trauma survivors.

DeBell and Jones (1997) reviewed seven experimental studies that examined EMDR treatment and its effectiveness in the treatment of trauma. Each study varied in their designs, complexity, and how effective treatment was measured. All seven studies used control groups, which consisted of male and female participants diagnosed with PTSD. Four out of the seven studies found EMDR procedures, as measured by the Subjective Units of Disturbance scale (SUDs; Wolpe, 1982), to be superior in reducing distress from traumatic memories. Three studies found that EMDR process was no more effective in reducing subjective distress than other treatments of mental imagery and relaxation techniques. A small study conducted by Field and Cottrell (2011) consisted of eight case studies which included three controlled trials, two uncontrolled and three case reports on traumatized children and adolescents. The study concluded that EMDR had a positive effect on traumatized children, but did not show to be superior to cognitive behavioral therapy (CBT), even though it showed to be more efficient. The
study concluded that the EMDR therapeutic process works best with an integration of family therapy for children and adolescents (Edmund, Rubin & Wambach, 1999). Studies aimed at comparing efficacy and efficiency of CBT and EMDR in the treatment of survivors of trauma in general (Ironson, Freund, Strauss, & Williams, 2002) and CSA in particular (Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004) found that although the efficacy of both treatment modalities appear to be equal, EMDR appears to be more efficient, with fewer sessions required, higher rate of change per session, and lower drop-out rates. According to both studies, the lower drop-out rates can be attributed to decreased levels of stress during and between sessions, reduced amount of homework and motivation required, and the shorter length of treatment. Furthermore, as these studies were conducted with trauma survivors of different cultural backgrounds, it appears that EMDR higher efficiency applies across cultures.

**Eye Movement Desensitization and Reprocessing**

One of the primary goals of this literature review is to examine how effective Eye Movement Desensitization and Reprocessing (EMDR) is in reducing the trauma symptoms among women who have been sexually abused as children. As discussed earlier in this review, data indicate that CSA can create long-term negative effects such as trust issues, anxiety, and problems with interpersonal functioning (Finkelhor, Browne, & Finkelhor, 1986; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; Smith et al., 2012). CSA can cause symptoms that can be persistent and debilitating, leaving the victim feeling hopeless and helpless. Finding a treatment that can specifically address CSA and assist with the healing process is much needed in the field of mental health. Information discussed so far supports that EMDR is an effective treatment for CSA. EMDR is a treatment modality that assists people to heal from symptoms and emotional distress caused by a traumatic event.
History

Francine Shapiro was on a walk in the park one day and noticed that her disturbing thoughts were less distressing. Curious about what she was noticing, she decided to investigate why this was happening by revisiting the distressing thoughts. She closely observed what was going on with her body, noticing that her eyes were moving rapidly back and forth while she was revisiting her distressing thoughts. She suspected that the back and forth eye movements might be creating a therapeutic power. She developed a hypothesis that rapid eye movement may create therapeutic power by decreasing the distress triggered by a traumatic memory. Shapiro decided to test her hypothesis by performing her own case study in 1980. In 1989, Shapiro published the results of her doctoral dissertation, a study focused on the therapeutic effects of EMDR on clients who were diagnosed with PTSD. The study focused on victims of traumatic incidents of the Vietnam War, childhood sexual molestation, emotional abuse, and physical/sexual assault. During EMDR the clients were asked to revisit a traumatic memory as they simultaneously focused on the external stimulus of lateral eye movements directed by the therapist. The study concluded that a single session of 50 minutes of EMDR achieved 75-80% desensitization in victims who experienced trauma (Shapiro, 1989). The EMDR process had immediate positive therapeutic success in desensitizing anxiety, but the study did not claim that EMDR cured all PTSD symptoms nor equip the victim with coping strategies. A follow up with participating clients three months after the EMDR process concluded that participants maintained their new altered cognition. Since she conducted her study there have been many more studies testing the effectiveness of EMDR, specifically on clients who have experienced some form of trauma. This discovery gained much attention from psychiatrists and clinical psychologists, who were used to spending a considerate amount of time in desensitizing the
traumatic memories in their clients. Shortly after Shapiro completed her doctorate she founded the EMDR institute, Inc. and started to conduct training workshops held throughout the world. By 1991, the EMDR institute required one to attend “Level I and Level II” workshops in order to become fully certified in EMDR. The eight-phase process was developed during this time and continues to be part of the EMDR training sessions.

**Eye Movement Desensitization and Reprocessing Process**

The EMDR process is completed in an eight-phase methodology and reportedly only effective if the therapist is properly trained. According to Shapiro (1995), EMDR is “an interactive, intra psychic, cognitive, behavioral, body-oriented therapy whose goal is to rapidly metabolize the dysfunctional residue from the past and transform it into something useful” (p. 52-53). Shapiro (1991) stated that the EMDR process is not a simple technique and it requires specific training in order for it to work effectively. The eight phases process developed by Shapiro (1989) includes, “Client history taking, client preparation, assessment, desensitization, installation, body scan, closure and reevaluation” (p. 67-68). The entire eight-stage process is performed within a single therapy session. In the first phase, the therapist collects and evaluates client’s history. The therapist processes the presenting problem and then evaluates the readiness of the client’s ability to revisit trauma. It is important for the therapist to evaluate the client and their ability to move forward before going to stage two. In Stage two the EMDR process is explained to the client in detail, relaxation techniques are taught, safety and control factors are set, and a safe environment is created. During the second phase the therapist can introduce different forms of bilateral stimulation and the client can then choose which one they are most comfortable with. The different forms of bilateral stimulation include; alternation sounds,
tapping, bilateral hand stimulation with a electronic pulsing, and moving hand or finger back and forth (left to right).

In the third phase the therapist asks the client to remember and describe a visual image of a past traumatic event. The client is asked to rate the trauma based on a scale of one to seven, with one being completely false and seven being completely true. This is called the Validity of Cognition Scale (VOC), which was created by Shapiro (1995). The client is asked to combine the traumatic memory with a negative feeling. The negative cognition is rated on the Subjective Units of Distress scale (SUD) (Wolpe, 1991). Wolpe’s SUD scale measures the severity of the distress, with zero indicating no distress and ten indicating severe distress. The therapist then asks the client to scan their body, to self examine if they are feeling any physical sensations throughout their body. The therapist also asks for details about what they are physically feeling and where the feeling is located in their body.

In the forth phase, the client revisits and evaluates the trauma with the negative feeling while the therapist is using some form of bilateral stimulation, causing the clients eyes to move back and forth involuntarily. This is the stage for which EMDR is most known and where the desensitization process takes place. The therapist administers at least 24 alternating taps, tones or movements, while occasionally checking with the client and observing the client’s reactions. The next phase begins once the client reports a zero on the SUD scale and is the phase during which the client installs the desired belief and eliminates the negative belief. In the sixth phase the therapist asks the client to scan their body and evaluate while holding the new belief along with the traumatic memory, checking in to see if there is any residual tension. If there continues to be residual tension present, more bilateral stimulation is installed. When residual tension is a zero, the client and therapist can move to the seventh phase, which is bringing the session to
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closure. The final phase is re-evaluation, which starts at the beginning of the next session and evaluates the client’s progress since the last session.

**Proposed Mechanisms of Action**

Bridging the gap of neurological scientific evidence and the practice of EMDR can allow for better and faster clinical practice (Engelhard, 2012). The article, “Making science work in mental health care” states that, “by merging the academic and clinical environment, both research and clinical care are optimized” (Engelhard, 2012, p. 1). EMDR is recognized as an effective therapeutic technique of choice for psychological trauma, however it is important to understand why it works. Can the brain do two things at once? Is EMDR a distraction, allowing an individual to revisit the trauma with minimal distress? What are the neurological findings of why and how does EMDR work? EMDR saccadic eye movements and clinical improvement have come under considerable amount of scrutiny among the field of psychology. Understanding why and how EMDR works would optimize the use of EMDR in the treatment of trauma symptoms.

Studies discussed so far conclude that EMDR does work and appears to be an effective treatment for women who have experienced CSA (Edmond & Rubin, 2004; Edmond, Rubin, & Wambach 1999; Ringel, 2012; Shapiro, 1989). Gunter, Ivanko, & Bodner (2008) tested the theory that horizontal eye movements work by promoting communication between the left and right brain hemisphere called “interhemispheric communication”. The study concluded that horizontal eye movements decreased vividness and emotionality while recalling a memory. The same results also happened with vertical eye movements; both methods were equally effective. Looking at the question from a different angle, a study by Smeets, Dijs, Pervan, Engelhard, and Van Den Hout (2012) tested the hypothesis that the “working memory” which is used for
cognitive tasks has limited space and capacity to concentrate on two tasks at once. The study found that eye movements tax working memory, therefore causing the memory to become less vivid. These authors also concluded that when the memory is less vivid the recalling creates less emotionality.

Stickgold (2002) attempted to explain how EMDR works based on current neurobiology and cognitive neuroscience. Shapiro’s (1989) original research article described EMDR eye movements as mimicking rapid eye movement (REM), which occurs 90 minutes after sleep onset. Stickgold explores the neurobiological and scientific explanation of how EMDR and REM mimic each other, as well as how it creates clinical improvement. Stickgold (2002) conclusion to his study states,

The constant reorienting of attention demanded by the alternating, bilateral visual, auditory, or tactile stimuli of EMDR automatically activates brain mechanisms which facilitate reorienting. Activation of these systems simultaneously shifts the brain into a memory-processing mode similar to that of REM sleep. The REM-like state permits the integration of traumatic memories into associative cortical networks without interference from hippocampally mediated episodic recall (pp. 71-72).

The model Stickgold developed is based on the explanation on how the brain processes trauma and how EMDR can be used to decrease the emotionality of the trauma when the victim revisits the traumatized memories. He compared the EMDR process as being similar to the REM state. This theory is testable but currently consists of only predictions based on the neurobiology of the brain. Other scientific studies are needed to support or refute this explanation.

Pagani et al. (2012) explored the neurobiological affects EMDR has on the brain, by using electroencephalography (EEG) to monitor the neuronal activation during the EMDR
sessions. This was a small study, consisting of ten clients with a history of major psychological trauma and a diagnosis of PTSD based on the DSM-IV-TR criteria. Five of the clients were sexually abused, three had a history of grief and loss, one abortion related trauma, and one was a victim of severe physical abuse. This is the first study investigating the real-time firing of the brain neurons in response the EMDR therapy. Findings indicated that traumatic events are processed at cognitive level following successful EMDR therapy. EEG showed that there was an activation shift in the limbic region associated with significant relief from negative emotional experiences following EMDR therapy. These findings suggest EMDR therapy had a direct effect on neurobiology of the brain and suggest possible pathways to explain the efficacy of EMDR in the treatment of trauma.

In summary, there is strong evidence that the EMDR process is an effective treatment for PTSD and other forms of trauma (Edmond & Rubin, 2004; Edmond, Rubin, & Wambach, 1999; Field & Cottrell, 2011; Ringel, 2012; Shapiro, 1989). The eight-phase treatment approach is aimed at assisting the client to tolerate and process traumatic events in a systematic approach. Although initial studies are encouraging in establishing a link between EMDR and neurobiology, further studies are necessary to increase the understanding of the mechanisms by which EMDR is effective in the treatment of trauma.

Despite the research findings that EMDR is effective in treating trauma victims, debate about the efficacy of EMDR continues. In addition, there are few controlled studies designed to determine the efficacy of the EMDR treatment process for women that have suffered from CSA, and further studies with this population are warranted. An argument also remains that due to the infancy of neurobiology, testing hypothesis about EMDR triggered neurological mechanisms is not possible at this time and that the explanation of EMDR process and the neurological effects
on the brain is currently purely speculative and requires further research and study (Ringel, 2012).

**Eye Movement Desensitization Reprocessing Effectiveness in the Treatment of Survivors Childhood Sexual Abuse**

Does EMDR work on women that have been sexually abused as children? As discussed previously, Jaberghaderi, Greenwald, Rubin, Zandi, and Dolatabadi (2004) found EMDR to be as effective as and more efficient than cognitive behavioral therapy in the treatment of Iranian girls, who were survivors of CSA. Many studies have been conducted on the effectiveness of EMDR and different types of trauma, but few geared toward women and the effects of CSA. Edmond, Rubin, and Wambach (1999) studied 59-adult female survivors of childhood sexual abuse, with a mean age of 35, divided into three groups, consisting of EMDR treatment, routine individual treatment and delayed treatment group. The results indicated that while EMDR was successful at reducing anxiety, PTSD symptoms related to trauma, depression, and negative beliefs, it was more effective than routine individual treatment.

Rothbaum, Astin, and Marsteller (2005) aimed to evaluate the efficacy of EMDR and prolonged image exposure (PE) in the treatment of survivors of sexual abuse. The study was limited to 60 women who were victims of rape and suffering from PTSD. The study evaluated PE and EMDR treatments compared to the waitlist group, who received EMDR and PE treatment four to five weeks later. The study was a strong study, using rigorous methodology, clearly defined symptoms and treatment-outcomes. These authors found that PE resulted in a 90% improvement while the EMDR resulted in a 75% improvement with both groups failing to meet the criteria for PTSD diagnosis after treatment. The study concluded that EMDR and PE treatments were effective in treating PTSD of those who had been victims of rape.
Several studies were found in which a follow up was conducted on the effectiveness of EMDR process on clients at three, six, nine and 12 months (Edmond, Rubin, & Wambach, 1999; Rothbaum et al., 2005; Shapiro, 1989). Few studies have examined outcomes after one year of the termination of the study. Edmond and Rubin (2004) evaluated the long-term effects of EMDR from an 18-month follow up study on adult female CSA survivors. The study followed up on 42 of the 59 female of the original study by Edmond et al. (1999). Findings for the follow up study of 18 months indicated the results that the therapeutic gains demonstrated by those in the EMDR treatment conditions at three months were maintained at 18 months. A reduction and alleviation of traumatic events was indicated as well as the symptoms of anxiety, depression, and PTSD. The EMDR group not only held positive therapeutic gains on every standardized test, but actually showed improvement at 18 months. This study shows in a statically significant manner that EMDR can be effective and is able to produce long-term improvements on symptomology. Follow up studies on the long-term success rate of EMDR are few and are needed to determine the long-term efficacy of this treatment process. The writer also determined throughout the research process that there is a need for more controlled studies geared toward adult females that were sexually abused as children.

In summary, the EMDR therapeutic process can be effective in treating individuals who have experienced different forms of trauma, indicated by many studies discussed throughout this literature review paper (Edmond & Rubin, 2004; Field & Cottroll, 2011; Rothbaum, Austin, & Marsteller, 2005; Shapiro, 1989. The Edmond et al. (1999) study was a study found that focused specifically on EMDR and adult female survivors of childhood sexual abuse. On every measure the EMDR participants scored significantly better than the control groups. The Edmond et al. study showed that the EMDR process is effective in reducing anxiety, depression,
negative beliefs and PTSD symptoms. The study was one of the largest controlled studies found on the effectiveness of EMDR process on adult women survivors of childhood sexual abuse.

**Integration of Eye Movement Desensitization and Reprocessing Into Therapeutic Practice**

EMDR is an adaptable approach, which can be used with many different clients as well as integrated into many different types of theoretical orientations. EMDR invites the therapist to address the full clinical picture of the client by addressing past events which have created the present dysfunction, current events that elicit distress, as well as working through traumatic events by desensitization and acquiring skills for the future needed for a more useful way of functioning. DiGiorgio, Arnkoff, Glass, Lyhus and Walter (2004) examined the view of three therapists from different theoretical orientations (psychodynamic, humanistic and cognitive/behavioral) who integrated EMDR into their work with clients. All three therapists were impressed with EMDR’s effectiveness and agreed that it works more quickly than other techniques. Each therapist indicated that they would be cautious using EMDR with clients that have dissociative tendencies, obsessive-compulsive behaviors, and clients who were skeptical or resistant to EMDR. They argued that using EMDR treatment on clients who may have dissociative disorder carries a high risk of pulling out an alter ego that is deep within the client. If the therapist is not properly trained on how to deal with this situation, there is a risk of leaving the client in hyper-arousal state. This can then lead to possible re-traumatization and may cause the client to see the therapist as the perpetrator, permanently damaging the client/therapist relationship. They also argued that using EMDR too soon on clients who are emotionally volatile, labile and have been sexually abused might have adverse affects. Establishing relationships and trust is essential before using the EMDR technique (Shapiro, 1989). Overall findings concluded EMDR is effective and can be successfully integrated into
differing theoretical orientations (DiGiorgio et al., 2004). Following this literature review this writer will explore how to integrate the theoretical perspective of Alfred Adler, the technique of ERs (Early childhood recollections) and EMDR technique when treating women with a history of CSA.

**Individual Psychology and Treatment of Childhood Sexual Abuse**

Individual psychology has an excellent vantage point in treating those who have experienced CSA. It has an emphasis on encouragement as well as motivating the client to move from felt minus to a perceived plus, while becoming aware of mistaken beliefs. As discussed in Mosak and Shulman (1988), Alfred Adler believed that all individuals, as small children, develop a lifestyle by cause and effect, trial and error, compare, contrast, test and retest. The lifestyle is defined as, “the cognitive blueprint for behavior, which is required when no instinctual blueprint exists. The lifestyle is not merely a collection of rules, it is the organization of all rules into a pattern which dominates not only the rules but all coping activity” (Mosak & Shulman, 1988, p. 3). Rules, structure, and organization help an individual to deal with the world in a less chaotic way. Lifestyle can have distorted belief systems that are based on ‘private logic’. Within the private logic of an individual, unconsciously mistaken beliefs can take root and are based on distorted thinking. According to Adlerian view, even though traumatic events take place, such as CSA, the survivor chooses a path of recovery that can be either positive or negative (Mosak & Shulman, 1988).

Adler viewed the individual as a product based on two worlds, the social context as well the individual development of lifestyle (Mosak & Shulman, 1988). Incorporating the person (lifestyle) and the situation (world) allows the therapist to take a holistic approach throughout the therapeutic process. Breaking apart and separating the survivor’s lifestyle and social context
is not helpful and does not allow the therapist to see the entire story. These two worlds are interweaved and understanding of the interconnection allows the therapist to counsel from a holistic perspective (Maniacci & Johnson-Migalski, 2013). The individual will meet their life tasks of social, love, spiritual, work, and self according to their lifestyles (Maniacci & Johnson-Migalski, 2013).

The case study of a 22-year-old Caucasian woman, brutally raped and stabbed seven times in the chest integrated Adlerian principles combined with elements of Existential Theory during therapy sessions (Carich, 2001). The therapist in the first two sessions worked on establishing trust by providing an environment that was empathetic, accepting, and encouraging. As described by Carich, the first stage from an Adlerian theoretical perspective is to establish a strong therapeutic relationship. Second stage is to investigate and evaluate how a client is functioning in their roles of life at work, love, community (family and friends), personal (self-care and management of life), and spiritual. In the third stage, interpretation and awareness are established. In this case, the therapist identified faulty assumptions that ‘life should be fair’, then proceeded to challenge this faulty assumption. The client was able to see that her faulty assumption of ‘life should be fair’, was incorrect and also not serving her well both in her private and social life. After several sessions the therapist helped the client reorient her faulty assumption (forth stage), recognize her positive attributes and begin combating her negative self-concept. The therapist achieved this through encouragement. Through the intervention of encouragement the client was able to overcome feelings of discouragement, a restoration of self identity, worth, and self-respect. After eight sessions over a sixth month period applying Adlerian principles, the client reported an improvement of quality of life as well as an overall positive improvement in her life tasks (Carich, 2001). The client’s lifestyle was formulated
before the traumatic event; therefore the therapist was able to reconnect to positive memories and experiences prior to the trauma, creating motivation for change. It is unusual to see a change in lifestyle when the victim experiences trauma as an adult, nonetheless, “personally powerful life experiences may cause an alteration” (Sweeny diary as cited in Rosen, Matic & Marsden, 2013, p.225). A child who experiences CSA will most likely have difficult time on the development of a healthy lifestyle (Rosen et al., 2013).

**Early Recollections**

Collecting childhood memories is one technique used by Adlerians to discover an individual’s lifestyle, mistaken beliefs and what needs to be changed in order to live a healthy and productive life. Early recollections are stories that happened from birth up to ten years old. They serve as collections of mysterious metaphorical facts that fit together like a puzzle. According to Mosak and Di Pietro (2006) people before the age of ten are not able to remember memories in a sequence, so they fill in the blanks by projecting material in to complete their story. Mosak and Di Pietro state, “Because people cannot remember all parts of the recollection, they tend to attach or project certain details, feelings, and/or concepts onto the recollection to make it coherent. In addition, things that people choose to remember, or not remember, about the event add meaning to the recollection” (p. 2). Early recollections are projections of what they currently think, believe, and feel. Whether a memory really happened or not is not the issue, because the memory serves as projected belief on what is currently being held.

**Therapeutic Use of Early Recollections**

Alfred Adler was one of the first to discover and implement early childhood recollections throughout the therapeutic process. Harold Mosak reviewed and studied the
approach, providing an interpretation and application of early recollections. Harold Mosak is known as a world-renowned Adlerian clinician and teacher (Taylor, 1975). According to Adler a person’s early recollections are found always to have a bearing on the central interests of that person’s life. Early recollections give us hints and clues, which are most valuable to follow when attempting the task of finding the direction of a person’s striving. They are most helpful in revealing what one regards as values to be aimed for and what one senses as dangers to be avoided. They help us to see the kind of world which a particular person feels he is living in, and the ways he really found of meeting that world. They illuminate the origins of the style of life. The basic attitudes which have guided an individual throughout his life and which prevail, likewise, in his present situation, are reflected in those fragments which he has selected to epitomize his feeling about life, and cherish in his memory as reminders. He has preserved these as his early recollections (as cited in Taylor, 1975 p. 213).

Adler found that understanding early recollections gave a look into the depths of the client’s personality structure, therefore increasing understanding of the individual. What the individual remembers from his/her childhood can be directly related to the individual’s current thoughts, wants, and feelings.

**Collection of Early Recollections**

The initial stage of the Adlerian clinical assessment is collecting information to understand the client’s lifestyle. The factors that make up the persons lifestyle are based on collection of heredity factors, family atmosphere, family values, and family constellation. Collection and interpretation of early recollection is a technique used to unveil mistaken beliefs
as well the story of their life. An example of a methodology of collection of early recollection based on Brokaw, Hedberg, and Wolf (2011) include:

1. Explain to client what an Early Recollection is and why you are taking an early recollection (Informed consent signed): “An early recollection is a childhood memory that can help us better understand the problem(s) you are currently experiencing.” “By no later than age six, children create a roadmap of how to fit in and go through life.” “Because children are good observers and poor interpreters, often mistaken beliefs about how to fit in are created.” “These mistaken beliefs can interfere with and cause difficulties and the functioning of our adult life. If you’d like to find out what some of your mistaken beliefs are, we can identify them by collecting childhood memories and then you can have an opportunity to change them if you choose?”

2. Give parameters around collecting the ER: Therapist wants an early recollection not a report. No right or wrong; good/bad ER. Need age at the time of ER. Start with earliest ER. Go with whatever ER comes to mind and start and end it where you want to. Will be writing the ER down and repeating back to you. Repeating the ER increases accuracy, validates, and slows the client down, which allows more complete recall of ER. Take it down word for word. Never supply client with the feeling word, it must come from them.

3. Collect the ER: Ask the client to think back to an early memory or recollection and picture it in your head. Ask “How old are you?” Client gives ER and then the therapist asks, “What are you feeling and why?” and then ask, “What is the most vivid moment?” “What was the feeling at that moment and ask why that feeling?” “Because?” After five to six ERs are collected, the therapist needs to interpret the meaning of the ERs.
Interpretation of ERs will unveil an individual’s lifestyle as well as fictive beliefs, which are unconsciously suppressed (pp.81-82).

In a recent study, Rosen, Matic and Marsden (2013) incorporated collection of ERs throughout the use of art therapy. These authors concluded that Adlerian Art therapy provides a safe and effective way to assess lifestyle. Art therapy is found as a nonthreatening technique, allowing the client to speak without words as well as providing positive therapeutic affects that are cognitively, sensory, and relationally based (Rosen et al., 2013).

**Interpretation of the Early Recollections**

Interpretation is the second phase of ER process and can be complicated and confusing. Interpretation of ER involves professional training, supervision and practice. Using the headline method devised by Mosak and Shulman (1988) is a holistic approach, which examines the overall theme being told within the ER. Mosak and Di Pietro (2006) encourage the therapist to act as if they are a detective and search for small clues throughout the ER. The puzzle for discovering the “Headline” of the ER occurs when the therapist puts the pieces together forming a complete picture, unveiling the details of how the client perceives themselves, others, and the world. The book, “Early Recollection; interpretative method and application”, by Mosak & DiPietro is a useful tool in understanding how to collect and interpret ERs ERs are filled with, “symbols and metaphors that, correctly interpreted, describe fundamental aspects of individuals” (Mosak & Di Pietro, 2006, p. 1). Early recollections may or may not have occurred; regardless of whether they are true or not, recollections can be used as a projective tool to understand the client’s current view of the world as well as their individual lifestyle.

A second method of interpretations of an ER is the typological approach, which emphasizes a holistic approach versus breaking down the memory in parts (Mosak & Di Pietro,
2006). Mosak developed 15 different type labels to be used only as a tool to gain a general picture of the individual. Each individual is to be understood as being unique and different, emphasizing a holistic and individualistic approach when interpreting ERs. The 15 labels are described as follows:

1. The getter: The individual provides ERs that have the main theme of getting something. They often like to be the center of attention and obtain the center of attention by getting something for example for their birthday or Christmas.

2. The controller: The ERs are centered on events that indicate that “life is good” when one is in control and when that “life is not so good” when not being in control.

3. The driver: The individual will be a part of multiple activities, always busy and often not able to sit.

4. The person who must be right: ERs are often based on being right, elevating themselves above others because they know best. They often will get rewards for doing the right thing or making the right choice.

5. The person who must be superior: The individual will report ERs that present themselves as the best, special, and the one on top. If they are not the best they will report ERs that show inferior thoughts and feelings. The individual believes they must be the best in order to have significance and belong.

6. The pleaser: The individual will reports ERs as having to please and to please everyone. They are dependent on the approval of others and will feel bad about themselves when they do not receive approval.

7. The “aginner”: Recollections show that they are oppositional and often a rebel. There purpose for opposition is to stand up for non-conventional beliefs and convictions. An
example of a person(s), which exhibits aginner characteristics, would be Jesus or Robin Hood.

8. The victim: These people will have ERs where life is bad and unfair. They see themselves as victims of others and often will seek out relationships with those who continue to victimize in order to keep their status of being a victim.

9. The martyr: These people will have ERs where they die for a cause. They may appear to be a victim, but they are not and often have a cause that is related to their suffering.

10. The confuser: The confuser will give ERs where they are confused and life is confusing.

11. The feeling avoider: They do not report feelings in their ERs. They often report through observation. Feeling avoiders do not generate forward movement because of minimal or no feelings.

12. The social interest type: ERs consist of cooperation, collaboration, caring of others and sense of belonging. These ERs represent an individual who is healthy and is socially interested.

13. The excitement seeker: ERs will contain excitement and commotion. When life gets boring they will make sure there is excitement present.

14. The baby: They will refer to themselves as the “baby” regardless of positioning in their family. They prefer to be waited on and often resist when asked to take initiative for themselves.

15. The Inadequate Person: They will often report ERs where they feel inadequate and powerless (Mosak & Di Pietro, 2006, pp. 60-75).

These typologies are used to help guide the therapist’s interpretation of ERs, but the therapist also needs to be aware they do not give a complete comprehensive picture of the individual. In
order to utilize these types in the interpretation of early recollection the therapist needs to collect multiple ERs before interpreting and also needs to be aware that there can be an overlapping among types. It is also important to keep in mind that types refer to the behavior and do not define the person (Mosak & Di Pietro (2006).

Evidence Supporting the Use of Early Recollections as an Assessment Technique

A study completed by Lieberman (1957) was designed to test the hypothesis in which early recollections had a direct correlation to current projective data. She conducted a small study of eleven psychotic and eleven non-psychotic females, each of which completed a full battery test of the Wechsler-Bellevue, Rorschach, Bender-Gestalt, and House-Tree-Person drawings. ERs were collected and the experimenter wrote reports based on the interpretations of the early recollections. The staff psychologist composed reports on the same subjects based on the findings of the test battery. The experimenter and staff psychologist then compared results based on a checklist of descriptive items evaluating personality traits. Lieberman found that there was a significant correlation ($r = .65, P .001$) between the information collected from the ERs and the results from the psychological report. Liberman concluded that ERs could serve as a more rapid tool in collecting data with similar end results as those of a longer and more complicated battery test.

A workshop conducted by Mayman and Faris (1960), studied three sets of memories on a 24 year-old man presenting with current inter-personal and intra-personal problems. The three sets of ERs were collected from the client’s mom and dad as well as the client himself. The ERs were collected from the parents and client to analyze: “1.) The character structures of the patient, his mother and his father; 2.) The nature of the interpersonal and interpersonal forces that may have been significant factors in the patient’s formative interpersonal matrix; and 3.)
the resultant enduring relationship-predispositions which have become important facets of the patient’s adult character structure” (Mayham & Faris, 1960, p. 508). The questions presented to the client’s mom and dad included, “What was the most striking early memory; the most characteristic early memory; and any other memories which stand out. The client was asked for his earliest memory; his next earliest memory; his earliest memory of his mother; and earliest memory of his father. The data collected from the early memories of all three persons were interpreted and presented. The client then participated in the Rorschach and Thematic Apperception tests, results identified evidence of his past experiences and interpretation of them was transferred to how the client currently interprets who he is, others as well as how he sees the world. The belief and character patterns presented in ERs were consistent with results of Rorschach and Thematic Apperception Test, indicated that ERs are a valuable projective tool that can be used to discover information about transference patterns that are currently carried forward to the presenting problem and how these patterns are reenacted in the present situation (Mayman & Faris, 1960).

Martin Mayham’s legacy and scientific contributions inspired other studies to be conducted providing evidence ERs are an effective projective tool in the psychiatric field. Study conducted by Acklin, Bibb, Boyer, and Jain (1991) focused on the relationship of Early Memories (EM) and relationship episodes. The study concluded that EMs are a reliable tool in encoding relationship and personal functioning, as indicated by measure of attachment style (Separation-Individuation Test of Adolescents), mood (Profile of Mood States), clinical symptomatology (Symptom Checklist 90-Revised (SCL-90-R), and the Minnesota Multiphasic Personality Inventory (MMPI). The meta-study by Fowler, Hilsenroth and Handler (2000), examined research studies that incorporated Martin Mayhem’s personality assessment based on
early memory process, while integrating ego psychology and object relationship theory. The authors concluded to the in depth examination of other research as well as case studies performed, found that EMs are an effective tool in bridging the gap between personality assessment and psychotherapy. EMs also can be used to provide clinical value for the therapeutic process by understanding the way a client views their relationships based on past experiences. Understanding how the client views their relationships and how transference of those views can affect the therapeutic relationship can allow the therapist to be more strategic throughout the therapy. This strategic method can then lead to a more effective, shorter, and well-informed treatment process (Fowler, Hilsenroth, & Handler, 2000).

**Similarities and Differences of Early Recollections and Eye Movement Desensitization and Reprocessing Techniques**

Successfully integrating the techniques of EMDR and ERs into a therapeutic practice requires understanding the similarities and differences between these two techniques. Both EMDR and ERs require minimal amount of time to use in a counseling session and require little to no homework. ERs and EMDR are also tools that assess the subjective truth in order to gain a better understanding of the present truth. Both therapeutic techniques collect memories and examine most vivid moments and feelings associated with the memory. Both techniques have a goal to reorient beliefs, which is completed first by recalling a memory. ERs and EMDR transform the dysfunctional residue from the past into something more useful and replace the misguided belief with a desired outcome/belief. One of the main differences of EMDR and ERs is that EMDR requires the therapist to go through an eight-step treatment process. The EMDR process is completed in an eight-phase methodology and only effective if the therapist is properly trained. Training is expensive and requires time, energy and money to obtain
certification to practice EMDR. ERs do not require certification to incorporate into the therapeutic practice. ERs collect memories from early childhood from zero to ten years old, where EMDR focuses on collecting memories at any age and related to trauma. EMDR rates the traumatic event on a scale as well as assesses where the negative feeling is experienced within the body. In phase four of EMDR desensitization takes place using back and forth movements. Explanation of ERs is a technique designed to assist in unraveling the mystery of the client’s lifestyle and reorienting mistaken beliefs. EMDR and ERs appear to be effective techniques and can be a powerful combination used in therapy to treat CSA victims.

**Incorporating Eye Movement Desensitization and Reprocessing with Early Recollections**

Since child sexual abuse is not a unified phenomenon, it lacks a universal theoretical model, which a therapist can use consistently. It is likely that a variety of theories and interventions are required in order to ensure effective psychological treatment. A suggestion of a tailored treatment based on an individual’s needs and issues currently being presented in therapy would ensure a positive therapeutic outcome. The combination of EMDR and ERs appears to be useful when treating CSA. EMDR addresses the trauma that is brought forward consciously by the client through a structured eight stage process. The therapist takes the presenting problem and assists the client to move through the traumatic memory by creating alternating eye movements, creating less emotionality while revisiting the trauma, allowing for faster and effective therapeutic results. Incorporating the assessment tool of early recollections can allow the therapist to see what the client unconsciously believes about oneself. ERs allow the therapist to go into the client’s world on a deeper subconscious level, while also assisting the client to follow as well. Unveiling of lifestyle and private logic can create a subconscious shift in the client’s brain allowing for positive therapeutic results. Early recollections are not
only an assessment tool for both the therapist and client but allow a shift from the internal world (subconscious) to the external world (conscious).

**Conclusion**

This paper examines the prevalence of CSA among women, some of the potential long-term effects that can cause a woman to not lead a healthy and productive life, and the current approaches to treatment of survivors of CSA, with special focus on the use of EMDR and early recollections. Knowing the statistics and the specific negative affects of CSA on women can allow for a greater success in providing effective psychological treatment. Also, understanding the different types of therapy and what is most effective is vital to the success of treating CSA. Sexual abuse can create various symptoms and can be complicated; therefore integrating Adlerian holistic theory and EMDR can create a powerful therapeutic combination for CSA survivors. The working relationship with a survivor can be challenging, but can also be rewarding. A survivor often feels discouraged, low self-esteem, blames him or herself, and engages in self-destructive behaviors and relationships. When in doubt use encouragement, this is a simple and effective Adlerian tool that can be used for the sexual abuse survivor. As Dreikurs stated, because CSA creates great discouragement, the sexual abuse survivor responds to encouragement the way flowers do to a gentle rain after a long drought (as cited in Harrison, 2001).
References


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