Integrating Adler’s Individual Psychology into Current Trauma Models

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Abstract

Trauma continues to be a primary subject in therapy sessions throughout the world for people of all ages, ethnicities, religions and economic positions. Adler’s Individual Psychology places great importance on the child’s development and understanding of his or her environment. Since Individual Psychology is focused on the impact of the environment in early years a look into trauma’s influence is both necessary and expected. However, even with the multitude of evidence supported interventions for treating children and their families after a traumatic event, the field of Individual Psychology continues to be nearly silent on the issue. The purpose of this project is to explore and present potential interventions that parallel those already identified to work from other methods and compare these approaches to Adlerian views on trauma. The project examined several parallels and explored similarities as well as differences.
Integrating Adler’s Individual Psychology into Current Trauma Models

As a small boy growing up in Vienna, Alfred Alder experienced many potentially traumatic events including the death of his brother in his bed, hearing a physician tell his father he would die, falling ill with rickets and glottis, and being run over twice in the streets (Hoffman, 1994). However rather than demonstrating an expected reaction to trauma including intense fear, triggers, reactions and anxiety he went on to develop a major brand of treatment still used in modern day psychology (Carlson & Maniaci, 2012). Similarly, children continue to demonstrate varying levels of resiliency to a spectrum of potentially traumatizing events (Cohen, 2008).

Adler’s early childhood experiences shaped his beliefs about himself and the world around him through the formation of his lifestyle. Adler was quoted stating “we learn from the experience only to the extent that the style of life permits” (Strauch, 2001). The lifestyle developed between ages five and nine is a set of beliefs that dictates how individuals will think about themselves, their world and how things should be (Even & Armstrong, 2011). According to Goldfinch (2009), trauma also impacts how children learn about themselves as well as the world. The self-concept can be impacted by traumatic events allowing creation of a negative set of faulty beliefs (Strauch, 2011). Butler and Newlon (1992) noted that some children of trauma may develop similar set of beliefs about self and the world. The chart below, adapted from Butler and Newlon’s (1992) work shows some beliefs typically noted by these children.
The beliefs above shape the thoughts and feelings of children impacted by trauma considerably altering their interactions with peers, their world and even their attitudes toward themselves. Regardless of trauma history, children present a unique challenge to the clinician in their distinct natures and needs. Children unlike many adult clients are referred by others to deal with problems, primarily behavioral. Children under the age of 10 are different from adult clients since they may lack the verbal reasoning skills necessary to participate in traditional therapy methods (Even & Armstrong, 2011; Kottman, 1999). This lacking verbal capacity requires the helping professional to be creative and explorative in building a relationship and moving forward in the therapeutic process. Catani and colleagues (2009) studies demonstrated that this process does not need to be long and arduous for children to maintain progress.

The importance of treating children is indicated by the research on lifelong problems for those who do not receive adequate treatment. Research continues to indicate that children and adolescents exposed to traumatic events are at a greater risk for psychological, physiological and emotional problems (Fairbanks, 2008). Studies also indicate that these difficulties may persist well into adulthood increasing the likelihood of depression, posttraumatic stress disorder, difficulty keeping and maintaining employment, poor physical health and substance abuse

<table>
<thead>
<tr>
<th>Beliefs about Self</th>
<th>Beliefs about Others</th>
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<tbody>
<tr>
<td>“I expect bad things to happen to me.”</td>
<td>“People are untrustworthy and unwilling to be involved in my life.”</td>
</tr>
<tr>
<td>“I want to be special and have others take an interest in me.”</td>
<td>“The world is a place filled with trouble and conflict.”</td>
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<tr>
<td>“I expect to be alone and abandoned.”</td>
<td>“The world is unsafe.”</td>
</tr>
<tr>
<td>“I expect to be misunderstood.”</td>
<td>“Life is dangerously frightening.”</td>
</tr>
<tr>
<td>“I want others to understand me.”</td>
<td>“Life is out of control.”</td>
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<tr>
<td>“I want to take care of others.”</td>
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<tr>
<td>“I want to be excited.”</td>
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**Children of Trauma as a Unique Therapeutic Experience**

The beliefs above shape the thoughts and feelings of children impacted by trauma.
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(Fairbanks, 2008). Resiliency is impacted greatly by the level of support and the family atmosphere (Ellis et al., 2011)

Gfroerer, Kern and Curlette (2004) also emphasized the influence family atmosphere and early relationships have on child development and resiliency. The authors noted how the field of Individual Psychology has long promoted family atmosphere as comprising of parent child relationships, sibling relationships, family placement and perceptions within the home. The atmosphere described above is a primary focus of Alfred Adler’s Individual Psychology.

Individual Psychology and Children

Hans Vaihinger, introduced “The Philosophy of As If,” in 1911 allowing Alfred Adler a basis for his theory of goal directed movement (Bitter, 2009). This movement, undertaken by both children and adults, could be identified if one looked thoroughly at the final fictional goal of the individual (Bitter, 2009; Even & Armstrong 2011). Adler also believed in social psychology – that is all individuals must be considered in relation to their family and social systems (Bitter, 2009). A primary tenet of individual psychology is the idea of social interest; having a passion for one’s self and the world around them. Mental wellness can be measured by the degree of social interest present with the most well having the largest quantity of social interest (Gfroerer, Kern & Curlette, 2004).

Individual psychology as a mode of treatment is geared specifically toward encouraging the individual to build social interest and return to the useful side of life (Ansbacher & Ansbacher, 1956). Adlerian play therapy mirrors the original four phases of Individual Psychology in a manner that is relatable to a child (Kottman, 1999). The author suggests developing a relationship of equals is the first stage of play therapy and exploration of the lifestyle are moved together and attained through play and gathering data from parents and
school teachers. According to the same study, during the third stage the helping professional frames and reframes mistaken beliefs in play and in interactions with the child in order to help the child gain insight. Play can be used as a method to encourage the child to build social interest and influence change in the child’s actions and thought process (Suprina & Chang, 2005). Finally during the reorientation phase the helping professional and child work cooperatively to learn and practice new skills (Kottman, 1999).

Individual Psychology has long touted the importance of the family system and environment in the development and mental wellness of a child (Ansbacher & Ansbacher, 1956). Parent education is a primary investment in therapy as parents direct the family environment. Parent education needs to focus on building a cooperative relationship between the parent and child, communication skills, consistency and fairness in parenting and using natural or logical consequences (Gfroerer, Kern & Curlette, 2004). According to the authors further education on understanding the goals of misbehavior and democratic parenting strategies is also important to encouraging desired behaviors. Goldfinch (2009) advises that families that have experienced a trauma specifically work with the whole family to build safety, work in dyads to improve the relationship between parents and the child, build parenting skills and increase the frequency of positive experiences as a family. When negative experiences within the family environment arise, Adlerian therapists often provide education on the goals of misbehavior and how to use the Crucial Cs to treat those misbehaviors (Dreikurs & Stolz, 1987).

**Crucial Cs and Misbehavior**

Adler was quoted saying “to be human is to be inferior” (Suprina & Chang, 2005). Inferiority, the key motivator in the change process, provokes individuals to work in both sides of life – the useful and the useless (Ansbacher & Ansbacher, 1956). A larger feeling of
inferiority will provoke more powerful urges to change and more severe emotional agitation (Suprina & Chang, 2005). These urges in children result in misbehaviors at home and in school in an attempt to get their needs met.

These misbehaviors can be allocated into four categories: attention, power, revenge and assumed inadequacy (Dreikurs & Soltz, 1987; Even & Armstrong, 2011). Children demonstrating the goal of attention are striving for a sense of belonging (Dreikurs & Soltz, 1987). The authors noted that when the child’s attempts for attention are not rewarded the child, being ever creative may resort to power as a means of gaining superiority. They further noted that as the power struggle rages on and intensifies it may move into the goal of revenge in which the child has determined the only way to win a place in the family. Finally, they illustrated that, when everything has been attempted the child may turn to assumed inadequacy in which the child gives up entirely and begins to use avoidance to protect the self-concept.

Children of trauma may present as typical misbehavior due to the overall impact of trauma and must be assessed carefully by clinicians to seek out the purpose of the behavior. Hyperaroused children garner much attention due to their difficulty focusing, poor frustration tolerance, high anxiety and responses to seemingly neutral events. Avoidant children can be observed having difficulty completing tasks or separating from adults. Children who shut down as a response to trauma can present reduced peer engagement and difficulty participating in class (Goldfinch, 2009).

The Crucial Cs, created by Amy Lew and Betty Lou Bettner, can be used to redirected misguided misbehaviors while remaining encouraging to the child (Kottman, 1999). Connection, the first of the Cs, addresses the child’s need to belong. Through encouraging connection to peers and family Capability encourages competency in the child and his or her developing
abilities. Significance or knowing that they count is another way in which behavior can be encouraged. Finally, courage plays a dual role, not only does it allow the child to feel secure in risk taking it also increases resiliency to life’s little bumps (Bitter, 2009; Kottman, 1999).

Methods of treating these little bumps are as diverse as the number of psychological theories. Trauma Focused Cognitive Behavioral Therapy, Family to Family and Trauma Systems Therapy all appear to be promising treatments.

**Trauma Focused Cognitive Behavioral Therapy**

Trauma Focused Cognitive Behavioral Therapy (TFCBT) was developed by Judith A. Cohen and Anthony P. Mannarino as a method of treating trauma symptoms in children ages three to eighteen (Jennings, 2004). In Cohen’s 2008 study 100 sexually abused children and their families were treated with either TFCBT or a treatment as usual group. Results indicated that the children in the experimental group demonstrated a decrease in symptoms of Posttraumatic Stress Disorder while the parent group reported improvements in the child’s behavior and depressive symptoms (Cohen, 2008). Overall, TFCBT showed to be more beneficial than the control group.

TFCBT is successful for many reasons including awareness of and respect for the family’s lifestyle, values and beliefs (Little, Akin-Little & Gutierrez, 2009). TFCBT is a collection of skills that build on one another and are represented by the acronym PRACTICE: psychoeducation and parenting, relaxation, affect modulation, cognitive coping, trauma narrative, in vivo exposure, conjoint parent child sessions and enhancing safety (Mannarino et al., 2011). The model is designed to be flexible and meet the client and his or her parents at their stage of acceptance of the traumatic event (Little, Akin-Little & Gutierrez, 2009).

Developing a relationship in which communication is present between the child and non-offending parents is the primary goal of TFCBT. During parent only sessions parenting skills
including the use of active ignoring and use of time outs to manage undesired behaviors. During conjoint parent and child sessions relaxation and coping skills are taught to both the child and the parent to generalize. The child will also share his or her narrative with parents to build communication about the traumatic incident. The ultimate goal in TFCBT is to build self efficacy in both the child and also in the family unit. (Little, Akin-Little & Gutierrez, 2009)

TFCBT and Individual Psychology demonstrate some similarities as well as their differences. Both TFCBT and Individual Psychology support the importance of family development through enhancing cooperation, building communication and building self-efficacy. Goldfinch (2009) indicates the significance of the relationship between children and parents as a secure relationship has been demonstrated to moderate the impact of the traumatic event. According to Goldfinch (2009) the significance of the traumatic event increases only if the support decreases. However, TFCBT uses a narrative to bring forward and combat cognitive errors while Individual Psychology uses early recollections. Early recollections are early memories used to explore the lifestyle and personality of the child (Ansbacher & Ansbacher, 1956; Dreikurs & Stolz, 1987; Even & Armstrong, 2011). These recollections can be represented in a sandtray, told as a make believe story or even drawn without losing their clinical significance (Even & Armstrong, 2011). TFCBT and Individual Psychology are very similar in nature with one large difference – the use of and importance placed on the narrative.

**Family to Family**

The Family to Family program was developed by Joyce Burland with the National Alliance on Mental Illness for use with the families of mentally ill and traumatized individuals (Burland, 1998). Based on the work of Lindemann and Caplan it centers on the idea that not every bad thing that happens is someone’s fault, rather that sometimes bad things just happen.
Another primary concept is that it is normal to have a reaction to trauma and that people affected by trauma get better in stages. Family to Family is a twelve week lecture and discussion course led by trained family members.

Family to Family and Individual Psychology have more differences than similarities, however the Family to Family program is a working program that supports the idea of a problem rather than a shaming circumstance. Family to Family is one of the few experiences similar to Adler’s child guidance clinics. Adler first established child guidance clinics in Vienna in 1919 before introducing them in London and New York. Adler would collect around 20 parents and select an identified family prior to the clinic. During the clinic, Adler would first work with the family and then the children to identify the problem and also to understand how the problem was viewed from all sides. Adler would then send the children off stage and work with the parents to identify goals of misbehavior and come up with a plan to negate these behaviors in the future. By allowing it to be a group process, Adler was able to lower the stigma of the problem child and teach many families that they were not only going through a common problem but also that solutions were viable and available. Adler also completed a similar process in the schools of Vienna. Family to Family is a modern version of the Adlerian child guidance clinic; however, many changes would need to be made in order to make Family to Family a truly Adlerian affair (Hoffman, 1994).

**Trauma Systems Therapy**

Trauma systems therapy (TST) is a multidimensional approach to treating trauma in children ages six to nineteen and their families (National Children’s Traumatic Stress Network, 2008). The authors illustrate that unlike many modalities TST includes several supports working cooperatively including in home services, case management, skills training, therapy and
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psychiatry. Based on Bronfenbrenner’s social ecological model, the authors note, TST promotes awareness of the complex social environment encompassing individuals and also takes into consideration how disruptions in one piece of the social ecology can affect it as an entirety. According to the authors, TST is comprised of five stages: surviving, stabilizing, enduring, understanding and transcending. Children are placed in each category based on the degree of emotional and behavioral dysregulation demonstrated as well as the ability of the child’s environment to provide support (Ellis, et al., 2011). The authors noted that children and their families move through these stages based on the improvements noted by parents and treating professionals.

TST demonstrated a few parallels to Individual Psychology particularly in the areas of being socially embedded and also the unity of supporting professionals. Adler from the beginning has stressed that not only are all humans social creatures but that the impact in one area can affect all areas of life – social embeddedness (Bitte, 2009). Adler also began calling for the need for collaboration between school personnel, medical doctors, psychologists and social workers in the 1920’s (Hoffman, 1994). TST and Individual Psychology both recognize the systemic nature of an individual’s existence as well as the need for collaboration in practice.

Method

Participants

An invitation was delivered to each member of Sioux Trails Mental Health Center to attend lunchtime training in a conference room with a potluck lunch. Participants included eight staff from Sioux Trails Mental Health Center in St. Peter, Minnesota. Those attending represented a wide range of professionals in the mental health field including a psychiatrist, a psychiatric nurse, an outpatient services director, several therapists of varying degrees and a site
Familiarity to trauma treatment and Individual Psychology varied among the participants, although many reported learning about Individual Psychology for the first time that afternoon.

**Materials**

This training was presented in a conference room in which several popular Adlerian titles were made available around the room for participants to investigate at their leisure. Each participant was also provided a packet of materials including the five tasks of life wheel, a collection of evidence-based trauma methods, a handout on the Crucial Cs and goals of misbehavior, references and a survey. The PowerPoint presentation was presented through the use of a projector and screen. A second computer was used to record the presentation. A 1929 newsreel of Alfred Adler speaking about the development of the lifestyle was used to provide familiarity with Adler himself and to educate about the lifestyle. Several hundred buttons were used to complete a family constellation activity.

**Procedure**

Participants were gathered into the conference room, asked to gather their lunch and take a seat. The presentation began with a question posed to the audience about what they think may have become of a young man who had experienced potentially traumatic events. A further question was posed to identify the young man in the scenario as Alfred Adler himself.

Next, the presentation focused on educating participants about Individual Psychology. A brief outline of core components was provided including a video of Alfred Adler speaking about the formation of the lifestyle. Participants were asked to complete a button version of a family constellation and provide feedback (as shown in video). The second half of the presentation focused on specific trauma interventions and their parallels to techniques from Individual
Psychology. The process of early recollection collection and transformation was also explored. Participants were given a made up recollection to explore movement and attempt to identify mistaken beliefs in small groups and again provide feedback. The presentation wrapped up with question and answer time.

**Results**

Internet technology issues aside, the presentation appeared to flow with interest noted from participants. The technological issues required the presentation to be given in half the time it was scheduled and allowed little room for deviation from the presenter. Participant surveys indicated a high level of satisfaction with the presentation with a few lower scores in encouraging discussion and organization. This project would have greatly benefitted from having more participants, increased use of audience participation, less technical issues and a longer time frame.

**Future Plans**

In future work, this writer hopes to work primarily with children and families. With the large numbers of individuals experiencing trauma it will be helpful to have had a primer in what exists in Adlerian literature and also how to integrate Adlerian concepts into evidence based trauma models. The Adlerian concept of family cooperation can be utilized in encouraged in trauma based therapy through building communication between family members, boosting the parent’s abilities and confidence in his or her parenting abilities and hosting weekly family meetings. Through increasing family cooperation this writer hopes to build family support and lessen the impact and severity of trauma on the family unit. Increasing safety through building support would also be of paramount concern.
Adler’s early parent education forums are fascinating and extremely relevant to society today, especially in systems experiencing or with a history of trauma. Historically, traumas have been deemed shameful or not even reported. If education on the prevalence and impact of trauma was provided to parents and young people, would it provide families an opportunity to protect children from some of these traumatic events? Could education and training help those who suffer especially those young boys or girls at such a crucial point of development?
References


http://www.annafoundation.org/MDT.pdf


