Individual Psychology, Brainspotting, Trauma, and Addiction

An Experiential Project

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirement for

the Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

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January, 2018
Acknowledgments

*Lord, how may I serve you*

*I am your Instrument.*
Abstract

Due to the number of Americans suffering from addictions and the increased attention on trauma, an increased demand exists for trauma-informed therapeutic approaches and techniques to address the effects of addictions and trauma. An integration of Individual Psychology and Brainspotting techniques can have a positive impact on the treatment outcomes related to addiction and trauma. The proposed dual treatment modality could effectively change how therapists use talk therapy and intervention models in psychotherapy.

*Keywords:* brainspotting, Individual Psychology, addiction, trauma
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Individual Psychology, Brainspotting, and Addiction

According to Ansbacher and Ansbacher (1956), Alfred Adler believed all humans strive to fulfill three basic needs: safety, significance, and a place to belong. Stevens (2017) suggested Adler’s principles of Individual Psychology are extremely relevant and applicable in present-day culture. While there are many root causes of isolation and separation, this project includes a focus on the unresolved trauma that can lead to addiction.

The World Health Organization (WHO) reported 1 in 20 people between 15 and 64 years of age use an illicit drug (WHO, 2017, para. 1). The National Institute on Drug Abuse (NIDA) reported current American generations, now more than previous generations, have experienced the widespread devastation and magnitude of addiction to prescription drugs (Volkow, 2014). A connection exists between substance addiction and/or prescription drug addiction and loneliness (Hosseinbor, Yassini Ardekani, Bakhshani, & Bakhshani, 2014). According to Volkow (2014), the use of prescription drugs has become an epidemic in the United States of America, and rapid and effective therapeutic interventions are necessary at this time. A holistic approach to addictions could offer hope for a future that includes a decrease in the number of people addicted to substances.

Individual Psychology is a holistic theory that connects physiology, psychology, and a humanistic philosophy of living (Mosak & Maniaci, 1999). Individual Psychology shares similarities with current addiction treatment methods, and the application of Individual Psychology to the addiction epidemic can foster courage, community significance, and a goal-orientated attitude that could encourage people to work together within a community.

In addition to Individual Psychology techniques, brainspotting offers individuals the opportunity to process negative events in the mind and body to resolve and restore the whole self.
(Grand, 2013). As a result, a person can once again engage in the community and establish purpose and meaning. Like Individual Psychology, the techniques used in brainspotting share similarities with current addiction methodologies and offer individuals an effective and holistic opportunity to address unresolved trauma stored in the body (Grand, 2013).

The purpose of this paper is to explore the use of Individual Psychology and brainspotting as an effective, integrated intervention model for individuals coping with addiction. The physical response to trauma and the connection of trauma to addiction suggests the potential effectiveness for the use of brainspotting techniques within the field of addictions.

**Trauma and the Body**

Trauma is defined as “…a disordered psychic or behavioral state resulting from severe mental or emotional distress or physical injury” (“Trauma,” n.d.). Trauma is a subjective physical, emotional, or psychological experience that is unique to each individual (Boals, 2017). Psychological and physical responses to trauma vary, however, it is widely accepted that some levels of anxiety may be linked to an earlier event that was not processed through the mind and the body. Van der Kolk (2016) described trauma as unresolved negative experiences held in the body. Scaer (2007) stated symptoms of stress might occur when traumatic memories are stored in the area of the brain that regulates the body (limbic system). According to Scaer, when the nervous system responds with the flight, fright, freeze, or faint response, most body organs are unable to maintain a proper balance which results in “dis-ease.” Scaer stated when the nervous system works too hard for too long; physical illness can occur. Trauma creates a physiological response of the nervous system and results in altered functioning (Grand, 2013; Levine, 2010; Siegel, 2012; van der Kolk, 2016).
The Brain

Siegell (2012) encouraged clinicians to view the brain as a circle with two lines and three sections. For instance, the front of the circle is the prefrontal cortex, which is the executive decision-making area of the brain. The middle of the circle, or the midbrain, is the home of emotion regulation and reflexes. The bottom of the circle, or the hindbrain, houses the essentials such as breathing, swallowing, and heartbeat. The back of the brain serves as an instinctual epicenter. That is, the back of the brain responds with the flight, fight, freeze, and faint responses necessary in early development (Siegel, 2012). Siegel stated when cortisol is released, it covers the front and middle portions of the brain (i.e., the brain’s executive and emotional functioning) and allows the individual to engage instinctual responses in the hindbrain. In other words, non-survival functions are disengaged, survival mechanisms are engaged, and a greater opportunity exists for survival.

The Nervous System

The body uses the nervous system to send and receive signals from one part of the body to another (Siegel, 2012). Essentially, the nervous system is the electrical wiring of the human body. Structurally, the nervous system consists of the brain, spine, and neurons (or messengers). As part of the nervous system, the sympathetic nervous system prepares the body for intense activity, while the parasympathetic nervous system does almost the exact opposite (Siegel, 2012). For instance, the parasympathetic nervous system relaxes the body and inhibits or slows high energy function. The sympathetic and parasympathetic nervous system work together to control the responses within the body, and after high response, the ability to return to a balanced state.
Siegel (2012) suggested that when a clinician attends training on the topic of trauma, the training structure will likely include information about the nervous system. Siegel recommended clinician’s increase their understanding of the role of the nervous system in regulating emotions and extreme stress. For example, a regulated nervous system is when individuals experience a rise in stress levels and return to a calm state after a stressful event. According to van der Kolk (2016), trauma moves typical activation of the nervous system beyond its normal limits. For instance, when trauma occurs, especially repeated trauma, the nervous system does not return to typical functioning, and the nervous system remains “on.” When the sympathetic and parasympathetic nervous systems are consistently overstimulated, a person experiences anxiety, panic, anger, hyperactivity, hypo-activity, and restlessness (Scaer, 2007). In addition, when consistent overstimulation exists, the flight, fight, faint, or freeze response is triggered.

**Trauma and Arousal**

As previously outlined, the nervous system reacts to distress and triggers the survival instinct (Siegel, 2012). When the survival instinct is triggered, the front and mid-brain receive a flood of cortisol and adrenaline (van der Kolk, 2016). When the client and the clinician understand symptoms from a survival perspective, behaviors begin to make sense, people feel less “crazy” and more hopeful, and begin to understand the concept of brain plasticity and mind-body growth (Siegel, 2012; van der Kolk, 2016). When clinicians work with clients who have experienced trauma, they can normalize and facilitate understanding and recognition of triggers, cues, and the need for safety (Ecker, Ticic & Hulley, 2012).

**Threshold of arousal.** Every individual has a unique range of arousal influenced by life experiences and genetic predisposition (van der Kolk, 2016). For example, people who have experienced a traumatic event, or related traumatic events, develop a narrow range of daily
arousal and an individual threshold for self-regulation (i.e., emotions). A narrow range of arousal decreases the ability to effectively control behavioral and emotional responses (Porges, 2011; van der Kolk, 2016). Siegel (2012) stated the narrow arousal range is created after spending too much time in arousal. Siegel described the dichotomous nature of the arousal threshold as hyper-arousal (e.g., panic, racing thoughts, or muscle tension) or hypo-arousal (e.g., numbness, dissociation, or shutting down). According to Siegel, when people experience trauma, they do not demonstrate a normal, healthy daily arousal and cannot cope with varying levels of distress. That is, the skills needed to feel relaxed or calm in the body, or the ability to manage a range of emotions and cognitions when triggered by internal or external stimuli, are underdeveloped after a trauma experience.

**Psychological Response to Trauma**

Herman (1992) viewed psychological trauma as experienced events that overwhelm the human system and render an individual powerless over the situation. Van der Kolk (2000) defined trauma as a stressful event that produces a shock or threat that may temporarily or permanently change the ability to cope with a perceived threat. Also, the stressful event may overwhelm the person’s conscious thoughts and decrease the individual’s sense of purpose and pleasure. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) psychological responses to trauma include symptoms consistent with generalized anxiety disorder, panic disorder, and posttraumatic stress disorder.

**Posttraumatic Stress Disorder**

The *DSM-5* (APA, 2013) defined posttraumatic stress disorder (PTSD) as a mental health disorder that includes a re-experiencing of a negatively held event or events, avoidance or
isolation, and hyperarousal. The nervous system is affected by negatively held experiences whether the event is influenced by mood-altering substances or destructive behaviors (Brick, 2012). Dvir, Ford, Hill, and Frazier (2014) stated emotional dysregulation difficulties impair the ability to regulate and/or tolerate emotions and could affect both mind and body. Posttraumatic stress disorder can be marked by fear, hypervigilance, poor sleep, unwanted thoughts, anger, and frustration (U.S. Department of Veterans Affairs, 2015). As a result of the symptoms associated with PTSD, the individual may struggle to cope with the symptoms and turn to drug and alcohol use (Khoury, Tang, Bradley, Cubells, & Ressler, 2010).

According to the national comorbidity survey, individuals diagnosed with PTSD are 14 times more likely to have a substance use disorder than those without PTSD (McCauley, Killeen, Gros, Brady, & Back, 2012). Additionally, 34% of individuals that met criteria for PTSD also met criteria for at least one substance use disorder. McCauley et al. stated 52% of males and 20% of females with PTSD met the criteria for alcohol abuse or dependence.

Van der Kolk (2016) stated when trauma or PTSD symptoms persist, those symptoms become greatly held experiences in the body and mind. Similarly, Dube et al. (2003) suggested when individuals experience a traumatic event, they may have unprocessed emotions in the mind, body, and nervous system. Dube et al. found the unprocessed emotions led to potential mental health disorders such as depression and anxiety. In addition, individuals affected by PTSD are six times more likely to develop generalized anxiety disorder, four times more likely to experience panic disorder, and seven times more likely to experience depression (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Shaley et al. 1998).
Generalized Anxiety Disorder

According to the *DSM-5* (APA, 2013), generalized anxiety disorder (GAD) includes worry about everyday events that moves beyond normal worry. For instance, worry may become constant and constitute a pathological state. Symptoms associated with GAD affect the ability to function and solve problems (APA, 2013). Generalized anxiety disorder is marked by rumination of thoughts and worry for a period of at least six months. Physical symptoms of GAD include restlessness, fatigue, irritability, muscle tension, poor concentration, and diminished quality of sleep. An estimated 4% of the population will experience GAD at least once in life (APA, 2013).

Through a national survey, Alegria et al. (2010) researched the connection between GAD and substance use disorders. Alegria et al. found that of the 43,000 participants surveyed, 2% met the criteria for GAD and substance use disorders. Individuals diagnosed with GAD were two times more likely to use substances and experience increased vulnerability for substance use to relieve symptoms of GAD. Alegria et al. concluded increased vulnerability exists for the development of other mental health concerns while engaged with substance use.

Panic Disorder

According to the *DSM-5* (2013), panic disorders, or panic attacks, are characterized by symptoms that can last five to fifteen minutes, occur several times a day over several weeks for at least one month, and cause an individual to avoid places or situations. Panic attacks occur in an estimated 5% of the population (APA, 2013). Symptoms of panic attacks include heart pounding, chest pain, sweating, chills, hot flashes, trembling, sensations of shortness of breath, feeling dizzy or light-headed, fear of losing control or dying (APA, 2013).
Panic attacks could have similar symptoms and signs as those connected with trauma, including PTSD. According to Kim, Dager, and Lyoo (2012), one similarity between panic attacks and PTSD is that in many instances the actual threat is not present. Rather, the symptoms are a result of fear associated with reappearance or reoccurrence of the threat. Kim et al. (2013) believed therapy that identifies and reprocesses the area of the brain that controls emotional regulation would create great potential for the treatment of both PTSD and panic disorders.

**Depression**

According to the *DSM-5* (2013), depression is a mood disorder characterized by low mood, fatigue, apathy, sleep problems, decreased interest, guilt, hopelessness, decreased appetite, or thoughts of self-harm. Additionally, depression may lead to negative thoughts about an event that could trigger depression. As a result of the negative thoughts, an individual may withdraw, isolate, or delay task completion.

O’Donnell, Creamer, and Pattison (2004) explored the relationship between PTSD and depression at a level-1 trauma center. O’Donnell et al. reported that 3 months after the initial contact, 337 participants experienced similar traumatic stressors. The stressors became predictors of PTSD and depression and reflected a shared vulnerability to short-term trauma. O’Donnell et al. suggested more than one disorder can be present. In addition, trauma and negatively-held experiences have an impact on an individual’s mood. O’Donnell et al.’s findings suggest a depressive mood-related disorder may develop in conjunction with a trauma disorder.

Siegel (2012) suggested trauma has two chemical reactions that can affect mood and the ability to regulate emotions. The first chemical reaction blocks the area of the brain that moves information from short-term to long-term memory. The second chemical reaction is when higher levels of adrenalin increase encoding of unconscious memory (Siegel, 2012). Siegel asserted
that traumatic memories feel as though they reside in the present moment; however, the memory and process occurred in the past. Unresolved intrusive, confusing, and terrifying thoughts, feelings, disassociations, and memories represent unresolved experiences in the mind and body that could be captured through more than one diagnoses. In addition, individuals may experience the first symptoms of trauma during childhood.

Adverse Childhood Experiences

In 1995, the Center for Disease Control (CDC) and Kaiser Permanente began to study the impact of childhood abuse on health (Felitti, 2002). Felitti stated the Adverse Childhood Experiences (ACE) study included questionnaires to measure stressors and traumatic experiences in childhood. Traumatic childhood experiences included: abuse, neglect, illicit substance use, and household violence. The Substance Abuse and Mental Health Administration (2017) reported traumatic childhood experiences increased the likelihood of challenges throughout the life span. According to the U.S. Department of Veteran Affairs (2015), over 900,000 children had been affected by physical abuse, nearly 100,000 children were sexually abused, and countless other children had been exposed to parental substance use and household violence.

Swan (1998) stated abuse statistics represented roughly one-third of all reported cases. Swan reported the ACE study revealed that a large number of individuals in the U.S. experienced childhood trauma and was instrumental in raising awareness regarding the connection between childhood trauma and adult physical and mental health. Swan reported the results of the ACE study suggested childhood trauma increases the likelihood of adult illnesses.

According to Swan (1998), childhood trauma produced increased exposure to substances, smoking, dangerous behaviors such as unprotected sex, and illness. Dube et al. (2003) reported the ACE study revealed a direct correlation between childhood trauma and an increase in drug
and alcohol use. For instance, the presence of adverse childhood events revealed an increased use of illicit substances. This increase in illicit substance use was 3 times that of the general population. In fact, dating back to 1900s, the presence of ACE early in life revealed a compelling relationship between ACE and the early initiation of alcohol (Dube et al., 2006).

**Addiction and Trauma**

Khoury et al. (2010) suggested individuals affected by trauma are at a higher risk of developing a substance use disorder, which appears to be congruent with the National Childhood Traumatic Stress Network (2008). The National Childhood Traumatic Stress Network cited 59% of adolescents with a trauma-related disorder are affected by the illicit use of substances. Mental health concerns present, according to Dube et al. (2003), as anger, sleep issues, and changes in school performance. When trauma symptoms remain untreated and unresolved, trauma increases vulnerability and the potential to use substances (e.g., alcohol) in an effort to cope with the symptoms.

Brick (2012) suggested substance abuse may lead to a greater likelihood of traumatic experiences. When under the influence of mood-altering substances, individuals are more likely to engage in dangerous behaviors such as driving while intoxicated, exchanging needles, violence, risky and dangerous behavior, and drug-seeking behaviors. As a result, when individuals are under the influence of substances, they become increasingly vulnerable to predators. Too much arousal, or not enough arousal, results in poor integration of the nervous system and the brain (Siegel, 2012). That is, the body and brain either become over stimulated or incapable of initiating the fight, flight, faint, or freeze responses needed for protection from danger. In addition, Siegel (2012) and van der Kolk (2016) posited that recurrent exposure to illicit substances might alter the ability to engage in appropriate self-soothing behavior.
Providing a sense of safety, and engaging in useful actions within the community, may facilitate movement toward healing.

**Individual Psychology**

Alfred Adler was the third of seven children born in Austria to a Jewish grain merchant and his wife (Ansbacher & Ansbacher, 1956). As a child, Adler was afflicted with rickets and could not walk until he was four years old. Oberst and Stewart (2003) stated after Adler recovered from pneumonia, he decided to become a physician, a decision supported by his father. Adler attended the University of Vienna Medical School (Bottome, 1939); however, during his professional career, Adler learned and mastered the contemporary ideas of psychology. Adler was not impressed with the progress in the field of psychology and shifted his professional focus from ophthalmology and neurology to pursue his interest in psychology (Bottome, 1939; Hoffman, 1996; Oberst & Stewart, 2003). As a result of his childhood illness, it is possible Adler found personal significance in becoming a physician (and not through the use of drugs and alcohol). Adler may have satisfied a childhood need for approval and significance within his family and his community.

In 1902, Sigmund Freud invited Adler to attend discussions at Freud’s home to discuss various topics such as Freud’s psychoanalysis (Oberst & Stewart, 2003). By 1910, Adler became president of the Vienna Psychoanalytic Society. Due to professional differences, Adler severed ties from the Psychoanalytic Society one year later. In 1912, Adler founded the Society for Individual Psychology (Ansbacher & Ansbacher, 1956). Shortly after that, Adler joined the Viennese army during World War I and served in hospitals for three years (Mosak & Maniacci, 1999). When the war ended, Adler established child guidance clinics, began to work in public schools, and accepted a position at Columbia University (Stein, 2005).
Sigmund Freud, Carl Jung, Otto Frank, Frederich Nietzsche, and Soren Kierkegaard had an immense impact on the formation of Individual Psychology (Oberst & Stewart, 2003). Awareness of the conscious and unconscious mind, exploratory ideas of existentialism, and the philosophy of perspective contributed to the development of theory (Oberst & Stewart, 2003). Oberst and Stewart stated Adler held a holistic view of the individual and believed all things in life are interconnected. In contrast, Freud believed individuals are composed of separate parts; these parts are driven by urges which are the guiding mechanisms for growth (Abramson, 2016).

Ansbacher and Ansbacher (1956) stated Adler believed individuals would strive from a felt minus to a perceived plus. For instance, the discouraged individual would have thoughts and behaviors that align with the view of self, others, and the world. The individual would experience either a lack of safety, personal significance, or a sense of belonging. On the other hand, an encouraged individual (i.e., encouraged throughout early childhood years) would be able to strive toward a feeling of safety, significance, and belonging. (Ansbacher & Ansbacher, 1956; Oberst & Stewart, 2003). Adler (1956) considered this process of moving from inferior feelings to a sense of encouragement as a component of the individual’s striving for superiority.

Steffenhagen (1974) stated Adler believed when individuals experienced neurotic symptoms, the symptoms existed to safeguard self-esteem. That is, dangers are to be avoided, and the individual escapes through acute feelings of inferiority (Steffenhagen, 1974). On the other hand, therapeutic treatment could begin with understanding and encouragement to face feelings of inferiority. Clients could then modify and adapt their lifestyle.

According to Ansbacher and Ansbacher (1956), Adler believed humans constantly strive for superiority. Adler believed striving for superiority occurred due to feelings of inferiority. Adler proposed individuals develop unique personalities shaped by genetics, family of origin,
environment, and subjective perception of how the individual views and organizes the world. According to Griffith and Powers (2007), Adler referred to *teleology* as the combination of an individual’s personality, distinctive and creative goals, and the unique path used to achieve those goals. The *lifestyle* is organized through a framework of personality, goals, and perceptions (Griffith & Powers, 2007). Adler (1956) would call this collection of concepts in the lifestyle, *holism* or the cooperative sum of an individual’s life.

**Holism**

Ansbacher and Ansbacher (1956) stated Adler believed the sum was greater than individual parts (i.e., holism). The concept of holism was developed to encompass the individual’s thoughts, feelings, and actions. During the time Adler was developing the concept of holism, many believed the individual’s psyche was separate and distinct from other parts of the individual (Powers & Griffith, 1987). Treatment of trauma-related disorders, addictions, or co-occurring disorders through the lens of holism, creates an opportunity for increased treatment options and treatment modalities. In addition, treatment through the lens of holism allows for access to the whole individual and not simply behavior modifications or psychotropic medications.

**Lifestyle**

Adler believed, “Life moves at the level of events, not words” (Ansbacher & Ansbacher, 1956, p. 195). Oberst and Stewart (2003) stated Adler referred to the lifestyle as an assessment tool to measure an individual’s attitudes and movements within the social context. The lifestyle assessment would be used in a therapeutic setting to discuss the client’s *private logic* and goals of life. For instance, early in life, thoughts, feelings, and actions were used to make sense of the environment, and these unique behaviors and beliefs created an unconscious means to meet the
needs and demands of the family of origin (Oberst & Stewart, 2003). The individual’s behaviors and beliefs act as if the individual responds to the requirements of a private meaning formed earlier in life (Ansbacher & Ansbacher 1956). Adverse childhood experiences could alter the values, beliefs, and attitudes that could later form thoughts, feelings, and actions in adulthood to meet unconscious needs and demands from the family of origin. For example, Dube, Anda, Felitti, Edwards, and Williamson (2002) reported increased intimate partner violence in childhood increases the self-reported risk for alcoholism, illicit drug use, IV drug use, and depressive symptoms later in adulthood.

Oberst and Stewart (2003) stated Adler believed that individuals with poor mental health lacked social interest. For example, if an individual consistently strives to obtain perfection, the individual may struggle with the completion of life tasks and may need courage (or encouragement) to move beyond feelings of inferiority. Inferior feelings may emerge as cognitive distortions such as all-or-nothing thinking or mind-reading. Changes in behavior could present as a decrease in social contact, which could lead to increased isolation or symptoms related to anxiety or depression. A lifestyle analysis may be used to uncover an individual’s unique way of responding to challenging life events such as trauma or addiction, provide insight to unconscious attitudes and biases related to the therapeutic process, and to develop an individual’s strengths and goals.

**Life Tasks**

Adler believed all problems are inherently social problems and that all people experienced similar problems or tasks of life (Ansbacher & Ansbacher, 1956). The life tasks include the social task, work task, and love task (Oberst & Stewart, 2003). An individual’s’ early life and family life experiences (i.e., from birth to six years) contribute to personality
development, which has an impact on the unconscious and conscious decisions regarding how an individual will meet the tasks of life (Oberst & Stewart, 2003).

**Social task.** Ansbacher and Ansbacher (1964) stated Adler suggested every individual needed to find his or her place and learn to cooperate with others. The *social task* refers to the ability to get along with others and the intrinsic need to belong. Individuals rely on a social connection to maintain existence, and social adjustment is critical to human development (Ansbacher & Ansbacher, 1964).

Trauma, whether it is a recent event or a struggle for many years, may have an impact on the social task. After a traumatic experience, the *DSM-5* (APA, 2013) described symptoms that could interfere with an individual’s trust, emotional closeness, communication, and the ability to solve relationship conflicts. For instance, when an individual experiences trauma, the effects of trauma may lead to deep feelings of emotional pain, alienation, or discouragement because the survivor has not been able to overcome or cope with the symptoms of trauma (Turow, 2017).

Addiction may also have an impact on the social task. According to the *DSM-5*, an addiction includes the continued use of a substance despite the negative impact on interpersonal relationships (APA, 2013). As a result, addiction interferes with the completion of the social task.

**Work task.** Ansbacher and Ansbacher (1964) stated Adler believed the *work task* was one of the most difficult tasks of life. The work task enables one to survive and thrive and includes obligations and responsibilities. In addition, the work task is more than a financial task. For instance, the work task for a student would be attending school, and the work task for a stay-at-home-spouse could include homemaking.
Because the work task is one of the most difficult tasks in life (Ansbacher & Ansbacher, 1964), after an individual experiences trauma, the trauma could potentially make the work task more difficult. Workplace stressors could be exaggerated by effects of trauma that include fear, avoidance, and involuntary flashbacks (APA, 2013). If unmanaged, the aforementioned symptoms of trauma could compromise an individual’s ability to learn new job tasks, think through new processes, manage change, and engage in workplace communication (Turow, 2017). In addition to trauma, addiction includes a great deal of time dedicated to obtaining, using, and recovering from the use of alcohol or other substances (APA, 2013). Addiction may interfere with the completion of the work task because of the impact on occupational and recreational functioning due to the amount of time dedicated to maintaining the substance use.

**Love task.** The love task is defined as the task of intimacy (Ansbacher & Ansbacher, 1964). Ansbacher and Ansbacher stated as children grow and develop, they learn what it means to be a man or a woman. Adler (1956) believed encouragement and community feeling foster love, courtship, and marriage. On the other hand, if the child is discouraged and does not experience community feeling, he or she will attempt to overcome feelings of inferiority with a hesitating attitude or act with hostility toward others (Ansbacher & Ansbacher, 1964).

The results of a traumatic event can affect not only the individual but his or her partner. For example, Cook, Riggs, Thompson, Coyne, and Sheikh (2004) found trauma survivors often reported a decrease in relationship satisfaction, expression of emotion, sexual activity, communication, and adjustment. Cook et al. suggested individuals have an impact on themselves and others when they begin to process emotional healing through increased awareness. In addition to the impact of trauma, the APA outlines the negative impact of addiction on interpersonal relationships (APA, 2013). For instance, Dembo, Belenko, Childs,
and Wareham (2009) reported the use of alcohol and drugs leads to higher rates of unsafe sex, risky intimate behaviors, and sexually transmitted diseases.

**Social Interest**

One of Adler’s key concepts, *social interest*, creates the framework through which the lifestyle is developed in order to manage the life tasks of the world (Ansbacher & Ansbacher, 1956). Social interest is the natural condition of humanity that binds societies and civilizations together (Ansbacher & Ansbacher, 1956). Every individual is responsible for his or her behavior in the community (Griffith & Powers, 2007). According to Griffith and Powers, Adler believed people view the world through a personal lifestyle, or *phenomenology*, and suggested an individual engages in a private assessment of the self and the world. Griffith and Powers stated when people promote and contribute to the community, this is considered striving on the *useful side of life*. In contrast, private interest and felt-superiority toward others would be acting on the *useless side of life*.

Ansbacher and Ansbacher (1956) reported Adler believed all behavior had a purpose. For instance, useless movement through life remains purposeful because it is used for the attainment of individual goals. Oberst and Stewart (2003) stated individual development in the family and community shapes the degree of social interest demonstrated by a child. As previously stated, early family experiences are considered critical in the formation of the lifestyle, the development of social interest, and the ability to manage life tasks.

Ansbacher and Ansbacher (1956) stated Individual Psychology and Alcoholics Anonymous (AA) create a connection among the therapist, the client, and the AA community. This connection could increase the client’s creative power, striving, and social interest. Ansbacher and Ansbacher stated Adler described the feeling of inferiority as pampered failure, a
lack of courage, and a lack of social interest. Adler posited, “Very frequently, the beginning of addiction shows an acute feeling of inferiority marked by shyness, a liking for isolation, oversensitivity, impatience, irritability, and by neurotic symptoms like anxiety, depression, and sexual insufficiency” (p. 423).

**Organ Jargon**

Adler described a person’s line of reasoning as an evaluation of the self, others, the world, and requirements of life (Ansbacher, 1969). Griffith and Powers (2007) stated Adler referred to the language of body movement as *organ jargon*. For example, the body displays signs and symptoms that reveal an individual's attitudes and opinions. The body expresses an opinion congruent to verbal language. Private reasoning is the necessary conclusion to an individual’s behavior. Useful forms of expression are considered successful when they are beneficial to the community (Powers & Griffith, 1987). Adler believed when an individual acted on the useful side of life, this would reflect the individual’s private logic and benefit the community (Griffith & Powers, 2007).

Yoshimaso (2012) explained addiction causes several different somatic responses in the brain and body. Similar to Adler’s organ jargon, somatic symptoms may affect social and interpersonal relationships. When individuals struggle with addiction, they may experience physical and psychological withdrawal, co-morbid mental illness, co-morbid infectious diseases, somatoform disorders, and behavior related to intoxication (Yoshimasu, 2012).

In addition to addiction, trauma could cause complaints similar to those described in Adler’s concept of organ jargon. For example, Gupta (2013) suggested trauma may present somatic symptoms such as chronic nausea, heart palpitations, tremors, increased arousal, and changes in emotions. If an individual travels for work, sudden nausea and intense emotions may
hinder the ability to travel. The implications of addiction and trauma on the mind and body could influence private reasoning used in organ jargon to reach an individual’s desired goal.

Organ Inferiority

Alfred Adler coined the phrase *organ dialect* or *organ inferiority* to describe signs and symptoms that are expressed in the individual’s lifestyle (as cited in Ansbacher & Ansbacher, 1956). Additionally, Adler said, “Trust only movement. Life happens at the level of events, not of words. Trust movement” (Ansbacher & Ansbacher, 1956, p. 195). Therefore, Individual Psychology is a theory of movement and expression. Expression of an Individual’s perceived organ inferiority manifests through the body as described previously with organ jargon, and symbolically attaches to the individual’s meaning regarding the function of the selected organ. In other words, physical symptoms speak a language related to the individual’s lifestyle. The body always expresses truth and is subject to the law of movement (Griffith, 1984). The *law of movement* is the language used by an individual regarding problems of life. Similar to Individual Psychology, brainspotting includes a physical activation and examines the individual’s physical and emotional reactions to the events of life.

Early Recollections

In Individual Psychology, Adler utilized a technique he referred to as *early recollections* (Griffith & Powers, 2007). Adler believed that memories are retained throughout life and provide a subjective framework for the individual when compared to current events or challenges of life (Oberst & Stewart, 2003). The facts of stored memories are irrelevant because the purpose of the memory is to uncover present convictions, attitudes, and biases (Griffith, 1984). For example, a few memories are retained and brought forth without explicit awareness of the meaning or purpose of the memory. Therefore, the subjective nature of the memory informs
Current experiences. Early recollections may serve as means to view client progress and the individual’s subjective framework throughout the therapeutic process. Early recollections could help those who struggle with addiction because the early recollection could help the client identify convictions, attitudes, and biases through the stages of change.

Similar to Adler’s early recollections (Griffith, 1984), brainspotting evokes affect and somatic symptoms that serve as messages from the nervous system (Grand, 2013). The use of early recollections as a method for accessing activation may prove beneficial at pre-and post-brainspotting intervention. The stimuli that trigger specific memories related to an area of bodily activation may deepen the therapeutic process by bringing forth attitudes, opinions, and biases linked to a memory that holds negative encapsulated energy in the nervous system (Grand, 2013).

**Brainspotting**

Dr. David Grand (2013) created brainspotting after he discovered the technique while applying eye movement desensitization and reprocessing (EMDR) with his clients. Brainspotting is a mind-body therapeutic technique that identifies, processes, and releases encapsulated negatively-held energy in the mind and body (Grand, 2013; Scaer, 2007). Negative energy is created when an individual expresses pain, trauma, dissociation, and other challenges that affect the mind-body regulation (Grand, 2013).

Grand (2013) is a mental health clinician, a performance coach, and trained in somatic experiencing. Somatic experiencing is a holistic therapy targeted at alleviating trauma-related health problems by focusing on the individual’s body sensations (Levine, 1997). Grand developed natural flow EMDR, a technique integrating both somatic experiencing and EMDR. While Grand worked with the September 11th, 2001 trauma survivors, he used natural flow
EMDR and added a technique of the fixed eye position that brought out physical responses, catharsis, and memories.

Brainspotting can be beneficial in the treatment of addiction because the brainspotting technique is used to access the reward center of the brain and the circuitry of the limbic system. Emotional regulation is housed in the limbic system and fires within the reward center of the brain (Grand, 2013; Siegel, 2012). The part of the brain that controls reward, emotion, and memory is also linked with addiction (Siegel, 2012). When negative experiences in the brain have not been processed through traditional talk therapy, brainspotting techniques could help the individual access, identify, and process underlying concerns about the addiction and the individual’s mental health.

Brainspotting was born from Grand’s training in other contemporary fields of therapy (Grand, 2013). While processing through stages of EMDR, Grand noticed differences in client eye movement when he moved a pointer across the field of vision (Grand, 2013). Throughout exploration of his technique, Grand discovered brainspotting was an effective therapeutic tool to help people identify, process, and integrate the mind and the body. When the mind and body become integrated, an individual will move through a negative experience and obtain healing and wholeness (Grand, 2013).

The Brainspotting Process

Through reported negative experiences, the brainspotting technique accesses the nervous system through the visual field (Grand, 2013). For instance, similar to trauma-related symptoms, negative experiences could be characterized as flashbacks, panic attacks, pain, anxiety, or dissociation (Grand, 2013; Scaer, 2007). When practicing brainspotting, the clinician watches for somatic reflexes on the client’s face or the body which may indicate a release of energy from
the nervous system (Grand, 2013). Grand considered these reflexive signs an entry point for brain-body access. Negatively held energy is accessed and may be discharged in session through cathartic emotional outbursts, reflexive responses, changes in heart rate, and involuntary verbal processing.

Brainspotting (Grand, 2013) elicits arousal of the sympathetic nervous system to identify and process the brain-body experience. In addition, the parasympathetic nervous system acts as a coping resource to soothe the nervous system and the body. The parasympathetic nervous system and sympathetic nervous system unconsciously initiate the mind-body experience (Grand, 2013). The emotions, reflexes, and cathartic responses indicate activation of the sympathetic nervous system, and deep breathing, a sense of calmness, relaxation, or refocused attention is the parasympathetic nervous system response (Siegel, 2012). Additionally, cathartic expressions reflect deep emotional processing that is released from the spinal cord and nervous system. The deep emotional processing is key to the body healing itself (Scaer, 2007).

During a brainspotting session, therapists could use headphones for *bio-lateral stimulation* (Grand, 2013). Bio-lateral stimulation is a rhythmic alternating between right and left hemispheres of the brain. Bio-lateral stimulation accelerates the mind-body activation through the senses and encourages extraordinary free-associative processing between mind and body. This free-associative processing may trigger thoughts, emotions, memories, and body sensations and move them from ingrained patterns or reactions to new levels of self-awareness and identification. For instance, the use of auditory stimulation requires both hemispheres of the brain, which allows individuals to access the primitive brain structures involved with motivation, reward, and emotions (Grand, 2013).
Brainspotting Techniques

According to Grand (2013), the essence of brainspotting works from an uncertainty principle, that is to say, the neurobiology of the brain and body are so vast that the human system dictates how and where brainspots are located and processed. A brainspot is a stimulated reflex that appears without the client’s conscious awareness and indicates a point of importance (Grand, 2013). Brainspotting activation techniques are from either an activation spot in the body (i.e., through the outside window or inside window technique) or from body resource techniques referred to as the gazespot or the resource model. The gazespot and the resource model are accessed from a point of calmness or a sense of grounding within the individual.

The outside window. When therapists use the outside window technique, the therapist will observe the client’s eyes and watch the client’s field of vision in search of reflexive responses (Grand, 2013). The eyes are moving horizontally from one side of the field of vision to the other side of the field of vision. The therapist may notice a reflex (or brainspot) without the client’s awareness of the reflexive response. The process of activation occurs as result of the client’s reflexes.

The inside window. The inside window technique refers to when a client will have an activating event (i.e., brainspot) located from within the body (Grand, 2013). The client may use felt senses to access distress or resources. For instance, the client would start the intervention by communicating with the therapist by moving the pointer to a certain location in the field of vision that feels particular activation in the body (Grand, 2013). The therapist will confirm with the client that the located spot in the field of vision produces the greatest amount of distress. The therapist may hold that location with a pointer while the client internally focuses on the distress and will fixate on a specific point within the field of vision.
**Gazespotting.** Grand (2013) stated gazespotting is an unconscious or spontaneous look toward a location while in conversation with others. Scanning the field of vision through unconscious mechanisms could reflect an internal process that is connected to a distressful event (Grand, 2013). The process appears more fluid and normal for individuals who may struggle with hyper-activation or have a difficult time locating sensations in the body.

**The resource model.** The resource model is a variation of the activation model (Grand, 2013). The activation model is used to intentionally elevate the nervous system and locate activation. Through the resource model, the therapist would intentionally search for the position of calmness located within the sympathetic nervous system. In preparation for the individual brainspotting session, the therapist may talk with the client about what calms and grounds the client. This conversation could be part of the therapeutic process. Clients can take time to learn to locate (i.e., within thoughts and within the body) the smallest degree of feeling “okay.” Clients can use this location as a reference when distressing and elevating activation occurs. When the client uses the resource model, he or she will identify and develop coping strategies for negatively-held experiences. The client and therapist may discuss expectations from a place of calm or grounding. For example, the client may be asked to think of a time or place when he or she had a calming experience (Grand, 2013). This sense of grounding or calmness works because clients can locate this sensation in the body, which may act as an *island*, security, or a coping skill to process an activating event. An island refers to a grounded space that continues to grow and develop. In addition, the island is used as a coping skill to manage distressful or negative thoughts and emotions (Grand, 2013).

The resource model may be used as a starting point for clients who are easily activated and cannot begin an integration process. At times, clients are unable to start with distress due to
dissociation, complex trauma, or a lack of trust with the therapist or in the therapeutic process. Otherwise, the therapist may begin with a resource spot as a component of the treatment plan used to develop coping strategies for when stressful and activating events arise outside of therapy.

**Discussion**

Freud, Jung, and Adler are considered the founders of modern psychotherapy, yet Adler’s ideas could appear in most major approaches to psychotherapy (Goodwin, 2015). Several of Adler’s ideas and concepts such as lifestyle, encouragement and discouragement, and family of origin can be found in many conceptual frameworks. According to Abramson (2016), Adler stressed:

- social relations,
- striving for self-actualization,
- a subjective, person-centered approach to helping, and
- the importance of empathy as a key strategy to building relationships.

The relationship formed between the clinician and client is paramount for any intervention (Grand, 2013). Trauma and addiction can be obstacles to connection, so building rapport and effective therapeutic interventions would benefit the therapeutic process. The brainspotting technique includes an emphasis on the brain-body repair, and similar to Individual Psychology (Ansbacher & Ansbacher, 1956), a framework to treat the whole person (Grand, 2013).

**Implications for Practice**

Limited evidence and long-term studies exist regarding the overall effectiveness of brainspotting with many different demographics. A clinician’s level of training and degree of
supervision should be considered when using brainspotting techniques because of the variety of symptoms that may present in the treatment process. For example, when clinicians use brainspotting techniques with clients who experienced traumatic experiences, trauma-informed training would ensure ethical practice with this population. In addition, when clinicians use brainspotting with clients who suffer from complex disorders such as dissociative disorders, they would want to seek adequate training and competent supervision.

Brainspotting allows for the advancement of the field of psychotherapy. For example, brainspotting delivers positive results and outcomes evidence by initial research. Clinicians report the effectiveness of the brainspotting technique in male and female clients, within different ethnic and cultural backgrounds, and with diverse mental health issues (Grand, 2013). Also, brainspotting may have a significant impact on the community. After clients experience trauma, and process that trauma through brainspotting, they are encouraged to strive for belonging within the community. When individuals experience safety, significance, and belonging, they may increase the potential to have an impact on others.

**A dual intervention model.** Individual Psychology and brainspotting could be an alternative model to traditional talk therapy. Within this dual intervention, therapists could use Individual Psychology as the framework to set the context and reference point in therapy. Brainpotting would serve the client as an alternative intervention to talk therapy, and a means to facilitate change.

Through the use of early recollections (Griffith, 1984), therapists could provide a method for accessing activation during brainspotting. For example, bringing forth attitudes, opinions, and biases linked to memories could trigger specific memories related to an area of body activation that holds negative energy within the nervous system (Grand, 2013). Negative energy
is stress that directly affects the ability to function and results in anxiety, disruptive thoughts or feelings, acute illness, etc. (Grand, 2013; Scaer, 2007). The therapeutic effectiveness of brainspotting could be measured by utilizing another set of early recollections after the initial intervention.

Negatively-held experiences within the lifestyle could be processed through brainspotting. As a result, clients could learn to strive toward goals with increased empathy and trust. Increased empathy and trust could allow the individual to achieve a community feeling. By processing the negatively-held unresolved trauma, the individual may be more inclined to join family and society in working toward collective physical and mental health.

**Dual intervention and addiction.** Addiction can be treated as a negatively-held experience based on thoughts, behaviors, and consequences observed within the body, and the degree of connection to the community (Grand, 2013). A psychological theory provides a frame of reference, or framework, through which the therapist can view the client. Brainspotting could be used as a frame of reference or a tool through which the therapist can facilitate mind-body change. Through identification of triggers and moments of emotional dysregulation before and after substance use, brainspotting may be a worthy intervention to process brain-body emotions related to substance use triggers and emotional dysregulation. Therefore, the combination of Individual Psychology (Ansbacher & Ansbacher, 1956) and brainspotting intervention techniques (Grand, 2013) could allow clients to process negatively-held events that not only affect their lives but also affect lifestyle and the community.

**Recommendations for Future Research**

Future studies could advance the use and effectiveness of a dual intervention process that includes Individual Psychology and brainspotting techniques. Researchers could advance the
knowledge of the field and create the potential for increased positive outcomes with continued research on the impact of brainspotting techniques with clients diagnosed with substance use and trauma disorders. At the time of this writing, and within the literature reviewed for this project, limited research existed on the application of brainspotting within the field of addictions. Further research could explore the effect of brainspotting on diverse sample populations. For example, researchers could study the impact of brainspotting according to gender, age, assigned diagnoses, and other possible uses for the brainspotting technique. Through a theoretical orientation that includes Individual Psychology, researchers could determine the impact of Individual Psychology on the effectiveness of the brainspotting techniques.

**Conclusion**

Ansbacher and Ansbacher (1964) stated Adler said, “to see with the eyes of another, listen with the ears of another, and feel with the heart of another,” (p. 164) would encourage our communities to join together, develop a sense of belonging, and foster hope and compassion. It is the duty of mental health practitioners working in direct client care to impress upon the community—the courage to be imperfect. As a result, mental health practitioners could change attitudes, actions, and communities. Individual Psychology and brainspotting could offer an opportunity to view and treat the whole person. Through this dual intervention model, those that struggle with addiction and/or trauma could work with compassionate and competent professionals that foster mental health and well-being.
References


doi:10.1111/146

