

Adlerian Therapy & EMDR: Partners in Play?

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### Abstract

Terry Kottman created the process of Adlerian play therapy so that the fundamentals outlined in Alfred Adler's theory of Individual Psychology would be accessible as a therapeutic approach for children through play. Francine Shapiro's therapeutic model: Eye Movement Desensitization, and Reprocessing (EMDR), has also been adapted to incorporate play and meet the developmental needs of children. Adlerian play therapy and EMDR can be successfully integrated to enhance the therapeutic outcome for children. It is this writer's opinion that the combination of Adlerian play therapy and EMDR provides an outcome better than the use of either approach independently.

### Adlerian Therapy & EMDR: Partners in Play?

Even very small children experience pain and suffering. Loss of a parent or sibling, severe injury, chronic illness, childhood neglect or abuse, bullying, and other experiences cause some children to develop beliefs that perpetuate feelings of judgment, separateness, and shame. How can wounded children heal?

In 1987, while interning at the University of North Texas, Terry Kottman developed Adlerian play therapy (AdPT), an approach to counseling children that combines the ideas and techniques of Alfred Adler's Individual Psychology, with the strategies of play therapy. Also in 1987, Francine Shapiro, discovered a therapeutic process, Eye Movement Desensitization and Reprocessing (EMDR), which includes a protocol designed especially to help children recover from traumatic experiences.

Is play a necessary component in both Adlerian play therapy and EMDR with children? What are the foundations of each approach to therapy, and how is each approach adapted to meet the developmental needs of children? Is it possible to integrate Adlerian play therapy with EMDR? Does integration of the two processes allow for a better therapeutic outcome for the child compared to the use of either approach individually? This writer endeavors to review the literature and present an answer to these questions.

#### **Why Play?**

Virginia M. Axline (1947), a pioneer in play therapy stated:

play therapy is based upon the fact that play is the child's natural medium of self expression; it is an opportunity which is given to the child to 'play out' his feelings and problems just as, in certain types of adult therapy, and individual "talks out" his difficulties. (p.9)

In play therapy experiences, the child learns about him or herself in relation to the therapist. The therapist behaves in ways that convey to the child the security and opportunity to explore the playroom, the toys, and him or herself. As a result of this experience of self-in-relation-to-others, self-expansion, and self-expression, he or she learns to accept and respect not only him or herself but others as well; he or she learns to use freedom with a sense of responsibility (Axline, 1947). “Play has the power not only to facilitate normal child development but also to alleviate abnormal behavior” (Schaefer, 1993, p. 3).

Many children under the age of ten do not have the abstract reasoning and verbal abilities to express their thoughts, feelings, reactions, and attitudes clearly. Therefore, therapists who work with young children often use play to help them communicate their needs in a developmentally sensitive and concrete manner. Play therapists also use play because they respect the child’s development, and desire to join the child in the child’s world (Carlson, Watts, & Maniaci, 2006; Kottman, 2003; Landreth, 2002).

Bratton, Ray, Rhine, & Jones (2005) conducted a meta-analysis of the results of play therapy. Interpretation of the data obtained from a total of ninety-three controlled studies revealed a large treatment effect (.80) for children who received play therapy compared to children who did not. Study participants included children who presented with a variety of concerns and in a variety of settings.

In play therapy, toys, art, and other manipulative and creative mediums are the vehicle for communication between the child and the therapist. Use of these objects helps the child constructively act out feelings of anxiety, tension, or hostility. Children are also able to explore their desires and goals. The creative use of manipulatives allows the therapist to establish rapport, create a relationship in which children can test limits, and explore their perceptions of

themselves, others, and the world. The therapist's interactions with the child in the playroom create an atmosphere in which the child can gain insight about their own behavior and motivation, explore alternatives, and learn about consequences (Kottman, 2001). For children to "play out" their experiences and feelings is the most natural dynamic and self-healing process in which they can engage" (Landreth, 2002, p. 14). "Play therapy is a modality that honors the child's ways of communicating and helps to bring about an environment of healing" (Snow, Buckley, & Williams, 1999, p. 340).

### **Adlerian Play Therapy**

#### **Individual Psychology and the Therapist's View of the Child**

"In 1987 Terry Kottman completed her dissertation, which involved training therapists in the concepts and skills of Adlerian play therapy (AdPT)" (Meany-Walen, 2010, p. 4). AdPT, as developed and taught by Kottman, combined the ideas and techniques of play therapy with a version of Alfred Adler's philosophy of Individual Psychology (1956/1964) that had been adapted to meet the developmental needs of children (Meany-Walen, 2010).

Accordingly, Adlerian play therapists believe children have the ability, from infancy, to uniquely create their own individual lifestyle, based on their perceptions of the world (Adler, 1927/1998). Children have the ability to develop social interest; they are able to meet their needs for belonging and at the same time are able to contribute to others (Adler, 1956/1964). Adlerian play therapists also believe that children's sense of significance and their understanding of relationship is heavily influenced by their family-of-origin (Adler, 1956/1964). In response to their environment, children create fictional goals that they strive to meet in order to maintain a sense of belonging in the world. Adlerian therapists believe that children become discouraged as they experience feelings of inferiority. Inferior feelings arise when the way children view

themselves is not the way they think they should be (Adler, 1927/1998, 1956/1964; Mosak & Maniaci, 1999). Consequently, children are in constant movement from a position of a felt minus, or a feeling of inferiority, towards a position of a felt plus, or feeling of superiority, perfection, mastery, or significance (Adler, 1956/1964). Adlerian therapists agree that when children feel inferior, they become discouraged and are not willing to actively engage in the life tasks of: society/friendship, work/school, sex/love, spirituality, and self (Adler, 1927/1998; Mozak & Maniaci, 1999).

### **Adlerian Play Therapy: An Overview**

In AdPT, an empathetic, genuine, and unconditional relationship is fostered by the therapist and experienced by the child. The therapist takes care to provide the child with a collection of toys, art supplies, and other manipulatives that might stimulate the child to express a range of emotions, thoughts, and experiences (Meany-Walen, 2010). By encouraging the child, the therapist provides an atmosphere of acceptance and helps the child learn through their expressions (Snow, Buckley, & Williams, 1999). In the Adlerian playroom, the child has a chance to practice socially useful behaviors and experiment with new thoughts and feelings within the safety of a secure relationship (Kottman, 2003; Watts, 2006). “The play therapist encourages the children to be themselves while they develop lifestyles that allow them to be their best. The Adlerian play therapist helps children gain insight into better ways of achieving their goals” (Snow et al., 1999, p. 340).

### **Adlerian Play Therapy: A Unique Approach**

AdPT is unique in its emphasis on collaboration with the child’s parents. In Adlerian parent consultation, the therapist combines consultation with teaching and counseling techniques.

With education, parents are better able to understand their own roles in the maintenance of the child's self-defeating behaviors and attitudes (Kottman, 2001).

Adlerian play therapists believe that all behavior is purposeful and implement limit-setting in a unique manner that helps them hypothesize about the goals of the child's behavior. Limit-setting is a four-step process. The therapist does not redirect the child's misbehavior; instead, the therapist: (1) sets the limits; (2) makes a guess about the child's feeling or purpose of misbehavior; (3) engages the child in the redirection of his or her own behavior, and; (4) negotiates logical consequences for continued violation of the limit (Kottman, 1995, 2011).

The Adlerian approach to picking up toys and other play materials in the playroom is based upon a specifically structured collaboration between the child and the therapist. The child is in charge of who picks up what and how the picking-up time proceeds. The purpose of this specific structure is to promote cooperation and an egalitarian relationship through the partnership between the child and the therapist (Kottman, 2001, 2003).

During the second phase of therapy, information that is unique to Adlerian play therapy is gathered. The unique information includes: family constellation including birth order, family atmosphere, goals of misbehavior, and the Crucial C's. The Crucial C's include being connected to others, being capable of taking care of oneself, knowing that one counts, and having courage (Bettner, 2000). This distinctive combination of information is gathered to assist the therapist in conceptualizing the child's lifestyle, and often times, the parents' lifestyles as well (Kottman, 1999, 2011; Kottman & Ashby, 1999).

Adlerian play therapists use two techniques unique to Adlerians: spitting in the soup and meta-communication. The technique of spitting in the soup can be used when the therapist notices that the child is interfering with his or her own functioning. This interference typically

takes place because of the child's mistaken beliefs or their striving toward goals of misbehavior. For example, the therapist might spit in a child's soup by reminding the child of a time when he or she had created a fine painting, after the child had stated that they weren't a good enough painter to attempt a painting. To utilize the Adlerian strategy of meta-communication, the therapist observes the child's nonverbal reactions, responses to the therapist's comments, patterns and themes across sessions, and patterns and themes in the child's lifestyle. These observations allow the therapist to form a more comprehensive interpretation of child than relying solely on the child's verbalizations would. Adlerian play therapists use these techniques with both children and parents to help them gain insight into their beliefs, goals, and motivations (Kottman, 2001).

Adlerian play therapists place a great emphasis on the use of encouragement in AdPT. Adlerian play therapists focus on the use of techniques that emphasize the assets, efforts, and improvements of both the children and their parents. This focus on encouragement increases the child's sense of usefulness and reduces his or her feelings of inadequacy and discouragement (Kottman, 2001).

The four phases of Adlerian play therapy range from being nondirective to highly directive (Kottman, 2001). According to Kottman (2001):

the sequence of the phases incorporates the deliberate emphasis on three elements of the therapeutic process: (a) the relationship between the client and the therapist; (b) insight into intrapersonal and interpersonal dynamics and the workings of the family system; and (c) cognitive, emotional, and behavioral change. (p. 9)

The use of all three of these elements, rather than one or two, is a distinctive feature of AdPT (Kottman, 2001).

**Adlerian Play Therapy: The Basic Therapeutic Process**

Adlerian play therapy can be practiced successfully with children suffering from a variety of troubling issues. AdPT is especially appropriate for use with children who have an increased need for power and control, who have experienced a traumatic event, who have poor self-concepts, who experience discouragement, who have poor cooperation skills, or those who have weak social skills (Kottman, 2003; Meany-Walen, 2010).

In addition to using unique Adlerian concepts and techniques, Adlerian play therapists employ the skills of tracking, restating content, reflecting feelings, and returning responsibility to the child, throughout the therapeutic process. To track, the therapist describes, in a literal and non-interpretive way, what the child is doing or what the play objects are doing. For example, if a child places a toy, the therapist could say, "You put the car in the box." Tracking is a way for the therapist to show the child that he or she is important and worthy of being paid attention to, and that the child's communication in play is important to the therapist. Restating content is the same as paraphrasing. The therapist mirrors the child's words to let the child know that the therapist is listening and hearing what the child has to say. Children have feelings, but they may not be able to adequately express them. When the therapist makes guesses about the child's feelings, the child has the opportunity to understand their emotions and feelings. Returning responsibility to the child is a skill that is based upon the belief that is not helpful to do anything for a child that a child can do for his or her self. Returning responsibility to the child is empowering; it increases the child's sense of self-confidence and self-efficacy. In addition, the therapist demonstrates to the child that he or she believes the child is capable and able to problem-solve. Tracking, restating content, reflecting feelings, and returning responsibility to

the child, strengthen the relationship between the therapist and the child and help the child in their personal development (Kottman, 2011).

There are four phases in Adlerian play therapy. The first phase is building an egalitarian relationship with the child. The second phase explores the lifestyle of the child. In the third phase of Adlerian therapy, the therapist helps the child gain insight into his or her lifestyle. Finally, in the fourth phase, the therapist provides reorientation and reeducation for the child when necessary.

**Phase I: Establishing the egalitarian relationship with the child.** In the first phase of Adlerian therapy the play therapist offers to join the child in a variety of play opportunities with the goal of establishing an egalitarian relationship. Through consultation, the therapist also works to create a connection with the child's parents. The child may change very little during this phase, but may increase his or her willingness to enter into relationship with the therapist. Parents are not yet asked to change their parenting; rather, they are given the opportunity to talk freely and openly about their child. Often, in this conversation between therapist and parents, connection and relationship begin to develop between the parent and the child (Kottman, 2001).

In AdPT, the child's uniqueness, choice, and creativity are honored. It is the child's decision whether or not to answer questions, join in play activities, and to participate with or avoid the therapist. The child's play choices are respected (Meany-Walen, 2010). The child needs to experience a relationship with the therapist where he or she feels a sense of responsibility, collaboration, power, and respect (Kottman, 2003).

Therapists use several techniques to build the democratic relationship with the child during the first phase of Adlerian play therapy. Tracking behavior, restating content, reflecting feelings, returning responsibility to the child, encouraging, setting limits, answering and asking

questions, engaging the child in cleaning the room, and joining the child in play all promote the development of an egalitarian child/therapist relationship. Incorporating these techniques allows the therapist to focus their attention on the child and to encourage the child to believe that he or she is worthy of attention; all of his or her actions and words are important. The therapist affirms the child's view of the world, their place in the world, and provides empathy. All of these therapeutic actions serve to increase the child's self-understanding and self-reliance, and help build a foundation of trust between the child and therapist (Kottman & Warlick, 1989).

“Because Adlerian therapists believe that all beings are socially embedded, play therapists seek to understand and help children by gathering information from other significant adults in the children's lives and try to improve the social atmosphere of their clients” (Walens-Meany, 2010, p. 24). Once the Adlerian play therapist has developed an egalitarian relationship with the child and has also established a connection with the child's parents and the other important people in the child's life, the therapeutic process moves into the second phase.

**Phase II: Exploration of the lifestyle.** In the second phase of Adlerian play therapy, the therapist gathers information to formulate hypotheses about the child's lifestyle (Kottman, 2001, 2003; Watts, 2006). To establish and maintain a sense of belonging children observe their world and figure out a way to gain significance and belonging. If a child cannot find a positive, or useful way to belong, he or she will find a way to belong in a negative, or useless way (Kottman, 2003). According to Kottman (2003):

eventually, this way of establishing his or her belonging becomes his or her lifestyle: the way the child views himself or herself, the world, and others and the repertoire of behaviors based on these views. As the child grows and matures, he or she will act out his

or her lifestyle in various social contexts: the neighborhood, school, work, dating, and marriage. (p.18)

The therapist also gathers information from the parents to determine their lifestyles as they relate to their parenting practices. The child plays out his or her lifestyle in the playroom and answers questions posed by the therapist. These observations and communications assist the therapist in the hypothetical formulation of the child's lifestyle (Kottman, 2001).

Consideration of four specific concepts guide Adlerian play therapists in their conceptualization of the child's lifestyle: the goals of misbehavior, Crucial C's, personality priorities, and mistaken beliefs (Kottman, 2011; Meany-Walen, 2010).

***Goals of misbehavior.*** According to Dreikurs and Soltz (1964), children misbehave in order to fulfill their need to belong. The four goals of misbehavior are undue attention, struggle for power, retaliation and revenge, and complete inadequacy. Adlerian play therapists believe that children who misbehave are discouraged and unable to use more socially useful behaviors to connect with others (Dreikurs & Soltz, 1964). The therapist examines the child's behaviors, other people's reactions to the child's misbehavior, and the child's reaction to correction of the misbehavior, in order to determine which goal the child is striving for (Dreikurs & Soltz, 1964).

***Crucial C's.*** Lew and Bettner (2000) found that healthy and resilient children display four functional beliefs that serve as unconscious behavioral guides, called the Crucial C's. According to Lew and Bettner (2000) these beliefs are the internal certainty of:

- Being *connected* to others, feeling a sense of family and community
- Being *capable* of taking care of oneself
- Being valued by others, knowing that one *counts* and makes a difference
- Having *courage* (p. 3)

By asking questions and gathering information by other means, the Adlerian play therapist searches to understand if the child has established these beliefs as part of their perception of self (Kottman, 1999). If the child has not incorporated these four beliefs into his or her view of self, then the therapist will provide experiences in the playroom to foster those beliefs during phase three and four of play therapy (Kottman, 2003).

*Personality priorities.* “Personality priorities can influence the behavior that gets limited, the children’s involvement in the limiting process, and their reaction to limit setting. The therapist will frequently want to tailor the (play therapy) process to children’s priorities” (Kottman, 2003, p. 174). Children’s personality priorities fall within one of four categories: control, pleasing, superiority, or comfort. Children whose personality priority is control often test the limits in the playroom and put much energy into demonstrating to the therapist that he or she cannot control their behavior. Meta-communicating choices and limiting choices are helpful strategies for the therapist to use in the playroom with children who strive for control. Once engaged, these children become vigilant rule enforcers. Children who are pleasers may be tentative in the playroom because they are hyper-concerned about the therapist’s approval of their behavior. They rarely break the rules. With children who are pleasers, therapists may want to relax the rules and consequences in the playroom and encourage such children to branch out and take risks. Children who strive for superiority don’t break playroom rules very often, but when they do, they tend to argue, believing they have the superior understanding of how negotiations and consequences proceed. When the play therapist is able to remain calm, yet firm, and not take the superior child’s challenges personally, these children will cooperate eventually. Children whose personality priority is comfort don’t make the effort to break the rules, and offer little effort when asked to help generate alternative behaviors in the playroom.

Often it is the therapist's efforts that move the child into making a choice of acceptable behavior. Once made, the child who desires comfort follows along to avoid stress (Kottman, 2003).

***Mistaken beliefs.*** According to Ling and Kottman (1991), mistaken beliefs are the original ideas the child creates in order to feel a sense of significance and belonging. These beliefs are mistaken because they are formed from a child's perspective as he or she is trying to make sense of the world. "Children are expert observers but make many mistakes in interpreting what they observe. They often draw wrong conclusions and choose mistaken ways in which to find their place" (Dreikurs and Soltz, 1964, p.15). In phase two, the therapist's work is to uncover the child's mistaken beliefs so that the child can later become aware of his or her mistaken beliefs and correct them (Ling & Kottman, 1991).

In phase two of Adlerian play therapy, therapists also utilize three other methods of exploration to facilitate the distillation of the child's life-style: family atmosphere, family constellation, and early recollections (Kottman & Warlick, 1989).

***Family atmosphere.*** The therapist learns about the atmosphere of the family during consultation with the parents and through participating in the child's play in the playroom. The child believes that the atmosphere of their family is a representation of how all of life's relationships work and how all of life is supposed to be (Kottman, 2003). Family atmosphere is based on several factors including:

- Parental attitudes toward the children
- The parents' lifestyles
- Parental discipline philosophies
- Family values
- The family atmosphere of the parents' family of origin

- The marital relationship
- The parenting skills of the parents
- Any personal problems that might interfere with parents' abilities to provide warmth, respect and structure for children (Manaster & Corsini, 1982).

When the therapist offers to engage in play with a child using a dollhouse with family miniatures, he or she can often learn a great deal about the family atmosphere of the child (Kottman, 2003).

***Family constellation.*** The family constellation contributes greatly to the child's lifestyle because the family arrangement during the child's formative years influences the child's fundamental attitudes and approach to life (Ansbacher & Ansbacher, 1956). To assess the family constellation, the therapist must consider many factors:

- The birth order of the children
- The gender of the children
- The age differences of the children
- The size of the family
- The sibling subsets
- The personality traits of each individual member of the family
- The emotional connections between family members
- The dominance or submission of different family members (Dinkmeyer, Dinkmeyer, & Sperry, 1987).

The Adlerian therapist gives the greatest weight to the information provided by the child.

Collages, family symbol pictures, and other artistic techniques lend themselves to exploring the child's family constellation (Kottman, 2003).

*Early recollections.* Early recollections represent the child's current view of self, others, and the world (Ling & Kottman, 1991). "Thus, an essential part of the Adlerian lifestyle assessment, the early recollection represents an unparalleled contribution to a teleoanalytic understanding of the individual's present subjective reality" (Statton & Wilborn, 1991, p. 338). Interpretations of early recollections reveal the child's mistaken beliefs and private logic (Ling & Kottman, 1991).

Once the therapist has an understanding of the child's family constellation and the movement of the child is known, the early recollection should be a validation of the emerging life-style. When confronted with their mistaken beliefs, the child will exhibit a recognition reflex if the therapist's interpretation is correct (Dreikurs, 1964). To obtain early recollections in the playroom, the therapist actively engages the child by asking him or her to tell a story about when he or she was little. The child may choose puppets, art materials, play-acting, toys, or other manipulatives to tell his or her story (Kottman, 2003). Early recollections are consistent with child's present frame of reference, and will change as the child's view of self, others, and the world changes (Ling & Kottman, 1991). Because Adlerian providers believe that the lifestyle is established by the time a child is approximately five years old, the Adlerian play therapist is in a position to help children redirect their mistaken beliefs regarding how to achieve a position of significance in the home, school, and community. Adlerian play therapists should use early recollections routinely as a tool to confirm the child's current lifestyle and later, throughout the therapeutic process, to note the change and progress that has occurred in the attitude of the child (Bordon, 1973).

During phase two, the therapist may be directive or nondirective in the playroom; sometimes the child leads and other times the therapist directs the child in a specific activity

(Kottman, 2003). The therapist seeks to accommodate the developmental needs of the child and join in his or her world. Phase two play is generally free, spontaneous, and uninhibited. Family drawings, school drawings, puppet shows, role plays, and miniature play are examples of some of the activities the play therapist can utilize to gather information about the child's lifestyle (Meany-Walen, 2010).

In phase two of the Adlerian approach to play therapy, "there is little pressure from the play therapist for change on the part of the child or the parents, although sometimes they gain insight simply from the exploration process, which may lead to change" (Kottman, 2001, p.5). At the conclusion of phase two, the Adlerian play therapist will have gathered all of the information needed to formulate a hypothesis of the child's lifestyle. All of the interventions made in the third and fourth phases of the therapeutic process are based on the data the therapist gathers in phase two (Kottman, 2003).

**Phase III: Helping the child gain insight.** Phase three introduces a major shift in the therapist's expectations for the child and the parents to change. The therapist helps the child confront mistaken beliefs and goals, develop insight into his or her lifestyle, and encourage the child in more useful ways of being. With awareness, the child is then free to make decisions about whether or not he or she wants to change and how to go about making those changes. Parents develop further understanding of their child, and also become more aware of their own lifestyle issues that might be interfering with effective parenting. Both children and parents are expected to make a shift in attitudes towards themselves, one another, other people, and the world (Kottman, 2003).

The language the therapist uses during goal disclosure, sharing inferences about the lifestyle, and pointing out parallels between behaviors in and out of playroom must be done

gently, in the form of a guess or tentative hypothesis. This approach allows the child to feel less defensive, allows the therapist room for mistakes, and encourages cooperation between the child and therapist to work together to find alternative explanations (Kottman & Warlick, 1989).

**Goal disclosure.** During goal disclosure, the therapist reveals his or her guess about the purpose of the child's behavior to help the child stop self-defeating behaviors and perceptions. Through observation of the child's behavior and their response to the correction of those behaviors, the therapist decides which of the four goals of misbehavior the child exhibits: desire for attention, desire for power or superiority, desire for revenge, or the display of inadequacy (Kottman & Warlick, 1989). In the playroom, a toy telephone could be used to initiate a conversation about the purpose of the child's behaviors. The phone conversation might take place between the therapist and an imaginary third person, or with the child. Or, to disclose the child's goal, the therapist might use two puppets to have a conversation about the purpose of the child's behavior. One puppet could say to the other puppet, "Do you know why Peter won't help pick up the toys in the playroom?" The other puppet could respond, "Could it be that Peter wants to show Jenny (therapist) that she can't make him pick up the toys?" A toy telephone could be used to initiate a conversation between the therapist and an imaginary third person, or with the child, to converse about the possible purpose of the child's behavior (Kottman & Warlick, 1989). Sometimes the therapist "spits in the child's soup" during play time; the therapist points out the child's behaviors that are preventing him or her from achieving their goals (Meany-Walen, 2010).

**Sharing inferences.** When Adlerian play therapists share inferences with the child, it helps the child gain insight. The therapist's inferences are based upon the information collected about the child's family atmosphere, family constellation, early recollections, patterns of

behavior, and the child's perception of self, others, and the world (Kottman & Warlick, 1989). Therapists look for themes evident in the child's play, listen to the child's words, observe family interactions and attitudes, and consider the child's birth order to hypothesize guesses to disclose to the child. The therapist shares inferences with the child during the process of play in the playroom (Kottman & Warlick, 1989).

***Feedback about the relationship.*** Kottman & Warlick (1981) have observed that: in their relationship with the therapist, children will usually duplicate some of the attitudes and behaviors manifested in their relationships with other important adults in their lives. This duplication gives the therapist the opportunity to experience children in ways which are similar to the ways in which significant other adults experience them. (p. 441)

Therefore, the therapist can have confidence that the reaction they mirror to the child about his or her behaviors and attitudes are similar to those of the important adults in the child's life. The therapist can share with the child how he or she is feeling with the purpose of providing the child with insight and encouragement for change. As with other forms of confrontation, the therapist must be careful to be non-critical of the child in order to protect the child from feeling blame.

***Pointing out parallels.*** During the insight phase of Adlerian play therapy, it is important for the therapist to point out parallels between the child's behaviors, relationships, and feelings inside and outside of the playroom. Pointing out parallels is done at the same time as reflecting feelings and sharing inferences. Once a parallel is pointed out, puppets or other toys can be used intentionally to help the child and therapist act out how a positive behavior is working in the playroom and practice how this parallel behavior could be used at home (Kottman & Warlick, 1989).

**In the playroom.** In Kottman & Warlick's (1989) opinion, in play therapy: inferences about life-style should be shared through interpretations of children's behaviors and verbalizations in the playroom. These interpretations help facilitate children's insight into the patterns in their behavior by linking the abstraction of the pattern to the concrete experiences in the playroom. By communicating to children in the language of play, the therapist can help them to understand concepts that young children are not capable of discussing because of their limited abstract reasoning skills and limited verbal abilities. (p. 440)

Also during the insight phase of Adlerian play therapy, the therapist at times cautiously and respectfully proposes guesses to help the child gain insight into their lifestyle. At other times, the therapist challenges the child to confront mistaken beliefs. The therapeutic approach can be directive and non-directive, depending upon the specific needs of the child, but is always done through the experience of play, with the goal of leading the child to a more successful and useful way of being in the world (Kottman & Warlick, 1989). The therapist will know when the child and parents are ready to begin phase four when they have made noticeable shifts in their attitudes towards themselves, one another, other people, and the world (Kottman, 2003).

**Phase IV: Reorientation/reeducation.** In the fourth and final phase of Adlerian play therapy, there is the expectation for change in the child and parents. The therapist's role is active, and intrusive, if need be, acting as a teacher and encourager. Adlerian play therapy provides opportunities for the child to apply their new understandings and behaviors in the playroom and in other settings and relationships. Children receive training in assertiveness skills, negotiation skills, social skills, and coping skills. Parents and teachers are educated about the child's current level of functioning and encouraged to provide an environment that is

conducive to positive change for child. Parents and teachers are sometimes invited into the playroom to join the therapy process with the child and therapist. The therapist may provide the parents direct training in parenting skills such as, setting consequences, providing encouragement, or recognizing goals of misbehavior (Meany-Walen, 2010). As stated by Kottman and Warlick (1989),

in Adlerian play therapy, the reorientation phase consists primarily of helping the child generate alternative behaviors to replace inappropriate behaviors, encouraging the child to try new behaviors and patterns of interaction, and working with the parents on different types of discipline and ways of relating to the child. (p. 442)

***Generating alternative behaviors.*** Once a child has gained insight into the purposes of their behavior in phase three, learning to generate alternative behaviors in phase four helps children learn to change their behaviors. The therapist uses opportunities that develop in the playroom to teach basic problem-solving skills. If a child is misbehaving in the playroom, the therapist helps the child generate alternative behaviors by asking the child to: define the problem behavior, brainstorm possible solutions or alternative behaviors, test the alternatives, choose an alternative behavior, and finally, evaluate the success of the alternative behavior chosen (Kottman & Warlick, 1989).

***Encouragement.*** Encouragement is used throughout the four phases of Adlerian play therapy, but is essential to the child's success in the reorientation phase. The therapist encourages all of the child's efforts, not just their successful results. Frequent and immediate encouragement is needed to support the child as he or she learns to formulate new attitudes and behaviors (Kottman & Warlick, 1989).

**Acting as if.** “Because the Adlerian play therapy process is fluid rather than static, the counselor can use procedures from the reorientation/reeducation phase, like acting as if, whenever a child seems ready to change a maladaptive belief or behavior” (Carlson, Watts, & Maniaci, 2006; Kottman, 2003). In the acting “as if” technique, the therapist asks the child to begin acting as if they were already the person they wanted to be. The therapist asks the child to play act and emphasize that the child is only pretending. When the child has the chance to play “as if” in the playroom, they are more likely to try the newly generated behavior outside of the playroom. Also, if the child is not able to act “as if” with a new behavior, then the therapist knows to continue work with client to determine what kept him or her from being able to adopt the new behavior (Watts & Garza, 2008).

**Consultation with parents.** Adlerian play therapy is unique in the manner in which parents are asked to be active partners in all phases of therapy. Teaching parenting skills is an essential component of the fourth phase of therapy (Kottman, 2011). Sometimes, parents are invited into the playroom to help them better understand their child’s world and enhance feelings of family unity and cooperation. Inviting parents into the playroom also gives the therapist an opportunity to model appropriate behaviors for parents. Usually, part of the process in the fourth phase includes family therapy involving the child’s parents and other siblings. At times, it is necessary for the therapist to meet with the child’s parents, without the child, to teach them the skills they need to encourage their child’s behavioral adjustment. In the fourth phase of therapy, the therapist consults weekly with parents about child’s progress at home. Parental feedback becomes a source of continued work for the child in the playroom. Adlerian play therapists also consult with the child’s teachers so that they can also encourage the child’s success (Kottman & Warlick, 1989).

Adlerian play therapists incorporate the use of toys, art, role play, puppetry, games, music, dance, and brainstorming, among other teaching tools, to help children learn and practice new behaviors, more adaptive patterns of thinking, and more appropriate expression of feelings. Children are most likely to follow through with new solutions for behaviors when they have been actively engaged in generating those solutions (Meany-Walen, 2010).

The therapist will know when the child is ready to terminate therapy when the child demonstrates positive change in perceptions, attitudes, and behaviors in the playroom, at home, at school, and in his or her other relationships. Sometimes the Adlerian play therapist will make home and school visits to confirm the child's readiness for termination (Kottman, 2003).

### **Summary**

Kottman and Warlick (1989) indicate that:

concepts and techniques used by Adlerian therapists with children can be enhanced by introducing play media to form a unique procedure for helping children. Adlerian play therapy utilizes such basic tenets as the democratic relationship, assessment of lifestyle, goal disclosure, confrontation, and encouragement to help children develop more confidence and approach life tasks in a more useful manner. (p. 444)

Children first practice new attitudes and behaviors in the playroom, then in their families, schools, and greater communities. Parents and teachers are actively engaged throughout the four phases of therapy. By termination, the child has the courage and skill to behave in a more useful manner, and his or her parents and teachers are better equipped to support and encourage the child in this change (Kottman, 2001).

### **EMDR: A Chance Discovery**

Eye Movement Desensitization and Reprocessing (EMDR) was developed by psychologist, Francine Shapiro, in 1987, following a chance observation she made while out walking. Shapiro noticed that the disturbing thoughts she was contemplating at the start of her walk had disappeared suddenly. In addition, when Shapiro brought those thoughts back to mind, they were not as disturbing as they were before. Specifically, Shapiro noticed the rapid and diagonal motion of her eyes as she walked and contemplated disturbing thoughts. Again, while walking, the original thoughts lost their disturbing effect. Shapiro began making eye movements deliberately, while concentrating on disturbing thoughts and memories, with the same result. The disturbances disappeared. Shapiro branched out and experimented by intentionally combining disturbing thoughts with eye movements. Shapiro enlisted friends, colleagues, and students in an effort to explore and standardize her approach to processing memories with eye movements. Over the course of six months, with the help of seventy individuals, Shapiro developed a standard procedure of using eye movements that consistently alleviated her subjects' complaints. In 1989, the first controlled treatment outcome study of EMDR for Post Traumatic Stress Disorder (PTSD) was published in the *Journal of Traumatic Stress*. Later, in 1990, Shapiro discovered that other forms of bi-lateral stimulation, tactile taps, auditory tones, and visual lights, had the same affect on processing as eye movements (Shapiro, 2001).

EMDR is a well-studied therapeutic approach for treating individuals who are struggling in the aftermath of traumatic incidents (Solomon, Solomon, & Heide, 2009). EMDR has been studied across fourteen different populations; thirty studies indicate positive treatment outcomes when utilizing EMDR treatment techniques (Shapiro 2001). In twenty controlled studies, EMDR proved to be more effective in treating trauma than pharmaceuticals and other forms of

psychotherapy (Van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, & Korn, et al., 2007). A dozen randomized studies testing the eye movements in isolation have found them to be associated with facilitated memory retrieval, reduced negative emotions, increased vividness of mental imagery, and attentional flexibility (Sack et al. 2008).

EMDR has been validated as an evidence-based approach and included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (Gomez, 2013). The California Evidence-Based Clearinghouse for Child Welfare has accepted EMDR therapy as an evidence-based approach for children (Gomez, 2013). Also, EMDR has been recommended as a first line of treatment in numerous practice guidelines, including those of the American Psychiatric Association (2004).

EMDR is a comprehensive psychotherapy that is compatible with all contemporary theoretical orientations. According to Shapiro (2001), EMDR is an integration of a multitude of theories: psychodynamic, behavior, cognitive, experiential, hypnotic, and systems theory. EMDR is based on the notion that traumatic experiences affect all domains of thought, emotion, sensation, and physical parts of the self. EMDR is a front-line trauma treatment applicable to a broad range of clinical issues (Shapiro & Laliotis, 2011).

### **EMDR: The Mechanism of Change**

The precise neurobiological basis of EMDR is unknown. One hypothesis is that the visual, tactile, or auditory bilateral stimulation alternately stimulates the right and left sides of the brain, forcing a shift of attention across the midline (Solomon, Solomon, & Heide, 2009).

Another hypothesis is that the repetitive redirecting of attention in EMDR induces a REM-like sleep state, which facilitates the activation of the episodic memories. The memories are then processed and integrated into neural networks in the neo-cortex as semantic (narrative) memory

(Stickgold, 2002). Elofsson, von Scheele, Theorell, & Sondergaard (2008) explored the physiological correlates of eye movements during EMDR and found that during EMDR, eye movements activate the parasympathetic system and inhibit the sympathetic system, a response similar to the brain's physiological response during REM sleep. Another hypothesis was made following a neuro-imaging study of EMDR. Brain scans were administered before and after EMDR treatment of six PTSD subjects who each received three EMDR sessions. The investigators reported an increase in bilateral activity that modulates the limbic system and helps individuals perceive the difference between real and imagined threat. The increase in brain activity suggests a decrease in hyper-vigilance. Results of this study also found an increase in prefrontal lobe metabolism that suggested a greater ability to make sense of incoming sensory stimulation (Levin, Lazrove, & Van der Kolk, 1990).

### **EMDR: Guided by the Adaptive Information Processing Model**

EMDR is guided by the adaptive information processing (AIP) model. In the AIP model, disturbing memories are typically processed by thinking, talking, and dreaming about the experience. As the brain processes a memory, the memory is transferred from the limbic system to the left cerebral cortex and is stored with other memories. Stored memories can later be retrieved to understand new experiences (Solomon, Solomon, & Heide, 2009).

When an individual experiences a traumatic incident, the associated thoughts and feelings are highly charged and emotionally overwhelm the brain's capacity to process information. Therefore, it is difficult for the brain to integrate traumatic incidents into memories, connect them with similar memories, and store them in the left cerebral cortex. Rather, the memory of the experience may not be fully processed and instead dysfunctionally stored in the limbic system indefinitely (Solomon, Solomon, & Heide, 2009).

Dysfunctionally stored traumatic memories can lead to maladaptive coping strategies. A dysfunctionally stored memory remains stored with all of the emotions, physical sensations, and beliefs that were part of the original event. When activated, the unprocessed memory is experienced as it was originally, with the emotions, physical sensations, and beliefs fundamentally unchanged. Regardless of how much time has elapsed or whether the person remembers it, the memory remains unaltered and provides the basis of current responses and behaviors (Shapiro & Laliotis, 2011).

For example, many children have experienced humiliation sometime in school. Some children are able to integrate the event with other events, both positive and negative, and the memory is largely forgotten. For other children, the experience of the humiliation is perceived as being overwhelming and traumatic. The memory of the humiliating event does not get processed; it is stored with all of the original emotions, sensations, and beliefs associated with the event. Stored dysfunctionally, activation of the memory becomes the foundation for inappropriate, or maladaptive, responses in the future. When a similar experience occurs in the future, it triggers the dysfunctionally stored memory, which then automatically colors the child's perception of the present experience (Shapiro & Laliotis, 2011).

Hence, the AIP model guides therapists to identify the child's relevant past experiences that are perpetuating maladaptive patterns of response, as evidenced by the child's symptoms, and to process those memories to the level of adaptive resolution. In the process, the part of the memory that is useful is incorporated, that which is useless is discarded. Once resolved, the memory of the event serves to guide the child appropriately in the future (Shapiro & Laliotis, 2011).

The unprocessed components of memory are accessed in a systematic way during EMDR processing. Shapiro & Laliotis (2011) describe the process stating:

the targeted memory that is “frozen” in time becomes “unfrozen,” and new associations are made with the previously disconnected adaptive information related to survival, positive experiences, and one’s sense of identity. As this assimilation occurs, new insights and emotions emerge and the earlier affect states and perceptions are generally discarded. Clients are no longer subject to the same emotional volatility, distorted perceptions and intense somatic responses, and instead experience a new sense of self that is congruent with their current life situation. The overall goal of EMDR is to address the individual’s current problems of daily living by accessing the dysfunctionally stored memories that are being triggered by the client’s current life conditions, and engage the natural neural processes by which these memories are transmuted into appropriately stored memories. (p.193)

Since EMDR is an integrative psychotherapy approach, guided by the AIP model, therapists can incorporate techniques and interventions from other disciplines, as necessary, to meet the clinical needs of the child. According to Shapiro and Laliotis (2011):

the hallmark of EMDR therapy is the emphasis on physiologically stored memory as the primary foundation of pathology, and the application of specifically targeted information processing the primary agent of change. EMDR a distinct integrative psychotherapy approach used to address both individual and systemic issues. (p.192)

### **Adaptive Information Processing and the EMDR Protocol for Children**

The AIP model concludes that emotional, behavioral, and mental health symptoms originate from the maladaptive storage of previous life events. In the future, as those

maladaptively stored experiences are activated, the child experiences disturbances and dysfunction in his or her current life (Shapiro, 2001). Furthermore, the AIP model proposes that the brain processes trauma similarly to the way the body processes physical injury. When injured, the body automatically searches for ways to heal, and continues towards complete healing unless interfered with by infection or other mechanism that halts the healing process. When the body's natural healing process is interfered with, interventions, such as antibiotics, are necessary to resume and complete the process of healing. Maladaptively stored experiences are not fully processed, or healed. An intervention is needed to resume the healing process and allow the memory of the experience to be fully processed and adaptively stored. The EMDR protocol is the intervention used to access the child's memory networks. The protocol focuses on reprocessing the accessed information so that the client can proceed with the healing process (Adler-Tapia & Settle, 2008).

It is difficult for children to access and communicate the information for reprocessing because children have not developed the language skills to report the experience to the therapist. Accessing and communicating information for reprocessing is difficult for children because they have not developed the emotional literacy to report the experience to the therapist. Therefore, the EMDR protocol for children is adjusted to meet the child's developmental level. Children often store memories of events in a sensory-motor format. They are able to report the sensations related to maladaptively stored memories when they are activated during processing. In addition, play therapy and art therapy are useful tools to use to help children communicate with the therapist (Adler-Tapia & Settle, 2008).

According to Beer and Bronner (2010), the earlier the intervention to reprocess maladaptively stored information, the more positive the impact on the child's personality and

overall health. EMDR should be considered whenever a child has suffered from trauma, and exhibits symptoms such as intrusive memories, flashbacks, nightmares, anxiety, or guilt feelings. EMDR is also recommended when a child's reactions interfere with their recovery process or acceptance of new situation.

There are many strengths associated with the use of the EMDR protocol for children. Children experience quick relief through reprocessing. Once a disturbing memory has been reprocessed, children report strong, positive, and lasting results. In addition, EMDR is a relatively easy procedure for children because they don't have to talk too much (Beer and Bronner, 2010).

### **Eight Phases of EMDR**

EMDR offers a comprehensive template for mental health case conceptualization. The EMDR therapist believes in the significance of client's negative self-perceptions, beliefs, and cognitions. They take note of the child's emotions and unique body sensations knowing that they are the root of child's symptom manifestation. EMDR's three-pronged approach of past, present, and future guides the clinician in identifying the targets a child needs to process and the order in which to proceed with processing those targets. In EMDR, a target is an indication of an unresolved memory that manifests itself in the child's current symptomology. During the eight phases of EMDR, using the children's protocol, and accompanying scripts for each of the phases, the therapist helps the child process the relevant past experiences that inform the client's problems in the present, the ongoing present experiences that continue to trigger the child's maladaptive responses to current life demands, and also works with the child to process templates of future actions to strengthen the child's ability to respond adaptively in the present and future (Adler-Tapia & Settle, 2008).

**Phase one: client history and treatment planning.** In the first phase of EMDR, the therapist focuses on gathering information from the child and the parents in order to develop a treatment plan. Parents and children often report differences in symptom manifestation. Parents tend to report external symptoms: such as temper tantrums; while children tend to report internal symptoms such as getting in trouble for the temper tantrum. Information about positive and negative past events are gathered to develop a targeting sequence clustered around the child's negative cognitions and beliefs. Parents are also asked a simple question to determine the child's presenting problem. A question such as, "How will we know when your child is finished with therapy?" or "Why do you seek therapy for your child now?" are two possible questions a therapist might ask.

During phase one, the therapist listens for the client's negative self-perceptions, beliefs, and cognitions and watches the child express their emotions and unique body sensations. The child's affect, emotions, and body sensations are clues to what the child's maladaptively stored memories may be and also helps the therapist predict how the child might process during phase four. The therapist may use a variety of toys and art materials to help the child feel safe and comfortable in the playroom, help the child join with the therapist, and help the child communicate to the therapist (Adler-Tapia & Settle, 2008).

In phase one, the therapist also assesses the child's affect management, affect tolerance, emotional regulation skills, self-soothing skills, and other needed skills that are important to the therapeutic process. The therapist makes a note of which of these skills to teach the child during phase two of EMDR. In some situations, the child does not have enough skill development in these areas to proceed with processing. In that case, a great deal of time must be spent on preparation in phase two (Adler-Tapia & Settle, 2008).

It is important to explain the EMDR process to both parents and children during phase one. Therapists provide psycho-educational information and materials to the parents to help them understand trauma and to help them learn to teach affect regulation to their child at home. When the therapist has conducted the intake and written an initial treatment plan, therapy then proceeds with the Preparation Phase of EMDR (Adler-Tapia & Settle, 2008).

**Phase two: preparation phase.** The primary goal of the second phase of therapy is to prepare the child for reprocessing in remaining phases of EMDR. Along with continued psycho-education and teaching about the mechanics of EMDR, the therapist teaches the child the Stop Signal and Safe/Calm Place, Metaphor, skill building, and how to make a container to store disturbing memories (Adler-Tapia & Settle, 2008).

“Bilateral stimulation (BLS) is any external movement that produces alternating stimulation of the two sides of the brain” (Adler-Tapia & Settle, 2008, p. 26). To be effective, eye movements must go back and forth while crossing the midline of the child’s body. In phase two, the therapist introduces the child to the different methods of providing BLS, starting first with hand movements. Some children might prefer or be more responsive to tactile (tapping or device) stimulation, auditory stimulation, visual (light bar) stimulation, or a combination of the forms. When using hand-movements to provide bilateral stimulation, children might enjoy using finger puppets, magic wands, stuffed animals, or other selected toys. Besides being fun, these objects help young children attend to the hand movements. In addition to assessing the child’s preferences in method of bilateral stimulation, the therapist tests and determines the effective number of saccades (passes back and forth) and the speed of saccades that work best for the child (Adler-Tapia & Settle, 2008).

The Stop Signal is a resource that the child can use to communicate to the therapist that they are too overwhelmed to continue with reprocessing. To use the stop signal, the therapist teaches the child how to hold his or her hand up like a stop sign to stop the processing and take a break. The Stop Signal helps give the child a feeling of safety and control over the process (Adler-Tapia & Settle, 2008). Children may enjoy using a toy stop sign, or a stop sign that they have made together with the therapist in the playroom.

The Calm/Safe Place is taught as a tool to help children titrate intense affect. If in the course of processing, the child becomes overwhelmed, they are taught to go to their metaphoric Calm/Safe Place. Effective use of the Calm/Safe Place allows the child to feel more capable and in control of the therapeutic process which further allows the child to be more engaged and successful in therapy. Even very young children can create and use the Calm/Safe Place. Children may need to draw pictures or make collages of their Calm/Safe place to use during processing sessions. Both the Stop Signal and the Calm/Safe Place are practiced in the playroom and at home during the preparation phase of EMDR therapy. The therapist uses the child's preferred method of BLS and the Calm/Safe Place protocol and script to install the child's Calm/Safe place (Adler-Tapia & Settle, 2008).

A Metaphor is taught to children to help them distance themselves from the intensity of desensitization during phase four. To teach the Metaphor, the therapist asks the child to pretend that they are on a train ride and that their thoughts and feelings are just going by; they are just watching out the window. Besides being a distancing tool, use of the Metaphor allows the child to feel a sense of movement through the intense affect (Adler-Tapia & Settle, 2008).

It is during phase two that the therapist spends the necessary time engaging the child in skill-building activities. Guided imagery, breathing exercises, progressive muscle relaxing

exercises, systematic desensitization, problem-solving, and assertiveness training, are all skills the child can learn to help them learn to manage affect and achieve readiness for processing later in phase four (Adler-Tapia & Settle, 2008).

Containers can be used to help the child store memories that have been activated but not yet processed. Sometimes these memories are activated as part of an incomplete session, and at other times the memories are activated in-between sessions, outside of the playroom. Children can make containers out of a box, they can draw a picture of the activated memory to contain it, or they can use other creative methods to give the activated memory a concrete form and therefore contain it. Contained memories can be stored in this manner until they are ready to be reprocessed during a later EMDR session (Adler-Tapia & Settle, 2008).

Sometimes during phase two, the therapist installs resources and mastery experiences using BLS, corresponding protocols, and scripts. Installing resources and mastery experiences allows the child to develop healthy experiences from which to draw on when processing traumatic memories later in phase four (Adler-Tapia & Settle, 2008).

Once the client has been taught EMDR and the mechanics of EMDR, and the client has learned the skills to manage intense affect and participate in the remaining phases of EMDR, the treatment process continues with the assessment phase (Adler-Tapia & Settle, 2008).

**Phase three: assessment phase.** In phase three, the therapist and the child identify the specific targets for reprocessing. The selected target may be a memory, issue, experience, or incident. Children have success when they use drawings, role play, sand tray play, puppets, and other art materials to help them describe their target and then identify the worst part of that target. The worst part of the target is the image. Again, the target is the event or memory; the image is the worst part of that event or memory (Adler-Tapia & Settle, 2008).

Once the worst part of the target has been imaged, the child's negative and positive cognitions must be distilled. Negative and positive cognitions are the child's core beliefs that connect with the identified target and image. Children's negative and positive cognitions may be very concrete and trauma specific. The positive cognition may be a feeling word such as, "John bad". The positive cognition would be, "John better now". When a negative cognition resonates with a child, he or she often exhibits an obvious reaction to the cognition. Because it is difficult for children to verbalize negative and positive cognitions, pre-made phrase strips and picture clues are helpful in this phase of the process. Identifying the negative cognition connects the client to the memory network. After identifying the negative cognition, the therapist helps the child to identify their positive cognition. The positive cognition is the opposite of the negative cognition; it is what the child would like to believe about him or her self instead of the negative cognition (Adler-Tapia & Settle, 2008).

After identifying both the negative and positive cognitions, the therapist measures the Validity of Cognition (VoC) of the positive cognition. The VoC is measured on a seven-point scale with one being completely false, and seven being completely true. Children need to use manipulatives to participate in this step. The therapist asks the child for a number from one to seven that tells how true the VoC feels. The child can move an object down a "road" marked with seven steps to identify the VoC. Capturing the VoC moves the therapeutic process from the thinking level to the feeling level as the child has to identify how true the VoC feels, not how true he or she thinks it should feel (Adler-Tapia & Settle, 2008).

Once the VoC has been measured, the therapist asks the child for an emotion associated with the target. The child will be able to provide a feeling because a feelings vocabulary was

developed with the child during phase two; pictures of feelings words are helpful (Adler-Tapia & Settle, 2008).

Having named a feeling associated with the target, the therapist asks the child to rate how disturbing the feeling is. Measuring Subjective Units of Disturbance (SUD's), the therapist asks the client to assess, on a scale from zero (no disturbance) to 10 (most disturbance), how disturbing the emotion feels to him or her. As with the VoC, providing a concrete means of measuring the number is helpful with children. As soon as the child gives a SUD measurement of the feeling, the therapist asks the child for a body sensation. The therapist wants the child to state where he or she feels the disturbance in his or her body (Adler-Tapia & Settle, 2008).

Once the therapist connects the image, negative cognition, and feeling together, the therapy process continues with the Desensitization Phase of EMDR (Adler-Tapia & Settle, 2008).

**Phase four: Desensitization phase.** Phase four of EMDR begins when the image, negative cognition, and feeling in the body are linked together. In the Desensitization Phase, the goal is to reprocess the maladaptively stored memory and bring the event to an adaptive resolution. The therapist's ability to stay out of the client's way is critical. The therapist uses very few words, typically repeating the phrase, "Just go with that," after each set of BLS (Adler-Tapia & Settle, 2008).

The therapist must also be able to tolerate and manage the intense affect that can be exhibited by the child during reprocessing. One way in which the therapist can manage the child's affect is to moderate the speed of BLS so the child does not become overwhelmed and shut down. Usually, slowing the speed of BLS allows the child to slow down their processing and reduces intense affect (Adler-Tapia & Settle, 2008).

During the Desensitization Phase of EMDR, the therapist often lets the child sit on his or her parent's lap during processing. Parents are asked to encircle their child with their arms, like a hug, and then alternately pat their child's arms, upper legs, or knees during BLS (Adler-Tapia & Settle, 2008a). Sometimes, the child can butterfly hug his or her self to apply BLS. To create a butterfly hug, the child crosses his or her arms over his or her chest with each hand alternately patting the upper part of opposite arms (Pocock, 2011).

The therapist will continue to let the child process until the memory channel is clear, meaning that no new information related to the memory appears after a couple sets of BLS. Processing and desensitizing can take minutes to many sessions depending on the complexities of the child's memory channels. When the therapist observes that the memory channels are clear, the therapist asks the child to return to the initial target and reevaluate where he or she is in the reprocessing of the target by measuring the SUD. If the client identifies any disturbance at all, the therapist continues with reprocessing. At this point in EMDR, the therapist must be patient and diligent in working with the child until the SUD measures zero. The therapist depends on his or her therapeutic skill combined with a keen understanding of the individual child, gained during earlier phases of EMDR, to provide a unique processing experience that will allow the child to complete processing the target. A SUD measurement is taken to verify that the subjective unit of disturbance is at a zero (Adler-Tapia & Settle, 2008).

Children may become very still as they are reprocessing or may become very agitated. Either behavior reflects significant change in behavior that was not evident prior to beginning of the Desensitization Phase and the reprocessing of an identified target. It is best for the therapist to encourage the child to, "Just notice what is happening," during reprocessing and, "Go with,"

whatever comes up during reprocessing until the child begins to report successive positive statements (Adler-Tapia & Settle, 2008).

To complete a target, the therapist asks the child to return to the initial event and give SUD and VoC measurements. The target is complete if the SUD is at a 0, and the VoC is at a 6 or 7 (Adler-Tapia & Settle, 2008).

The Therapist may need to change the types of BLS he or she uses in processing to keep the child engaged. The therapist may also need to engage the child in more activity as they process through play, art, drawing or other concrete activities (Adler-Tapia & Settle, 2008).

When the child gives a measure of the VoC that is greater than 5, and it is evident that the child is presenting with the positive cognition or a close approximation, the therapist can then consider that the child is ready to move to the Installation Phase of EMDR.

**Phase five: Installation phase.** The Installation Phase of EMDR with children begins once the child reports a SUD of 0. The goal of the Installation Phase is to combine the image of the original incident with the positive cognition and to check the original positive cognition to see if it still fits. If the original positive cognition does not fit, the therapist helps the child create a more fitting positive cognition. Then, the positive cognition is installed, using BLS, until the child reports a VoC of 7. After each set of BLS, the therapist measures the child's VoC until it measures a 7 and holds through a few more sets of BLS (Adler-Tapia & Settle, 2008).

Children process through the Installation Phase very quickly. With children, it is important for the therapist to use the same type, speed, and frequency of BLS that was used during the Desensitization Phase. Doing so will help the child bring up any unresolved information related to the target memory if it still exists (Adler-Tapia & Settle, 2008).

When the child reports a VoC of 6 or greater, and the VoC holds, the child is ready to move onto the Body Scan Phase of EMDR (Adler-Tapia & Settle, 2008).

**Phase six: body scan.** After desensitizing the target and installing the positive cognition the therapist conducts the body scan. The goal of the Body Scan Phase is for the child to report that they do not feel any negative sensations in their body related to the target memory (Adler-Tapia & Settle, 2008).

Following the EMDR protocol and script for phase six, the therapist asks the child to hold the original incident together with the positive cognition and to scan his or her body from head to toe checking for any physical disturbance or negative sensation. If the child feels calm and reports no disturbance, the process moves to closure. If a disturbance exists, the disturbance is desensitized. To desensitize, the child brings up the disturbance, the therapist directs the child to “Go with that,” then the therapist begins BLS. BLS continues until the child’s body feels calm and a clear body scan is achieved. If a positive sensation is reported, the therapist can use BLS to install and strengthen the child’s positive feeling (Adler-Tapia & Settle, 2008).

Children may need education and practice to be able to complete the body scan. Children have the tendency to notice external injuries such as cuts and bruises, and have to be shown how to identify inner sensations such as chest tightness, tummy aches, and headaches. Giving children a metaphor of an X-Ray machine may assist them in looking for inner physical feelings of disturbance. Toys, such as a magnifying glass, can be used as concrete supports during the Body Scan Phase (Adler-Tapia & Settle, 2008).

After the child has achieved a clear body scan, he or she is ready for phase seven of EMDR, the Closure Phase (Adler-Tapia & Settle, 2008).

**Phase seven: closure phase.** The procedure used for completing the Closure Phase of EMDR depends upon where the child is in the eight-phase process as the EMDR session is about to close. If the child has completed processing through the Body Scan Phase, the session ends with the Closure Phase and the installation of the future template. If the child has not completed processing the target memory, the session is considered to be incomplete (Adler-Tapia & Settle, 2008).

With a completed session of EMDR, the body scan is clear, the SUD is reported to be 0, and the positive cognition has been installed and reported to have a VoC of 7. When closing a completed session, the therapist helps the child choose a future template, and then installs it using BLS. It is important for the child to choose a future template that relates back to the original symptoms he or she presented with at the start of EMDR therapy. For example, if the child's presenting problem at the start of therapy was that he or she could not manage to go to school, then, an appropriate future template might be, "I am ready to go to school tomorrow." The future template helps the child rehearse desired behaviors and outcomes for the future.

Children who successfully complete a session of EMDR experience a feeling of mastery. These children are more likely to return for EMDR therapy and initiate reprocessing of additional, and sometimes even more difficult targets (Adler-Tapia & Settle, 2008).

In an incomplete session, a child's memory is still unresolved. These children might still be obviously upset, or the SUD is above a 1 and the VoC is less than a 6. When incomplete, a session closes with stabilization of the client and instructions for in-between sessions. To begin closure of an incomplete session, the therapist must stop processing in time to ground child in the playroom and contain any disturbing material before the session is over. Before leaving the playroom, the therapist guides the child in practicing self-calming and soothing techniques that

were learned in the Preparation Phase. The therapist will also explain to the child and the child's parents that reprocessing may continue between sessions. When that happens, the child is instructed to use the container that was made during the Preparation Phase to hold any disturbing memories until they can be brought to the playroom for reprocessing. The therapist will also talk with the child to help them remember the persons they decided would be good to talk with if they needed support. The incomplete session is ended when the child is grounded in the present and is aware of the skills he or she can use to manage any disturbing information that may come up between sessions (Adler-Tapia & Settle, 2008).

**Phase eight: reevaluation phase.** The final phase of EMDR is the Reevaluation Phase. The Reevaluation phase is especially important with children because they do not always demonstrate much affect during reprocessing. Reevaluation allows the therapist to be certain that the child's traumatic memory has been stored adaptively. The therapist reevaluates at the start of every session after EMDR has been introduced to determine the progress of treatment and to see if the traumatic memory that was activated during the previous session is resolved. The therapist asks the child to bring up the original event, asks them what they get when they bring up the memory, and make certain that there is no remaining disturbance related to the memory (Adler-Tapia & Settle, 2008).

Another way that reevaluation is used in the treatment process is to aid the therapist in determining when the child is ready for discharge. When the child and therapist are able to review all of the child's targets that have been processed successfully, without evidence of disturbance, and the child's presenting symptoms have been addressed, the child is ready for discharge. In EMDR therapy with children, discharge is the goal for everyone (Adler-Tapia & Settle, 2008).

**Summary**

EMDR is an easily learned, frequently powerful, and often surprisingly brief method of intervention to use with children when overt or hidden trauma is operating (Pocock, 2011). Although there is minimal research on EMDR with children, in practice, even very young children respond well to all phases of EMDR therapy. The therapist must use clinical skills and techniques designed especially for children to help them process the phases of the EMDR. Protocols and scripts for each of the eight phases of EMDR therapy have been developed specifically so that they are developmentally appropriate and effective for use with children. Integrating the pieces of the protocol with play and art therapy techniques is especially effective with children (Adler-Tapia & Settle, 2008).

Even very small children experience pain and suffering. Loss of a parent or sibling, severe injury, chronic illness, childhood neglect or abuse, bullying, and other experiences cause some children to develop beliefs that perpetuate feelings of judgment, separateness, and shame. How can wounded children heal?

In 1987, while interning at the University of North Texas, Terry Kottman developed Adlerian play therapy (AdPT), an approach to counseling children that combines the ideas and techniques of Alfred Adler's, Individual Psychology, with the strategies of play therapy. Also in 1987, Francine Shapiro, discovered a therapeutic process, Eye Movement Desensitization and Reprocessing (EMDR), which includes a protocol designed especially to help children recover from traumatic experiences.

**Discussion**

Both Adlerian play therapists and EMDR therapists who work with young children often use play to help children communicate their needs in a developmentally sensitive and concrete

manner; they communicate with children in the language of play because young children are limited in their abstract reasoning skills and have limited verbal abilities. They also use play because the creative use of manipulatives allows therapists to establish rapport, create a relationship in which children can test limits, and explore their perceptions of themselves, others, and the world. Therapists' interactions with children in the playroom create an atmosphere in which children can gain insight about their own behavior and motivation, explore alternatives, and learn about consequences. Adlerian play therapists and EMDR therapists respect children's development, and desire to join children in their worlds.

Adlerian play therapy depends upon the skill of the therapist to lead the child through four phases of therapy. AdPT emphasizes collaboration with the child's parents and teachers. Each phase of therapy includes the incorporation of unique Adlerian techniques. Gathering information about the child's family constellation, birth order, family atmosphere, goals of misbehavior, assets, Crucial C's, early recollections, and personality priorities helps the therapist to generate a hypothesis about the child's lifestyle. The therapist engages the child and his or her parents in experiences that will them gain insight into their lifestyles, and encourage them to choose attitudes and behaviors that will lead to healthier ways of being. In all phases, the therapist's action is essential to the child and parents' outcomes.

Like Adlerian play therapy, EMDR is a comprehensive psychotherapy. However, EMDR lacks depth in its procedure for gathering information about the child in the first phase of therapy. Emphasis is placed on identifying targets for processing and preparing for desensitization. EMDR assumes that therapists who work with children understand play therapy are able to incorporate techniques and interventions from other disciplines, as necessary, to meet the clinical needs of the child. In addition, EMDR includes the parents in the therapeutic process

and in reeducation, but does not offer parents the opportunity to work on their own lifestyle awareness and adjustments. Teachers and other important persons in the child's life are not typically included in the scope of the therapeutic approach.

EMDR does have some advantages over Adlerian play therapy. In EMDR, the child can process their traumatic symptoms with a minimum of talking. Children experience powerful and quick relief through reprocessing. Once a disturbing memory has been reprocessed, children report strong, positive, and lasting results. EMDR is based upon an evidence-based, clear, and consistent children's protocol, with accompanying scripts for each of the phases. The therapist is able to help the child resolve symptoms and install future templates to strengthen results of reprocessing.

Integrating Adlerian play therapy with EMDR would strengthen both approaches. Adlerian play therapists are skilled in gathering the information needed to generate the child's lifestyle. In EMDR, words can be bypassed completely; the therapist can rely on somatic complaints only. Although EMDR therapists follow scripted protocols, there are times within the process that the therapist must prompt the client. When the EMDR therapist is helping the child name a negative or positive cognition, he or she will be more accurate and effective in guiding the child if the lifestyle has been richly conceived through the use of Adlerian techniques. Likewise, once mistaken beliefs have been identified, it would be more efficient for the therapist to utilize EMDR to process the mistaken beliefs than it would to talk or play them through.

The success of both therapeutic processes relies mainly on the relationship between the child and the therapist. The therapist must meet the child in play, use technique and skill, and guide the child towards self-healing. EMDR and Adlerian play therapy seem to be likely partners in an effective treatment to heal suffering children.

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