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THE EFFICIENCY OF EMDR THERAPY IN TREATING EARLY MULTIPLE TRAUMAS - A CASE REPORT

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INTRODUCTION

During childhood, many people are exposed to complex traumatic experiences in their families. According to the definition of the NCTSN (The National Child Traumatic Stress Network 2017), the term "complex trauma" refers to an exposure to multiple traumatic events that typically begin early in the life. Complex trauma is the most often of an interpersonal nature, i.e. it involves various types of neglect and/or abuse perpetrated by people close to the victim. It seems, however, that there is no global consciousness that certain events within a family are actually forms of neglect and abuse and can potentially become a trauma. Shapiro (2002, 2012) defines such early experiences as traumatic and denotes them with lowercase "t", emphasizing that a long-term exposure to traumatic experiences and their cumulativeness have disruptive effects to one's general development and health.

The impact of early multiple traumas on functioning in adulthood period of traumatized individuals has been presented in various theories. Also it has been investigated in numerous research studies (Kravić et al. 2013). Exposure to developmental traumas shapes our model of attachment, usually in the form of distrust of other people, fear of rejection, and experiencing difficulties in sharing emotions (Brandth 2017). Complex trauma intensifies vulnerability to current stressors, including vulnerability to re-victimization, and increases the risk of developing problems in friendships and partner relationships (NCTSN 2017). According to the same source, dissociation occurs frequently, including blanks in memories of one's own past. Emotions that develop through experiences of rejection by close people create the basis for the development of self-confidence; therefore, they influence the perception of the self and one's own life in adulthood (Pelham & Swann 1989) and they contribute to forming negative opinions of the self and of one's own capabilities (Kendler et al. 1998, according to Burić et al. 2007). Such emotions also create the basis for the development of interpersonal inflexibility, anxiety, depression, and a tendency towards solitude (Jonovska et al. 2007). Cognitive difficulties and a negative impact on the development of immune system are expected as well. Consequently, acute and chronic somatic problems can occur more frequently than in people who have not experienced complex trauma (NCTSN 2017). While PTSD symptoms mostly correlate with psychosomatic symptoms and anxiety and depressive reactions (Vulić-Prtorić 2004), symptoms of multiple early trauma go beyond PTSD symptoms and they additionally include difficulties in establishing attachment, emotion regulation, behavior control, as well as cognitive difficulties, and often even health problems and dissociation (Briere et al. 2010, Gersoni & Rappaport 2013).

Both the existing literature and clinical practice provide the evidence of the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) therapy in treating symptoms caused by early multiple traumas.

The main goal of the study is to demonstrate the efficiency of EMDR therapy in treating cognitive, behavioral, and psychological symptoms caused by early multiple traumas.

CASE REPORT

An unstructured interview that included cognitive, psychological, and behavioral symptoms was used for the initial and control evaluations, as well as the following scales: the Beck Depression Inventory (BDI-II 1996), the Beck Anxiety Inventory (BAI), and the Inventory of Psychosomatic Complaints (Vizek-Vidović 1982).

The standard EMDR protocol was used after the initial evaluation.

The client is a 35-year-old woman with early multiple traumatic experiences (psychological and physical abuse by the father). She has been recently divorced, she has no children, and she currently lives with her parents who are both retired and of poor health. The client is unemployed, but is about to complete the Master's studies that she started abroad while she was still married. She is preparing for a validation exam that would enable her to work abroad in her area of expertise. She is currently in a relationship with a man whom she has known before.

The client visited the psychotherapist of her own accord. On one hand, she did that because she has been

feeling "listless, apathetic and numb" for the last several years. This has intensified recently, and because of anxiety attacks that have been occurring in the last 10 years, particularly during stressful periods. She also reports a low work and cognitive efficiency (concentration disruption while studying) and a series of somatic complaints.

The client also describes low self-confidence and a lack of assertiveness, which results in negative consequences in a whole spectrum of social situations, including poor partner relationships. On the other hand, she claims that she is aware of a series of stressful and traumatic events in her life and their connection to the current symptoms and low efficiency, as well as that she was reading about EMDR therapy and would like to undergo the treatment.

The initial psychometric test indicates a borderline score approximating moderate anxiety on the Beck Anxiety Inventory. The prevalent symptoms include: the inability to relax, stomach problems, vertigos, nervousness, the feeling of terror, weariness, and the fear that the worst is going to happen. The Beck Depression Inventory indicates a moderately severe depression with prevalently cognitive symptoms (self-criticism, the feeling that a punishment is inevitable, self-disappointment, the feeling of failure and worthlessness, difficulties to concentrate), vegetative symptoms (loss of energy, fatigue, more frequent crying spells). The Inventory of Psychosomatic Complaints indicates moderately severe somatic complaints.

In her life history, several different events are potentially targeted. She was growing up in a dysfunctional family, with a father whom she describes as "unpredictable, quick-tempered, and explosive", a submissive mother, and a younger brother who would often be her only support. Her childhood and youth were marked by frequent physical and emotional abuse by the father. She states that those situations were so similar that it seems to her that "several different situations blended into one". The next set of stressful and traumatic events is related to the war, to the period when she was 12. War memories encompass shelling, life in refuge, separation from her mother, rejection by her peers, loneliness, and poverty. The war events are intertwined with traumatic memories of the abuse by her father. That is the period the client singles out as the most difficult, while memories of conflicts with her father still cause extreme distress. Another set of potential targets is a series of stressful partner relationships characterized by her low-confidence and by partners with whom it was impossible to establish a stable and functional partner relationship for reasons such as: their personality, sexual orientation or relationship status. However, she perceives herself as the main reason for her partner relationship breakups; more precisely, she considers that she is "not worthy of someone's love and attention". Seven years ago, she gets married and goes abroad with her husband. The marriage abounds with emotional abuse by the husband, neglect, economic manipulation and dependence, and isolation from the people she knows and is close with. During the marriage, she also suffers mobbing in the workplace, which results in her quitting the job three years ago. She says that she still sometimes dreams about the mobbing scenes and she avoids passing by the workplace, as well as encountering certain co-workers, because those are all reminders that make her extremely distressed.

We should remark that, during the entire treatment, the client is continually exposed to psychological abuse by her father whom she still perceives as "big and threatening". She views herself as "weak, helpless, worthless" in the relationship with her father.

Following the mapping of traumatic events, the target was selected using the staircase method. The reason for that is the client's inability to clearly remember an earlier and/or a more specific situation of abuse. The beginning is a present situation, a disagreement with the current boyfriend that the client distorts ("I am not worthy of love and attention") and that initiates a negative mood, distress, and crying. Through earlier situations, when she was feeling the same, we reach a clearly isolated episode of physical and emotional abuse by her father – in elementary school. This is the earliest clear memory she was able to recall.

An installation of safe space followed the evaluation. She chooses her current boyfriend's room as her safe space (the bed, desk, sunlight seeping through the curtains, and serenity in the room). The sessions following the installation of the safe space focus on reprocessing. The first session is initiated by the analysis of the selected target.

The client selected an episode of abuse by her father when she was in elementary school age, as the most disturbing memory. After a "regular" fight caused by a minor reason, her father "pushed" her into a small bathroom and beat her there.

She had a hard time deciding on the worst part of the event; recalling it made her extremely agitated and overwhelmed her with fear. She describes "the kind of feeling like you are unprotected... like someone can do to you whatever they want to".

The worst part of selected memory was: In the small bathroom, the father pulls her hair, hits her on the head. She reports that she was screaming and calling for help at that moment.

The negative cognition (NC): "I am not worthy".

The positive cognition (PC): "I am worthy".

Validity of positive cognition (VoC), on the scale from 1-7 (where one is completely false and seven is completely true) was two: 2

When she was asked about her emotions related to the worst part of selected memory: At first, she could not "bring back the feeling". After she revisits the worst part of the event: she reported: "I feel sad"!

The subjective assessment of disturbances (SUD) was nine on the scale 0-10 (where 0 is completely neutral and 10 were the most disturbing).

The location of body sensation was her stomach.

During the whole first session, the client mostly dissociates. The dissociation is manifested in different ways. She struggles to go back to the given event, to recall an image, describing it as "vague", or completely failing to recall the event ("And now nothing, there is nothing", "Nothing, empty!"). She describes the feeling as "somehow detached", as if "it was happening to someone else, and not to me", "I can see it, but I am not there, I can see myself, but I don't have the feeling that I'm there, it's like I'm watching it on television", "In a way I feel completely numb". In the reprocessing she reports that "her brain is escaping to a safe spot".

The periods of dissociation take place interchangeably with rare periods of active reprocessing, when she manages to come back to the initial image (which is usually achieved by focusing on the sensation of nausea in the stomach), and then she starts crying, comfortless, failing to notice that the mucus from her nose is dripping over her clothes. She starts hugging herself unconsciously, her eyes closed, so we performed bilateral stimulation by shoulder tapping, which would automatically trigger the recalling of traumatic experiences. She found it helpful to hug a stuffed elephant toy. Different images and fragments of abuse experiences would alternate quickly, "like flashes". Fragments of marriage abuse and workplace abuse appear already in the first session. The sets of bilateral stimulation are very long. The feelings of misery and insecurity prevail, and nausea and the urge to vomit are present.

The same continues in the following sessions, while the episodes of dissociation are less frequent. She is trying very hard to enter the traumatic space (since she was highly motivated, from the very beginning, to undergo the EMDR treatment). The situations and fragments of the situations mostly related to the abuse by her father, abuse in the marriage, mobbing in the workplace, and war appear alternately. Throughout the sessions, the memories are becoming clearer and the images more stable. The nausea is present all the time, and she often vomits between the sessions and feels physically exhausted. Emotions alternate ranging from the feeling "miserable and unprotected", over sadness and shame, to the feeling of anger for her father, her mother, her ex-husband, the society "which allowed for something like that". She reports that shoulder tapping triggers most memories ("As soon as you start tapping my shoulder, I see war").

The value of positive cognition, as of the 6th session, is 5, and, during the reprocessing, traumatic memories mix with pleasant memories (e.g. "I mean, it is not morbid, but you know… that same body and the war are there, but the images of California, and the pool, and blue sky also appear", or "Again the images from wartime, but some very beautiful memories – '94, spring, eighth grade, plants blossoming, us going to F.'s place to try smoking and listen to the Sex Pistols"). As the positive memories arise, the client explains how the positive emotions from the same period are also coming back: "You know, you really… I lost something that I had had back then, that feeling of happiness and, I don't know, carelessness… I don't know, we had such a great time. You know, it's like I've established a connection with that part… with my own self". During the session, she mostly feels "nice and fulfilled", and the belief in her own worth has a scale value of 7. During the session "there are flashes of all the things that I, you know, did well, of every success", which was also installed in that particular session.

During the following sessions, the memories of early childhood years (both the ones related to the abuse and those beautiful) appear ever more often. The relationships with her brother (who was a huge support to her throughout her life) and her submissive mother are in focus. There are also more and more images of recent situations in the relationship with her parents. The initial target of the sessions does not change over time, and it keeps causing distress. During the latest sessions, the level of distress decreases significantly. The client finds it easier to describe the selected event, faces no difficulties in verbalization of the events, and finds it curious that any emotional or physical reactions to the event are missing. The positive belief about the self-worth often decreases, i.e. it varies between the values of 5 and 7, up until the last reprocessing sessions when it becomes stable at the value of 7.

The twelfth session included the closing of the channel, since the scale value of the positive belief "I am a worthy person" is 7, while the level of distress is 0 (body scan). The retesting using Beck's Inventories for Anxiety and Depression and the psychosomatic checklist/ Somatic Symptom Scale showed that the symptoms and their intensity remain within normal limits.

At the end of the treatment, the unstructured interview indicates the following: the maximum level of efficiency in studying, efficiency in the workplace (gained during the treatment), a reduction in somatic symptoms, high self-esteem (i.e. the ability to see herself, her achievements and capacities, in a realistic way), the assertiveness both in the relationship with the father, and in a series of other social situations. The perception of her father is normalized and he is no longer seen as "big and threatening", but rather "somehow small and shrunken". A significant positive outcome of the therapy is the establishment of a stable and functional partner relationship with her current boyfriend, which resulted in a marriage one year after the completion of the treatment.

The client is currently a happily married woman. She lives abroad and is actively preparing for her validation exam. Unfortunately, not long after completing the treatment, she was diagnosed with a rare autoimmune disease. She does report, however, that the EMDR therapy helped her "become stronger and face the disease and all its challenges", and "to live a happy and more fulfilling life" in spite of the disease.

DISCUSSION

A young woman voluntarily decides to undergo EMDR therapy since she has been going through early multiple traumatic experiences (abuse by her father) since childhood that would still occur during the treatment. According to the existing findings on outcomes of early multiple/complex trauma (NCTSN 2017, Brandth 2017, Pelham & Swann 1989, Jovanovska 2007), the following symptoms prevail in this client's case: anxiety, depression, somatization, a decrease in working and cognitive efficiency, a low self-confidence, the absence of assertiveness in a whole set of various interpersonal relations, and problems in partner relationships.

Although a positive effect of EMDR therapy on cognitive, psychological, and behavioral symptoms caused by complex trauma was confirmed, we would like to bring forth several facts which are characteristic of this case that demonstrate the power of EMDR therapy.

The client exhibits a strong dissociation in the sense that she is unable to clearly remember certain events and that she has blanks in the memories of preschool and early school age. Before the reprocessing, the earliest traumatic event the client can clearly recall and single out, in fact, took place only in her puberty. During the reprocessing, she spontaneously recalls events from early childhood as well; the memories do not refer only to events as images, but also to physical sensations, colors, smells, and sounds. Memories of the abuse become clearer, while the situations and segments of the situations become more separated from each other. By reprocessing traumatic experiences, positive memories, of which the clients says that she has "established a connection with that part... with my own self", return to her consciousness.

All reprocessing sessions were initiated with the same, worst moment of the selected target (the instance of physical abuse by her father in the small bathroom). However, during the reprocessing sessions, new channels of other targets (the relationship with her mother, friends, partners, the war, mobbing in the workplace) would spontaneously open, be reprocessed, and closed. Those targets were usually connected to each other either by a negative cognition or by an emotion that was prevalent in the session. Therefore, at the end of the treatment, memories related to other mapped traumatic experiences were also reprocessed together with the corresponding negative cognitions and accompanying somatic symptoms and distress.

We have already referred to the works of Pelham and Swann (1989) who claim that early interactions influence the development of the perception of oneself and one's life and (according to Kendler et al. 1998) they contribute to forming opinion of oneself and one's capabilities. Hence, they create the foundation of basic cognitions. The negative cognitions that occurred to the client during the reprocessing sessions would most frequently fall into the categories of responsibility/self-defectiveness ("I am worthless", "I am incapable", "I am not worthy of anybody's love and attention"), safety/vulnerability ("I am helpless"), and control/choice ("I cannot stand up for myself", "I cannot succeed"). We find a similar categorization of cognitions in cognitive therapy (Beck 1995) that states that the so-called core beliefs are divided into the helpless and unlovable core beliefs; they develop through early interactions and situations, and they influence current behavior. While cognitive therapy, among other things, focuses directly on core beliefs, which leads to a reduction of current symptoms and changes in current behavior, EMDR technique does not focus directly on negative cognitions, but, at the end of a treatment, the conviction of a parallel positive cognition reaches the maximum level. We would like to emphasize the importance of correcting negative cognitions/core beliefs, i.e. the importance of self-image, in the reduction of current symptoms and in changing current behavior, with the reflection on future choices and behavior.

During the reprocessing, the most intense reactions (primarily those somatic in the form of headaches, nausea, vomiting, widespread demographics, and uncontrollable crying) and traumatic memories, including the early ones that she could not willingly recall, are induced by tactile bilateral stimulation. Somatic symptoms (including, mainly, constant nausea, frequent vomiting, uncontrollable crying spells and a sleeping disorder accompanied by confusing dreams and frequent sleep interruptions) prevail between the sessions. More intense somatic reactions occur particularly during the reprocessing of early and/or physical traumatic experiences. The aforementioned information supports the theories claiming that the human body stores traumatic experiences (Tyrka et al. 2009, Van der Kolk 2003). Considering the aforesaid, we assume that tactile bilateral stimulation is preferred to bilateral eye movement stimulation in cases of early and/or physical trauma.

After 11 reprocessing sessions, all positive cognitions have a scale value of 7. The somatic symptoms completely disappeared, so the client became more functional in her everyday life. The perception of her father is normalized, so he is not a "big and threatening" figure anymore, but he is "somehow smaller, shrunken"; she views and perceives him more realistically – as an old, ill, and helpless person. The functional analysis indicates that she now reacts assertively, not only in the interaction with her father, but in a range of social situations. The self-confidence she built positively influences her professional life; she found a new job and is progressing rapidly. She also visited the previous workplace and the colleagues, whom she now perceives more positively. She successfully completed her Master's studies and is preparing for her validation exam more efficiently. She behaves more adequately in the relationship with her current boyfriend, without a constant reconsideration of her actions and without

cognitive distortions where she would interpret typical relationship situations as indications that she is "not worthy of anyone's love and attention". The relationship was crowned by marriage a year after the completion of the treatment. The EMDR therapy entirely eliminated the cognitive, psychological, and behavioral symptoms that we have associated with complex trauma. We should remark that the client was extremely motivated to start the treatment. Unfortunately, she was diagnosed with an autoimmune disease, but we may claim that EMDR therapy also strengthened her general capacities to cope with future life challenges and possible stressors.

CONCLUSIONS

Early traumatic memories can stay deeply blocked on a somatic/physical level, and, in this case, tactile bilateral stimulation proved efficient in their de-blocking and reprocessing.

Considering the existing findings, the client's negative cognitions developed early, through traumatic relationships with parents, and they modeled the current behavior, especially social relations, including the choice of a partner.

In line with the current research findings and the clinical practice, the application of EMDR therapy proved once more, in the presented case, an efficient tool in overcoming cognitive, psychological, and behavioral symptoms conditioned by an early multiple/ complex trauma.

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Lejla Smajić Hodžić: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the article and gave final approval of the version to be submitted.

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