



EMDR Annual Conference & AGM 2019

**EMDR Interventions for adults and
couples with attachment issues**

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Slides can be downloaded:

www.arunmansukhani.com/documentos

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This work represents the presenters work. Please
reference it if used. Thank you

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Contents of the Keynote and Workshop

- EMDR and trauma (defense system)
- Attachment. Attachment trauma.
- Beyond attachment: Other behavioral control systems susceptible of being traumatized.
- Adaptations in the EMDR-AIP protocol for individual and couple interventions in attachment problems.

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EMDR

ORIGINATOR AND DEVELOPER

FRANCINE SHAPIRO, Ph.D

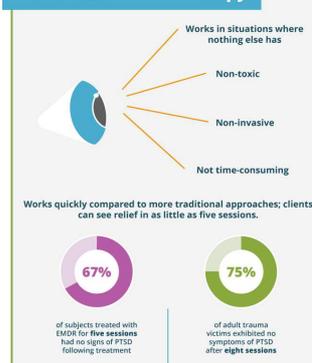
In 1987, Dr. Shapiro was taking a stroll in the park and had some disturbing thoughts flash through her mind. After moving her eyes from side to side she noticed the negative feelings immediately dissipate. She assumed that the eye movements had a desensitizing effect.

Eye Movement Desensitization (EMD) was introduced in 1989, later called (EMDR) Eye Movement Desensitization and Reprocessing (1991) to reflect the cognitive changes that occur during treatment and to identify the information processing theory.

P bar Y Safety Consultants



Benefits of EMDR Therapy:



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PTSD

Phobias

Depression

Dependence

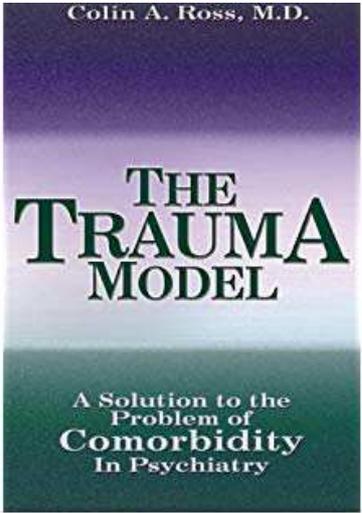
BPD

Psychosis

Personality Disorders

Complex PTSD

...?!



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Child Abuse & Neglect



Psychopathology in a large cohort of sexually abused children followed up to 43 years^a

Margaret C. Cutajar^{a,*}, Paul E. Mullen^a, James R.P. Ogloff^a, Stuart D. Thomas^a, David L. Wells^b, Josie Spataro^c

Table 1
Comparison between the rates for various mental disorders in all the child sexual abuse and the control subjects. Child Abuse Negl. 2010

Diagnostic group	Controls (n=2677)		Cases (n=2688)		OR	95% CI	p
	n	%	n	%			
<i>Mental health contact</i>	206	7.7	627	23.3	3.65	3.09–4.32	<0.001
<i>Axis I clinical disorders</i>	187	7.0	495	18.4	3.01	2.52–3.59	<0.001
Psychotic disorders	37	1.4	78	2.9	2.13	1.44–3.17	<0.001
Affective disorders	86	3.2	173	6.4	2.07	1.59–2.70	<0.001
Organic disorders	0	0.0	9	0.3	–	–	–
Posttraumatic stress disorder	20	0.7	108	4.0	5.56	3.44–8.99	<0.001
Other anxiety disorders	60	2.2	155	5.8	2.67	1.97–3.61	<0.001
Eating disorders	6	0.2	7	0.3	1.16	0.39–3.46	0.79
Paedophilia	0	0.0	3	0.1	–	–	–
Known alcohol abuse	13	0.5	75	2.8	5.88	3.26–10.63	<0.001
Known drug abuse	20	0.7	115	4.3	5.94	3.68–9.58	<0.001
Other disorders	17	0.6	60	2.2	3.57	2.08–6.14	<0.001
<i>Axis II personality disorders</i>	18	0.7	96	3.6	5.47	3.30–9.08	<0.001
Non-cluster B PD	7	0.3	31	1.2	4.45	1.96–10.13	<0.001
Cluster B PD	12	0.4	65	2.4	5.51	2.97–10.22	<0.001
Borderline PD	8	0.3	48	1.8	6.07	2.87–12.85	<0.001
Antisocial PD	4	0.1	17	0.6	4.26	1.43–12.66	0.007 ^a
<i>Non-psychiatric complaint</i>	18	0.7	92	3.4	5.24	3.15–8.70	<0.001

^a Fisher's exact test.

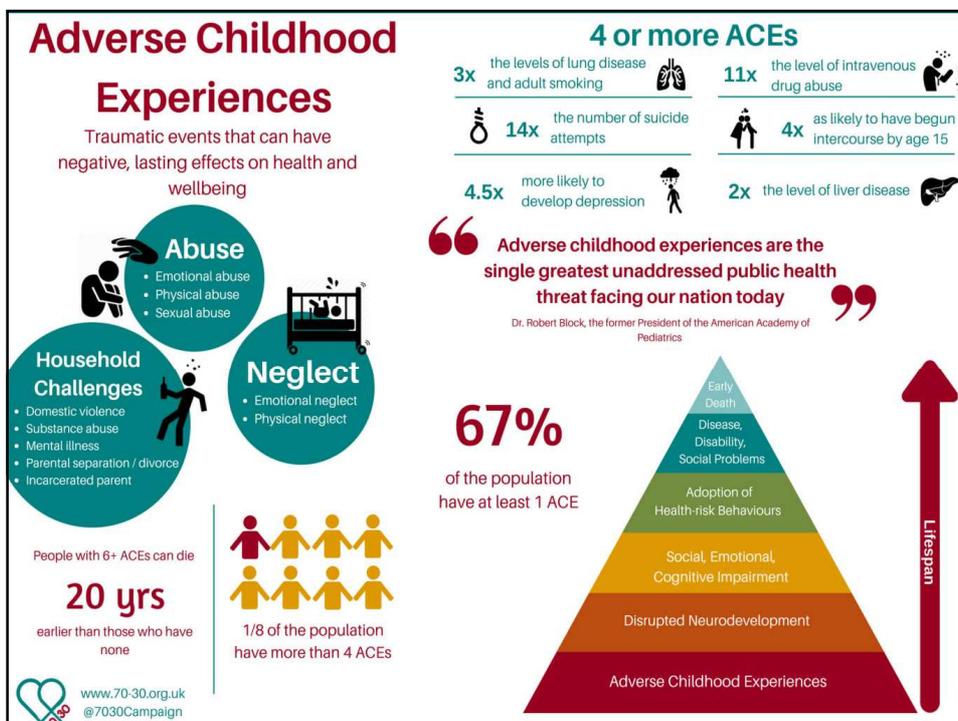
Slide courtesy of Dr. **Benedikt L Amann**
FIDMAG Germanes Hospitalàries Research Foundation CIBERSAM

Adverse Childhood Experience study

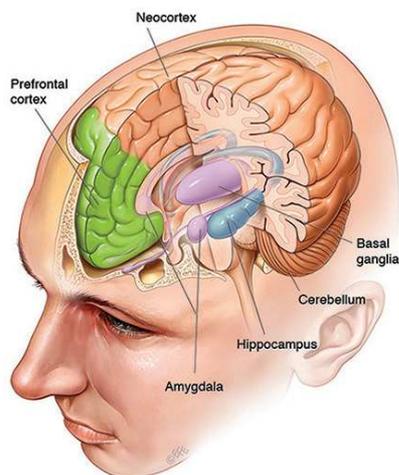
(Felliti and Anda, CDCP since 1995. +17000 subjects).

- Emotional abuse
- Physical abuse
- Sexual abuse
- Cohabitation with substance user
- Cohabitation with person with mental problems
- Witness parent treated violently (mother)
- Incarcerated household member
- Parental separation or divorce
- Emotional Neglect
- Physical Neglect.

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ACE affects brain structures



- Corpus Callosum reduced area (deficient hemispheric integration).
- Abnormal Amygdala size (depending on type/time of abuse)
- Decrease in the size of the Hippocampus.
- PFC: AC, of-vm PFC and dlPFC.

↑ *NE* (Amsten et al 2015)

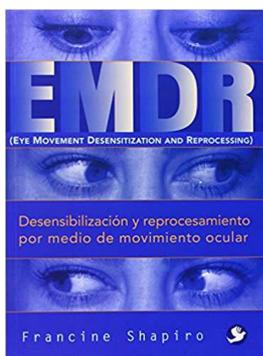
↓ *GABA* (Anderson and Schmitz 2017)

Martin Teicher 2017

AIP Model

- Traumatic episodes are not processed and can't be integrated into narrative and biographic memory networks.

(Van der Kolk 1995, Shapiro 2004).



- Dysfunctionally stored implicit memories (information) are the cause of a wide range of psychological symptoms and disorders.

(Shapiro 2004,).

- Bilateral stimulation activates the brain's homeostatic healing process modifying the sensory, affective and cognitive components but also self perception and social relations.

(Hofman 2016).

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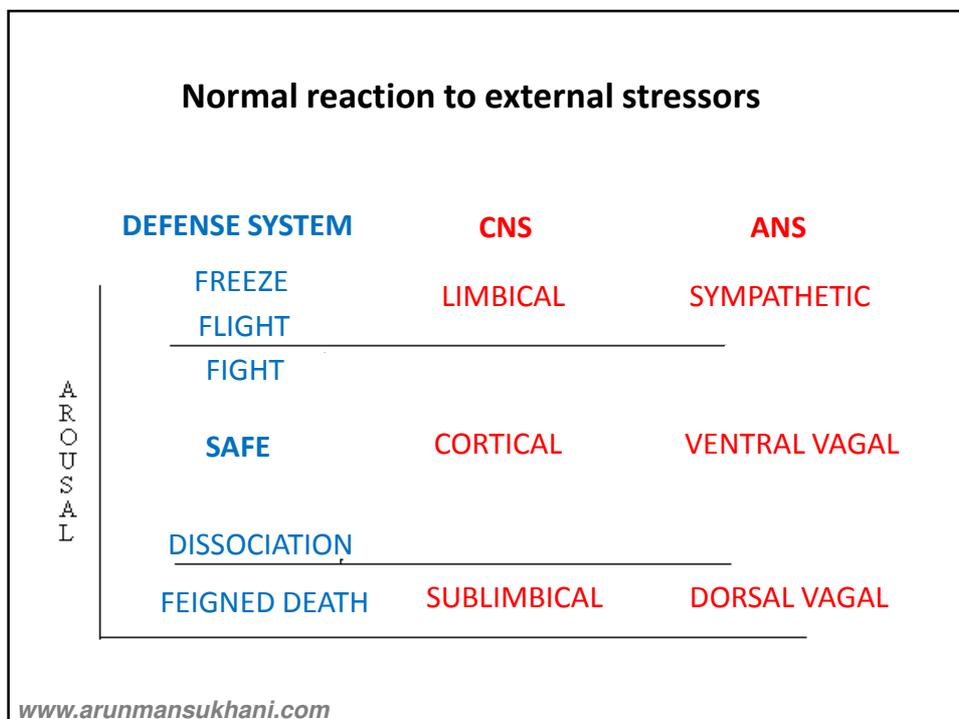
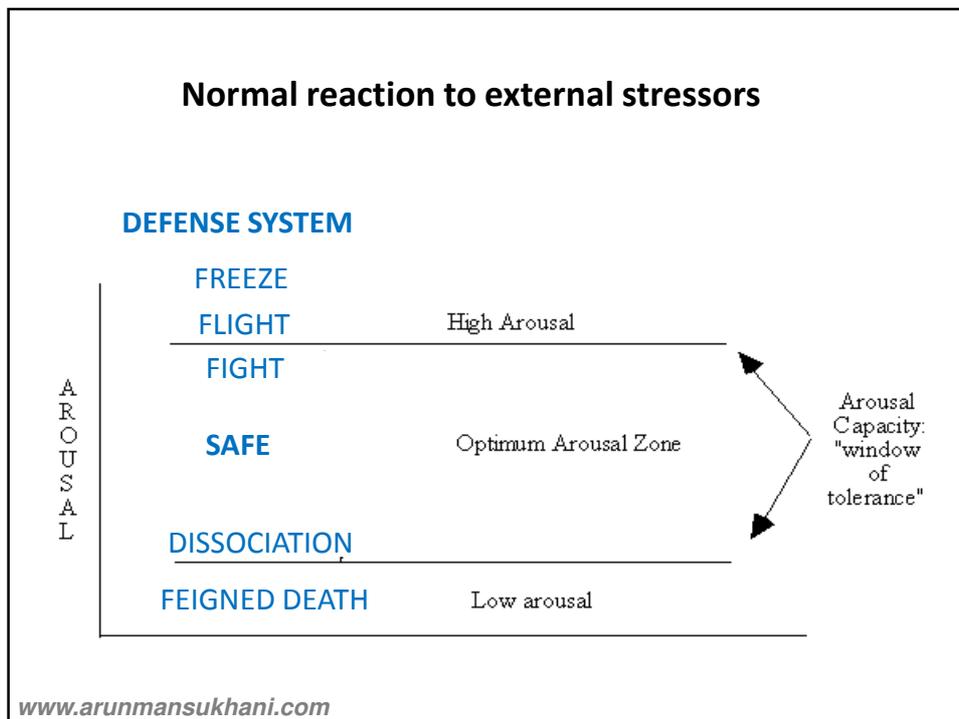
What is...

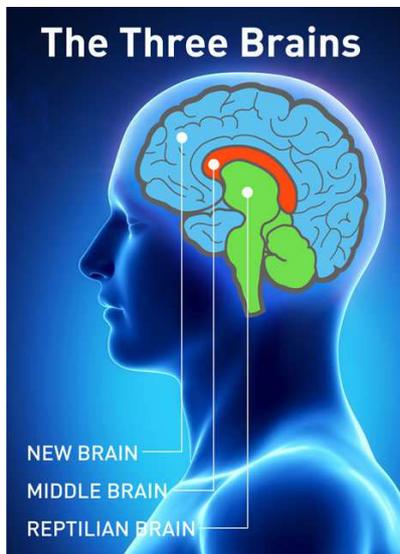


Adverse Childhood Experience study

(Felliti and Anda, CDCP since 1995. +17000 subjects).

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- Physical Neglect.





Trauma is when our brain and our nervous system produce a **stress reaction (fear)** not to a present threat but to **dysfunctionally stored “memories”** and internal cues, **deregulating**, hypo or hyper activating, **one or more of the behavioral systems.**

Chronic or long term trauma is... when this deregulation persists in time, causing a **sensitization of the system.**

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Which systems can be deregulated (traumatized)?

	ATTACKED	LOSS OR ABANDONED	ISOLATED
	DEFENSE	ATTACHMENT	SOCIAL RANK
	FREEZE	Attachment cry	Dominance
	FLIGHT	Seeking behav.	
	FIGHT		
A R O U N S U K H A N I	SAFE	CONNECTED	COOPERATIVE
	DISSOCIATION	Suppression of E-F	
	FEIGNED DEATH	IP Avoidance	Submission

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A few words about Social Ranking System

- Regulated by serotonin levels. Social animals.
- Parent-offspring conflict theory: Childrens demands vs parents output (Trivers 1974). Parents are SR agents.
- Attachment and SRS are partly opposite. When children perceive “weak” parents, tend to go to dominant positions:
 - Higher anxiety levels, less self-regulation, more impulsive behaviors (Peterson 2018).
 - Anger at parents for lack of protection.
 - Higher Reactive and Displaced y aggresive behaviour to lower stress levels (“stress induced displacement aggression”, Card y Dahl 2011).
 - Lower self-esteem (Sapolsky 2017). www.arunmansukhani.com

Which systems can be deregulated (traumatized)?

	DEFENSE	ATTACHMENT	SOCIAL RANK	SEXUAL
A R O U S A L	FREEZE	Attachment cry	Dominance	Hyper sex
	FLIGHT	Seekin behav.		
	FIGHT			
	SAFE	CONECTED	COOPERATIVE	SEXUAL ENGAG.
	DISSOCIATION	Supression of E-F		Hypo sex
	FEIGNED DEATH	IP Avoidance	Submission	Compulsive Sex

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Behavior control systems
(Affective or motivational)

**Bowlby 1958,, Hilburn-Cobb
2004, Liotti 2011, Pankseep and
Biven 2012)*

Defense

Social ranking

Attachment/Caregiving

Exploration

Pleasure/Seek.

Sexual

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Behavior control systems

- Flexible goal oriented responses that serve evolutionary functions (survival or reproduction).
- Linked to subcortical and sublimbical structures and ANS.
- Implicit memory networks. Procedimental more than Declarative.
- Activated by stress and internal conditioned cues.
- Tend to homeostasis (regulation).
- Attachment is the most important (regulation) and “has an organizing effect on the child” (West and Sheldon K 19995).
- Initially on/off systems, gradually develop in a harmonic way becoming in the adult more: sophisticated, differentiated, integrated and under cortical control.

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¿Why is attachment so important?

It's "the organizing principle around which psychological development takes place" (Holmes 2001):

- ▶ It' a protection against ACE: prevention and repair
- ▶ It creates the implicit knowledge of "how to do things with others" (Lyons-Ruth, 1988). Expectations regarding security and availability of AF .
- ▶ Basis of self regulation (co and auto regulation).
- ▶ Expectations about the self: Has to do with self-esteem, self-image and self- compassion You treat yourself as others treated you. (Zessin et al 2015).
- ▶ Closely related to mental health and well being:

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THE NATURE OF THE CHILD'S TIE TO HIS MOTHER

By
JOHN BOWLBY, LONDON

1. An abbreviated version of this paper was read before the British Psycho-Analytical Society on 19th June, 1957.
2. Although in this paper I shall usually refer to mothers and not mother-figures, it is to be understood that in every case I am concerned with the person who mothers the child and to whom it becomes attached rather than to the natural mother.




The Nature of Love
Harry F. Harlow (1958)
University of Wisconsin

First published in *American Psychologist*, 13, 673-685
Address of the President at the sixty-sixth Annual Convention of the American Psychological Association, Washington, D. C., August 31, 1958.
First published in *American Psychologist*, 13, 573-685.

“Attachment is the propensity of human beings to make strong affectional bonds to particular others”. *Bowlby 1977.*



“The infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment [and if this should not occur] will result in severe anxiety conditions and psychopathic personality”. *Bowlby 1951, WHO Report.*

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Attachment

- It's a primary bond: it doesn't form because of fulfilling any function ("cupboard theory") but rather, once the bond is formed it serves several functions (security, regulation, etc).
- It's a feeling state within both the infant and the caretaker (Condon, Corkindale y Boyce, 2008).
- 4 defining aspects: Safe Haven, Separation Anxiety (Attachment Cry), Proximity Maintenance, Secure Base.
- Different Attachment Types are formed in repeated patterns of parent-child interaction (Holmes 2001)

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Mary Ainsworth



-SSP: Investigarion and Attachment as a dimensional and interactive variable. Identifies types (1964):

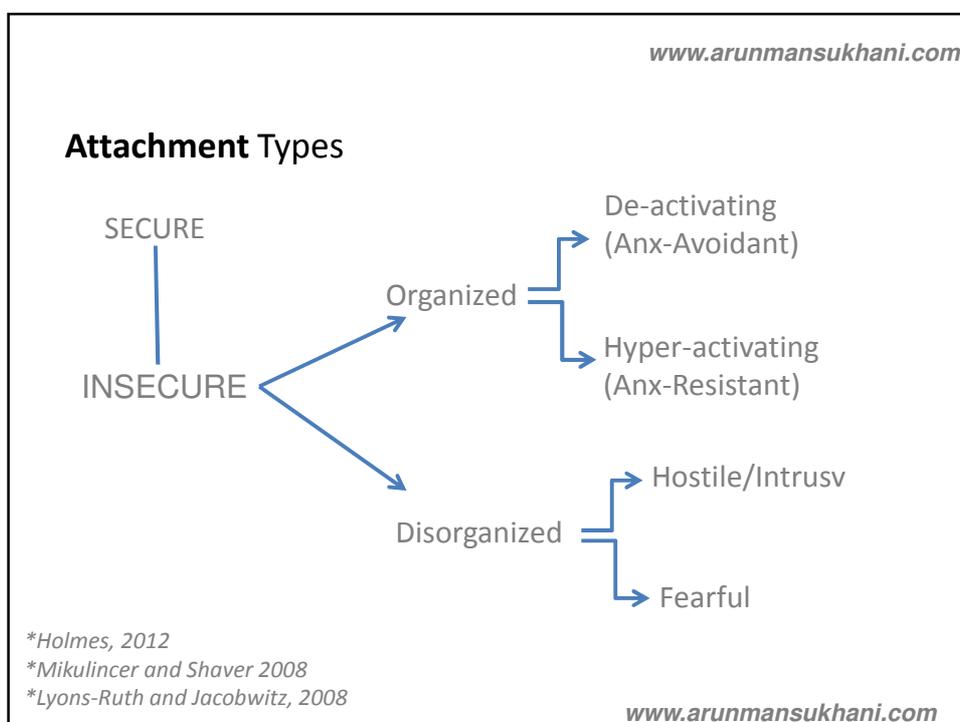
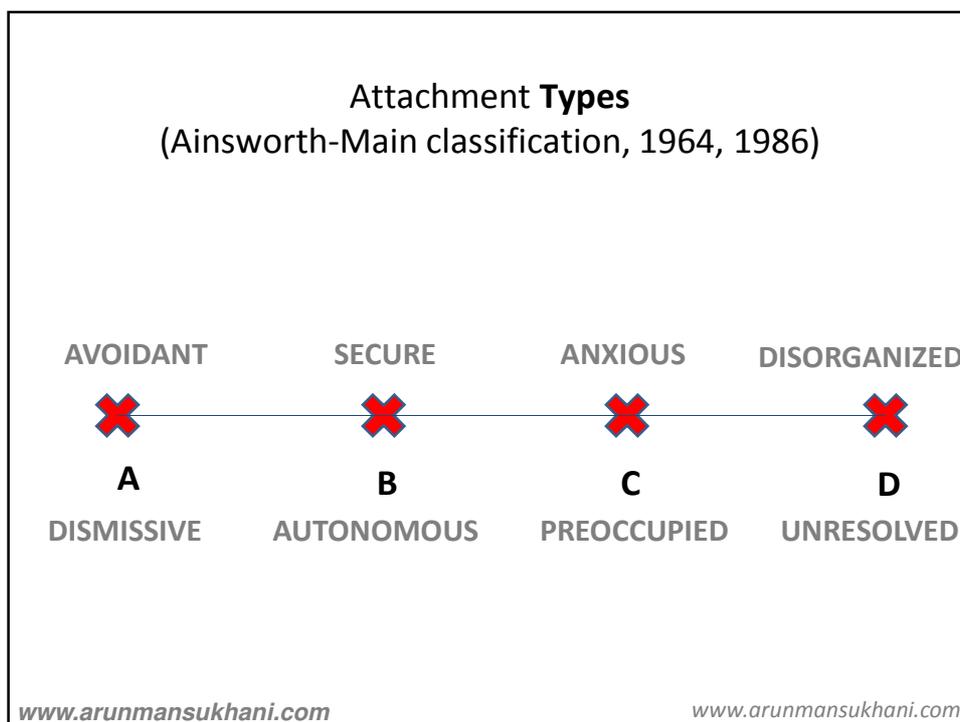
- Secure Attachment
- Insecure attachment (divided into avoidant and anxious ambivalent).



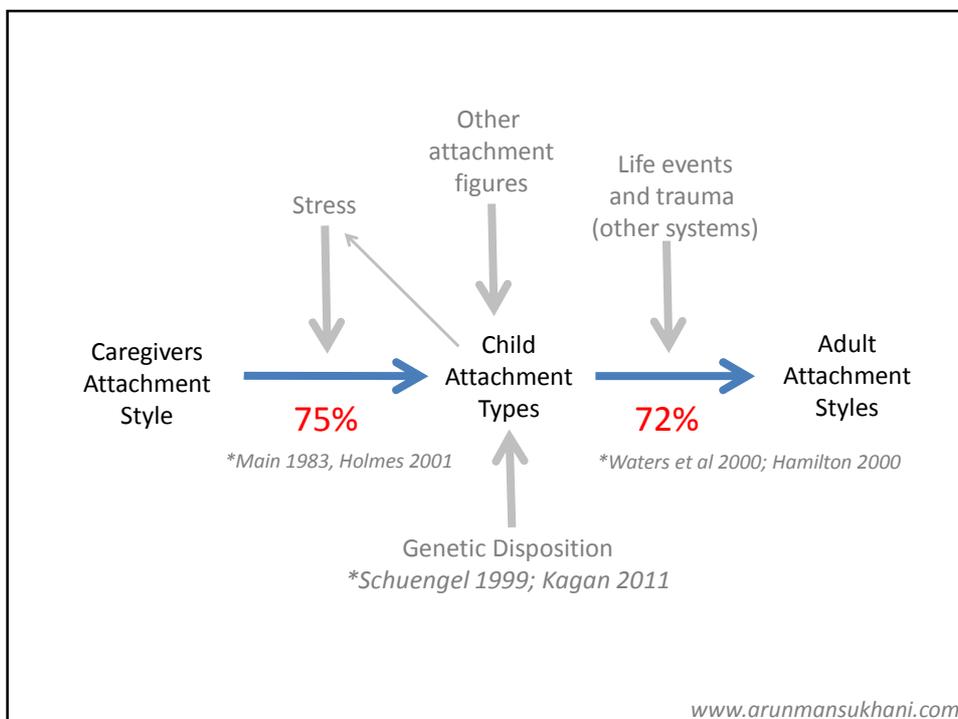
Mary Main

-Identifies Disorganized attachment (1986)
 -Designs AAI.
 -Extends attachment studies to adults: narrative and relational level.

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Caregivers Parenting Styles	Children attachment Types
Responsive, sensitive, attuned, positive affect...	Secure
Inconsistent, insecure... Avoidant (tired caretakers)	Insecure but organized ambivalent
Cold, dismissive, critical, Too invasive	Insecure but organized avoidant
Frightening or afraid. Absent or confusing. Dissociation. Sever pathology	Disorganized



Adult attachment

- -It's an implicit memory system (Amini et al 1996).
- -It will activate under stress, loss, loneliness, intimacy, etc.
- -They can be an overall style, although people exhibit different styles under different circumstances.
- Frequently emmeshed with other systems.
- -Disorganized attachment is not a 4th category.
- -In Insecure Patterns, the AS activates more frequently and in a more dual manner. "In insecure attachment, the individual's relational strategies are dominated by set, clearly repetitive patterns of attachment" (West y Sheldon-Keller 1994).

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Adult attachment

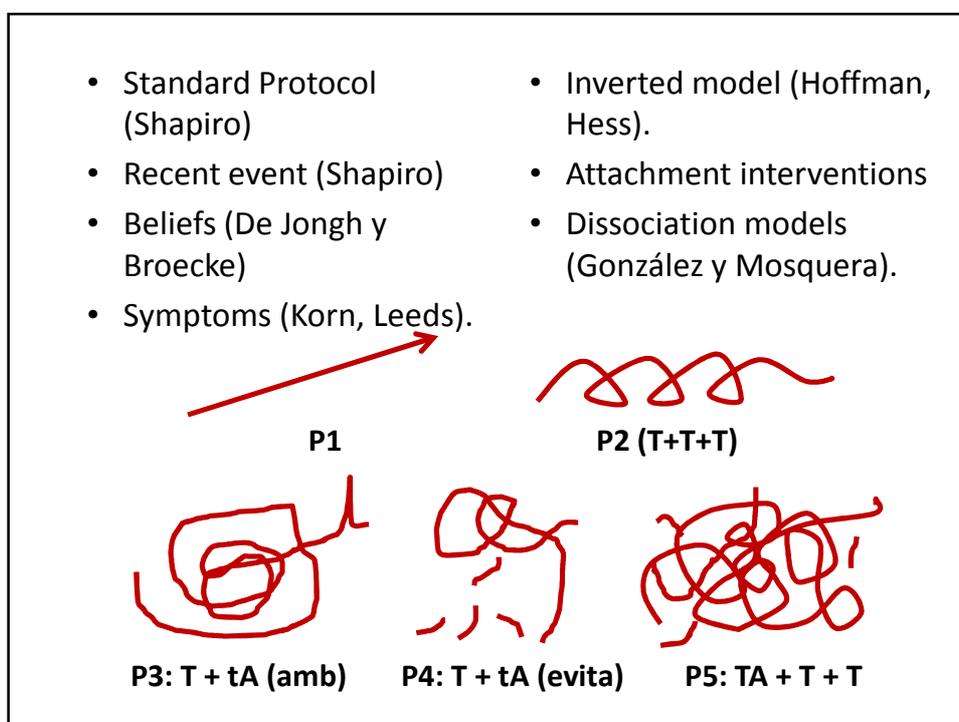
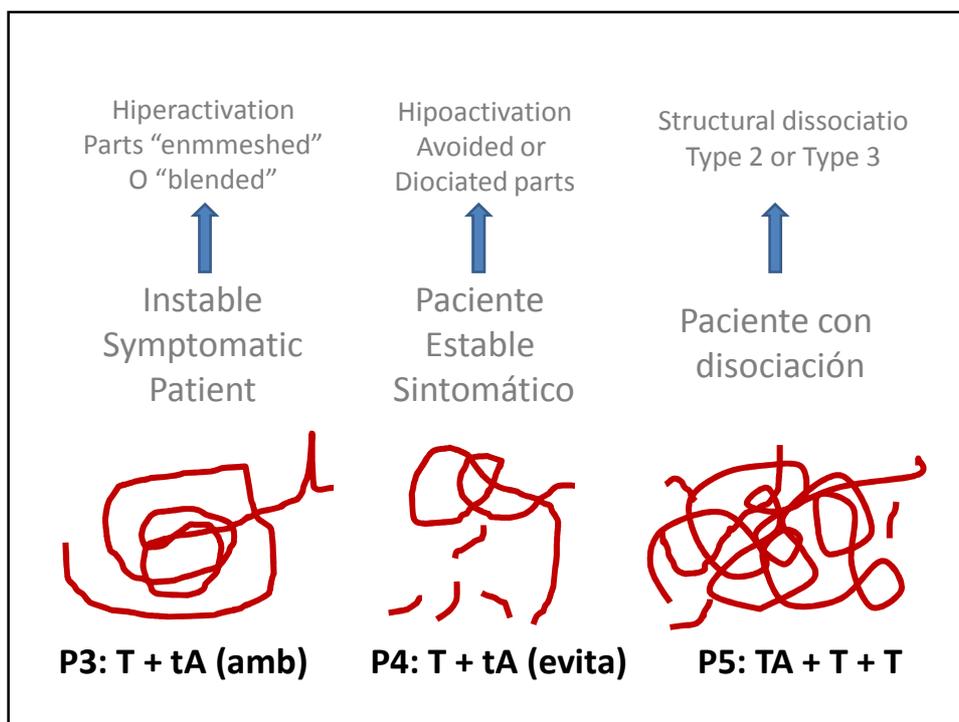
- Varies in flexibility-rigidness: secure attach. accommodate to new information, while insecure assimilate all new information under old guidelines:
"The insecure attached project strong negative feelings into their current attachment figures. Unable to view themselves as deserving and the others as wellcoming, once these feeling states are projected in current relationships, they have a very great likelihood of evoking corresponding feelings in other people [...] in a self fulfilling way" (Kobak and Sceery 1988).
- In adult insecure attachment, people exhibit a combination of avoidant and ambivalent features.

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“Adult patients with insecure attachments present a combination of avoidant and resistant features”. *Holmes, 2009.*

Avoidant features	Resistant features
Autoregulation: intimacy avoidance	Co-regulation: solitude avoidance
CNS: up down. ANS: Dorsal vagal	CNS: Down up. ANS: Sympathetic
Window of control. Stability: emotions and sensation suppression	Narrow Window of Tolerance. Frequent deregulation
Internal resources Emotional independence	External resources Emotional dependence

Types of patients





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Adapting EMDR for adults and couples with attachment issues

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3 prong approach

8 phases of EMDR

	Phase	Objective	
Prong Past Present Future	1. History	Assessment and introduction to AIP. History taking.	
	2. Preparation	Stability, security, understanding	
	3. Assessment	Target and take to point of processing	
	4+5+6. DS-Instal-BS	Desensitisation and Reprocessing	
	7. Closure	Get the patient back	
	8. Re-evaluation	Link	

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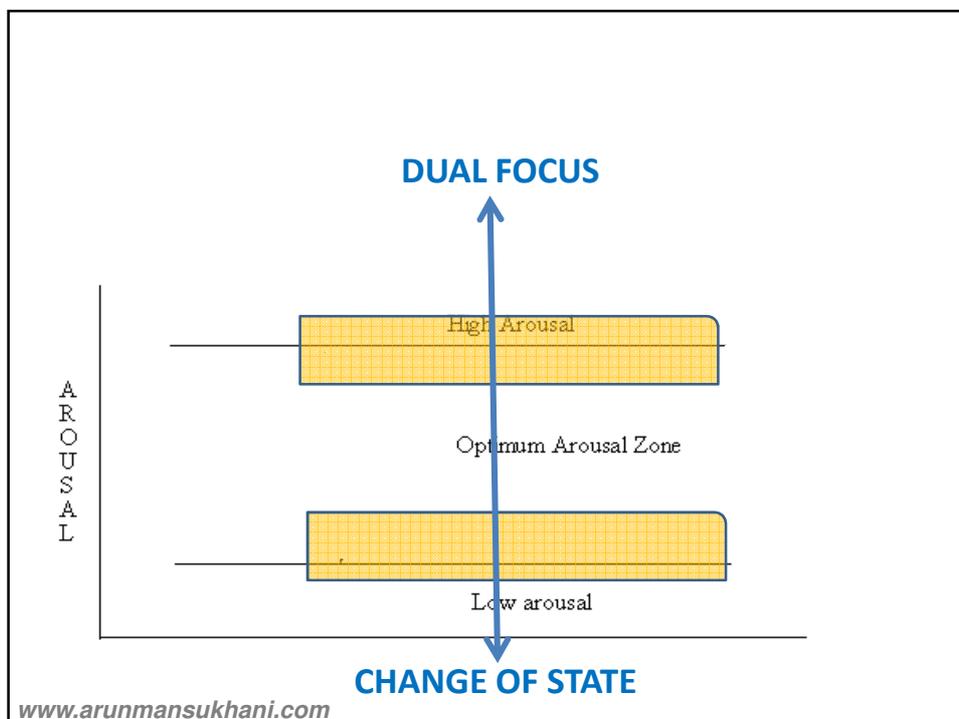
**Farrell D & Lalotia D, 2017*

Standard preparation interventions are sufficient for clients who are able to:

DUAL FOCUS

- Access their experience and their response to it
- Maintain dual attention
- Tolerate distress without becoming overwhelmed or shutting down
- Can shift from one state to another (distress to calm and viceversa)
- Observe and reflect about the experience instead of being completely absorbed by it
- Access positive experiences.
- Self-sooth between sessions

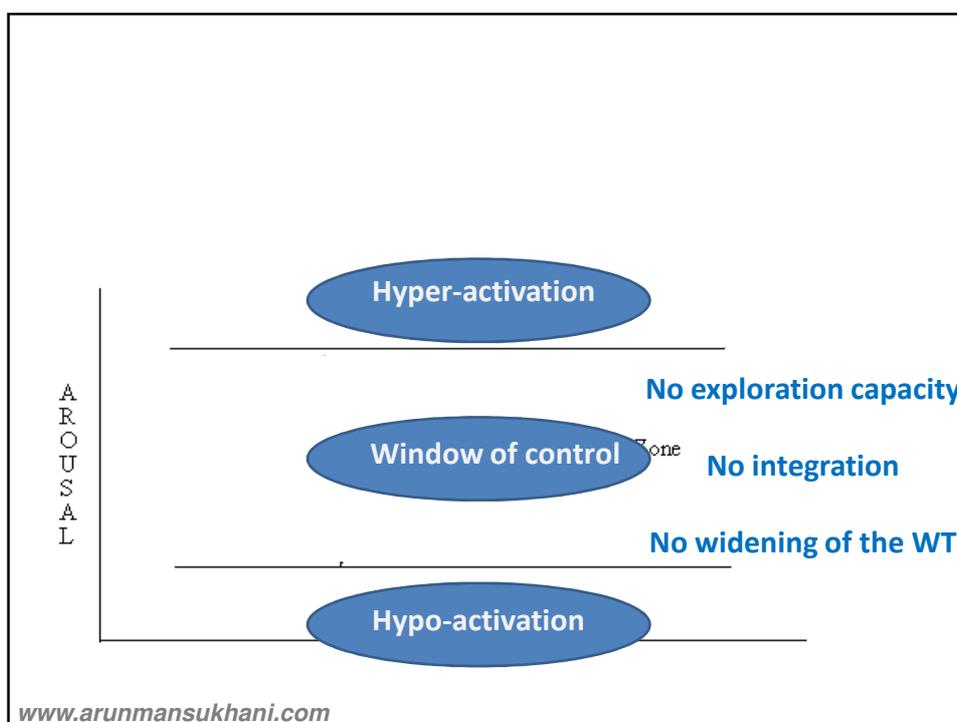
CHANGE OF STATE



What stops/hinders processing?: Loss of DF.

- **Leaving the WoT (loosing DF):**
 - Hyper-activate and get locked out.
 - Hypo-activate and shut down.
- **Fear of leaving the WoT.** Fear of unmanageable feelings or other mental content . Activate Avoidance Defense Mechanisms:
 - Conscious Suppression. Avoiding, redirecting attention.
 - Denial, idealization.
 - Unconscious suppression (Window of control).
 - Partial Dissociation: BASK model (Brown 1988).
 - Defenses: Introjection, Identification
- **Structural Dissociation** (defense and/or failure of integration).

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8 phases of EMDR

Phase
1. History
2. Preparation
3. Assessment
4+5+6. DS-Instal-BS
7. Closure
8. Re-evaluation

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Patients with attachment issues

- History taking is deregulating and evocative (Steele 2016)
- No explicit memories (Amini et al. 1996) Attachment blind (Siegel 2012) Destabilize when activate their AS (hyper and get locked out, hypo and get shut down) and/or
- Fear of de-stabilizing (window of control)
- Problems with recall and connection: dissociative features, semantic (resistant) vs. episodic (avoidant) memory problems, BASK dissociation (Braun 1988), Suppression...

3 prong approach

8 phases of EMDR

Phase	Objectives/ Tasks
2	-Build therapeutic relationship -RDI: Security – Future Temp.
2 - 1+5	-Widen window of tolerance -Affect tolerance (+ and -)
2 - 1+3+4	-Mentalization -Understanding
2 - 1+3+4	-Partial processing -Work <i>with</i> defenses
2 - 3-8	-EMD
3+4+5+6+7+8	-EMDR

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Phase 2- Therapeutic relationship

“Therapy is an in-vitro experiment in intimacy”
(Holmes 2010).

Clients

Activate their (damaged) attachment system:

- Low self regulation and/or extreme control.
- Difficult at an interpersonal level. Positive and negative transference. Frequent enactments (Schoore, 2015).

Therapist

Activate his/her own attachment (damaged?) system. Frequently anxious-resistant, care-giving. (Diamond et al 2003; Barr, 2006). This will happen especially during enactments.

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Phase 2- The therapist in the therapeutic relationship

- Be sure that the past that is being re-created is not his own but the patient's:
 - Have worked on his/her attachment history. (**Earned Secure Attachment**, Mayn & Goldwyn, 1984; Hess 2008).
 - Be a **Safe Base** for the patient (Johnson 2016).
 - A interactive co-regulator: capacity of being in relational mindfulness.
- Has to enter (and therefore validate) the clients' worldview before challenging it. This implies understanding (the function) and respecting bonding patterns and “parts”.
- Understand the importance of enactments and handle them. Frequently, they are the beginning of therapeutic change and the first chance the patient has of experimenting a healthy relationship.

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Phase 2:

- The most relevant phase, present throughout therapy, with 3 main objectives:
 - **Stability:** Emotional regulation.
 - Relational **Security** .Start feeling safe enough to explore insecurity (Holmes 2010)). (USE BS)
 - **Understanding:** Help mentalize (understanding and integration of life history) (Use BS).
- What we do:
 - Usual phase 2: calm place, RDI, Affect tolerance, self-care, ego-strengthening, etc.
 - Therapeutic relationship.
 - Adjust the rhythm of therapy to patients needs.
 - Specific techniques.

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Phase 2- Working towards safety, stability and understanding

- Perceive overwhelming / avoidance pattern and where the patients difficulties lie.
- Check for resources (during session) and self-soothing.
- Help the patient perceive them and voluntarily start regulating them.
- See the main attachment style. Interaction with therapist. Detect other Behavioral action systems at play.
- Address the patient's fears towards therapy. Don't be invasive.
- Keep an eye on NC and PC. References to the past. Out of place words.
- Realize the rhythm the patient requires, to be exposed to manageable bits of disturbance. Widen the WoT.

Regulation = Safety = Attachment

Phase 2- Adjusting the rhythm in sessions Widen WoT

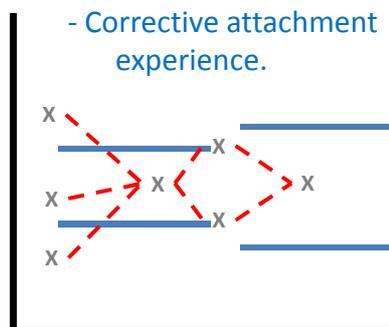
Phase oriented treatment:

- Stabilization and symptom reduction
- Memory processing
- Integration and rehabilitation

In each session:

- Regulation: help to be inside the window of tolerance.
- Processing (taking the person to the limits of the WT)
- Installation and orientation to external life.

- Capable of managing activation.
- Insight and understanding.
- Adult as a secure base.
- Corrective attachment experience.



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Phase 2- Some specific techniques

Couple

- Positive and negative affect tolerance
- Interactive regulation
- Conflict analysis
- Healthy limits
- Positive interaction, positive activities.
- Sex as re-traumatization

Individual

- Homeostatic regulation
- Routines and structure.
- Future templates
- Healthy limits.
- Adiction protocols:
 - Past: Idealization (Knipe)
 - Worst fear protocol: jealousy, being left, envy.
 - Future + Urge (Popky)
 - Guilt

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Phase 2 + 1: History taking

- Once stabilized and secure, start with the co-creation of life history. From present to past.
- Defense mechanisms and emotions will be activated in first place. Distinguish defensive emotions and hurt emotions. Work with defenses.
- Most of the At and AT memories won't appear until the person activates his/her Attachment System. Before processing, these memories have to be integrated into life history. Normally this will overwhelm. Use:

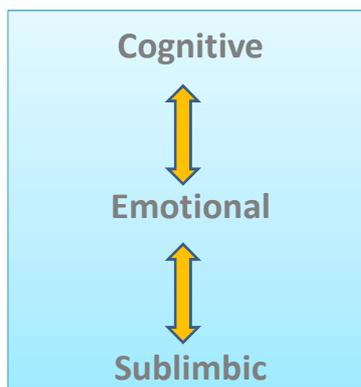
DF - short/slow BS - tactile BS - Partial processing - CIPOS

(Knipe 2009)

- Will widen the WT of the patient and help them mentalize (Fonagy 1997/2007) and enhance their reflective functioning (Bowlby 1988) and allow us to come closer to standard processing.

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Partial processing



- Connects with his biography
- Past – present differentiation.
- Internal – external differentiation

When AIP is blocked, separating cognitive and emotional aspects and focussing on the sensory-body can be useful to stimulate AIP (**Shapiro, 1995/2001; Gómez y Ogden, 2013**).

Phase 3-6: Targets.

- They are not “close to the surface”, only appearing gradually as AS gets activated. We have to **work towards the emergence of targets**.
- Appear in reverse hierarchical order: least important will appear first.
- It will initially be difficult to get complete targets (due to overwhelming or disconnection) so we have to use partial processing: using two modalities and short BS to integrate and desensitize them (Shapiro 1995/2001; Gomez 2013).
- Frequently, only after working with present and minor targets, allowing to widen the window of tolerance, will the deeper rooted and more pathological situations emerge.

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Phase 3-6: Targets.

Other option: use present interpersonal conflicting situations:

1. Couple: positive affect intolerance better than negative.
2. Problems with children:
 1. Reinforce them as parents for their sensitivity and concern
 2. Ask for the feelings while the child misbehaves. Start with the Main AF.
 3. Suggest to work on their emotions to help the child.
 4. Talk about feeling and expectations: brings up the idealization (the defense against the attachment wound).
 5. Work either with the wound or the defense. Or use SP with a present difficulty and take it to positive end (opens up the attachment system).
 6. Make them understand that you can't fight the past and the present at the same time

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Phase 3-6: Images.

- Specific images related to particular situations.
- Symbolic images: mother's face, back, etc. They don't represent particular moments as much as general aspects of the pathological relationship with the attachment figures, etc.
- Projections: own or other children, movies, pets, etc.
- Imagine how... (for situations that occurred very early in life)
- Scenarios (recurrent situations) and Nodal memories (Holmes 2001) , related to more than one memory network (and therefore different cognitions).

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Phase 3-6: Cognitions.

- Activation of different BS, situations frequently are related to more than one type of NC. We can install different PC with same target.
- Responsibility/defectiveness are the most frequent in attachment.
- Safety/Vulnerability and Power/control group NC are more frequent in T trauma. So NC can be a useful way to distinguish if we are in attach or trauma mode. If the same situation is related to both type of NC, normally we shall process first the T.
- PC may be unavailable at the beginning (maybe too unbelievable). We can use **progressive installation** of PC:
 - it's over / it's over and I am safe now / I learnt / I am free of guilt...
 - I am learning to be loved... / I am learning that everybody makes mistakes... / I am starting to think that everybody deserves to be loved.

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Phase 3-6: Emotions.

- Basic emotions (wound):
 - T: panic, disgust, vulnerability-helplessness, ...
 - At: anxiety, sadness- loneliness, ...
 - AT: all the previous.
- Defensive emotions: anger, guilt, shame + counter-shame (hate and aggressiveness)
- Also child part emotions vs the adult emotions. Process both.

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Phase 3-6: Sensations.

- Can be overwhelming at times and may require DF at initial stages to calm them. They may also block the processing and have to be separated at times from emotion and cognition to allow processing (DF very useful for this).
- Can also be absent or felt only in the head. In these cases (except when its a headache) it's very useful to ask:
 - “You feel this in the head and were else?” or “when you feel this in your head, what do you notice is happening in your body?”
 - “As you think about this, ¿what’s happening (or changes) in your body?”

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Thank u!

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