

## Treating Interpersonal Dependence and Pathological Bonding Patterns with EMDR

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- Great subjective suffering in people messed up in disruptive relations and others that have given up on having a (healthy) relationship.
- Interpersonal Dependence and Pathological Bonding Directly related to major social problems as gender and domestic violence, including suicides an admiring sin Adults (ID-PBP)
- Underlying feature or co-morbid in most emotional and mental disorders. Related to all five major symptoms clusters in psycho-emotional disorders (S-Seglert, 2006).
- cPTSD: Pervasive difficulties in 3 areas: (1) self organization, (2) affect regulation and (3) relational security. ID-PBP related to all 3.
- Under diagnosed and not treated in most cases, due to lack of comprehensive and integrative models.

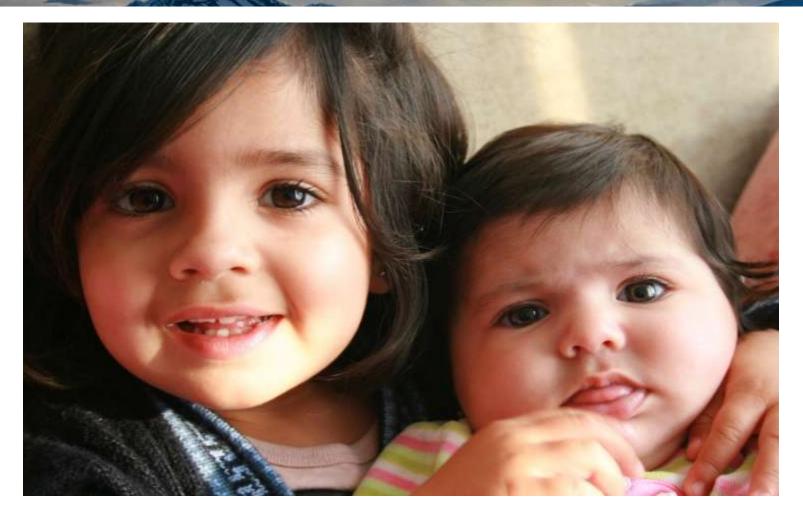
#### Frequently ignored cases

- People that exhibit egosintonic PBP.
- People whose PBP is masked by a DSM diagnosis
- People who present symptoms only in when in couple and are stable when not in a relationship.
- People who exhibit problems only in certain types of couples. Frequently have chosen compatible PBP types.
- The avoidant types.

ID-PBP

#### **CASE CONCEPTUALIZATION**





Independence

Healthy dependence (Healthy bonding patterns)

Regulation + Security

Healthy dependence

Healthy bonding patterns Auto-regulate + secure when alone

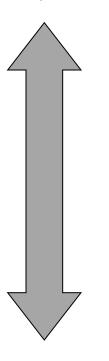
Autonomy

Intimacy

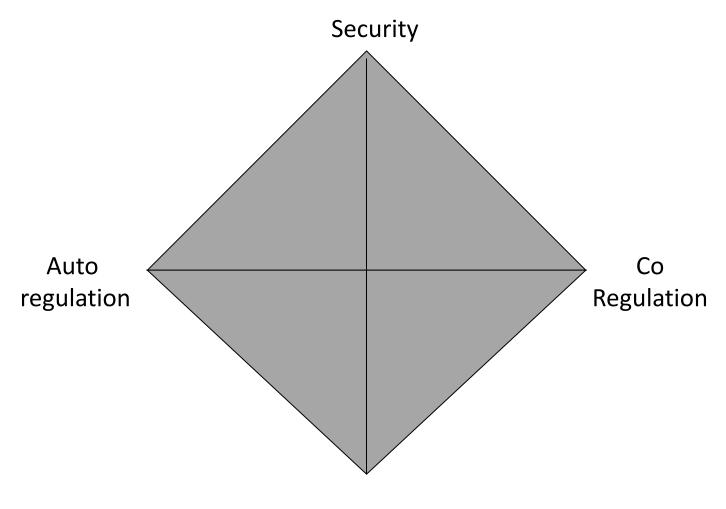
Reciprocal attachment – Horizontal relation: Mutual caregiving, cooperation and regulation

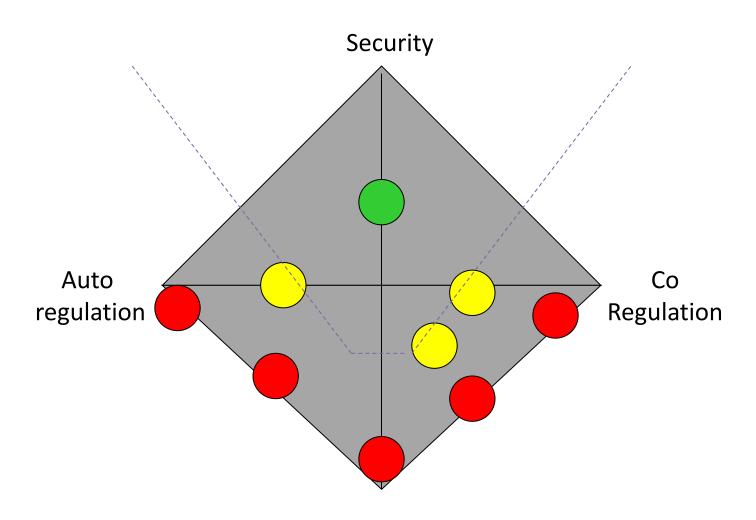
# Regulation + Security Auto Co Regulation Regulation

#### Security (trust)



Fear (distrust)





#### **PBP - Types**

Pleasing (caretaking) **SUBMISSIVE** Helpless \*Oscillating Agressive DOMINANT Passive-Agressive \*Carer-Codependent (Inverse Dep) Manifest **AVOIDANT** Emotional (pleasing or caretaking) \*Suspicious/Seductive

PBP	BASIC EMOTION	FEAR EXTERNAL	FEAR INTERNAL	SAFETY	BEHAVIOR
SUBMISSIVE	Anxiety	Abandoned Not valued Not noticed	Worthless Not lovable	Co-Re	Submit Please Care
DOMINANT	Fear, (Anger)	Rejected Hated Dominated	Abject Pitiful Damaged	Co-Re In control	Dominate Control Care
AVOIDANT	Sadness, (Distrust)	Controlled Invaded Loss of liberty	Sadness Loneliness Vulnerable	Auto-Re via supression	Rigid Detached Pleasing Care

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Helpless

\*Oscillating

Agressive DOMINANT

**AVOIDANT** 

Passive-Agressive

\*Carer-Codependent (Inverse Dep)

Manifest

Emotional (pleasing or caretaking)

\*Suspicious/Seductive

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Pleasing (caretaking)

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Pleasing (caretaking)

Helpless

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#### THE NATURE OF THE CHILD'S TIE TO HIS MOTHER

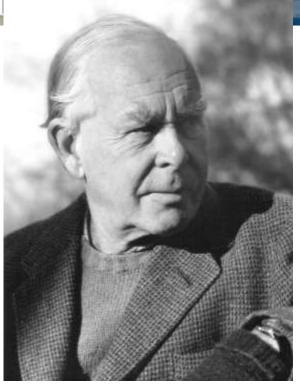
By

#### 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.





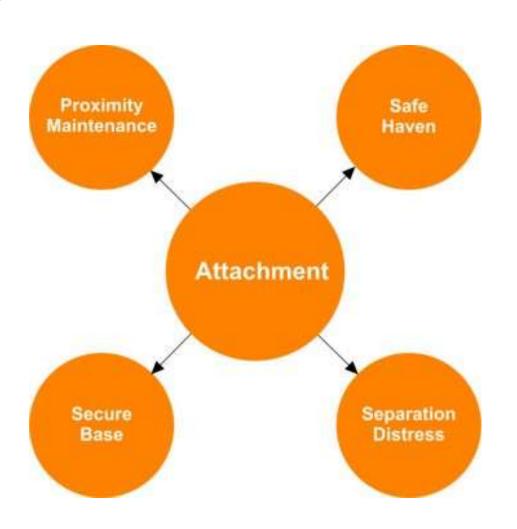
#### The Nature of Love

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 sever anxiety conditions and psychopatic personality".

Bowlby 1951, WHO Report.

#### **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.
- It's an action system, activated under:
  - Stressful situations.
  - Abscence (real or emotional) or fear of absence of the attachment figure (no attunement, unconsistent, emotionally distant, etc).

- A healthy attachment develops from a series of warm, sensitively attuned, and responsive interactions with the caregiver (Bowlby1969; Davies 2011).
- It is a caregiver's "positive affect" during these interactions and during the activities they engage in with their child that further cements the attachment relationship and makes it enduring and healthy for the child (Sroufe & Waters1977).
- ▶ Depends on right brain interaction between child and caregiver [...] releasing endogenous opiates (Schore 1997)
- It's a complex psychophysiological state [...] created in early stages that affects neurodevelopment (Rosenblum et al 1994).
- ▶ [Different] Attachment Types are formed in repeated patterns of parentchild interaction (Holmes 2001)



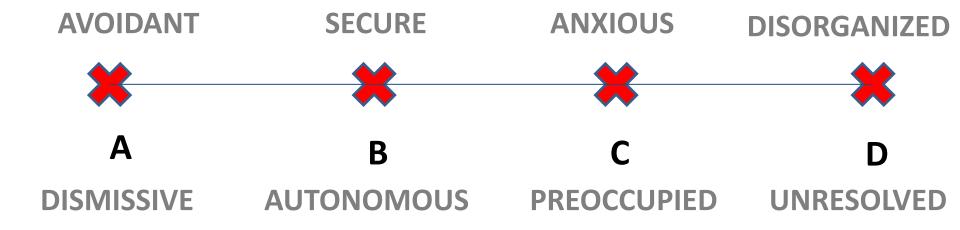
#### **Mary Ainsworth**

- -Strange Situation Procedure: Investigarion and Attachment as a dimensional and interactive variable (grades of emotional availability). 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.

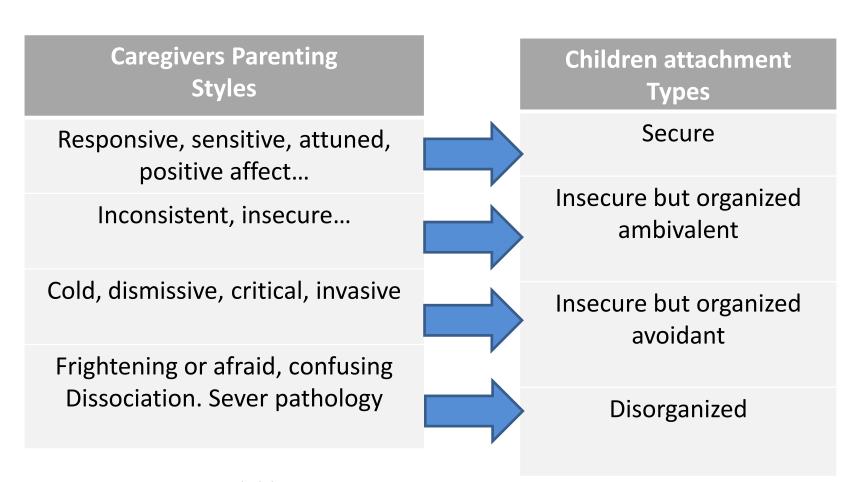


Attachment **Types** (Ainsworth-Main classification, 1964, 1986)

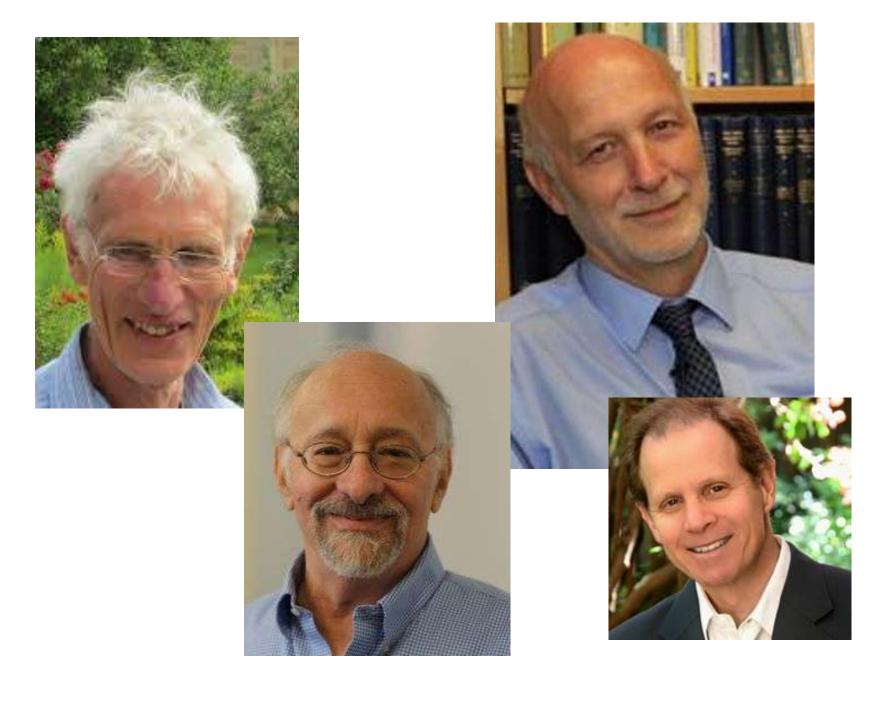
Attachment types are universal (Hazan & Shaver 1994) they represent a reliable an valid measure (West & Sheldon-Keller, 1994)



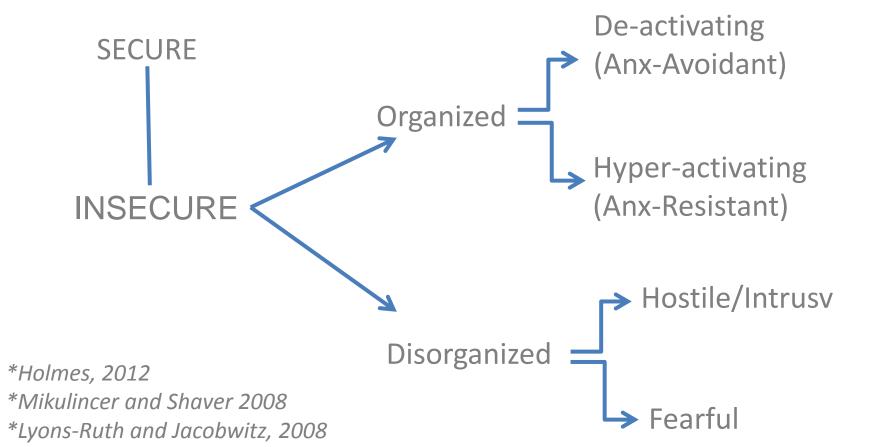
Van IJzendoorn, M.H., & Kroonenberg, P.M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange-situation" *Child Development* 59, 147-156. N=2000

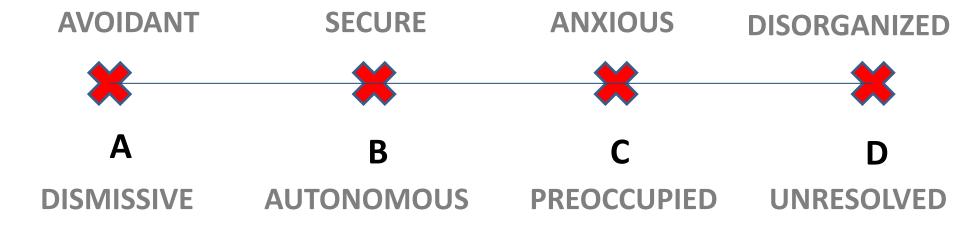


Holmes 2001: Parenst AAI to Children SSP: 75%



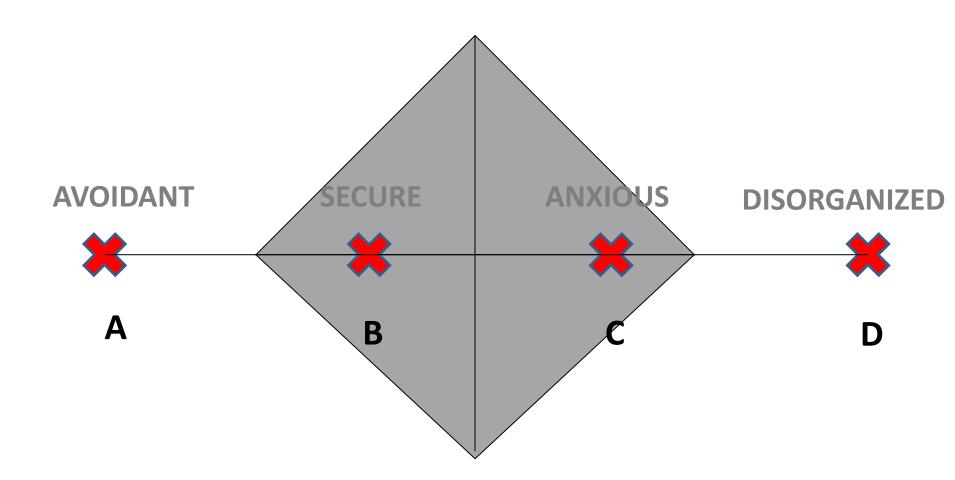
#### **Attachment** Types

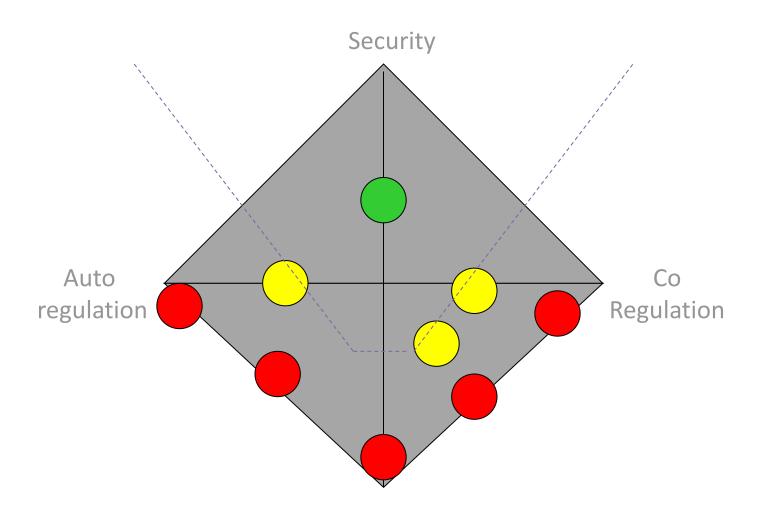


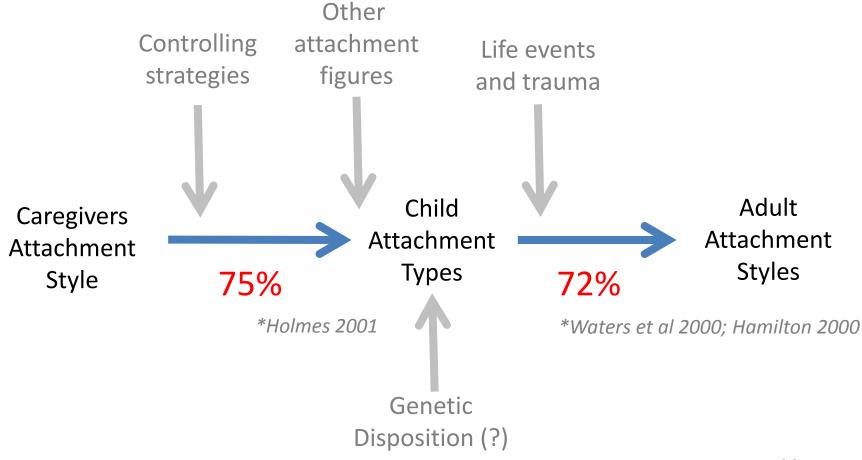


Attachment Types

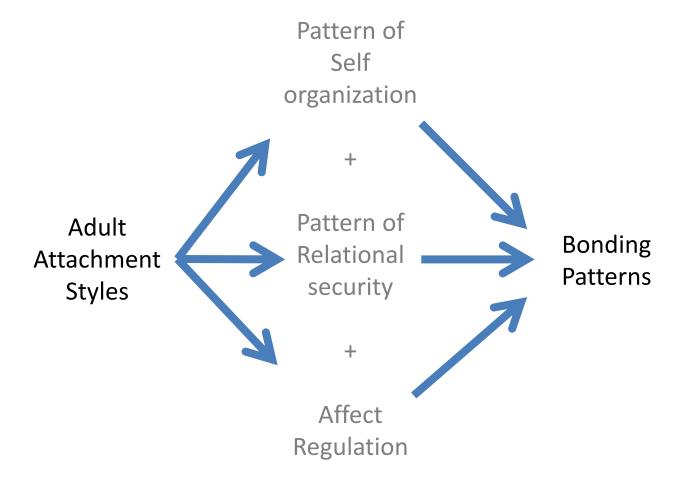
(Ainsworth-Main classification)







Adult Attachment Styles



-Most patients with insecure attachment have a combination of avoidant and resistant features (Holmes 2009).

Avoidant features	Resistant features	
Hipo – Parasympathetic active (ventral dorsal)	Hiper-Sympathetic activation	
Cortical: suppresse emotion and feeling	Limbic: emotional dysregulation	
Auto regulation	Co-regulation	
Tend to self	Tend to others	
Internal change	External change.	

ID-PBP

#### ATTACHMENT INFORMED EMDR TREATMENT

#### 3 prong approach

#### 8 phases of EMDR

Prong
Past
Present
Future

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

TT	Event	Defense	Emotions
t	Ego threatening events	-Emotional resp.	
T	Life threat Body integrity threat Life threat on attach figure	-Survival: fight, flight, freeze, submission, FD.	Fear, disgust, guilt
At	Suboptimal parenting Insecure attachment	-Attachment: hyper or hypo activation	Anxiety, guilt, shame, anger, sadness, loneliness
AT	Neglect. Severe attach ment issues.  AF are traumatizing figures (fritghtening or afraid)	-Simultaneous actvate SD + AD -Failure of Defensive systems.	All the previous + aggression. Structural Dissociation.

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

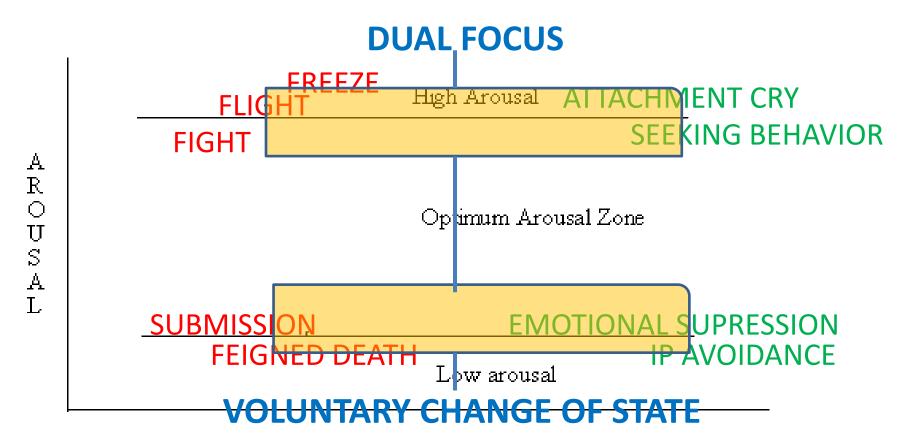
#### **DUAL FOCUS**

- 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 absorved by it
- Access positive experiences.
- Self-sooth between sessions

# **VOLUNTARY CHANGE OF STATE**\*Farrell D & Laliotis D, 2017.

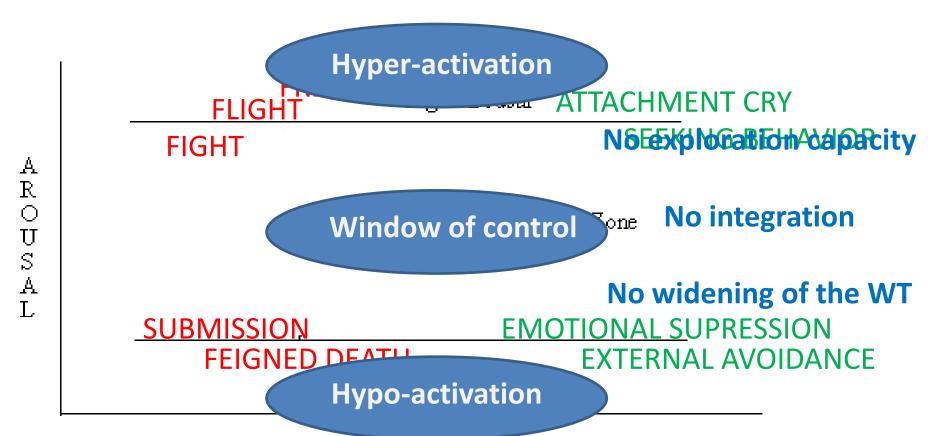
#### **SURVIVAL RESPONSES**

#### **ATTACHMENT RESPONSES**



**SURVIVAL RESPONSES** 

**ATTACHMENT RESPONSES** 



### What stops/hinders processing?: Loss of DF.

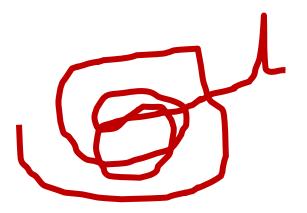
- Leaving the WOT:
  - Hyper-activate and get locked out.
  - Hypo-activate and shut down.
- Fear of leaving the WOT. Fear of unmanageable feelings or other mental content. Activate Avoidance Defense Mechanisms:
  - Conscious Suppression. Avoiding, redirecting attention.
  - Denial, idealization.
  - 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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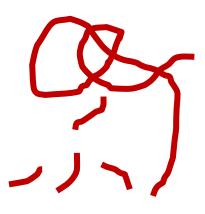
Types of patients - evolution

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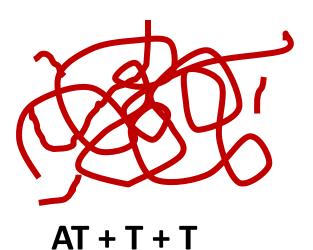
Unstable Symptomatic Patient Stable Asymptomatic patient Patient
Dissociative
features



At (amb) + T



At (avoid) + T



#### 8 phases of EMDR

#### Phase

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

#### Patients with attachment issues

- History taking is deregulating and evocative (Steele 2016)
- Attachment blind (Siegel 2012)
- Problems with recall and connection: dissociative features, semantic (resistant) vs. episodic (avoidant) memory problems, BASK dissociation (Braun 1988)
- Highly defensive (control) and/or
- Destabilize when activate their AS and DS

#### 3 prong approach

#### 8 phases of EMDR

Prese	nt
	Near Future
Recent past	
Pre	sent
Remote pas	
	<b>/</b> Far future

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 with defenses
2 - 3-8	-EMD
3+4+5+6+7+8	-EMDR

#### Phase 2:

- The most relevant phase, present throughout therapy, with 3 main objectives:
  - Help learn emotional regulation (stability and security)
  - Help mentalize (understanding and integration of life history)
  - Start feeling safe enough to explore insecurity (Holmes 2010)
- What we do:
  - Usual phase 2: calm place, RDI, Affect tolerance, self-care, egostrengthening, etc.
  - Therapeutic relationship.
  - Adjust the rhythm of therapy to patients needs.
  - Specific techniques.

### 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 (Schore, 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. As an attachment figure:
  - Have worked on his/her attachment history. Able to interact safely (Earned Secure Attachment, Mayn & Goldwyn, 1984; Hess 2008).
  - Ba a Safe Base for the patient (Johnson 2016). A interactive coregulator: have the capacity of being in relational mindfulness. (selfregulating and self-soothing). Be very careful and clear with limits.
- Has to enter (and therefore validate) the clients's worldview before challenging it. This implies understanding (the function) and respecting bonding patterns and "parts".
- Understand the importance of enactments and handle them. Frquently, they ar the begining of therapeutic change and the first chance the patient has of experimenting a healthy relationship.

# 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. Transference and counter-transference.
- 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.

Regulation = Safety = Attachment

### Phase 2- Adjusting the rhythm in sessions

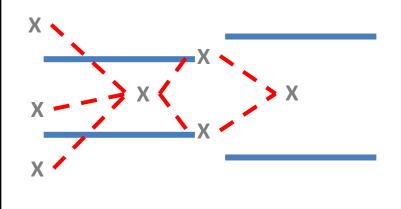
#### Phase oriented treatment:

- Stabilization and symptom reduction
- Treatment of memories
- 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.



### 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

- Positive and negative affect tolerance
- Future templates
- Healthy limits.
- Specific protocols:
  - Past: Idealization (Knipe)
  - Worst fear protocol: jealousy, being left, envy.
  - Future + Urge (Popky)
  - Guilt

### 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.

#### EMDR Basics – Phases 3-6:

Right Hemisphere Image Cognition: NC + PC Left Hemisphere **Emotion - SUD** Limbic System and ANS Body Sensation. **Brainstem and ANS** DF + BS Desensitizing Past - Present Reprocessing Associate Cognition – Emotion – Sensation

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, will the deeper rooted and more pathological situations emerge.

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).

### Phase 3-6: Cognitions.

- Situations frequently are related to more than one type of NC. We can install different PC with the same target situation.
- 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 se shall process first the T.
- Many time PC are unavailable at the beginning of the processing (or 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...

Phase 3-6: Emotions.

- Basic emotions (hurt):
  - 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.

#### 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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