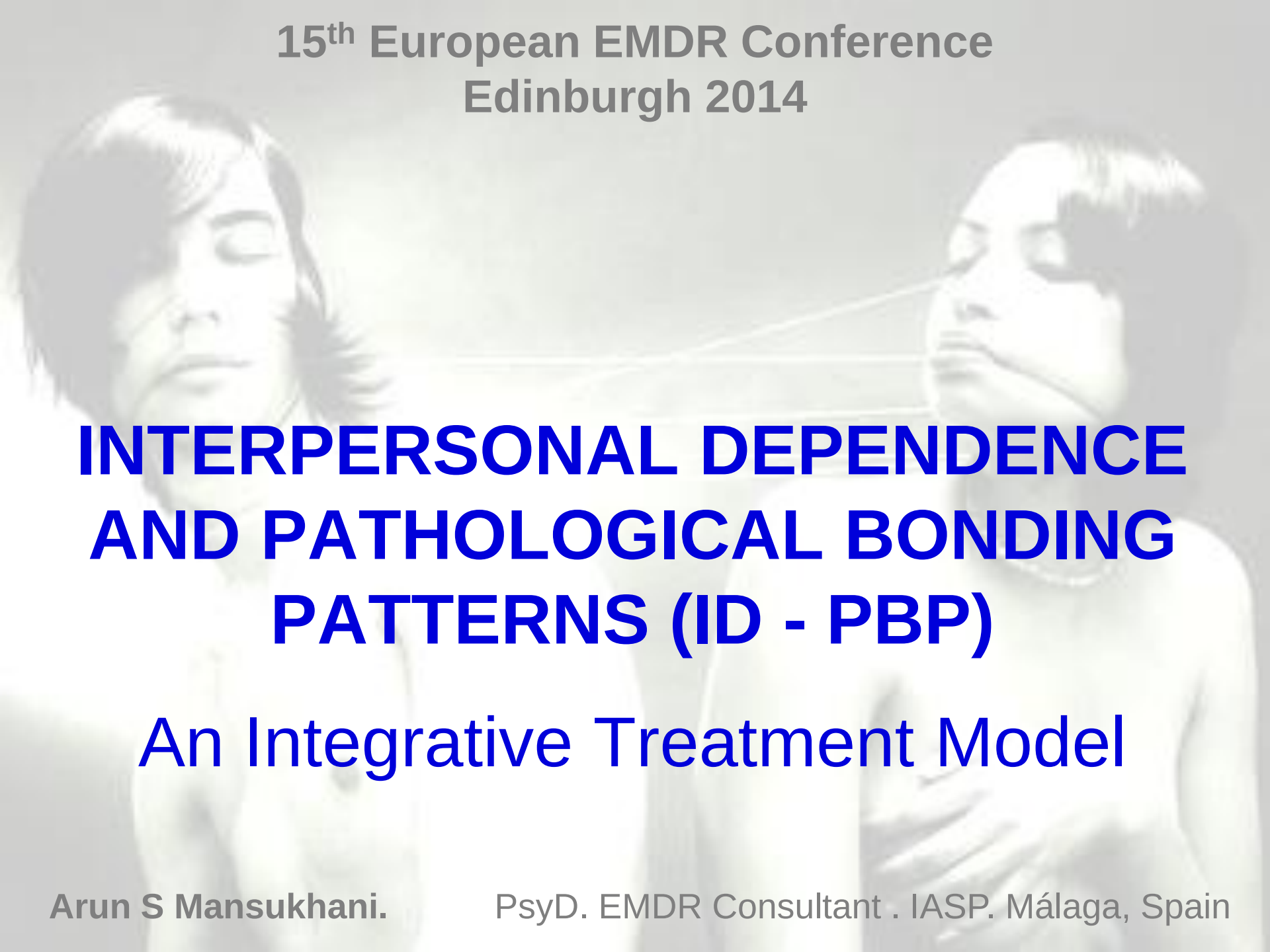
15th European EMDR Conference
Edinburgh 2014



INTERPERSONAL DEPENDENCE AND PATHOLOGICAL BONDING PATTERNS (ID - PBP)

An Integrative Treatment Model

Arun S Mansukhani. PsyD. EMDR Consultant . IASP. Málaga, Spain

ID (and PBP) is a major social and clinical problem:

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- Underlying feature or comorbid in most emotional and mental disorders. Related to all five major symptomps clusters in psycho-emotional disorders (S-Seglert, 2006).

- Great subjective suffering in people messed up in disruptive relations and others that have given up on having a (healthy) relationship.

- Directly related to major social problems as gender and domestic violence, including suicides and homicides.

ID + PBP

High number of direct and indirect cases

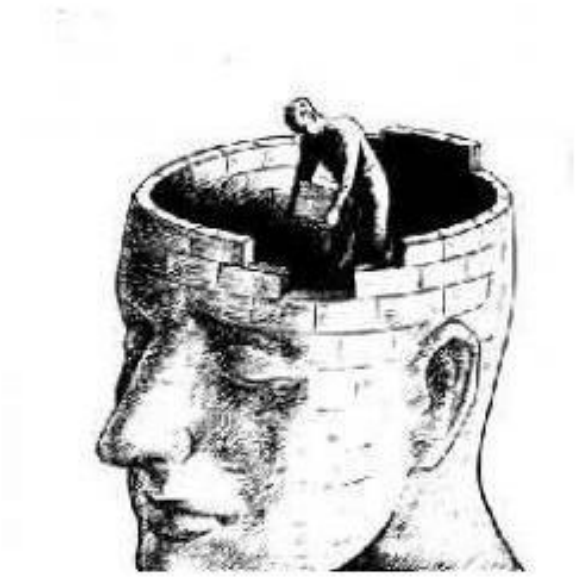
Major soc. & clinical problem

ID+PBP is overlooked and remains unattended in most cases

UNDERDIAGNOSED

UNTREATED

Lack of integrative models to assess and treat PBP



1. ID and PBP?


pooh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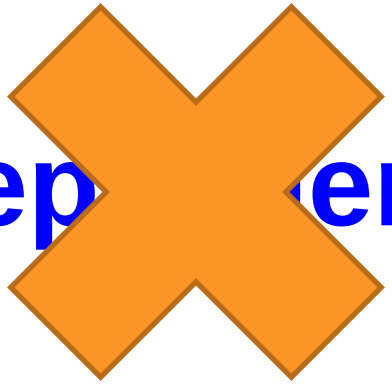


Healthy dependence
(Healthy bonding patterns)

Healthy dependence (Healthy bonding patterns)

Self depend (Uni Rglt.)

+

Inter depend (Co Rglt.)

=

Horizontal Relationship

2. Diagnosis

When do ID and BP become pathological?

A persistent pattern or tendency:

-To have a number of conflictive interpersonal relationships adopting submissive, dominant or avoidant (manifest or emotional) patterns in their various forms.

-Forsake having a partner or interpersonal relationships through manifest or emotional avoidance.

-To feel that our emotional needs are not being fulfilled in the relationship with significant others feeling frequently frustration, responsibility, deception or betrayal.

PBP - Characteristics.

-Emotional de-regulation:

- -Frequent hyper o hypo arousal.
- -Excessive need of co- (fusion) or uni- (separation)
- -External regulation

-Deregulation of self:

- -Externally cued sense of identity.
- -Fragile and changing self esteem.
- -Difficulty maintaining sense of self

PBP - Characteristics

-Interpersonal-Behavioral deregulation:

- -Difficulty managing self needs and others needs. Difficulty establishing limits.
- -Pathological bonding patterns: clinging or avoidant.
- -Need to control partners behavior: direct or indirect means, due to fear.
- -Need to harm (emotionally or physically).

PBP-Types & Subtypes

SUBMISSIVE
(Anxiety)

Pleasing
Helpless
*Oscilatting

DOMINANT
(Fear/Anger)

Agresive
Pasive-Agresive
*Carer-Codependent
(Inverse Dep.)

AVOIDANT
(Sadness/Empty)

Manifest
Emotional
*Suspicious/Seductive

Variables that underly PBP

SECURITY

Security

Vs.

Fear

SELF REGULATION

Uni-Regulation

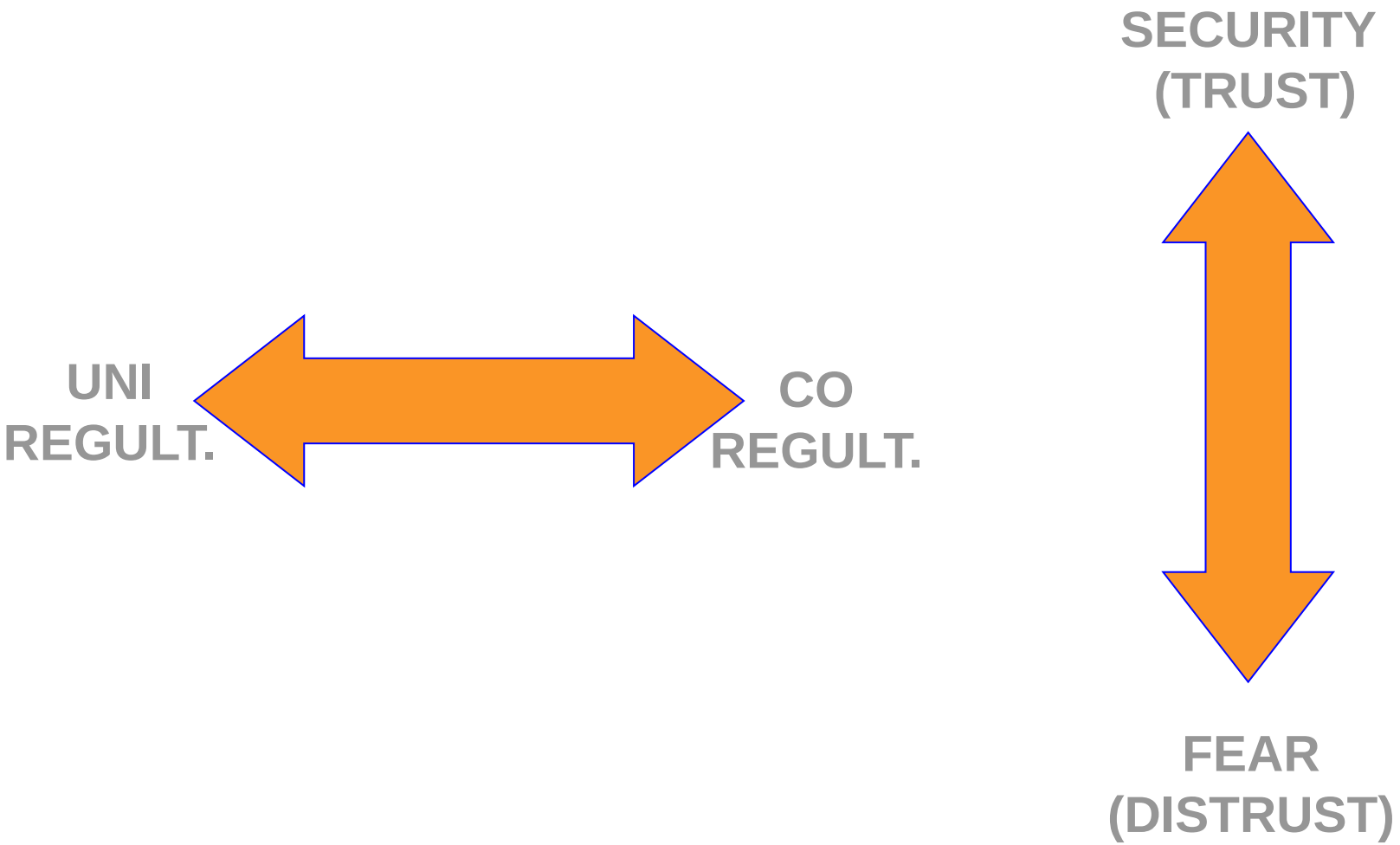
Vs.

Co-Regulate

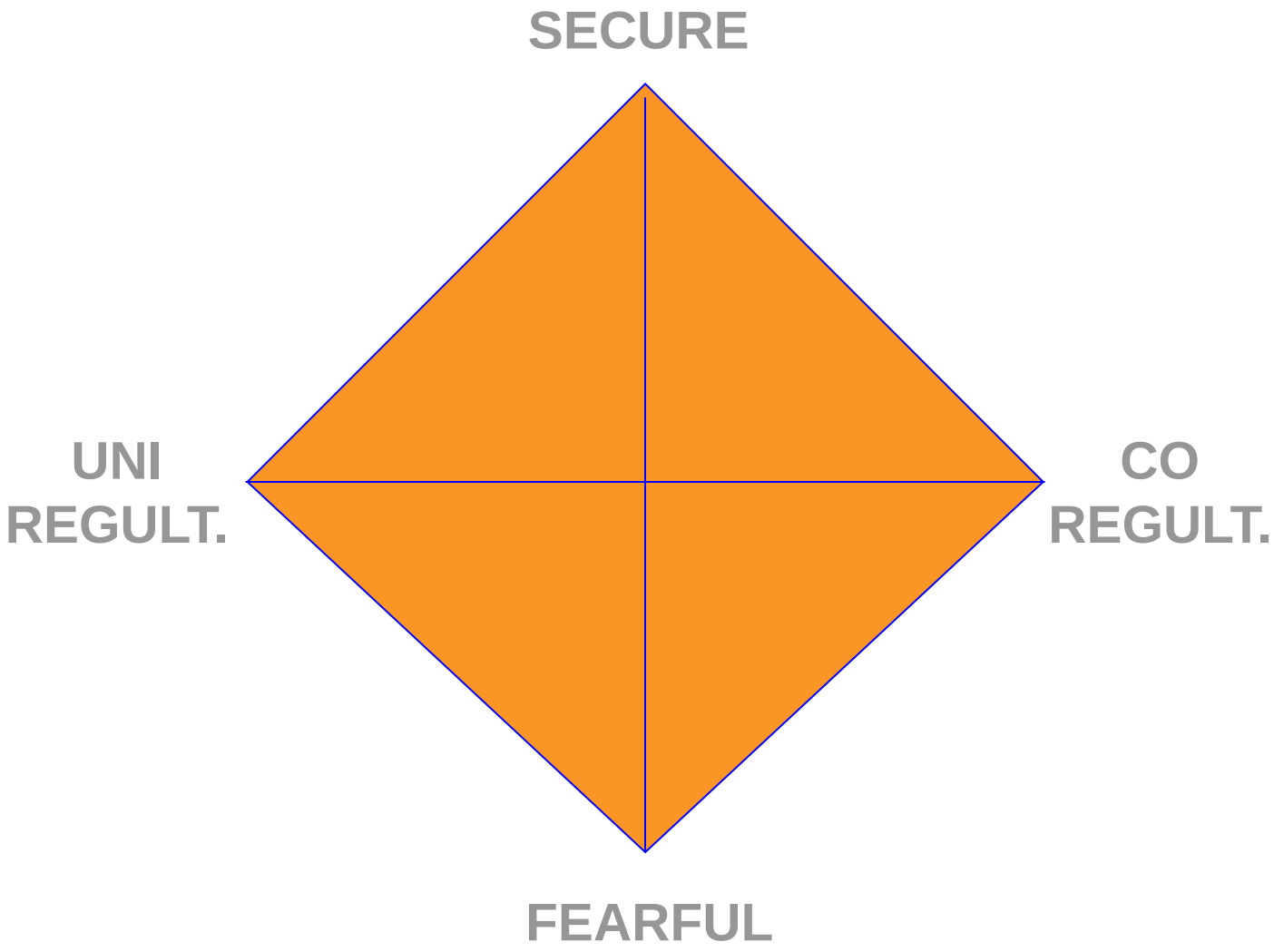
Myers 1940, Van der Hart 2006, 2010,
Panksepp 1998. Porges 1995, 1998
DLAS - DAS
Ventral vagal – Symphatetic – Dorsal Vag.

Attachment: Bowlby, Harlow, Ainswort, Tronic;
Gerzon 1998, Sanz 2007
Fusion-Separation.

Variables that underly PBP



Bonding patterns



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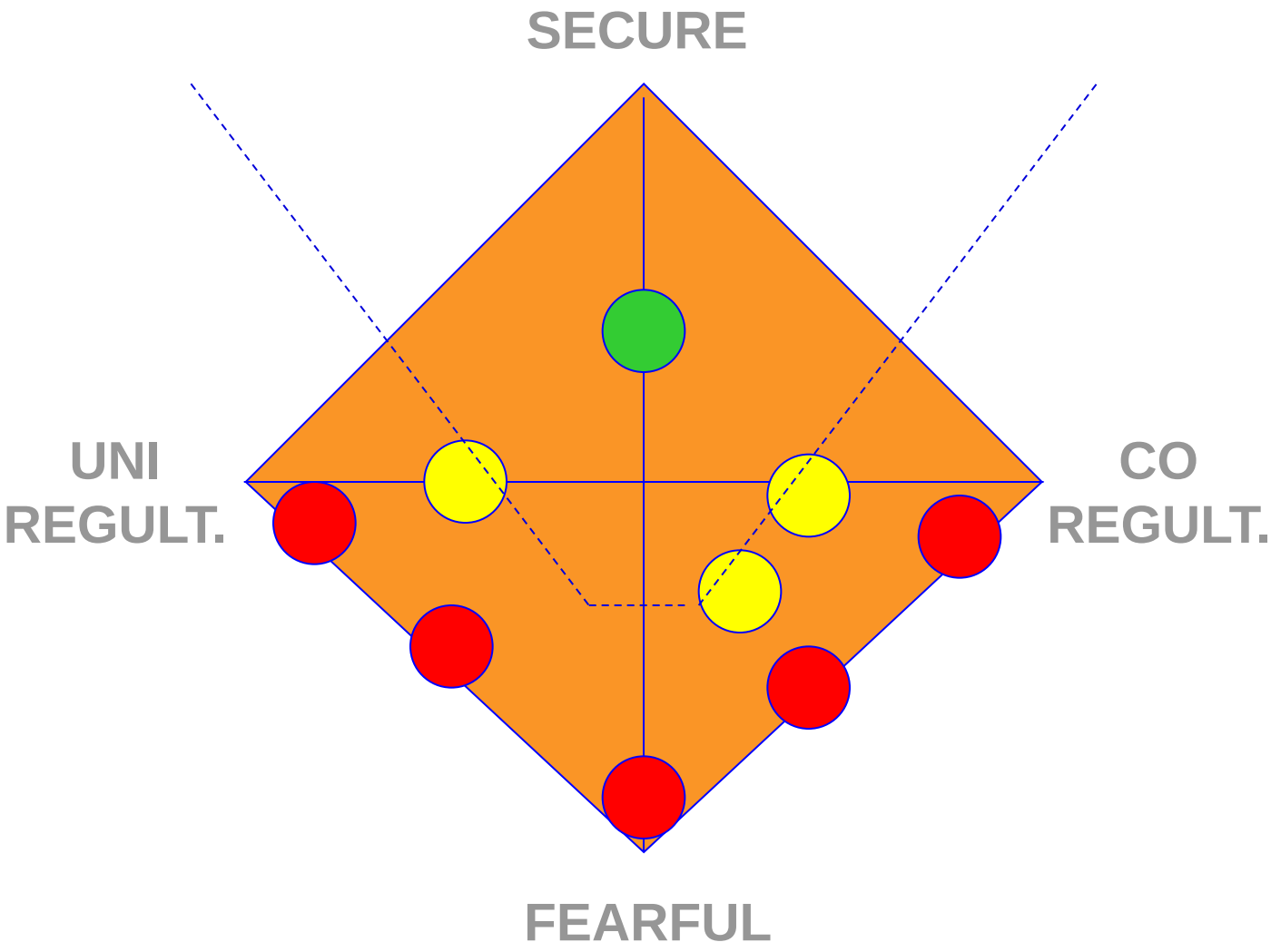

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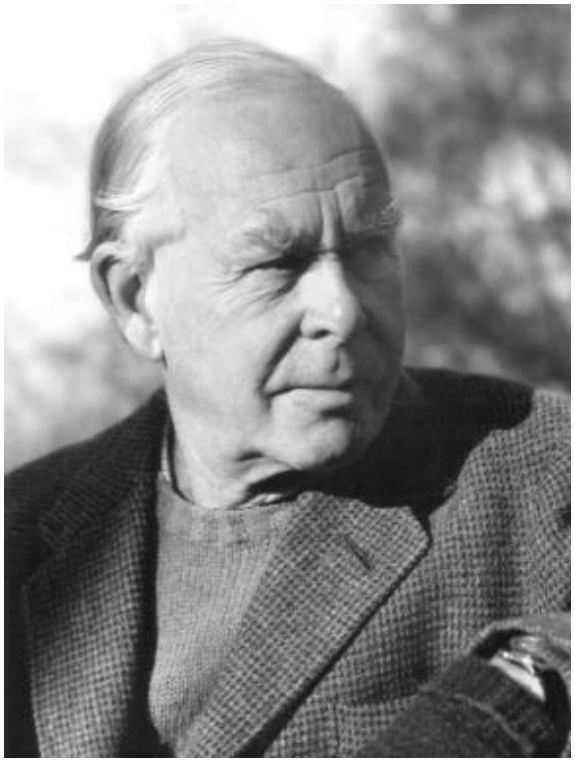


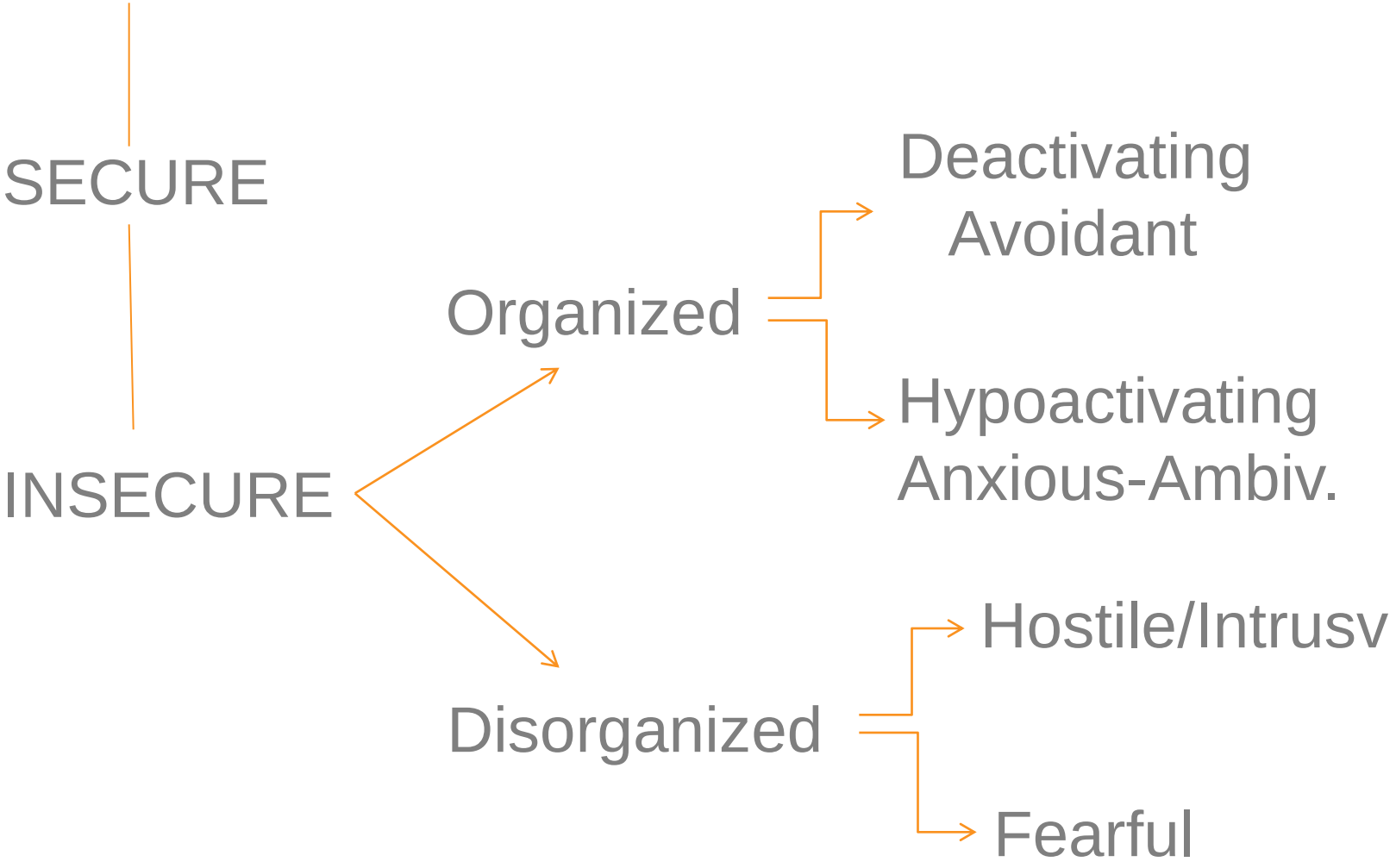
"Attachment theory regards the propensity to make intimate emotional bonds to particular individuals as a basic component of human nature, already present in germinal form in the neonate and continuing through adult life into old age."

Bowlby, 1988. A secure base.

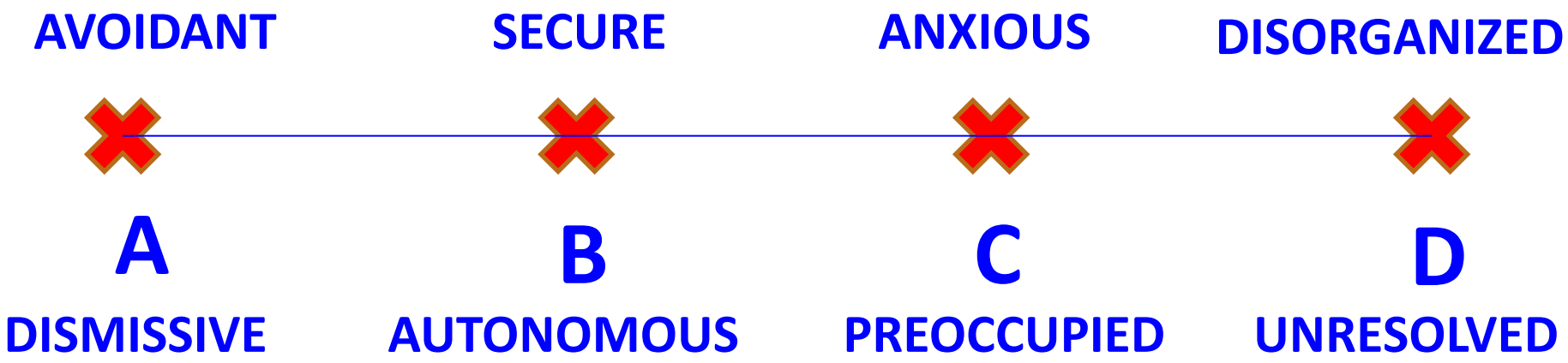
“There is a strong continuity between infant attachment patterns, adolescent patterns and adult attachment patterns"

Main & Goldwyn, 1993

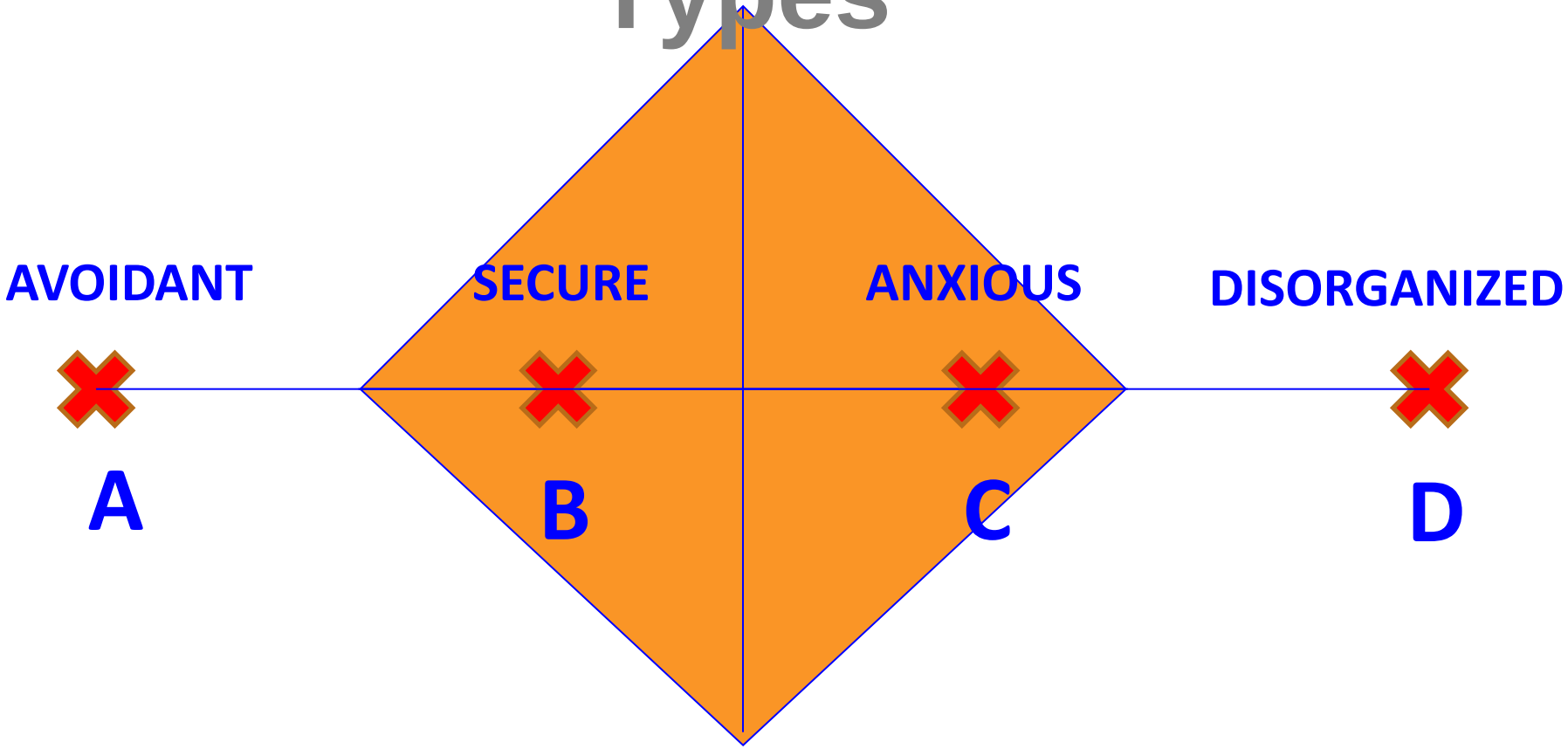
Attachment Types



Attachment
Types



Attachment Types



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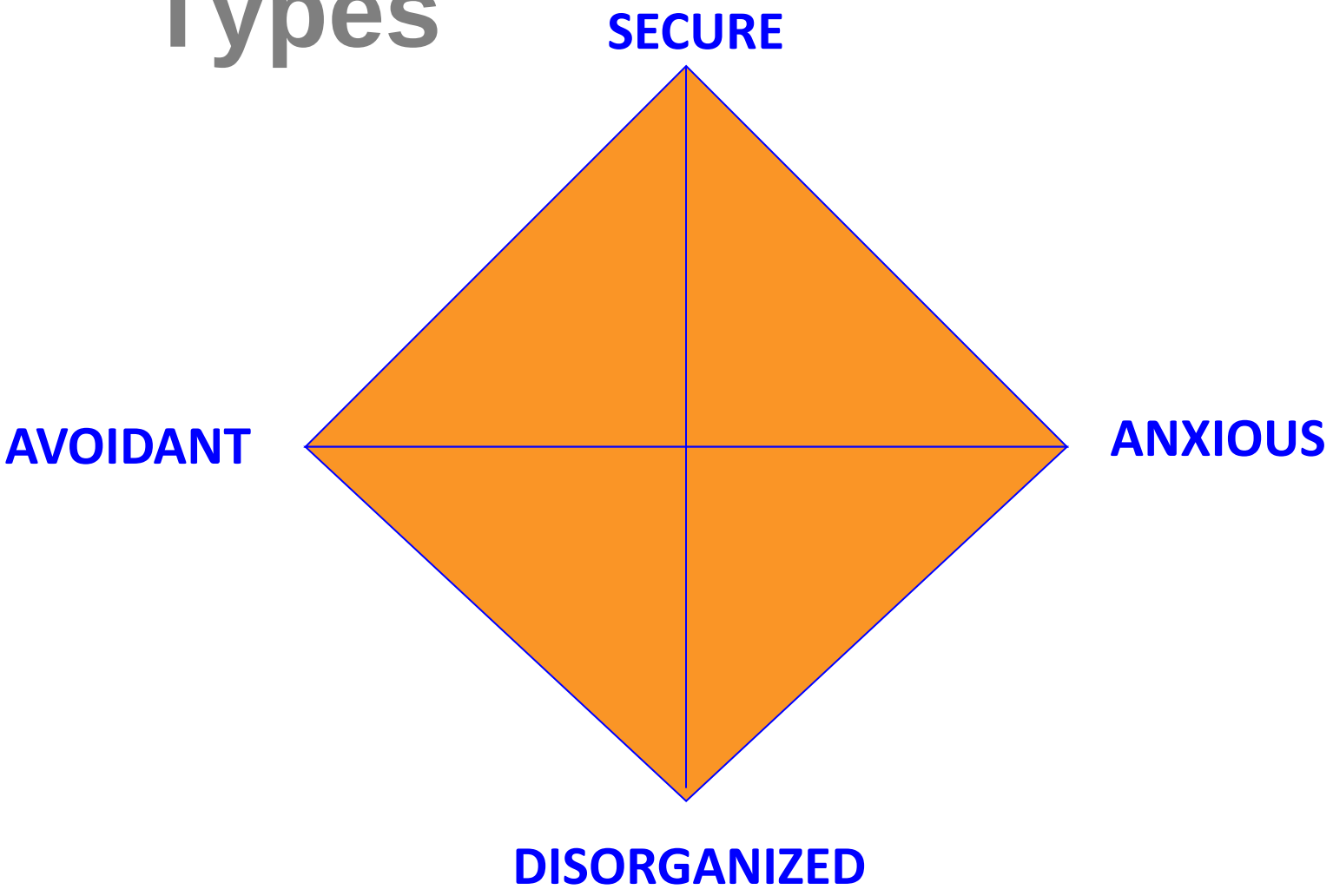
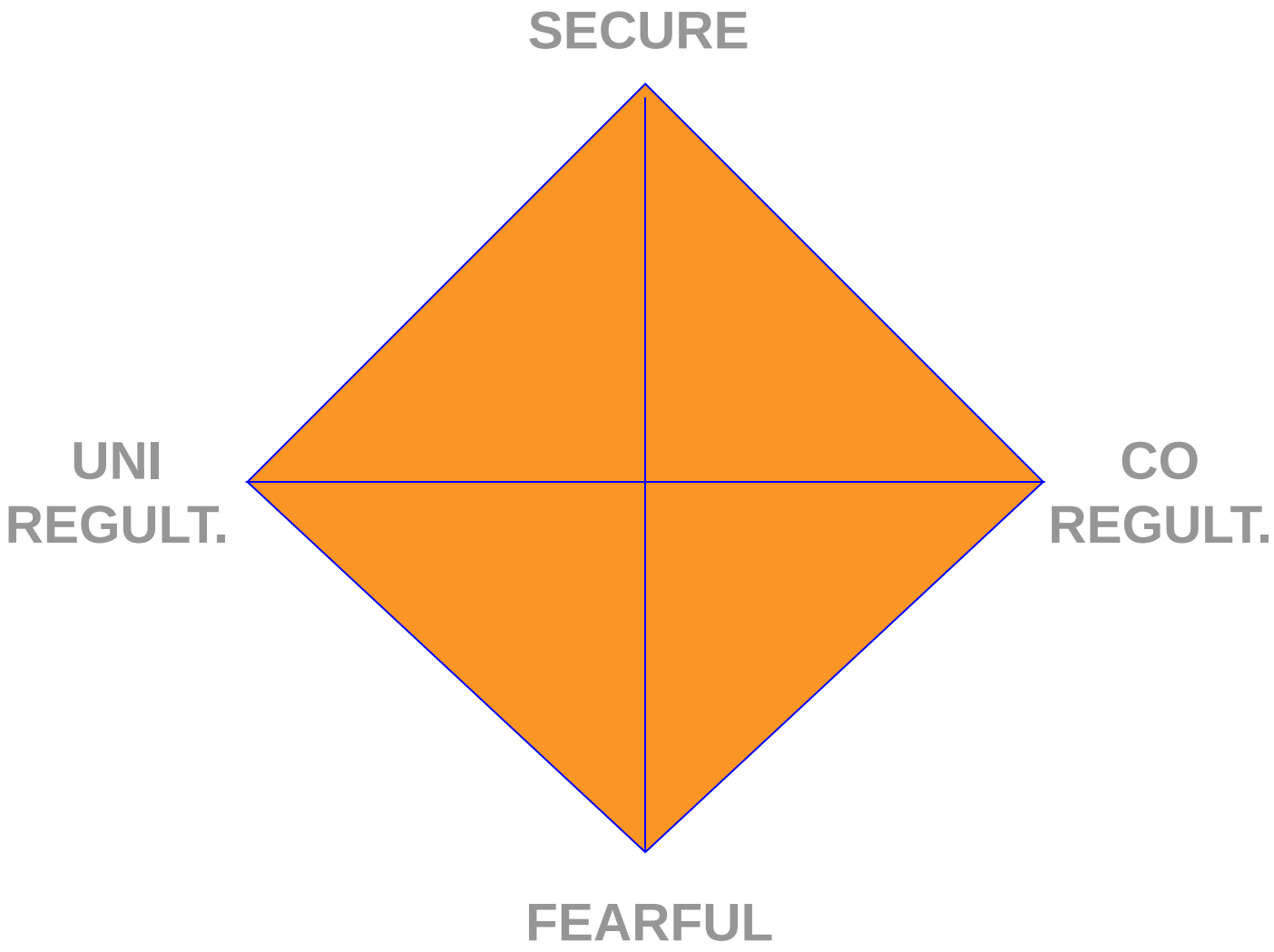
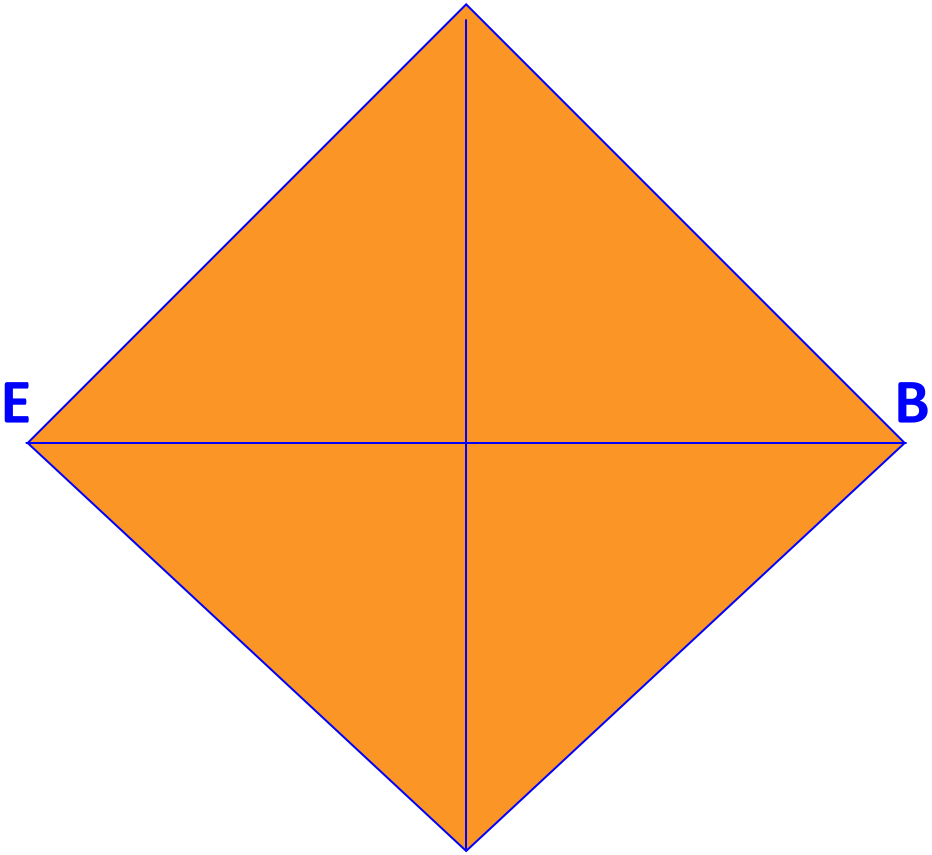


Bonding patterns



Parts


SOCIAL P
(ANP)
PROTECTIVE
P (EP)
BONDING P
(EP)
FEARFUL OR
DESTRUCTIVE EP

3. Treatment

PHARMACOLOGICAL TREAT.

*Cabello-Santamaría, 2013

SSRI: Paroxetine, 20-40 mg/d
TCA: Chlorimipramine: 25-150 mg/d

Propanolol (40 mg x 3)
Topiramate (25-200)
Lamotrigine (25-200)

Sulpiride
Quetiapine
Aripirazol
Risperidone (1 mg)
Pimozide

Treatment – Basic Assumptions

-Pathology expresses itself in intimacy relationships.

-Rigid interaction patterns reflect and create absorbing emotional states (neuroendocrine response patterns).

-For many patients, the external world is suffused with the feelings belonging to the inner world (Fonagy and Target's, 1997).

-Psychopathology is seen in terms of the persistence into adult life of earlier response patterns or the activation of DAS (Fonagy et al 2002).

-Emotions (states) are the center of change.

-People cope as optimally as they can, given their current circumstances and life history.

-Change involves a new undertsanding and experience of the self, of the other and the interaction.

Treatment – Therapeutic Relation

-Therapy is an "*in vitro* experiment in intimacy" (Holmes J, 2010). Intimacy is the core of problems of these patients

-The therapist:

  -As an attachment figure must have worked on his/her attachment history and be able to interact safely and securely (Earned Secure Attachment, Mayn & Goldwyn, 1984; Hess 2008).

  -As a interactive co-regulator should have the capacity of being in relational mindfulness

  -Has to enter (and therefore validate) the clients's worldview before challenging it. This implies understanding the patients bonding patterns and respecting them and accepting all parts.

-Work with subtlety and finesse (Janet), gradually helping the patients to expose themselves to manageable bits of disturbance and discomfort.

Phased Treatment

0. Reception:

- Tune one's interaction to the attachment mode of the patient.
- Accept all parts, specially the "inner monsters".
- Create a space of acceptance and calm from which exploration is possible and not fearful.

*With Avoidant/dismissive patients, help them to

- Understand that the therapist is not going to be invasive or manipulative.
- Be aware of their "comfort zone"
- To start understanding the reason behing extreme experiential avoidance (Hayes et al, 1996).

Phased Treatment

1. **De-scalation and stabilization**:
   - Restore security: help understand and deal with the negative interaction cycle:
     - Initial self regulation techniques: window of tolerance.
     - Start using parts language.
   - Initial conflict reduction.
   - Relapse prevention/prescription: a chance to observe interaction and what failed.
   - Start differentiating correct responses from wrong ones.

Phased Treatment

2. **Detect personal traits in safety and self regulation: underlying variables.**

3. **Endue and strengthen resources.**

   - Self-care abilities: Learn how to listen, respect and cover needs. (starting fr. homeostasic).
   - Create rutines and structures.
   - Initiate pleasurable activities: hedonic and eudaimonic.
   - Strengthen ANP. Work with the Inner child

Phased Treatment

4. Solve current interaction and intimacy problems

- Work on limits.
- Comunication and interaction styles. Window of tolerance.
- Understand interactive and co-regulation.
- Understand dependence and it's cycles.
- Solve specific couple therapy problems.

Phased Treatment

5. **Work with parts**:

**Mosquera & González, 2012*

- Co-conscienceness. Internal and external interaction types. Internal cooperation
- Understanding the needs of all parts.
- Phobia reduction. Acceptance of parts. Integration.

Phased Treatment

6. **Analyze attachment patterns, and when and how they were formed.**
   - Progressive insights about attachment history
   - Attachment styles of parents and relevant attachment figures. Combined effect.
   - The role adopted in interaction with attachment figures.
   - Mourning of the idealized family (Jung, 1967)
7. **Learn healthy bonding patterns:**
   - Capacity to self-regulate and co-regulate.
   - Heal past relations.
   - Generalize to other relations. Future relations

Thank you!

www.arunmansukhani.com

www.iasexología.com

+34 952 602828

arun@arunmansukhani.com