



# **EMDR intervention for adults with childhood insecure attachment & attachment trauma**

**Bristol 31<sup>st</sup> Jan & 1<sup>st</sup> Feb**

**Arun Mansukhani.**

**PsyD. EMDR Consultant and Facilitator.**

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**These slides represents the presenters work. Please reference it if used.  
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Contact info:

[arun@arunmansukhani.com](mailto:arun@arunmansukhani.com)

+34 607803803.

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## Contents of Workshop

- Attachment theory.
- Attachment from childhood to adulthood.
- Trauma: evolution of the concept. Present definition of trauma.
- Types of trauma: defense, attachment and beyond attachment: other affective systems that can be traumatized.
- Assessing attachment issues.
- EMDR and attachment: specific interventions and modifications in the standard protocol for individual and couple interventions.

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## Attachment Theory

B  
A  
C  
K  
G  
R  
O  
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D



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## Attachment Theory

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B  
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D



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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)[1]

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.

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“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 [... otherwise...] will result in severe anxiety conditions and psychopathic personality”.



**Bowlby 1951 Maternal care and mental health (WHO).**

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

**Bowlby 1977.**

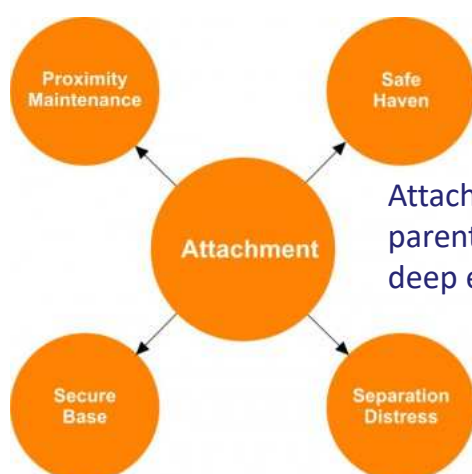
Most primates differ from other animals (including most mammals) in that gaining proximity to a protective conspecific, as opposed to a place (e.g., a den or burrow) provides our primary solution to situations of fear.

**Bowlby, 1958, 1969/1982.**

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Strong affectional bond that develops over a series of repeated interactions between an infant and his/her caregiver



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).

Attachment is a feeling state within both the infant and the parent (Condon, Corkindale, & Boyce, 2008), characterized as a deep emotional, psychological, and personal connection

It's activated with fear, pain, tiredness or inaccessibility or unresponsiveness of the attachment figure. (Bowlby 2005)

It's an innate behavioural system, that meets multiple functions (not only security, but also regulation, learning, etc) and is essential for survival (Bowlby 1999).

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### Mary Ainsworth

- Designs the SSP (observation). Starts investigation.
- Converts attachment into an interactive and dimensional variable. Identifies:
  - Secure attachment
  - Insecure attachment (divided into avoidant (A) and resistant-ambivalent (C)).



### Mary Main

- Identifies disorganized attachment (D).
- Designs AAI (narrative).
- Extends attachment to adults.

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### Strange Situation Procedure

1. Caretaker (CT) enters the room
2. CT interacts with the child.
3. Stranger (S) enters the room, interacts with CT, gradually interacts with the child. CT leaves the room.
4. S interacts with the child.
5. CT enters the room. S leaves.
6. CT leaves the room.
7. Repeat Phase 3.
8. Repeat phase 5 and end.

9 – 18 months

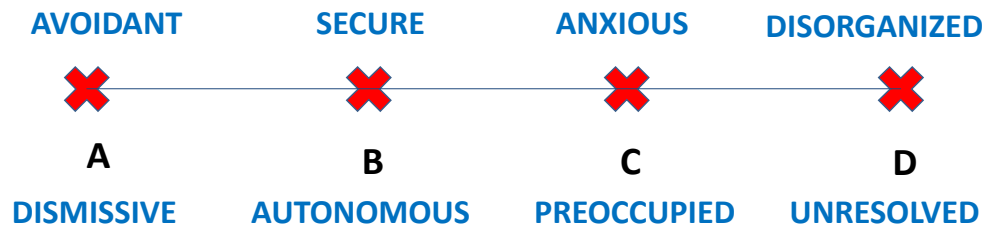
20 minutes

#### **Observe:**

- Exploration.
- Regulation.
- Behavior with CT and with S.
- Regulation during reunión.

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



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## Attachment **Types** (\* *Ainsworth-Main classification*)

HYPOACTIVATION



### AVOIDANT

Efforts to reduce feelings. Equally regulated with or without the AF.

### SECURE

Confident and regulated with the AF. Fast repair.

HYPERACTIVATION



### ANXIOUS RESISTANT

Anxious efforts to maintain their parents attention and responsiveness

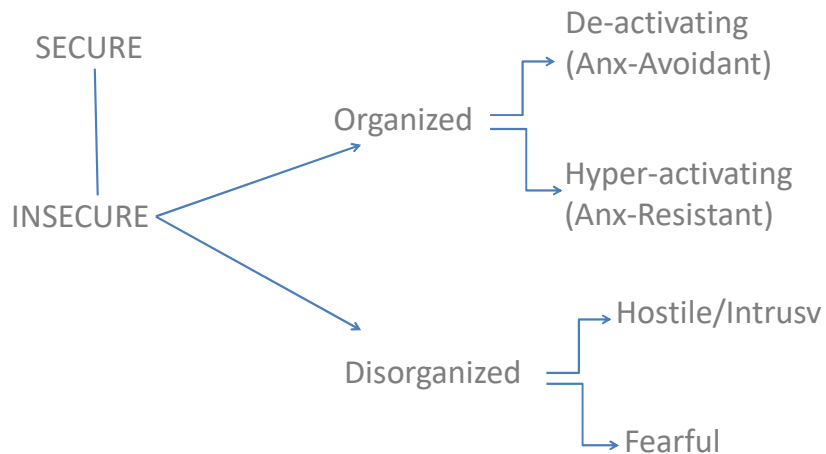
### DISORGANIZED

Disorganized and contradictory behaviour. Unclear objective. Collapse.

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## Attachment Types



\*Holmes, 2012

\*Mikulincer and Shaver 2008

\*Lyons-Ruth and Jacobwitz, 2008

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Attachment types are universal (Hazan & Shaver 1994) and present a high reliability and validity (West & Sheldon-Keller, 1994)

## Distribution in general population.

- Type A\* ➡ 21%
- Type B ➡ 65%
- Type C\* ➡ 14%





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

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From 1990 D category is introduced.

### Distribution in general population.

- Type A\*  23%
- Type B  55%
- Type C\*  8%
- Type D  14%

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### CT features/abilities that correlate with secure attachment

1. **PHYSICAL AVAILABILITY:** Proximity, accessibility, reliability (consistency and predictability). (Bowlby) **EMOTIONAL AVAILABILITY (ATTENTION):** Sensitivity to child's needs. Responsiveness. Capable of Tuning. Cooperative (Ainsworth, 1989). Capable of reflective functioning (Bowlby) mentalizing ability (Fonagy and Steele) or Mindsight (Siegel)
2. **POSITIVE AFFECT:** Engagement, positive affect, play, non responsive warmth. Mutual gratification.
3. **REGULATION:** Regulate and able to regulate. Help in assimilating negative experiences. (Stiles et al. 1990). Capaces of repairing (Tronick) and setting limits (negative affect tolerance).

→ The Child receives what needed behaving as a child.

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### CT features/abilities that correlate with anxious attachment

1. **PHYSICAL AVAILABILITY:** Too much or too little, inconsistent accessibility and low reliability **EMOTIONAL AVAILABILITY (ATTENTION):** Too sensitive or erratic sensitivity. Erratic responsiveness. Not good at Tuning (child's needs). Interference (Ainsworth, 1989). More moved by their own than child's needs.
  2. **POSITIVE AFFECT:** Difficult for them. Frequently anxious or hyper activated (anger, frustration, etc). Also tired and hypo activated.
  3. **REGULATION:** Frequently hyper, not good at regulating, assimilating negative experiences. (Stiles et al. 1990), repairing (Tronick) and setting limits (negative affect tolerance).
- The Child has to optimize attachment with the caregiver (demands, anger,...). Has to self-regulate and sometimes co-regulate.

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### CT features/abilities that correlate with avoidant attachment

1. **PHYSICAL AVAILABILITY:** Excessive (invasive) or defective proximity. Consistent. **EMOTIONAL AVAILABILITY (ATTENTION):** Low and not tuned to the child's needs.
  2. **POSITIVE AFFECT:** Difficult for them. Frequently tired or frustrated.
  3. **REGULATION:** Frequently hypo, not good at regulating, assimilating negative experiences. (Stiles et al. 1990), repairing (Tronick). Child has to learn how to self-regulate through emotional suppression.
- The Child has to optimize attachment with the caregiver through avoidant behaviour: maintain proximity with someone who doesn't tolerate it very well.

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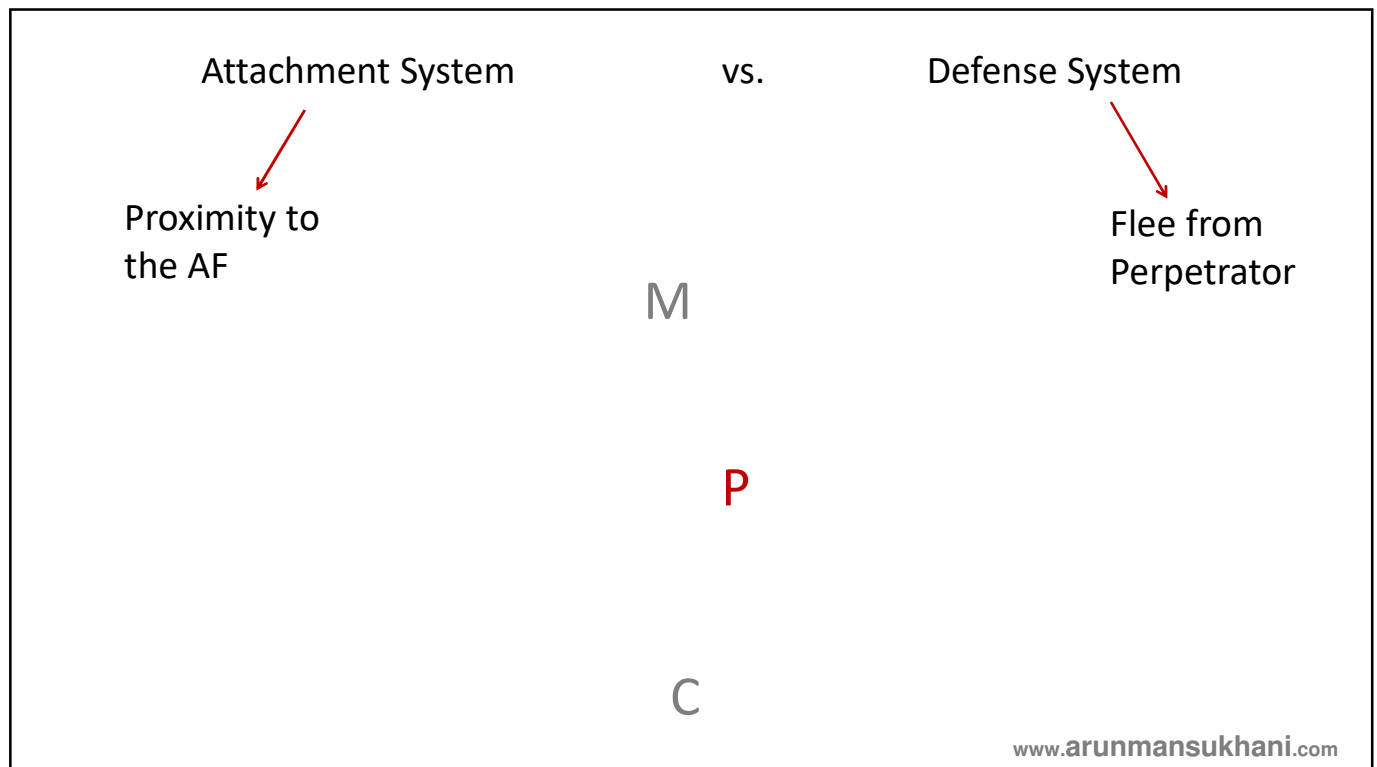
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### CT features/abilities that correlate with disorganized attachment

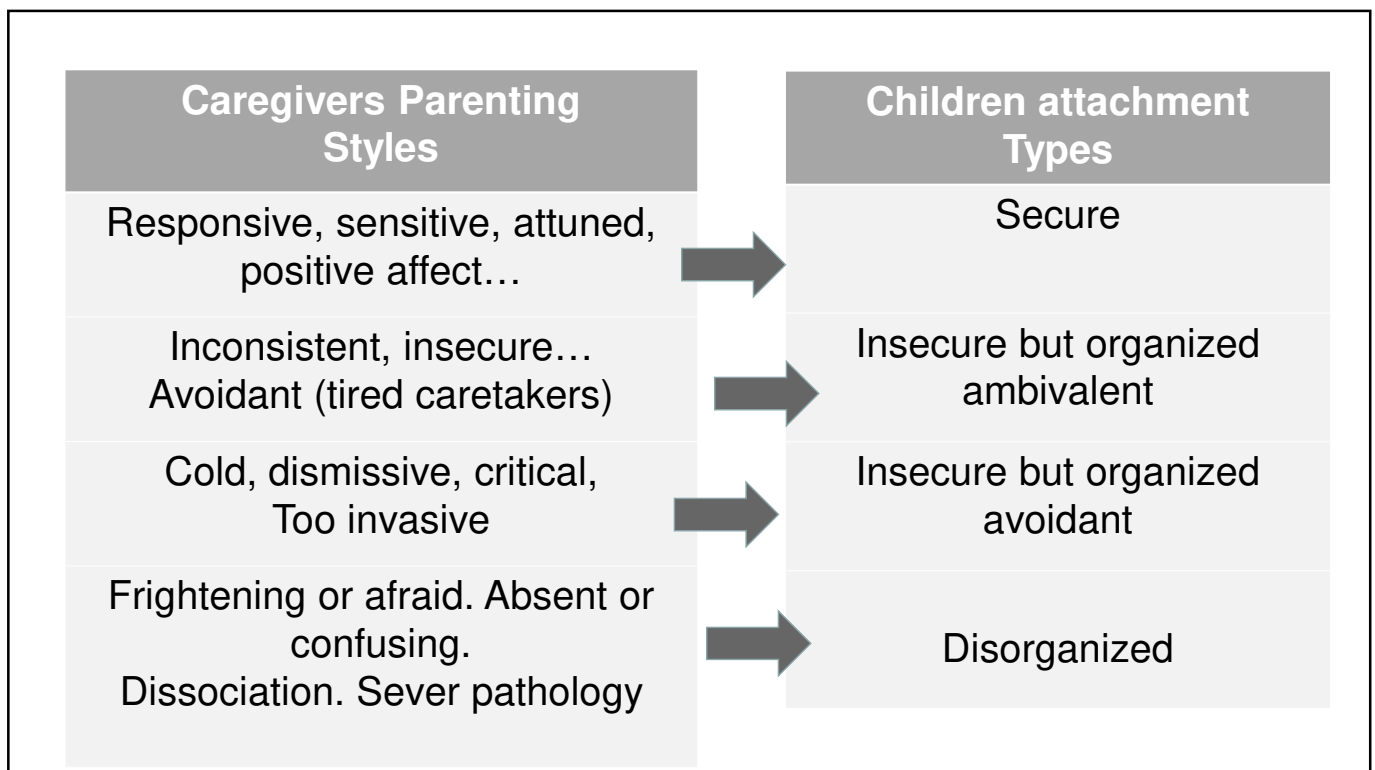
- “Fright without solution” - “Approach-flight paradox” (Hess y Main 1992 / 2006):
  - Afraid or fearful (Hess y Main 2006). Hostility or helplessness.
  - Unresolved trauma. Absent. Dissociated (Hess y Main 2006).
  - Neglect. Mental illness.
- Simultaneous activation of attachment system and other systems. Paradoxical bind: the more stress, the more the attachment.
- Child will try to optimize attachment with behaviours belonging to other systems.

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## Multiple attachment

Schaffer and Emerson, Glasgow Study, 1965:

- 7 m: 29% attached to 2 persons.
- 10 m: 60% more than one attachment figure.
- 18 m: 87% more than one AF y 30% 4-5 AF.

Ainsworth et al, 1978:

From 30 months onwards, the primary attachment figure type will have more influence than other figures (Ainsworth et al. 1978)

Main y Weston 1981:

After 24 months, the attachment type exhibited by the child will start stabilizing as an internal model of attachment is created.

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### Attachment throughout life span

- ▶ 0-6 m: Primary or dual attachment.
- ▶ 6-9 m onwards: Secondary figures: grand parents, uncles, teachers, pets...
- ▶ 2-3 y onwards: growing independence
- ▶ Teenage: peer groups and first romantic relationships.
- ▶ Adulthood:
  - ▶ Reciprocal attachment with friends, couples, etc.
  - ▶ Attachment with children.
  - ▶ Change of relationship with parents.

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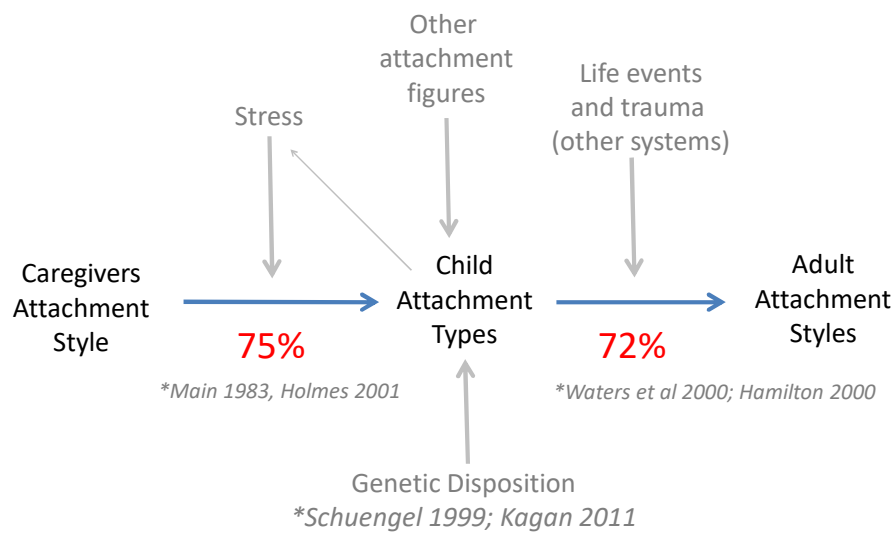
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### Attachment throughout life span

- **Holmes 2001:**
  - Intergenerational continuity parents AAI – children SSP: 75%.
- **Waters et al 2000; Hamilton 2000:**
  - Concordance at 20 between SSP y AAI): 72%
  - **Weinfiel et al 2000:** Traumatic experiences are responsible of the most part of disruptions in continuity between child and adult patterns
- **Jeff Simpson y colb. (Minessota Longitudinal Study, 20 a), secure children in SSP:**
  - At 6 higher social competence (according to their teachers).
  - AT 16 higher levels of intimacy and closer relations with significant others.
  - 20s Higher level of positive experiences in intimate relations; higher conflict resolution capacity.

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"Attachment theory [...] 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 [...] It performs a natural healthy function, even in adult life".

**Bowlby 1988/1992.**



"In adulthood the **attachment system** operates coordinated together with the **mating (sex) system** and the **care-giving system** to accomplish the set goal of the pair bonding system".

**Ainsworth 1985/1999.**

*Hazan y Shaver 1986, Sue Johnson 2016, Mikulincer y Shaver 2016, Fisher 2016*

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### Adult attachment

- It's an implicit memory system (Amini et al 1996).
- It will activate under stress, loss, loneliness, intimacy, fear, etc.
- They can be an overall style, although people exhibit different styles under different circumstances.
- "Adult patients with insecure attachments present a combination of avoidant and resistant features" (Holmes, 2009).
- 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).
- Disorganized attachment is not a 4th category and occurs due to enmeshment of attachment and other systems.

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Avoidant features Hypo activation of AS	Resistant features Hyper activation of AS
Auto-regulation: intimacy avoidance Emotional independence	Co-regulation: solitude avoidance Emotional dependence
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	External resources

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## Psychology and trauma

19<sup>th</sup> century: Hysteria. Charcot. Freud y Janet.

20<sup>th</sup> century in between wars. C. Myers

70s and 80s. The Vietnam War: PTSD.

End of 20<sup>th</sup> and beginning of 21<sup>st</sup> century:

1. Gender and intra-familial violence.
2. Sexual aggressions and sexual abuse.
3. The distinction of different types of trauma and it's relation to psychopathology.

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-Charcot: Let's now press the hysterogenic point (a man touches the ovarian area) ... Here we see the tongue bite, look at the typical arched back.

-Patient: Mom, I'm scared.

-Charcot: Observe the emotional discharge. If we continue soon we will have epileptoid behavior.

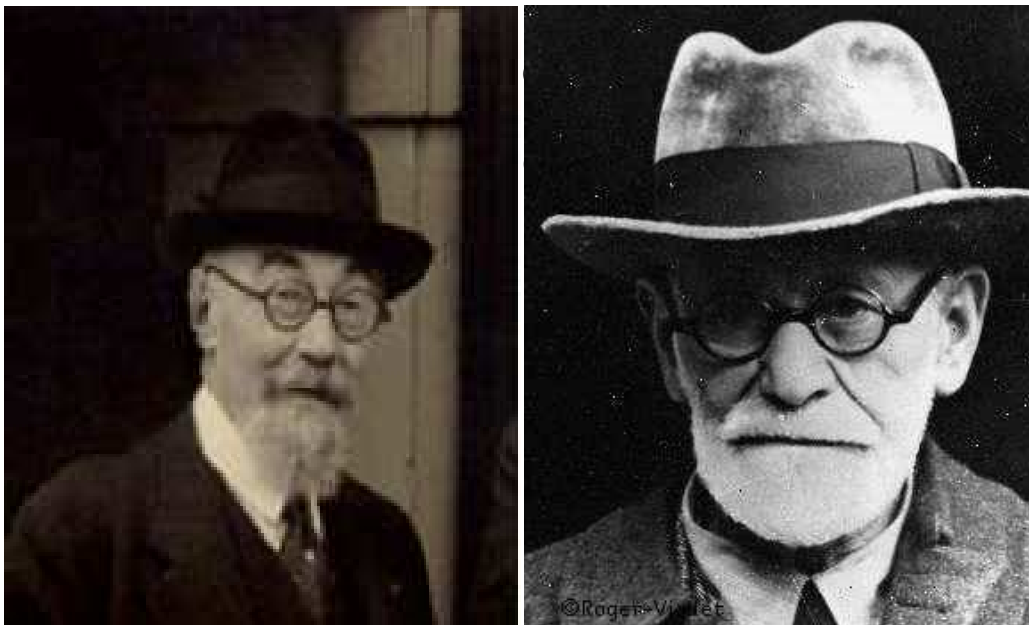
-Patient: Mom, mom (cries).

-Charcot: Watch those screams. It is a lot of noise about nothing.

*GOETZ 1987-Charcot the Clinician: The Tuesday Lessons.*

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**Around 1880...**



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"I propose the theory that behind each case of hysteria there are one or more episodes of premature sexual experiences, episodes that occurred in the earliest childhood, but that can be recovered by psychoanalysis despite the decades that have passed."

*Freud 1896: The Etiology of Hysteria.*

"I was finally forced to admit that these seduction scenes had never happened, they were just fantasies that my patients invented."

*Freud. Letter to Fliess, 1897*

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"If there is the case of women who tell such an event in the history of their childhood, in which the father usually appears as the seducer, we cannot harbor **any doubt about the imaginary nature of this accusation** or the reason that led to it. [...] whether it actually occurred or if it is the result of fantasies [...] so far we have **not found any difference** as to the consequences [...] fantasies have a psychic reality and gradually we are understanding that in the world of neurosis it is the psychic reality that is determinant "

*Freud Introduction to psychoanalysis*

REAL EVENT - FANTASY  
TRAUMA - FRUSTRATION  
DISSOCIATION - REPRESSION

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- 1890: William James describes mental pathology resting on trauma in Principles of Psychology.
- 1890 Alfred Binet develops the concept of trauma and dissociation in On Double Consciouness.
- 1893: Pierre Janet publishes Disociation, relating mental pathology to trauma.
- 1893: Freud and Breuer describe Double Conscience.
- 1896: Alfred Binet publishes describes the alters in Alterations of Personality.
- 1910-1970: practically no relevant work is published regarding dissociation and trauma (exceptions such as Mayers, etc).

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### Post war investigations



- ▶ 1910-1970: no work is published regarding dissociation, except:
- ▶ 1917: Rivers: Soldier's Declaration.
- ▶ 1915: Myers Shell Shock, The Lancet. Síntomas:
  - ▶ Tinitus, amnesia, headache, dizziness, tremor, and hypersensitivity to noise.
  - ▶ Neurasthenia: fatigue, anxiety, headache, neuralgia, depressed mood
  - ▶ Conversion disorder, mutism and fuge.
- ▶ 1940: Describes Apparently Normal Part of the Personality / Emotional Part of the Personality
- ▶ II GM: Soldier fatigue.

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# EMDR

## ORIGINATOR AND DEVELOPER

FRANCINE SHAPIRO, Ph.D

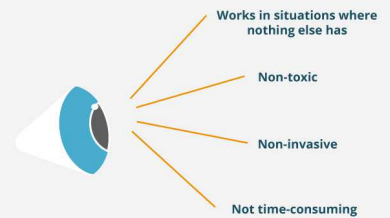
In 1987, Dr. Shapiro was taking a stroll in the park and had some disturbing thoughts flash through her mind. After moving her eyes from side to side she noticed the negative feelings immediately dissipate. She assumed that the eye movements had a desensitizing effect.

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:



Works quickly compared to more traditional approaches; clients can see relief in as little as five sessions.



of subjects treated with EMDR for **five sessions** had no signs of PTSD following treatment



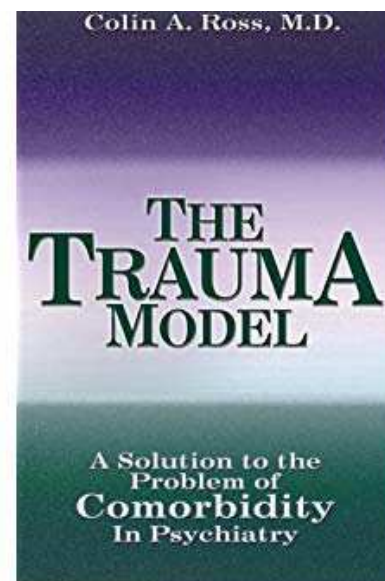
of adult trauma victims exhibited no symptoms of PTSD after **eight sessions**

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## PTSD

Phobias  
Depression  
Dependence  
BPD  
Psychosis  
Personality Disorders  
Complex PTSD  
...?!



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## CSA

### Developed countries:


25% girls - 16% boys (1 d 4/1 d 6)  
Only 1-2 out of 10 is reported.

### Developing countries (India):


53.22% total. 52% 94 children. 47.06% girls.  
21.90% sever forms of sexual abuse.

1973 Ann Burgess y Lynda Holstrom  
Diana Rusell 1983: Abuso intrafamiliar.  
Finkelhor 1990: 1st National Survey.  
1994: Firs Spanish National Study.  
Cabello (con Mansukhani y Gonz. De la Rosa) 1995. N=3000.  
CDC 2005; 2008. N=17.000  
Govt of India 2007 Study on Child abuse. N=15000.

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### Child Abuse & Neglect



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

Psychopathology in a large cohort of sexually abused children followed up to 43 years<sup>☆</sup>

Margaret C. Cutajar<sup>a,\*</sup>, Paul E. Mullen<sup>a</sup>, James R.P. Ogloff<sup>a</sup>, Stuart D. Thomas<sup>a</sup>, David L. Wells<sup>b</sup>, Josie Spataro<sup>c</sup>

Child Abuse Negl. 2010

**Table 1**  
Comparison between the rates for various mental disorders in all the child sexual abuse and the control subjects.

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 <sup>a</sup>
<i>Non-psychiatric complaint</i>	18	0.7	92	3.4	5.24	3.15–8.70	<0.001

<sup>a</sup> Fisher's exact test

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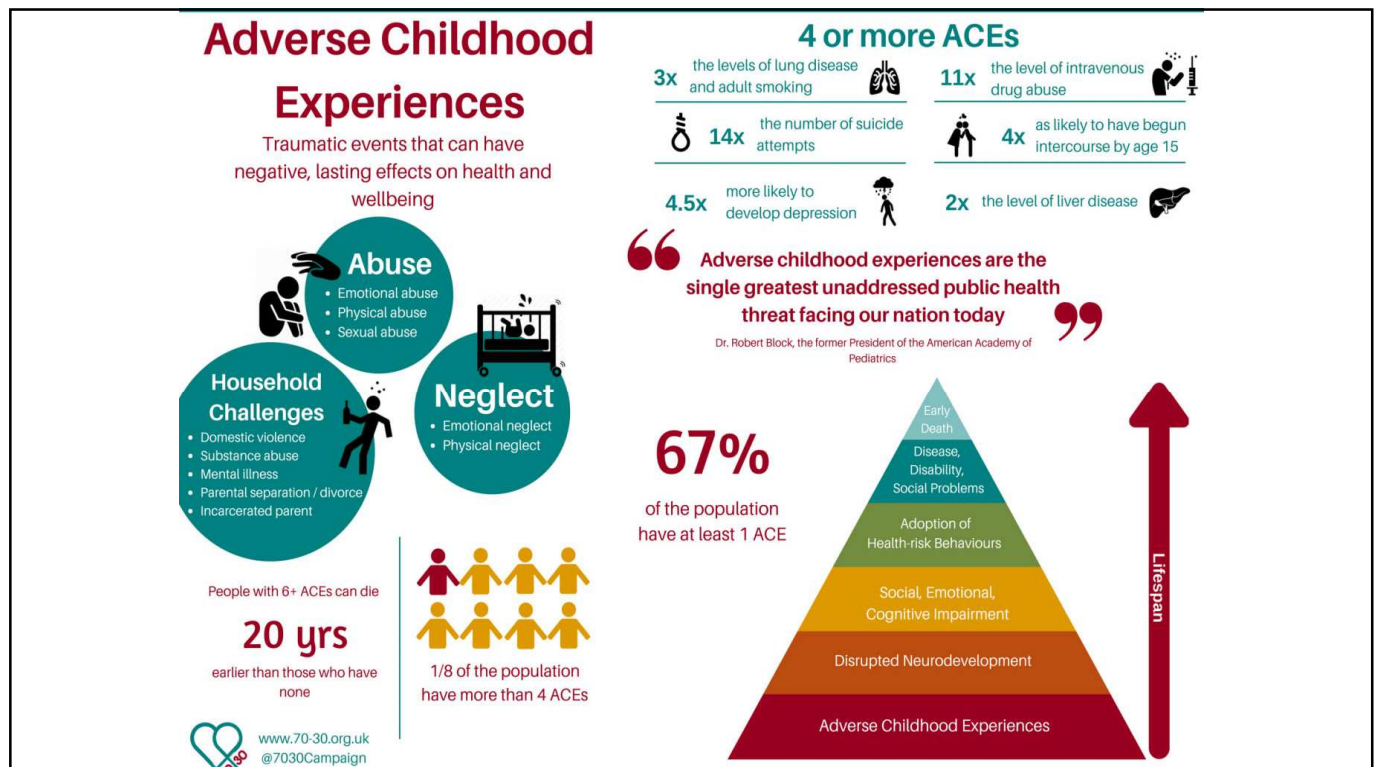
## Adverse Childhood Experience study

(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.

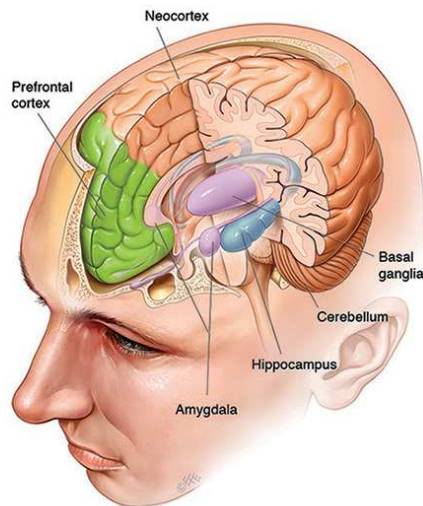
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## ACE affects brain structures



- 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 dIPFC.

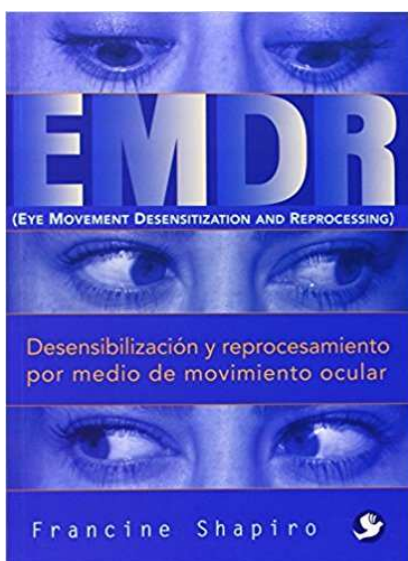
↑*NE* (Amsten et al 2015)

↓*GABA* (Anderson and Schmitz 2017)

*Martin Teicher 2017*

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## 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.

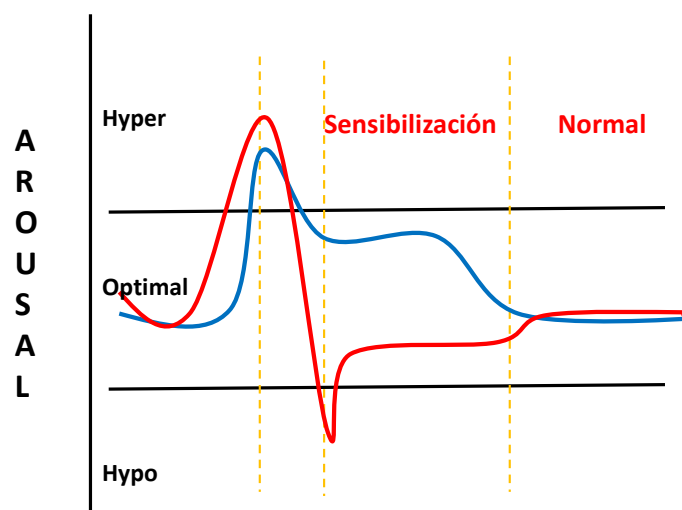
*(Hofman 2016).*

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What is...

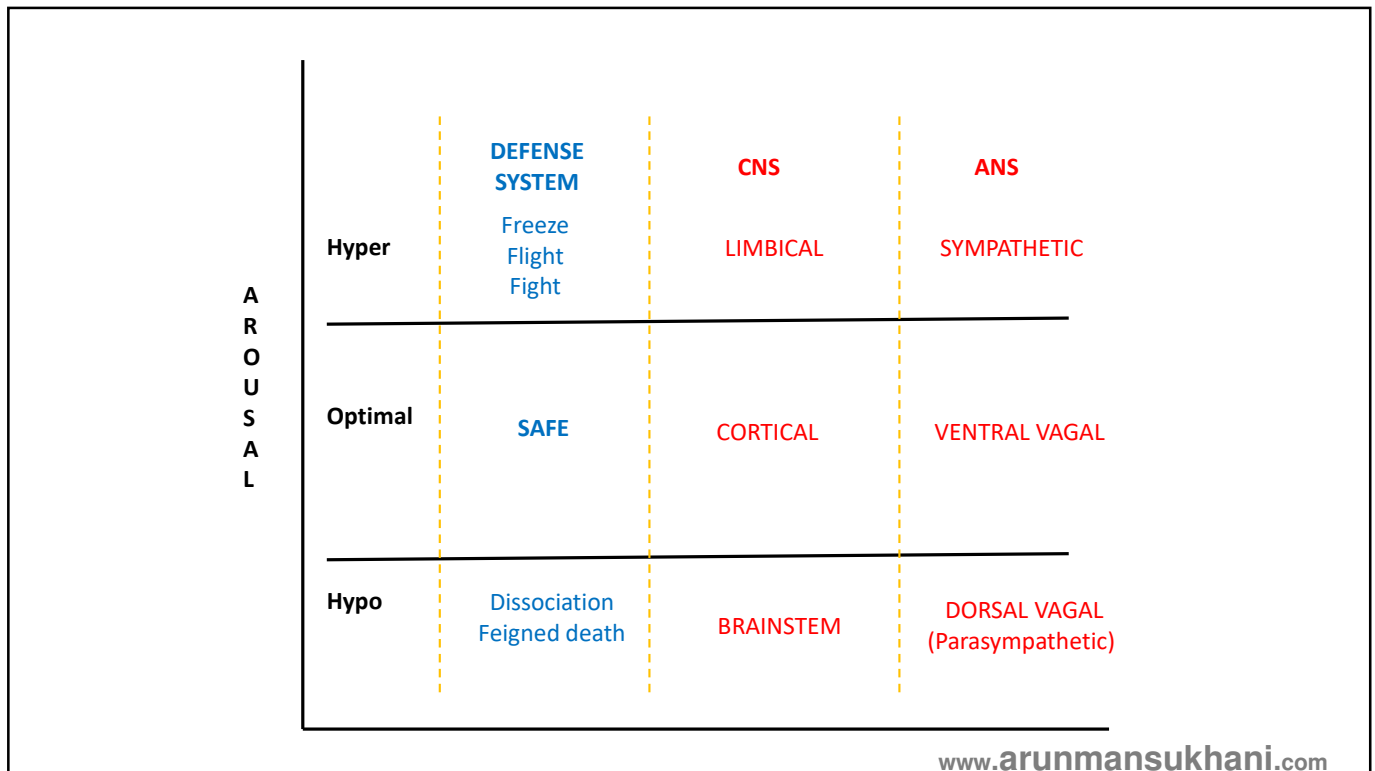


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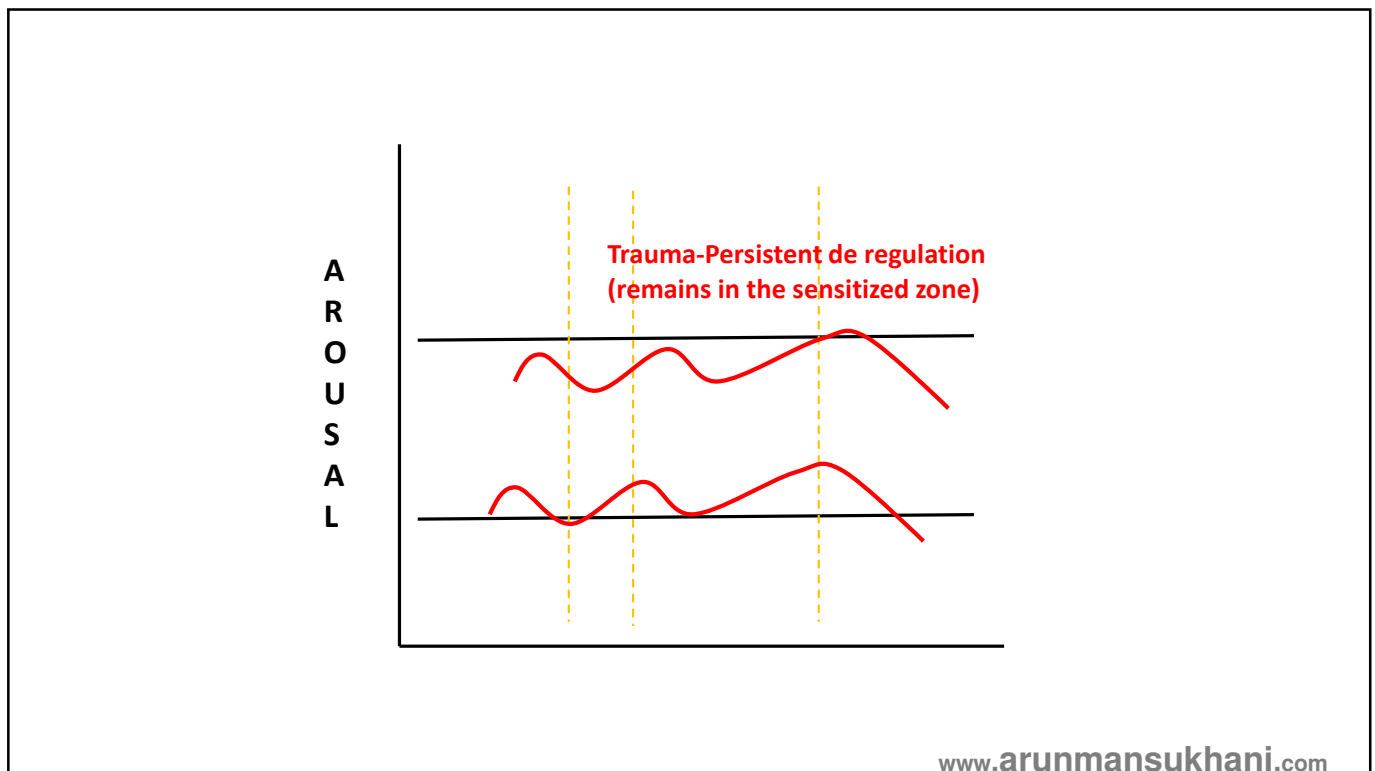


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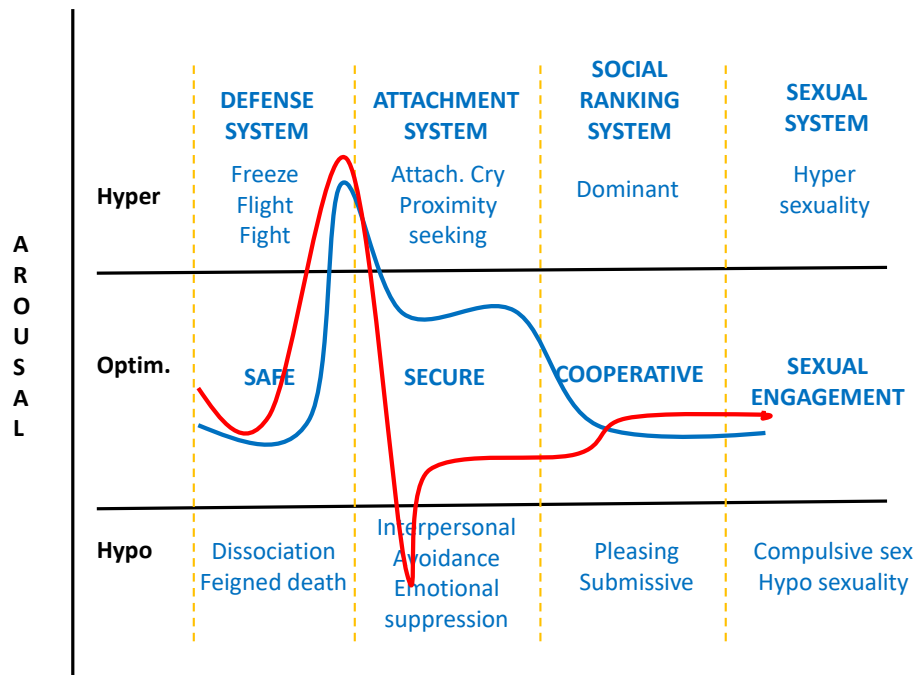


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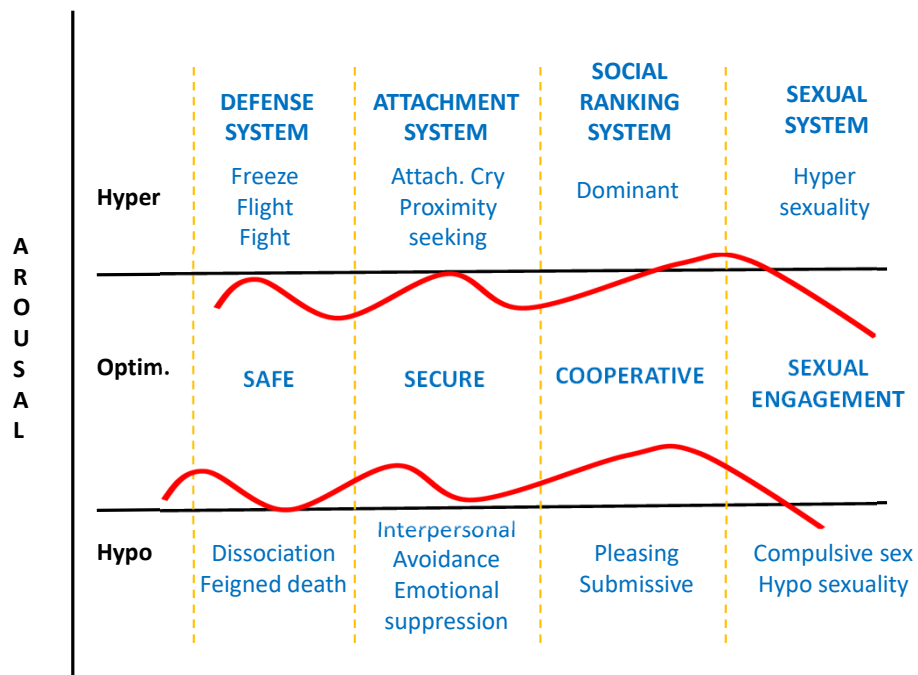


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### A post traumatic response:

Our nervous system fails to go back to optimal arousal levels (homeostasis) after hyper or hypo activating events, remaining in a sensitized mode that results in frequent deregulation and, therefore, producing stress reactions (fear) not as a reaction to present threats but to dysfunctionally stored “memories” and internal cues.

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### Systems: Control/Behavioral – Motivational – Action – Affective

- Biologically evolved neural programme, universal and that organizes some aspect of behaviour in a way that enhances survival or reproductive chances of an individual (*Mikulincer y Shaver 2016*).
- Implicit memory networks, they function as “automatic protocols” (*Bargh 2018*) that get activated and tend to homeostasis (*Sapolsky 2017*) f
- Flexible goal oriented responses (*Bowlby 1969*).
- In childhood they function as on/off (binary) systems gradually developing in the adult as sophisticated, integrated and under cortical control responses.
- Under stress situations, they go back to binary functioning.
- Attachment is the main system because it “has an organizing effect on the child” (*West and Sheldon-Keller 1995*), through regulation of the nervous system.

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## Why is

## ATTACHMENT

It's "the organizing principle around which psychological development takes place". **Holmes 2001**. "It's the key system in the development [...] and the complete expression of the rest of the systems". **West y Sheldon-Keller 1994**.

It's a protection factor for ACE, working both as prevention as well as repair.

Sets the implicit knowledge of "how to do things with others". **Lyons-Ruth 1988**. The base for the future adult relations.

Affects self concept, self esteem and self compassion. **Zessin et al 2015**.

Deeply influences self-regulation.

## So important ?

Related to health and mental health: insecure patterns are related to vulnerability factors for psychological problems (**Holmes 2001/2010**) and disorganized aspects to severe mental illness (**Liotti 2014**)

## A few words about Social Ranking System

- Present in all social animals. Regulated by serotonin levels (Peterson 2018).
- Parent-offspring conflict theory: Children's demands vs parents output (Trivers 1974). Parents are main Social Ranking agents.
- Attachment and SRS are partly opposite. When children perceive "weak" parents, they 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 aggressive behavior to lower stress levels ("stress induced displacement aggression", Card y Dahl 2011).
  - Lower self-esteem (Sapolsky 2017).

## Contents of Workshop

- Attachment theory.
- Attachment from childhood to adulthood.
  
- Trauma: evolution of the concept. Present definition of trauma.
- Types of trauma: defense, attachment and beyond attachment: other affective systems that can be traumatized.
  
- Assessing attachment issues.
- EMDR and attachment: specific interventions and modifications in the standard protocol for individual and couple interventions.

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## Otras medidas de evaluación en apego infantil

### CONTROLADAS:

- SA extendida a 2- 4 ½: elicitar estrés con separaciones prolongadas, cambios de género, etc
- 6 a: Prueba de Main y Cassidy: 1 hora de separación.
- MIM (Marschak – Yale).

### ENTREVISTA:

CAI (Target et al 2003): 7-11.  
AICA (adolescentes).

### OBSERVACIÓN

- 1-5 a. Q-Set (Waters y Deane 1985): 100 ítems

### REPRESENTACIÓN:

- Métodos con muñecos: MSSB (3-8), SSAP (4-8) y MCAST (4-8)
- Completar historias: ASCT (3-9) – Bretherton
- Viñetas: SAT (versión para 11-17 y 4-7)

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### Adult Attachment - Assessment

- AAI (Main y Godwyn 1993).
  - AAI – Reflective Function (Fonagy y Target 1997).
  - AAP (George y West 2001):  
[www.attachmentprojective.com](http://www.attachmentprojective.com)
  - ECR Scale (Brennan, Clark y Shaver 1998):  
[www.psyweb2.ucdavis.edu/labs/Shaver](http://www.psyweb2.ucdavis.edu/labs/Shaver)
  - RSQ (Bartholomew y Horowitz 1991)  
[www.sfu.ca/psyc/faculty/bartholomew/research/index.htm](http://www.sfu.ca/psyc/faculty/bartholomew/research/index.htm)
- \* Risky Situation (Paquette y Dumont, 2013)

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### Adult Attachment - Assessment

- ▶ We will see a combination of avoidant and anxious-ambivalent traits: activation patterns.
- ▶ Different attachments horizontally, vertically upwards (their parents) and vertically downwards (their children): for example very anxious-ambivalent caretaker towards the mother and avoidant towards the children.
- ▶ Different attachments to different people: one towards the first child and one towards the second (depending on, for example, the level of demand from that child, gender, temperament, who reminds me of, etc).
- ▶ Level of present stress affects the pattern shown by the adult.
- ▶ We will have to asses % disorganization.
- ▶ Look out for features of other action systems

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### **Autonomous adult attachment narrative**

- ▶ Consistent narrative, the person explains, goes into details. Realistic, not polarized or idealistic. Makes sense.
- ▶ Wide range of internal work models (IWM). Flexible.
- ▶ Differentiates healthy relationships. Values positive interactions.
- ▶ Cooperative and able to protect himself.
- ▶ Has an intuitive understanding of attachment and considers attachment bonds very important.
- ▶ Is regulated (neither excessively excited nor excessively distanced) and with appropriate emotions according to the narrative (within the window of tolerance).
- ▶ Autonomy.

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### **Narrative of preoccupied adult attachment (ambivalent)**

- ▶ Defines childhood as good. Gives many details but contradictory or erroneous. Hard to follow.
- ▶ Goes from exaggerating to minimizing the importance of attachment.
- ▶ Self regulation is poor. High emotional expressiveness. Can express different emotions towards the same person.
- ▶ Frequently shows dependency patterns.
- ▶ Difficulties in self-regulation and especially co-regulation.
- ▶ Insecure. Low self-esteem
- ▶ Frequently disturbed when talking about childhood, showing anxiety, worry - anger, guilt. A lot of emotion and little containment.
- ▶ Hyperactivation patterns.

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### **Narrative of avoidant adult attachment**

- ▶ Defines childhood as "good", "without problems" or "normal". Does not give many details. Few memories. Little flexible narrative.
- ▶ Minimizes the importance of attachment relationships and the importance of childhood.
- ▶ Does not perceive other adults as regulators or comforters.
- ▶ Strategies to avoid privacy. Self-dependent, counter-dependent.
- ▶ Sometimes, good capacity for social analysis.
- ▶ Self-regulatory deficit that leads to restricted emotional capacity. A lot of cognitive analysis.
- ▶ Distanced from emotions while narrating childhood events. Disdain or attitude "deep down you can not trust anyone." A lot of contention, little emotion.
- ▶ Avoidance patterns, control, hypoactivation and self-soothing.

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### **Disorganized adult attachment narrative**

- ▶ Very few memories. Disorganized and incoherent narrative. Frequent fabulation. Very difficult to follow.
- ▶ Has no sense of security.
- ▶ Sudden emotional changes or dissociated behavior.
- ▶ Impulsive. Changing and contradictory behaviors.
- ▶ Difficulties with self-regulation.
- ▶ Impulsive. Bizarre behaviors: fearful or fearsome.
  
- ▶ Can be very much under control until the attachment system is activated, becoming confusing and disorganized at that time (Liotti 2011) and expressing a lot of emotion.

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## Types of patients

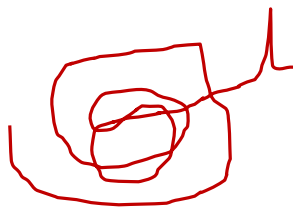
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Hiperactivation  
Parts "enmmeshed"  
O "blended"



Instable  
Symptomatic  
Patient



Hipoactivation  
Avoided or  
Diociated parts



Stable  
Asymptomatic  
Patient



Structural dissociatio  
Type 2 or Type 3



Patient with  
Dissociative  
features

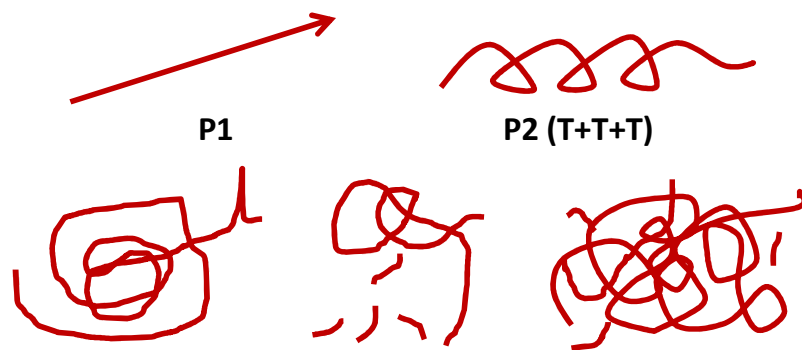


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- Standard Protocol (Shapiro)
- Recent event (Shapiro)
- Beliefs (De Jongh y Broecke)
- Symptoms (Korn, Leeds).
- Inverted model (Hoffman, Hess).
- Attachment interventions
- Dissociation models (González y Mosquera).



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### 3 prong approach

### 8 phases of EMDR

Prong	Phase	Objective
Past	1. History	Assessment and introduction to AIP. History taking.
	2. Preparation	Stability, security, understanding
Present	3. Assessment	Target and take to point of processing (DF)
	4+5+6. DS-Instal-BS	Desensitization and Reprocessing
Future	7. Closure	Patient back to present (Leave DF)
	8. Re-evaluation	Link to previous

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*\*Farrell D & Lalotitis D, 2017*

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

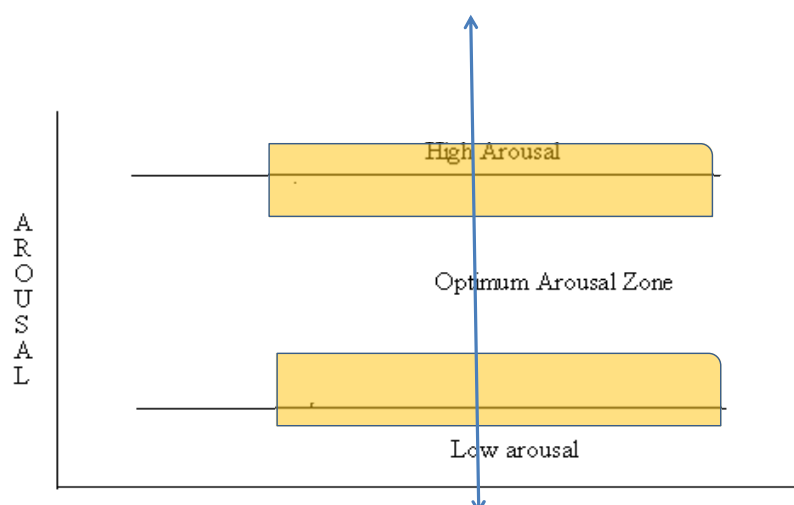
### **DUAL FOCUS**

- 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**

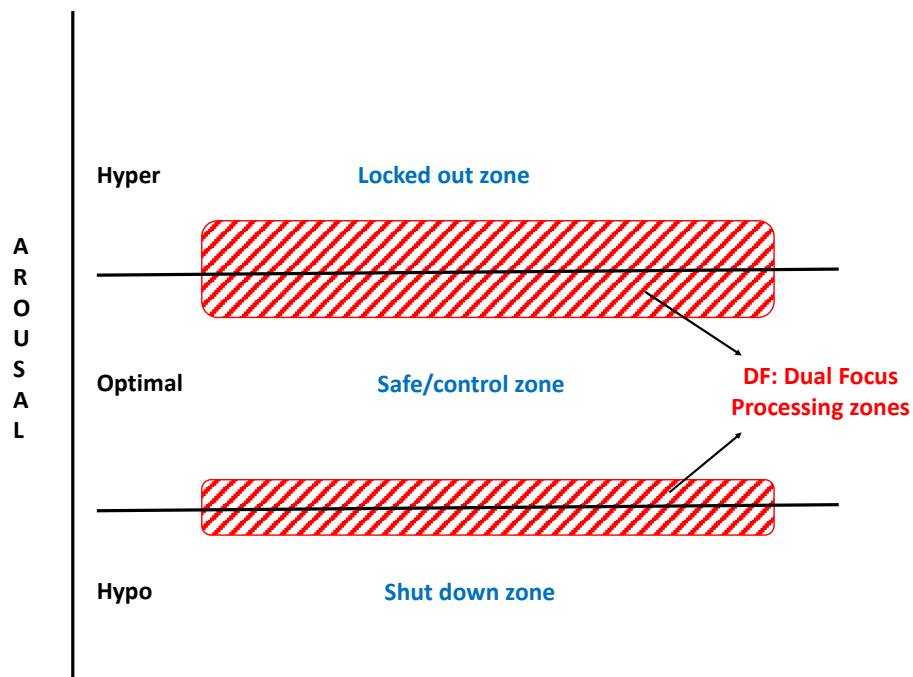
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### **DUAL FOCUS**



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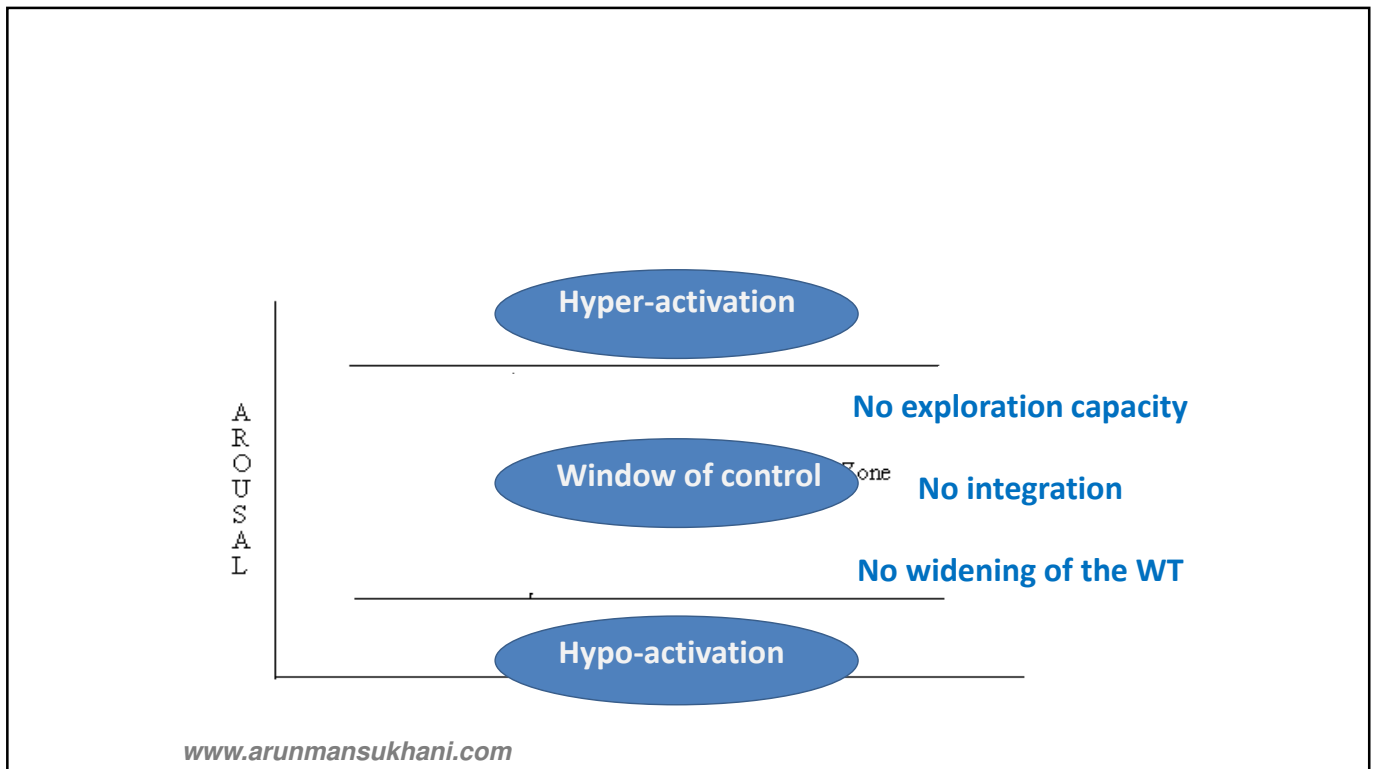
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### What stops/hinders processing?: Loss of DF.

- **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

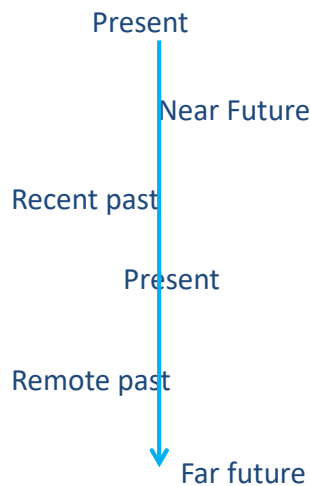
Phase
1. History
2. Preparation
3. Assessment
4+5+6. DS-Instal-BS
7. Closure
8. Re-evaluation

## Patients with attachment issues

- Don't understand why we have to work on the past instead of current 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...

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**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	-Mentalisation -Understanding
2 - 1+3+4	-Partial processing -Work <i>with</i> defenses
2 - 3-8	-EMD – EMDr – EMDR (Tx).
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 (Schoe, 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).
  - Ba 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'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.

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## Phase 2:

- The most relevant phase, present throughout therapy, with 4 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).
  - Capacity to reprocess: **dual focus** with disturbing material
- 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

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## Phase 2- Adjusting the rhythm in sessions Widen WoT

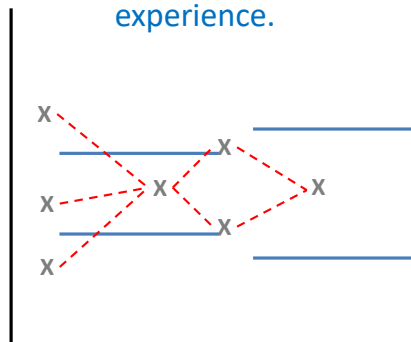
Phase oriented treatment:

- 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.
- Addiction protocols:
  - Past: Idealization (Knipe)
  - Worst fear protocol: jealousy, being left, envy.
  - Future + Urge (Popky)
  - Guilt

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## Phase 2 - Specific techniques (individual)

The objectives will be: emotional regulation, energy regulation, creation of **healthy internal adult** and improve internal dynamics (self-compassion):

- Build a secure base within the self.
- Assertiveness, work with limits.
- Self-knowledge Self Acceptance Self-compassion (starting at homeostatic).
- Creation of routines and structures. Work with regulation of energy levels.
- Beginning of pleasant activities: hedonic and eudaimonic.
- I work with the inner child. "Loving eyes."
- Differentiation of emotional parts
- Future templates.
- Meeting place

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## **Phase 2 - Specific techniques (couple)**

The objectives: improve co-regulation and safety.

- Restore safety and auto and co-regulation: Tolerance window.
- Techniques to promote co-regulation in sessions.
- Improve Communication.
- Positive and negative affect tolerance.
- Conflict Reduction Relapse prescription.
- Work in limits
- Conflict analysis: conflict as a window to another type of relationship.
- Work with specific problems: sexual, etc.

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## **Phase 2 - Specific techniques (individual-addiction)**

Objective: not to go back or break relationship.

- Major fear, flashforward. Attachment system.
- Near future templates.
- Addiction free future (Popky). Reward system.
- Positive moments of the relationship - idealization (Knipe). Reward system
- Triggers ("Urge" by Popky). Reward System
- Specific resources (CraveEx, Hase). Reward system.
- Specific past: previous triggers, previous relapses, dependency onset, etc. Reward system.

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### Phase 2 ends or is not needed when

- Security: in your life and in consultation.
- Stability: Reduction of symptoms and conflicts.
- The most anxious patients should start to learn emotional regulation (stability and security)
- The most avoidant patients will begin to connect with their emotions and feel safe and regulated by doing so.
- Understanding: understanding and integration of vital history.
- Connection capacity and dual focus.

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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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## Work with Defenses

Awareness

Appreciate function / praise

Process with the defense protocol

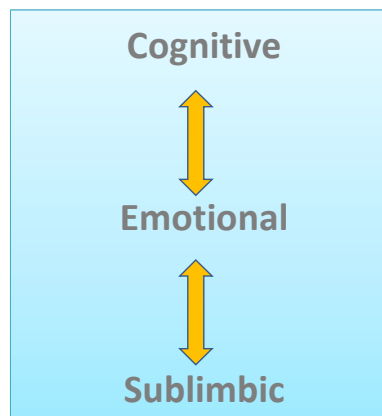
Connect with the cost

Process double defense / wound

Work as part

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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**).

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### 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. Take 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.

- They take more to appear or will not appear at all
- They may be specific images related to particular situations but also:
- 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.

- Due to activation of different systems, 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 unavailable at the beginning (or 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.
  - She is alive / I survived / I am alive.

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### Phase 3-6: Emotions.

- Basic emotions (wound):
  - T: panic, disgust, helplessness, ...
  - AT: anxiety, sadness, loneliness, ...
- Defensive emotions: anger, guilt, shame + counter-shame (hate and aggressiveness)
- Also child part emotions vs the adult emotions. Process both.
  - Emotion of the adult when sees the child: What do you feel now when you see that child? EB. (If very intense negative emotions work with parts)
  - If defense process as defense.
  - How is / was the child? How do you feel about that? BS.
  - Can you feel (adult) what the child feels? BS.
  - Joint processing (lap or through the eyes)

\* If Inner Child spontaneously appears, it is a self resource, reprocessing is not over.

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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!

Arun Mansukhani

+34 607 803 803

[arun@arunmansukhani.com](mailto:arun@arunmansukhani.com)

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