EMDR
WEST MIDLANDS
REGIONAL SUPPORT GROUP

EMDR: Working with adult clients with attachment trauma

12th March 2021.

Arun Mansukhani.
PsyD. EMDR Consultant and facilitator.

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www.arunmansukhani.com/documentos

These slides represents the presenter's work. Please reference it if used. Thank you.

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Contents of Workshop

- What is Attachment Trauma:
  - Trauma. Neurobiology of trauma: Behavioral affective (control) systems.
  - Types of trauma according to systems involved.
  - Adults with childhood trauma and attachment issues.
- Clinical assessment of attachment trauma in adults.
- How to work with EMDR with patients that have childhood trauma and attachment issues underlying their present clinical problems.

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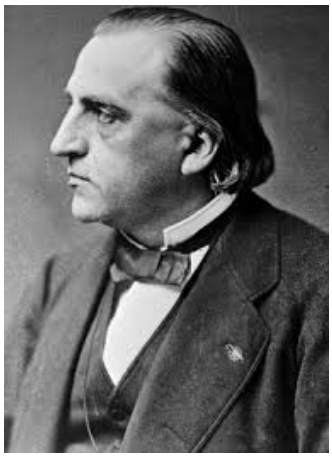
Psychology and trauma: historical overwiev



19th century: Hysteria. Charcot. Freud y Janet.

20th century in between wars. C. Myers

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

End of 20th and beginning of 21st century:

1. Gender and intra-familiar 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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- 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 Consciousness.
- 1893: Pierre Janet publishes Dissociation, 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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1983, National Vietnam Veterans Readjustment Study (NVVRS):

- 15% M and 9% W suffered PTSD.
- 30% M and 27% W would suffer PTSD at some point after Vietnam
- Reports of hippocampus atrophy (Sapolsky, 2017; pg78).

EMDR

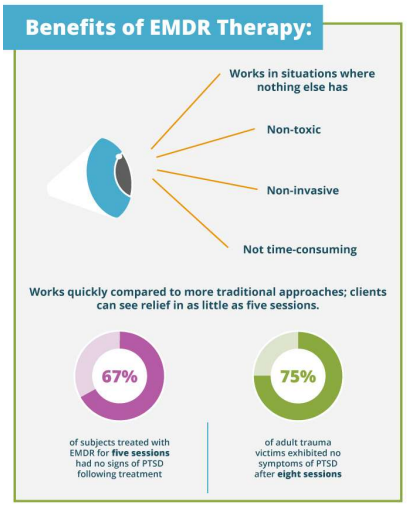
ORIGINATOR AND DEVELOPER

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



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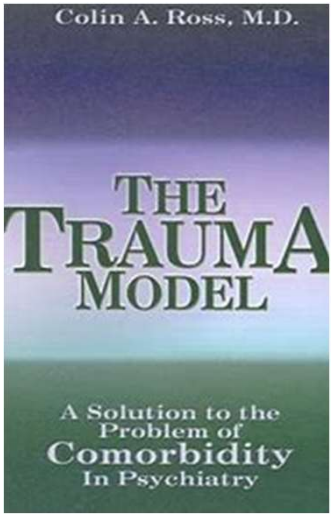
PTSD

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



Findings suggest that early childhood adverse experiences could be related to 32% psychopathology in adults and up to 44% in children (Green et al, Archives of Psychiatry, 2010).

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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: In-family abuse
Finkelhor 1990: 1st National Survey.
1994: First 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☆

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

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	%			
Mental health contact	206	7.7	627	23.3	3.65	3.09–4.32	<0.001
Axis I clinical disorders	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
Axis II personality disorders	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]
Non-psychiatric complaint	18	0.7	92	3.4	5.24	3.15–8.70	<0.001

[a] 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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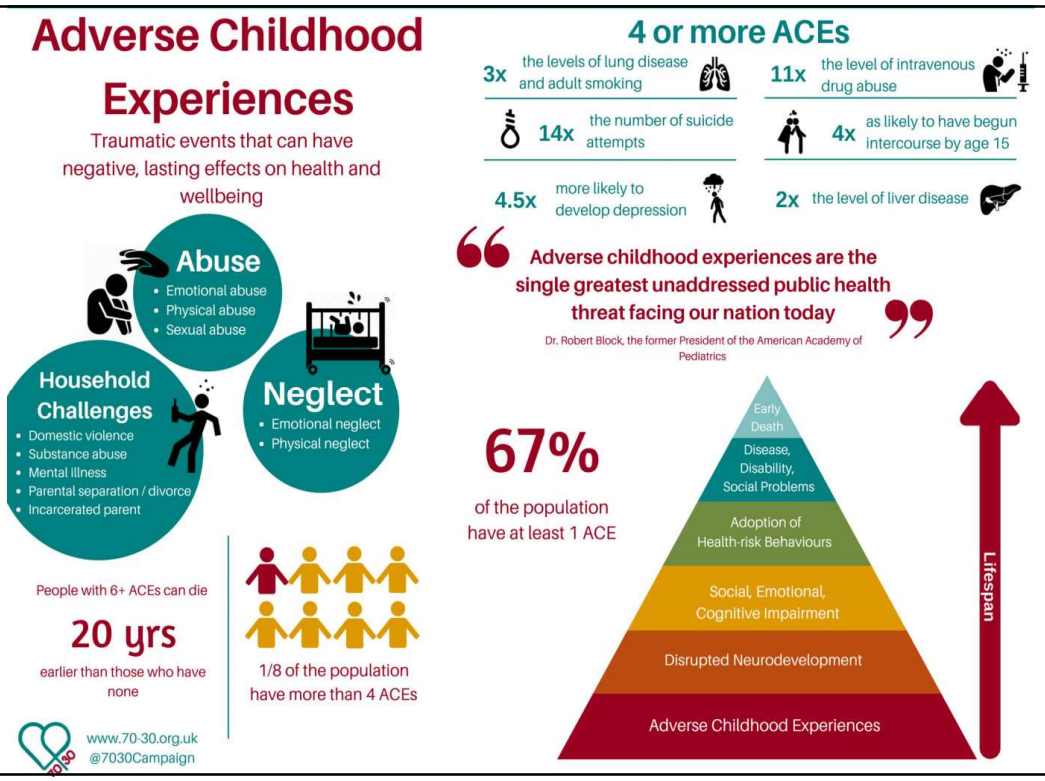

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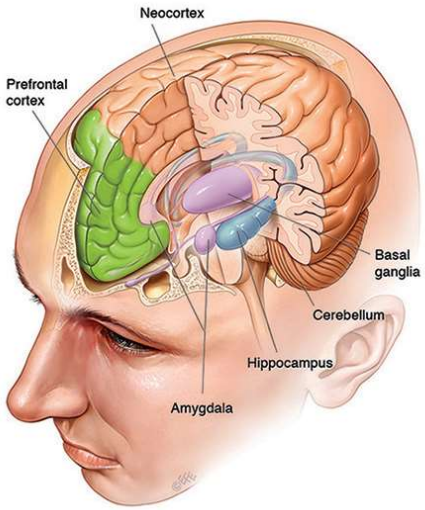
ACE affects brain structures



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

Martin Teicher 2017

↑*NE* *(Amsten et al 2015);* ↑ ↓ *Cortisol (R. Yehuda)*
↓*GABA (Anderson and Schmitz 2017)*

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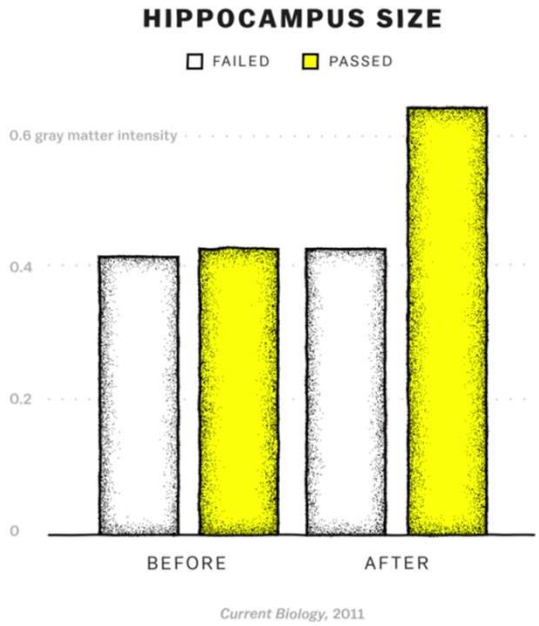

"Adult hippocampal neurogenesis is abundant in neurologically healthy subjects".

Mª Llorens-Martín

Centro de Biología Molecular Severo Ochoa

Moreno-Jiménez, E.P., Flor-García, M., Terreros-Roncal, J. *et al. Natural Medicine* **25,** 554–560 (2019).

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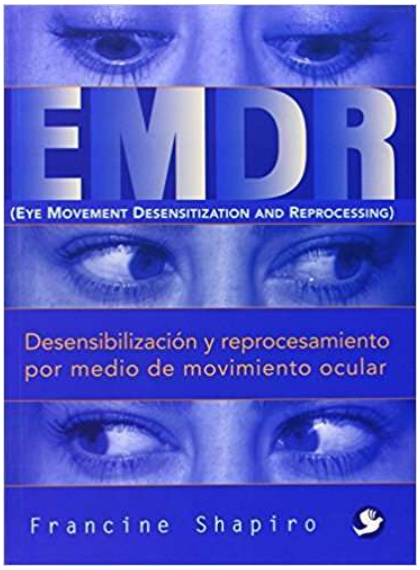
AIP Model



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

  (Van der Kolk 1995, Shapiro 2004).

- Dysfunctional 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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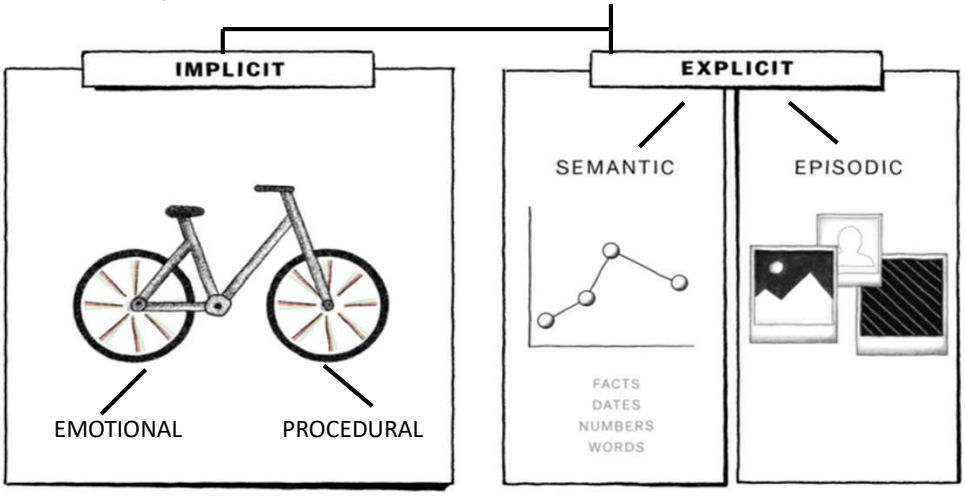
Sensory Memory (raw) STM **LTM**



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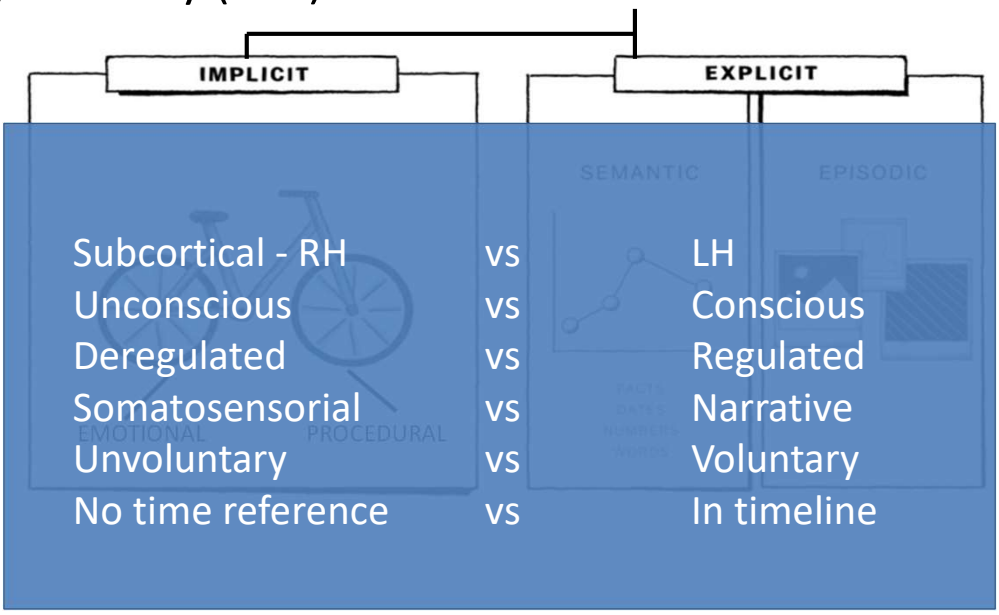
Sensory Memory (raw) STM **LTM**



Subcortical - RH	vs	LH
Unconscious	vs	Conscious
Deregulated	vs	Regulated
Somatosensorial	vs	Narrative
Unvoluntary	vs	Voluntary
No time reference	vs	In timeline

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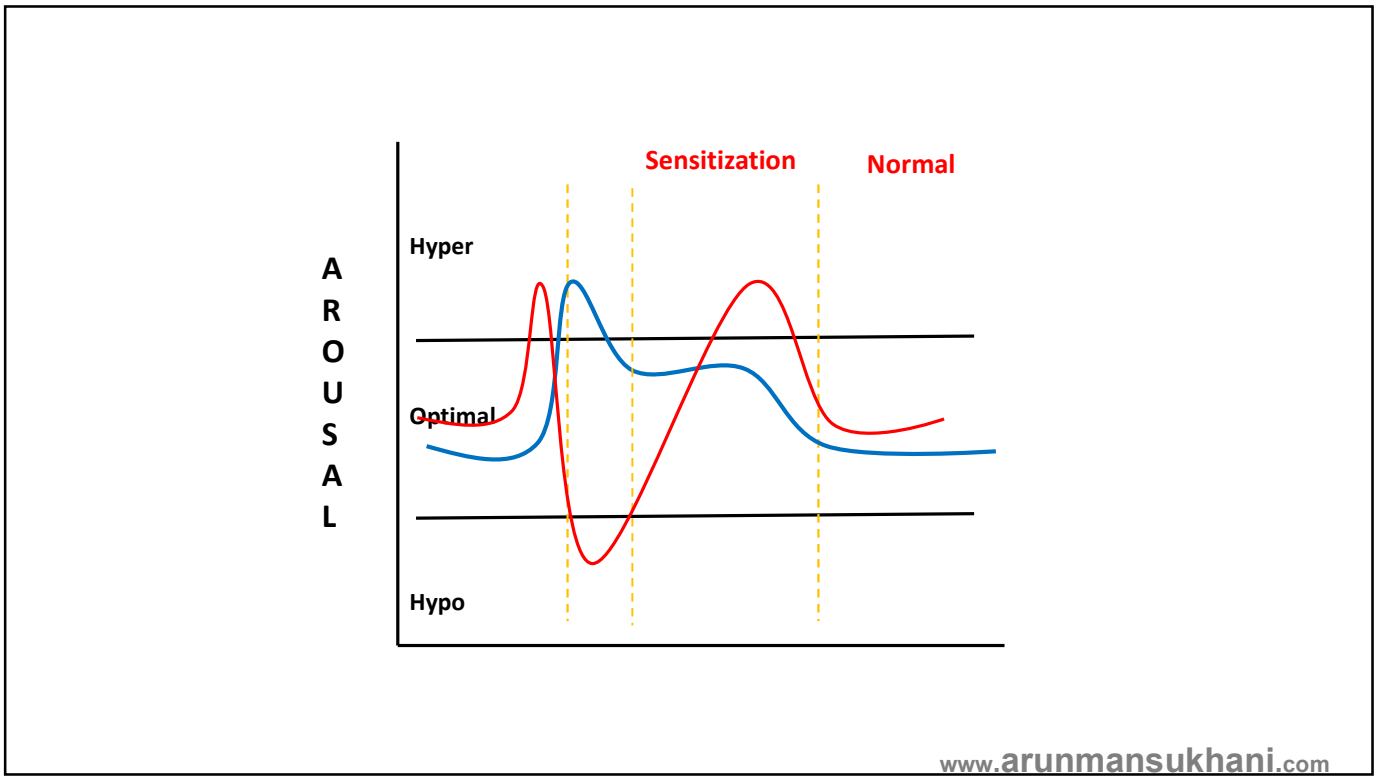
Sensitization
Normal
AROUSAL
Hyper
Optimal
Hypo
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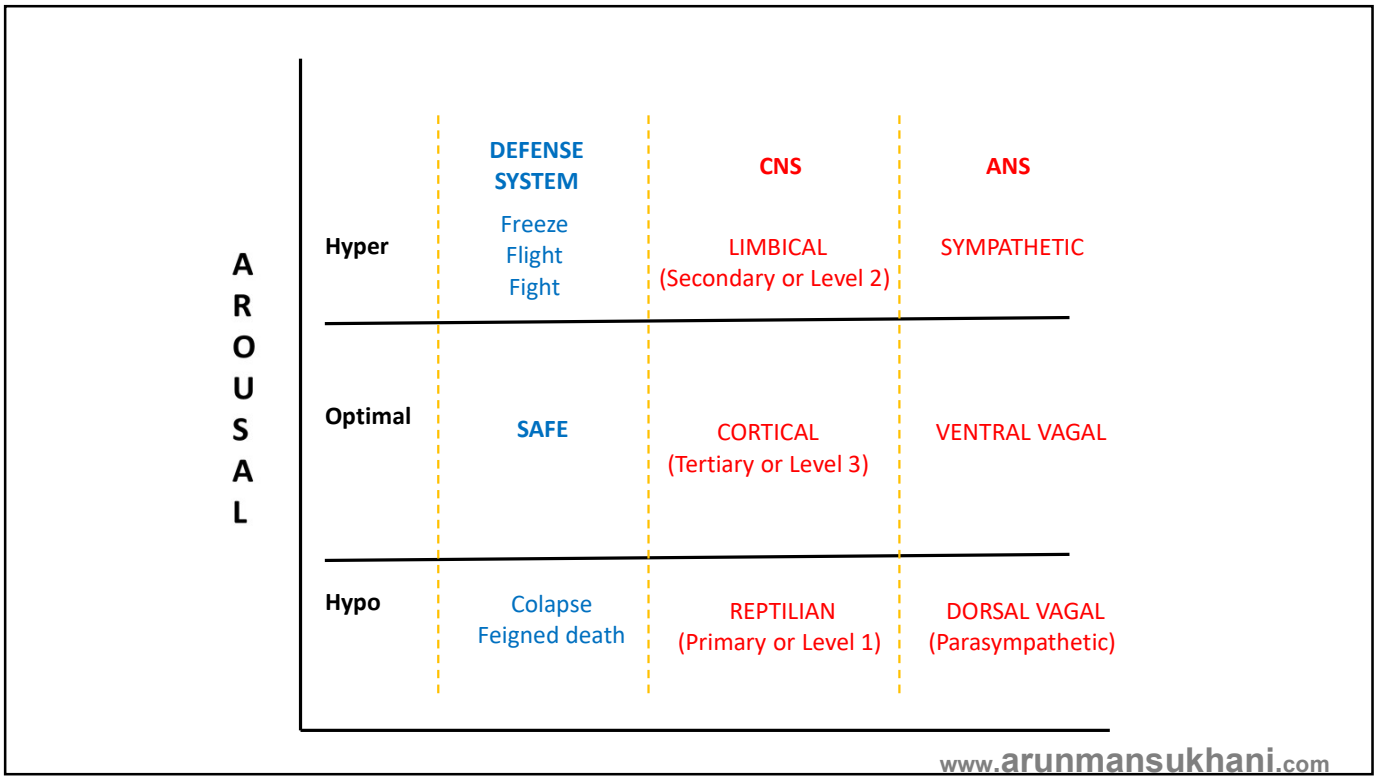
AROUSAL
DEFENSE SYSTEM
CNS
ANS
Hyper
Freeze
Flight
Fight
LIMBICAL
(Secondary or Level 2)
SYMPATHETIC
Optimal
SAFE
CORTICAL
(Tertiary or Level 3)
VENTRAL VAGAL
Hypo
Colapse
Feigned death
REPTILIAN
(Primary or Level 1)
DORSAL VAGAL
(Parasympathetic)
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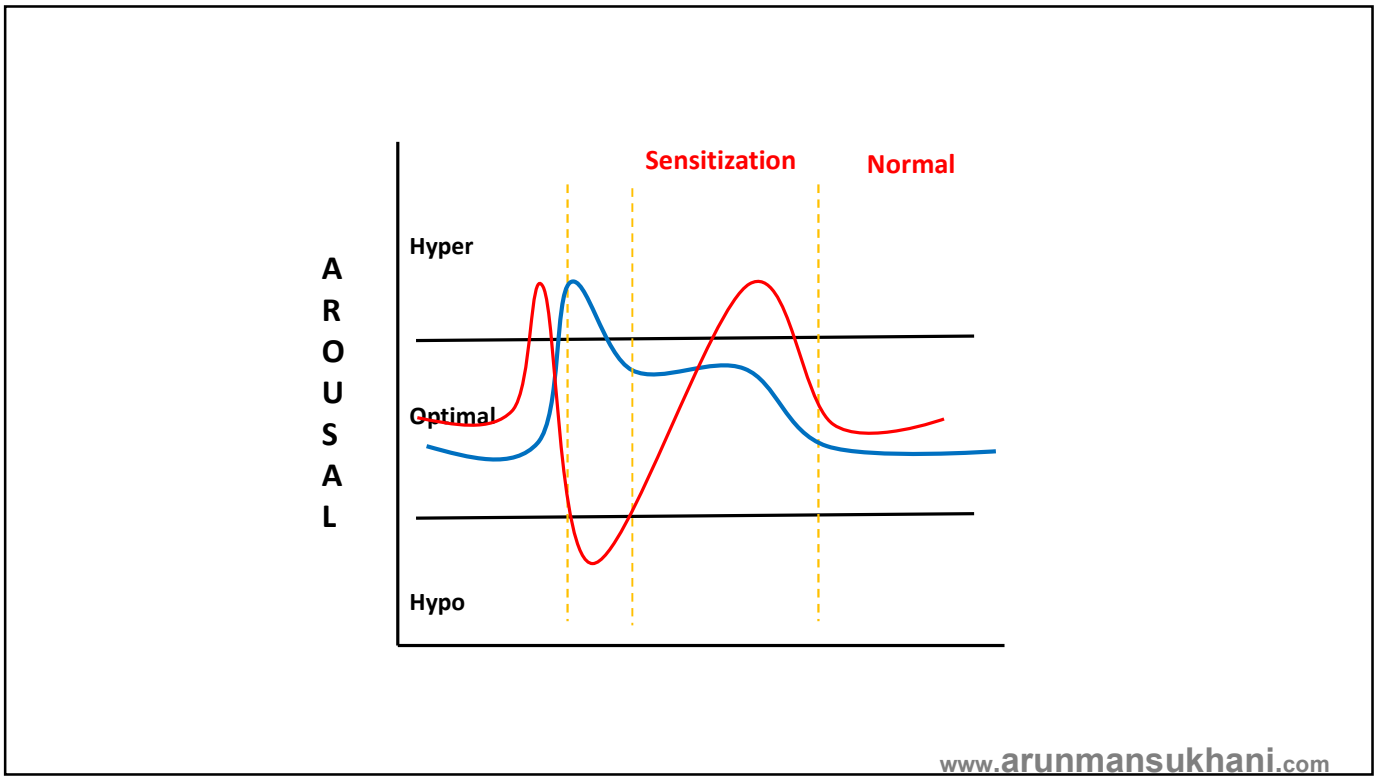
Sensitization
Normal
AROUSAL
Hyper
Optimal
Hypo
www.arunmansukhani.com

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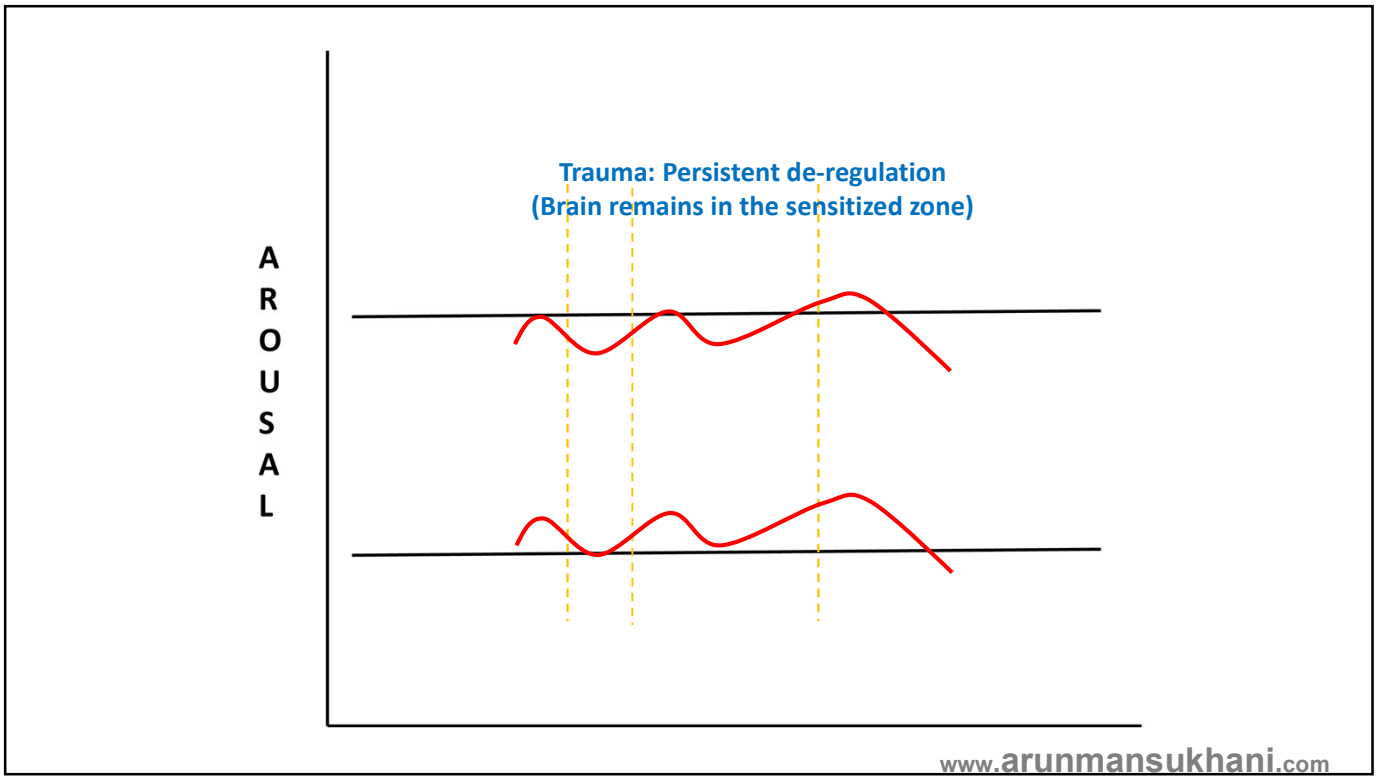
Trauma: Persistent de-regulation
(Brain remains in the sensitized zone)
AROUSAL
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In a post traumatic response, our NS:

fails to go back to homeostasis (optimal arousal levels) after activation (hyper/hypo) of one of the BA systems,

remaining in a sensitized mode that results in frequent deregulation and

producing a stress response, not as much as a reaction to present threats, but to dysfunctional stored "memories" and internal cues.

Internal World ≥ External world
(Projecting past here and now)

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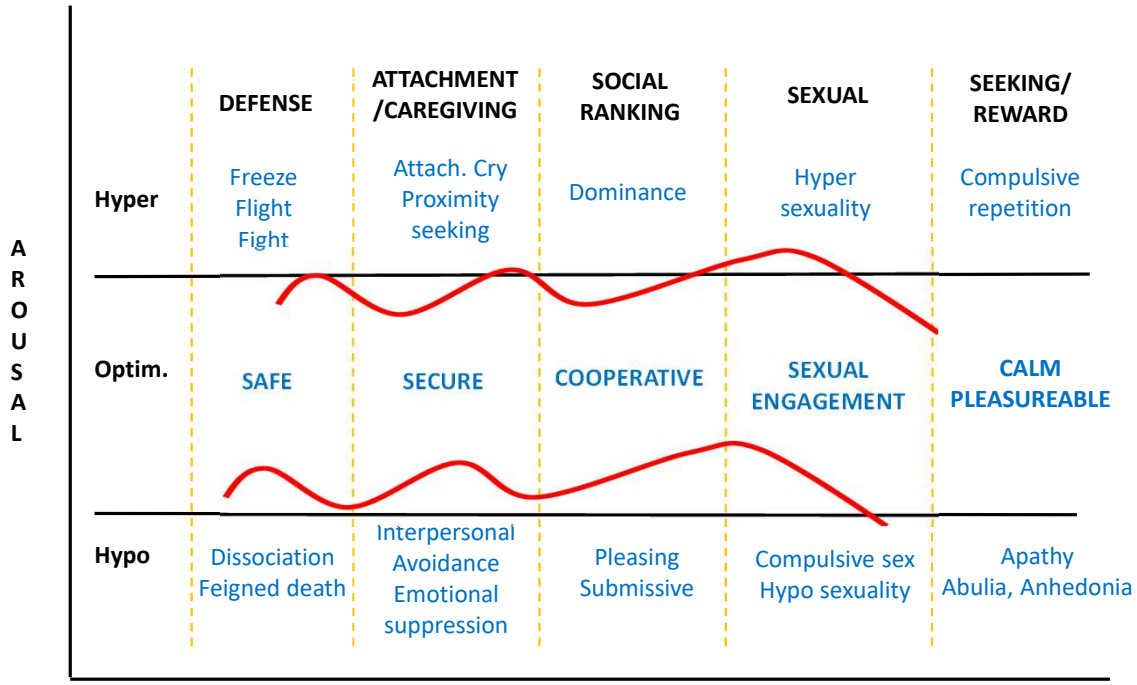

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Systems: Control – Behavioral – Motivational – Action – Affective

- Biologically evolved neural programmes, universal and that organize some aspect of behaviour in a way that enhances survival or reproductive chances of an individual (*Mikulincer & Shaver 2016).*
- Implicit memory networks, they function as "automatic protocols" (*Bargh 2018)* that get activated and tend to homeostasis (*Sapolsky 2017*).
- Flexible goal-oriented responses (*Bowlby 1969)*.
- In childhood they function as on/off (binary) systems gradually developing in the adult into sophisticated, differentiated, integrated and under cortical control responses. Under stress, 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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Attachment System vs. Defense System

Proximity to the AF

Flee from Perpetrator

- ↑Oxytocin and ↓ Central Amygdala
- ↓ Fear and anxiety
- ↓ Symphatetic Response, inducing calm response

M

P

C

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Why is ATTACHMENT So important ?

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. Most trauma is interpersonal.

Sets the implicit knowledge of:

- "How to do things with others". **Lyons-Ruth 1988**.
- Assumptions about the world (benevolence, meaning) and others.
- Self worth and self compassion.

Deeply influences self-regulation.

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**)

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A few words about Social Ranking System

- Present in all social animals. Regulated by serotonin levels (Peterson 2018) and influences testorterone levels (Sapolsky 2017).
- Parent-offspring conflict theory: Children's demands vs parent's 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). Hyper activation without regulation.
  - Anger at parents for lack of protection.
  - Higher Reactive and Displaced aggressive behavior to lower stress levels ("stress induced displacement aggression", Card & Dahl 2011).
  - Unstable self-esteem (perceived value and importance for others).

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A few words about Social Ranking System (2)

Individuals that perceive themselves as higher SES are/have (Piff et al, 2012):

- More self-focused pattern of social cognition and behavior (Krauss, Piff & Keltner, 2011).
- Less cognizant of others (Krauss, Piff & Keltner, 2009).
- Worse at assessing others emotional states (Krauss, Coté & Keltner, 2010).
- More disengaged during social interaction (Krauss & Keltner, 2009).
- Less generous and altruistic behavior (Piff et all, 2010).

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Attachment Theory

B A C K G R O U N D

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Attachment Theory

B
A
C
K
G
R
O
U
N
D

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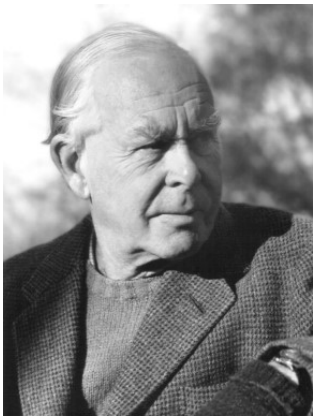
THE NATURE OF THE CHILD'S TIE TO HIS MOTHER

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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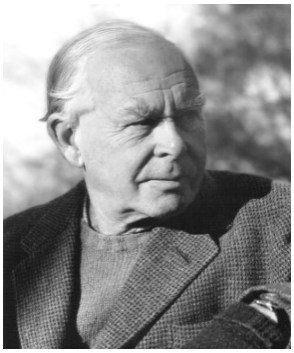
"The infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment [… otherwise…] will result in sever anxiety conditions and psychopatic personality".

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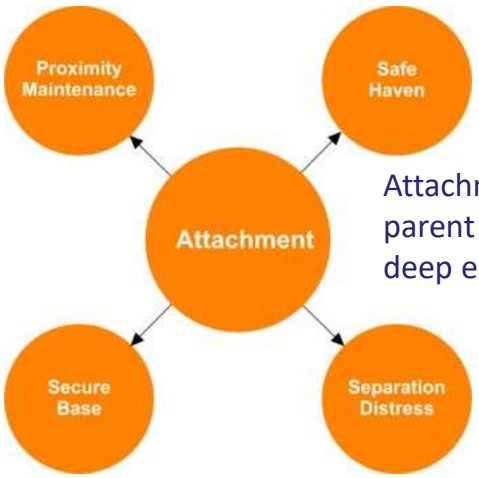
Strong affectional bond that develops over a series of repeated interactions between an infant and his/her caregiver



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 pase 5 and end.

9 – 18 months

Observe:

- Exploration.
- Regulation
- Initiates contact w/ CT
- Regulation in reunion.
- Behaviour with CT and with S.

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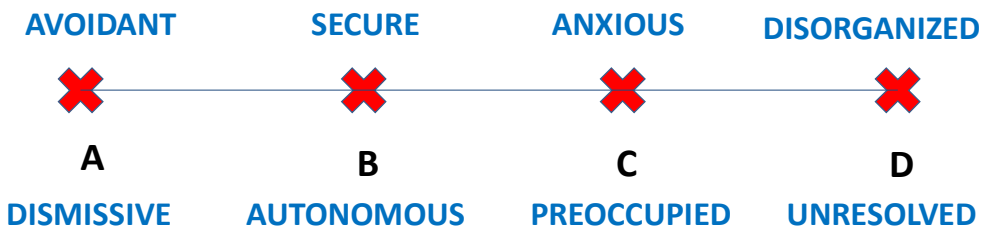
Attachment **Types**
(Ainsworth-Main classification, 1964, 1986)



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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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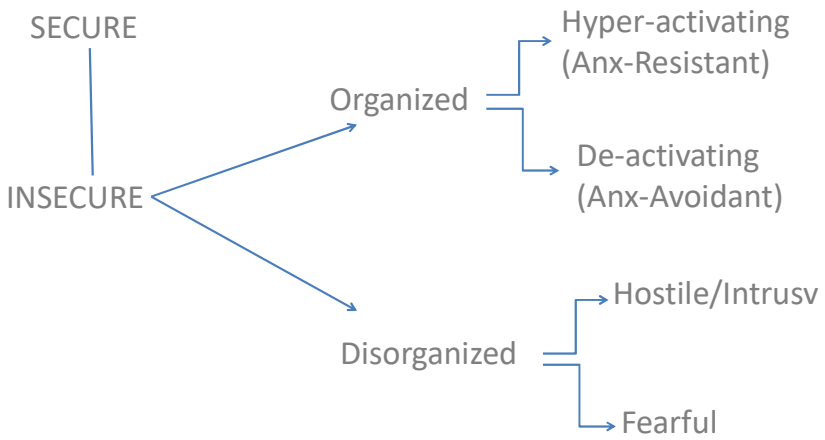
Attachment Types



**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 (ATTUNEMENT):** Sensitivity to child's needs. Responsiveness. 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) 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 (ATTUNEMENT):** Too sensitive or erratic sensitivity. Erratic responsiveness, non reliable.. 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 with his behaviour (demands, anger, take care of…). The child organizes the adult's behaviour.**

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

1. **PHYSICAL AVAILABILITY:** Excessive (invasive) or defective proximity. Consistent. **EMOTIONAL AVAILABILITY (ATTUNEMENT):** Low.
2. **POSITIVE AFFECT**: Difficult for them. Themselves avoidant or controlling. 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 or fending off invasive caretakers.**

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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 because attachment system has not been able to organize parent's behaviour.**

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Attachment System vs. Defense System

Proximity to the AF

- ↑Oxytocin and ↓ Central Amygdala
- ↓ Fear and anxiety
- ↓ Symphatetic Response, inducing calm response

Flee from Perpetrator

M

P

C

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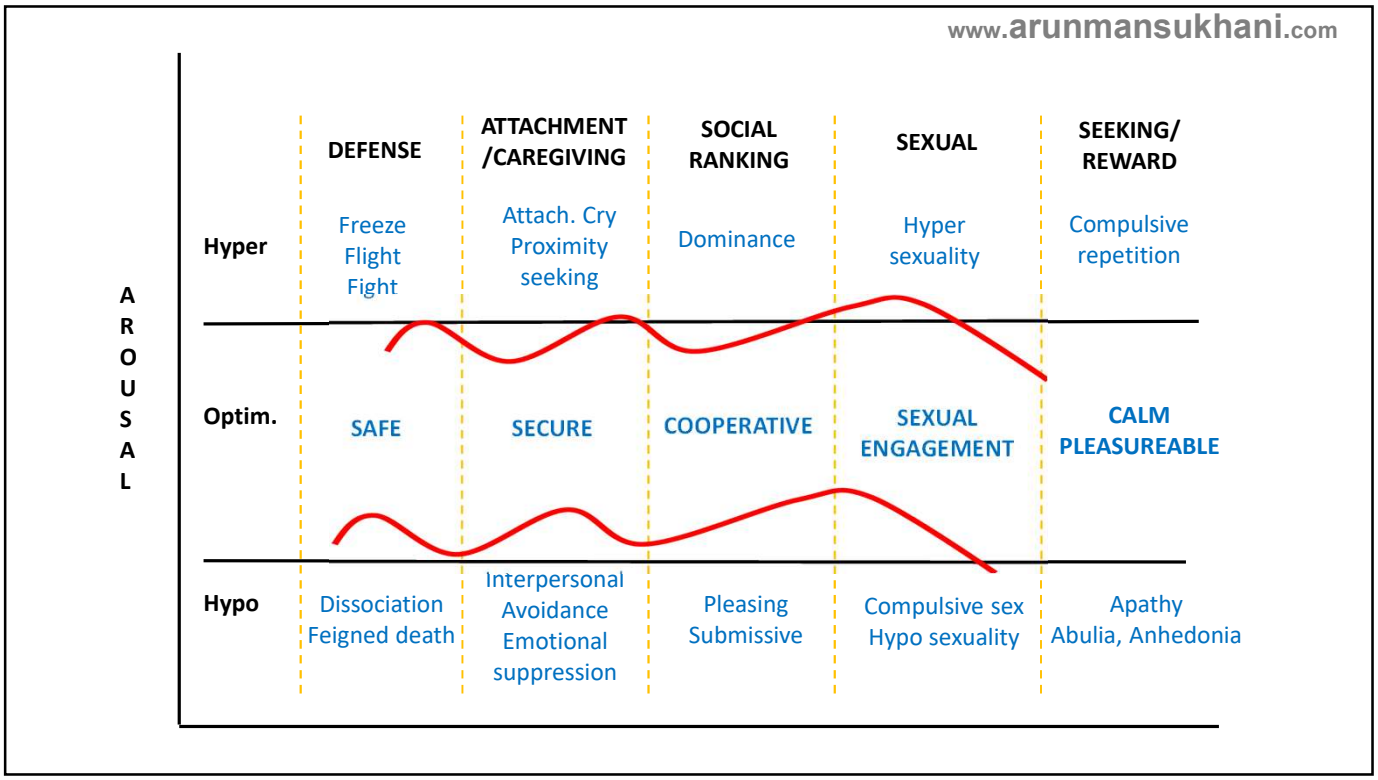

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Caregivers Parenting Styles		Children attachment Types
Responsive, sensitive, attuned, positive affect…	→	Secure
Inconsistent, insecure… Avoidant (tired caretakers)	→	Insecure but organized ambivalent
Cold, dismissive, critical, Too invasive	→	Insecure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

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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 then other figures (Ainsworth et al. 1978)

Main y Weston 1981:

After 24 months, the attachment type exhibited by the child will star 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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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, since 1975),** secure children in SSP:*
  - At 6 higher social competence (rated by 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.
  - greater sense of self-agency, better emotional regulation, higher self-esteem

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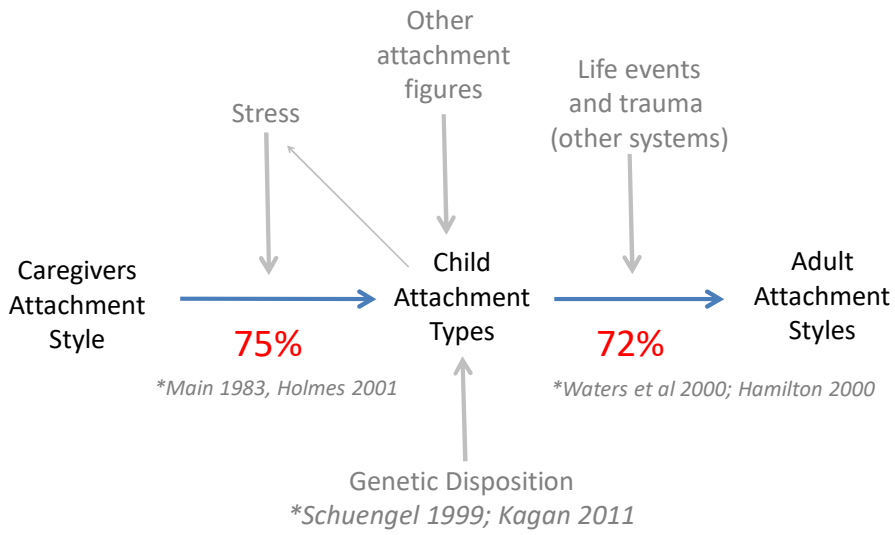

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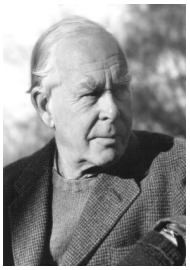

"Attachment theory […] propensity to make **intimate emotional bonds** to particular individuals as a **basic component of human nature**, already present in germinal form in the neonate and **continuing through adult life** into old age […] It performs a natural healthy function, even in adult life".

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 "adult patients with insecure attachments present a combination of avoidant and resistant features" (Holmes, 2009).
- Will show different styles horizontally, vertically, with different children....
- 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). In secure patterns, the system is more flexible.
- Disorganized attachment is not a 4th category and occurs due to enmeshment of attachment and other systems.

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Contents of Workshop

- What is Attachment Trauma:
  - Trauma. Neurobiology of trauma: Behavioral affective (control) systems.
  - Types of trauma according to systems involved.
  - Adults with childhood trauma and attachment issues.
- Clinical assessment of attachment trauma in adults.
- How to work with EMDR with patients that have childhood trauma and attachment issues underlying their present clinical problems.

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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
- ECR Scale (Brennan, Clark y Shaver 1998):
  www.psyweb2.ucdavis.edu/labs/Shaver
- RSQ (Bartholomew y Horowitz 1991)
  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.
- 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 assess % disorganization: Look out for features of other systems

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Avoidant features
Hypo activation of AS

- Auto-regulation: up-down.
- Intimacy avoidance
- Emotional independence: tend to instrumental interpretations of situations, relations and behaviours
- ↓ Emotional empathy. ↑ Need of setting limits
- Window of control. Stability: Emotion and sensation suppression/avoidance
- Internal resources

Resistant features
Hyper activation of AS

- Co-regulation: down-up
- Solitude avoidance
- Emotional dependence: tend to give emotional meaning to situations, relations and behaviors
- ↑ Emotional empathy. ↓ setting and accepting limits
- Narrow Window of Tolerance: Frequent deregulation
- External resources

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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).

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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.
- Can express different emotions towards the same person.
- Hyperactivation patterns, poor self regulation. High emotional expressiveness. Frequently shows dependency patterns.
- Difficulties in self-regulation and especially co-regulation.
- Unsecure. Low self-esteem
- Frequently disturbed when talking about childhood, showing anxiety, worry - anger, anger, guilt. A lot of emotion and little containment.

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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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3 prong approach

Prong
Past
Present
Future

8 phases of EMDR

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

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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

**Farrell D & Laliotis D, 2017*

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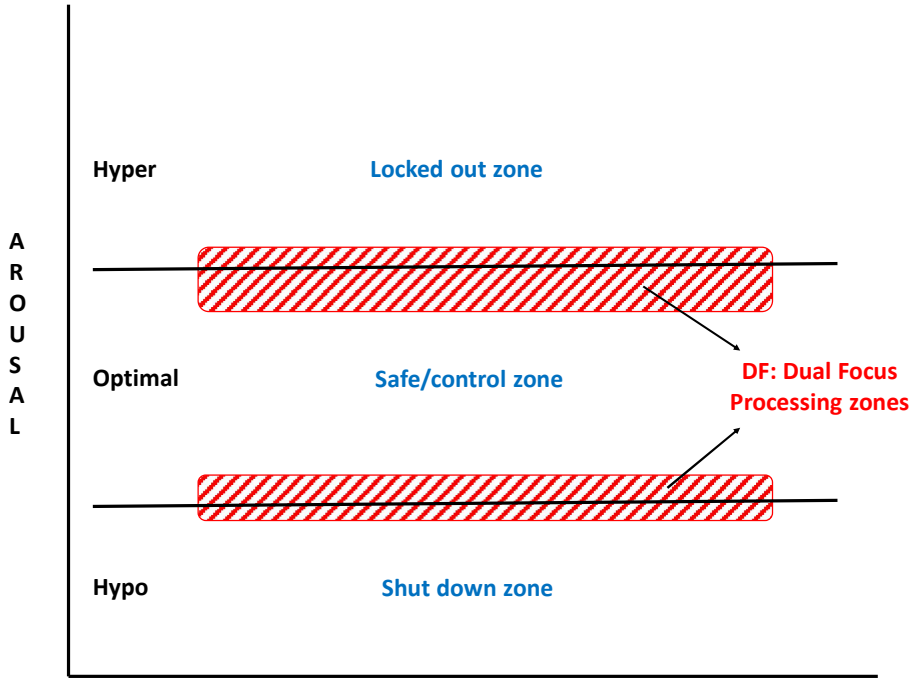

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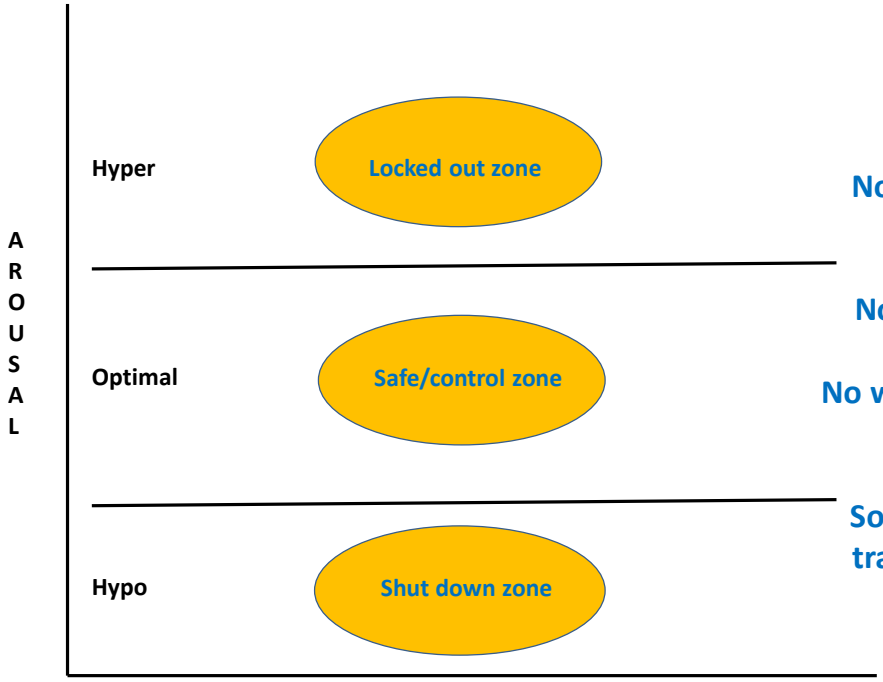

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Patients with attachment issues

- 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 blindness (Siegel 2012).
- Frequently destabilize when activate their AS (hyper and get locked out, hypo and get shut down) or are very afraid of destabilizing so they stay in control zone.
- Activate Avoidance Defense Mechanisms:
  - Conscious Suppression. Avoiding, redirecting attention.
  - Denial, idealization. semantic (resistant) vs. episodic (avoidant) memory problems
  - Unconscious internal suppression, no DF (Window of control).
  - Partial Dissociation: BASK model (Brown 1988).
  - Structural dissociation.

"A consistent focus on trauma processing per se in patients with complex trauma related disorders may be contraindicated" (Brown and Elliot, 2018).

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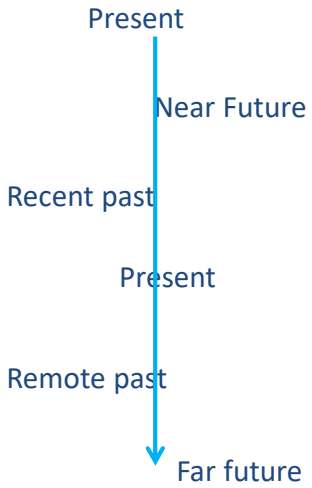
3 prong approach



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 *with* 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 (Schore, 2015).

Therapists

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. Frequently, they are the beginning of therapeutic change and the first chance the patient has of experimenting a healthy relationship.

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Enactments

- Therapeutic relationship may be the first healthy relationship that a patient has had. But therapists are not perfect, and make mistakes.
- Sometimes can be very subtle (i.e., pleasing patients).
- Enactments are situations where the patient's (and/or the therapist's) wound has been accidentally touched:
  - Therapists behaves as someone from patient's past.
  - Client behaves as someone from the therapist's past.
- This activates the pain and defence mechanisms.
- They are ruptures in the therapeutic relation and an excellent chance for repair.
- Reacting authentically, with a "non-defensive recognition" leads to a corrective experience

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Working with enactments

- Realize that an enactment is happening. Be able of staying in co-regulation.
- Speak carefully but openly:
  - Explore what just happened, the system, including the therapist.
  - Admit possible mistakes. Express the therapists feelings.
  - Very important not to react as someone from the patient's past (or the therapist's).
  - Watch what is happening to the client: help them express their negative feelings; help them talk about the "soft" feelings beneath the "hard" ones.
  - Non-defensive recognition. How can we solve this? / what can we learn from this?
  - Try and connect with past situations/people where the person felt the same.
- Don't question the therapeutic bond.

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Phase 2: Stability, Security and Understanding

- The most relevant phase, present throughout therapy, with 4 main objectives:
  - **Stability**: Emotional regulation. Capacity of self-soothing.
  - Relational **Security**. Start feeling safe enough to explore insecurity (Holmes 2010)).
  - **Understanding**: Help mentalize (understanding and integration of life history) (Use BS) and start connecting present issues to the past and external conflicts with internal conflicts.
  - Capacity to talk about disturbing situations while staying in **dual focus** or a **mindful state**, with the therapist's help.

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Phase 2- Working towards safety, stability and understanding

- Perceive overwhelming / avoidance pattern and where the patient's 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.
    - Resistant: help with regulation.
    - Avoidant: help with connection (with themselves).
- As they connect with past, help put in timeline and understand feelings that arise.
- Help distinguish intense memories from "going back there". Help distinguish Flashbacks.
- 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. Use BS.

Regulation = Safety = Attachment

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Phase 2- Adjusting the rhythm in sessions Widen WoT

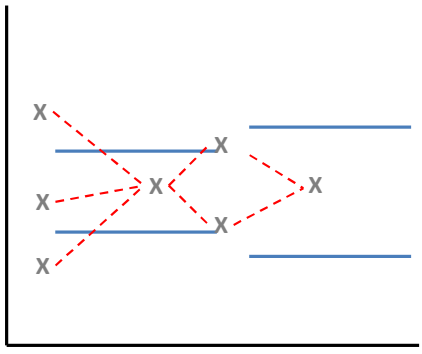
Phase oriented treatment:

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

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

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.



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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-care:
  - Creation of routines and structures. Work with regulation of energy levels.
  - Addictions.
  - Beginning of pleasant activities: hedonic, eudaimonic and met objectives
  - Assertiveness, work with limits (own / others).
  - Detect and avoid non secure places / people.
- Improve internal dynamics: Self-knowledge. Self-acceptance. Self-compassion.
- Develop a healthy inner adult that acts as a safe base withing the self.
- Use RDI. Future templates.
- Differentiation of emotional parts. Work with the inner child. “Loving eyes”.
- Meeting place.

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Phase 2: Inner adult

Traumatic experiences interfere with the development, sometimes even maturation, of the NS, not developing a healthy adult or developing “false adults” (act as such externally but not internally).

Help create/get in touch with the **Healthy inner adult:**

- Calm, self regulated, able to co-regulate, in contact with his needs (self-care) and empathic (caring for others).
- Not counter-phobic, tired, angry, hurt,…
- Capable of autonomy and intimacy.
- Compassive. Self-reinforcing and capable of reinforcing others.
- Resources (not defences).
- Capable of setting limits for himself and others.

Make aware and/or install when appears spontaneously

Use the inner adult protocol.

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Phase 2: SRS specific

We can have either dominant behaviour or submissive behaviour.

- Submissive behaviour: Standard EMDR
- Dominant behaviours (hyper activation without regulation):
  - Teach self-regulation techniques.
  - What to do when the previous have failed: loss of control:
    - Help understand that loss of control is the taking over by another part of the self
    - Understand that part and what needs it is trying to fulfil.
    - Where did it learn that this behaviour was valid?
    - Help connect with the “soft” emotion under the “hard” emotion.

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Defenses: Inner parts

- **Good Me**: Conscious and liked.
  - Everything (thoughts, behaviours, etc) that was re-inforced.
  - What I like about myself, what I am willing to show to myself and others
- **Bad Me**: Conscious and disliked.
  - Whatever was punished or denied.
  - What I don’t like about myself, what I am not happy to show.
- **Not Me**: Not conscious, phobic.
  - Those aspects of myself I am not conscious of having.
  - Phobic reaction towards these parts.
  - They appear during interaction with others, during conflicts… When I “loose control… that’s not me”.

80

Phase 2 - Specific techniques (individual-addiction)

Objective: not to go back or break relationship.

- Worst 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 - 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 and interaction patterns.
- 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 (sex as re-traumatization).

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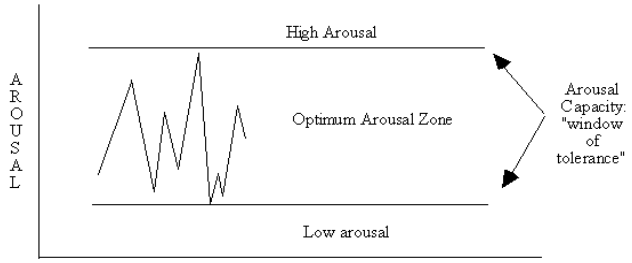
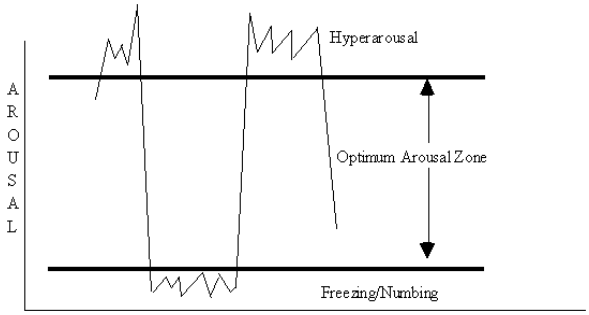
window of afective tolerance





Dan Siegel

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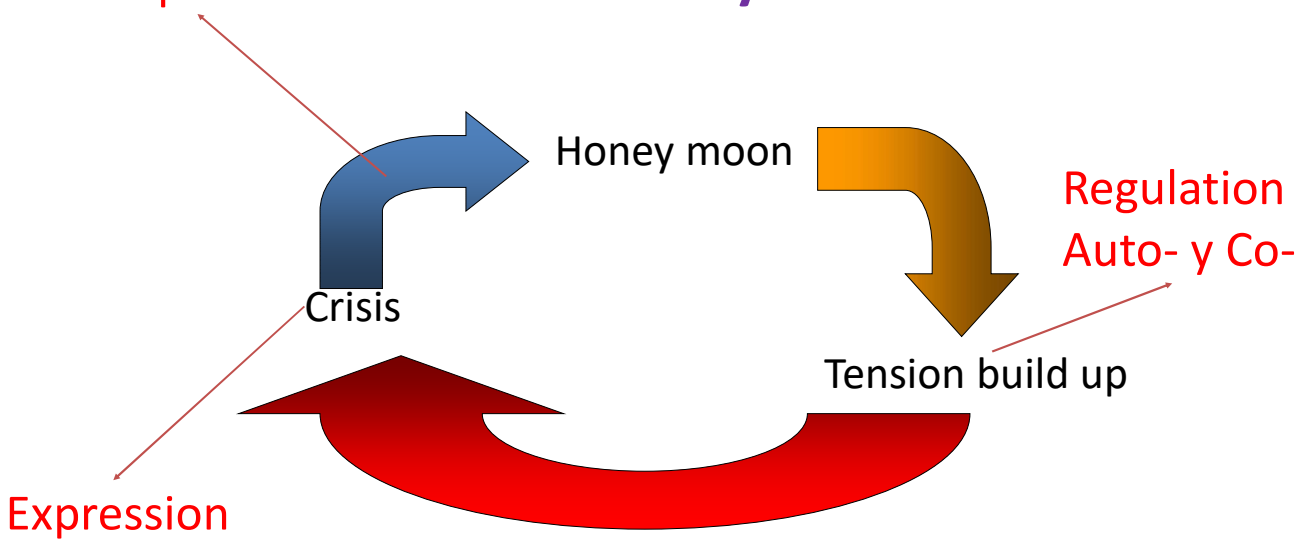
Conflict cycle



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Positive affect tolerance
(Andrew Leeds)

It's important to start working with positive affect tolerance, before going to negative affect tolerance. It will help self compassion and self care.
Difficulties that arise will help us connect to the client's life story:

- Sometimes it can be very evocative because it was not previously received, being seen, feeling of not deserving, impostor syndrome.
- It can sometimes evoque self-criticisism or de-stabilize the inner world.
- It may connect with fear of being hurt (or ridiculed) because of past experiences.
- Mistrust, because people that treated me well in the past hurt me.
- Fear of hope, because hope makes me vulnerable.

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Phase 2: Work with Defenses (Strategy)

It can be the best way many times to enter into the past:

- Help increase awareness and volitional control.
- Understand and appreciate function.
- Connect with the cost:
  - process the cost:
    - I have to be perfect / I can fail (and they won't stop loving me)
    - I can't trust / I can learn when (or who) to trust.
  - and/or go to the wound:
    - where did you learn that…?
    - If you were not perfect, what would that say about you?

- Process with the defense protocol
- Work as part

86

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 staying in dual focus.

87

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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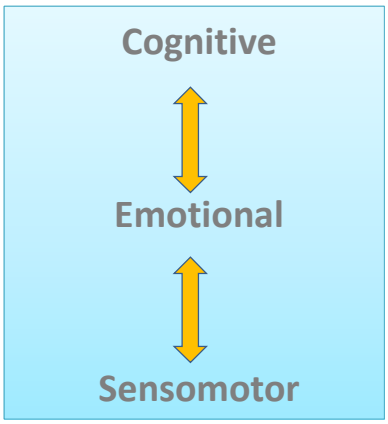
Partial processing



Helps and we can install:

- Conects present with 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**).

89

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.

90

Phase 3-6: Targets.

Other option: use present interpersonal conflicting situations:

1. Couple: positive affect intolerance better then negative.
2. Problems with children:
    1. Problems with children:
    2. Reinforce them as parents for their sensitivity and concern, and being brave enough for consulting about their children.
    3. Start with the Main AF:
        1. Ask for the feelings while the child misbehaves. When did they feel this before?
        2. Make them understand that you can't fight the past and the present at the same time.
        3. Sugest to work on their emotions to help the child.
        4. Work the present wound or help them connect with the past (opens up the attachment system).
    4. Other option: Talk about feeling and expectations, brings up the idealization (the defense against the attachment wound).

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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.
    - Gaze: arises very intense feelings in childhood sexual abuse: connects to NC.
- 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.
  - T trauma: Safety/Vulnerability and Power/control group are more frequent.
  - Attachment: Responsibility/defectiveness are the most frequent.
  - SRS: Power/Control and connection/belonging are more frequent.
- PC may be unavailable at the beginning (or unbelievable). 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.
  - It is normal to feel guilty…
  - She is alive / I survived / I am alive.
- In sexual abuse, NC of guilt can be very difficult to manage, having to help the person distinguish between what happened and what I am: damaged goods (It's not what happened, it's what I am / It happened to me because of what I am / I am because this happened to me).

93

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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Contents of Workshop

- What is Attachment Trauma:
  - Trauma. Neurobiology of trauma: Behavioral affective (control) systems.
  - Types of trauma according to systems involved.
  - Adults with childhood trauma and attachment issues.
- Clinical assessment of attachment trauma in adults.
- How to work with EMDR with patients that have childhood trauma and attachment issues underlying their present clinical problems.

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Thank you!

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