

# Trauma, attachment and affective behaviour systems: Implications for EMDR therapy

*Why do abused children love their abusers? How does a loving, uncritical mother end up with a domineering and contemptuous son? When might it not be a good idea to begin EMDR therapy at Phase 1? It's all to do with attachment and other affective behaviour systems according to Arun Mansukhani, one of the keynote speakers at this year's Annual Conference in Birmingham*

EMDR therapy, developed by Francine Shapiro since the late 1980s, has proven to be very effective and has helped a large number of patients put an end to their suffering. The way that EMDR has reshaped psychotherapy in the past 30 years will remain Shapiro's enduring legacy. But, as any good therapist appreciates, it is not 'one-size fits all'. This is particularly true when the patient is an adult with severe attachment deficits. For this complex group we need to appreciate the interplay between affective behaviour systems and how this influences their interactions with significant others, crucially with the EMDR therapist. The traumatised adult must be able to tolerate dual focus; able to regulate sufficiently to stay with their disturbing material in the session. This is a big ask. Affective behaviour systems assume control below the level of awareness in severely traumatised people. Helping our traumatised clients to keep one foot here with us and the other in contact with the disturbing memories is, probably, our biggest challenge. But first we should agree on what we

mean when we talk about trauma and affective behaviour systems.

## **What do we mean by trauma?**

In the context of the AIP model, trauma is related to certain life episodes that have not been processed in the ordinary way and are therefore not integrated into the (mainly cortical) narrative and biographic networks. Instead, they are stored (or maybe remain) in different networks, which we can call traumatic networks. These traumatic networks are mainly subcortical and therefore implicit. It's obvious that we are here using the word memory in its widest sense, meaning not only images but also emotions and/or sensations (Shapiro, 2006); indeed, some authors have suggested that we should use alternative terms to accommodate all internal states (González & Mosquera, 2012).

So, why are certain events not processed and integrated into biographic memory networks? The answer is that integration requires homeostasis. Abnormal levels of arousal of the nervous system, either hyper- or



*Arun Mansukhani: "Perhaps the most important aspect is the therapist's attunement and sensitivity"*

hypoactivation, prevent integration. Let's use as an example the response to a threat: if someone with an axe enters a room filled with people, we know exactly what's going to happen. Some bystanders will freeze, some will prepare to fight while others will try to escape. These are the three basic hyperactivation responses of the Defence System (DS), mediated by a sympathetic activation of the Autonomic Nervous System (ANS). If none of these are possible, then the ANS will initiate a parasympathetic (or dorsal vagal) response; the entire body will enter into hypoactivation and, in extremis, will enter the state known as feigned death. It's all about survival and damage reduction: if my body can't escape, my mind will.

Norepinephrine levels rise during the hyperactivation response (Masten *et al.*, 2015). At the same time gamma-amino butyric acid (GABA) – a neurotransmitter involved in affect regulation – will decline (Anderson

et al., 2017). The result is that the prefrontal cortex (PFC) starts to shut down and limbic structures, especially the amygdala and hippocampus (Teicher et al., 2017), are hyperactivated. If these measures are still not effective to deal with the threat, then the limbic structures will start shutting down leaving only the sublimbic structures functioning.

Under any of these circumstances, and due to the shutting down of the PFC, integration of information into the cortical memory networks is impossible. In fact, integration will not take place until optimal levels of arousal/activation are re-established. Until then, recall of any aspect of this memory will again lead to deregulation, preventing post-trauma integration.

The level of arousal associated with the recall of a particular memory gradually reduces in time. When the level is sufficiently low to permit cortical activation during recall once again, the memory of the event is 'transferred' to cortical-biological memory networks. If, however, the arousal due to the recall of the event doesn't erode with time, the 'transfer of memory' will not happen; in this case the PFC remains hypoactive and the limbic system hyperactive. In this state, the person will have some measure of difficulty distinguishing past from present and inner world from external world.

The Window of Tolerance, coined by Dan Siegel, is a useful metaphor to understand this. For each of the three arousal zones, we can describe how the Central Nervous System (CNS) and the Autonomous Nervous System (ANS) will respond (see Figure 1).

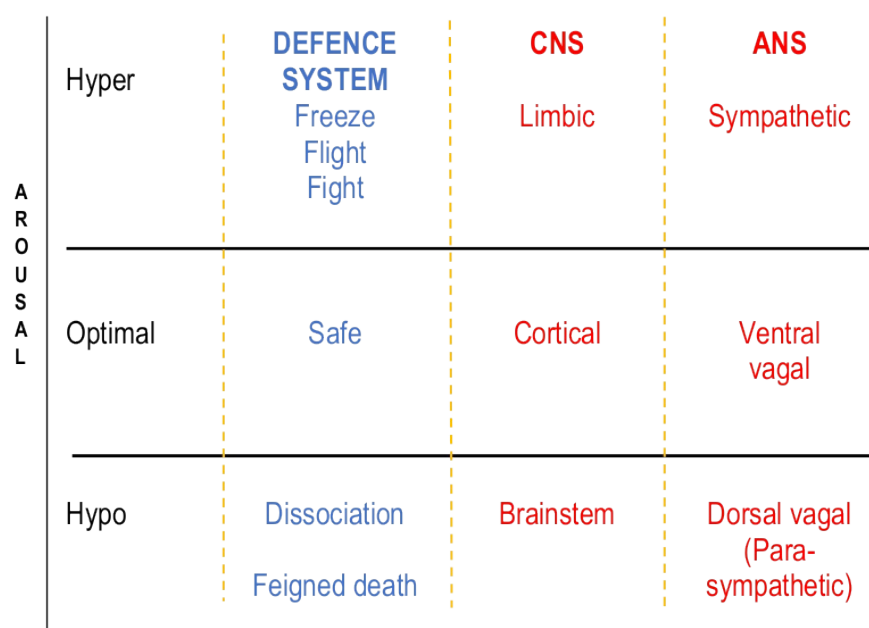


Figure 1: Nervous system response to a threat (Defence System hypo- or hyperactivation)

In threat situations, the whole nervous system gets hyper- or hypoactivated. This is appropriate in response to present, actual threat. But when this occurs as a reaction to past threats – and there is no present threat in the external world – we are talking about a post-traumatic response.

So a post-traumatic response in the context of psychotherapy is a stress reaction produced by the brain and nervous system as a reaction to the activation of dysfunctionally stored memories and internal cues which deregulate one or more of the behaviour control systems (hypo- or hyperactivating them).

### Affective behaviour systems

So far, we have just focussed on the Defence System (DS). But the DS is not the only affective system we have. This leads us to our next question. If the DS is not our only system, can the other behaviour or affective systems be sensitized and traumatized in a similar way? Let's try to answer this question.

Affective or Behaviour Systems regulate flexible goal-oriented responses that serve evolutionary functions (survival or reproduction). They are linked to subcortical and sublimbic structures and the ANS. They are stored in implicit memory networks and have therefore more to do with procedural than declarative memory. They get activated by stress and by external and internal conditioned cues. They tend toward homeostasis (regulation). These on/off systems are present early on in life but gradually develop in a harmonic way so that, by adulthood, they are more sophisticated, differentiated, integrated and under cortical control.

Although there is not complete agreement about how many systems we have, nearly all authors agree that human beings have the following: Defence, Social Ranking (Social Hierarchy), Attachment/Care-giving (considered by some authors as different systems), Exploration, Pleasure/Seeking and Sexual. Of these, Attach-



ment is considered the most important as it has an “organizing effect on the child” (West & Sheldon-Keller, 1995).

### **Attachment/caregiving**

Although attachment has been studied since the 1950s, it is only recently that we have begun to understand it from a trauma perspective. As for the Defence System, the Attachment System (AS) can be in homeostasis, hyperactivated or hypoactivated. And the activation pattern within the CNS and the ANS will also be very similar to that seen in defence: cortical for the CNS and Ventral Vagal for the ANS, meaning optimal arousal; Limbic CNS and Sympathetic ANS, for hyperactivation; Sub-limbic CNS and Dorsal Vagal ANS (parasympathetic) in hypoactivation. When the DS is in homeostasis, the person feels safe; in the same way the person feels connected and secure when the AS is in homeostasis. This is known as a secure response in attachment. But when a person feels stress or fear (of loss or abandonment, for example) the AS will be hyperactivated, leading to behaviours such as ‘attachment cry’ and ‘seeking behaviour’ (proximity to the attachment figure). This hyperactivation of the AS is what we recognize as an anxious ambivalent attachment style (Mikulincer & Shaver, 2008). Just as with defence, if these hyperactivation strategies are not useful, the person will enter into hypoactivation; the behaviours observed now will be avoidance of interpersonal contact and suppression of internal negative feelings. This is what we recognize as avoidant attachment. As in the DS, attachment is hierarchically organ-

ized. The first response to threat results in hyperactivation of the system (the anxious-ambivalent response) and the second response results in hypoactivation (the avoidant response). Again, the AS can be traumatized (read ‘sensitized’) according to life events. As a result of this process the adult develops a main pattern of attachment that is the result either of hyperactivation or hypoactivation of the system.

### **Disorganized attachment**

This, then, is how attachment types are related to arousal. But what about disorganized attachment? Disorganized attachment was initially described by Mary Main through the approach-flight paradox which explains what happens when both defence and attachment systems are activated simultaneously, by the same external stimulus.

Under threat, a child’s DS will become activated. However, when the child’s attachment figure is present, the child’s AS gets activated and this overrides and calms the DS, because the attachment figure makes the child feel secure. But what happens when the same person is the perpetrator of e.g. violence and is also the attachment figure? The same person activates the threat hyper response (flight) and the attachment hyper response (seeking proximity of the attachment figure). This is the paradox described by Main. In human children, the AS is stronger than the DS. So despite being battered or abused by their parents, children will maintain strong ties to them. In a way, the bigger the threat, the more hyperactive the attachment response. In cases where one

parent is abusive but very much engaged with the child, and the other is not abusive but emotionally absent, we see that the child will consider the abusive parent as the main attachment figure. This perfectly explains what is happening in disorganized attachment as described by Main at an affective/behavioural level: both Attachment and Defence Systems become enmeshed due to the attachment figure and the perpetrator being one and the same person.

In fact, if attachment were not a major behaviour system in us and we were like most other animals - let’s say like crocodiles or octopuses - we would have no dependency problems. If I were being abused or ill-treated in a relationship, such treatment would activate my DS and I would simply run away. But in humans we see the opposite, and not just in children. In gender violence, for example, a woman who has been contemplating leaving her abusive partner was close to doing so, becomes less likely to leave him immediately following a renewed attack.

So attachment/caregiving overrides the DS as the primary protector system in humans, even in adults. Let us revisit the example I gave earlier of the three possible reactions of bystanders confronted by a man armed with an axe. If a bystander was with his/her child they might well sacrifice themselves to save the child; the Attachment System could override the Defence System and a fight-flight-freeze response. And this is not limited to parent-child relations: adults can put themselves at risk to help other adults they are close to or to help unrelated children.

► There are other systems, too, that can be deregulated, sensitized and traumatized.

### Social ranking

One of these is the Social Ranking System (SRS), often confused with attachment. (Bullying, for example, has more to do with the SRS than with attachment, although they are quite interrelated, as we shall see.) All social animals have a SRS, and we are the most social of all animals. In humans, as in other species, the SRS is mediated by serotonin levels (Peterson, 2017).

Again, as for the Defence and Attachment systems, the SRS can also be in homeostasis (leading to cooperative behaviour) or be hyperactivated (giving rise to dominance behaviours) or hypoactivated (leading to pleasing and submissive behaviours). The CNS and ANS activation will be very similar to what we have seen in the defence and attachment systems because the 'hardware' - the machinery beneath these various systems - is partly shared.

The AS and SRS evolve closely together. Children's demands outstrip the capacity of their parents to meet them (Trivers, 1974). So, to cope with that demand, and also to control children's behaviour, parents become active social ranking agents. This is particularly true in more developed societies where families tend to be smaller and children spend far less unsupervised time with other children. Because attachment and social ranking systems are partially opposed to each other, certain dysfunctions may arise:

- Children who perceive their parents as weak, tend to hyperactivate their social ranking system, attaining dominating

positions and expressing anger at their parents.

- Such children show Higher Reactive and Displaced Aggressive behaviour to lower stress levels, what is known as "stress-induced displacement aggression" (Card & Dahl, 2011).

- They learn less self-regulation, tend to be more impulsive and less able to tolerate frustration.

- They also have lower self-esteem (Sapolsky, 2017).

As we saw with the DS, enmeshment between the SRS and AS may occur, leading to dependency problems in adult relationships (Mansukhani, 2017).

These three systems have evolved to protect and keep us safe when we are under threat. They are, in fact, based on fear, albeit different types of fear: in the case of the DS it is the fear of being harmed or injured by a predator; in the case of the AS it is the fear of being neglected or abandoned and, for the SRS, it is the fear of being humiliated, isolated or harmed by a group member. Thus it is possible for these three systems to become activated simultaneously and repeatedly. Another common aspect is that all three, in their hyperactive mode, can result in angry and aggressive behaviours. A last aspect to take in account is that they can compensate each other, and frequently do so. For example, a person fearing abandonment (AS) may assume either dominating or submissive behaviour (SRS) in order to maintain interpersonal proximity (Mansukhani, 2017).

We frequently see people whose responses have created problems for them in that they are inappropriate, an over-reaction, an under-reaction or a

failure to respond. In many cases this results from activation of the wrong system.

Ideally, a child will have good enough attachment figures and consequently their behaviour systems differentiate and then integrate under cortical control so that, as adults, they are able to respond in an appropriate and sophisticated way. When this does not occur and there is repeated activation of different systems at the same time with the same stimulus, it leads to these systems not differentiating and becoming enmeshed with each other; hence the aberrations in behaviour.

We can see this with any of the systems mentioned above. We have already seen how the AS and SRS can become enmeshed. Another example is enmeshment of the sexual system or pleasure/seeking systems. In many cases the sexual system has been sensitized and is either chronically hyper- or hypoactivated. It is often used to compensate other systems. We see clear indications of sexual systems enmeshed with attachment or with social ranking systems. Many sexual offences actually have more to do with dominance than with sexual pleasure, and dominance is related to the SRS. The same is true for the pleasure/seeking system; for example hypoactivated in certain depressions or hyperactivated in various addictions (Hoffman & Hase, 2012). The use of EMDR addiction protocols in adult attachment problems responds to this logic.

It is important for clinicians to distinguish between the AS and the SRS. We can imagine the case of a mother that has a reasonably secure attachment style with her child. But as this



► child matures, he starts exhibiting demanding and dominant behaviour towards his mother. If his mother had a very strict and dominating parent she might, in order to avoid being like her parent, avoid exhibiting any corrective behaviour; this mother may well have a tough time dealing with her child's tantrums and plays for dominance. The child can perceive this as submissive behaviour and adopt an even more dominating stance. If this goes on long enough, the attachment relationship between them will start to deteriorate because it is very difficult to treat with love someone who is displaying abusive behaviour towards you. Such parents frequently start exhibiting anxious and/or avoidant behaviour. If at some moment this dyad of mother/son, for example, start therapy, the therapist could well think that the anxious-avoidant traits observed in the attachment figure are the cause of the tantrums in the child. In many cases an EMDR therapist can get lost looking for initial targets of avoidant behaviour and processing them without

managing any improvement. In such cases it's much more useful to work on the child's self-regulation and to teach co-regulation to the parent, as well as parenting skills. It can also be very useful to process the mother's childhood memories with the dominant parent.

### Healthy attachment

Defence and social ranking (evolved from territoriality) are very old systems, perhaps 300 million years old, or more. Attachment, on the other hand, is much more recent. As far as we know, the AS developed when mammals started flourishing, somewhere in the last 65 million years. And the high levels of attachment exhibited by humans and other hominids are even more recent, perhaps just a few million years old. In spite of that, attachment in humans is more important than the other two affective systems, due to the immaturity of our offspring. In fact, as Jeremy Holmes states (2001): it's "the organizing principle around which psychological development takes place". This is due to various factors:

- The AS protects against ACE (Adverse Childhood Experiences), in terms of both prevention and repair. Statistically, children with parents with secure attachment suffer fewer traumatic experiences, both in and outside of family settings.
- The AS creates implicit knowledge of "how to do things with others" (Lyons-Ruth, 1988). Secure attachment in childhood is related to healthy adult relations.
- The AS sets the base for self-regulation, both coregulation and autoregulation. Regulation is the base of a healthy development.
- The AS contributes to self-esteem, self-image and self-compassion. We treat ourselves as others treated us (Zessin et al., 2015).
- The AS mediates mental health and well-being.

A child that grows up in a healthy emotional environment, who enjoys mainly secure attachment relationships, tends to be regulated most of the time and enjoys healthy mental development. This allows all the affective systems to develop, differentiate and integrate under cortical control, resulting in sophisticated adult behaviours. On the other hand, if the child grows up in an environment in which his/her arousal is frequently hyper- or hypoactivated, the affective system responses will be not differentiated and will not be under cortical control. Repeated hyper- or hypoactivation results in narrow windows of arousal and unsophisticated behaviours ensue.

When this absence of regulation has been especially serious, the development of cortical structures is hindered and incomplete, favouring distinct

A R O U S A L	Hyper	DEFENCE SYSTEM Freeze Flight Fight	ATTACHMENT SYSTEM Attachment Cry, Proximity seeking	SOCIAL RANKING SYSTEM Dominant	SEXUAL SYSTEM Hypersexuality
	Optimal	Safe	SECURE	COOPERATIVE	SEXUAL ENGAGEMENT
	Hypo	Dissociation Feigned death	Interpersonal Avoidance Emotional suppression	Pleasing/ submissive	Compulsive sex Hyposexuality

Figure 2: Hyper- or hypoactivation of the various Affective Systems and associated behaviours

ego states and, in extreme cases, dissociative parts (see Figure 2).

### **EMDR and adult attachment**

We should remember some basics about Attachment before considering how to work with it from an EMDR perspective:

- It is an implicit memory system (Amini et al., 1996) which activates under conditions of stress, fear, loss, loneliness, intimacy situations, etc.
- The AS is frequently enmeshed with other Affective Systems. We can see people who tend to respond in intimacy relationships from the Social Ranking System, The Defence System or the Sexual System.
- Some people have an overall attachment pattern, although they frequently exhibit different styles under different circumstances.
- In adults with insecure attachment, we often see people with ambivalent and avoidant features.
- It varies in flexibility-rigidity: people with secure attachment styles find it easier to accommodate to new information than those with insecure attachment styles, who will assimilate all new relational information under old guidelines.
- Except in extreme cases, disorganized attachment is not a fourth category; most adults vary in their level of disorganization.
- In those with insecure styles, the AS activates more frequently and interpersonally. “The insecurely attached project strong negative feelings into their current attachment figures. Unable to view themselves as deserving and the others as welcoming, once these feeling states are projec-

ted in current relationships they have a very great likelihood of evoking corresponding feelings in other people [...] in a self-fulfilling way” (Kobak & Sceery, 1988)

- When the patterns are very dysfunctional, they tend to result in repetitive negative relationships that mirror the person’s initial attachment problems: “In insecure attachment, the individual’s relational strategies are dominated by set, clearly repetitive patterns of attachment” (West and Sheldon-Keller, 1994).

### **Standard protocol**

The Standard EMDR Protocol (8 stages, 3 prongs) is a fabulous tool for intervention. But it requires, as Farrell and Laliotis (2017) have shown, clients who can: access their experience and their response to it, maintain dual attention, tolerate distress without becoming overwhelmed or shutting down, shift from one state to another (distress to calm and vice versa), observe and reflect about the experience instead of being completely absorbed by it, access positive experiences and self-soothe between sessions.

Clients with attachment issues frequently will not meet most of the above criteria, requiring EMDR Phase 2 interventions before we can start processing directly past memories. Plus, these clients have certain problems that make Phase 1 of EMDR difficult, such as:

- They often have no explicit memories of their childhood attachment experience, or these are inaccurate. In fact, the more severe the attachment deficit in childhood, the less aware the adult patient is about it. This is known as “attach-

ment blindness” (Siegel, 2012).

- History taking is deregulating and evocative (Steele *et al.*, 2016). Patients will destabilize when they activate their AS. They enter in either hyper (and get locked out of normal arousal) or hypo (and get shut down).
- They may have a great fear of destabilizing, not allowing themselves to come in contact with any inner or outer stimulus that could connect them with emotion and/or feeling. This is what we call the ‘window of control’. It is narrower than the optimal arousal zone and it confines the patient within it. Therapists often confuse this with dissociation-hypoactivation but they are different states and require different therapeutic approaches.
- Problems with recall and connection due to dissociation or partial dissociative features: avoidance, emotional suppression, semantic and/or episodic memory dissociation, BASK dissociation (Braun, 1988), etc. All the above make it impossible to start our intervention from Phase 1. So, what do we do when we can’t start from Phase 1? We do the next best thing and start from Phase 2.

### **Phase 2: The therapeutic relationship**

Phase 2 becomes the first phase in EMDR treatment with complex attachment patients. Attachment has to do with intimacy and therapy is “an

in-vitro experiment in intimacy” (Holmes, 2012). We therefore have to be especially careful with the therapeutic relationship. Patients with childhood attachment issues easily activate their (damaged) AS in therapy. We have to remember that they have low self-regula-



tion and/or extreme control (sometimes both). Due to the nature of their problems, they are also very challenging at an interpersonal level. They will show positive and negative transference. In more difficult cases, we could have serious enactments of their past in therapy (Schoore, 2015). If therapist and patient manage to develop an adult relationship in therapy this will help the patient develop his 'inner adult', a concept we work on more with each therapy session.

At the same time, therapists too have their Attachment System which can also become activated. Frequently, the worst enactments have to do with issues from the patient's past that somehow drag the therapist into a confrontation that activates scenarios from his/her own past (countertransference). So, the therapist should try to:

- Be sure that the past that is being recreated is not his/her own but the patient's; have developed an inner adult.
- have worked on his/her attachment history and have an Earned Secure Attachment (Main & Goldwyn, 1984; Hess, 2008).
- Be a Safe Base for the patient to explore his/her insecurity (Johnson, 2016); be able to provide a safe therapeutic setting for the patient that is predictable and has clear limits.
- Be an interactive coregulator, with the capacity of being in relational mindfulness.
- Enter (and therefore validate) the client's worldview before challenging it. This implies understanding (the function) and respecting bonding patterns and 'parts'.
- Understand the importance of enactments: they mirror a pa-

tient's attachment problems as a child. Handled correctly, they can be a powerful corrective experience for the patient. Often, they mark the beginning of therapeutic change and the first chance the client has of experiencing a healthy relationship with an adult.

## Phase 2: Resourcing

In general terms, we could consider that the objectives of Phase 2 are to achieve:

- Stability (symptom reduction); this is true for all cases except for certain patients with a marked avoidant pattern whose pathology is precisely their extreme stability.
- Security, in the present and in sessions. We have to be sure that the patient's present is safe and that we can keep them connected / bring them back to the present in sessions.
- An understanding of pathology and treatment from an EMDR perspective. Also, how the patient's particular life events and attachment history has led them to their current situation. This frequently is not attainable in this initial stage of therapy and will happen gradually during the second phase (in attachment cases, Phase 1: history taking).
- Being able to connect without overwhelming or numbing (Solomon, 2016).

But these objectives are seldom met completely in complex cases. In some cases, this is because patients are destabilized and highly symptomatic when they arrive. In other cases, they start destabilizing when they start talking about their past. There is yet a third group of patients who are extremely stable and disconnected. Beneath this appearance, there is a great fear of

destabilizing so they require a lot of Phase 2 interventions. Not only is Phase 2 the initial phase, in the most complex cases it overlaps with the other phases of therapy.

We can divide the stabilization intervention in three large categories:

- Individual external: self-care habits such as sleeping, eating, resting, sports, etc; energetic level regulation, pleasurable activities (hedonic, eudemonic and achieved goals), reduction of toxic habits and addictions (TV, alcohol, substances, etc) and distinguishing safe from dangerous activities, people or environments.
- Individual internal: Safe/Calm place, Resource installation, Self-soothing techniques, positive future templates, self-understanding and self-compassion, inner child, inner adult, etc.
- Couples: When we are working with couples, the ongoing conflict is one of the main causes of destabilization during therapy. Phase 2 techniques with couples could therefore entail conflict reduction, mutual coregulation, positive activities and positive interaction, healthy limits and all the addiction protocols adjusted to interpersonal dependency (very useful with toxic and dependent relationships).

## Phase 1: History taking

Once certain levels of stabilization and security have been attained, we can begin Phase 1. In these patients, it takes the form of a co-creation of life history. Frequently this is done from present to past, starting with present interpersonal conflicts and tracing them back to childhood relationships.

Most of the attachment

▶ trauma memories won't appear until the person activates his/her AS. Before processing these memories, they have to be integrated into a life history. This has usually not happened because the patient has felt overwhelmed when thinking about them and has therefore avoided them, activating all their defence mechanisms. To avoid this, and to facilitate processing, we use various techniques such as staying in dual focus (letting the person feel emotions that are coming up and just being able to stay with them until they start losing intensity), short or slow BS, tactile BS while the person is talking, partial processing (using BS with dual focus on small bits of memory or feeling/emotion) and the CIPOS technique (Knipe, 2009). It is very important to understand that in EMDR, dual focus is just as important, possibly even more important, than BS. Without dual focus, processing of traumatic memories is not possible. And dual focus, from an arousal perspective, occurs at the edges of the window or tolerance, when the patient has one foot here (cortical) and the other in contact with the disturbing memories (hyper- or hypoactivation) (see Figure 3).

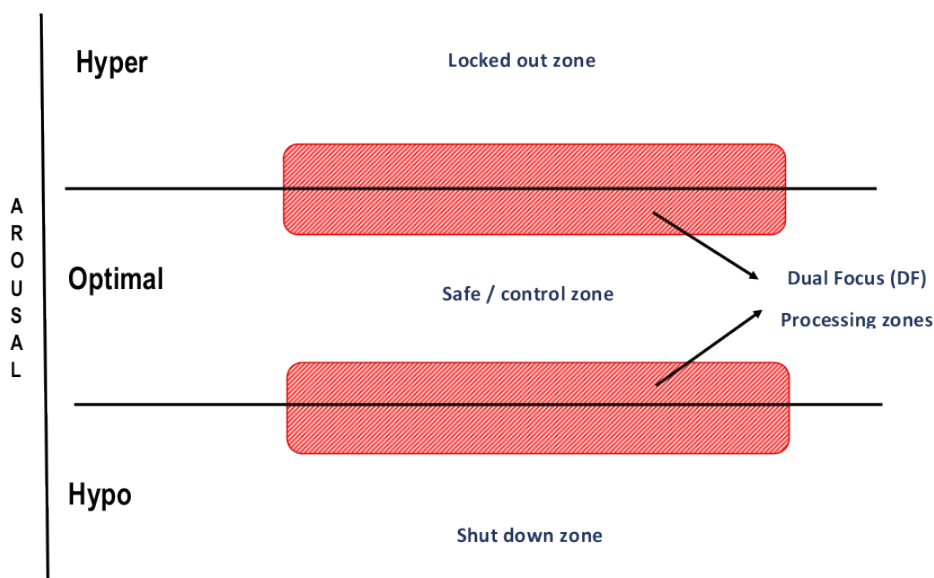


Figure 3: Dual Focus and processing, in relation to level of arousal

increases the likelihood that they are able to make the connection between their attachment problems and their current issues. At the same time, it's important that they are able to regulate following exposure to manageable bits of disturbance. This will gradually allow us to come closer to standard processing and understand the rhythm the patient requires. It is very important that patients manage to be regulated and calm at the end of each session, widening their Window of Tolerance, making them confident in the technique and the therapist, helping them achieve insights and feel secure and in overall control.

### Phases 3 to 6: Targets

Unlike in simpler cases, targets for this patient group are rarely 'close to the surface'. Targets tend to appear gradually as narration activates the AS. So we have to work towards the emergence of targets. These will normally appear in reverse hierarchical and temporal order, the most recent and less important ones appearing first. Frequently, only after working

with present and minor targets, encouraging the Window of Tolerance to gradually widen, will the deeper rooted, older and more pathological situations emerge.

Initially it may be difficult to get complete targets (due to overwhelm or disconnection) so we have to use partial processing: using two modalities (sensory, emotional or cognitive) and short saccades to integrate and desensitize them (Shapiro, 1995, 2001; Gomez, 2013). This is also useful when the patient gets blocked during processing. Sometimes, something as simple as changing the speed of the stimulation can be very helpful. The use of EMD in initial stages is helpful. Also, techniques designed to overtax the working memory have proved to be very useful in these cases.

### Phases 3 to 6: Images

We can work with many types of image in attachment. They may be specific images related to particular situations, just as in standard processing, but also:

- Symbolic images: mother's



▶ face, back, etc. Such targets don't represent particular moments but general aspects of the pathological relationship with the attachment figures, etc. They are frequently useful to elicit attachment-related negative cognitions (i.e. "What words come to you as you see the image of your mother's back now?").

- Projections: own or other children, movies, pets, etc.
- Imagine how... (for situations that occurred very early in life). Frequently these situations will have to be processed twice, once from an adult perspective and a second time from a child perspective.
- Scenarios (recurrent situations) and nodal memories (Holmes, 2001), related to more than one memory network (and therefore different cognitions). These types of situations will require the installation of different PCs, related to different systems.

### Phases 3 to 6: Cognitions

Due to the nature of intra-familial trauma, the same situation may have provoked activation of different Affective or Behaviour Systems. This will usually result in identification of more than one type of Negative Cognition (NC). So we can install different Positive Cognitions (PC) for the same target (about being safe, then guilt and then about the self, for example).

Responsibility/defectiveness cognitions are the most commonly found in attachment. The cognitions concerning Safety/Vulnerability and Power/Control are more common in DS trauma. The NC can be a useful way to distinguish if we are in attachment or trauma territory. If the same situation

is related to both types of NC, we may have to decide on the order of processing. If there is a strong inner adult, normally we would process first the defence trauma. If this is not the case, we have to work first with the inner world and attachment traumas before being able to process acute trauma.

Another difference with this patient group is that PCs are often unavailable at the beginning of the processing (or maybe too unbelievable). In such cases, we can use progressive installation of the PC, starting from PCs that are easier to believe and, as we manage to install them with VOC7, progress to deeper PCs that are more related to the self. For example:

- it's over / it's over and I am safe now / I learnt / I am free of guilt.
- I am learning that everybody makes mistake / Everybody deserves to be loved / I am learning to be loved / I deserve to be loved.

In our experience, it is better to end processing with a VOC of 7 than with a deeper PC that never reaches VOC7.

### In the service of dual focus

These suggestions should not be seen as alternatives to the Standard Protocol but as modifications aimed at bringing the client closer to being regulated enough and, at the same time, sufficiently in touch with the events of his/her life history to process them. As I stated previously, DF is as important or more than BS in EMDR processing. In fact, what hinders or prevents processing is the client's difficulty to stay in dual focus. This is even more true, as we have discussed, when attachment is emmeshed with

other affective and behavioural systems.

Perhaps the most important aspect is the therapist's sensitivity and attunement, informing them, moment by moment, of what manageable bits of disturbance the client is ready to be exposed to. This gradual approach widens slowly the patients window of tolerance. This, in turn, increases the client's reflective capacity (necessary for integration) and makes the client feel safer with the therapist and more confident with the method. And all this brings the client closer to the possibility of completing processing with the Standard Protocol. Perhaps the most useful skills that EMDR therapists can learn are aimed at helping the client stay in dual focus while processing difficult childhood memories. I hope this article offers some simple steps in that direction.

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