ESSENTIAL THERAPY TRAINING

A Training Company for Therapists run by Therapists

Working with clients with Interpersonal Dependency and Pathological Bonding Patterns (ID-PBP)

16th September 2021

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Slides can be downloaded, as well as other documents, from:

www.arunmansukhani.com/documentos

They presenter's work. Please reference it if used. Thank you.

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Program

- ID-PVP as a clinical and social problem.
- Human Sociability and brain development.
- Action Systems.
- Interpersonal dependency patterns and strategies in adults
- Intervention with clients with ID-PBP

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Frequently overlooked cases

People that exhibit egosintonic PBP.

People whose PBP is masked by a DSM diagnosis

People who present symptoms only in when in couple and are stable when not in a relationship.

People who exhibit problems only in certain types of couples. Frequently have chosen compatible PBP types.

The avoidant types.

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ID-PBP as a clinical and social problem

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

Underlying feature or co-morbid in many emotional and mental disorders. Related to all five major symptoms clusters in psycho-emotional disorders (S-Seglert, 2006).

cPTSD: Pervasive difficulties in 3 areas: (1) self organization, (2) affect regulation and (3) relational security. ID-PBP related to all 3.

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

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ID-PBP as a clinical and social problem

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

Underlying feature or co-morbid in many emotional and mental disorders. Related to all five major symptoms clusters in psycho-emotional disorders (S-Seglert, 2006).

cPTSD: Pervasive difficulties in 3 areas: (1) self organization, (2) affect regulation and (3) relational security. ID-PBP related to all 3.

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

Infidelity…

-First cause of relationship breakup (Medina, Colin and Martínez 2013).

-Related to abuse, violence and murder (Tolosa 2016, Vera 2015).

-Related to depression and anxiety (Cano y Leary 2000).

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We are highly dependent

We are the most social species on the planet.

Our sociability is based on emotions (empathic and psychopatic).

Emotions are closely related to brain development and maturation

Interpersonal aspect is the most important in trauma.

Strongly related to beliefs about the world, others and myself.

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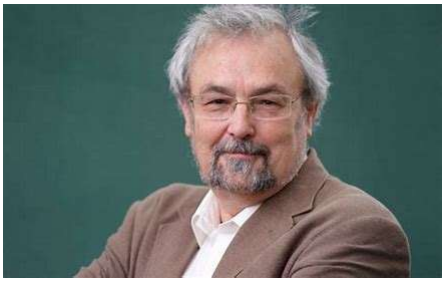
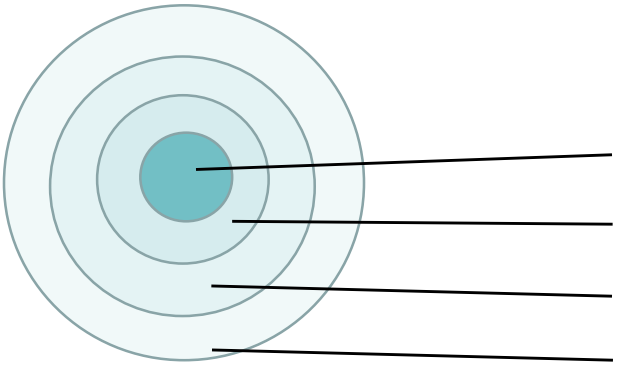
Intimacy levels

(Dunbar numberr = 150)





Intimate relations (3-5)

Close relations (10)

Frequent relations (35)

Social relations (100)

Ignacio Tamarit, José A. Cuesta, Robin I. M. Dunbar, y Angel Sánchez, 2018: Cognitive resource allocation determines the organization of personal networks. PNAS

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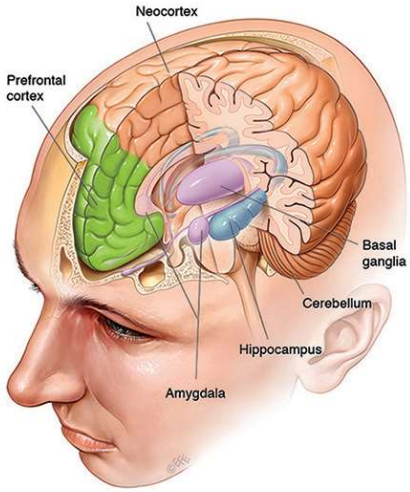

ACE affect brain structures

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

Martin Teicher 2017

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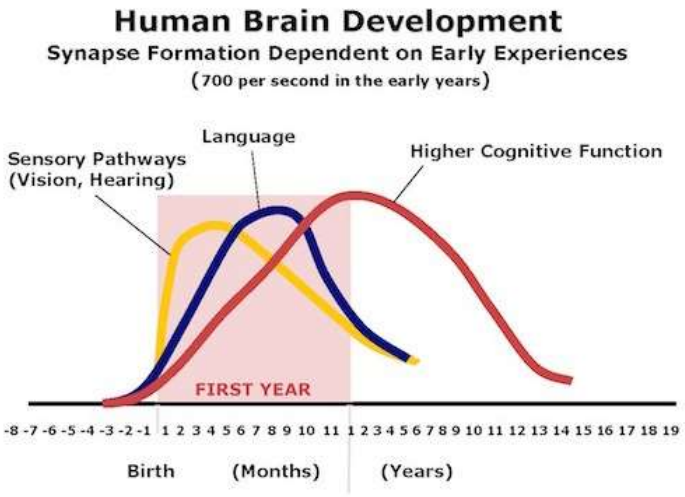

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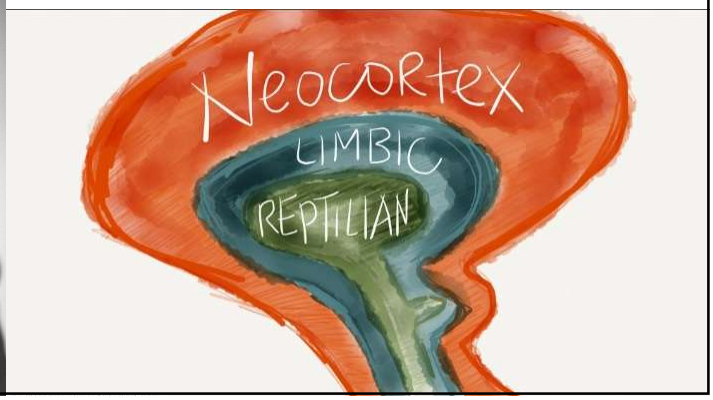
Paul Broca
James Papez

Paul D McLean



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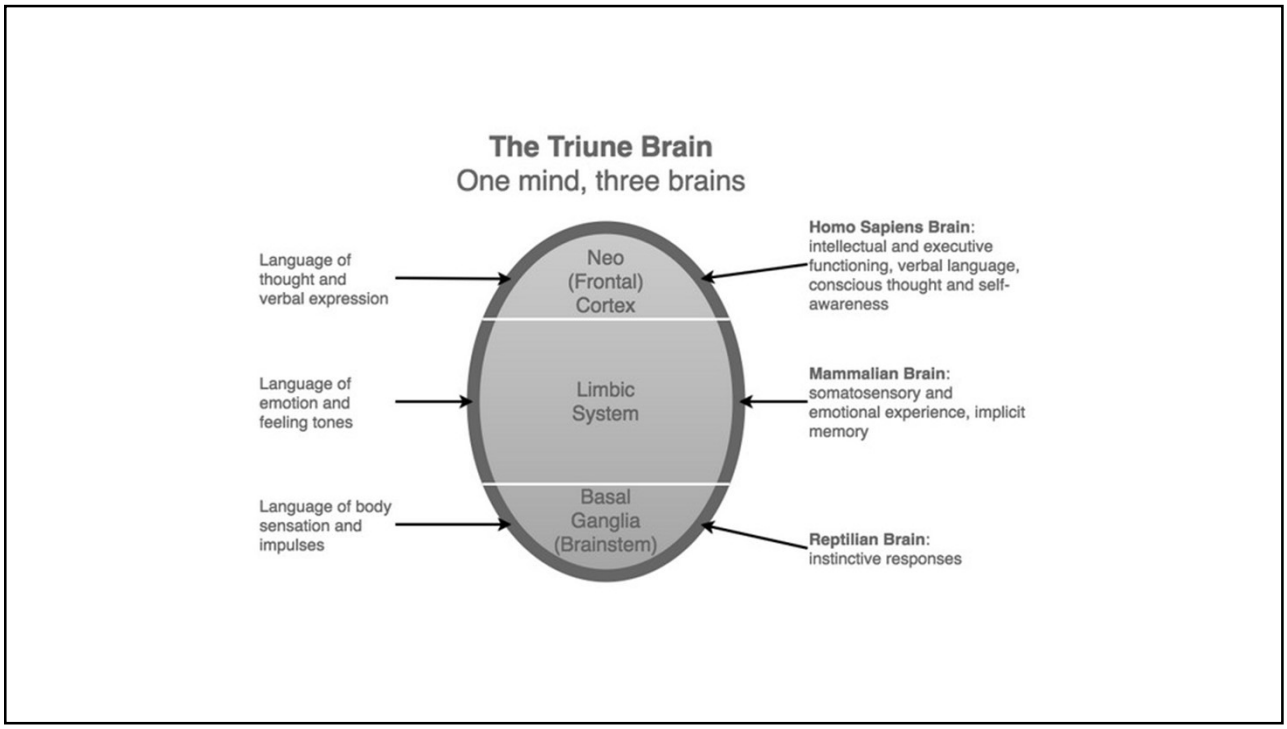
The Triune Brain
One mind, three brains
Language of thought and verbal expression
Neo (Frontal) Cortex
Homo Sapiens Brain: intellectual and executive functioning, verbal language, conscious thought and self-awareness
Language of emotion and feeling tones
Limbic System
Mammalian Brain: somatosensory and emotional experience, implicit memory
Language of body sensation and impulses
Basal Ganglia (Brainstem)
Reptilian Brain: instinctive responses

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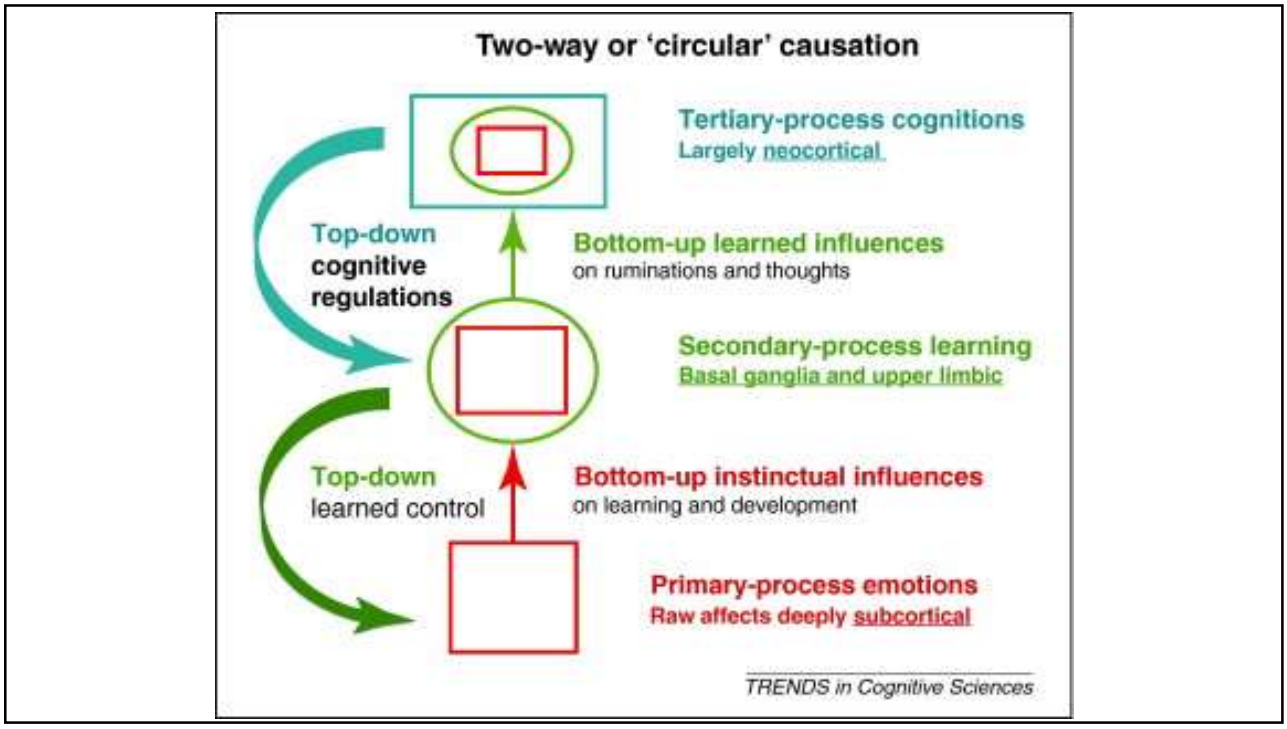
Two-way or 'circular' causation
Tertiary-process cognitions
Largely neocortical
Top-down cognitive regulations
Bottom-up learned influences
on ruminations and thoughts
Secondary-process learning
Basal ganglia and upper limbic
Top-down learned control
Bottom-up instinctual influences
on learning and development
Primary-process emotions
Raw affects deeply subcortical
TRENDS in Cognitive Sciences

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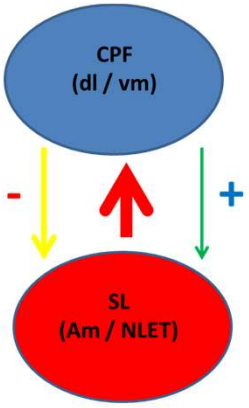

Adaptado de LeDoux (1999) y Teicher (2017)

- Loss of context information
- Problems in inhibiting (behaviours, memories, etc).
- Difficulties in up down inhibition of the amygdala: difficulties in emotional regulation.
- Dificulties with working memory and long term memory integration.

Thayer 2007, Bar 2009,

Preston 2013, Liberzon 2016

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Control – Behavioral – Motivational – Action – Affective SYSTEMS

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.

- Innate neural organizations (Steele 2016). They function as "automatic protocols" (*Bargh 2018)* that get activated and tend to homeostasis (*Sapolsky 2017*).
- Universal and linked to survival/reproduction through "emotional behaviours" (non volitive) (Panksepp 2012). Linked to Implicit memory.
- Flexible goal-oriented responses (*Bowlby 1969)*: Goals are fixed, behaviours are acquired/modified through learning. They overlap and can over-compensate.
- In childhood they function as on/off (binary), gradually developing in the adult into sophisticated, differentiated, integrated and under cortical control responses. Under stress, they go back to binary functioning.

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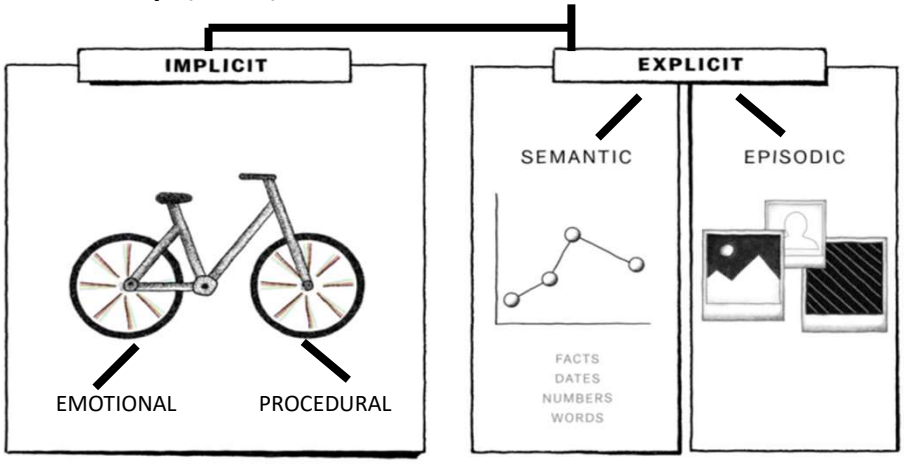
Sensory Memory (raw) STM **LTM**



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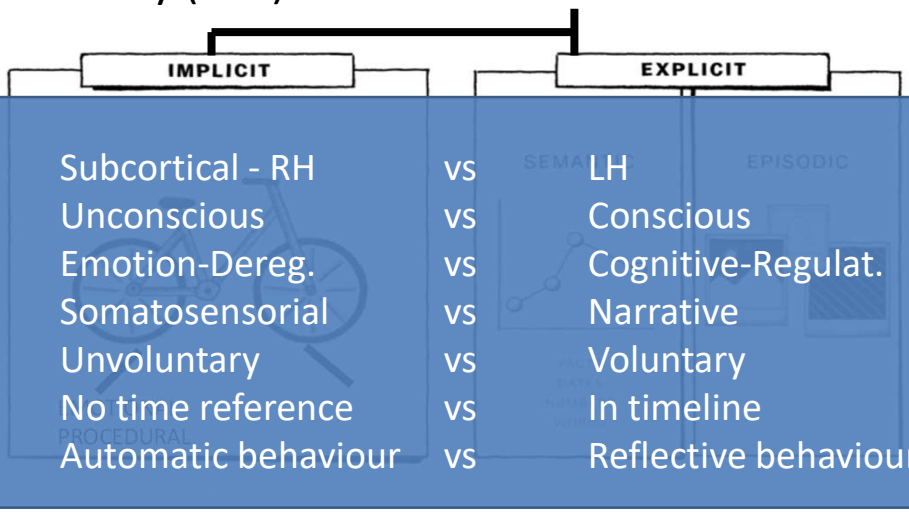
Sensory Memory (raw) STM **LTM**



Subcortical - RH	vs	LH
Unconscious	vs	Conscious
Emotion-Dereg.	vs	Cognitive-Regulat.
Somatosensorial	vs	Narrative
Unvoluntary	vs	Voluntary
No time reference	vs	In timeline
Automatic behaviour	vs	Reflective behaviour

Activation/Emotional state (Container)

Thinking (Content)

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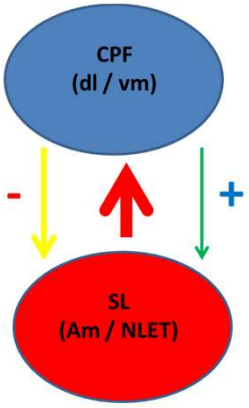

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Thayer 2007, Bar 2009,

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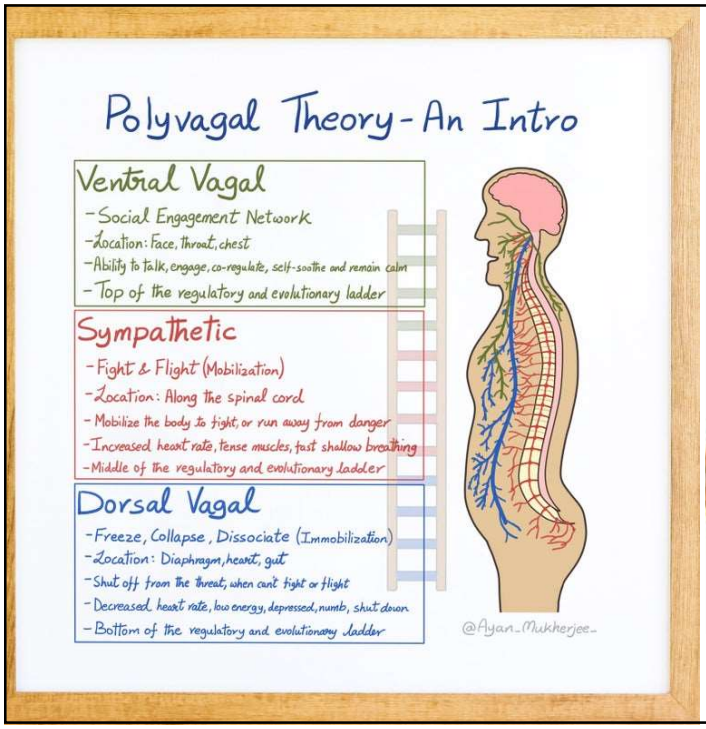

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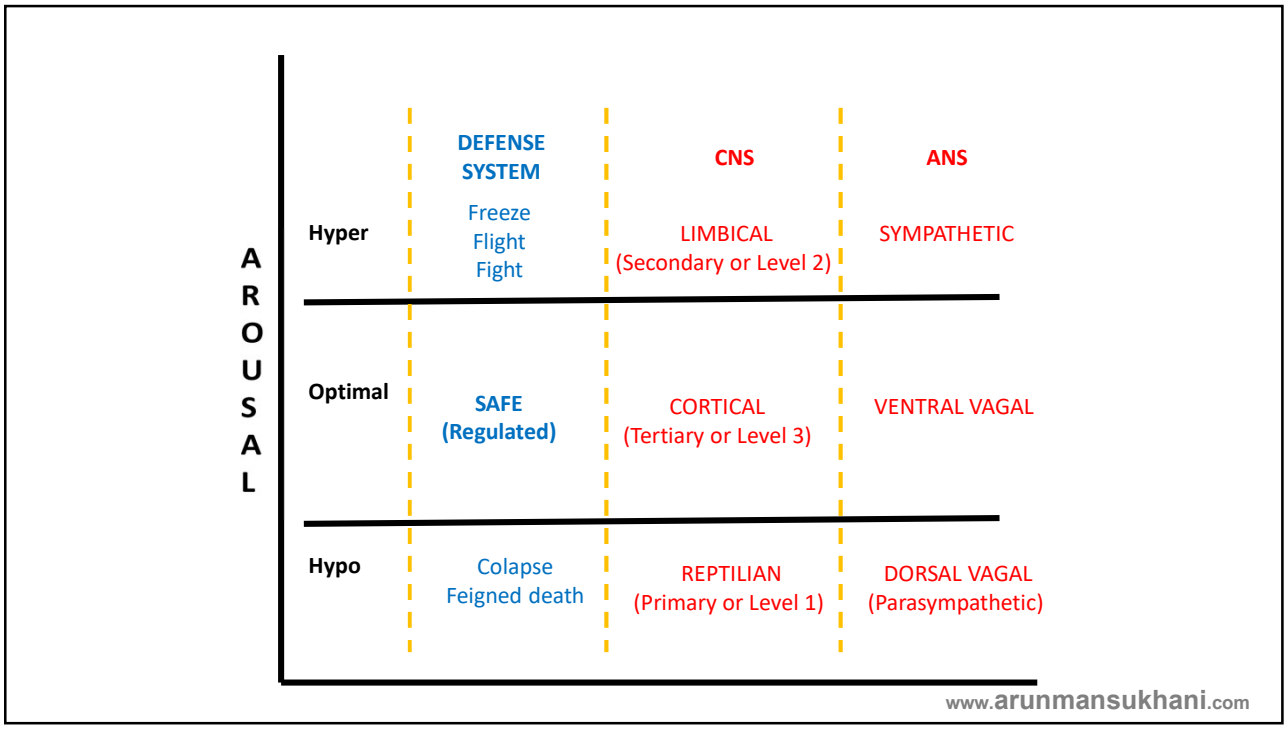
AROUSAL
DEFENSE SYSTEM
CNS
ANS
Hyper
Freeze
Flight
Fight
LIMBICAL
(Secondary or Level 2)
SYMPATHETIC
Optimal
SAFE
(Regulated)
CORTICAL
(Tertiary or Level 3)
VENTRAL VAGAL
Hypo
Colapse
Feigned death
REPTILIAN
(Primary or Level 1)
DORSAL VAGAL
(Parasympathetic)
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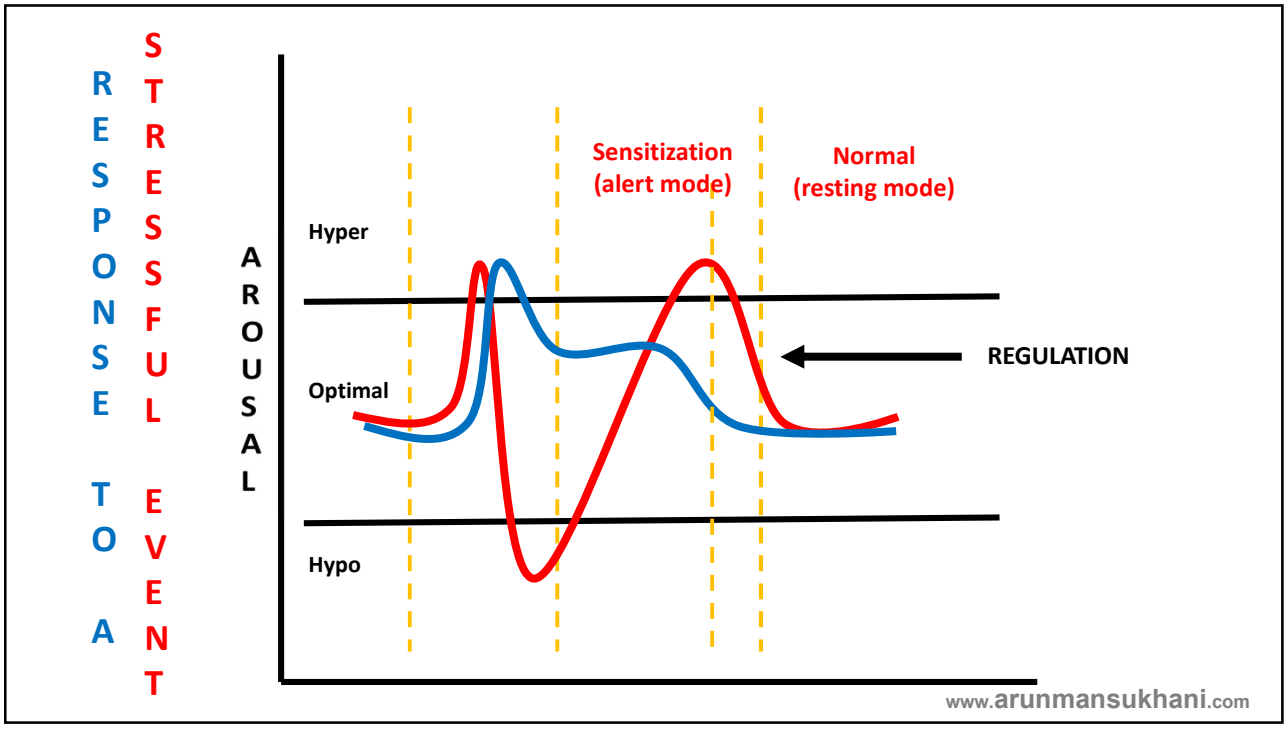
RESPONSE TO A
STRESSFUL EVENT
AROUSAL
Sensitization
(alert mode)
Normal
(resting mode)
Hyper
Optimal
Hypo
REGULATION
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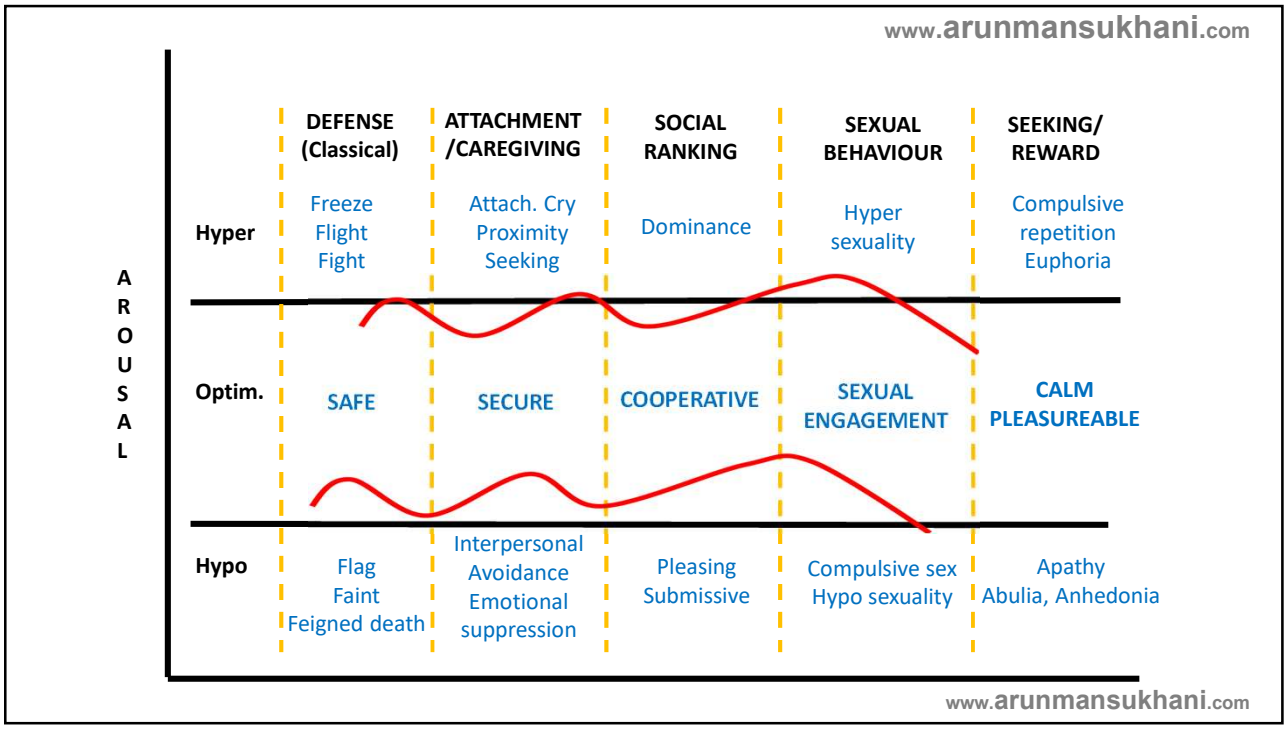

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Why is

ATTACHMENT

So important ?

It's "the organizing principle around which psychological development takes place". **Holmes 2001**. "It's the key system in the development […] has an organizing effect on the child". **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: ↑Oxytocin, ↓Central Amygdala (fear and anxiety), inducing a calm response (ventral vagal).

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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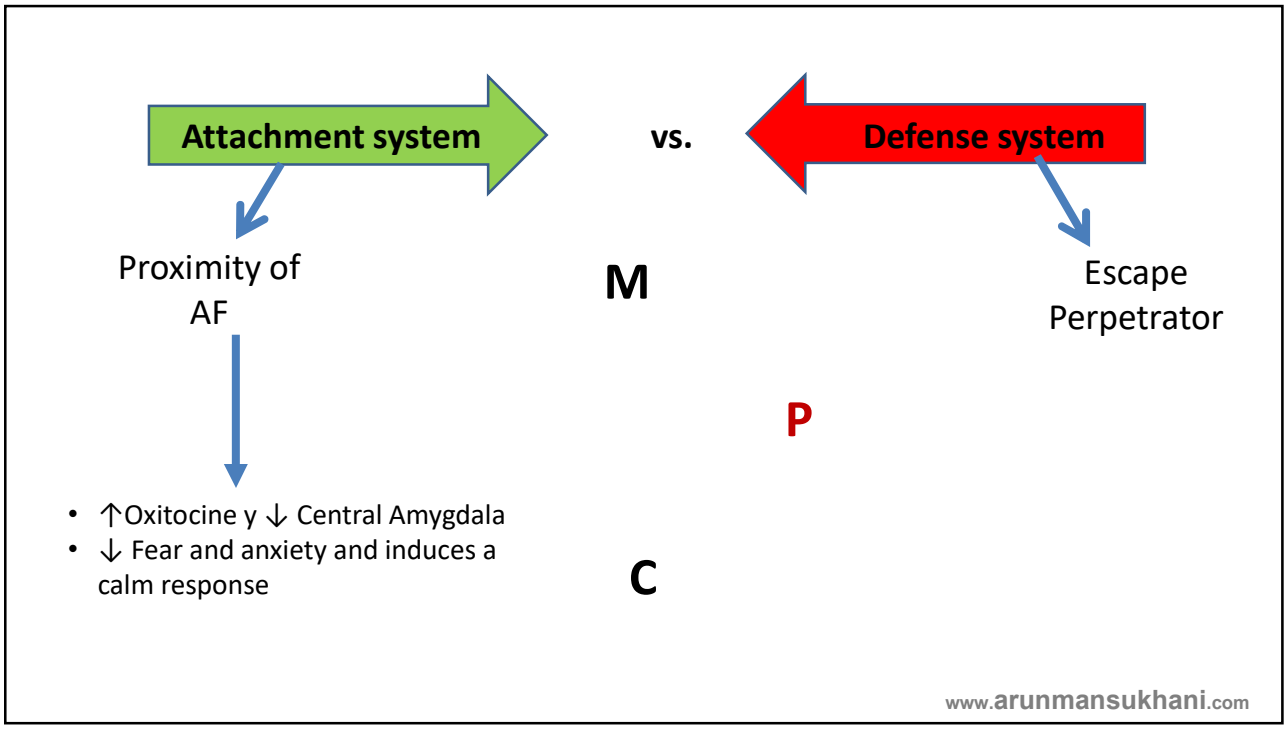

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Watch out for popular versión of attachment theory

- Maternocentric vision.
- Exclusive parental model: guilt and anxiety.
- Helicopter parents: mistakes anxious strategies with secure strategies
- Not much attention on autonomy.
- Don't pay attention to other systems.
- Doesn't take in account conflictive nature of relationships.
- Doesn't take in account rupture/reparation.
- Justification of present difficulties, not asuming personal capacity of change.

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A few words about Social Ranking System

- Present in Social animals. Related to Sexual System. Correlates with cortex size (vmPFC, orbital PFC) and amygdala (Sapolsky 2017). Regulated by serotonin (Peterson 2018), testorterone (Panksepp 2012) and oxytocin.
- Intertwined frequently with attachment. Parent-offspring conflict theory: Children's demands vs parent's output (Trivers 1974). Parents are main Social Ranking Agents, forcing children to submissive or dominant positions: when children perceive "weak" parents.
  - Hyper activation without regulation. Higher anxiety levels, less self-regulation, more impulsive behaviors (Peterson 2018).
  - Regulation through Reactive and Displaced aggressive behavior ("stress induced displacement aggression", Card & Dahl 2011).
  - Anger at parents. Feedback loop with attachment.

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A few more words about Social Ranking System

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).

Individuals that perceive themselves as los SES status have lower Self-concept (value and agency) and have more negative emotions.

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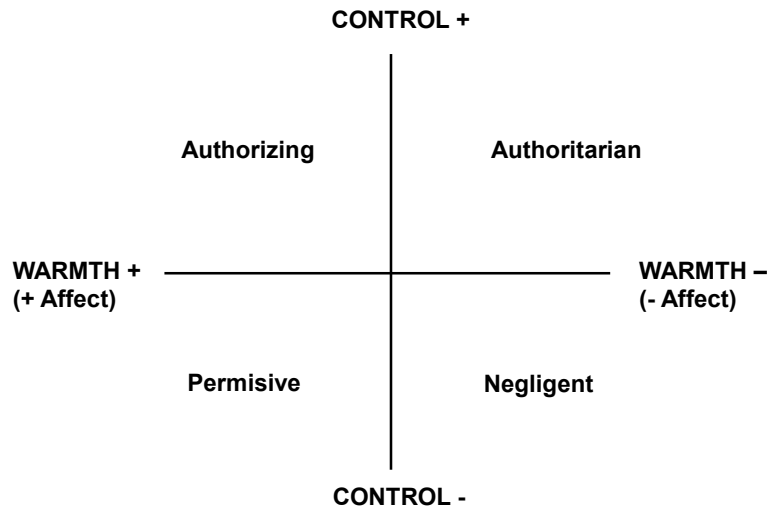
Schaeffer 1959; Baumrind 196; Maccoby y Martin 1960



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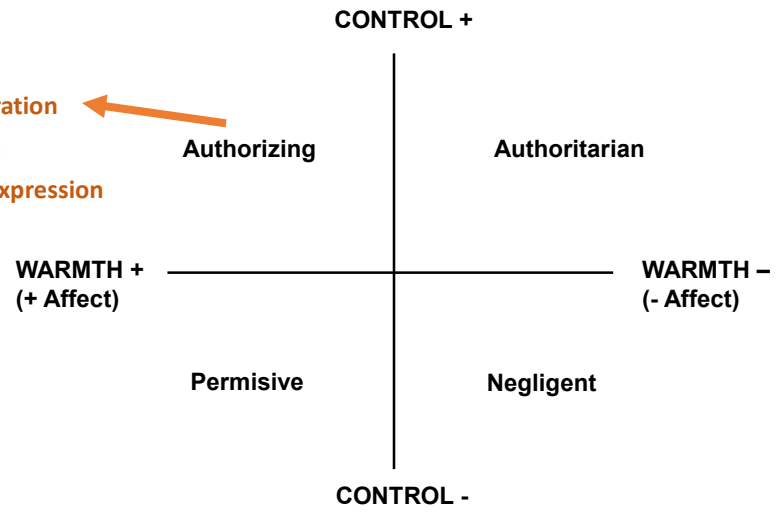
Schaeffer 1959; Baumrind 196; Maccoby y Martin 1960

Empathy
Security
Tolerating frustration
Regulación
Correct emotional expression



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Sexual Behaviour System

- Enhances reproductive success (Birnbaum 2006). Testosterone, Estrogens, Progesterone. Oxytocin and Vasopressin.
- Works closely with attachment and social ranking. Should be differentiated and integrated in adults.
- Sexual trauma from AF disorganizes this system, but not only.

Seeking / Reward System

- Dopamine. Induces a state of excitement, curiosity, anticipatory eagerness.
- Homeostatic imbalances in other systems and negative affective states (inc. fear) de-regulate SRS (Panksepp 2012): Compensates trauma.
- Linked to addictive/compulsive states (hyper) and despair/learned helplessness (hypo). Makes small stimuli rewarding.
- Problems with self-care in hypo and hyper states.

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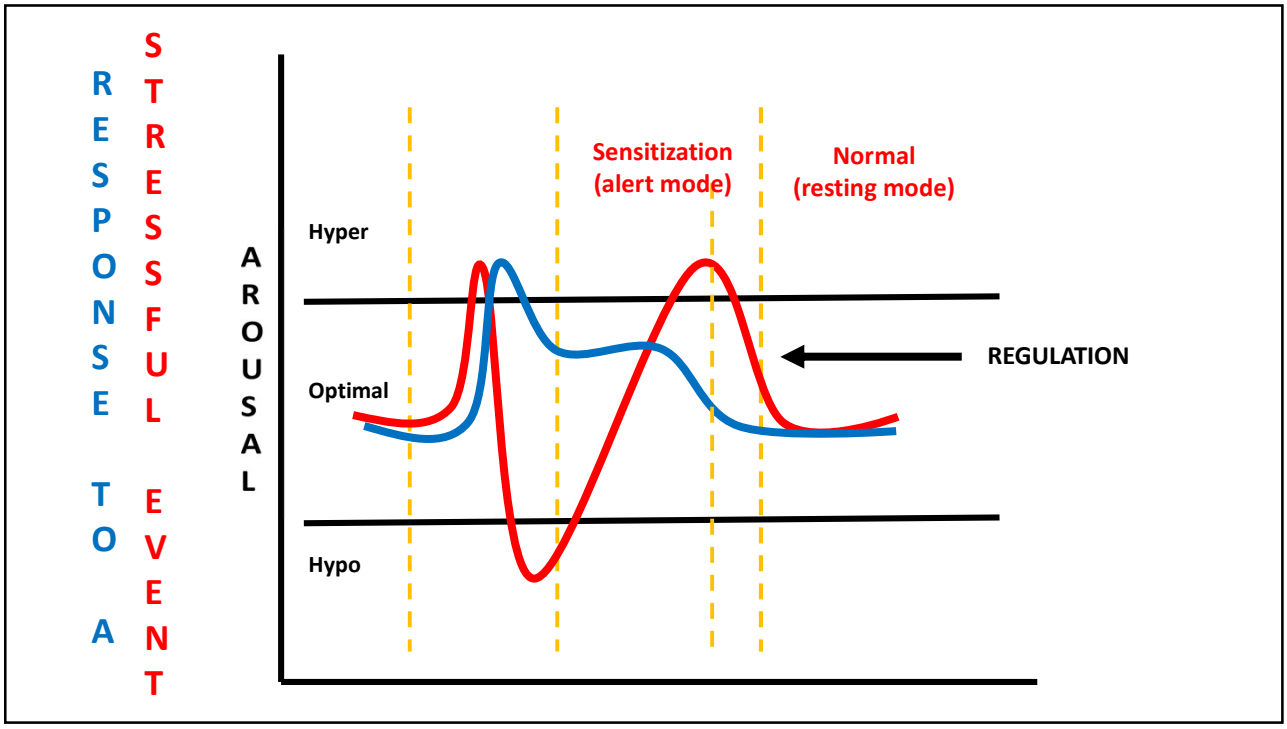

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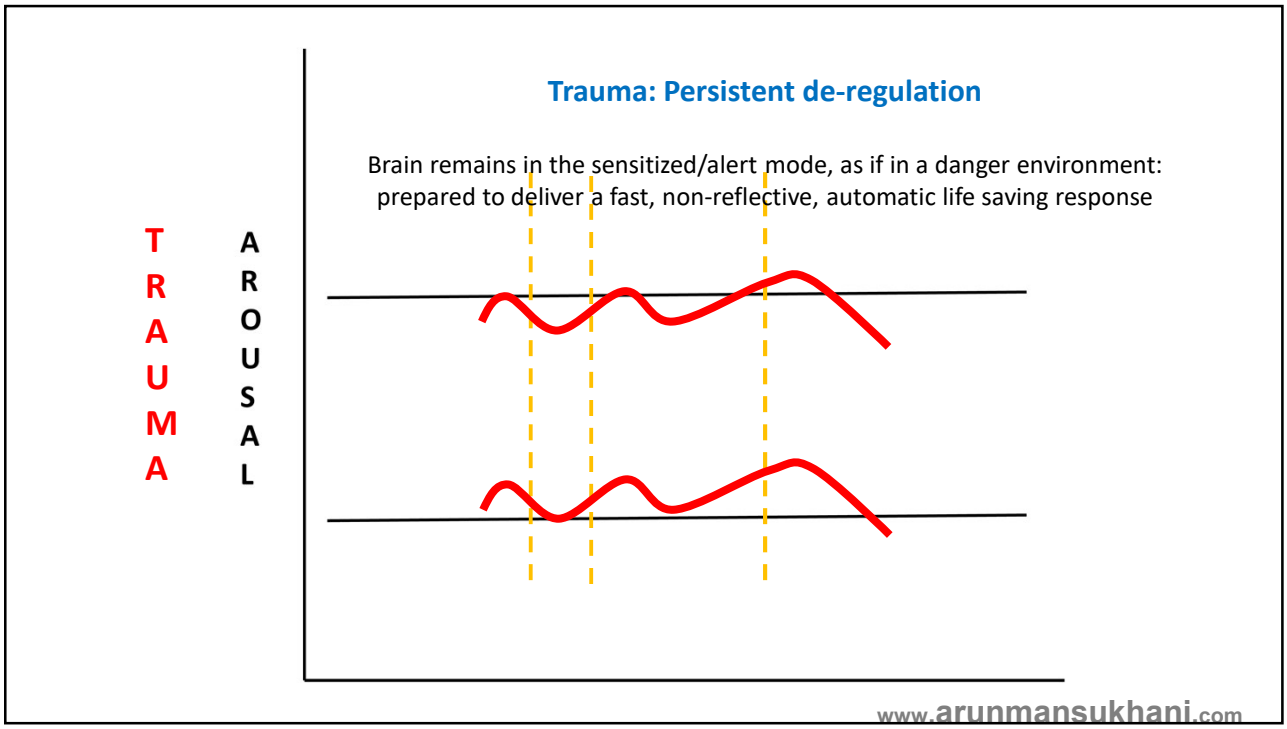
Trauma: Persistent de-regulation
Brain remains in the sensitized/alert mode, as if in a danger environment:
prepared to deliver a fast, non-reflective, automatic life saving response
TRAUMA
AROUSAL
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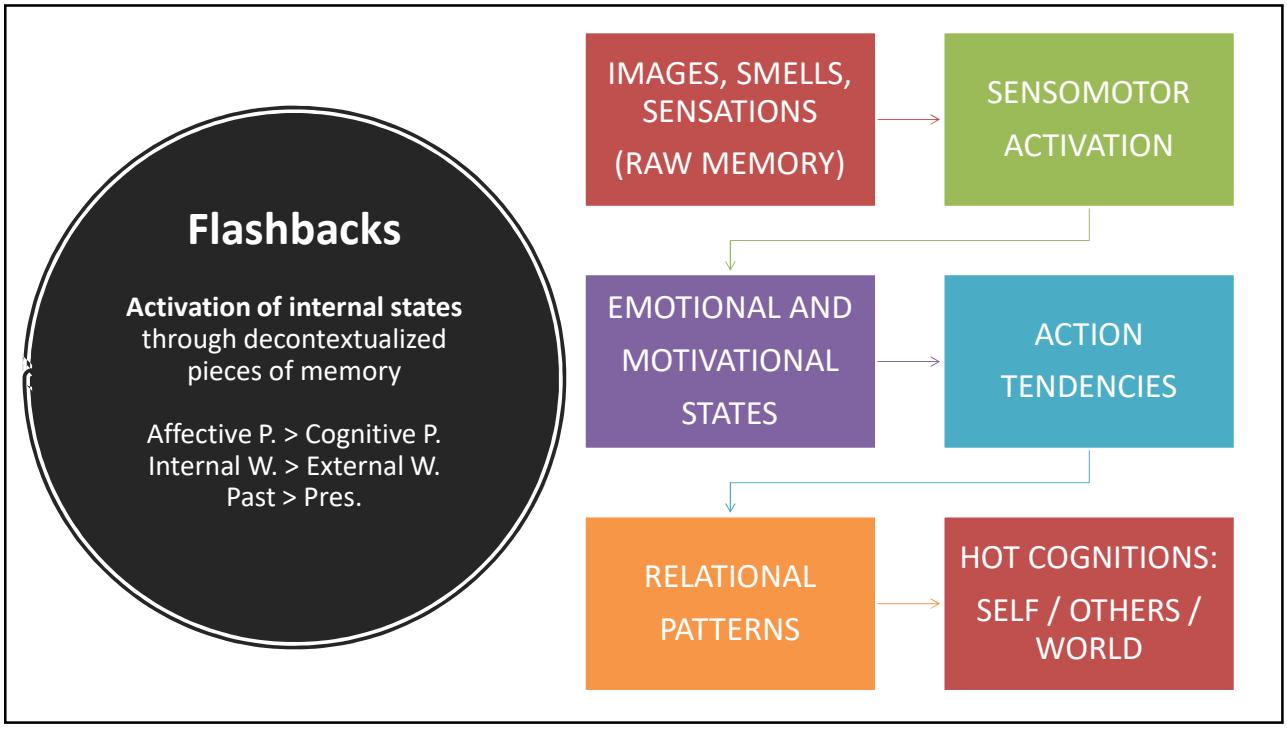
Flashbacks
Activation of internal states through decontextualized pieces of memory
Affective P. > Cognitive P.
Internal W. > External W.
Past > Pres.
IMAGES, SMELLS, SENSATIONS (RAW MEMORY)
SENSOMOTOR ACTIVATION
EMOTIONAL AND MOTIVATIONAL STATES
ACTION TENDENCIES
RELATIONAL PATTERNS
HOT COGNITIONS: SELF / OTHERS / WORLD

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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 (flashbacks).

Implicit traumatic and non-traumatic memories are the core of psychopathology.

Hofmann and Hase 2012.

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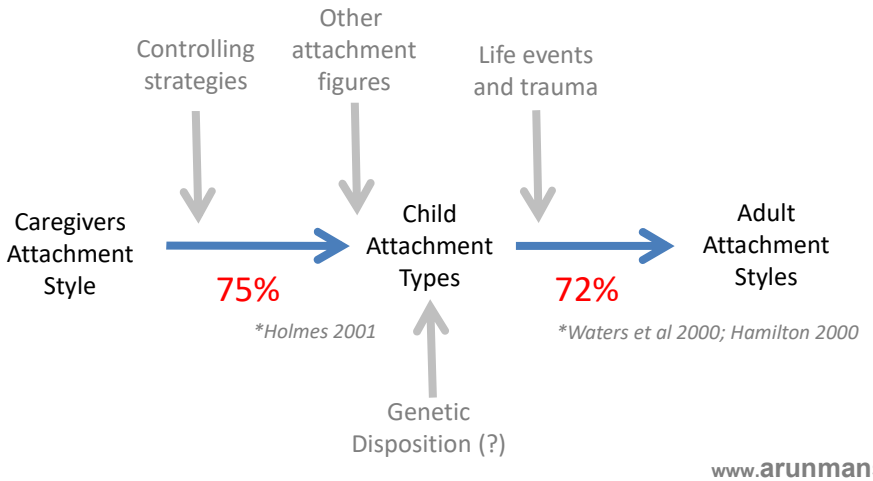

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Healthy dependency (Non pathological bonding patterns in adults)

Autonomy (self-regulation + secure)

+

Intimacy (co-regulation + secure)

=

Horizontal relationship

(Reciprocal attachment)

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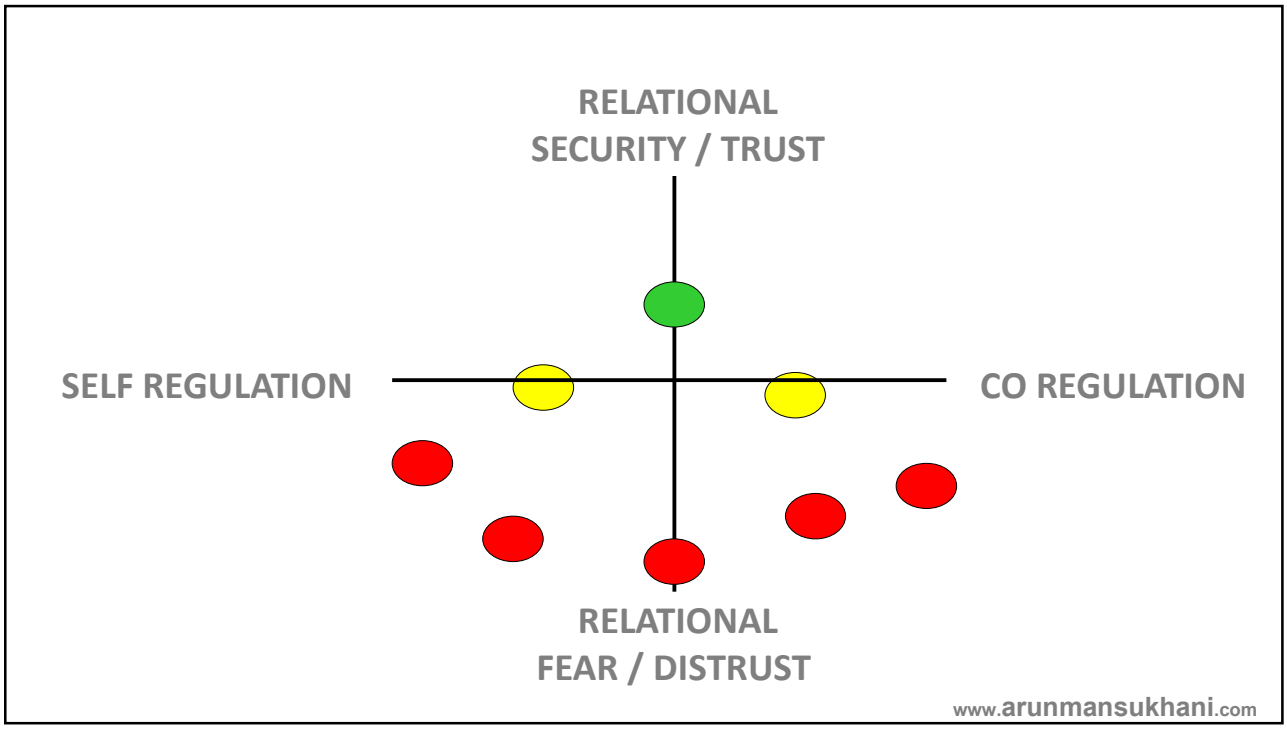
RELATIONAL
SECURITY / TRUST
SELF REGULATION
CO REGULATION
RELATIONAL
FEAR / DISTRUST
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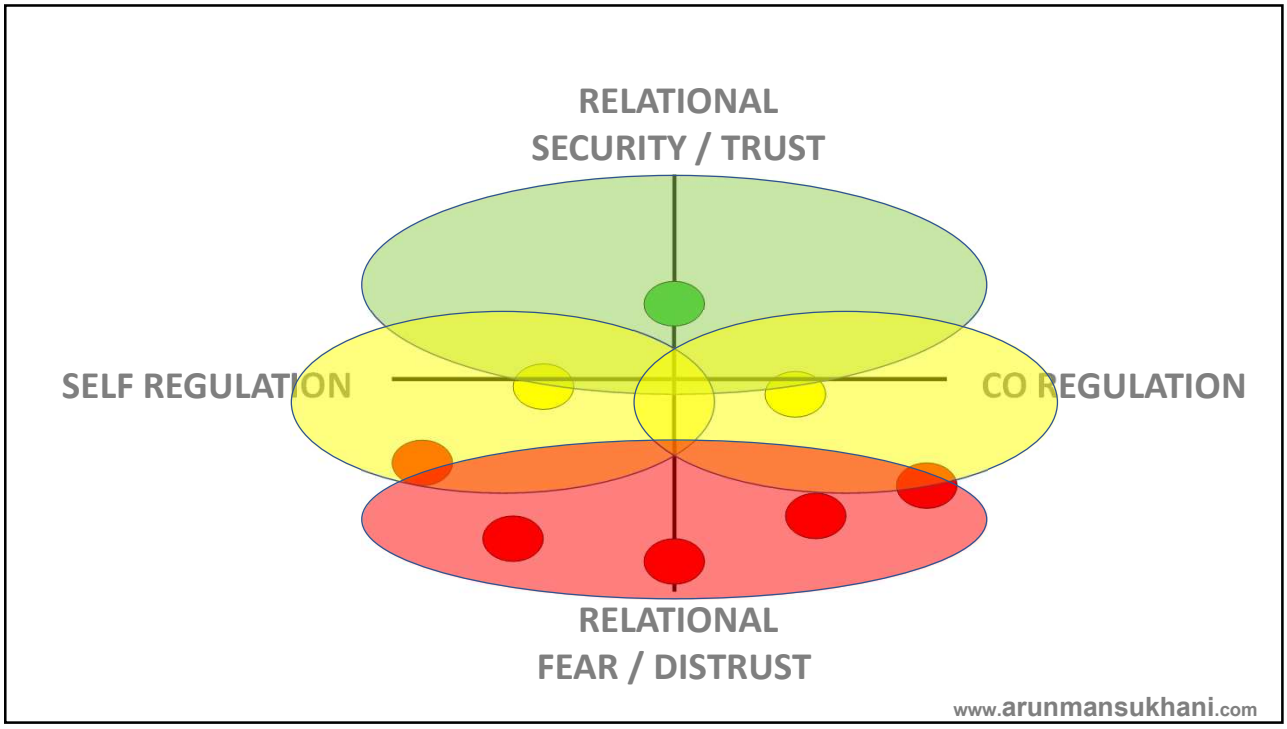
RELATIONAL
SECURITY / TRUST
SELF REGULATION
CO REGULATION
RELATIONAL
FEAR / DISTRUST
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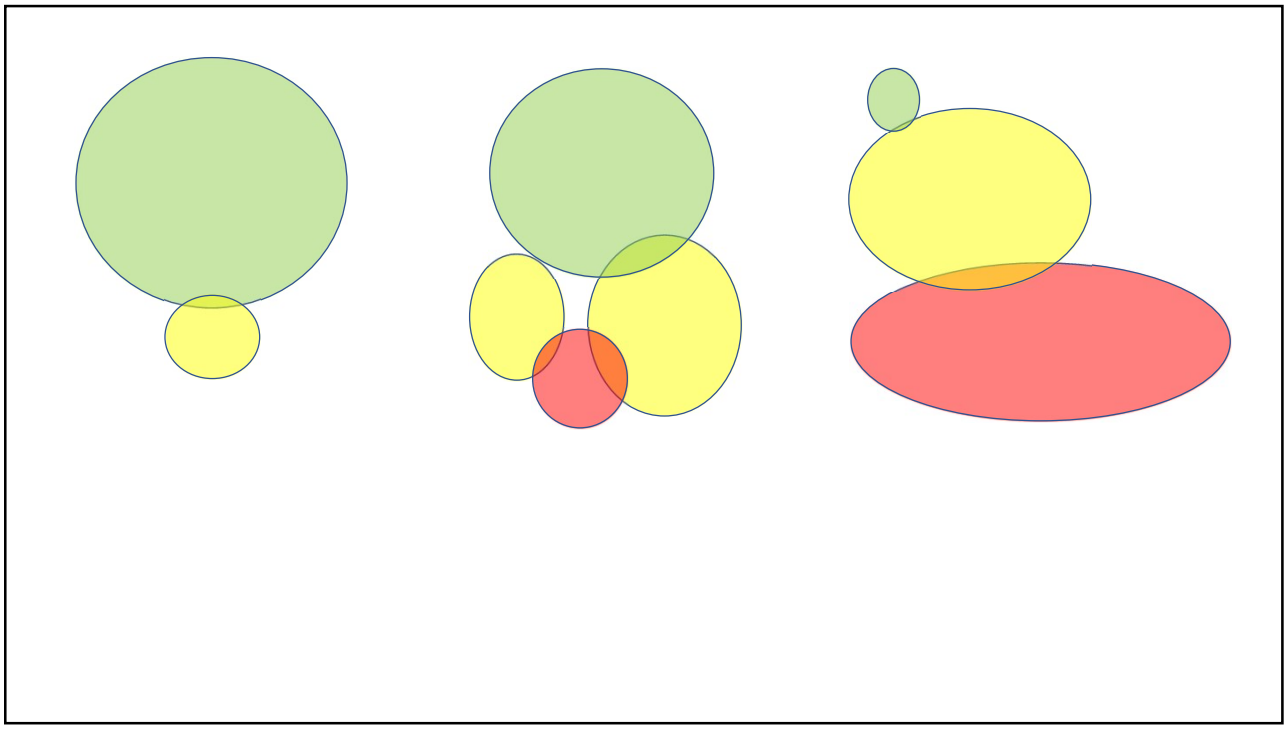

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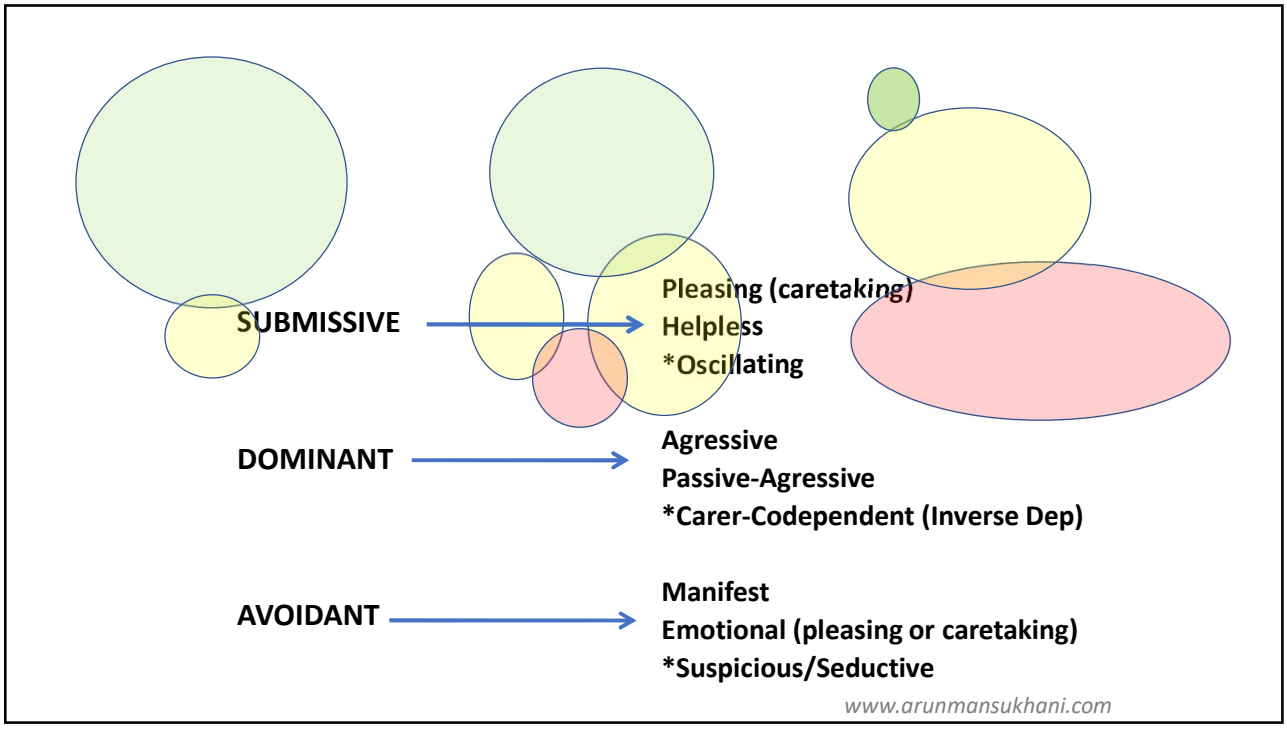
SUBMISSIVE
Pleasing (caretaking)
Helpless
*Oscillating
DOMINANT
Agressive
Passive-Agressive
*Carer-Codependent (Inverse Dep)
AVOIDANT
Manifest
Emotional (pleasing or caretaking)
*Suspicious/Seductive
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PBP	BASIC EMOTION	FEAR EXTERNAL	FEAR INTERNAL	SAFETY	BEHAVIOR
SUBMISSIVE	Anxiety	Abandoned Not valued Not noticed	Worthless Not lovable	Co-Re	Submit Please Care
DOMINANT	Fear, (Anger)	Rejected Hated Dominated	Abject Pitiful Damaged	Co-Re In control	Dominate Control Care
AVOIDANT	Sadness, (Distrust)	Controlled Invaded Loss of liberty	Sadness Loneliness Vulnerable	Auto-Re via supression	Rigid Detached Pleasing Care

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Avoidant strategies (Hypo activation)	Anxious Strategies (Hyper activation)
CNS: up-down – ANS: Dorsal vagal	CNS: down-up – ANS: Simp.
Self regulation: Intimacy avoidance	Co-regulation: Solitude avoidance
Emotional independence: Instrumental explanations of situations, relations and behaviors.	Emotional Dependence: Emotional attributions of situations, relations and behaviors.
↓ Empathy (emotional). ↑ Limits	↑ Empathy emotional ↓ Limits
↑ IW control: resources and change	↑ EW resources: “slaves” to IW
Control zone: Emotional and sensorimotor supression	Narrow WoT: frequente deregulation

44

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Cognitive

Emotional

Behavioral

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Phased intervention

- Fase 0: Reception and initial assesment.
- Fase 1: Stabilization (symptom reduction)
- Fase 2: Work with the inner world.
- Fase 3: Work with past (traumatic) memories.

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Phase 0

Therapeutic relationship

"Therapy is an in-vitro experiment in intimacy" (Holmes 2010).

- Clients and therapists activate their damaged (?) attachment system
- The past that is being re-created is not therapist's but 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).
  - An **interactive co-regulator**: capacity of being in relational mindfulness.
- Treat them as **capable adults**: adopt a **collaborative stance** more than attachment based interaction (Liotti). Ask, explain, give options, implicate, participate.
- **Validate** client's worldview/strategies before **challenging** them (costs).
- Understand the importance of **enactments** and handle them.

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Phase 0: Enactments – Relational Flashbacks

-Situations were the therapist reacts as someone in the client's past (or vice versa) entering in a negative relational dynamic: **past intrudes the present during session**.

-Very frequent in complex cases. Can be very **subtle. 2 types:**

1. **Client's wound has accidentally been touched**, activating pain and defensive strategies (client and/or therapist), dragging the therapists into a negative interaction and responding emotionally.
2. **Client relates to therapist through his strategy**: pleasing, need to be rescued, seeking childlike affectivity, idealizing the therapist... And the **therapist corresponds with a complementary strategy**.

-Represent **ruptures** in the therapeutic relation: an excellent chance for **repair**.

-**Reacting authentically, with "non-defensive recognition"** (Holmes, 2010). Can be the beginning of therapeutic change and the first chance the patient has of experimenting a healthy and adult relationship.

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Phase 0: Working with Enactments

- Realize that an enactment is happening. Be non-reactive; stay in MF.
- Speak carefully but openly and explore:
  - What just happened, the system, including the therapist.
  - Focus on present. Go from the content to the relational dynamic.
  - Admit possible mistakes (non-defensive recognition) related to therapist's internal dynamics. Express the therapists "soft" feelings.
  - Help client understand and express their "soft" feelings.
  - Look for solutions: How can we solve this? / what can we learn from this?

  (… *only if all is moving smoothly, otherwise, leave for the next session*)

  - Try and connect with past situations/people where the person felt the same: targets.
- Don't question the therapeutic bond, especially at this point.

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Phase 1

IDENTIFY and help client BE AWARE:

- Present stress factors, conflicts… triggers: past intruding the present.
- Flashbacks (much more than just intrusive images).
- Capacity of DF: numbing, response latency, difficulties articulating.
- Regulation capacity and resources.
- Repetitive defensive strategies.
- Disorganized strategies. Overlapping/overcompensating of systems.
- References to the past and out of place words.
- Basic assumptions about self, world and others (Janoff-Bulman 1992).
- NC that start appearing. Pay attention to the "reverse NC", typical of the Defensive strategies.
- Present life objective conditions: better if they contradict the NC. Easier to change a behavior than a cognition (Festinger 1957).
- What will change if they assume their past? Are they prepared?

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Phase 1

Most relevant phase in complex cases, with 3 main objectives, needed **in daily life** or at least **in sessions**:

- **Stability**: Emotional regulation. Capacity of self-soothing.
- Relational **Security**. Start feeling safe enough to explore insecurity (Holmes 2010).
- **Understanding**: Start connecting present issues and symptoms with:
  1. Internal emotional states.
  2. Past events, that are the cause of those states.

that will help working with the past make sense to the client.

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Phase 1

working towards **stability**, **security** and **understanding**

1. Therapeutic **relationship**-Enactments.
2. **Regulation**:
   - **Behavioral**: Self-care and addictions (Primary Regulation).
   - **Emotional**: Self-soothing and gradual exposition (Secondary Regulation).
   - **Cognitive**: Psychoeducation (Tertiary Regulation).
3. Detect and understand **defence mechanisms (interpersonal strategies)** and turn them into resources that the adult self can use at will.
4. Improving internal dynamics: **Inner adult**.
5. Positive affect tolerance.
6. Work with **present interpersonal conflicts and help connect to the past**. Present conflicts are due to repetitive patterns and are connected to the client's past.

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Phase 1: Behavioral (primary) regulation – self care

Clients lack these abilities due to very negative self-perceptions (don't deserve), addictive (short term) strategies and negative internal dynamics:

- Reduce stress:
  - Help create self-care routines: sleep, food… (William James).
  - Addictions and bad habits. Energetic levels (Pierre Janet).
- Pleasure-Growth activities: hedonic, eudaimonic and met goals.
- Limits (own/ others). Learn to look for and ask for help, care, etc.
- Detect dangerous places / people.

Use RDI and future templates (near and far). **Create positive networks**.

Self care will lead to self acceptance and self compassion: it will help process past later on. Easier if clients' present contradicts their NC.

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Phase 1

Emotional (secondary) regulation

- Emotional regulation techniques.
- Present Orientation techniques and Calm state.

- Differentiate intense memories from "going back there".
- Help identify flashbacks. Make them put words.

- Help notice self soothing strategies, turn them into resources.
- Help realize defensive strategies/emotions and emotions beneath. Help articulate:

Defense – Cost – Wound

- As they start connecting to the past, help put in timeline.
- Adjust rhythm during sessions to gradually expose to disturbing material – Widen the WoT

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Phase 1

Cognitive (tertiary) regulation:
Psychoeducation and understanding

Talk openly about their **fears and doubts** about therapy and therapist.

Should be **short** and in the "**proximal development zone**":

Attachment, Action Systems, Functions of Guilt (3 types), attachment to perpetrators, emotional parts, Introjection, Trauma and self, sexual response during sexual abuse, etc...

Understand how past is blocked and at the same time Past=Present:

- Past emotion, sensations, relational dynamics become present.
- Present responsibility attribution is passed on to the past.

Trying to leave your past out actually makes it intrude not consciously.

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Phase 1: Addictions (Seeking/reward system)

Can be used with any behaviour that follows an addictive pattern

(Short T benefits > Mid/Long T costs)

- Worst fear: Flashforward (Logie & De Jong 2015). Attachment system.
- Addiction free future (DeTur-Popky 2007).
- Positive moments - idealization (Knipe 2008).
- "Feeling state" (Miller 2016).
- Triggers ("Urge"; DeTur-Popky 2007). "Craving" (Cravex-Hase 2010).
- Specific resources.
- Specific past: previous triggers, previous relapses, dependency onset, etc.

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Phase 1: Social Ranking System or dominant behaviours

- Dominant behaviours due to hyper activation without regulation:
  - Help Create/Reinforce the Inner adult. Teach self-regulation techniques. Use RDI and future templates.
  - Work as displaced aggression (addictive behavior).
  - Work with the idea of loss of control:
    - Loss of control is really control taken over by another part of the self.
    - Understand that part and needs. Needs are legitimate but not the means:
      - Where did you learn that this behaviour was valid? Process these situations (cognitions related to regulation, being capable, etc).
      - Help connect with the "soft" emotion under the "hard" emotion.
- Other option: work as with defences.

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Phase 1

Sexual System

Frequently enmeshed with: Defense (disgust), Attachment (to the perpetrator or lack of attention-protection), Social Ranking and Seeking/Reward.

Shame: In CSA, especially when perpetraded by AF, NC of guilt/shame can be very difficult to manage (therapist worsens) being frequently a blocking point in therapy and in occassions creating a very strong sense of being bad/worthless:

- I am damaged because this happened to me.
- It happened to me because of what I am.
- It's not what happened, it's what I am

This will create frequent blocks in future processing. Psychoeducation in phase 1 (that later will be used in cognitive interweaves) is very important: Attachment to perpetrator, excitement, sexualizing relations, re-traumatizing relations, dissociative features, etc.

What changes in the client's life if he/she accepts what happened?

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Phase 2

Present conflicts with couples

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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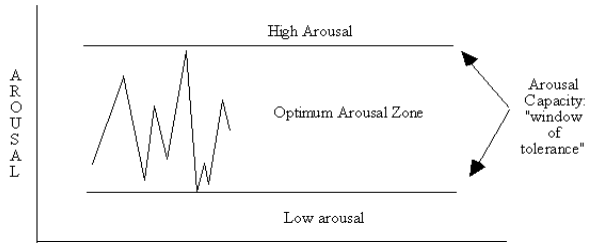
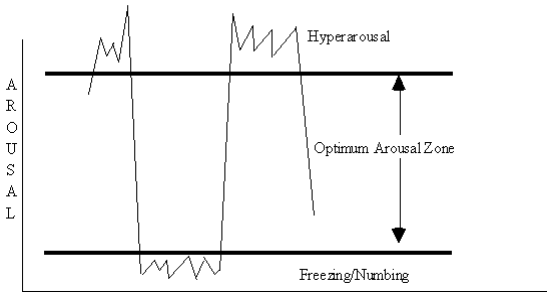
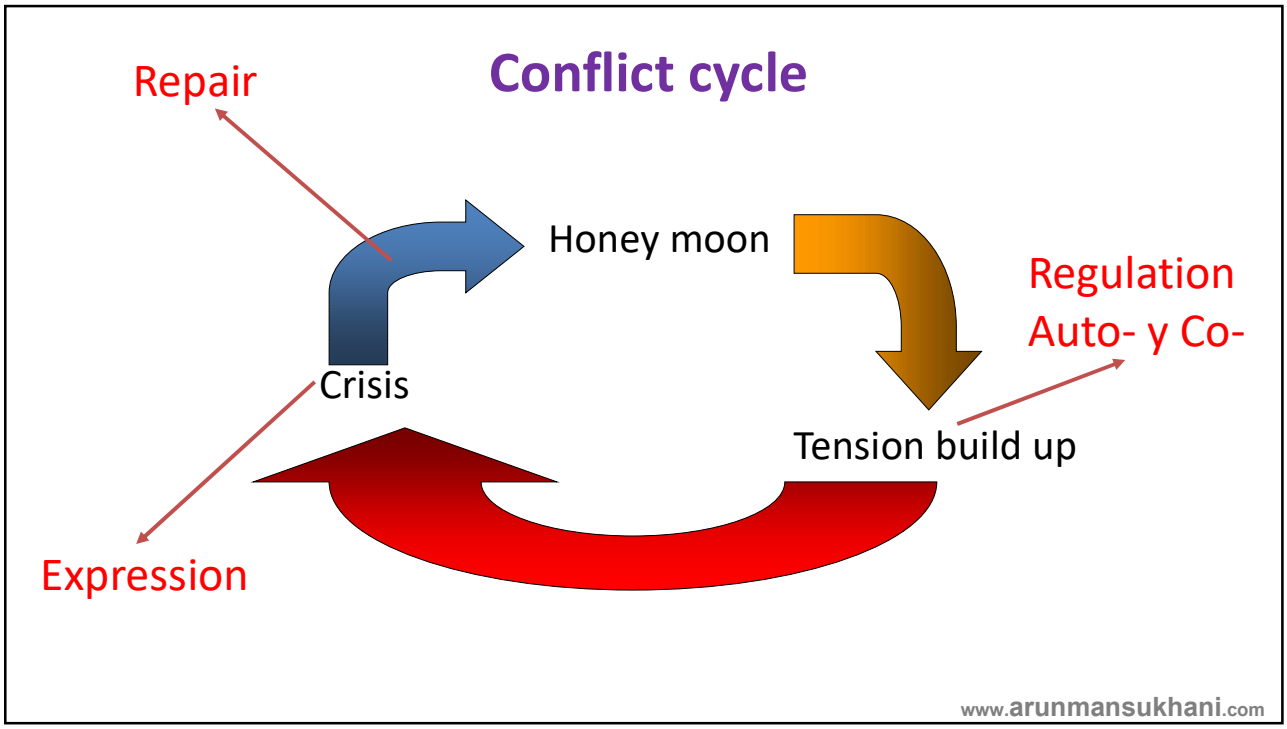
window of afective tolerance





Dan Siegel

60



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Phase 1

Present conflicts with children

1. **Reinforce** them as sensitive and implicated parents.
2. Start with the main attachment figure:
   1. **Feelings** as child misbehaves. When did they feel this **before**?
   2. Help them see we can't function well in the present when past is being activated. **Suggest we work with their emotions** to help the child.
   3. Work the **present** (reduces activation and helps open up the attachment system) or help them **connect with the past**
3. Other option: Help them talk about their **expectations** as parents: Uncover **idealization**. It's the opposite normally of their own childhood (what was lacking: compensation fantasy).

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Phase 2

Positive affect tolerance (Andrew Leeds 2011)

In some cases, start with positive affect tolerance, before going to negative affect tolerance. It has to do with trusting others and being deserving; It will promote self compassion and self care, that will help later processing.

Difficulties that may arise…

- Be evocative because it was not previously received connecting with the feeling of being seen, of not deserving... Impostor syndrome
- It can evoke strong 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.

…will help us connect to the client's life story

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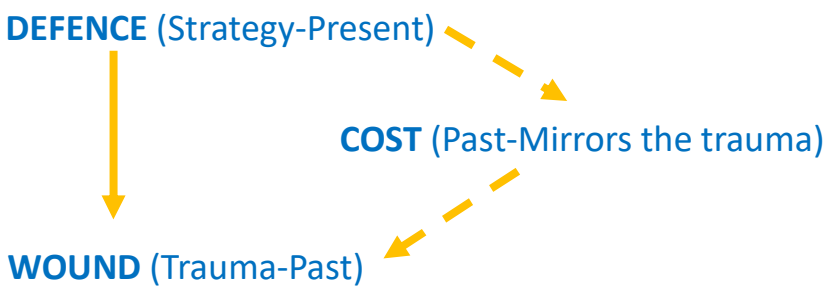
Phase 1: Work with Defenses (Interpersonal Strategies)

- Help increase **awareness** (and volitional control). **Understand** the need beneath.
- Re-label as **interpersonal strategies** (learned patterns of response). **Praise** and appreciate this strategy/part. We **don't want to get rid of them**, we want to turn them into **resources** (conscious and under volitional control of the adult)
- Understand the function, the need, the cost. Work with the strategy, not against it



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Phase 1

Work with Defenses (Interpersonal Strategies)

1. **Triggers** and create **new strategies** in present.
2. **Connect with the cost** and process:
   -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.
   -I have to control / I can learn to leg go.
3. **Go to the wound** (attachment):
   -where did you learn that…?
   -If you were not perfect, what would that say about you?

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Traumatic experiences or early assumption of responsibilities/care (one's own or others) interfere with development of **healthy adult** or develop "false adults".

Childlike emotional states

"False adult" states

- "False adult" states behave as adults but are rigid, non-regulating, counter-phobic, perfectionist, tired, angry, disappointed… Represent the child's efforts to adapt to external demands. May be felt as a **thin fuctionality cloak** (impostor síndrome, etc).
- Adult states, like other, are **not a continous state**, but intermitent. When more present, they **calm and regulate** the child, adolescent and false adult states.

Phase 2: Inner Adult State

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Phase 2:

Developing
+
Strengthning

The Adult State

Characteristics of the Inner Adult state (remember: not a constant state)**:**

-Self sooth, calm others, open to be regulated. Has resources.
-In touch with own needs and emphatic.
-In touch with own emotions, can sustain others emotions.
-Compassive and self compassive.
-Self reinforcing and reinforcing of others. Open to positive affect.
-Capable of self-care, caring for others and being cared for.
-Capable of setting limits for others and for oneself.
-Behaves as adult with other adults and with children.

- Make aware, reinforce and/or install when appears spontaneously.
- Use specific techniques to install Inner adult.
- Work with the inner child, "loving eyes protocol" (Knipe 2008).

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Phase 2: Working with the Inner World

- Contradictory behaviour
- Contra volitional behavior.
- Low Self Esteem.
- Under developed adult
- Strong emotiona reactions (EP).
- Dissociative features
- Structural Dissociation

- DBT-Linehan (1993).
- Hipnosis-Livingstone (2006).
- Voices-Ross (2000); Ross and Mosquera (2019).
- IFS– Schwartz (1995).
- Schema Therapy (2003).
- Structural Dissociation-Van der Hart (2005).
- Ego State Therapy-Forgash y Copeley (2008).
- Progressive Approach-Gonzlz y Mosq (2012).

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Phase 2: Working with the Inner World

Resource

Defense

Emotional state

EP

Structural Dissociation

- Conscious / Unconscious
- Flexible / Rigid
- Volitional control / Automatic
- Present orientation / Past orientation
- Adaptative / Unadaptative
- Regulated / Unregulated
- Amnesia and mental autonomy
- Related to the self and identification
- Executive control .

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Phase 2: Working with the Inner World

Daily life parts: Social, functional, "manager" parts (Scwhartz 1995; Forgash y Knipe, 2015). ANP. (V. der Hart et al, 2006).

Emotional parts:

- **Defensive**:
  - Dependent parts: clingy, needy, demanding, etc.
  - Avoidant, addictive, hippie or Budha parts.
  - IW controlling: avoid showing weaknes, vulnerability…
  - EW controlling parts: aggressive, strong…
- **Disorganized**: Defensive, but with self destructive behaviours.
- **Wounded parts**, "Basic Fault" (Balint 1979). Fixated on past/trauma. Vulnerable, weak…

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Phase 2: Working with the Inner World

Although parts vary in the needs they want to fulfill and the behaviours they consider fit to meet those needs…

- They can evolve, if they find new ways of meeting needs.
- They Will calm down as adult state strengthens.
- They all have the same final objective.

- Strenghten adult state.
- Present orientarion – Shared awareness, co-consciousness.
- Understanding (function), compassion.
- Acknowledgment and Identification.
- Integration

Static phase: Descriptive, Psychoeducation.
Dynamic Phase (symbolic): Drawings, Inner child, dissociative table, etc…

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Phase 3: Working with memories - Processing

- ACT
  - S. C. Hayes (2004)
- EMDR
  - F. Shapiro (2001).
- FOCUSSING
  - E. T. Gendling (2001).
- SOMATIC EXPERIENCING
  - P. Levine (1997).
- SENSORIOMOTOR PSYCHOTHERAPY
  - P. Ogden y K. Minton (2000).

- **MBP**
- **MBSR**
- **MBCT**
- **ACT**
- **MBPP**
- **Etc.**

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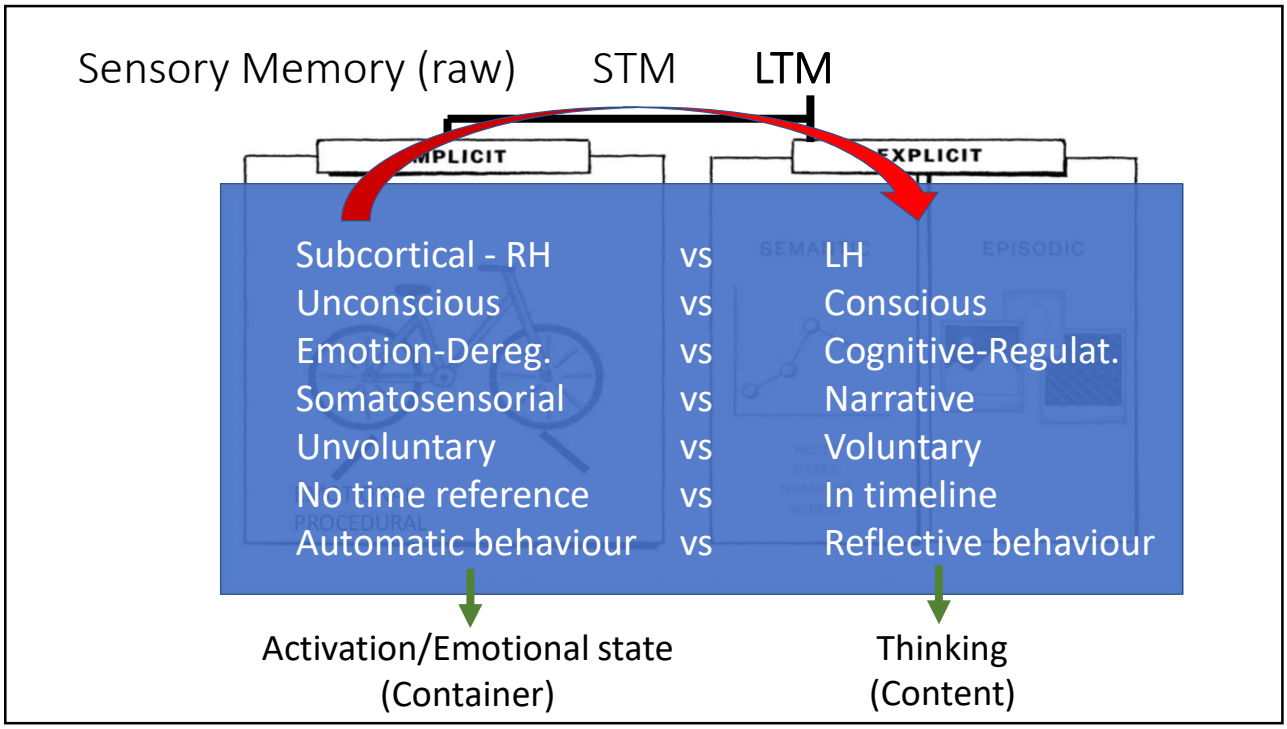
Sensory Memory (raw)
STM
LTM
Subcortical - RH vs LH
Unconscious vs Conscious
Emotion-Dereg. vs Cognitive-Regulat.
Somatosensorial vs Narrative
Unvoluntary vs Voluntary
No time reference vs In timeline
Automatic behaviour vs Reflective behaviour
Activation/Emotional state (Container)
Thinking (Content)

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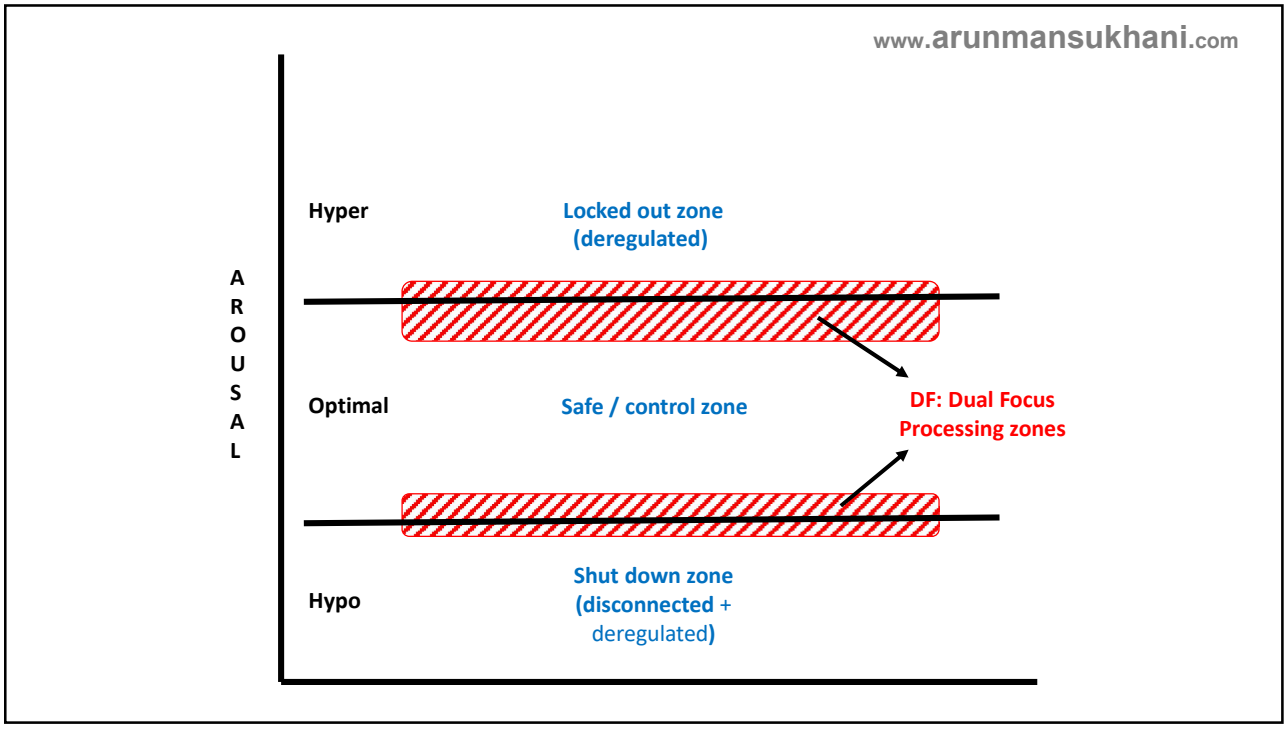
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AROUSAL
Hyper
Locked out zone (deregulated)
Optimal
Safe / control zone
DF: Dual Focus Processing zones
Hypo
Shut down zone (disconnected + deregulated)

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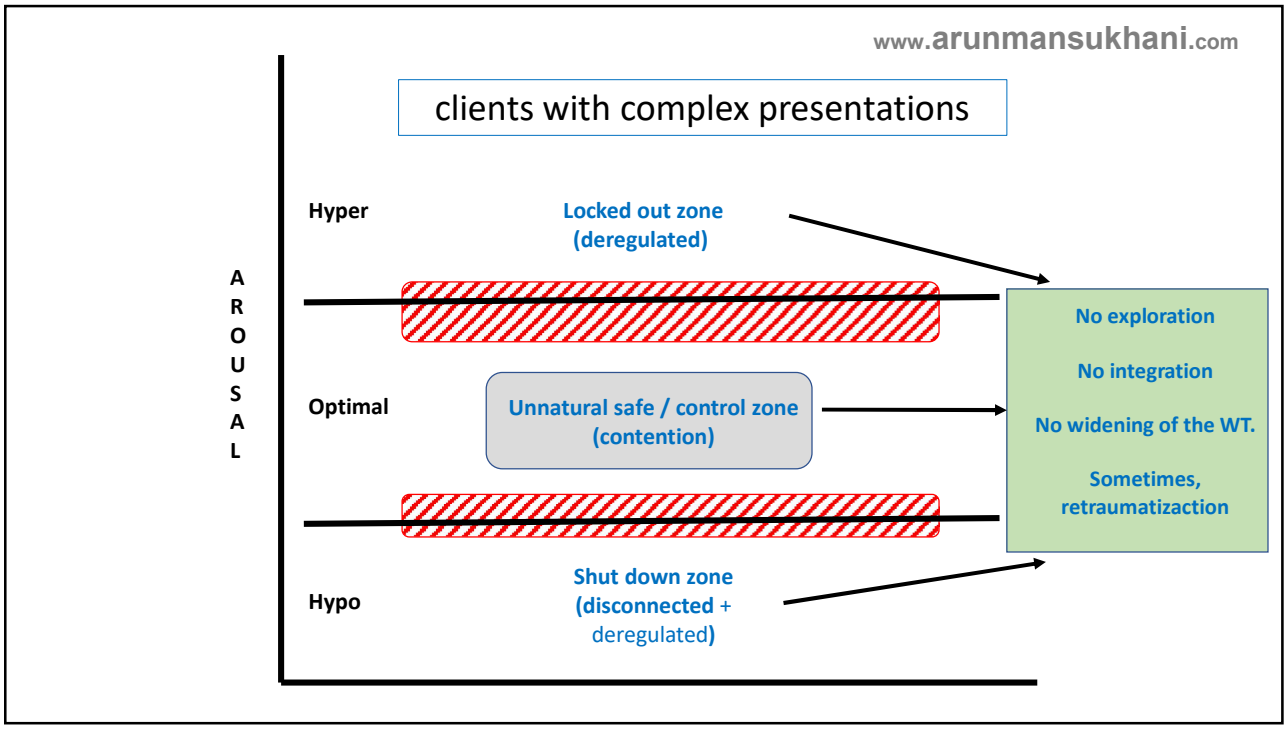

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Inter-subjective field

- Originally proposed by H. S. Sullivan (1892-1949), More recently by Daniel Siegel.
- Based on Porges and co-regulación.
- Experimental support in recent years with investigations about brain synchronization (Dikker 2017; Pérez 2017).
- Relational mindfulness – leads to personal mindfulness
- Enhances:

1. Attention and cognitive flexibility (Moore y Malinowski 2009)
2. Enhances experience integration (Schore 2014).
3. Improves personal integration and self-compassion (Campos et al 2016).

Phase 3: Working with memories - Processing

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Phase 3: Exposure rhythm during sessions

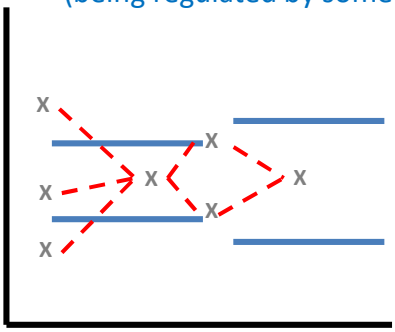
Phase oriented treatment:

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

In each session:

- Regulation: help to be inside the window of tolerance.
- Processing (taking the person to the limits of the WT)
- Installation and orientation to external life.

- Capable of managing activation.
- Insight and understanding.
- Adult as a secure base.
- Corrective attachment experience (being regulated by someone).



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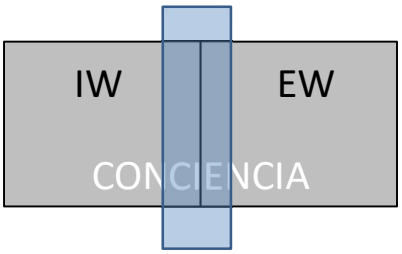

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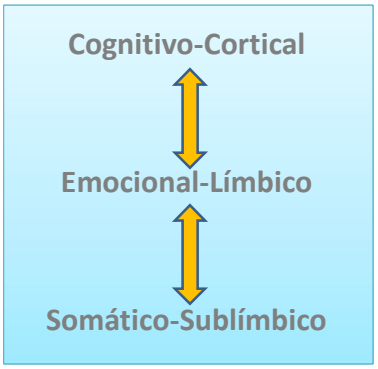

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Phase 3: Working with memories - Processing

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"Know all the theories, master all the techniques, but as you touch a human soul be just another human soul."

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