EMDR Responses to the Challenges of this Decade

Thinking EMDR beyond attachment: Interventions with multiple affective systems

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1983, National Vietnam Veterans Readjustment Study (NVVRS):

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

PTSD

Phobias
Depression
Dependence
BPD
Psychosis
Personality
Disorders
Complex PTSD
…

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

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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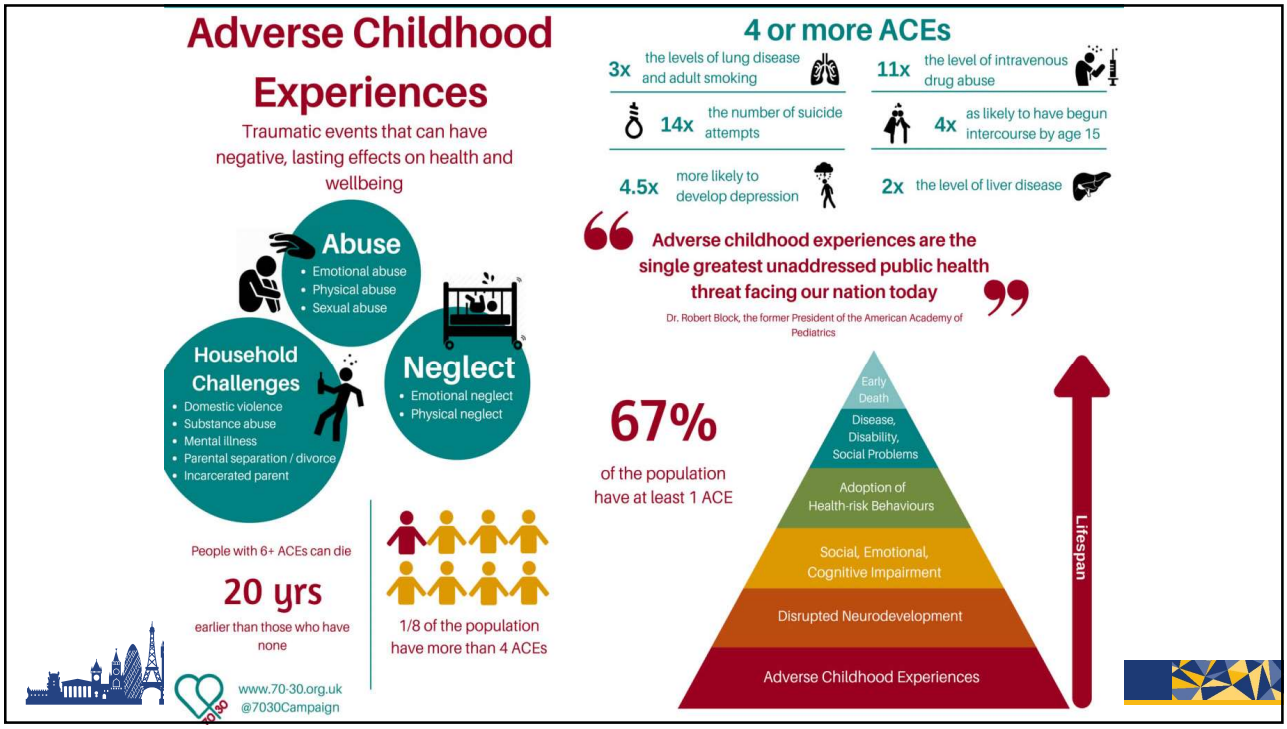

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> Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today
>
> Dr. Robert Block, the former President of the American Academy of Pediatrics

Dysfunctional stored implicit memories (information) are the cause of a wide range of psychological symptoms and disorders.

(Shapiro 2004,)

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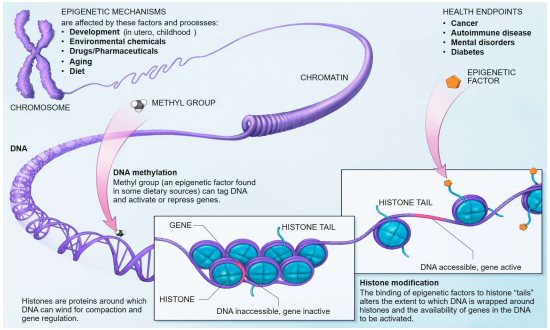
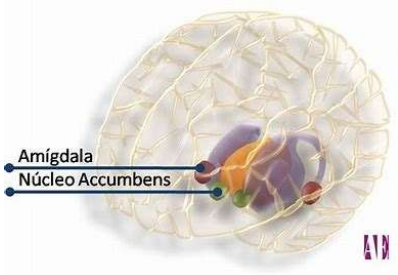
STRESS alters **EPIGENETICS**





[Nature - Published: 15 March 2021](#)
Mount Sinai Hospital
Long-term behavioral and cell-type-specific molecular effects of early life stress are mediated by H3K79me2 dynamics in medium spiny neurons

Early life stress *induces* ***epigenetic modifications*** *in D2-type medium spiny neurons in the nucleus accumbens* ***increasing the susceptibility to stress in adulthood.***

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STRESS

A
F
F
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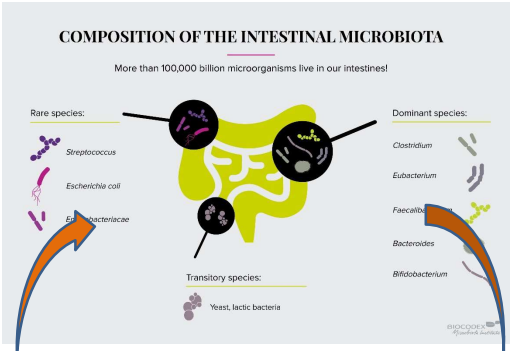
C
T
S

MICROBIOTA



Composition of Gut Microbiota has been related to:

- **Anxiety** like behaviours in mice (2004).
- **Gene expression** and **brain development** (2010)
- **BDNF**: Brain-Derived Neurotropic Factor (2011).
- Lactobacillus linked to **GABA** levels in cortex, amygdala (2011)
- **Depression** like behaviours (2011).
- **Social** Behaviours (2021)
- **Fear** in human babies (2021)

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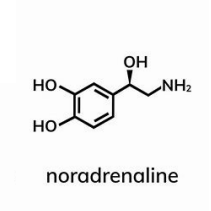
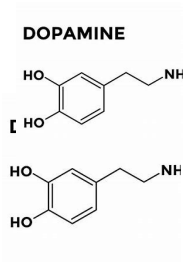
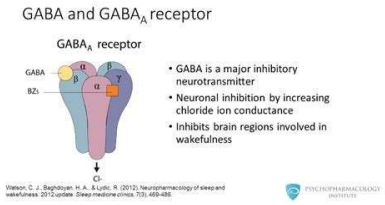
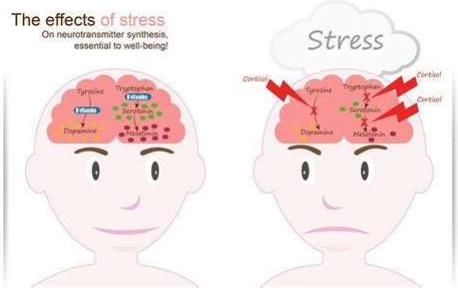
Stress Affects our Neurotransmitters







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



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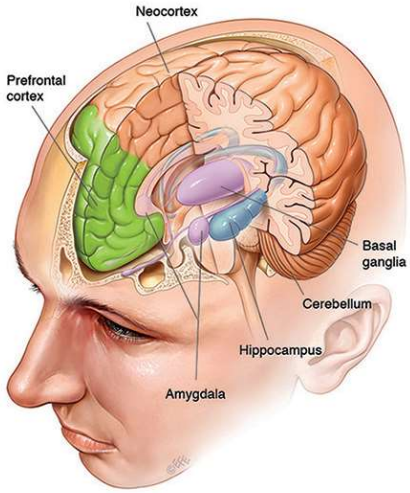
ACE affect brain structures



- 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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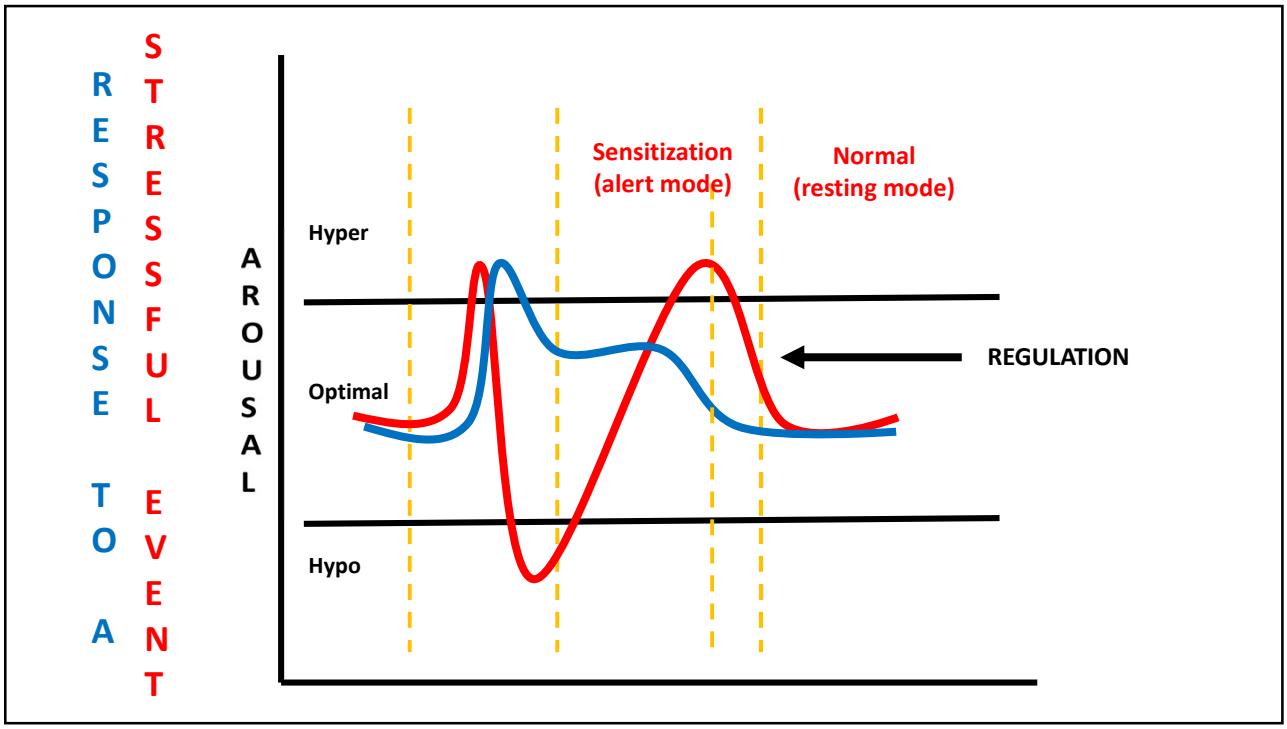
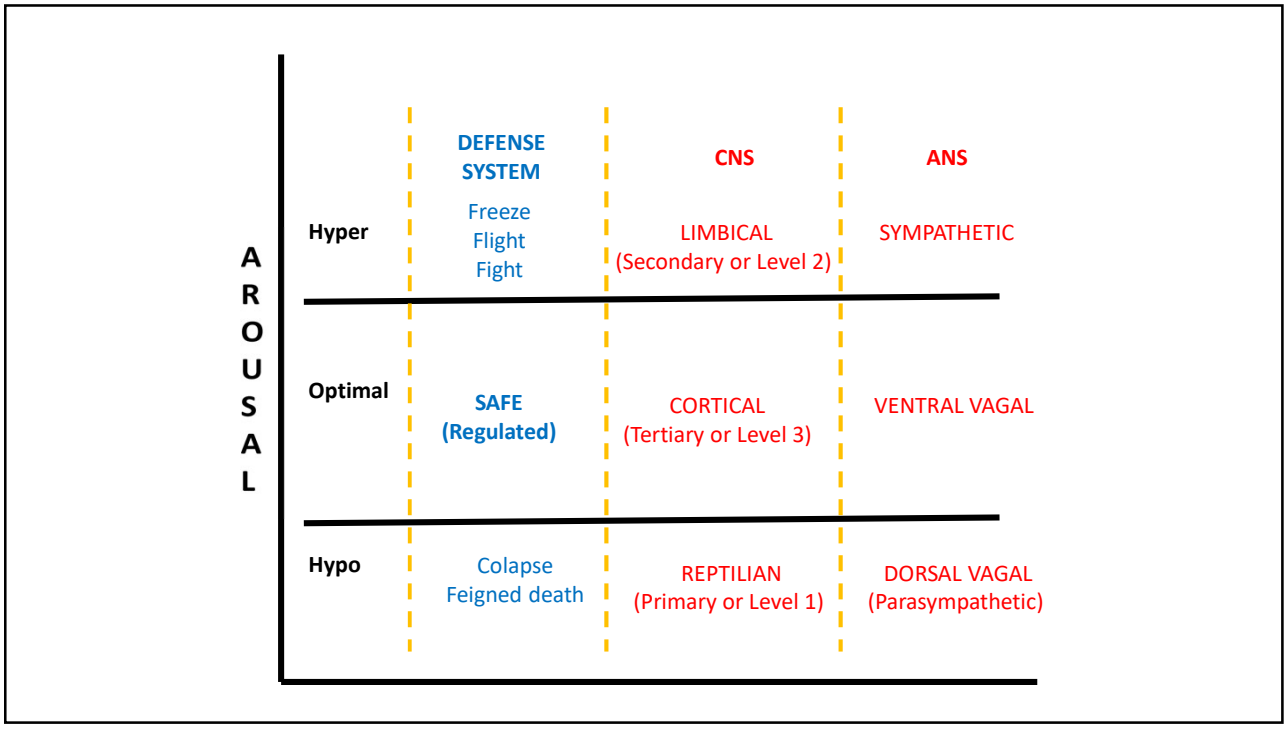

RESPONSE TO A STRESSFUL EVENT
AROUSAL
Hyper
Optimal
Hypo
Sensitization (alert mode)
Normal (resting mode)
REGULATION

11


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

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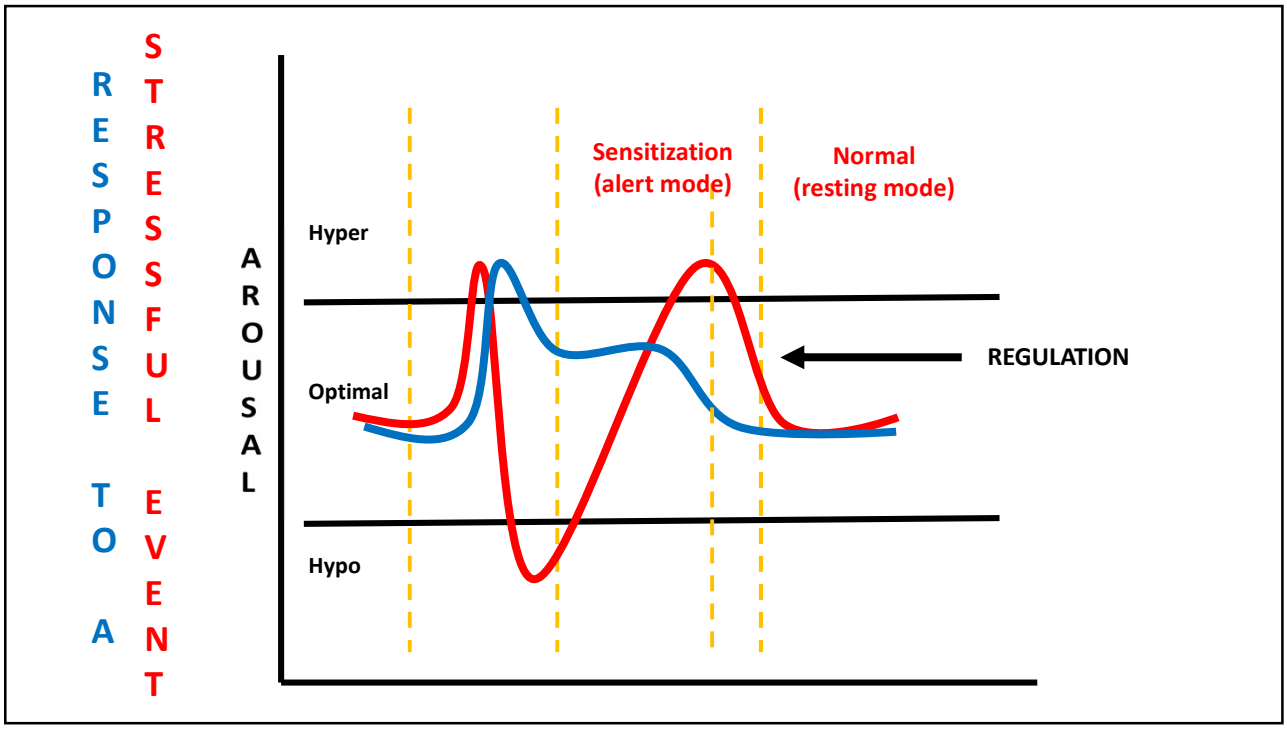
RESPONSE TO A
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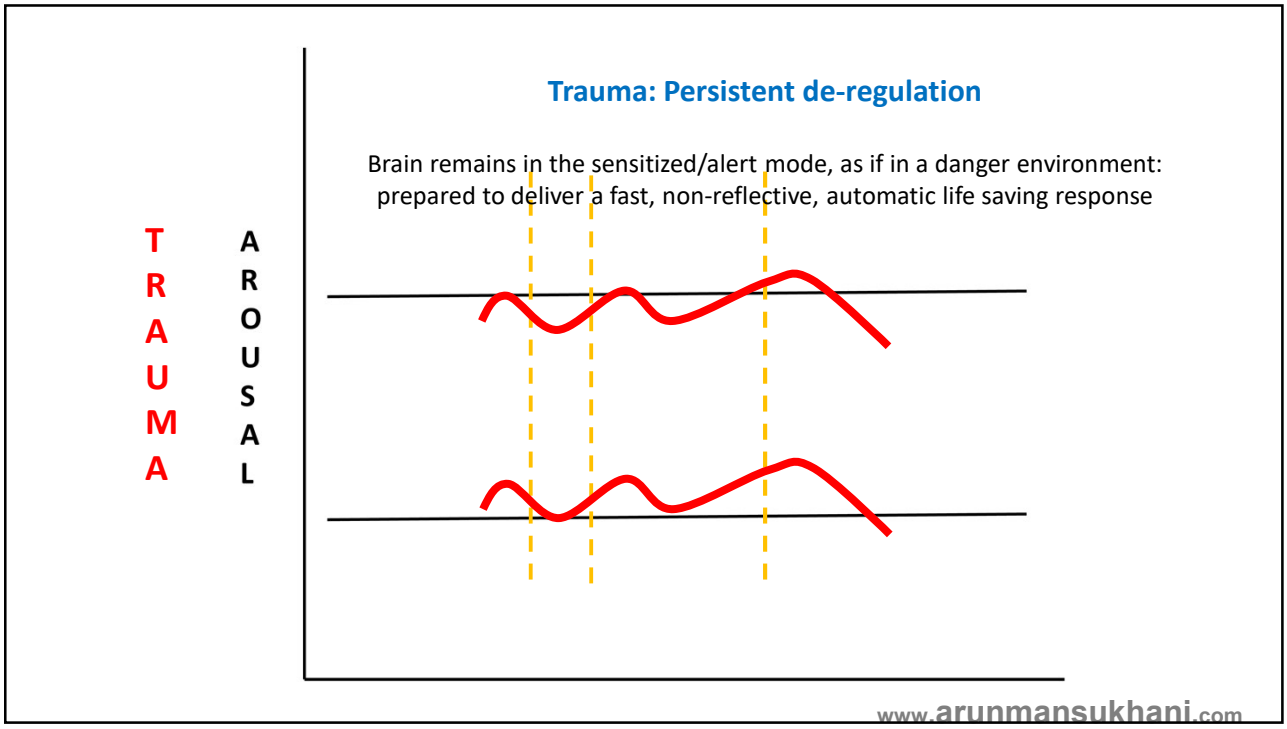
TRAUMA
AROUSAL
Trauma: Persistent de-regulation
Brain remains in the sensitized/alert mode, as if in a danger environment:
prepared to deliver a fast, non-reflective, automatic life saving response
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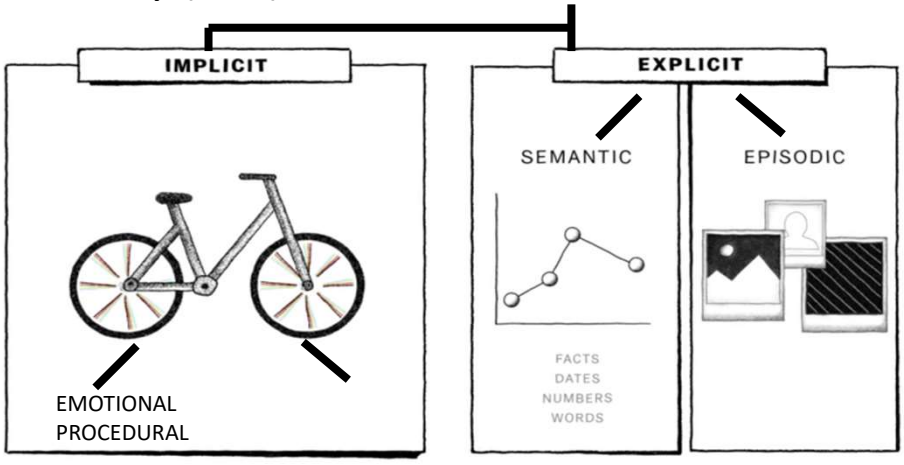
Sensory Memory (raw) STM **LTM**



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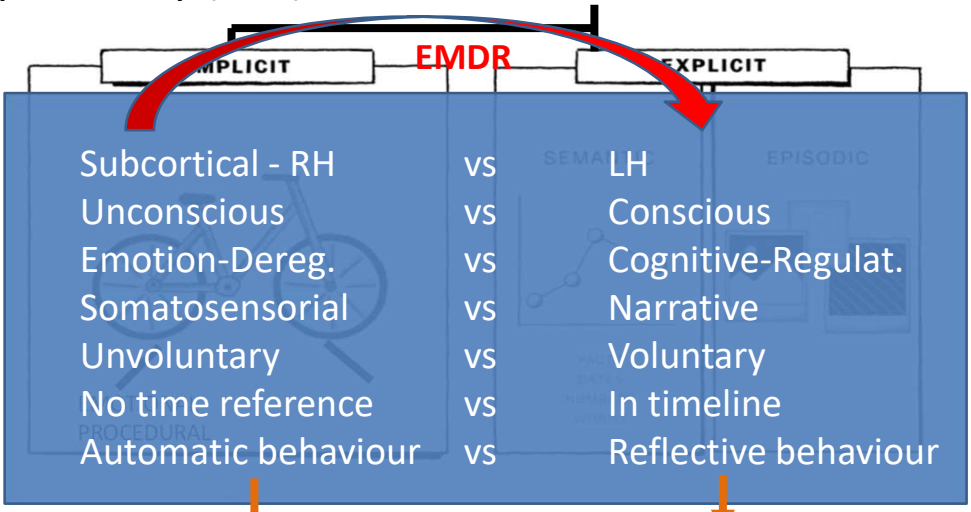
Sensory Memory (raw) STM **LTM**



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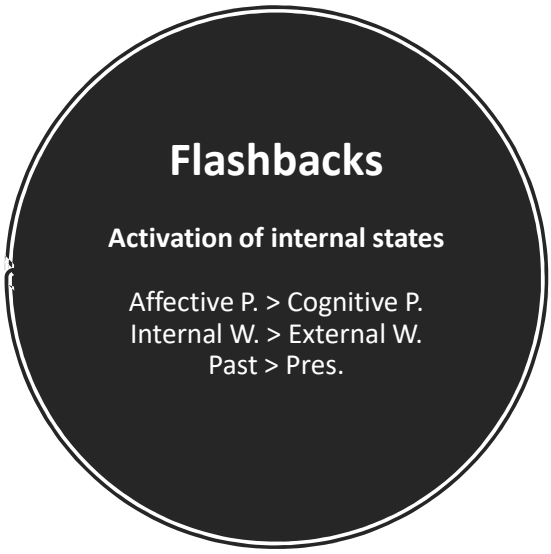

IMAGES, SMELLS, SENSATIONS (RAW MEMORY) → SENSOMOTOR ACTIVATION

EMOTIONAL AND MOTIVATIONAL STATES → ACTION TENDENCIES

RELATIONAL PATTERNS → HOT COGNITIONS: SELF / OTHERS / WORLD

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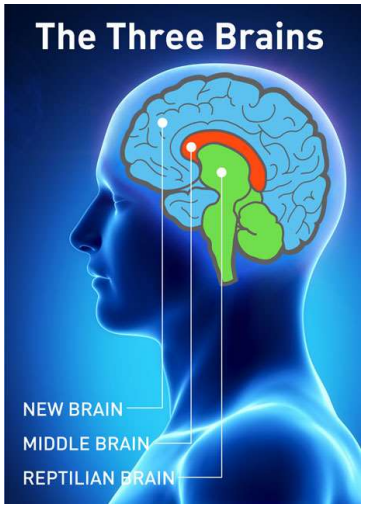

In a post traumatic response, our NS:

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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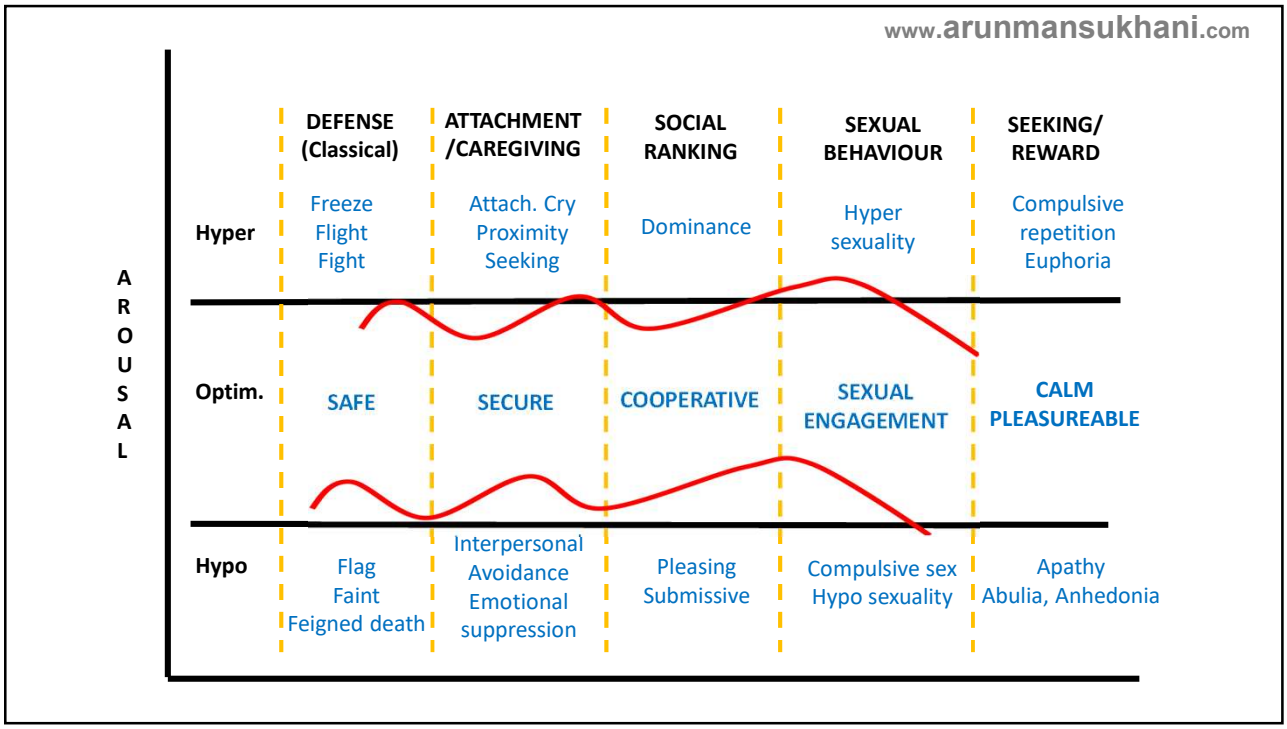

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Systems: Control – Behavioral – Motivational – Action – Affective

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.

- 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" (Panksepp 2012)
- 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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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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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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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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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

**Farrell D & Laliotis D, 2017*

CHANGE OF STATE

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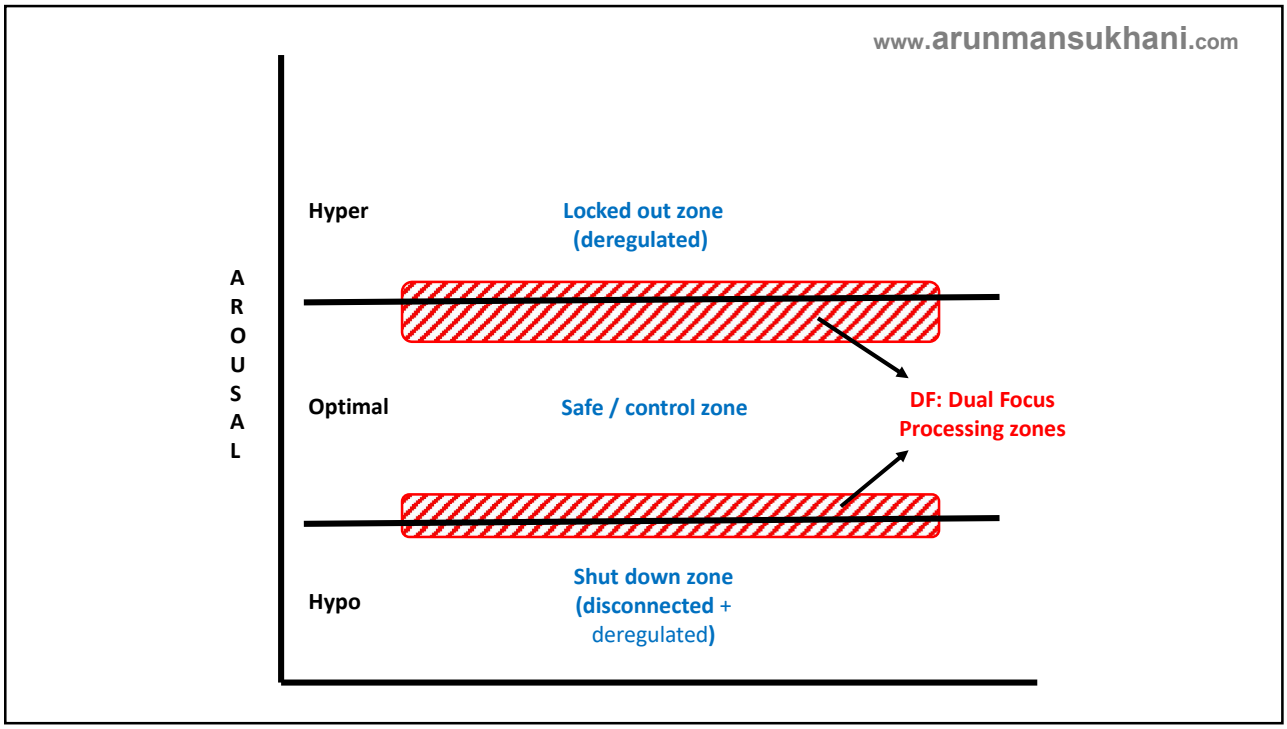
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AROUSAL
Hyper
Locked out zone
(deregulated)
Optimal
Safe / control zone
DF: Dual Focus
Processing zones
Hypo
Shut down zone
(disconnected +
deregulated)

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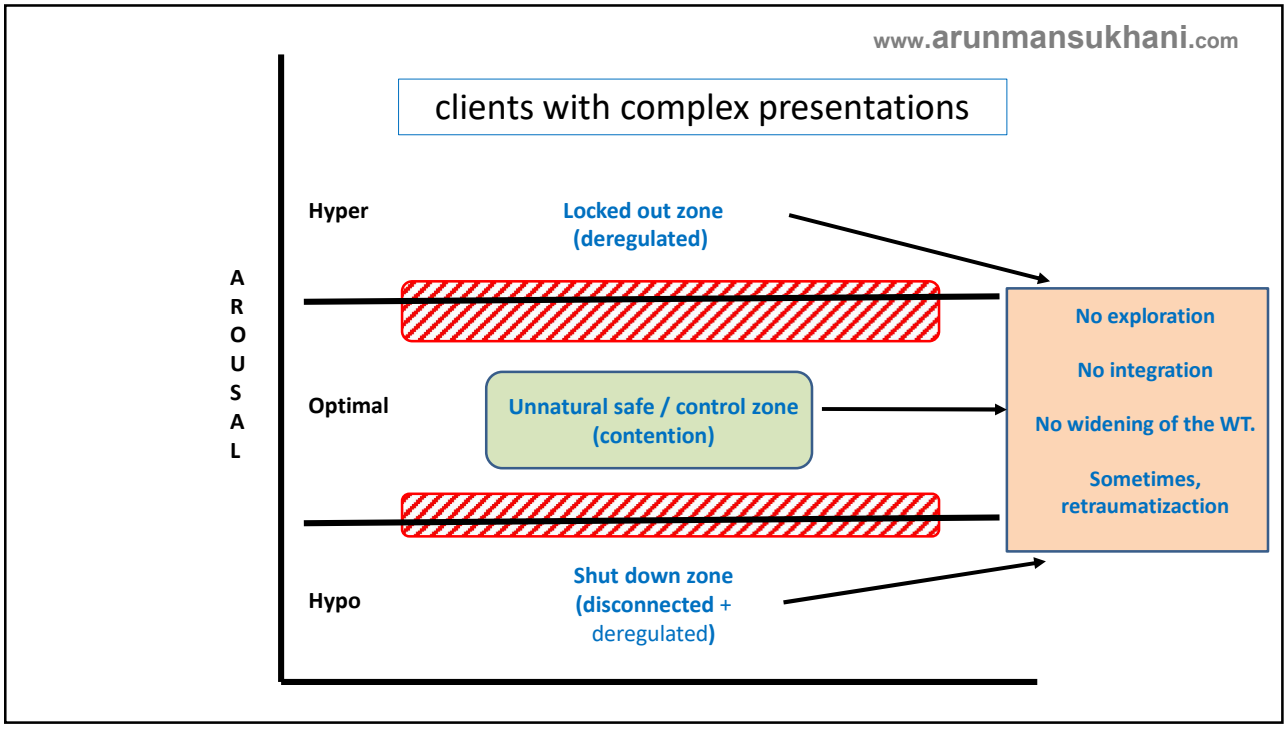
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clients with complex presentations
AROUSAL
Hyper
Locked out zone
(deregulated)
Optimal
Unnatural safe / control zone
(contention)
Hypo
Shut down zone
(disconnected +
deregulated)
No exploration
No integration
No widening of the WT.
Sometimes,
retraumatizaction

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- Clients with complex presentations, **DON'T WANT TO WORK ON THEIR PAST**:
  - **Don't relate their current difficulties to past events**: No explicit memories (Amini et al. 1996): Attachment blindness (Siegel 2012). Omission trauma (more difficult to detect).
  - High **Present stress** (symptoms and conflicts) **is de-regulating** and keeps attention in present.
- **CAN'T WORK ON THEIR PAST** (INITIALLY CAN'T STAY IN DF):
  - **HISTORY TAKING IS DEREGULATING** due to activation of intense emotional states (fear, disgust, shame) and **EVOKING** of unwanted memories (Steele 2016).
  - **FEAR** OF DE-REGULATING AND EVOKING **ACTIVATES AVOIDANCE DEFENCE STRATEGIES**:
    - Conscious Suppression (avoiding, redirecting attention, non-stop talking…) - Unconscious internal suppression (denial, idealization…). Window of control.
    - Partial Dissociation: BASK model (Brown 1988) - Structural dissociation.
- At the same time, **PAST** is constantly intruding in form of complex flashbacks.

PRESENT=PAST

clients with complex presentatios

- Don't start with standard P-1. Start at P-2. The more complex the case, the more P-2. **Phases will overlap** each other, we will be switching during initial stages.
- Think of phases more as **processes** during intervention.
- P-1 serves various purposes:
  - **Assesment** and case conceptualization. From the start.
  - **History taking**. Co-construct our client's life history while processing:
    - Activation-deregulation reduces. Fear reduces.
    - Has more resources: Defensive strategies/parts start calming down.
    - Is able to mentalize and understand and, finally, accept his own life history and moarn the negative and missing aspects:
      - The childhood they had. The consequences.
      - The childhood they didn't have. The consequences.

3 prong approach

8 phases of EMDR

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

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3 prong approach

8 phases of EMDR

Prong	Phase	Objective
Present Past Future Past Present Etc.	2 + 1a 2 + 1a + 5	Stability, security, understanding Assessing. Case conceptualization.
	2 + 1 + 4 3 + 4 + 5 + 6…	Stability, security, understanding. Resources. Partial processing techniques. Mentalization. Start History co-construction EMD – EMD+R – EMDR (Tx)
	…	
	EMDR	Finally!!

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Phase 1 a

assesment and case conceptualize

IDENTIFY and HELP CLIENT REALIZE:

- 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 2

Most relevant phase in complex cases. **If client can process, not needed**.

A main **objective**: Help clients reach the point where they can **maintain DF** in presence of the **therapist** and work on their **past.**

For that, we need, **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 with integration of life history (mentalize).

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Phase 2

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**. Positive affect tolerance.
5. Work with **present conflicts and help to connect to the past**. Present conflicts are due to repetitive patterns and are connected to the client's past.

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Phase 2

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. 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 2: 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 2: 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 2: 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).

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 2

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 2: Exposure rhythm during sessions

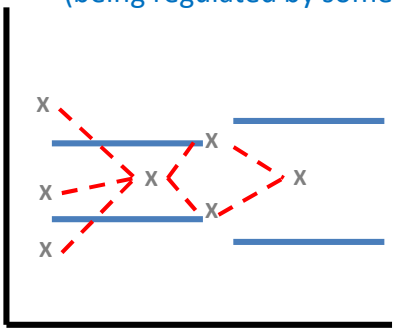
Phase oriented treatment:

- 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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Phase 2

Cognitive (tertiary) regulation:
Psychoeducation and understanding

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

EMDR links dysfunctional information with **present functional information:** Psychoeducation provides, later inter-weaves

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

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

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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 RDI to install Inner adult.
- Work with the inner child, "loving eyes protocol" (Knipe 2008).

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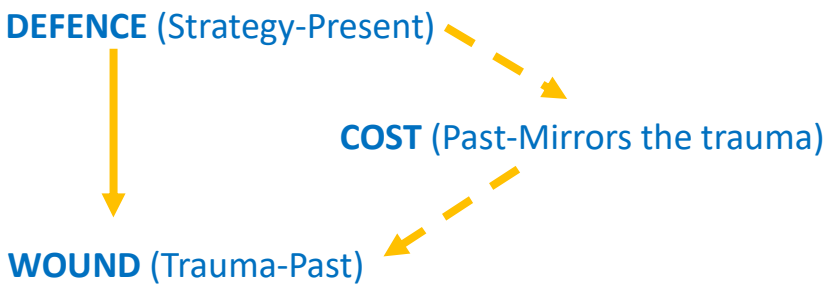
Phase 2: Work with Defenses (Interpersonal Strategies)

- 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 2

Work with Defenses (Interpersonal Strategies)

1 **Triggers** and install **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?

***Other options**:
- Process with the defense protocol (Knipe 2008).
- Work as part (Mosquera 2020)

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Phase 2: Social Ranking System

- Submissive behaviour: Standard EMDR
- 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.
- Dominant behaviours as a defence (empowered): work as with defences.

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Phase 2

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 2 (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 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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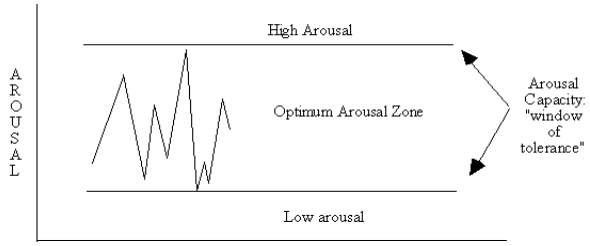
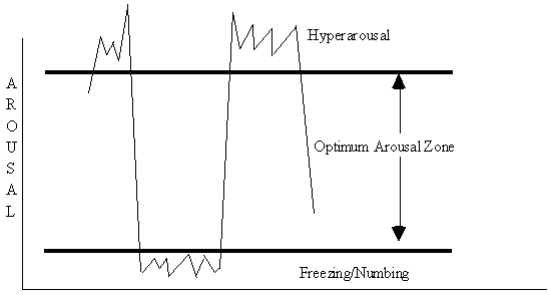
window of afective tolerance





Dan Siegel

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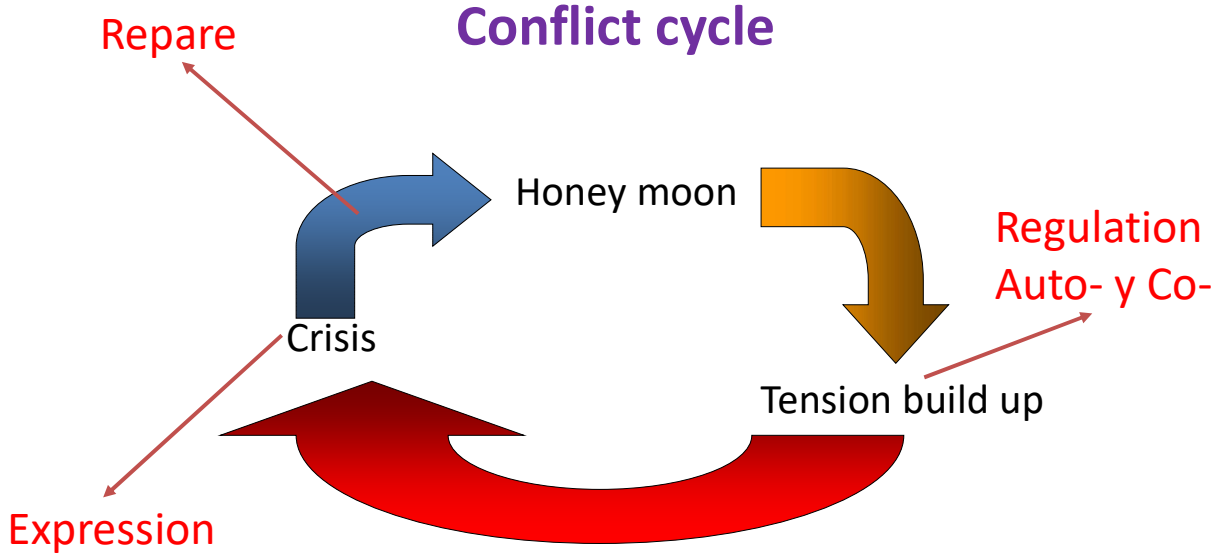
Conflict cycle



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Phase 2

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 2 + 1: History taking

- With all the previous work, we start with the **co-creation of life history**.
- Psychoeducation about attachment, trauma and BA Systems is helpful.
- Defense mechanisms and emotions will be re-activated. Emotions will evolve (anger, sadness,…).
- Gradually, childhood memories will appear. Before processing, these memories have to be partly integrated into life history. Normally this will overwhelm. Use:

DF - short/slow BS - tactile BS - Partial processing - Taxing BS - CIPOS

(De Jong 2010 - Knipe 2009)

- Widen the WT and help mentalize (Fonagy 1997/2007) enhancing reflective functioning (Bowlby 1988) allowing us to come closer to standard processing.

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Phase 3-6: Targets.

They are not "close to the surface", only appearing gradually as AS gets activated. We have to **work towards the emergence of targets:**

- Appear in reverse hierarchical order: least important will appear first.
- It will initially be difficult to get complete targets (due to overwhelming or disconnection) so we have to use partial processing: using two modalities and short BS to integrate and desensitize them (Shapiro 1995/2001; Gomez 2013).
- Frequently, only after working with present and minor targets, allowing to widen the window of tolerance, will the deeper rooted and more pathological situations emerge.
- Don't look only for attachment targets but also Social Ranking or other.

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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 CSA: connects to NC and shame.
- **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, targets frequently are related to more than one type of NC. We can **install different PC with same target**.
  - T rauma: 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**:
  - it's over / it's over and I am safe now / I learnt / I am free of guilt…
  - I am learning that everybody makes mistakes… / I am starting to think that everybody deserves to be loved / I am learning to be loved…
  - It is normal to feel guilty…

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Phase 3-6: Cognitions.

- Careful with PC that have to do with the strategy (unrealistic) and that have to be reversed in order to process or reach the wound.
- In early CSA perpetraded by AF, NC of guilt/shame can be very difficult to manage, being frequently a blocking point in therapy:
  - 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 (in early CSA). This creates very strong emotional parts that are felt as being the "true self": I am damaged, dirty, filthy, unworthy, etc.
- Psychoeducation to diferentiate what happened and what I am.
- During sessions, help distinghish past/present and remembering something intensely and re-living it.

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Phase 3-6: Emotions.

- Distinguish Basic emotions (panic, disgust, helplessness, sadness…) from Defense emotions (anger, guilt, shame + counter-shame (hate and aggressiveness)).
- Realize which emotions improve with the therapists presence (i.e., fear) and those that worsen (i.e., shame).
- 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 spontaneous resources appear, frequently 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, especially those difficult to assume (excitement, genital sensations, very negative feelings about the self, etc.) and should have been addressed during psychoeducation phases.
- Can also be absent or felt only in the head. In these cases (except when it's a strong headache) it's very useful to ask:
  - "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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"Know all the theories, master all the techniques, but as you touch a human soul be just another human soul."

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Thank you!
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