

WORKING WITH SELF-CARE PATTERNS: A STRUCTURED PROCEDURE FOR EMDR THERAPY

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ABSTRACT

Self-care is a concept developed by Gonzalez and Mosquera (Mosquera, 2004; González 2007; Mosquera & Gonzalez, 2011; Gonzalez & Mosquera, 2012) to describe the way in what an individual take care of her or himself in different areas of functioning. This article presents a structured procedure for working with self-care patterns as part of the preparation phase in EMDR therapy. Initially designed for working with complex trauma and dissociation, it can be used in different clinical diagnosis.

INTRODUCTION

The self-care procedure for EMDR therapy is inspired in the loving eyes procedure proposed by Knipe (2008). From the clinical experience of using this procedure (Gonzalez, Seijo & Mosquera, 2009; Gonzalez & Mosquera, 2012) the authors have designed a more elaborated protocol. This procedure is part of a set of interventions oriented to restore a healthy self-care pattern in patients which have distortions in this area.

Positive Self-care can be thought of as having three distinct elements: 1) an attitude or state of mind of valuing and loving the self – an attitude that motivates the individual to take good care of the self, 2) an absence of self-defeating actions and 3) specific actions that provide benefit, growth or value to the individual. Of these elements, the attitude of positive self-care seems intuitively to be primary – an attitude of positive self-care provides the motivation for the other two elements.

Early neglect and trauma severely disturb the ways in which people take care of themselves. Patients who grow up in a neglectful or abusive environment have not internalized a self-care pattern (Chu, 1998; Ryle, 2002).

Highly traumatized people did not learn self-care because as children, nobody taught them either the behaviors or attitudes of valuing and caring for themselves. In many cases, the adults who were supposed to take care of the child mistreated him or her or failed to provide adequate care. Many learned that “needing” was “bad”; needing was “selfish” and was not permitted. Through their caregivers’ poor modeling, others even learned how to “punish” themselves instead of learning how to care for themselves. Frequently they continue to look at themselves through their neglecting attachment figure’s eyes or the abuser’s eyes.

Focusing on improving self-care is a way of reorganizing the attachment system and a way to access and process memories related with attachment disruptions, that may be difficult to approach just searching for memories. A more detailed description of the work on self-care and other different interventions related with this concept can be consulted in the chapter “Introducing Healthy Patterns of Self-care” (Gonzalez, Mosquera, Knipe & Leeds, 2012. In *EMDR and Dissociation: The Progressive Approach*. Gonzalez & Mosquera, 2012)

THE SELF CARE PROCEDURE FOR EMDR THERAPY

PREPARING THE PROCEDURE

The self-care patterns scale and patient’s history is reviewed, avoiding to focus on any traumatic event. The goal is to cooperate with the patient and reframe the problem. We explain to the patient that how s/he feels is very different from what s/he does with her or his distress: the way s/he treats her or himself, how to talk to her or himself, if s/he asks or not for help when is feeling badly, and if s/he accepts this help when somebody is providing it. It is also important to know how the patient takes care of her or himself in general, explaining to her/him that when she/he does not ask for what she/he needs or does not adequately protect him/herself from what is hurting, sooner or later the harmful feelings will show.

Attachment and trauma history will be linked with the self-care scale (Gonzalez & Mosquera, 2012; Gonzalez &, Mosquera, Knipe & Leeds, 2012) in order to make the patient understand how most of the relevant issues in the scale are related with her/his problem and its intensity.

After this introduction, we try to help the patient how to understand “where s/he learned” her or his dysfunctional self-care patterns. We explain that frequently, people who do not take care adequately of themselves, do this as a reflection of how they have been taken care by others when they were children. If nobody realizes how we feel, we may learn to disconnect from our sensations, or we may not know how to deal with them. If when we felt bad, or showed a specific emotion, this was censured in any way, we may tend to reenact internally the same way all our life.

It is better to use specific examples from the patient's history, connecting them with her or his present self-care pattern. This way a **reframing of the patient's problem** is being constructed.

We will insist during all the procedure not to deepen on specific memories. The main goal is to set the basis for further processing of traumatic memories, but not to work with them *directly*. The patient may find this difficult to do, so in this case the therapist will explain that *"what happens is one issue, and who we are is a different one. Here we are working with the image of yourself, not with the bad things that happened to you"*. With this information we try to reinforce differentiation. In some cases we can consider allowing the patient to do some associations with traumatic content, but never a long associative chain. If we decide to do this, we will make sure to introduce information about differentiation and often go back to the target, which is the child eyes. The criteria for allowing some traumatic associations would be the clinician's judgment about how much trauma processing the patient can tolerate at that therapeutic stage.

When the patient has a high degree of idealization of her/his primary caregivers, we shall discharge them from responsibility about how they have taken care of their children. We can say that: "parent's do what they can and often they don't realize how their children feel because they are disconnected themselves from their own emotions, or when the child is feeling bad, they feel overwhelmed and bad, so the child becomes also overwhelmed or needs to worry about the adult, to maintain her/his caregiver present. In other cases parents have suffered events which are blocking them, and these elements may be triggered by their child's presence, reacting automatically. We are not judging them; we are only trying to understand how these issues may influence you, and trying to help you learn to do things in a different a more adaptive way for you, in order to break that *learned cycle*."

We can explain the process of safe attachment with the following example of a child and parent interaction (using the same sex gender as the patient):

Imagine a little girl who falls and gets hurt. Her knee is bleeding, so she goes running home. Her father looks at her affectionately (with a loving gaze, without remorse, with adequate care, worried but without agony) and says to her: "Poor girl, it hurts, doesn't it? (recognizing the child's suffering). Come here (holding her). I will clean your wound (with a nice gesture of care). Of course, it hurts! Let me put a Band-Aid on it. Come here and sit on my lap for a while (comforting her through physical contact until she calms down)". Soon the girl will get bored and will want to play. So if the father asks her if her knee still hurts, she will probably tell him "no" and will run out through the door to continue playing.

Now, think about another little girl in the same street, a little bit further down, who also hurt her knee in the same way. She ran home but her father said to her: "Stop crying or I will give you a reason to cry for! Or, in a subtler way, tells her: "What's wrong? Nothing happened, that's nothing, come on, stop crying". Or the father becomes anxious and distressed watching his daughter as she cries. So, now this second girl has two problems: Her knee still hurts, and she's behaving badly if she cries or doesn't seem to be authorized to feel bad. If she gets hurt again, further on, it is not probable that she will go home asking for help. This girl may blame herself each time she feels bad (give an example from the patient's reaction in front of her or his present problems) or may say to herself that nothing is wrong, as if her suffering is not important or rightful (give an example from the patient). This makes it easier for emotions that accumulate and the girl doesn't know how to deal with, so she may try to disconnect from them or become overwhelmed when she feels them. These patterns will easily stay with us until we become adults.

Based on the information gathered from the story and the self-care patterns scale, we search *where and when* the patient learned how to take care of her or himself in the way s/he does. The patient may talk about a specific event or a stage on her or his life. If s/he says "it was always that way" we will ask her or him for a representative example from her or his childhood, or to think on an image of her or himself as a child, asking how old this child is or feels.

Stage 1. Image

In the case the patient is talking about a memory, we ask her or him to focus on the image of her or himself, saying: We will work in overcoming all these situations, but now we are trying to understand how you see and treat yourself. This is what this exercise represents. So, please leave the memory aside and just focus on the child, on this child's image. You, as an adult, sitting here in the office with me, looking at the child you were.

Hold in your mind an image of that ... year old child, an image of that child who was living those situations. Just the way you see it.

If the patient cannot imagine any image, we shall ask her or him to think on any photograph of that period.

Step 2. Reaction in front of the image and degree of connection

We ask the patient: Sitting here as the adult you are now, can you just look at that child?

If the patient says “yes”, we ask her or him to describe how s/he sees the child. We are looking for indicators of **disconnection** (s/he cannot see the child, cannot do the exercise, sees a static photogram which doesn't provoke any emotion or sensation ...), which may be related with dissociation or an early dismissing attachment of **extreme connection or “emotional infection”** (looking at the child the patient becomes overwhelmed with the same emotion, or shows signals of avoidance) which may be related with dissociation or an early preoccupied attachment, a high mental autonomy in the child (the child acts in a way that surprises the patient as an adult: the child turns his back, hides, the adult says that the child doesn't want to talk to the adult or describes an emotional reaction from the child that the adult does not recognize like his own), which is indicative of dissociation. In every situation we should help the patient to overcome her or his difficulty:

- If **disconnection** is present, we will help the patient to contact the child saying: What can you see in this child, how do you think s/he could feel, from her or his point of view, what is happening inside this child... (changes in this case requires a patient and supportive attitude from the therapist)
- If there is **extreme connection**, we shall ask the patient: how could we help a child deal with her or his pain without feeling the same pain s/he feels?
- In front of a **high degree of mental autonomy**, specific negotiation processes for working with dissociative parts will be needed.

Step 3. Somatic sensation and emotion.

We ask the patient to look at the child's eyes, without judgment, and just notice her or his somatic sensation and emotion doing this. Even if the patient shows denial or can see the child without difficulties, we shall ask the patient to locate her or his sensation in his body while s/he is doing it. Somatic sensation is more reliable than the emotions, in many situations the adult has little awareness of her or his denial toward the child s/he was, but s/he can still identify some disturbing somatic sensation.

We shall evaluate the SUDs level from (0 to 10)

When there is a strong avoidance to perform the procedure, or to notice the somatic sensation, the therapist may ask: “What is positive about not looking at this child?” The client may answer something like: “If I don't look at him, I don't have to share those feelings” or “If I don't look at her or him, I don't have to see how terrible it was”. Whatever the client's answer is, the therapist may say: “Think about that” and apply bilateral stimulation.

In this last situation, we score the *level of avoidance in a scale from 0 to 10* where 0 would be “no avoidance” and 10 the maximum avoidance

Step 4: Processing

Any impairment for the adult patient is not being able to look at the eyes of the child s/he was with love and acceptance, will be processed with bilateral stimulation, similar to the standard protocol phase 4, targeting the somatic sensation.

If the patient starts to associate negative memories, we can follow the sequence for a while, trying to not to go into an extended associative chain. A prolonged associative process is not desirable, that's why we return to target from time to time. If the patient connects to a memory with a high SUDs, and the therapist considers that it is not adequate to work on it at that time of therapy, we will tell the patient: “this is a very important memory, and we will work on it when you are ready to do it, but now we are working **with the child you were**, not with **what happened to that child**” (here we are establishing a clear difference between “who I am” and “what happened to me”). If the process stays in the tolerance window, and the therapist considers it adequate, processing may follow until a positive or neutral association comes in. If there is any doubt, going back to the target is preferable: the child's eyes.

When we go back to the target, we ask the patient as an adult to look at the child again and tell us what s/he can see, “what is different now” (enhancing the change) and what he or she is realizing (enhancing insight and meaning). We ask the adult to notice the somatic sensation again (reinforcing contact is very relevant) and we continue using BLS until SUDs is 0. When we need to process an avoidance defense, frequently we will be able to access and process the disturbance later on, achieving a 0 SUDs level

Step 5. Installation

If the way that the adult looks at the child s/he was, is evolving toward an adaptive pattern (looking at her or his eyes with love, understanding, realizing how s/he felt) we ask the patient to notice her or his sensation looking the child in such a way, and when this is positive, we install it with BLS. If any disturbance emerges, we return to step 3 until it is complete, and then we will try to install again. This might take more than one session, this process should not be forced.

Step 6. Reinforcing

We ask the adult to try **to realize what that child needs**. In order to achieve this, we may ask if the child is old enough to understand and talk about these questions (asking a one year old child would not be appropriate, because s/he is too little to realize what s/he needs, but in traumatic environments children use to be asked things that are not proper of their chronological age). In any case, the therapist will help the patient as an adult to “realize” beyond what the child may see, to develop mindsight.

In order to do this, all the necessary adaptive information will be offered. For example, when the child states that she/he does not need anything, the therapist may say: “this child is used to pretending to be strong, to forget what s/he liked or needed, because the adults were always so preoccupied... But as an adult you can see that, it would be better as a child, not to have to worry about anything and just enjoy and let others take care of him... How could you explain all those things to this child?... That s/he has been concerned not to worry the adults for so long, but that s/he doesn't have to do the same with you, that s/he can allow her or himself to just be a child now...”

Even when the patient as an adult can only realize a small part of this information, focusing on that new understanding, we will do BLS to reinforce it.

Step 7. Enhancing capacity to take care in the adult.

We ask the patient as an adult to notice how capable s/he feels to take care of that child on a scale from 1 to 7, being 1 “I don't feel capable at all” and 7 “I feel absolutely capable of taking care of her or him”. If the score of 5 or above, we ask the patient to focus on that, and reinforce it with BLS.

If the score is lower than 5, we help the patient to identify an efficient caregiving role. If the patient knows any child who generates (in the patient) the impulse of caregiving, or who the patient likes to take care of, we would ask the patient for a detailed description of how s/he would do it, how s/he feels when s/he does that, what sensations or feelings come up, and what does s/he notice at a somatic level when s/he thinks about it. This caregiving role will be reinforced with BLS. If the patient is not a healthy caregiver of any child, we can resort to any caregiving role: of another adult, a pet, any little animal... and we will follow the same procedure.

After reinforcing the caregiving capacity, we will tell the patient that when she/he feels capacity to take care of others, to look at this child inside, and turn that capacity towards the child. After this we will ask the patient to measure his or her own capacity to take care of the child in a scale from 1 to 7, focusing on how much s/he feels s/he can do it, not depending on if s/he feels it lower or higher. For example, if the patient scores 2, we will ask him or her to focus in this capacity to take care of the child and we apply BLS. We can do some additional sets, to reinforce positive sensations or to process obstacles that might emerge.

Once the patient as an adult (with the necessary help from the therapist), can identify what the child needs, the adult will try to satisfy it in imagery. For example, if the child needs love, we ask the patient as an adult to imagine her or himself giving the child the love s/he needs, in the way that the adult considers more adequate. We reinforce this with BLS.

We do not have to try to achieve a level 7 for the caregiving capacity, we only try to achieve any improvement that is possible at that moment. Some patients may just say “I can learn to take better care of myself” and we will work with this phrase as a possible adaptive belief.

Step 8. Embodying the procedure

Since this procedure has so much to do with positive connection with oneself, connecting the patient with her or his body will be reinforced all along the procedure. If the process evolves to an adult being able to look at the eyes of the child s/he was, with love and unconditional acceptance; understanding her or his need and trying to have them met, we will reinforce the embodiment of this essential resource.

We ask the patient to locate it in the body: “Where do you notice this child inside you, in what part of your body do you feel him or her?” The patient may answer, for example: “on my chest”.

Then we ask the patient to look at her or his adult hands, these hands that are capable of giving care and to place her or his hands on the place of the patient’s body where s/he is noticing the inner child, making a caring gesture.

The therapist should make sure the gesture is really a caregiving gesture, and that the patient is not pressing or trying to rip the sensation from her or him; helping the patient to realize this is crucial in this procedure.

If sensations and gesture are positive, we perform BLS.

Maintaining the gesture and the sensation we introduce the information that both we and the patient understand is more adaptive: “Let the child notice that you are here, let the child realize that you understand how s/he felt, let the child notice how important s/he is for you...”

Step 9: Enhancing Realization

On many occasions along the procedure, the patient usually has interesting insights about her or himself, her or his problem and self-care. In this stage we take note of those insights, and also outline the adaptive information that the patient needs to reinforce.

We also stimulate reflective mental functions by asking things such as: “What did you realize by doing this exercise? What does this experience mean to you? Do you understand more things about yourself or what happened? Do you understand more about your problem or how to overcome it?” We can enhance any new realization with BLS.

Step 10: Closure

In patients with a relevant attachment disturbance, completing this procedure may take several sessions, and cannot be completed before proceeding to the trauma processing phase. Any change toward recovering a healthy self-care will be considered as positive, and this will be pointed out to the patient.

The therapist explains to the patient that s/he may experience changes days or weeks after, and that it is important to observe them without analysis, and to take mental notes about it. We should explain that as a result of this work, she/he may feel intense emotions, both positive and negative. S/he may also experience well-being and a positive change in feelings about the self. Memories from childhood may emerge, sometimes associated to a changing perspective. Sometimes behaviors indicating an inadequate self-care diminish; favoring an increase of the most functional ones. If the patient is aware of this information, we will diminish confusion and destabilization since the patient will be able to see this as transitory and know it will calm down later on. This allows patients to deal with possible disturbing sensations much better.

Finally it is important that we ask the patient not to evaluate the changes as good or bad, just to take notes of them and comment them in our next session. We explain that immediate changes are relevant but also those happening days or weeks after.

SPECIAL CIRCUMSTANCES

Difficulties that emerge when working with self-care patterns that are initially overwhelming, can turn into enriching achievements, through the modeling and psychoeducation from the therapist. For example if the patient loses self-control and the therapist stays present and calm, keeping a calm and warm tone of voice, approaching the patient as a capable adult and suggesting possible ways to regulate the child, the patient will embody this pattern in her or his neuro network, a new model of emotional regulation. The therapist may state “Children often take time to settle down, you know, adults must have patience, just by letting them know that we are there, supporting them, they will regulate on their own. Sometimes we must give them time, and simply be there”. BLS may be introduced while stating these expressions or not, it depends on the clinical judgment of the therapist (in some patients it may reinforce the way they assimilate the information; in others it may increase emotional activation).

There are two circumstances that must be taken into special consideration:

Sometimes **Structural Dissociation** is more noticeable than what expected, when working with self-care a hostile dissociative part may appear as a voice, thought or physical sensation, that is generated by the belief that the child does not deserve to be taken care of, that attention is dangerous and malicious or that there is a risk that the child may reveal a forbidden secret. These circumstances require additional negotiation with the internal system.

Another case is when patients have extreme difficulties to connect with their own weakness. His survival has depended on “being strong”. This procedure may be very disturbing for these patients and they may be exhausted during or after the session. In this case, the therapist will start again in the facility of self-caring resources. So to speak, we shall work with recent or present situations, where the patient is able to take care of himself in an adequate way, in several areas.

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