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INTRA-TP
INSTITUTO DE INVESTIGACIÓN Y TRATAMIENTO DEL TRAUMA Y LOS TRASTORNOS DE PERSONALIDAD

EMDR EUROPE

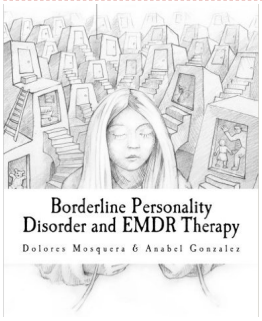
EMDR Therapy for Borderline Personality Disorder

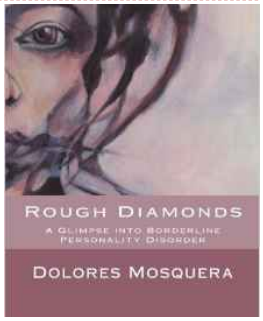
Dolores Mosquera

Confidentiality of Videos

- Case information and comments cannot be recorded.
- Videos cannot be video or audio recorded.
- Client information is confidential, and must not be discussed outside of this workshop or in any media, not even in professional forums.

Based on the books





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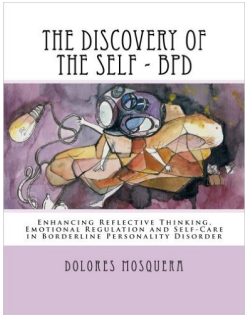

Types of BPD patients

- Boon & Draijer (1993, 2011) found several groups of BPD patients with a different dissociative symptom profile:
  - A BPD group with histories of emotional neglect reporting hardly any dissociative symptoms
  - A BPD group with comorbid C-PTSD or PTSD (these patients also reported histories emotional neglect, physical, sexual abuse or other trauma, and more dissociative symptoms
  - A BPD group with a comorbid DID or OSDD (reporting histories of emotional neglect, physical, sexual abuse etc, age of onset earlier than group 2 and more perpetrators) and dissociative disorder
  - A BPD group with a false positive dissociative disorder

Not just one type of BPD patients

- Zanarini (2000) examined 290 borderline patients.
  - Their average DES score was 21 (SD 18.6).
  - However, one third of the patients reported hardly any dissociative symptoms at all (DES< 10), one third had a score between 10 and 29, and one third had a high DES score (DES 35 or higher).
- Zanarini's study therefore shows that the severity of the dissociative symptoms in borderline patients is rather more heterogeneous than was previously supposed.
- Risk factors (predictors) for high scores on the DES in this study were: inconsistent care on the part of the primary caregiver, sexual abuse by primary caregiver, witnessing sexual violence in childhood, and rape as an adult.

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FECS Scale Study, 2013
Preliminary data in a BPD sample

Mosquera, Gonzalez, Baldomir, Eiriz, Bello, Soto & Fernández

Family in Childhood Experiences Scale

- 73,5 % reported that frequently **nobody noticed what was happening to them or how they were feeling**
- 73% felt very insecure during childhood.
- 72,3% reported **frequent shouting and arguments at home**.
- 71% reported that **laughter and fun was unusual or absent** at home.
- 66% reported that frequently there were so many things going on in their home, that they **tried to be invisible**. 25% felt invisible most of the time; 46,8% felt invisible frequently.
- 64,6% reported that most of the time **their concerns were not relevant to other people**.
- 59,2 % reported **hardly being praised when they did things right**.

Family in Childhood Experiences Scale

- 58,3% reported that their family frequently **made them feel ridiculous** when they expressed their thoughts or emotions.
- 50% reported that in their family there was **more concern about the adult's needs than theirs** (child's needs).
- 41,8% reported that the **person who took care of them** during childhood **was severely depressed or mentally disturbed**.
- 40,4% reported **hardly ever or never knowing what could be expected of others**.
- 32,6% learned to **take care of themselves since they were very young** (lack of support / role reversal...).

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Family in Childhood Experiences Scale

- **52%** of our sample refer some **type of amnesia between ages 5 and 15** (frequent in dissociation and complex traumatization).
- **Sexual abuse**: 54% (36% answered *yes*, 18% answered *not sure* but had clear memories of sexual abuse - they just were not sure whether or not that was abuse).
- **61% Overprotection**

Translating DSM criteria to clinical practice

Mosquera, 2010
Mosquera & Gonzalez, 2014

DSM criteria

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternation between extremes of idealization and devaluation.
3. Identity disturbance - markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging, e.g. spending, sex, substance abuse, reckless driving or binge-eating.
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood, e.g. intense episodic dysphoria, irritability or anxiety, which usually lasts for between a few hours and several days.
7. Chronic feelings of emptiness
8. Inappropriate, intense anger, or difficulty controlling anger, e.g. frequent displays of temper, constant anger or recurrent physical fights.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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1.Frantic efforts to avoid real or imagined abandonment

- An inconsistent and neglectful attachment figure generates a preoccupied insecure attachment.
- Expressed in an adult romantic relationship as: *"**Don´t leave me.**"*

Criterion 1. Frantic efforts to avoid abandonment. Where does it come from?

Abandonment or important losses in the first years of life	Lack of attunement	Parent emotionally and even physically absent
Lack of predictability	Variability in the rules	Not knowing what to expect
	Role reversal	

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

- In **insecure and disorganized** early attachment, *defensive action systems* are activated toward the primary caregiver in alternation with the *attachment system*.
- With adult attachment figures, "fight" alternates with "attachment cry".

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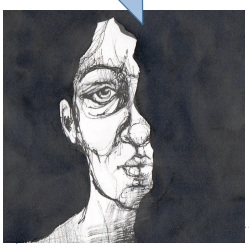
Criterion 2. Unstable and intense personal relationships. Where does it come from?

- Variability in the way of relating to the child and responding to his or her needs
- Variability in the way of perceiving the child (idealized, devalued) Invalidation
- Variability in the demonstration and expression of affect (I love you, I hate you)
- Internalization of toxic and volatile messages
- Lack of modeling / inconsistent models
- Conflict between attachment and defense system
- Caregivers with intense and conflicted relationships

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

"I don´t know who I am, what I think, what I feel"



- A low integrative capacity: In some cases, metacognitive functions are very low.
- With limited frontal lobe functions, tendency to "think from the amygdala".
- Difficulties to identify their needs: they learn to act according other's needs but seem demanding to others when triggered.
- As adults they tend to do what others expect.

Criterion 3. Identity and self-image alteration. Where does it come from?

- Variability in the way of relating to the child and responding to needs
- Variability in the way of perceiving the child (I accept you, I reject you) Invalidation
- Variable and extreme negligence
- Lack of attunement (attachment figure does not reflect / represent / respond to what the child is feeling)
- Being or having to be invisible because of the family situation
- •Lack of modeling and positive reinforcement
- •Internalization of contradictory parental messages
- •Difficulties in the process of differentiation
- •Role reversal
- •Overprotection

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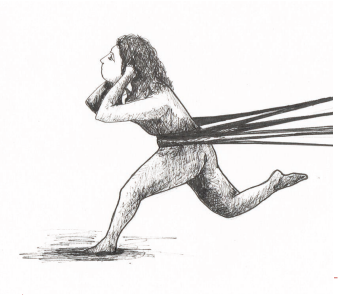
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

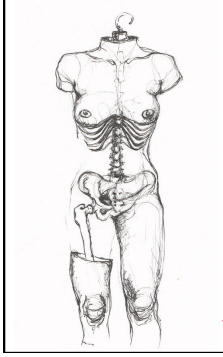


- Can be related to genetic factors.
- Or can be an activation of traumatic triggers.
- Or a way of avoiding trauma with substitute behaviors: trying "*not to think*."

Criterion 4. Impulsivity
Where does it come from?

Impulsive and / or aggressive models	•Parents are destructive towards them and/ or others	•Lack of attunemennt
•Lack of emotional regulation	•Reinforcement of impulsive responses (more attention)	•Lack of boundaries / invasion of boundaries
•Temperament / biology	•Severe trauma - dissociative parts	

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior



- Sometimes physical pain is "more bearable than emotional pain" (phobic avoidance of trauma).
- In dissociative cases, some parts can punish other parts, for example, if they consider these parts guilty for the abuse or see them as weak.
  - The punishing parts may also express as intrusive thoughts or voices (hostile or critical voices).

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Criterio 5. Self-harm and destructive behaviors. Where does it come from?

- Lack of emotional regulation
- •Neglect, lack of affection and/or interest
- •Abuse / punishment for expressing emotions or needs
- •Humiliation, teasing, invalidation
- •Witnessing others: Learning that it is a valid way to solve problems

6. Affective instability due to a marked reactivity of mood (intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

- "Black and white" thinking.
- Different dissociative parts with polarized perceptions, thoughts, emotions, and behavioral actions: *a coherent response to an incoherent and chaotic family of origin*
- Difficulties in maintaining their emotions within the window of tolerance (hyper-aroused or hypo-aroused) can be due to attachment figures who did not or could not regulate the child.

Criterion 6. Instability and high reactivity Where does it come from?

- Impulsive models
- •Ovewhelmed and dysregulated parents
- •Caregivers who only respond to emotions they can tolerate
- •Absence of attunement and modeling
- •Lack of emotional regulation
- •In some cases hereditary / biology
- •Physiological hyperactivation, characteristical PTSD reactivity

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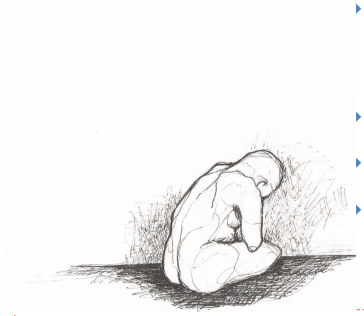
7. Chronic feelings of emptiness



- Experiences of emotional neglect, distancing or withdrawing from the caretaker.
- Persistently unmet attachment needs.
- Feeling invisible as children.
- Many clients report a feeling of emptiness that they "cannot fill with anything".

Criterion 7. Chronic feelings of emptiness
Where does it come from?

Extreme negligence	•Physical and / or emotional absence	•Lack of attunement / resonance
•Invisibility - nobody sees me or realizes what is wrong with me	•Basic needs not covered	•Lack of affection / rejection
	Activation of the dorsovagal in response to trauma	

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

- Anger outbursts from "fight" parts can be related to the reactivation of traumatic memories.
- The client can experience those reactions as "not me" (reflecting a certain absence of first-person perspective – front lobe offline.)
- This rage in the client sometimes resembles an early violent environment, that the client rejects and dissociates.

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Criterion 8. Inappropriate rage. Where does it come from?

- Models with impulsive and / or aggressive styles
- •Parents are violent towards them and / or others
- •Witness how violence is a way of solving problems
- •Lack of emotional regulation / reinforcement of explosions for attention
- •Emotional repression - which leads to explosions
- •Lack of complete emotional learning - difficulties in tolerating other emotions
- Overprotection

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

- Paranoidism or traumatic memories being activated by present triggers?
- Dissociative symptoms are usually under-detected or misunderstood as "attention seeking behaviors".
- Important: to do a systematic exploration of dissociative features: intrusive symptoms, amnesia, hallucinations…

Criterion 9. Transient paranoid ideation. Where does it come from?

- Distrustful models: "Others will hurt you," "You cannot trust anyone," "The world is dangerous"
- •Lack of emotional resonance, difficulties in interpreting what the child feels or does (or the reasons)
- •Activation of the warning / danger system as a consequence of adverse and traumatic experiences
- •Lack of safety, sudden and strange behaviors in caregivers
- •Bullying at school, teasing, humiliation, constant alertness

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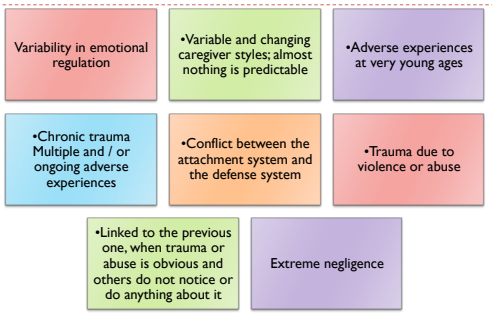
Criterion 9. Severe dissociative symptoms. Where does it come from?



- Video 1. Click

Why is BPD so difficult to treat?

Mosquera, 2011

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The problem of BPD is not the diagnosis … The "other DSM"

- Therapist's "informal" comments about Borderline Personality disorders tell us a lot more about the management of these cases than the classifications.

The real diagnosis …

THERAPIST BURNER
SELFISH
EXAGGERATED
MANIPULATOR
THEATRICAL
FADDISH
LIAR
IMMATURE
UNTREATABLE
IMPULSIVE
AGRESSIVE
INCONSISTENT
BRAT
PEEVISH
STORYTELLER
PUERILE
CHILDISH
ATTENTION SEEKING

We like patients who

- Come asking for our help
- Tell us their problem clearly
- Accept our help
- Do what we tell them to do
- Improve
- Recognize their improvement
- The family acknowledges the improvement
- Thank us for our work

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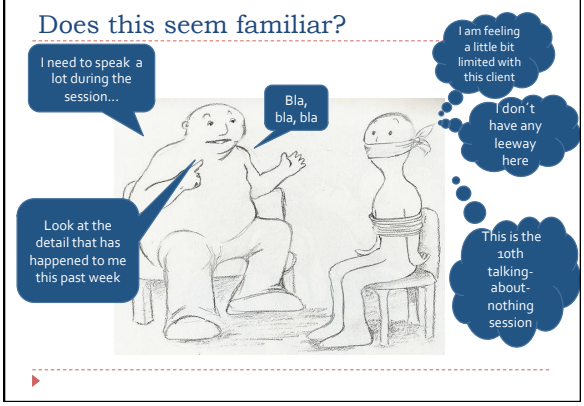
The problem with these attitudes is that they lead to…

- Judgments
- Generalizations
- Simplifications
- Lack of depth in the assessments
- Lack of interest in working with Personality Disorders
- Difficulties connecting with the patient and establishing an alliance
- Biased or out of date information, which usually leads a **lack of motivation in the patient:**
  - *"Why should I tell him how I feel if he already has made up his mind about me."*

The importance of trauma triggers & dissociation in the treatment of BPD

Does this seem familiar?



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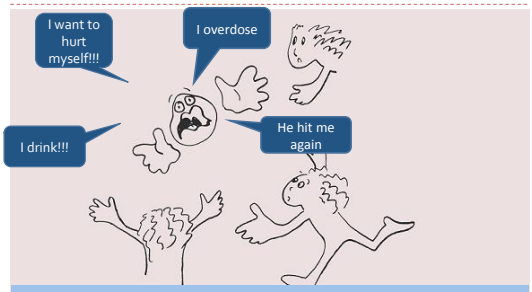
What could this mean? Possible translation

- I can´t approach trauma
- I can´t talk about feelings, I can´t contact them
- I can´t realize about trauma
- I am not prepared for trauma work, but I can´t say "no".
- I don't trust you (or part of me doesn't trust you)

How about this? Does it sound familiar?



From crisis to crisis..

What could this mean? Possible translation

- I can´t approach trauma so I focus on other problems.
- I´ve been living like this for so long that I don't know there are other options; new options seem scary
- As long as I have problems, others will see me: I felt invisible when I was a child, I needed to get attention with extreme behaviour.
- I am phobic of normal life.

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How to Adapt EMDR to BPD? Basic aspects to keep in mind

Basic aspects to keep in mind from the beginning of the work

- People with BPD are very sensitive and are easily overloaded by emotions (positive and negative ones).
- Adaptive Information is not available in many cases.
- Therefore, Psychoeducation (new adaptive information) will be needed all along the therapeutic process
  - About emotional regulation, defenses, boundaries, problem solving, needs and Self-care.

Basic aspects to keep in mind from the beginning of the work

- The foundations of stabilization and an adequate treatment plan is built on:
  - Establishing rapport
  - Developing a clinical assessment and case formulation
  - Understanding the client's current strengths and difficulties

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Basic aspects to keep in mind from the beginning of the work

There can be a great tendency on the part of clinician and client to move too rapidly toward uncovering traumatic material without first understanding:

- The client´s capacity to cope with day to day challenges.
- The client´s capacity to tolerate all range of emotions.
- The challenges of confronting traumatic material, including "realization".

Basic Aspects: Finding balance with the most challenging cases

In many cases it will not be a good idea to begin with the worst episodes or with trauma reprocessing.

First we have to build the client´s capacity to self-regulate, to say "stop" and to stay within their window of tolerance.

How do we know when it´s necessary to adapt or not?

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Adaptations are not always needed

- Although it is important to be careful in the more complex cases, it´s important to point out that in many BPD cases, we can proceed in a very Standard way.
  - We can gather a complete history.
  - We won´t need a long stabilization (Phase 2). In fact in some cases the best stabilization procedure we can use is the Standard Protocol.
  - We can begin reprocessing the earliest memories in an orderly way.
- Clinicians should not be confused by the chaotic presentation.
- Case conceptualization is crucial to differentiate when we can proceed in a Standard way or need adaptations.

In simple PTSD: Past, present, and future

- The current problem/s or symptom/s are identified as well as the trigger/s.
- We identify the memories connected to the current problem/s or symptom/s.
- Those memories are seen as dysfunctionally stored memories that are maintaining and feeding the current problem/s.
- Once the dysfunctional memories are reprocessed, we work on the present situation as well as on a projection for the future.

In Personality Disorders things get a bit more complicated:

- We also identify the current problem/s or symptom/s as well as the trigger/s.
- But trying to identify the memories connected to the current problem/s or symptom/s is not always easy.
  - We can get a "cascade a memories" that block the system like in many cases of BPD.
  - Responses that are defensive and do not seem as adequate targets for EMDR processing.
  - Or a lack of any type of response that can help us get an idea of where to begin to work.

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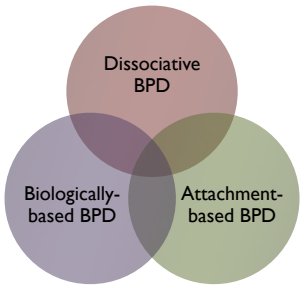
In Personality Disorders things get a bit more complicated:

- The Key in many cases is to remember that Dysfunctionally Stored Information goes beyond memories.
- In some cases, it´s complicated to access any trauma work in the earlier phases directly due to layers of defenses.
  - But we can identify other targets that can help us access the traumatic material. For example: Dysfunctional Positive Affect in cases of defensive idealization.

Case conceptualization Three Groups of BPD

Three groups of BPD
(Mosquera, Gonzalez & Van der Hart, 2011)



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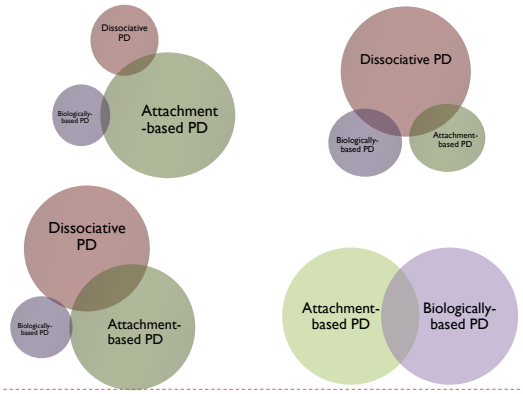
And it even gets more complicated since *combinations* of these 3 groups are possible …



How is this three group classification relevant for EMDR case conceptualization?

- Dissociative PD should be approached with procedures that are similar to the ones used with dissociative disorders.
- Attachment-based BPD need to be treated with certain adaptations of the standard protocol (based on Mosquera, Leeds & Gonzalez, 2014; Mosquera & Gonzalez, 2014).
  - The work with attachment issues can be more challenging than the work with some traumatic events.
  - The stabilization phase needs specific interventions (self-care, psychoeducation, emotional regulation skills…).
- Genetic and biological factors imply the need to use medication as a complementary treatment.

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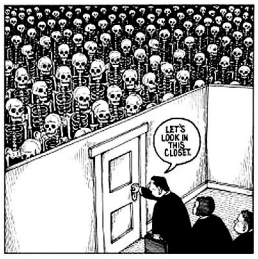
Phase 1. History taking

Mosquera, 2010

Frequent problems in Phase 1

- BPD is frequently related to complex traumatization. We must be careful not to "open too many doors".
  - As one client stated "*there are many skeletons locked away in closets and I don't even know how many of them are there or what is in them*"



Frequent problems in Phase 1

- In severely traumatized people, amnesia is frequent so it can be difficult to get a complete history

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Frequent problems in Phase 1

- Chaos
- Identity issues
  - Who am I?
  - What do I think?
  - What do I like?
  - What do I need?
- In severely traumatized people, trusting the therapist can be complicated.
- Defenses can interfere with the history taking
- Lack of realization can also interfere with the history taking

Other problems in Phase 1

- Some clients have difficulty identifying or accepting "targets". They do not recognize those experiences as disturbing or problematic.
  - The relationship between past experiences and present symptoms is not always evident for them.
- Therapists tend to focus on the list of the top ten traumatic events; overlooking foundational issues.
- Foundational issues – Called "contributory experiences" by Leeds (2009) - often involve early attachment experiences defended by minimization, idealization and/or structural dissociation.

Gathering information in Phase 1

- The foundations of stabilization and an adequate treatment plan are built on:
  - Establishing rapport.
  - Developing a clinical assessment and case formulation based on AIP, the presence of relevant dissociation and attachment classification(s).
  - Understanding the client's current strengths and difficulties.

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How to gather relevant information in the first sessions? Basic steps

- Important not to focus just on traumatic events,
- Identify skills; strong points.
- Allow the client to tell his or her story (as long as it can be tolerated and is helpful) without getting into too much detail (debriefing).
- Explore aspects related to phase 2.
  - For example can a calm or safe place be accessed and/or if it is possible to create it. At times it is a trigger and this is relevant information.
  - The capacity to stay present is also relevant.
  - Resources that are missing or that could be reinforced.

Gathering information in Phase 1

- There can be a great tendency on the part of clinician and client to move too rapidly toward identifying and/or uncovering traumatic material without first understanding:
  - The client's capacity to cope with day to day challenges.
  - Degree of dissociative symptoms, Dissociative Parts and Phobias.
  - The challenges of confronting traumatic material.
  - Defenses related to the different Personality Disorders.

How to gather relevant information in the first sessions? The therapist's attitude

- Caution and tactfulness
- Finding an equilibrium between proximity and maintaining an appropriate distance
- Do not act as investigator; instead offer "gradual" interest
- Act as "regulator" (help the client to go on if needed and slow down if he or she does not know how)
- Maintain clear boundaries and predictability
- Structure (we cannot function in a chaotic way when chaos is the norm)
- Follow a structured (but flexible) treatment plan

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Useful tools for History Taking

- DERS.
  - Difficulties in Emotion Regulation Scale (Gratz y Roemer).
- DES.
  - Dissociation Experiences Scale (Carlson & Putnam).
- Reasons for living Inventory
  - Exploring motives to stay alive (Linehan, Goodstein, Nielsen & Chiles).
- FECS / EARLY
  - Family Experiences in Childhood Scale (Gonzalez, Mosquera & Leeds).
- Self-care Scale
  - Different areas of self-care (Gonzalez, Mosquera, Leeds & Knipe).

Phase 2

Important: Avoid extending the stabilization work when not needed

- Some clinicians believe that we must work on psychoeducation and emotional regulation for years until clients end up in similar conditions as individuals with simple trauma, and then start with the trauma work phase.
- But some BPD clients who are severely deregulated and show serious risk behaviors tolerate working on traumatic memories with EMDR very well.
  - In some cases, we could even say that this is the most powerful stabilization maneuver we can perform.

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Keeping balance

- But we can also encounter the reverse situation.
  - Some clients become destabilized just by touching on early memories that are too painful.
- It could occur that even the exploration of targets to work on or the identification of the memory elements in phase 3 might make a client anxious or start a defensive response.
- This is not necessarily predictable based on the functional level of the individual, the presence of risk behaviors, or the degree of emotional regulation.
  - This is why case conceptualization is crucial.

What Indicators Help Us Decide when to Start Processing Memories?

- Much of the information we need will proceed from a good exploration in phase 1 and prior preparation work in phase 2.
- It is not only working with trauma that the person may find hard or unmanageable.
- For many clients, who may work smoothly on the memory of a terrible beating, it can be destabilizing to connect with their own vulnerability in working with self-care, because their core defensive identity is "I am strong" and looking into the eyes of the helpless child they once were implies an intolerable intensity.

What Indicators Help Us Decide when to Start Processing Memories?

- Other people may process a part of the memory associated with various emotions and feelings, but the idealization of early dysfunctional attachment figures comes up amidst the processing and blocks it: it is too soon to leave that defense, which would expose individuals to assume "they had no parents" and "nobody loved them."
- Knowledge of clients, their history, their defenses, and their peculiarities, are the fundamental criteria that guides decision-making processes.

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What Indicators Help Us Decide when to Start Processing Memories?

- A specific element that will define our work style is the presence of significant dissociation.
- Therefore, a thorough exploration of dissociative symptoms is essential, even more in BPD, given the high prevalence of these symptoms among some borderline clients.
- Amnesia of the past or memory gaps in the present, marked depersonalization experiences, frequent auditory hallucinations and egodystonic thoughts, a high degree of internal conflict, phobias toward certain parts of the personality, or intense phobia of mental actions can be some of the alarm signals.

Frequent defenses

Frequent defenses in BPD

Dichotomous thinking	Idealization-devaluation	Avoidance	Projective identification
"Selective" mood changes	Pleasing others	"Magical thinking" / Magical solutions	Denial
Minimization	Rationalization	Procrastination	Non-realization
	Dissociation		

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Defenses as resources

- It is important to reformulate defenses as resources.
- Many defenses like dissociation were the only resource available during trauma.
- Trauma resources are not the only ones available nor the most effective ones for daily life but BPD clients need to learn new resources to be able to let go of defenses.

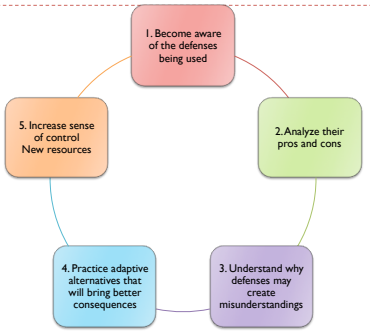
What was good about … then?

What is good about … now?

How was … helping then?

How is … helping now?

Defenses as resources



Defense mechanisms: Subtle defenses

- Sometimes defenses are subtle and more difficult to identify (judgments, rationalization, changing topics…)
  - But they are constantly interfering in the work we do.
- Let's see an example of this type of intervention.
  - Video

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Useful interventions for Personality Disorders in Phase 2

Useful interventions for PD Mosquera, 2015

- Developing reflective thinking / functioning
- Psychoeducation / Adaptive information
  - Emotions
  - Defenses
  - Boundaries
  - Self-harming behaviors
  - Self-care and emotional regulation
- Resource development / Skills
- Boundary work
- Differentiation
- Work with defenses
- Self-care work / Positive stance towards the self

Useful interventions for dissociative PD Mosquera, 2015

- Exploring the internal system
- Grounding
- Maintaining Dual attention
- Specific Psychoeducation about trauma responses
- Knowing that the danger is over (related to differentiation)
- Working with parts / aspects
  - Meeting place procedure
  - Playmobil
  - Maps, drawings
- Main goals:
  - Reducing the conflict
  - Promoting empathy, collaboration and compassion

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Target selection

Based on Mosquera, Leeds & Gonzalez (2013)
Mosquera & Gonzalez (2014)

Selecting Targets. Frequent difficulties

- In Borderline Personality Disorder selecting targets may be challenging for a variety of reasons.
  - There may be (too) many relevant targets: with many adverse life experiences, and many unique or recurring traumatic experiences.
  - In complex trauma cases, amnesia or fragmented memories may interfere with finding targets in the past.
  - When there are identified memories, defense mechanisms may not allow them to be addressed directly.
- Sometimes, defenses themselves need to be targeted and reprocessed until sufficient affect tolerance is developed.

Selecting targets. Frequent difficulties

- A relevant aspect to keep in mind is that sometimes we can work with certain traumatic targets, and not others.
- As the client achieves mastery in working with difficult situations, s/he will progressively feel prepared to proceed with the most difficult material.

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Criteria for choosing targets (Mosquera, Leeds & Gonzalez, 2014)

Although we must take into account each individual client's characteristics, in general these are perhaps the most interesting places to start:

- Intrusive memories and recurring thoughts and sensations
- Targets related to risk behaviors for themselves and others
- Targets related to the most debilitating or destabilizing symptoms.
- Current triggers
- Start with a past event.

Criteria for choosing targets (Mosquera, Leeds & Gonzalez, 2014)

Intrusive memories and recurring thoughts and sensations (with thoughts or feelings, we search for episodic memories connected with them in an obvious way or via the affect bridge).

Targets related to risk behaviors for themselves and others or to the most debilitating or destabilizing symptoms. If clients can tolerate working on early memories, it is interesting to go from the symptom to the target that is most closely connected with these symptoms. If we are able to work on early nuclear memories connected to current problematic behavior, the potential effect on improving clients' situations is very high.

Criteria for choosing targets (Mosquera, Leeds & Gonzalez, 2014)

Current triggers (if there are specific triggers that relate to the worsening of symptoms). We can select an uncomfortable situation of daily life, with the idea that if there is some change, clients will see the benefit in a direct and immediate way.

It may also be appropriate to **start with a past event**. We can choose a memory that is not associated with a long string of difficult experiences. For example, working on the memory of a car accident may be easier than a situation that is more related to attachment, and the effect of processing such memories is more "visible."

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Criteria for choosing targets (Mosquera, Leeds & Gonzalez, 2014)

- In working with memories that are part of a cluster, it is important to work with *limited processing* in the first few sessions.
  - Going back to target more frequently can be a good way to keep the reprocessing contained.
- This way, we prevent becoming overwhelmed and opening multiple targets, which may lead to re-traumatization and later wanting to avoid EMDR work all together, or even dropping out of therapy.
  - It is important that we facilitate, as much as possible, a good first experience with EMDR for the clients.

Experiments: "You can't do EMDR wrong"

- The central idea of all initial experiments is to introduce the processing of memories with EMDR as an **experiment with no possibility of error**.
- If the memory is processed, this is great, because we can improve things that are now most troublesome for the client. If the memory cannot be processed, this gives us essential information on how to structure the therapeutic work.
- It is not good for clients with frequent feelings of "I do everything wrong" to leave their first experience of EMDR with a confirmation of their core negative belief.

From symptom to target

- Some relevant targets might not come up during the history taking.
  - Every day experiences may not be deemed relevant for clients with attachment disturbances.
  - They may regard those experiences to be normal when compared to their more traumatic experiences.
  - Some of the current symptoms might be rooted in early every day experiences: "threads" (Mosquera, 2010).

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Phase 3

Phase 3

- Clients who grew up in abusive, neglectful or less than good-enough environments have internalized many of the messages they received
  - Openly or covertly through the caregiver´s behaviors.
- Clinicians should be attentive to "learned cognitions".
  - These are the cognitions that the person repeats because they have heard them over and over, and has internalized them.
  - Traumatized clients often continue to see themselves through the abuser´s eyes and can give us many negative cognitions.

Phase 3

- Important: everyday cognitions about the self are not necessarily the underlying cognition related to the specific target.
  - This can lead to a more chaotic work where many other targets open up.
- The more precise the elements of Phase 3, the more contained processing can be.

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Phase 3. Frequent difficulties in BPD

- Clients with BPD can easily give us 20 NC.
  - It is important that the NC is related to the target and not how they see themselves usually.
- During phase 3 the therapist should not push too hard to get a self-referencing positive cognition.
  - This can be a challenging task for many BPD clients.
  - Any small shift can be relevant.
    - For example: "I can learn to protect myself" is usually better accepted (and more realistic) than "I can protect myself".

Phases 4-7

General examples of situations we might encounter during Phases 4-7 with BPD

- Sometimes the therapist may need to take an active stance to guarantee that some emotions or aspects are included in the desensitization phase.
  - Borderline clients will need help with their intensity, some times they have learned that their emotions "frighten others".
- Interweaves such as "Allow yourself to feel ALL your feelings" or "Let it out. It's ok." might be needed.

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General examples of situations we might encounter during Phases 4-7 with BPD

- To notice and stay with anger might be complicated for some clients, some might feel they will explode without control, and even be afraid to hurt the therapist.
- It is important for the client to sense we can take whatever comes. Examples:
  - Intense abreactions in BPD.
  - Suicidal ideation, urge to hurt themselves.
  - Anger, feeling out of control BPD.

General examples of situations we might encounter during Phases 4-7 with BPD

- In phase 5, we should not always expect "good cognitions". In some cases, apparently negative cognitions are actually positive.
  - Example: "I am guilty" is more adaptive than "Others are responsible for my problems." (in situations where the client has responsibility.)
- Such examples of reprocessing may seem like "a reversal reprocessing" and it is important to understand, that what is coming up is actually **adaptive**.

General examples of situations we might encounter during Phases 4-7 with BPD

- Remember not to be too ambitious:
  - It is better to do a modest amount of good work and finish with an incomplete session in an optimal moment, than to push too much.
- And the reality is that some targets might only be reprocessed to completion after several sessions.

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Examples of situations we might encounter during trauma work

- Clients might
  - Try to "avoid crying", because the family system covertly disparaged it or because clients were punished or insulted if they cried.
  - Try to reprocess quickly to be a "good client" and please the therapist.
  - Say they can go on when they are overwhelmed
  - Resort to anger to avoid feeling painful emotions
  - Stay cognitive to avoid connecting to pain or sadness
- Our best resource as therapist will be attunement. This can be a very good learning experience for clients. It counters their experience and predictions and is a way to repair attachment.

But remember: the tolerance window is about the client, not the therapist

Phase 8 in BPD

- The revaluation phase is crucial for an adequate reprocessing of targets.
  - It is important not lose focus and to avoid "target hopping."
- The client might bring different issues to work on, but it is important to find a balance between acknowledging current concerns while maintaining a focus and keeping on track.

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Thank you for your attention and time!