DSM-5 Criteria for PTSD

All of the following criteria are required for the diagnosis of PTSD.

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

- Intrusive thoughts
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Two specifications:

- **Dissociative Specification.** In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
- **Depersonalization.** experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- **Derealization:** experience of unreality, distance, or distortion (e.g., "things are not real").

Delayed Specification. Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

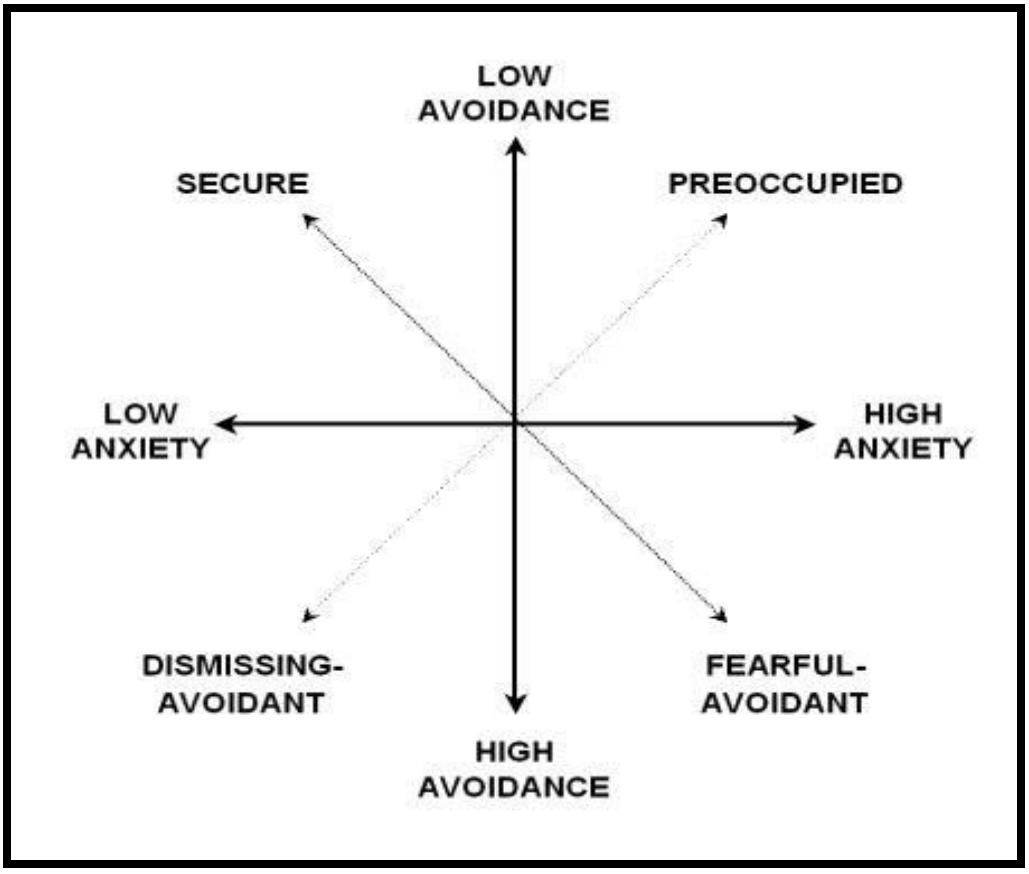
Additional features commonly experienced by sexual trauma survivors:

- Co-morbid diagnoses of depression, anxiety
- Dysregulation of emotion
- Somatization, sexual dysfunction, body dysmorphia
- Coping mechanisms aimed at controlling the echoes of trauma become destructive in and of themselves such as eating disorders, substance abuse
- Relationships with other people are colored by distrust and a sense of isolation and

estrangement.
- Sexual compulsivity or avoidance

Attachment Styles

Bartholomew and Horowitz



Secure

Securely attached people tend to agree with the following statements: "It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or others not accepting me." This style of attachment usually results from a history of warm and responsive interactions with their attachments. Securely attached people tend to have positive views of themselves and their attachments. They also tend to have positive views of their relationships. Often they report greater satisfaction and adjustment in their relationships than people with other attachment styles. Securely attached people feel comfortable both with intimacy and with independence. Many seek to balance intimacy and independence in their relationship.

Secure attachment and adaptive functioning are promoted by a caregiver who is emotionally available and appropriately responsive to his or her child's attachment behavior, as well as capable of regulating both his or her positive and negative emotions.

Insecure

Anxious–preoccupied

People with anxious-preoccupied attachment type tend to agree with the following

statements: "I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like", and "I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them." People with this style of attachment seek high levels of intimacy, approval, and responsiveness from their attachment figure. They sometimes value intimacy to such an extent that they become overly dependent on the attachment figure. Compared to securely attached people, people who are anxious or preoccupied with attachment tend to have less positive views about themselves. They may feel a sense of anxiousness that only recedes when in contact with the attachment figure. They often doubt their worth as a person and blame themselves for the attachment figure's lack of responsiveness. People who are anxious or preoccupied with attachment may exhibit high levels of emotional expressiveness, emotional dysregulation, worry, and impulsiveness in their relationships.

Dismissive–avoidant

People with a dismissive style of avoidant attachment tend to agree with these statements: "I am comfortable without close emotional relationships", "It is important to me to feel independent and self-sufficient", and "I prefer not to depend on others or have others depend on me." People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with attachments, whom they often view less positively than they view themselves. Investigators commonly note the defensive character of this attachment style. People with a dismissive–avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (e.g. their attachments).

Fearful–avoidant

People with losses or other trauma, such as sexual abuse in childhood and adolescence may often develop this type of attachment and tend to agree with the following statements: "I am somewhat uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others."

People with this attachment style have mixed feelings about close relationships. On the one hand, they desire to have emotionally close relationships. On the other hand, they tend to feel uncomfortable with emotional closeness. These mixed feelings are combined with sometimes unconscious, negative views about themselves and their attachments. They commonly view themselves as unworthy of responsiveness from their attachments, and they don't trust the intentions of their attachments. Similar to the dismissive–avoidant attachment style, people with a fearful–avoidant attachment style seek less intimacy from attachments and frequently suppress and deny their feelings. Because of this, they are much less comfortable expressing affection.

Attachment and Trauma

Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness.
--McFarlane and van der Kolk, (1996)

Traumatic Experience

Floods us with physical fear/helplessness

Colors the world as dangerous/unpredictable

Creates overwhelming emotional chaos

Threatens a coherent sense of self

Assaults self-efficacy and a sense of control

Scrambles the ability to engage fully in the present, and so to adapt to new situations

Secure Attachment

Soothes and comforts

Offers a safe haven

Promotes affect regulation/integration

Promotes personality integration

Promotes confidence/trust in self and others

Promotes openness to experience, risk taking, and new learning

--Susan Johnson, *Emotionally Focused Couple Therapy with Trauma Survivors*, p.37

Attachment Questionnaire

Siegel, Daniel J., & Hartzell, Mar. (2004). *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive.* (pp. 133 – 134). New York: Jeremy P. Tarcher/Penguin.

Name _____ Date _____

Please use additional paper to answer these questions so your responses will not be limited.

1. What was it like growing up? Who was in your family?

2. How did you get along with your parents early in your childhood? How did the relationship evolve throughout your youth and up until the present time?

3. How did your relationship with your mother and father differ and how were they similar? Are there ways in which you try to be like, or try not to be like, each of your parents?

4. Did you ever feel rejected or threatened by your parents? Were there other experiences you had that felt overwhelming or traumatizing in your life, during childhood or beyond? Do any of these experiences still feel very much alive? Do they continue to influence your life?

5. How did your parents discipline you as a child? What impact did they have on your childhood, and how do you feel it affects your role as a parent now?

6. Do you recall your earliest separations from your parents? What was it like? Did you ever have prolonged separations from your parents?

7. Did anyone significant in your life die during your childhood, or later in your life? What was that like for you at the time, and how does that loss affect you now?

8. How did your parents communicate with you when you were happy and excited? Did they join with you in your enthusiasm? When you were distressed or unhappy as a child, what would happen? Did your father and mother respond differently to you during these emotional times? How?

9. Was there anyone else besides your parents in your childhood who took care of you? What was that relationship like for you? What happened to these individuals? What is it like for you when you let others take care of your child now?

10. If you had difficult times during your childhood, where there positive relationships in or outside your home that you could depend on during those times? How do you feel those connections benefited you then, and how might they help you now?

11. How have your childhood experiences influenced your relationships with others as an adult? Do you find yourself trying not to behave in certain ways because of what happened to you as a child? Do you have patterns of behaviors that you'd like to alter but have difficulty changing?

12. What impact do you think your childhood has had on your adult life in general, including the ways in which you think of yourself and the ways you relate to your children? What would you like to change about the way you understand yourself and relate to others?

Preparation work and protocols for upcoming family events

Planning out participation in a family event:

Given where the client is in treatment, what does the client want to accomplish?

Choices to keep in mind:

Whether to go to the event
How long to stay
Who to interact with
Who not to interact with and how to handle this
How to take breaks if necessary
How to self-soothe in difficult moments
Remembering all the options and choices available to an adult

If it goes well, what would that look like? How would that be?
What is the worst that can happen?

Safe place, grounding, containment
Resource development and installation (RDI):

Take developed resources, enhance and install them. They may be necessary tools for coping prior to and during the event as well as useful interweaves for the processing of disturbing materials.

EMD:

Desensitize the face or other sensory experience of the challenging family member/perpetrator

Pendulation:

Switching back and forth between disturbing image and resource for the purpose of desensitizing and practice at state change.

Present triggers:

Use recent encounters with difficult family members, phone message, letters, email, or other communication within the family that trigger the client. Set up as an EMDR target and process. These targets may not go down to zero given that the earlier traumas are still active.

Future target of anticipated event: (Float forward)

When you think about going to the (wedding, Thanksgiving dinner, birthday party, etc.) what do you imagine is the worst thing that could happen? (Or what are some of the things that could really throw you off and would be hardest to recover from?)

IMAGE: Can you picture how that might go? (set up as clear a picture as possible)

NEGATIVE COGNITION: What belief about yourself goes with that picture?

POSITIVE COGNITION: And what belief about yourself would you rather have solidly in your head if this scene actually comes about?

VOC: How true does that belief (the positive cognition) seems to you right now as you put it with the picture of (the worst thing that could happen) on a scale of 1-7 if 1 is completely false and 7 is completely true?

EMOTIONS: What emotions do you feel when you think of the (target image) and hold it with the words (negative cognition)?

SUDS: On a scale of 0-10…

BODY SENSATIONS: Where do you feel it in your body?

DESENSITIZATION THROUGH BODY SCAN: Same as standard protocol. Yet, since there are still unprocessed traumas, expect to utilize interweaves to facilitate processing.

Future template:

A rehearsal of the anticipated visit with client handling each trouble spot in a calm and firm manner is what is optimal. Since this may not be possible given the unfinished trauma work, a future template that installs an image of successful self-management at the event is fine. This may involve the use of a resource.

Healing from Toxic Relationships:

Integrating EMDR with Family Systems Approaches

Nancy Knudsen, LMFT
Presenter

April 8, 2017

Learning Objectives

- Identify common stuck patterns that clients have with members of their family of origin in the here and now.
- Learn strategies for managing exposure to childhood abuse perpetrators/family members during EMDR trauma treatment.
- Learn ways to “cool down” overheated relationships or bridge cut off relationships
- Use EMDR for present triggers and future events to reinforce new approaches.

A Look at the Family Systems of Traumatized Clients

What characterizes them?

Complex trauma families

- Chronic trauma environment/lack of basic safety, little tolerance for individual needs
- Often disorganized or fearful avoidance attachment style
- One or both caregivers are source of threatening behavior
- One or more caregivers attempt to meet own emotional needs through the child
- Children have a strongly developed radar for caregiver's emotional states
- Multi-generational foundation

The legacy of complex trauma

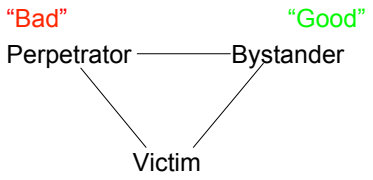
- **Self-blame: Negative view of self**
  ⬇
- **Other-blame: Negative view of other**
  ⬇
- **Beyond blame: Coherent narrative**

Goals for the client

- To feel like an adult around members of the family of origin in relation to each person.
- To have choice about being included.
- To be able to connect with an adult partner and form a healthy bond.

Ways the family system gets stuck

- Rigid triangle

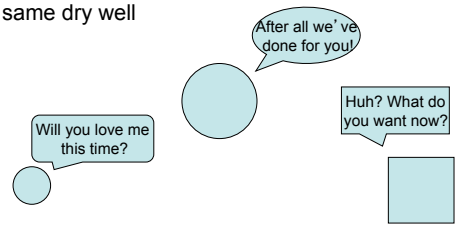


Ways the family system gets stuck

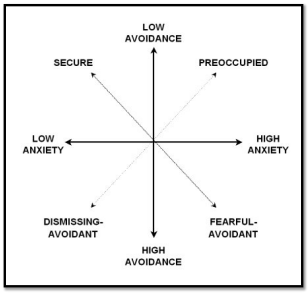
- Generalization of the entire family

Ways the family system gets stuck

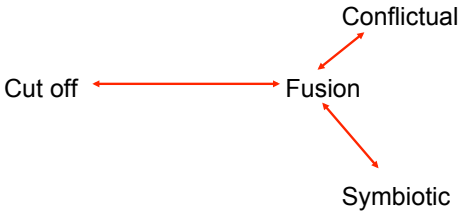
- Adult child still seeking unmet needs from the same dry well



Relational Patterns: Attachment Lens

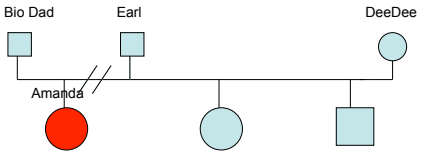


Relational Patterns: Bowen Lens

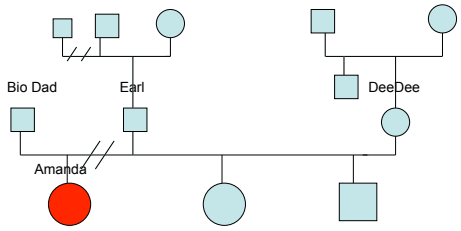


Tools for Assessment

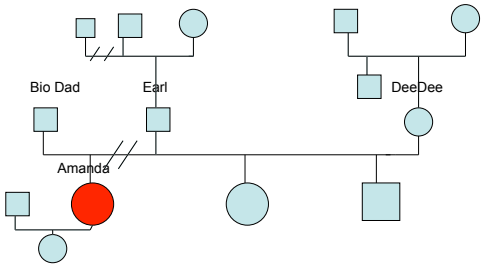
- Family diagrams or “Genograms”



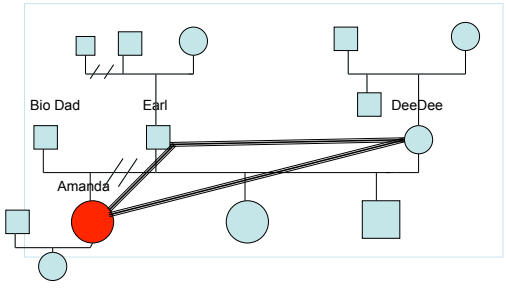
Three Generations



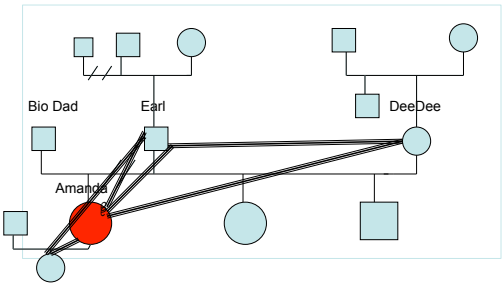
Four Generations



Triangles in this system



Triangle replication



Possible Time Line

- Age 5: Scary fight between parents
- Age 6: Father paying “special” attention
- Age 7: Grandmother’s death
- Ages 8-15 Mother’s not showing up
- Age 10: 1st “sex lesson” with father
- Age 10: Watching parents from door
- Ages 10-25 Sexual abuse memories

Thematic clusters

- Pre-abuse family atmosphere
  - Father, mother, self triangle (parent’s fight)
  - Waiting for mother (looking out the window)
  - Grandmother’s death
  - Mother yelling
  - Visit with bio-father
  - Being naked in the bathtub with father

Thematic clusters continued

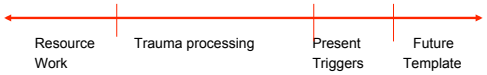
- Sexual abuse memories
  - First sex game at age 10
  - Watching parents from the door
  - Being touched by father in bedroom
  - Hearing him coming up the stairs
  - Dread of coming in the house

Disclosure attempts

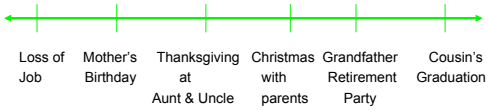
- First disclosure of abuse to mother
- DCF disclosure, retraction
- Threat to daughter and final disclosure

EMDR Time vs. Real Life Time

- EMDR Time



- Real Life Time



Between EMDR trauma processing sessions

- Observe shifts and changes in feelings and attitudes towards family members
- Permission to lay low (early on)
- Permission to “show up” (as progress is made)

What is the right amount of contact?

- Laying low vs. showing up
- How long is too long?
- Testing one’s strength in measured doses

Particular challenges in complex trauma family systems during EMDR trauma processing

- Managing exposure to perpetrators
- Divided loyalties: Dealing with doubters
- Disclosure issues
- Bridging long term cut off
- Cooling down overheated conflictual relationships

Incest and family system organization for adult survivors

Fusion  Cut off

- Level of contact with perpetrator(s)
- Level of contact with rest of family
- Spectrum of disclosure from not at all to full disclosure to family members

Family events in the middle of treatment

- Planning for optimal success and worst case scenarios
- Expecting predictable behavior in others
- Deciding to put trauma processing on hold
- Using EMDR for present triggers
- Using RDI
- Using “float forward” to run through the anticipated event

As trauma processing concludes…

- Coach clients to test their new found strengths in the presence of family members as EMDR treatment progresses.
- Help clients apply their new people skills in all their relationships. Couple therapy recommended!
- Use present day triggers as EMDR targets.
- Talk about coping with future upsets and use float forward protocol to rehearse.

Reading List

- Shapiro, Francine, Maxfield, Louise, and Kaslow, Frances, (Editors), (2007), Handbook of EMDR and Family System Processes, New York: John Wiley and Sons. Including "Integrating EMDR and Bowen Theory in Treating Chronic Relationship Dysfunction," by Nancy Knudsen.
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- Genogram Online Tools
- http://www.therapistaid.com/therapy-guide/genograms#genogram-how-to