Emotional detachment, somatization and alexithymia: Working with EMDR on the other side of emotional dysregulation

Anabel Gonzalez MD, PhD

www.anabelgonzalez.es anabelgonzalez@outlook.com

References:


Emotion dysregulation: What are we talking about?

- Good emotion-regulation capacities are considered by some EMDR authors as a prerequisite to proceed with stages of the trauma processing therapy, namely in complex trauma cases
- However, most of the concerns toward this matter affect patients with extreme emotional activation
- These patients usually feel overwhelmed by emotional contents and experience their emotions as very arousing and out of control

More than hyperarousal
Growing in early trauma: chronic hyper and hypo arousal
Alert
Danger detection
Hyper-reactive

Schimmenti & Caretti, 2016
- These two mechanisms likely represent the emotional precursors of compartmentalization and detachment responses, that is, the core domains of dissociative symptoms (Brown, 2006)

A simplistic perspective on emotion regulation: The tolerance window
Based on the concept of “optimal arousal zone” (Wilbarger), and Siegel (1999) defined an “emotional tolerance window”, there is an intermediate level of autonomic arousal in which various intensities of emotional and psychological elements can be processed without disrupting the functioning of the system.

It includes two different (and sometimes contradictory) dimensions: intensity of emotions (not too much, not too less) and acceptability of emotions.

**More dimensions of emotion regulation**
- Top down and bottom up emotion regulation
- Top-down regulation: Prefrontal areas in trauma-related disorders
- Top-down regulation is related to cognitive regulation, but also to unconscious, automatic regulation
- They are related to healthy modulation of affect, but also two different dysregulated styles
- It has been linked predominantly to some prefrontal areas

Lanius et al, 2010: neurobiology of PTSD and dissociative PTSD

Dysfunctional top-down regulation
- Under-regulation of affect
- Over-regulation of affect

A task for phase 2: Changing my internal self-talking

Complexity of Emotional Regulation: During reprocessing (categories are based on CERS; Pascual-Leone & Gillespie, 2009)

1. **Lack of emotional regulation**: “There isn’t anything I can do to feel better... I don’t know what I can do to feel better”

2. **General Intention to soothe**:
   - Passive coping
   - Denial
   - Venting/purging of emotion
   - Blaming external source
   - General statement of intention to seek information

3. **General distraction**: passive intent: Some behavior or action to interrupt, distract from, or avoid negative feelings is implemented:
   - Forced thinking about something unrelated to the situation or emotion
   - Leaving the situation: running away, avoiding conflict
   - Using entertainment as a distraction, impersonal activities
   - Attributing responsibility elsewhere
4. General **unrelated action**: Active attempt to regulate emotions and make oneself feel better using different activities, that are general, impersonal and do not upset the person.

5. **Specific meaning reflection**: Presence of some self-directed caring, tenderness, soothing or nurturing. There is:
   - Recognition/affirmation
   - Approval/acceptance
   - Affiliation/affection
   - Support
   - Nurturance
   - Autonomy
   - Inviolacy
   - Joy, beauty or playfulness in life

6. **Specific meaning transformation**:
   - Soothing or nurturance of child self by the adult self
   - Active self-coaching
   - Imagining nurturance/soothing
   - Imagining restorative scenes
   - Acknowledging existing resources
   - Sharing reflections
   - Religion
   - Healthy comparisons

Problems with complexity of emotional regulation:
- Presence of primary, less developed, regulatory systems
- Persistence of dysfunctional mechanisms as distraction or sensorimotor substitute actions after some time of processing: lack of fluency
- Appearance of dysfunctional regulatory mechanisms, incompatible with functional emotional processing

7. **Maladaptive emotion regulation**:
   - Intense **self-blame**
   - Clinging to dysfunctional beliefs and negative cognitions (cognitive fusion)
   - Unhealthy comparisons
   - Physical self-harming behavior or equivalent
   - Suicide ideation
   - Hateful meaning making
What is coming to your mind? The answer does matters in people with emotion dysregulation

- **Expression and analysis of one’s emotions** about unpleasant experiences have been associated with diverse physical and mental health benefits (e.g., Giese-Davis & Spiegel, 2002; Pennebaker, Mayne, & Francis, 1997; Stanton et al., 2000).

- **Ruminaiton** increases negative affect (e.g., Nolen-Hoeksema, 1991; Teasdale, 1988). Focusing on one’s negative feelings, and their causes and consequences, increases and prolongs negative affect (e.g., Nolen-Hoeksema, 2000; Rusting & Nolen-Hoeksema, 1998).

- Two different types of “why”

**Hot/cool systems model of self-regulation (Metcalf & Mischel, 1999)**

- Consistent with diverse findings and theorizing on self-regulation (Derryberry & Rothbart, 1997; Gross, 2001; Lieberman, Gaunt, Gilbert, & Trope, 2002; Posner & Rothbart, 2000; Trope & Liberman, 2003)

- In this model, stimuli can be mentally represented either in terms of their concrete, emotionally arousing, “hot” features or in terms of their abstract, informational, “cool” features. These two systems elicit different styles of reflexive processing
  - **Hot representations** elicit reflexive processing that is predominantly under stimulus control, leading to automatic approach and avoidance behaviors. Negative emotions are represented in abstract terms (“I am feeling bad”)
  - **Cool representations** enable cognitively driven, reflective processing that is more effortful and is instrumental in inhibiting automatic responses activated by hot representations. Negative emotions are represented in concrete terms (“I was angry with him because what he did to me that day”)

**Interruption of emotion regulation processes by dissociative responses:** “blown fuses”

- The emotion suddenly disappears (with or without distraction to other internal or external stimulus): disconnection
- Dorso-vagal parasympathetic activation: shutdown responses
- Change to a different (split) network: switching to another emotional part

These responses can be evident or covert: The patient pretends to be better, says that he is tired by an external reason, or experience a somatic symptom during the change to the emotional part, without awareness or disclosure about it

**Dissociation**

- More probable in complex trauma: Chefetz, 2015
- Development of the right brain, the hippocampus, the prefrontal cortex, the hypothalamic-pituitary axis, the noradrenergic system, and concentrations of corticotropin-releasing hormone, are sensitive to parental care.

- Such alterations may undermine the development of autobiographical narrative and may damage psychosomatic integration
• Significant alterations in the network of cortical and subcortical interactions that foster the development of self-awareness and the ability to organize mental and affective states are generated (Schimmenti, 2012)
• Tendency to disconnect or dysfunctionally distract from emotions may be increased in complex trauma patients
• Some therapist’s abilities to develop with disconnected patients

Dorso-vagal parasympathetical activation: shut-down responses
• Polivagal theory(Porges)

Auto and heterorregulation: emotional resonance
• Emotion regulation is interactive in human beings
• **Social engagement** system can be underdeveloped in traumatizing environments (lack of supportive figures)
• I need to be aware of my emotions and differentiate them from other’s emotions

When social engagement is not available as a regulatory resource:
• Sympathetic Autonomic Nervous System can be hyper-reactive in front of neutral stimuli
• Parasympathetical Dorso-Vagal reactions (shut-down responses) can be activated in front of not life-threatening situations
• The therapeutic relationship is not a source of security for the patient (Giovannozoli, 2016)

**Where do we learn our style of emotion regulation? The role of “meta” processes**
• Birth of the Agentive Self (Fonagy)
• Mentalization (Fonagy et al 2005)
• Capacity to envision mental states in self and others
• Operationalize as **reflective functioning**
• Represents a higher-order transformation of the attachment system
• Emerges in the context of the infant-caregiver relationship through early affect mirroring, and is essential to the development of intersubjectivity
• Infants become **independent subjects** only if they are recognized as such, as beings with minds, wills and feelings of their own
• It is a biofeedback model of affect mirroring as the mechanism through which infant affect regulation develops and attachment security (or lack thereof) is consolidated.
• Contingent marked mirroring of infant’s emotions enables the baby to modulate his own affect states
• Childhood trauma may inhibit the natural development of **mentalizing abilities** and the capacity to **think in terms of internal states**
• Schimmenti, 2017
• Childhood experiences of emotional neglect may foster difficulties mentalizing as well as problems with emotion regulation
• Individuals exposed to emotional neglect during their childhood may benefit from clinical interventions aimed to foster mentalized affectivity

**Mentalization and dissociation**

• Maltreated children may be constantly forced to dissociate in order to protect themselves from overwhelming relational experiences that cannot be mentalized (Liotti, 1999)
• In this case, dissociation may facilitate the reestablishment of regulation and adaptive functioning by compartmentalizing trauma-related memories, but at the cost of further inhibiting mentalization (Ensink et al., 2014, 2015)

**Alexithymia**

• It was described by Sifneos (1973) to describe a characteristic of patients with psychosomatic disorders
• The construct of alexithymia describes a difficulty identifying and describing feelings, externally oriented thinking, and a paucity of fantasies and dreams (Nemiah, Freyberger, & Sifneos, 1976; Taylor & Bagby, 2013; Taylor, Bagby, & Parker, 1997).
• The presence of increased levels of alexithymia is related to trauma exposure in the individual’s life (Bermond, Vorst, & Moormann, 2006; Güleç et al., 2013; Schimmenti et al., 2015a)
• Kyrstal (1988, 1997)
  • Alexithymia from bottom-up regulatory theories:
    Failure in the visceral feedback
  • Alexithymia from top-down regulatory theories: Schimmenti, 2017

**Somatization/somatoform dissociation**

1. **Dissociative parts. Emotional part and Apparently Normal Part: Defense and daily life**
• Parts can be evident or not: blurred patients
• Sometimes parts are not evident, and somatoform symptoms are the initial clinical presentation
• After some time of therapy working with these problems, parts appear in a clearer and direct form
• Conversion symptoms, somatoform dissociation is like a “fog” that protects the system to be exposed, and indirect communication should be understood
• With “blurred” patients we should understand indirect communication: Inner scan
• It’s always useful to check the existence of unknown elements
• We ask the patient to focus on his inside, and notice the more remote signal of anything (emotions, images, thoughts, and physical sensations…)
• The patient should focus inside for some minutes (do not accept quick answers)
• We should anticipate that all this communication is relevant and will be considered

2. **Somatic component of memories**
• Sensorimotor traumatic experiences not linked with other levels of experience block the system
• In some cases there are preverbal traumatic memories, that happened very early in life, when emotional an cognitive domains are still not developed

3. **Chronic hyperarousal (alert) in the nervous system**
• Sometimes the nervous system develops in this state
• High sympathetic activation is associated with somatic symptoms (HR, breathing, muscle tensión...)
• It triggers defensive reactions and dissociative mechanisms (characteristics of fear without solution)

4. **Lack of connection: Flat patients**
• Patients may talk about traumatic experiences without emotional resonance, or not be aware of which experiences were disturbing or problematic for them (because they are disconnected)

   **Unplugged patient Type I:** There was nobody giving meaning to my experience
   • There is no name for my emotions and sensations
   • I cannot identify when I am disturbed or the relationship among my sensations and environmental changes
   • I feel an undefined discomfort, without emotional differentiation
   • When sensations appear, it makes no sense to me
   The therapist’s work
   • Giving a name to emotions and sensations
   • Helping the patient to understand the meaning of the symptoms
   • Mindsight
   • Being present
   • Being very patient: it takes time

   **Unplugged patient Type II:** Underlying dissociative structure
   • Dissociative barriers of the parts are so strong, that I cannot feel anything
   • I think that external issues or internal experiences doesn’t affect me
   • I have no clues because I have no contact with the EP, that is who really feels and notice the disturbance
   • We can find the clues in Phase 1 (exploration consistent with disorganized attachment)

5. **Attachment disturbances influencing self development**

- Preverbal experience of safety
- Physical contact, caress in early ages is related to the basic sense of security
- Regulatory experiences should satisfy baby’s needs, not only calm them. Satisfying is supportive.
- People lacking of early satisfying experiences tend to develop self-calming procedures (Smadja, 1993; Schwecz, 1995). They are described as repetitive defensive movements, motor or proprioceptive-sensorial when there is traumatic experiences related to helplessness.

**Nurturance and Self-Care**

- Self care originates in the nurturing actions of others, which then are imitated and internalized as care-taking and nurturance towards the self.
- Nurturance affect has been identified by Panksepp (1998) as a core affect in mammals, and this affect seems to be activated through the early nurturance of others.
- Loving Eyes
- Caretakers of young children validate and consolidate the child’s experience as they observe that experience with “loving eyes” (Schore, 2000; Knipe, 2007)
- This nurturing connection is an essential element in the child’s learning of self-nurturing skills, basic trust in others and basic valuing of self.

**Self-care and early traumatization**

- 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)
- As children, nobody taught them either the behaviors or attitudes of valuing and caring for themselves
- The adult self (observer, reflective self) compassionately relating and accepting the experiencing self

6. **Dorsovagal reactions**

- They can appear as isolated symptoms (shut-down reactions) or as a more generalized tendency to underactivation
- During the processing it may need to specific interventions (more somatic than cognitive interweaves)

7. **Emotion dysregulation and somatic symptoms**

- Somatic sensations remain unprocessed or accumulate when there is not an adaptive regulation of emotions
- Relationship with the body and emotion regulation
- Disturbance does not activate caregiving gestures, but self-calming procedures in many patients
- The person presses the body area of disturbance, tries to get it out, do discharging movements, fight with it
- Sometimes this also happens at the cognitive level. The person is angry against himself, feels upset by feeling disturbance, and do not feel confident in his capacity to self-regulating

An intervention: Caring for the baby / caring for the sensation procedure
- Dysfunctional regulation strategies are identified and explained
- Disturbing sensations will be associated with a supportive and caregiving response
- We need an image which evokes a caregiving response
- We ask the patient to put his hand on the disturbing sensation, thinking that the sensation is a baby or a little animal of his choice
- A caregiving role is activated (use already existent caregiving capacities)
- The hand gesture should be kind, warm, trying to take care. If they patient press, try to get the sensation off, guidance from the therapist is needed
- The therapist models how doing the procedure, using a specific tone voice, introducing adaptive information...